

The background of the page is a photograph of the Kentucky State Capitol building, showing its iconic white dome and classical architectural details like columns and arches. The sky is blue with some light clouds. On the right side, there is a decorative graphic consisting of overlapping geometric shapes in shades of blue, yellow, and purple.

Kentucky Mobile Crisis Intervention Services Needs Assessment

April 2022

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Addiction Recovery Care (ARC)	Kentucky Voices for Health
Advocacy Action Network	Kentucky Youth Advocates
Aetna Better Health of Kentucky	Kentucky House Corporation
Anthem BlueCross BlueShield Kentucky Medicaid	Lexington Fire Department
Humana Healthy Horizons in Kentucky	Lifeskills, Inc.
Children’s Alliance – Kentucky	Mental Health America of Kentucky
Department of Corrections (DOC)	Mountain Comprehensive Care Center
Communicare, Inc.	New Vista
Comprehend, Inc.	NorthKey Community Care
Cumberland River Behavioral Health	Omni Family of Services (OFS)
Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID)	Operation UNITE
Department for Community Based Services (DCBS)	Passport Health Plan by Molina Healthcare Kentucky
Department for Medicaid Services (DMS)	Pathways Inc.
Four Rivers Behavioral Health	Pennyroyal Center
Frontier Health	Perry County Ambulatory Authority Inc.
Administrative Office of the Courts (AOC)	Ramey-Estep Homes, Inc.
Kentucky Association of Regional Programs, Inc. (KARP)	RiverValley Behavioral Health
Cabinet for Health and Family Services (CHFS)	Seven Counties (Centerstone Kentucky)
Department of Juvenile Justice (DJJ)	The Adanta Group
Kentucky Health Resource Alliance Inc.	UnitedHealthcare Community Plan of Kentucky
Kentucky River Community Care	University of Louisville Health - Peace Hospital
Kentucky State Police	Welcome House, Inc.
	WellCare of Kentucky
	WellFront RS, LLC.
	Wellspring Psychological Services

Executive Summary

Building Kentucky's model to improve delivery of mobile crisis intervention services across the Commonwealth



CHFS
KENTUCKY
Cabinet *for* Health and
Family Services



Executive Summary

Kentucky, as with many other states across the nation, is facing a behavioral health crisis that affects individuals, families, and many others within its communities.¹ To address this growing problem and strengthen behavioral health crisis services across the Commonwealth, the Kentucky Department for Medicaid Services (KDMS) was awarded a State Planning Grant for Qualifying Community-Based Mobile Crisis Intervention (MCI) Services by the Centers for Medicare & Medicaid Services



(CMS), which was created by the American Rescue Plan Act (ARPA) of 2021. This planning grant, awarded to KDMS in September 2021, supports development of community-based MCI services for Medicaid members who are experiencing a mental health or substance use disorder (SUD) crisis. In October 2021, KDMS partnered with Myers and Stauffer LC (Myers and Stauffer) to conduct a statewide needs assessment for community-based MCI services.

The purpose of the Kentucky MCI Services Needs Assessment (needs assessment) is to:

- Identify the current array of MCI services and related assets across the Commonwealth, including provider availability and capacity, Medicaid member utilization, service delivery, and financing mechanisms.
- Determine the unmet needs within the MCI continuum and service delivery in the community.
- Explore alternative response methods that shift responsibility for MCI service provision to qualified, multi-disciplinary teams able to intervene at the time and at the site of crisis.
- Inform the development of a three-year strategic plan to implement a coordinated, community-based MCI services model that improves access to high-quality, appropriate behavioral health care for vulnerable and underserved individuals in the Commonwealth.

Myers and Stauffer, in partnership with KDMS, used a mixed-method data collection approach that incorporated qualitative and quantitative data sources, including a comprehensive stakeholder engagement initiative to assess the current system of care and need for mobile crisis services in Kentucky. To inform the needs assessment, Myers and Stauffer analyzed over 100 national and state reports, policies, and best practices, and conducted 29 individual and small group interviews, five

¹ According to SAMHSA, the term behavioral health refers to the promotion of mental health, resilience, and wellbeing; the treatment of mental and SUDs; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities. For purposes of this needs assessment, the term behavioral health will refer to both mental health and SUD.

roundtable events, several workgroup sessions, and engaged with more than 50 organizations and 165 stakeholders representing the continuum of MCI services in the state.

The needs assessment considered both the successes of localities and national best practices in order to design and implement Kentucky's MCI services model that is enhanced and flexible to best meet the community needs across the Commonwealth. The needs assessment built on the conceptualization that three components of readiness must be considered when implementing new programs: 1) motivation; 2) general capacity; and 3) intervention specific capacity.²

Key Findings

MCI Service Policy Design and Communication Needs

- ***Ambiguous definitions of behavioral health and mobile crisis interventions services.*** Multiple definitions of MCI services currently exist within Kentucky policies and regulations. While these definitions are not entirely inconsistent, they are sufficiently ambiguous to generate confusion among providers and varying service delivery. In addition, stakeholders are seeking clarity and guidance regarding what specifically defines a behavioral health crisis, triggers Mobile Crisis Team (MCT) dispatch, and constitutes an MCI face-to-face encounter. For instance, three community mental health centers (CMHCs) reported walk-in crisis service to be an MCI service.
- ***Provider understanding of rendering practitioners and composition of the MCT varies.*** While CMHCs currently employ providers that are able to render MCI services within the state plan amendment (SPA), stakeholders do not have a common understanding as to what defines a multi-disciplinary team composition, which providers can bill for MCI services, and what billing practices are permissible.^{3,4}
- ***Limited provider awareness of MCI services.*** A review of Medicaid claims data showed that only four behavioral health service organization (BHSO) providers billed for MCI services during state fiscal years (SFY) 2019-2021. While many of these providers were largely unfamiliar with the MCI service delivery in Kentucky, they expressed interest in providing these services to individuals in crisis. Additionally, community advocates identified opportunities to educate providers such as pediatricians, private practicing behavioral health practitioners, primary care providers, urgent care centers, and others regarding MCI services and supports available to them should their client present in crisis. While CMHCs provide MCI services, the processes they apply to service delivery differ by organization. Stakeholders acknowledge the benefit of having clear and comprehensive process guidelines in addition to policy regulations.
- ***Provider awareness of MCI services and reimbursement-related concerns result in varying billing practices.*** Provider billing practices for MCI services vary significantly and many are not using mobile crisis-related billing codes. Based on MMIS paid claims information, it appears that not all CMHCs are billing for MCI services, and almost no BHSOs are billing for MCI

² Allison Dymnicki et al., "Willing, Able --> Ready: Basics and Policy Implications of Readiness as a Key Component for Scaling up Implementation of Evidence-Based Interventions," ASPE, 2014, <https://aspe.hhs.gov/reports/willing-able-ready-basics-policy-implications-readiness-key-component-scaling-implementation>.

³ "Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics," CCBHC Criteria (SAMHSA), accessed April 8, 2022, https://dgmaintest.ocweb-team.com/sites/default/files/programs_campaigns/ccbhc-criteria.pdf.

⁴ Four of the CMHCs also operate as CCBHCs, but for the analysis are considered and labelled as CMHCs only.

services. Further, Medicaid paid claims data indicates that there is relatively low utilization of and expenditures for MCI services. Stakeholders indicated that they do not bill Medicaid for MCI services for various reasons including:

- Cannot determine Medicaid eligibility status.
- Do not understand when the MCI code should be used, and so do not bill for MCI services.
- May be providing MCI services through contracts with hospitals (related to CMHCs), so these CMHCs also do not bill for services.

Several stakeholders expressed concern that community members, providers, schools, law enforcement and other first responders do not know about the MCI services available. This lack of knowledge could also contribute to reported low utilization of services.

Establish or Enhance Core Elements of Kentucky's MCI Service Delivery

- **CMHCs and CCBHCs continue to face challenges in the delivery of MCI services.** Staffing shortages, personal safety concerns, inconsistent access to transportation services for clients, limited funding, and large regional coverage areas challenge timely response and delivery of MCI services across Kentucky.⁵
- **MCI services are not consistently delivered to the person where they are experiencing a crisis.** Not all CMHCs respond to the individual experiencing a behavioral health crisis regardless of their location (e.g., in their home, in a parking lot, etc.). At least five CMHCs have internal policies limiting MCT response to designated safe places such as hospitals, schools, court house, jails, and other healthcare organizations. Other CMHCs rely only upon telehealth for MCI service delivery.
- **Transportation continues to be a major concern and an obstacle to short-term crisis stabilization for persons experiencing a behavioral health crisis.** Stakeholders reported emergency medical services (EMS) providers might be unwilling to transport behavioral health clients. CMHCs address transportation barriers through collaboration with natural supports (e.g., client's family, caregiver, friends, etc.), provision of public transit passes, gas reimbursement, and gift cards. One CMHC currently partners with UberHealth; however, this service is unavailable in the rural regions of Kentucky. Rural CMHCs stated they often rely on their law enforcement partners to transport a client after a crisis encounter.
- **Stabilization placement options are limited for children and youth.** Stakeholders reported difficulty locating short-term crisis stabilization and longer term hospitalization placements with the appropriate level of care for children and youth. As a result, CMHCs reported having to

⁵ Difference between Community Mental Health Centers (CMHCs) and Certified Community Behavioral Health Clinics (CCBHCs): CMHCs provide a comprehensive range of accessible, coordinated, direct or indirect mental health services through Kentucky's 14 regional MH/IDD boards. CCBHCs in Kentucky can be certified by the state under a 2 Year Demonstration facilitated by SAMHSA. Currently, four CMHCs received provisional certification from the state to operate as CCBHCs beginning January 2022 for the 2 Year Demonstration period. Note: SAMHSA has made available expansion grants to community behavioral health clinics or community-based behavioral health clinics, who are already or want to become certified as a CCBHC to apply directly to SAMHSA for grant dollars. Awardees must comply with federal oversight requirements.

resort to out-of-state placements or transporting the individual to other locations within Kentucky when beds for children and youth were unavailable in their region.

- **Minimal availability of short-term crisis stabilization facilities, 23 hours or less.** Twenty-three hour crisis stabilization units in Kentucky are limited to addiction stabilization with the recent exception of changes at one CMHC organization. Stakeholders reported that, in recent years, the 23-hour crisis stabilization units discontinued operation due to lack of available funding. Short-term stabilization is currently not included in the CMHC 2022 Children’s Crisis Services Array.⁶

Challenges to Rural Communities and Specialized Populations

- **Rural regions face unique challenges when providing an MCI response in the community.** The majority of the Commonwealth is considered rural which poses travel and broadband access challenges limiting the ability of the MCT to respond in person to an individual in crisis in a timely manner.
- **At-risk populations face barriers to receiving crisis services.** Stakeholders expressed concern regarding limited availability of crisis services and supports for youth, including justice-involved and those in foster care, the homeless and individuals facing housing instability, lesbian, gay, bi-sexual, transgender, queer (LGBTQ+), hearing and vision impaired, and individuals with intellectual and developmental disabilities (I/DD).
- **Diversity training to reduce equitable service delivery and reduce behavioral health stigma.** Current crisis intervention training for law enforcement and first responders does not include autism spectrum disorder or other neurodivergent and sensory disorders. CMHC stakeholders expressed a need to increase training and support for LGBTQ+ and cultural and linguistic minorities.

Opportunities to Enhance the MCI Service Delivery Infrastructure

- **MCI service data is fragmented, presenting an incomplete picture of member utilization, provider capacity, and reimbursement.** Medicaid billing data does not show the complete picture of MCI service utilization by members. This is due to providers possibly using other billing codes for MCI services. In addition, CMHCs provide crisis services funded via block grant funding, and/or CCBHC Substance Abuse and Mental Health Services Administration (SAMHSA) expansion grants that do not consistently collect detailed utilization information on MCI services.
- **Need to further explore the role of law enforcement and first responders to develop specific protocols for their involvement during delivery of MCI services by the MCT.** Although not Medicaid reimbursable, rural regions tend to rely on close partnerships with their local law enforcement agencies to help with intervention when the MCT is unable to respond in person. CMHCs using co-response, Crisis Intervention Teams (CITs), and Quick Response Teams, in addition to MCT have reported success in closing the crisis response gap.

⁶ Kentucky CMHC Annual Crisis Services Compilation Documents, SFY2022.

- ***Kentucky's current technology infrastructure is underutilized to support MCI services.*** The current MCI service-related system is fragmented and relies heavily on manual processes and/or siloed provider electronic health records (EHRs). Technology is a critical component of the MCI service system—specifically GPS-enabled mobile dispatch, real-time bed registry and coordination, centralized outpatient appointment scheduling, and performance dashboards—all of which are limited in use or non-existent in Kentucky.
- ***Use of telehealth for MCI services to address delivery barriers.*** The public health emergency (PHE) led to an increase in provider adoption of telehealth capabilities for delivery of MCI services. As a result, CMHC and CCBHCs realized the viability of telehealth as a solution to alleviate workforce shortages, significantly reduce MCT response times, reach individuals in remote locations, and provide services in potentially unsafe circumstances. At the same time, several provider stakeholders stated the use of telehealth to deliver MCI services will remain after the PHE is lifted due to the many benefits the technology provides. These benefits includes, providing an immediate response, outreach to individuals in remote areas, telecommute features allows provider organizations to hire staff from outside their region, increases personal safety for MCT members, and clients have reported a preference to meeting via telehealth rather than in-person. There are strong and differing opinions among stakeholders regarding future use of telehealth and their interpretation of what constitutes delivering MCI services in a “face-to-face” manner. Additionally, the Medicaid SPA and federal regulations are not clear regarding telehealth and the use of MCI services.
- ***Care coordination is a manual process.*** Care coordinators typically locate post-crisis placement (i.e., hospitalization, inpatient facilities, and stabilization) by calling a list of organizations or facilities until a bed is secured. Stakeholders reported this process could take longer than the crisis intervention.



Introduction

Building Kentucky's model of MCI service delivery across the Commonwealth



Introduction

It is estimated that one in every eight emergency department (ED) visits in the United States is related to behavioral health and/or SUDs, yet EDs are overburdened and ill equipped to provide quality care for individuals with behavioral health issues.⁷ In Kentucky, 50 percent of the 2.4 million ED visits reported a diagnosis of either mental health illness or SUD.⁸



The use of MCI services aids in the reduction of arrest among people experiencing a behavioral health crisis by allowing these individuals to receive immediate care from trained behavioral health professionals instead of law enforcement. Due to the strain that EDs face with overcrowding and staffing issues, MCI services are important in the efforts to reduce the number of ED visits by diverting individuals experiencing a behavioral health crisis to appropriate services or providing crisis stabilization services.

Increased demand for crisis-related supports in Kentucky has highlighted the need for greater access to MCI services. In 2020, there were 18,641 downstream interventions, including more than 5,000 law enforcement transports not related to an arrest. This is one indicator that upstream interventions have not adequately reduced the number of more serious law enforcement and court interventions. In addition, while there were more than \$14 million in overall crisis intervention services expenditures in 2019 and 2020 combined, only four percent of crisis intervention spending was on MCI services. Medicaid claims data for 2019 and 2020 from Kentucky Medicaid Management Information System shows very limited MCI service utilization.

Mobile crisis is a critical part of an integrated behavioral health crisis response services continuum. Community-based MCI services help stabilize individuals experiencing a behavioral health emergency by providing a short-term, direct response in a flexible environment. A successful MCI services model requires the provision of appropriate, accessible, and safe response to individuals in crisis. SAMHSA is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. They outline three requirements for a successful MCI services model within their best practices toolkit: 1) crisis lines accepting all calls and dispatching support based on the assessed need of the caller; 2) MCTs dispatched to wherever the need is in the

⁷ J. Priyana Vakkalanka, Ryan A. Neuhaus, Karisa K. Harland, Lance Clemson, Elaine Himadi, Sangil Lee, "Mobile Crisis Outreach and Emergency Department Utilization: A Propensity Score-matched Analysis," *West J Emerg Med*, 22(5) (2021):1086-1094.

⁸ Kentucky Hospital Association, "Kentucky's Growing Mental Health Crisis and the Effects of Hospital Emergency Departments," 2020, <https://www.kyha.com/assets/docs/DataDocs/KentuckysGrowingMentalHealthCrisisReport.pdf>.

community (not hospital EDs); and 3) crisis receiving and stabilization facilities that serve everyone that comes through their doors from all referral sources. All three of the requirements should be “for anyone, anywhere, and anytime.”⁹

Kentucky has demonstrated a significant investment in a system for receiving MCI services requests and linking individuals to a high-quality, recovery-oriented system of care. However, despite the number of programs and services, Kentucky’s continuum of crisis care delivery is fragmented across the Commonwealth. Data shows limited utilization of MCI services by Medicaid members which may be an indicator of a significant gap in service delivery.¹⁰

Project Objective and Goals

In September 2021, KDMS was awarded the State Planning Grant for Qualifying Community-Based MCI Services by CMS (herein referenced as the MCI services planning grant). The purpose of the MCI services planning grant is to examine the current array of crisis services and identify an alternative response model which shifts the responsibility for service provision more heavily to MCI services provided by well-trained, qualified multi-disciplinary teams that intervene on site in communities where the crisis occurs. The overall aim is to reduce law enforcement and first responder involvement and decrease unnecessary ED visits for individuals experiencing a behavioral health crisis. This will be accomplished by employing MCI services that will allow individuals experiencing a behavioral health crisis to receive the right care, at the right time, in the right place, diverting these individuals in crisis from EDs, jails, and prisons.

Through the MCI services planning grant, KDMS seeks to enhance and expand the current mobile crisis care infrastructure and develop qualified, multi-



MCI services should focus on reducing reliance on law enforcement, first responders, and EDs.

- Risk of being killed by law enforcement during response is 16 times higher for those with untreated serious mental illness (SMI).
- One in four fatal law enforcement encounters involves someone with SMI.
- In 2015, police shot 124 people experiencing a mental health crisis, which is 27 percent of all police shootings for that year. In 35 percent of those cases, officers were called to help get the individual medical treatment.
- Seventy percent of emergency physicians report hospital boarding of psychiatric patients despite patient safety issues and higher mortality rates.
- Patients with mental health emergencies wait an average of 11.5 hours in the ED—42 percent longer than other patients.

Fuller, D; Lamb, R MD; Biasotti, M; Snook, J. Overlooked and Undercounted. The Role of Mental Illness in Fatal Law Enforcement Encounters. Office of Research and Public Affairs. Treatment Advocacy Center.

Oberholtzer, E. Police, courts, jails, and prisons all fail disabled people. Prison Policy Initiative. August 23, 2017.

Psychiatric patients often wait nearly 12 hours in ER. MedicineNet. Practical Solutions to Boarding Psychiatric Patients in the Emergency Department. American College of Emergency Physicians. October 2015.

⁹ Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, *National Guidelines for Behavioral Health Crisis Care – Best Practices Toolkit*. Rockville MD: SAMHSA, 2020, [national-guidelines-for-behavioral-health-crisis-care-02242020.pdf \(samhsa.gov\)](https://www.samhsa.gov/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf) (accessed April 8, 2022).

¹⁰ SFY 2019-2021 Kentucky Medicaid Claims Data, Medicaid paid claims incurred and paid through DATE.

disciplinary teams that can provide crisis intervention services to Medicaid members in the communities in which they reside.

To achieve this objective, the following project goals are:

- **Goal 1:** Expand upon existing infrastructure to establish Kentucky's statewide MCI service delivery model.
- **Goal 2:** Standardize service delivery and set forth multi-disciplinary team requirements, including appropriate response approaches, such as trauma-informed care de-escalation strategies used with special populations.
- **Goal 3:** Establish a measurement framework to assess progress of MCI services planning grant efforts and guide policy and programmatic decision-making.

About the Needs Assessment

In October 2021, KDMS partnered with Myers and Stauffer to meet the requirements of the MCI services planning grant, including development of the needs assessment. The needs assessment will inform the design of a comprehensive, statewide MCI service model. This evaluation process will identify existing assets, examine current provider network, and determine system and service delivery gaps and opportunities. The assessment presents a set of recommendations and opportunities necessary to enhance and expand MCI service delivery infrastructure statewide.

Planning Grant Advisory Groups

The Kentucky MCI services planning grant advisory groups included:

- A project team of key personnel and decision makers.
- A core team comprised of KDMS, Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), 988 State Planning Team, CMHCs, CCBHCs, and additional subject matter experts.
- An executive governance committee comprised of the Commissioners from KDMS, DBHDID, Department for Aging and Independent Living (DAIL), and Department for Community-Based Services (DCBS).

These advisory groups were intentionally structured to include key partners from the Kentucky MCI services care continuum, as well as KDMS, DBHDID, DAIL, and DCBS. They support widespread community engagement and awareness, collaboration across a diverse group of stakeholders, post-planning, and strategic planning for the implementation of Kentucky's new MCI services model. Together, the advisory groups guide the overall strategy, development of the planning activities, and design post-planning implementation.

Throughout the work related to the Kentucky MCI services planning grant, the core team was strategically divided into three topic-focused workgroups: Service Design and Policy; Provider Capacity and Payment Models; and Technology, Data Sharing, Analytics, and Reporting. Members of the core team were assigned to a workgroup based on their experience and subject matter expertise. During

breakout sessions, participants worked in a collaborative manner to confirm current Kentucky processes, provided additional information where necessary, addressed outstanding questions, and participated in a dialogue that informed the recommendations in this report and will inform strategic planning moving forward.



Methodology

Examining all aspects of Kentucky's current MCI service delivery continuum

Methodology

The approach taken to develop the needs assessment applied a mixed methods research design to assess future and planned program capacity, and identify current and anticipated future MCI service delivery needs across the Commonwealth.

The methodology was founded on a set of key research questions developed by the project team and in conjunction with experts to identify and assess the many disparate assets of Kentucky's MCI service delivery landscape.



Figure 1. Key MCI Questions



What are the behavioral health needs of the population related to mobile crisis?



What barriers or challenges exist in delivering MCI services in the community, and how can they be mitigated?



What are the current MCI service utilization trends?



What are the current approaches for ED and detention/jail diversion?



How does the current system of MCI services operate in the Commonwealth?



What changes to Kentucky's current policy, regulations, and funding model may be necessary to advance MCI service delivery?



Where are the MCI service gaps and system assets?

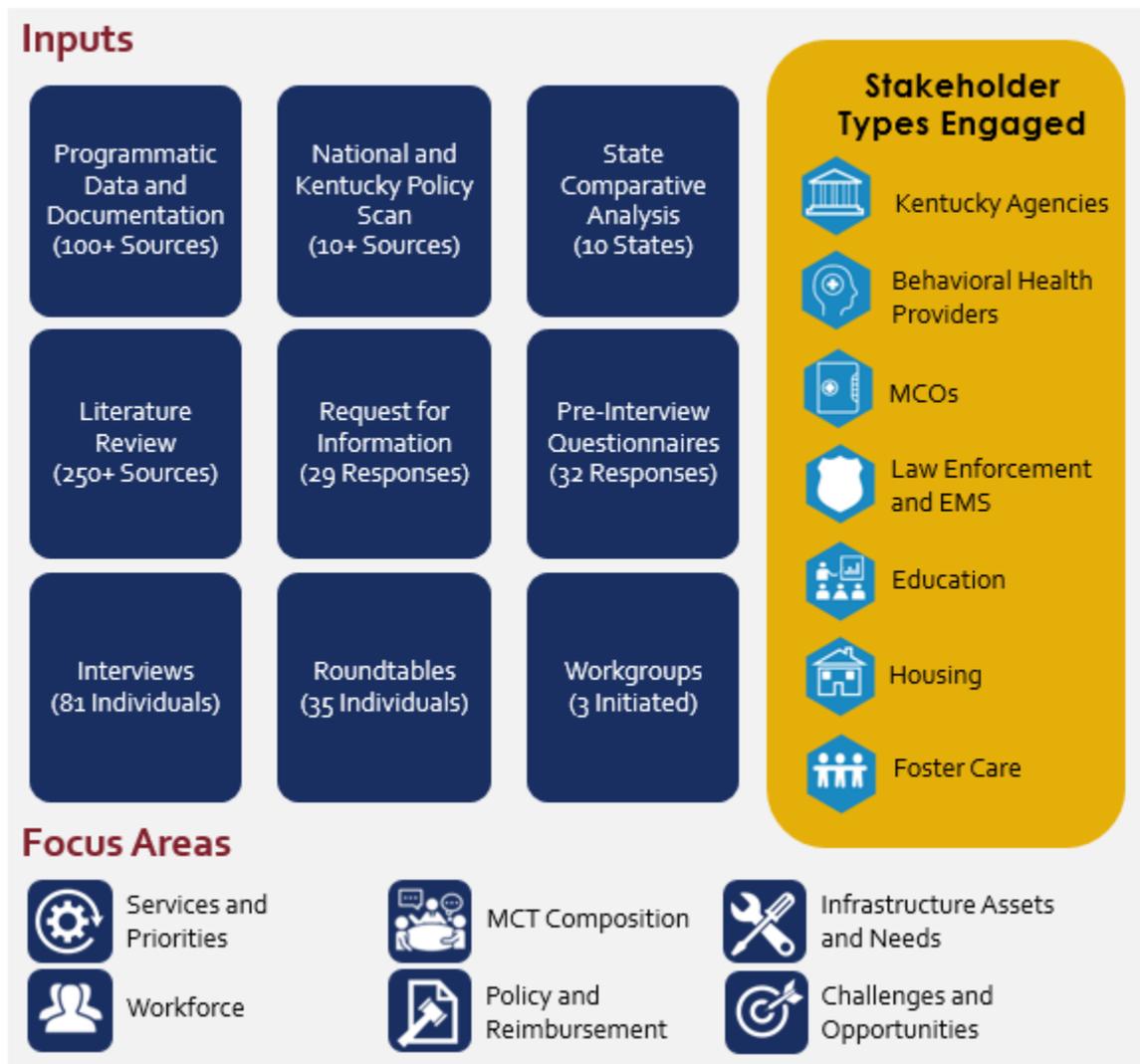


What are the concepts and recommendations to consider when developing Kentucky's statewide MCI services model?

The following outlines the research conducted and engagement performed to inform this needs assessment. Activities included review and analysis of relevant programmatic data, policies, available studies, scholarly articles, reports, and other materials, as well as the use of a multi-pronged stakeholder engagement initiative to collect relevant quantitative and qualitative data.

Figure 2 highlights the inputs used to develop this needs assessment, the key critical stakeholder types engaged, and the general focus areas reviewed. Data and information collected were synthesized in order to present a fact-based illustration of the current MCI service landscape across the Commonwealth, and are cited throughout the needs assessment. State-level stakeholders were engaged through an online information request, while both state and community-level stakeholders were engaged by way of key informant interviews, use of an online pre-interview questionnaire for CMHCs and BHSOs, roundtables events, and via workgroups and regular meetings.

Figure 2. Information Collection Summary



Research and Data Collection

Programmatic Data and Documentation

A thorough review of relevant past reports regarding Kentucky's MCI services delivery, behavioral health provider network, beneficiary utilization, workforce and training, and several related topics was conducted as a foundation for the needs assessment.

The information sources outlined in this section were analyzed to assess the core elements of the Commonwealth's MCI services continuum and program capacity, and determine key factors such as a baseline of behavioral health provider network and MCI service utilization, ED utilization for behavioral health, MCI service availability, and areas of highest need.

For a complete list, see *Appendix F: Data Sources*.

National and Kentucky Policy Scan

The project team evaluated the following Commonwealth policies to better understand Kentucky's requirements for the provision of MCI services, licensed behavioral health providers and Medicaid-rendering provider types, definitions of crisis and MCI, and Kentucky's policy requirement within the crisis continuum of care. Key policies reviewed were:

- Kentucky Telehealth Service Coverage and Reimbursement Amendment.
- Kentucky Initial Enhanced Home and Community-Based Services Spending Plan.
- 907 Kentucky Administrative Regulations (KAR) 1:045 Reimbursement Provisions for CMHC.
- CMHC Medicaid Services Manual.
- 907 KAR 1:044 Coverage Provisions and Requirements for CMHC.
- Kentucky Legislative CIT Training Curriculum.
- 907 KAR 15:015 Reimbursement Provisions and Requirements for behavioral health services provided by individual approved behavioral health practitioners, behavioral health provider groups, or behavioral health multi-specialty groups.
- 907 KAR 15:020 and 15:022 BHSO tier coverage provisions.
- Kentucky Medicaid SPA.
- Title XIX Social Securities Act Targeted Case Management Services.
- Title XIX Social Securities Act Medical Assistance Program.
- ARPA.

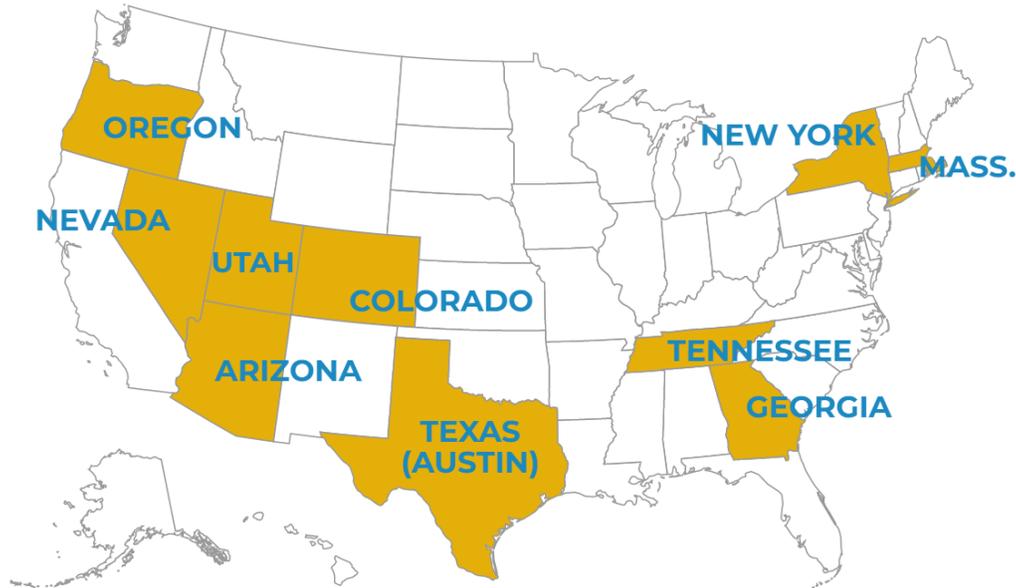
For a complete list, see *Appendix B: Information Sources*.

State Comparative Analysis

The project team reviewed the core elements of MCI-related state research and national guidelines. This information was used to create an MCI continuum standards-based template allowing for a state-

to-state comparison of behavioral health crisis services. The national literature identified a number of states demonstrating best practices in MCI services delivery and financing: Arizona, Colorado, Georgia, Massachusetts, Nevada, New York, Oregon, Tennessee, Texas, and Utah as seen in *Figure 3*.¹¹ These states were selected for analysis as aspects of their MCI services programs are cited as best practices by recognized national organizations and federal agencies.

Figure 3. Best Practice States



The states' behavioral health crisis services were analyzed based on the following eight components:

1. Crisis Call Center.
2. MCI Services, Tools, and Coordination.
3. Crisis Stabilization Services.
4. Emergent Intervention.
5. MCI Service Delivery Adequacy and Network Capacity.
6. Community Challenges, Partnerships, Outreach, and Engagement.
7. Technology, Data Access, and Exchange.
8. Financing, Program Administration/Oversight, and Sustainability.

Literature Review

A comprehensive review of national reports, scholarly documents, and other sources was conducted to gather information related to MCI service delivery core elements, guidelines for crisis care, system

¹¹ These states were selected by the project team, as they are most often cited as best practices by SAMHSA and other nationally recognized authorities.

adequacy in urban and rural communities, and other topics relevant to assessing Kentucky's MCI services delivery needs. For a complete list, see *Appendix B: Information Sources*.

Stakeholder Engagement

Topics and Methods

Using various methods to gather qualitative and quantitative data from Kentucky stakeholders allowed for multiple opportunities for input. Stakeholders targeted for participation were selected in collaboration with KDMS, DBHDID, DCBS, and DAIL leadership. These stakeholders represented Commonwealth and community interests.

Topics explored through the various stakeholder engagement activities include:

- Current understanding of MCI services in Kentucky including successes and challenges.
- Models, policies, and protocols related to the reduction of law enforcement, first responders, EDs, and/or correctional facilities.
- MCI services priorities.
- Availability of MCI and related services.
- Delivery methods of MCI services.
- Composition of the MCT.
- Usage of tools and technology for MCI services.
- Challenges and barriers in the current MCI service environment, such as Medicaid billing and reimbursement.
- MCI workforce and provider training.
- Populations served.
- Unique needs of individuals experiencing a behavioral health crisis, specifically adults, seniors, children and families, individuals with I/DD, and those experiencing homelessness.
- Barriers, challenges, and opportunities in providing MCI services.
- Recommendations for MCI services.

Methods of stakeholder engagement included the following:

Request for Information: An online tool to collect initial written information from stakeholders to inform engagement efforts.



Populations Addressed

- Kentucky agencies.
- Behavioral health providers.
- MCOs.
- Healthcare advocates.
- Law enforcement.
- First responders.
- Education.
- Housing.
- Foster care.
- Technology and information exchange.
- Adults and seniors.
- Children/youth.
- Individuals with I/DD.
- LGBTQ+.
- Racial and ethnic groups.
- Urban and rural populations.

Pre-Interview Questionnaire: A set of qualitative and quantitative questions distributed to CMHC interviewees prior to the interview to better facilitate the discussion.

Key Informant Interviews: Semi-structured, 30- to 90-minute discussions with individuals or small groups to collect qualitative information. Stakeholder interviews were guided by a script that included standardized questions asked of all stakeholders, as well as questions tailored to the stakeholders' designated category or type, and responses to the pre-interview questionnaire when relevant. This semi-structured approach allowed stakeholder perspectives and topics to emerge organically during the conversation. A companion PowerPoint presentation was used to provide basic information on the project including the current SPA definition of MCI services and the crisis continuum.

Round Table Events: Semi-structured 60- to 90-minute discussions with several individuals guided by a standardized set of talking points and probing questions tailored to specific topics. This semi-structured approach allowed stakeholder perspectives and topics to emerge organically during the conversation. A companion PowerPoint presentation was used to provide basic information regarding the MCI services planning grant, including Kentucky Medicaid's current SPA definition of MCI services and the crisis continuum. These events focused specifically on youth, adults, individuals with I/DD, persons with SUDs, non-billed BHSOs, and housing.

Workgroups: Sessions were held to address Kentucky's current MCI-related policy, process, and technology infrastructure in order to make decisions regarding development of the future MCI services model environment. For the needs assessment, the workgroups were utilized to confirm findings from the stakeholder engagement activities, data sources, and other informational sources. The three workgroups created were:

Key Interview and Roundtable Questions

- **MCT Composition.** What providers make up your typical MCT? How many team members are typically dispatched? What is the ideal team composition?
- **Service Delivery.** Would you please walk through the end-to-end scenario for providing MCI services? Please describe the process from 1) receiving crisis calls; 2) to dispatch; 3) to service delivery in person or remotely; 4) to resolution; and 5) any post-crisis follow-up.
- **Challenges and Barriers.** What barriers have you encountered in the care continuum when providing services to those who have experienced a mental health crisis or those seeking MCI services?
- **Transportation.** What are the current protocols or processes for non-emergent transportation when dealing with a behavioral health crisis in the field?
- **Coordination and Partnerships.** How do you coordinate with law enforcement, EMS, or other community partners such as housing?
- **Workforce and Training.** How does your organization address workforce retention, staffing, and recruitment issues? What trainings do MCI service providers receive?
- **Technology.** How do you use technology to support MCI service delivery regarding information sharing, identifying open beds, telehealth, EHR, information exchange, and coordination of services with providers?
- **Billing.** How is your organization billing or getting paid for delivering MCI services, and what reimbursement challenges exist?
- **Vision.** What improvements or changes do you or your organization envision for improved delivery of MCI services for children, youth, and their families or caregivers?

- Workgroup 1: Service Design and Policy.
- Workgroup 2: Provider Capacity and Payment Models.
- Workgroup 3: Technology, Data Sharing, Analytics, Reporting.

A fourth workgroup addressing long-term sustainability will be convened later in 2022.

Other stakeholder meetings: In addition to the stakeholder engagement methods outlined above, members of the project team attended regular meetings with other targeted stakeholder groups. These included regularly scheduled and ad-hoc meetings involving the advisory group, the 988 State Planning Team, crisis call center directors, and others to address key components of Kentucky's MCI services continuum.

- **Advisory Group:** The advisory group consisted of the project team, core team, and the executive committee. Key stakeholders were part of these groups, including but not limited to: KDMS, DBHDID, MCOs, CMHCs, and CCBHCs.
- **988 State Planning Team:** This team is responsible for the planning and implementation of the nationwide 988 number. Reports, findings, and insight from the 988 team was utilized for the MCI services planning grant. The MCI project team attended a regular weekly 988 coalition meeting. Many of the coalition member were engaged through the request for information, core team, workgroups, and ad-hoc requests.

Stakeholder Engagement Summary

More than 250 unique responses, representing more than 50 unique organizations throughout the Commonwealth, were received through all stakeholder engagement methods, as seen in *Table 1*.

Table 1. Stakeholder Engagement Summary

Stakeholder Engagement Method	Events Held	Unique Attendees/ Responses
Request for information	N/A	29
Pre-interview questionnaires – 13 CMHCs represented	N/A	32
All interviews	29	81
CMHC interviews	14	47
MCO interviews	6	15
Other interviews	9	19
Roundtables – 29 organizations represented	5	35

See *Appendix C: Stakeholder Statistics* for a detailed summary of specific stakeholders and organizations that participated by modes of engagement.

Information Analysis and Synthesis

All documents, reports, and stakeholder engagement methods including the request for information, pre-interview questionnaires, interviews, roundtables, workgroups, and other ad-hoc meetings with stakeholders were analyzed to develop key findings regarding Kentucky’s MCI services delivery continuum. *Figure 4* presents the steps taken to analyze information gathered from the various inputs and to inform the report.

Figure 4. Analysis Steps



Data Cataloging

All resources, documents, and literature collected were catalogued and organized into the following topic areas:

- **Crisis Call Center.** Use of crisis call centers to support delivery of MCI services including the use of technology and statistics related to calls.
- **MCI Services, Tools, and Coordination.** Utilization of MCI services throughout Kentucky and how services are delivered including the processes, policies, technologies, and tools.
- **Crisis Stabilization Services.** How crisis receiving and stabilization services are delivered and utilized throughout Kentucky.
- **Emergent Intervention.** Crisis services integration and related tools and capabilities. Approach to integrating crisis services and use of tools to meet MCI needs.
- **MCI Service Delivery Adequacy and Network Capacity.** Approach to expanding capacity and developing the state's workforce to meet MCI services needs.
- **Community Challenges, Partnerships, Outreach, and Engagement.** Community-based MCI services teams are maintaining relationships with relevant community partners.
- **Technology, Data Access, and Exchange.** Use of state, provider, and community information systems to improve interagency communication and secure, electronic data sharing to facilitate individuals' access to ongoing treatment and to prevent recurring crisis.
- **Financing, Program Administration, and Oversight.** Addresses administrative program details such as financing, reimbursement, state plan and waiver authorities, and return on investment.

Stakeholder Data Analysis and Synthesis

A complete analysis of the stakeholders' responses was conducted at an aggregate level and at the individual provider organization level. All stakeholder events were analyzed based on notes taken during the event and through transcripts. Additional information from the request for information and CMHC pre-interview questionnaire was also compiled for synthesis. Findings were compiled into an MCI services continuum summary, showcasing the MCI services delivery processes utilized by the CMHCs, CCBHCs, and other service providers. The MCI services continuum summary allowed for comparisons between individual providers to more easily identify differences in service delivery, policies, procedures, and technology. Four of the CMHCs also operate as CCBHCs, but for the analysis, they are considered and labelled as a CMHC only. The roles and responsibilities of the CMHCs and the CCBHCs are explained further in the *Kentucky CMHCs and CCBHCs* section of this report.

All analyses from the stakeholder activities were compared to research compiled from other states and federal guidance. Additional information collected from KDMS and partnering agencies supplemented stakeholder data when enhancements were needed.

The analysis provided an aggregate view of the MCI care continuum, as well as unique CMHC processes. General trends and specific findings from individual CMHCs and providers were analyzed by the main topic areas of services and priorities, MCT composition, infrastructure assets and needs, workforce, policy and reimbursement, and challenges and opportunities. Anecdotes, findings, and best practices,

as well as any general trends from the individual CMHCs and providers are described throughout the report. This analysis resulted in a comprehensive review of the current Kentucky MCI service environment, supplemented with information about best practices from other states.

CMHC Pre-Interview Questionnaire Considerations

Special considerations and analysis were completed for the CMHC pre-interview questionnaire. Both the qualitative and quantitative results were analyzed to confirm information obtained from other sources. Charts and tables were created for all critical quantitative questions to show differences between CMHC responses. **Only 13 of the 14 CMHCs provided responses.**

Of note, several CMHCs provided multiple responses from different individuals. These were reviewed for conflicting answers. One consolidated response was created for each CMHC to avoid skewing the results. The conflicting responses from a CMHC were merged into one consolidated response, but were also labelled. Conflicting responses rarely occurred, but when notable, they were identified in the charts and tables utilized throughout the report.

Limitations

Data Limitations. Analysis of data sources was limited to the data that was available at the time of the report writing. As discussed throughout the report, MCI service data is not always available, or if available, not complete. For data collected, there were many different data sources, and not all data was collected in the same manner, which limits the ability to draw direct comparisons. Some specific data limitations have been identified below.

- KDMS does not require physicians to list their specialty when they enroll, thus Medicaid cannot easily identify psychiatrists or advanced practice registered nurses (APRNs) with a psychiatric specialty.
- KDMS cannot currently track the volume of MCI services in the state for block grants and payers other than Medicaid, as access to other payer data is not easily or readily available.
- Data does not accurately reflect the number of MCI services provided during the study period. Many providers avoid using Medicaid MCI services billing codes today.
- Available reports provided the total number of Medicaid behavioral health enrolled providers, but not those enrolled in each MCO.
- SMI and serious emotional disturbance (SED) populations are not currently tracked by KDMS and DBHDID.
- One of the outcomes of the planning grant is to define better data collection processes for MCI services.

Stakeholder Engagement Limitations. A significant number of stakeholders were engaged to inform the needs assessment; however, gaps in information gathering still exist due to the limited number of responses received related to certain topic areas and/or information gather was based upon indirect knowledge or assumptions. Deductions were made based on information provided by KDMS, other stakeholders, and discovered by the project team through research and information gathering

activities. While every effort was taken to engage stakeholders, some individuals or organizations did not respond. Listed below are specific stakeholder limitations:

- Twenty-nine of the 50 stakeholders completed the request for information, which at the request of KDMS, was intended to replace interviews with government agencies and community stakeholders.
- Thirteen of the 14 CMHCs completed the pre-interview questionnaire.
- Multiple and sometimes conflicting responses were received from several CMHCs in the pre-interview questionnaire.
- Limited input was received from EMS and law enforcement stakeholders.
- KDMS determined the scope of stakeholder engagement should not include consumers and that standalone interviews with Commonwealth government stakeholders were not possible due to stakeholder availability issues.
- While participation in interviews and roundtable events was high, not all stakeholders targeted for participation were able to attend scheduled events.



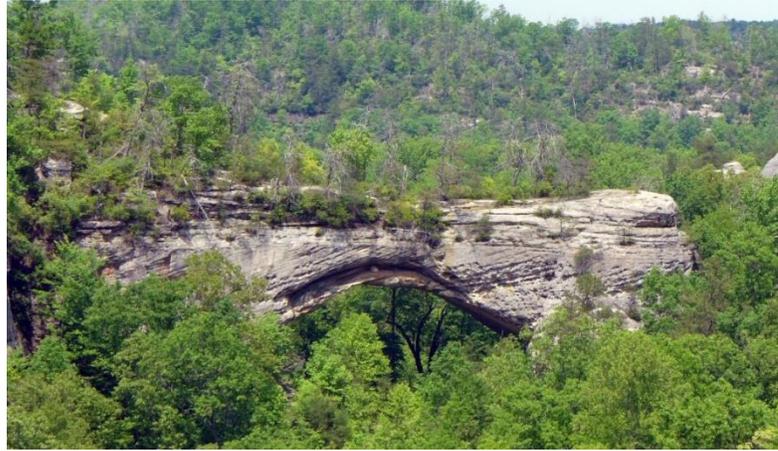
Behavioral Health in Kentucky

The prevalence of mental health and substance use disorder across the nation and throughout the Commonwealth

Behavioral Health in Kentucky

Status of Behavioral Health across the Nation

Behavioral health issues are common in the United States, and the COVID-19 pandemic and economic recession have created new stressors that continue to affect individuals, families, and caregivers across the nation.¹²



Behavioral health issues are on the rise. Reported unmet needs for suicidal ideation, drug overdose, youth with major depressive episode (MDE),¹³ and rates of substance use have increased annually.¹⁴

Age, race, ethnicity, and sexual orientation are each associated with higher rates of mental health issues. In 2020, young adults 18 to 25 years of age had the highest prevalence of any mental illness (AMI) at 30.6 percent, and prevalence of AMI was highest among those of two or more races.¹⁵ The persons that are LGBTQ+ are twice as likely as heterosexuals to experience a mental health condition or report experiencing persistent feelings of sadness or hopelessness.¹⁶

Mental health issues are more common in the justice-involved population. An estimated 44 percent of those in jail and 37 percent of those in state and federal prison have a diagnosed mental health condition,¹⁷ and 63 percent of those in jail and 58 percent in prison have an SUD.¹⁸ Seventy percent of youth in the juvenile justice system have at least one mental health condition.¹⁹

¹² According to SAMHSA, the term behavioral health refers to the promotion of mental health, resilience, and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities. For purposes of this needs assessment, the term behavioral health will refer to both mental health and SUD. <https://www.samhsa.gov/sites/default/files/samhsa-behavioral-health-integration.pdf>.

¹³ A major depressive episode is defined as a period of at least two weeks when a person experienced a depressed mood or lost of interest or pleasure in daily activities, and had a majority of specified symptoms such as problems with sleep or motivation.

¹⁴ Mental Health America, "The State of Mental Health in America 2022," Maddy Reinert, Theresa Nguyen, and Danielle Fritze, Alexandria, VA: 2021, <https://mhanational.org/sites/default/files/2022%20State%20of%20Mental%20Health%20in%20America.pdf>.

¹⁵ National Institute of Mental Health, Mental Health Information, Statistics, Mental Illness, last modified January 2022, <https://www.nimh.nih.gov/health/statistics/mental-illness>.

¹⁶ National Alliance on Mental Illness, "Your Journey: Identity and Cultural Dimensions, LGBTQI," accessed April 8, 2022, <https://nami.org/Your-Journey/Identity-and-Cultural-Dimensions/LGBTQI>.

¹⁷ Substance Abuse and Mental Health Services Administration, "About Criminal and Juvenile Justice," SAMHSA, last modified March 2, 2022, <https://www.samhsa.gov/criminal-juvenile-justice/about>.

¹⁸ Ibid.

¹⁹ National Alliance on Mental Illness, "Mental Health By the Numbers," NAMI, last modified February 2022, <https://www.nami.org/mhstats>.

Suicidal ideation among adults has increased annually since 2011.²⁰ In 2019, 4.6 percent of adults reported having serious thoughts of suicide. The largest annual increase in those reporting thoughts of suicide was 664,000, coinciding with the pandemic in 2020.²¹ In 2019, suicide was the 10th leading cause of death in the nation with more than 47,500 deaths by suicide occurring,²² and there were an estimated 1.4 million suicide attempts.²³ In 2019, adult veterans accounted for 13.7 percent of all suicides, and 38.6 percent of veteran suicide deaths were among those aged 55 to 74.²⁴ Rural communities have been experiencing an increase in suicide deaths, especially among youth ages 10 to 24.²⁵ Recent data show that during the COVID-19 pandemic, ED visits for suspected suicide attempts started rising among adolescents aged 12 to 17, and were 50.6 percent higher among girls in this age range than in 2019.²⁶

Substance use is associated with a substantial number of suicides and suicide attempts.²⁷ Among adults with mental illness, 18 percent



Behavioral Health across the Nation:

- In 2020, 21 percent, or one in five adults, experienced mental illness (52.9 million).
- One in 20 adults experience SMI annually.
- One in six youth aged six to 17 experience mental illness annually.
- In 2019, 11.4 million adults had serious suicidal thoughts.
- Forty-two percent of LGBTQ+ youth seriously considered attempting suicide.
- 15.5 percent of youth aged 12 to 17 and 8.4 percent of adults experienced a MDE.
- 7.7 percent of adults reported an SUD.
- Thirty percent annual increase in drug overdose deaths from 2019 to 2020.
- About 50 percent of Whites and 65 percent of Hispanic or African Americans with AMI (about 27 million adults) do not receive treatment.

Sources: National Institute of Mental Health; Mental Health in America, National Alliance on Mental Illness; The Trevor Project; CDC.

²⁰ Mental Health America, "The State of Mental Health in America 2022," Maddy Reinert, Theresa Nguyen, and Danielle Fritze, Alexandria VA. October 2021.

²¹ Ibid.

²² Centers for Disease Control and Prevention, "Leading Causes of Death and Injury," CDC, last modified February 10, 2022, <https://www.cdc.gov/injury/wisqars/LeadingCauses.html>.

²³ Substance Abuse and Mental Health Services Administration, "Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health" (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 2020, <https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFRRPDFWHTML/2019NSDUHFRR1PDFW090120.pdf>.

²⁴ US Department of Veteran Affairs, "2021 National Veteran Suicide Prevention Annual Report," <https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf>. Accessed April 9, 2022.

²⁵ The Trevor Project National Survey 2021. <https://www.thetrevorproject.org/survey-2021/?section=SuicideMentalHealth>.

²⁶ Ellen Yard et al. "Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12-25 Years Before and During Covid-19 Pandemic," *Morbidity and Mortality Weekly Report* 70, no. 24 (2021): 888-894, <https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7024e1-H.pdf>.

²⁷ Substance Abuse and Mental Health Services Administration, *Substance Use and Suicide: A Nexus Requiring a Public Health Approach*. In *Brief*, HHS Publication No. SMA-16-4935, Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services.

also have an SUD,²⁸ and half of individuals who experience an SUD in their lifetime will also experience a co-occurring mental health disorder.²⁹

Rates of substance use are increasing for both youth and adults. Substance use increased 0.07 percent for adults and 0.25 percent among youth between 2018 and 2019, prior to the pandemic.³⁰

Drug overdoses have surged to their highest levels. The U.S. is experiencing an epidemic of drug overdose deaths, with the national rate increasing by 137 percent since 2000, and an increase of 200 percent in opioid deaths over the same time period.³¹ Over 87,000 people across the country died from drug overdoses between 2019 and 2020.³²

Mental illness is associated with chronic physical conditions. People with SMI have an increased risk of chronic disease, such as hypertension, stroke, diabetes, or cancer, and a two-fold risk of cardio-metabolic disease.³³

Access to care and provider shortages are an ongoing issue. Among those with SMI, 48.7 percent of Hispanic or Latino individuals received mental health services in 2020, compared to 69.5 percent of Whites.³⁴ Fewer than one in three youth with severe depression receive consistent mental health care, and 60 percent of youth with severe, or major depression did not receive any mental health treatment.³⁵ At least 8.4 million Americans provide care to an adult with an emotional or mental illness, and caregivers spend an average of 32 hours per week providing unpaid care.³⁶ Even prior to the COVID-19 pandemic, the nation was facing severe healthcare provider shortages. As of September 2019, the U.S. needed an additional 6,166 practitioners in designated shortage areas.³⁷

EDs continue to serve as the conduit for mental health services. The lack of providers and increase in behavioral health crises has continued to drive ED utilization. EDs are often the source of care for individuals with behavioral health care needs, with National Alliance on Mental Illness (NAMI) reporting that one in eight of all ED visits nationally are related to mental disorders and SUDs.³⁸ Nationally, overall ED volume declined between 2019 and 2020, while the proportion attributable to mental health conditions increased.

Administration, Rockville, MD, 2016., [Substance Use and Suicide: A Nexus Requiring a Public Health Approach \(samhsa.gov\)](#) (Accessed April 9, 2022).

²⁸ National Alliance on Mental Illness, "Mental Health By the Numbers," NAMI, last modified February 2022, <https://www.nami.org/mhstats>.

²⁹ National Institute of Mental Health, "Substance Use and Co-Occurring Mental Disorders," NIH, last modified March 2021, <https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health>.

³⁰ Mental Health America, "The State of Mental Health in America 2022," Maddy Reinert, Theresa Nguyen, and Danielle Fritze, Alexandria, VA: 2021, <https://mhanational.org/sites/default/files/2022%20State%20of%20Mental%20Health%20in%20America.pdf>.

³¹ Rose A Rudd, "Increases in Drug and Opioid Overdose Deaths - United States, 2000–2014," Centers for Disease Control and Prevention (Centers for Disease Control and Prevention, January 1, 2016), <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm>.

³² Centers for Disease Control and Prevention, "National Center for Health Statistics," National Vital Statistics System, last reviewed July 2021, <https://www.cdc.gov/nchs/nvss/drug-overdose-deaths.htm#publications>.

³³ National Alliance on Mental Illness, "Mental Health by the Numbers," NAMI, last modified February 2022, <https://www.nami.org/mhstats>.

³⁴ National Institute of Mental Health, Mental Health Information, Statistics, Mental Illness, last modified January 2022, <https://www.nimh.nih.gov/health/statistics/mental-illness>.

³⁵ Mental Health America, "The State of Mental Health in America 2022," Maddy Reinert, Theresa Nguyen, and Danielle Fritze, Alexandria, VA: 2021, <https://mhanational.org/sites/default/files/2022%20State%20of%20Mental%20Health%20in%20America.pdf>.

³⁶ National Alliance on Mental Illness, "Mental Health by the Numbers," NAMI, last modified February 2022, <https://www.nami.org/mhstats>.

³⁷ Health Resources & Services Administration, "data.HRSA.gov," HRSA, Shortage Areas, data as of April 8, 2022, <https://data.hrsa.gov/topics/health-workforce/shortage-areas>.

³⁸ National Alliance on Mental Illness, "Mental Health by the Numbers," NAMI, last modified February 2022, <https://www.nami.org/mhstats>.

Substance abuse, anxiety, and mood disorders accounted for nearly 90 percent of mental health diagnoses during both periods. The COVID-19 pandemic was associated with higher levels of psychiatric distress, increased prevalence of SUD, relapse, and overdose, and an increased use of EMS for mental health conditions.³⁹ Recent data indicates the increase in ED utilization is higher among children and youth. In 2020, mental health-related ED utilization among child/youth aged 12 to 17 increased 31 percent compared to data gathered in 2019.

Despite poorer outcomes, spending on behavioral health has increased over time. There has been an increase of 52.1 percent in behavioral healthcare spending between 2009 and 2019, with Medicaid the largest payer, accounting for 30 percent of total spending, marking an increase of 74 percent in expenditures since 2009.⁴⁰

The system of behavioral healthcare services must include community-based and social service supports to address external factors that contribute to behavioral health issues. Social determinants of health (SDOH) are conditions in which people live, learn, work, and play that affect a wide range of health risks and outcomes, and addressing SDOH can lead to better mental health outcomes.⁴¹ While there are no causal relationships between behavioral health issues and SDOH, certain factors are known to be contributors, such as poverty, food insecurity, homelessness, and employment.

People living in high-poverty neighborhoods exhibit worse mental health outcomes compared to people living in low-poverty areas.⁴² Children with SED and adults with SMI living in these areas can experience significant mental health problems.⁴³ This relationship is complex. While poverty may intensify the experience of mental illness, poverty may also increase the onset of mental illness, and conversely, experiencing mental illness may increase the chances of living below the poverty line.⁴⁴

Recent survey data found that food insecurity is associated with a 247 percent higher risk of anxiety and a 253 percent higher risk of depression.⁴⁵ Food insecurity is associated with poorer mental health and specific psychosocial stressors across global regions, independent of an individual's socioeconomic status.⁴⁶

In the U.S., an estimated 20 to 25 percent of the homeless population suffered from a severe mental illness, and over half of adults living in permanent supportive housing either had a mental disorder or

³⁹ Stephanie Stroeve et al. "Emergency Dept. Utilization for MH Conditions Before and After COVID-19 Outbreak," *Am J Emerg Med* 47, (2021): 164-168, doi: 10.1016/j.ajem.2021.03.084.

⁴⁰ "The US Mental Health Market: \$225.1 Billion in Spending in 2019: Open Minds Market Intelligence Report," Open Minds, May 6, 2020, <https://openminds.com/intelligence-report/the-u-s-mental-health-market-225-1-billion-in-spending-in-2019-an-open-minds-market-intelligence-report/>.

⁴¹ "Social Determinants of Health: Know What Affects Health," Centers for Disease Control and Prevention, page last reviewed September 30, 2021, <https://www.cdc.gov/socialdeterminants/index.htm>.

⁴² Tama Leventhal and Jeanne Brooks-Gunn, "Moving to Opportunity: an Experimental Study of Neighborhood Effects on Mental Health," *Am J Public Health* 93, no. 9 (2003): 1576-82.

⁴³ Yange Xue et al "Neighborhood Residence and Mental Health Problems of 5- to 11-Year-Olds," *Arch Gen Psychiatry* 62, no. 5 (2005):554-563.

⁴⁴ Christopher G. Hudson, "Socioeconomic Status and Mental Illness: Tests of the Social Causation and Selection Hypotheses," *American J of Orthopsychiatry* 75, no. 1 (2005): 3-18.; Ujunwa Anakwenze and Daniyal Zuberi, "Mental Health and Poverty in the Inner City," *Health & Social Work* 38, no. 3 (2013):147-157.

⁴⁵ Di Fang, Michael R. Thomsen, and Rodolfo M. Nayga Jr, "The Association between Food Insecurity and Mental Health During the COVID-19 Pandemic," *BMC Public Health*. 21, no. 607 (2021).

⁴⁶ Andrew D. Jones, "Food Insecurity and Mental Health Status: A Global Analysis of 149 Countries," *American Journal of Preventive Medicine* 53, no 2, (2017): 264-273.

co-occurring mental disorder and SUD.⁴⁷ People experiencing homelessness are at a higher risk of overdose from illicit drug use, and those aged 65 and over who are homeless have a higher prevalence of unmet needs for substance use and mental disorder treatment compared to younger adults.⁴⁸

Rising rates of unemployment contribute to increasing behavioral and mental health issues, which leads to increased suffering and morbidity.⁴⁹ Those that are unemployed have higher rates of suicide,⁵⁰ and about one in six of those who are unemployed have an alcohol or drug addiction, a rate which is almost twice the rate for full time workers.⁵¹ Furthermore, populations with higher income inequality have a greater risk of depression, which is increased among women and lower-income populations.⁵²

The Kentucky Behavioral Health Landscape

About the Population

Kentucky is divided into 14 geographic regions for the purpose of planning and providing community behavioral health services. Together, the regional behavioral health boards serve 120 counties and 4.5 million citizens of which approximately one million are children. A large portion of the Commonwealth is rural, including a significant area of eastern Kentucky, which is in Appalachia.

According to 2020 census data, the current population estimate is 4,509,394, marking a 3.8 percent increase since 2010; however, rural areas experienced a decline.⁵³ Jefferson County has the highest population of 782,969 followed by Fayette County at a population of 322,570 as seen in *Figure 5*.

⁴⁷ U.S. Department of Housing and Urban Development, *Part 1: Point-in-Time Estimates of Homelessness: The 2016 Annual Homeless Assessment Report (AHAR) to Congress*, Meghan Henry et al., Office of Community Planning and Development, 2016, <https://www.huduser.gov/portal/sites/default/files/pdf/2016-AHAR-Part-1.pdf>. Accessed April 10, 2022.

⁴⁸ "Useful Resources on Opioid Overdose Prevention," Substance Abuse and Mental Health Services Administration, last modified February 13, 2020, <https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/useful-resources-opioid-overdose-prevention>.

⁴⁹ Karsten I. Pauland Klaus Moser, "Unemployment Impairs Mental Health: Meta-analyses," *Journal of Vocational Behavior* 74, no. 3 (2009): 264–282; Anne Case and Angus Deaton, *Deaths of Despair and the Future of Capitalism* (Princeton: Princeton University Press, 2020).

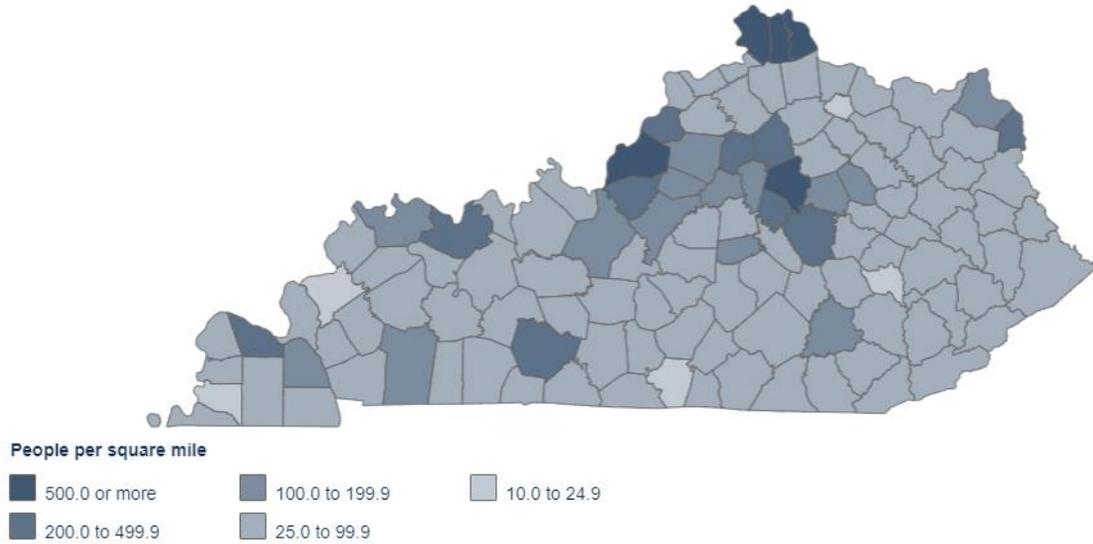
⁵⁰ T. A. Blakely, S. C. D. Collings, and J. Atkinson, "Unemployment and Suicide. Evidence for a Causal Association?" *Journal of Epidemiology and Community Health* 57, (2003): 594–600.

⁵¹ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, *National Survey on Drug Use and Health 2019, 2021*, <https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health>.

⁵² Vikram Patel et al., "Income Inequality and Depression: A Systematic Review and Meta-analysis of the Association and a Scoping Review of Mechanisms," *World Psychiatry* 17, no. 1 (2018): 76–89.

⁵³ United States Census, "QuickFacts: Kentucky," <https://www.census.gov/quickfacts/KY>. Accessed April 10, 2022.

Figure 5. Population Density by County



Kentucky is predominantly White at 88 percent, followed by African American at nine percent, Hispanic at four percent, and Asian at two percent.⁵⁴ Counties with the highest diversity indices are Jefferson County at 55.4 percent, Christian County at 54 percent, and Fayette County at 52 percent.⁵⁵ The diversity index measures the probability that two people chosen at random will be from different racial and ethnic groups.

In 2019, 22 percent of people under the age of 18 in Kentucky lived in poverty, compared to 18 percent nationally.⁵⁶ Review of the county level shows 44 percent of residents aged 18 and under in McCreary, Owsley, Lee, and Wolfe Counties lived in poverty as seen in *Figure 6*.⁵⁷ At the household level, 16.2 percent of families are living in poverty. Kentucky ranks 45th nationally.⁵⁸

⁵⁴ United States Census, "QuickFacts: Kentucky," <https://www.census.gov/quickfacts/KY>. Accessed April 10, 2022.

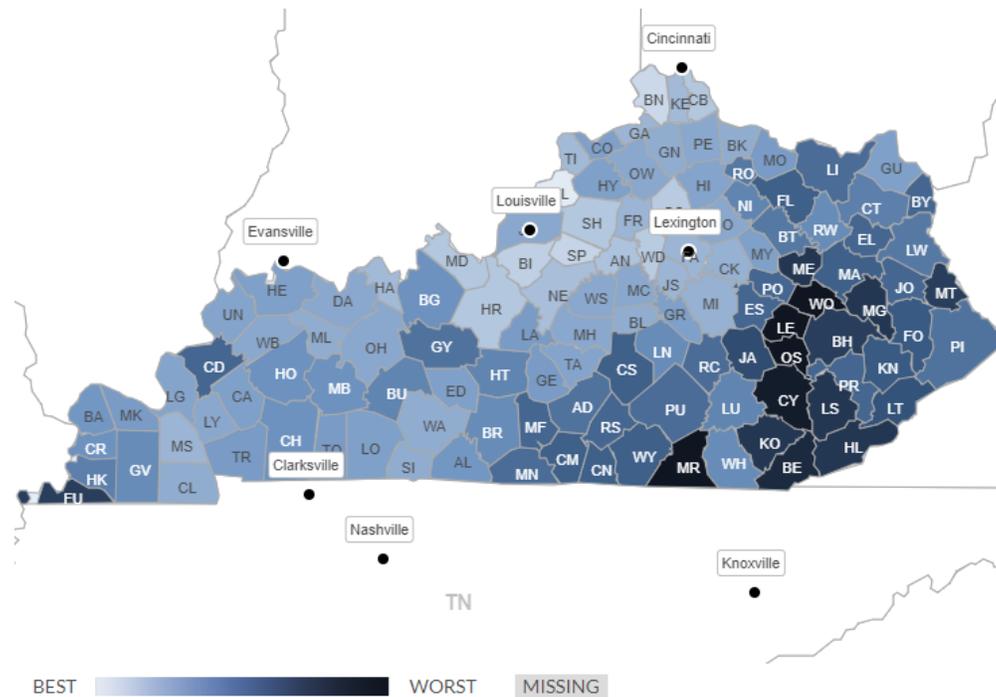
⁵⁵ Ibid. <https://www.census.gov/quickfacts/KY>.

⁵⁶ University of Wisconsin, Population Health Institute, "County Health Rankings State Report 2020," <https://www.countyhealthrankings.org/>.

⁵⁷ Ibid. <https://www.countyhealthrankings.org/>.

⁵⁸ United Health Foundation, "America's Health Rankings: 2021 Annual Report," State Summaries, Kentucky, <https://assets.americashealthrankings.org/app/uploads/2021-annual-report-%E2%80%93-state-summaries.pdf>.

Figure 6. Percentage of People under 18 in Poverty



In 2020, Kentucky had an estimated 277 family households, 399 veterans, 221 unaccompanied young adults, and 666 individuals experiencing chronic homelessness.⁵⁹ In 2019, Kentucky ranked 45th in the nation for food insecurity, with 13.8 percent of households unable to provide adequate food for one or more members due to lack of resources.⁶⁰

In Kentucky, 4.3 percent of those age 16 and older were unemployed, but seeking work, compared to 3.9 percent of the U.S. population.⁶¹ At the county level, Magoffin County had the highest percentage of unemployment at 11 percent, followed by Harlan County at 9.6 percent.⁶² The ratio of household income at the 80th percentile to income at the 20th percentile, a measure of income inequality, was 4.9 in Kentucky, but 5.1 in the U.S.⁶³ Owsley County had the highest income inequality ratio at 8.1.⁶⁴

⁵⁹ "Chronically Homeless," National Alliance to End Homelessness, last modified March 2021, <https://endhomelessness.org/homelessness-in-america/who-experiences-homelessness/chronically-homeless/#:~:text=Chronic%20homelessness%20is%20used%20to,use%20disorder%2C%20or%20physical%20disability>.

⁶⁰ United Health Foundation, "America's Health Rankings: 2021 Annual Report," State Summaries, Kentucky, <https://assets.americashealthrankings.org/app/uploads/2021-annual-report-%E2%80%93-state-summaries.pdf>.

⁶¹ University of Wisconsin, Population Health Institute, "County Health Rankings State Report 2020," <https://www.countyhealthrankings.org/>.

⁶² Ibid.

⁶³ A higher inequality ratio indicates a greater division between the highest and lowest ends of the income spectrum.

⁶⁴ University of Wisconsin, Population Health Institute, "County Health Rankings State Report 2020," <https://www.countyhealthrankings.org/>.

Figure 7. Unemployment Ages 16 and Older

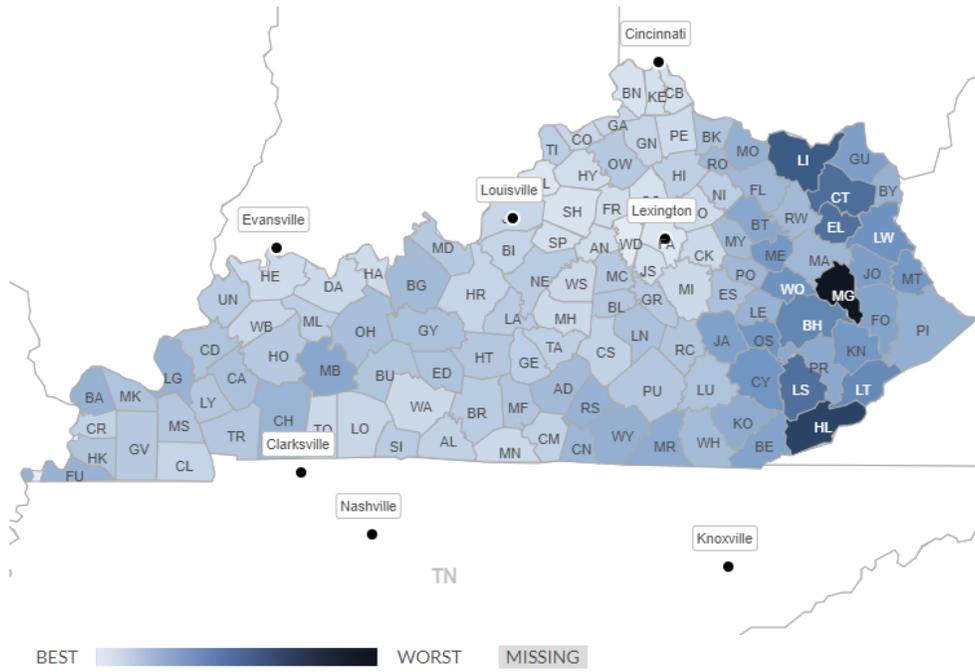
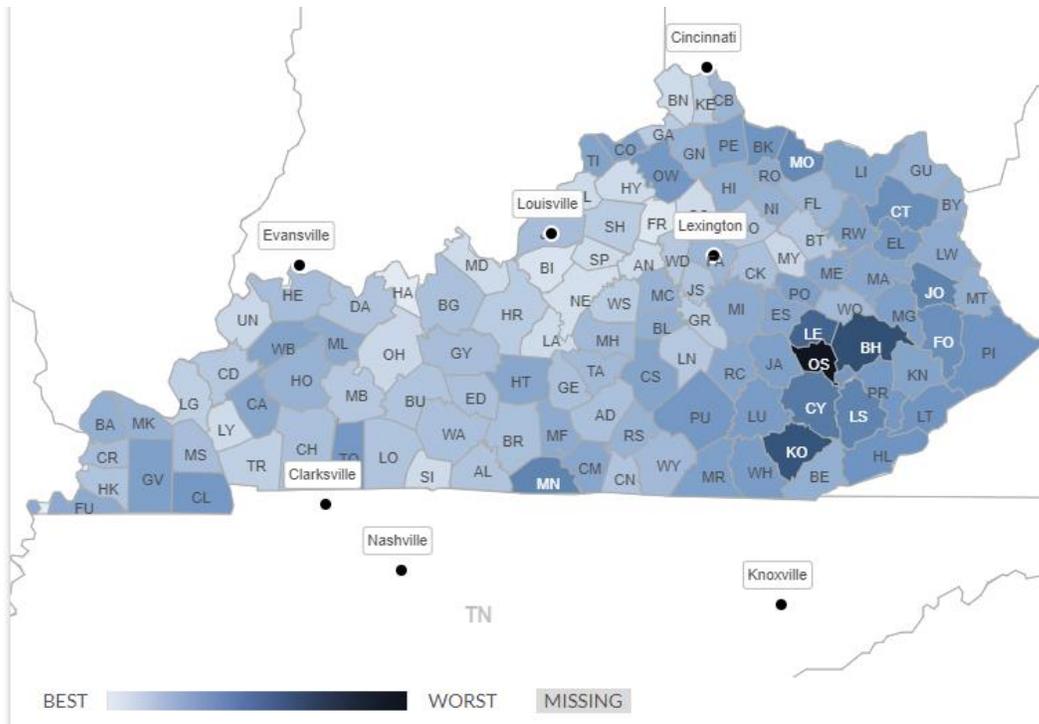


Figure 8. Income Inequality

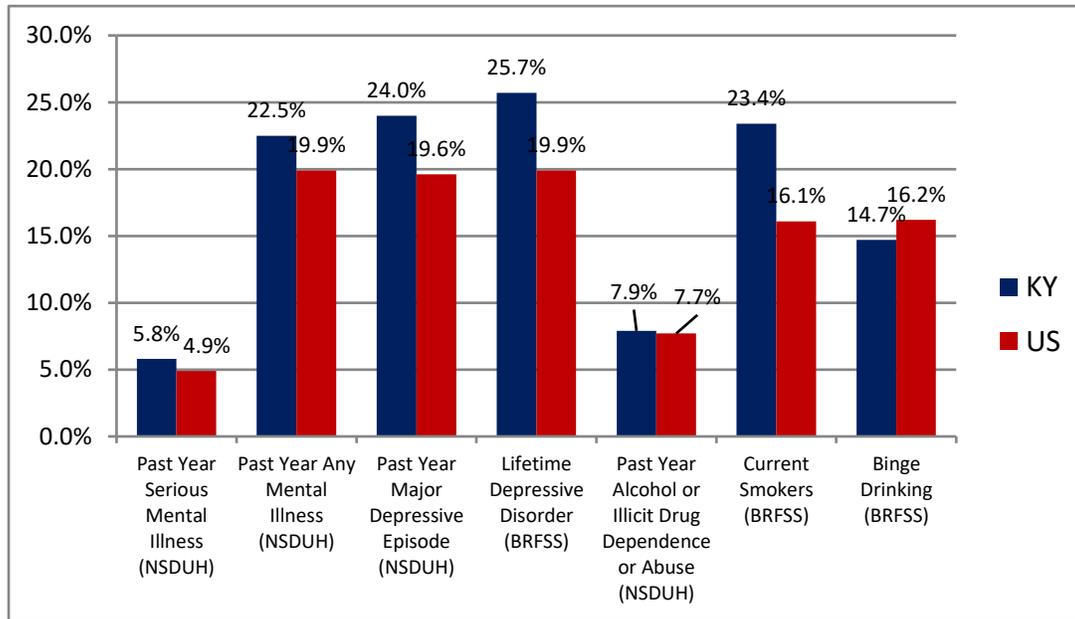


Behavioral Health in Kentucky

Behavioral health issues are rising across the Commonwealth, underscoring an increasing need for high-quality, accessible, and appropriate services.

In 2018, Kentucky had higher rates of SMI, major depressive disorder, and several other behavioral health issues as compared to overall U.S. rates as seen in *Figure 9*.⁶⁵

Figure 9. Adult Behavioral Health in Kentucky and the U.S., 2018



There are numerous publicly available data sources to assess the overall landscape of behavioral and mental health at a state level.

Mental Health America ranks overall mental health using a composite score of 15 measures described below. Kentucky ranked 17th in the nation.⁶⁶

- Adults with AMI: 22.5 percent, ranked 42nd.
- Adults with SUD in the past year: 7.9 percent, ranked 26th.
- Adults with serious thoughts of suicide: 4.7 percent, ranked 20th.
- Youth with at least one MDE in the last year: 15.2 percent, ranked 21st.
- Youth with SUD in the last year: 4.1 percent, ranked 23rd.
- Youth with severe MDE: 9.9 percent, ranked 17th.

⁶⁵ Kentucky CHFS, OHDA, "CCBHC Regional Needs Assessment," May 2021.

⁶⁶ Mental Health America, "The State of Mental Health in America 2022," Maddy Reinert, Theresa Nguyen, and Danielle Fritze, Alexandria, VA: 2021, <https://mhanational.org/sites/default/files/2022%20State%20of%20Mental%20Health%20in%20America.pdf>.

- Adult with AMI who did not receive treatment: 53.5 percent, ranked 23rd.
- Adults with AMI reporting unmet needs: 22.9 percent, ranked 13th.
- Uninsured adults with AMI: 4.2 percent, ranked 2nd.
- Adults with cognitive disability⁶⁷ without doctor due to cost: 22.34 percent, ranked 9th.
- Youth with MDE who did not receive mental health services: 59.3 percent, ranked 30th.
- Youth with severe MDE receiving “some consistent treatment”⁶⁸: 28.6 percent, ranked 24th.
- Children with private insurance that did not cover mental or emotional problems: 9.3 percent, ranked 38th.
- Students identified with emotional disturbance for individualized education program: 7.39 percent, ranked 28th.
- Mental health workforce availability:⁶⁹ 420:1, ranked 30th.

Table 2 presents estimates of key populations based on historical utilization as compared to the total Medicaid population in Kentucky.

Table 2. Kentucky Population Census Statistics

2019 Census Population of Kentucky 4,467,673 Residents ⁷⁰	
Individuals with I/DD in Kentucky DBHDID estimates 1.3 percent of the Kentucky census population fall into this category—approximately 58,080 individuals.	Individuals with SMI (Adults/Seniors) in Kentucky and Enrolled in Kentucky Medicaid DBHDID estimates 2.6 percent of the Kentucky census population fall into this category—approximately 116,159 individuals.

⁶⁷ Cognitive Disability: having a serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional disability. Mental Health America, “The State of Mental Health in America 2022,” Maddy Reinert, Theresa Nguyen, and Danielle Fritze, Alexandria, VA: 2021, <https://mhanational.org/sites/default/files/2022%20State%20of%20Mental%20Health%20in%20America.pdf>.

⁶⁸ Consistent Treatment: if youth visits a specialty outpatient mental health service, including day treatment facility, mental health clinic, private therapist, or in-home therapist, more than 7 times in previous year. Mental Health America, “The State of Mental Health in America 2022,” Maddy Reinert, Theresa Nguyen, and Danielle Fritze, Alexandria, VA: 2021, <https://mhanational.org/sites/default/files/2022%20State%20of%20Mental%20Health%20in%20America.pdf>.

⁶⁹ Mental Health Provider: Includes psychiatrists, psychologists, licensed clinical social worker, counselor, marriage and family therapists, and advanced practice nurses specializing in mental health care. NOTE: does not include peer specialists. Mental Health America, “The State of Mental Health in America 2022,” Maddy Reinert, Theresa Nguyen, and Danielle Fritze, Alexandria, VA: 2021, <https://mhanational.org/sites/default/files/2022%20State%20of%20Mental%20Health%20in%20America.pdf>.

⁷⁰ <https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-detail.html>.

2019 Census Population of Kentucky

4,467,673 Residents⁷⁰

Individuals with SED (Children/Youth) in Kentucky and Are Enrolled in Kentucky Medicaid

DBHDID estimates five percent of the Kentucky census population fall into this category—approximately 223,384 individuals.

Children in Foster Care in Kentucky and Are Enrolled in Kentucky Medicaid

DCBS estimates 0.4 percent of the under 18 Kentucky census population fall into this category—approximately 4,000 individuals.

America's Health Rankings analyzes more specific measures including depression, drug deaths, excessive drinking, frequent mental distress, non-medical drug use in the past year, and suicide to determine an overall behavioral health composite score. According to 2019 data, Kentucky ranks 47th in overall behavioral health as seen in *Table 3*.

Table 3. Kentucky Measures of Annual Behavioral Health

Measure	Data	Ranking
Percentage of adults with depression	24.2%	49
Drug deaths per 100,000 population	31.3%	42
Percentage of adults with excessive drinking	15.8%	11
Percentage of adults with frequent mental distress	17.4%	47
Percentage of adults with non-medical drug use – past year	15.0%	45
Suicide	17.0%	28

Frequent mental distress is increasing in Kentucky. Frequent mental distress is defined as feeling emotionally unhealthy, or very sad, anxious, or troubled, for at least 14 out of 30 days.⁷¹ In 2020, 13.2 percent of adults reported frequent mental distress nationally, compared to 17.4 percent of adults in Kentucky.⁷² This marks an increase of 26 percent of frequent mental distress reported by adults in Kentucky from 2015.⁷³ The counties with the highest percentages of frequent mental distress reported in 2018 were Harlan, Bell, Clay, Wolfe, McCreary, Knox, Breathitt, and Lee (22 percent each).⁷⁴

Kentucky has higher rates of poor mental health days than nationally reported in nearly all sub-populations. *Figure 10* below outlines the percentage of individuals who reported their “mental health was not good 14 or more days in the past 30 days” in a comparison between Kentucky and National data.⁷⁵

⁷¹ Robyn A. Cree et al. “Frequent Mental Distress Among Adults by Disability Status, Disability Type, and Selected Characteristics – United States 2018,” *Morbidity and Mortality Weekly Report (MMWR)* 69, no. 36 (2020): 1238-1243, doi: <http://dx.doi.org/10.15585/mmwr.mm6936a2>.

⁷² Ibid.

⁷³ Ibid.

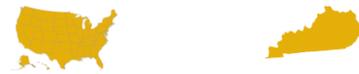
⁷⁴ University of Wisconsin, Population Health Institute, “County Health Rankings State Report 2020,” <https://www.countyhealthrankings.org/>.

⁷⁵ Kentucky Hospital Association Data Center, Kentucky’s Growing Mental Health Crisis: The Effects on Emergency Departments,” <https://www.kyha.com/assets/docs/DataDocs/KentuckysGrowingMentalHealthCrisisReport.pdf>.

Figure 10. Poor Mental Health Days

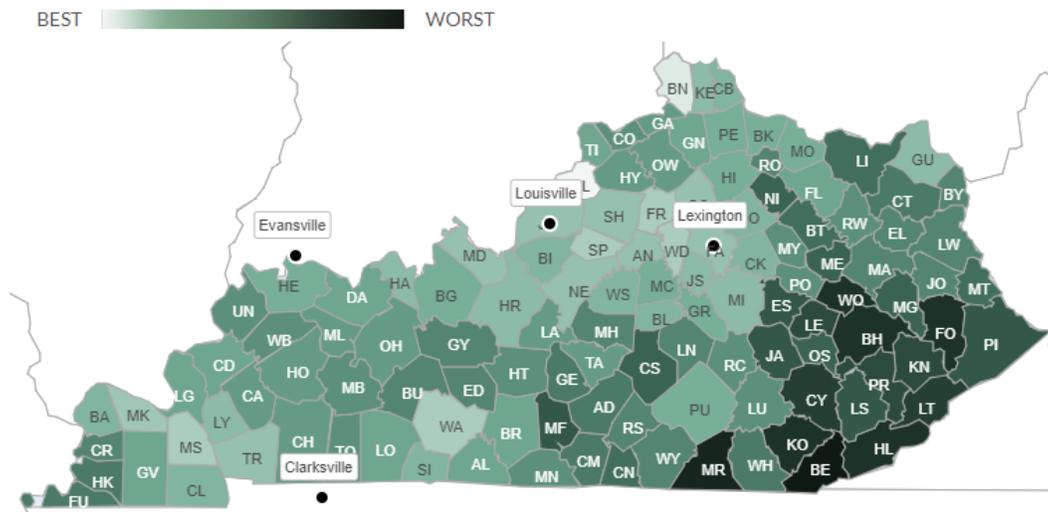
Citizens Affected by Poor Mental Health

	U.S.	KY
Adults ages 18-44	16.5%	21.5%
Multi-racial	20.8%	26.8%
American Indian/Alaska Native	21.3%	28.1%
Adults age 25 and older with a household income of \$25,000 or less	21.3%	28.1%
Adults ages 25 and older with less than a high school education	17%	22.8%



The average mentally unhealthy days in Kentucky per 30 days is five days. The top 10th percentile of the U.S. reports 3.8 mentally unhealthy days per 30 days. According to 2018 data, Kentucky counties with the highest number of mentally unhealthy days reported were Bell at 6.6 days, and McCreary at 6.5 days, followed by Harlan, Knox, Floyd, Wolfe, and Breathitt at 6.4 days as seen in Figure 11.⁷⁶

Figure 11. Average Number of Mentally Unhealthy Days Report



Kentucky has a high rate of adverse childhood experiences (ACEs). ACEs are potentially traumatic events that can have negative, lasting effects on health and wellbeing including early death.⁷⁷ In 2019, Kentucky ranked 33rd in ACEs, with 16.9 percent of children age 17 or under experiencing two or more of the following: parental divorce or separation; living with someone who had an alcohol or drug problem; neighborhood violence victim or witness; living with someone who was mentally ill, suicidal, or severely depressed; domestic violence witness; parent served jail time; being treated or judged unfairly due to

⁷⁶ University of Wisconsin, Population Health Institute, "County Health Rankings & Roadmaps," Kentucky 2021, <https://www.countyhealthrankings.org/app/kentucky/2021/measure/outcomes/42/map>.

⁷⁷ Kentucky Department for Public Health, Division of Maternal and Child Health, "Data Brief," 2016, [https://chfs.ky.gov/agencies/dph/dpqi/cdpb/Kentucky%20BRFSS%20Data%20Reports/Adverse%20Childhood%20Experiences%20\(ACEs\).pdf](https://chfs.ky.gov/agencies/dph/dpqi/cdpb/Kentucky%20BRFSS%20Data%20Reports/Adverse%20Childhood%20Experiences%20(ACEs).pdf)

race/ethnicity; or death of a parent (two-year estimate).⁷⁸ The national average for the U.S. was 14.8 percent.

Suicide death rates per 100,000 of the population in Kentucky surpass national averages among all age groups except ages 75 to 84 as seen in *Figure 12*.⁷⁹ Suicide is the second leading cause of death for youth and young adults in Kentucky (ages 10 to 34).⁸⁰ According to provisional data, in 2020, 105 children and young adults between the ages of 10 and 24 died by suicide in Kentucky.⁸¹ According to survey data, 18.4 percent of Kentucky high school students, or one in seven, reported having seriously considering suicide within a 12-month period, 15.9 percent had planned how they would do it, and 8.1 percent had attempted suicide. Among middle school students, 17.4 percent, or about one in five, reported they had seriously contemplated suicide in their lifetime.⁸²

In 2020, Kentucky ranked 32nd in age-adjusted death rate per 100,000 of the population by suicide,⁸³ and one person died by suicide every 11 hours in 2018.⁸⁴ Suicide is the fourth leading cause of death among ages 35 to 44, and the fifth leading cause of death among ages 45 to 54.⁸⁵

⁷⁸ <https://www.cdc.gov/brfss/index.html>.

⁷⁹ United Health Foundation, "America's Health Rankings: 2021 Annual Report," Suicide in Kentucky, https://www.america'shealthrankings.org/explore/annual/measure/Overall_a/state/KY.

⁸⁰ Kentucky Department of Education, "Suicide Prevention and Awareness," (2021), <https://education.ky.gov/school/sdfs/pages/suicide-prevention-and-awareness.aspx>.

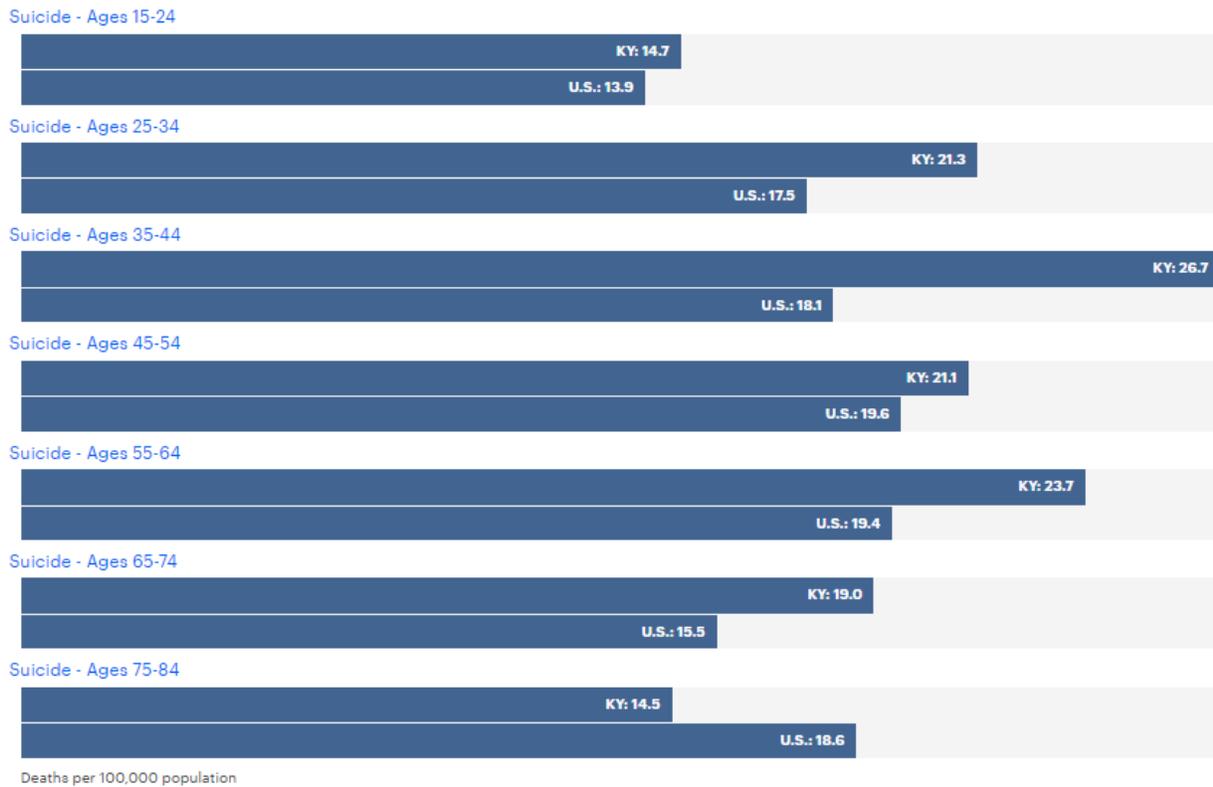
⁸¹ Kentucky Injury Prevention and Research Center for the Kentucky Department for Public Health, Kentucky Violent Death Reporting System data (2021).

⁸² Centers for Disease Control and Prevention, "High School YRBS," Kentucky 2019 Results, <https://nccd.cdc.gov/youthonline/app/Results.aspx?LID=KY>.

⁸³ Centers for Disease Control and Prevention, National Center for Health Statistics, "Suicide Mortality By State," <https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm>.

⁸⁴ American Foundation for Suicide Prevention, "Suicide State Fact Sheets," Suicide Data: Kentucky, 2020. <https://aws-fetch.s3.amazonaws.com/state-fact-sheets/2020/2020-state-fact-sheets-kentucky.pdf>.

⁸⁵ American Foundation for Suicide Prevention, "Suicide State Fact Sheets," Suicide Data: Kentucky, 2019. <https://aws-fetch.s3.amazonaws.com/state-fact-sheets/2021/2021-state-fact-sheets-kentucky.pdf>.

Figure 12. 2019 Suicide Death Rates Per 100,000⁸⁶

Overall, the annual average percentage of young adults age 18 to 25 with serious thoughts of suicide was at 10.5 percent and increased from 2008 and 2019. This rate is on par with the national average of 11.1 percent.⁸⁷ This did not significantly change among adults age 18 or older at 4.7 percent, which is also similar to the national average of 4.5 percent.⁸⁸

Substance use is higher in Kentucky than nationally. According to the Behavioral Health Barometer, Kentucky is showing improvements or stability across some measures of substance use. Among youth age 12 to 17, the annual average percentage of alcohol use was at 10.7 percent and has decreased from 2002 to 2004 and 2017 to 2019, but is higher than the national average of 9.4 percent.⁸⁹

Among people age 12 or older, the average percentage of heroin use in the past month was at 0.42 percent, and past-year misuse of prescription pain relievers was at 4.4 percent. These rates did not change significantly between 2002 and 2019, and are higher than the national average of 0.30 percent and 3.7 percent, respectively.⁹⁰

⁸⁶ Kentucky Department of Education, "Suicide Prevention and Awareness," (2021), <https://www.americashealthrankings.org/explore/annual/measure/Suicide/state/KY>

⁸⁷ Substance Abuse and Mental Health Services Administration, *Behavioral Health Barometer: Kentucky, Volume 6: Indicators as measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services*. HHS Publication No. SMA-20-Baro-19-KY. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020, https://www.samhsa.gov/data/sites/default/files/reports/rpt32834/Kentucky-BH-Barometer_Volume6.pdf.

⁸⁸ Ibid.

⁸⁹ Ibid.

⁹⁰ Ibid.

Among adults age 18 to 25, the annual average prevalence of opioid use disorder (OUD) was at 1.1 percent and did not significantly change between 2015 and 2019. Kentucky's annual average is similar to the national average of 1.3 percent. Among the same age group over the same time period in Kentucky, the annual average percentage of illicit drug use disorder was at 4.7 percent and is well below the national average of 7.5 percent. Between 2002 and 2004 and 2017 and 2019, there was a downward trend in alcohol use disorder with Kentucky young adults which is at 6.9 percent compared to the national average of 9.8 percent. In 2019, the annual average percentage of SUD was at 10.3 percent and did not significantly change, but is also lower than the national average of 14.7 percent.⁹¹

Among people age 12 or older in Kentucky, the average annual percentage of OUD was at 1.3 percent, which was higher than the national average of 0.7 percent, and did not significantly change between 2015 and 2019. The rate of illicit drug use disorder was at 3.3 percent, which also remained steady and similar to the national average of 2.9 percent. Rates of alcohol use disorder was at 5.0 percent and SUD at 7.5. These rates did not significantly change and are on par with national averages of 5.3 percent and 7.4 percent, respectively.⁹²

Kentucky had the second highest death rate by overdose in 2020, with 49.2 deaths per 100,000.⁹³ Provisional data indicate a 21.7 percent increase in drug overdose deaths in Kentucky between October 2020 and 2021.⁹⁴ Drug overdose deaths among Kentucky residents rose steadily over the five-year period of 2016 to 2020, the largest increase occurring from 2019 to 2020.⁹⁵ In 2020, overdose deaths of Kentucky residents totaled 1,964 compared to 1,316 in 2019, representing a 49 percent increase. A review of resident cases autopsied by the Kentucky Office of the Medical Examiner and toxicology reports indicated residents age 35 to 44 were the largest demographic, followed closely by adults age 25 to 34.⁹⁶ Fentanyl contributed to 71 percent of overdose deaths which totaled 1,393 cases.⁹⁷

Counties with the highest per-capita overdose deaths were Knott at 121.7, Clark at 104.3, Bourbon at 98.4, Henry at 88.0, and Carter at 82.3 as seen *Figure 13*.⁹⁸

⁹¹ Substance Abuse and Mental Health Services Administration, *Behavioral Health Barometer: Kentucky, Volume 6: Indicators as measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services*. HHS Publication No. SMA-20-Baro-19-KY. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020, https://www.samhsa.gov/data/sites/default/files/reports/rpt32834/Kentucky-BH-Barometer_Volume6.pdf.

⁹² Ibid.

⁹³ Centers for Disease Control and Prevention, National Center for Health Statistics, "Drug Overdose Mortality by State," 2020, https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm.

⁹⁴ Centers for Disease Control and Prevention, National Center for Health Statistics, "Vital Statistics Rapid Release: Provisional Drug Overdose Death Counts," <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>.

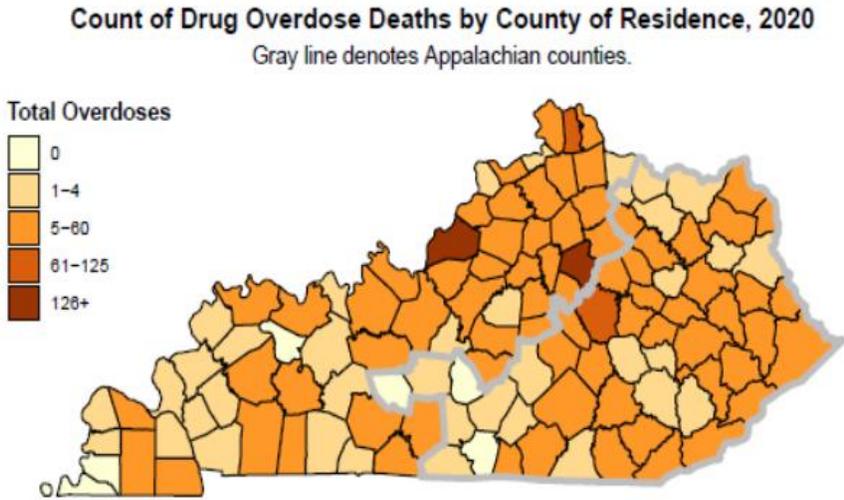
⁹⁵ Kentucky Injury Prevention and Research Center, University of Kentucky, "Kentucky Resident Drug Overdose Deaths 2016-2020, Annual Report," 2021, <https://kiprc.uky.edu/sites/default/files/2022-01/OD%20Death%20Annual%20Report.pdf>.

⁹⁶ Kentucky Office of Drug Control Policy, Commonwealth of Kentucky Justice and Public Safety Cabinet, "2020 Overdose Fatality Report," [https://odcp.ky.gov/Documents/2020%20KY%20ODCP%20Fatality%20Report%20\(final\).pdf](https://odcp.ky.gov/Documents/2020%20KY%20ODCP%20Fatality%20Report%20(final).pdf).

⁹⁷ Ibid.

⁹⁸ Ibid.

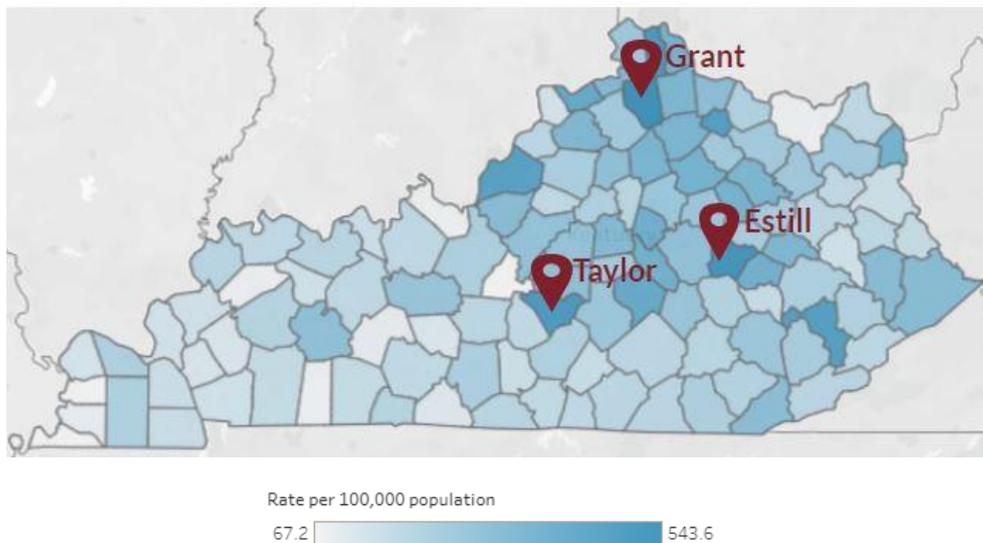
Figure 13. Overdose Deaths 2020



Produced by the Kentucky Injury Prevention and Research Center, as bona fide agent for the Kentucky Department for Public Health. May 2021. Data source: Kentucky Death Certificate Database. Kentucky Office of Vital Statistics, Cabinet for Health and Family Services. This report was supported by Cooperative Agreement Number NU17CE024971-02-01, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.

Non-fatal overdose visits to ED increased. Overall, in 2020 there were 288 per 100,000 population of non-fatal, overdose-related ED visits for any drug in Kentucky. This represents an increase of 33.3 per 100,000 from the previous year. The counties with the highest incidence of non-fatal, overdose-related ED visits were Grant at 543.6 per 100,000, Estill at 517.4 per 100,000, and Taylor at 497.9 per 100,000 as seen in Figure 14.⁹⁹

Figure 14. Non-Fatal, Overdose-Related ED Visits (Any Drug-Involved)



⁹⁹ Kentucky Injury Prevention and Research Center, University of Kentucky, "Kentucky Resident Drug Overdose Rates by State and County," <https://kiprc.uky.edu/programs/overdose-data-action/country-profiles>.

Behavioral Health Services and Kentucky Medicaid

In 2014, Kentucky expanded Medicaid and has since broadened overall access to behavioral health services. Nationally, Medicaid expansion has increased access to behavioral healthcare and addiction treatment for previously uninsured adults with coverage gained for adults with behavioral health and/or SUD at 29 percent (or around five million).¹⁰⁰ In SFY 2020, 272,263 Kentucky Medicaid members received behavioral health services. This number represents 80 percent of those estimated to have behavioral health needs based on commonly accepted prevalence estimates.¹⁰¹

Figure 15. Kentucky Medicaid Expansion



Kentucky Medicaid is the largest payer of behavioral health services, including mental health and SUD services. In 2020, Kentucky Medicaid was the payer for 56 percent of all ED suicide discharges within the Commonwealth. Kentucky Medicaid is also the largest payer of ED mental health and SUD discharges at 54 percent within the Commonwealth, followed by Medicare at 20 percent, and commercial payers at 17 percent.¹⁰²

In SFY 2022, Kentucky Medicaid reported the following number of individuals ages 18 to 64 presenting with each condition:¹⁰³

- SMI: 32,615.
- SUD clients: 13,220.
- Other mental health: 72,906.

Compared to national data, Kentucky has higher rates of SMI and major depressive disorder.¹⁰⁴ Medicaid estimates more than a quarter of Kentucky adults with SMI rely on Medicaid.¹⁰⁵ A Kentucky online service says that, according to SAMHSA, only 46.9 percent of adults with mental illness in

¹⁰⁰ James Maxwell, Angle Bourgoin, and Zoe Lindenfeld, "Battling the Mental Health Crisis among the Underserved through State Medicaid Reforms," *Health Affairs* 10, (2020) <https://www.healthaffairs.org/doi/10.1377/forefront.20200205.346125/full/>.

¹⁰¹ "Kentucky Mobile Crisis Unit Project Narrative." Kentucky Cabinet for Health and Family Services, n.d.

¹⁰² Kentucky Hospital Association Data Center, Kentucky's Growing Mental Health Crisis: The Effects on Emergency Departments," <https://www.kyha.com/assets/docs/DataDocs/KentuckysGrowingMentalHealthCrisisReport.pdf>.

¹⁰³ Kentucky Medicaid Data SFY2022.

¹⁰⁴ "Kentucky Mobile Crisis Unit Project Narrative." Kentucky Cabinet for Health and Family Services, n.d.

¹⁰⁵ Kentucky Hospital Association Data Center, Kentucky's Growing Mental Health Crisis: The Effects on Emergency Departments," <https://www.kyha.com/assets/docs/DataDocs/KentuckysGrowingMentalHealthCrisisReport.pdf>.

Kentucky receive any form of treatment from either the public system or private providers, and the remaining 43.1 percent receive no mental health treatment.¹⁰⁶

ED Visits for Behavioral Health

A recent study by the Kentucky Hospital Association (KHA) found that in calendar year (CY) 2019, 50 percent of Kentucky's 2.4 million ED visits reported a diagnosis of either mental health illness or SUD.¹⁰⁷ KHA reported that while the overall number of visits to the ED decreased during CY 2020, the percentage of ED visits of individuals reporting a behavioral health diagnosis increased by 53 percent. Kentucky continues to experience a rise in the percentage of ED patients with mental health and SUDs, with nearly 60 percent of visits in 2020.¹⁰⁸

ED visits and inpatient hospitalizations with SUD diagnoses were highest in Perry County with rates of 5,079 and 5,857 per 100,000 respectively. For both measures, the highest concentrations were in southeast Kentucky. ED visits in Leslie County had a rate of 4,908 per 100,000 for SUD diagnosis. (Figure 16 and Figure 17).¹⁰⁹



Medicaid in Kentucky

- Twenty-seven percent of the Kentucky population is covered by Medicaid/Children's Health Insurance Program.
- Medicaid is the largest payer of behavioral health services including mental health and SUD.
- One in four adults, age 19 to 64, are covered by Medicaid.
- Four in nine children are covered by Medicaid.
- Two in three nursing home residents are Medicaid recipients.
- In Kentucky, Medicaid covers three in seven individuals with disabilities.
- Fifty-five percent of children with special needs are covered by Medicaid in Kentucky.

Kaiser Family Foundation. "Fact Sheet: Medicaid State, KY | KFF Files." Medicaid in Kentucky, 2019. <https://files.kff.org/attachment/fact-sheet-medicaid-state-KY>.

¹⁰⁶ Rtor.org Gateway to Mental Health Services, "Mental Health Resources in Kentucky," <https://www.rtor.org/directory/mental-health-kentucky/>.

¹⁰⁷ Kentucky Hospital Association Data Center, Kentucky's Growing Mental Health Crisis: The Effects on Emergency Departments," <https://www.kyha.com/assets/docs/DataDocs/KentuckysGrowingMentalHealthCrisisReport.pdf>.

¹⁰⁸ National Alliance on Mental Illness, "Mental Health by the Numbers," NAMI, last modified February 2022, <https://www.nami.org/mhstats>.

¹⁰⁹ Kentucky Injury Prevention and Research Center, University of Kentucky, "Kentucky Resident Drug Overdose Rates by State and County," <https://kiprc.uky.edu/programs/overdose-data-action/county-profiles>.

Figure 16. SUD Diagnosis – Inpatient Hospitalizations

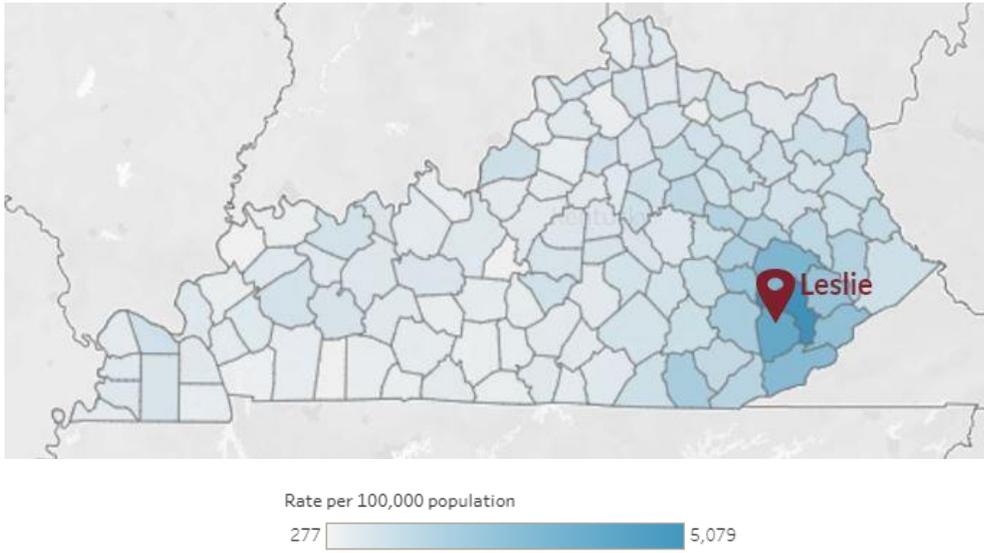
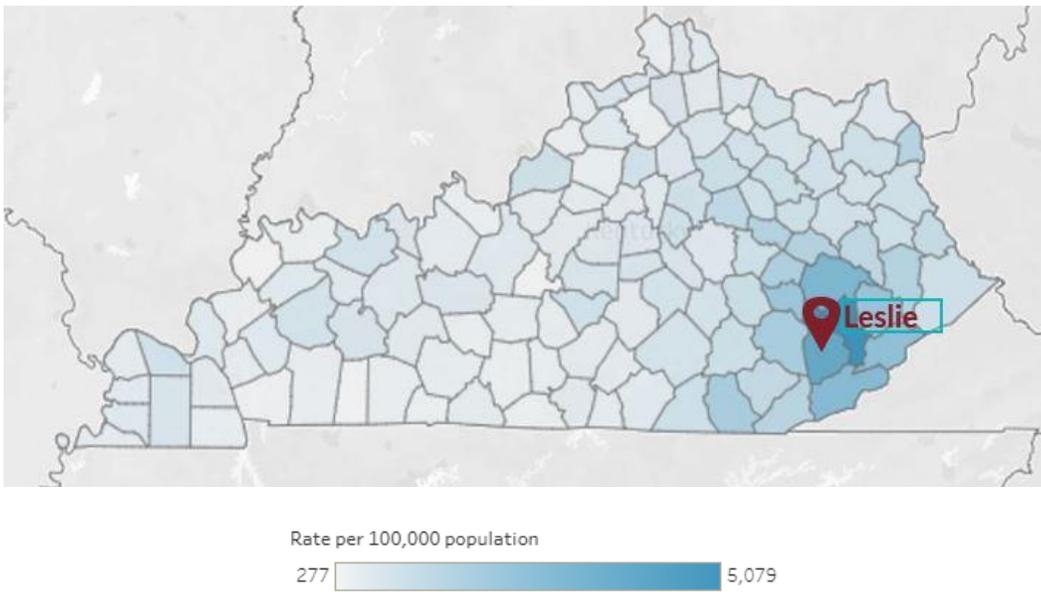


Figure 17. SUD Diagnosis – ED Visits





Kentucky's Current Definition of MCI Services and Rendering Providers Types

Definitions of Mobile Crisis Intervention Services and the provider types delivering community-based crisis care



Kentucky's MCI Services and Behavioral Health Crisis Definitions and Provider Types

MCI Services Defined

An important first step in assessing the needs associated with Kentucky's MCI services delivery continuum is to examine its definition of MCI services. Setting forth the definition of MCI services is key in delivering consistent crisis care. Crisis services are defined by SAMHSA as "(1) crisis lines accepting all calls and dispatching support based on the assessed need of the caller, (2) MCTs dispatched to wherever the need is in the community (not hospital emergency departments) and (3) crisis receiving and stabilization facilities that serve everyone that comes through their doors from all referral sources. These services are for anyone, anywhere and anytime."¹¹⁰



Kentucky's definition of MCI services is found in various policy documents, including KAR for BHSO MCI coverage and facilities, and CMHC covered services are outlined in the 2019 Kentucky Medicaid SPA.¹¹¹

Each definition of MCI from the various documents addresses the following components of the service:

- **Availability:** 24/7/365.
- **Duration of service:** Less than 24 hours, not overnight.
- **Services provided:** Face-to-face.
- **Access to:** Board-certified/eligible psychiatrist.
- **Multi-disciplinary team:** Includes behavioral health practitioners, behavioral health practitioners under supervision, and paraprofessionals (peer support).
- **Location of response delivered:** In home or community.

¹¹⁰ Substance Abuse and Mental Health Services Administration, *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit*, Rockville, MD: Center Mental Health Services, 2020, <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>.

¹¹¹ 907 KAR 15:020 (e) and 907 KAR 20:430 (5), 907 KAR 1:044; Kentucky Medicaid State Plan Amendment (2019), pages 5-10.

- **Safe transition of persons in acute crises:** To appropriate and least restrictive level of care.
- **Includes services and supports deemed necessary:** Such as integrated crisis prevention, assessment, disposition, intervention, continuity of care recommendations, and follow-up services.

Behavioral Health Crisis Definition

While the definition of a behavioral health crisis is different from the definition of MCI services, it is necessary in determining the correct dispatch of the multi-disciplinary crisis team into the community. The definition of a behavioral health crisis differs between policy documents and by providers.

KDMS defines a behavioral health crisis is defined as any behavioral, SUD, or psychiatric situation perceived to be a crisis by the individual experiencing the crisis, family members, or others who closely observe the individual that if left untreated, could result in an urgent or emergent situation in the placement of the person in a more restrictive, less clinically appropriate setting, including but not limited to, inpatient hospitalization or at the very least, significantly reduced levels of functioning in primary activities of daily living.

DBHDID defines a behavioral health crisis for individuals with I/DD for purposes of crisis response as follows: "A crisis is defined as a sudden, unanticipated, or potentially dangerous behavioral health condition, episode, or behavior. Individuals in crisis are defined as being at risk of losing the support they need to remain in the community when:¹¹²

- The individual is experiencing a behavioral or psychiatric emergency.
- The individual or family is experiencing an acute crisis as determined by the Institute on Complex Disabilities Crisis Triage Codes rating scale.
- It is determined that the individual has a history of multiple crisis episodes.
- The individual is at a substantial risk of future crisis and preventive efforts needed.
- Exhausting other supports prior to referral, these supports are extraordinary in nature."



Several stakeholders expressed confusion and frustration regarding the multiple definitions of mobile crisis within KARs and the Medicaid SPA. They specifically cited the following questions:

- What defines a behavioral health crisis?
- Clarification is needed on face-to-face. Are services required to be delivered in person, or can they be administered via telehealth?
- Further define multi-disciplinary team and that a "team" must be at least two.
- Outline response locations considered MCI: Are walk-in crisis clients considered mobile crisis? In home? Jails? Hospitals?
- Many providers attending the BHSO roundtable were unaware of MCI services or that they could render these services.

¹¹² Kentucky DBHDID Crisis Coordinator Manual, FY2023.

Aetna’s Better Health of Kentucky MCO defines a behavioral health crisis as:

“A condition of physical or mental instability or danger:

- A dramatic emotional or circumstantial upheaval in a person’s life that could lead to self-harm or harm to others.
- A life-threatening or potentially life-threatening physical condition.”

CMHC Region 15: New Vista defines a behavioral health crisis as:

“A mental health crisis occurs when an individual’s state of mind renders them unable to cope with or adjust to the everyday stresses of life. A crisis can be frustrating, but it is not life-threatening. A mental health emergency is a life-threatening situation in which an individual is threatening immediate harm to self or others, is severely disoriented or out of touch with reality, or is otherwise out of control.”¹¹³

MCI Services Provider Types Defined

In the evaluation of system adequacy for MCI services delivery, it is important to consider the current provider network and examine MCT composition. The first step in such evaluation is to examine the composition of the multi-disciplinary MCT. The Kentucky State Plan, KARs, and the CMHC Behavioral Health Services Manual were evaluated to identify the -practitioners working for either a CMHC or CCBHC who may deliver MCI services as shown in *Table 4*.

Table 4. Practitioners Permitted to Render MCI Services

Practitioner Type	Medicaid State Plan	902 Kentucky Administrative Regulation 20:091-CMHC ¹¹⁴	CMHC Behavioral Health Services Manual ¹¹⁵
Licensed Psychologist (LP)	•	•	•
Licensed Psychological Associate (LPA)	• with supervision	• with supervision	•
Licensed Psychological Practitioner (LPP)	•	•	•
Licensed Clinical Social Worker (LCSW)	•	•	•
Certified Social Worker, Master Level (CSW)	• with supervision	• with supervision	•
Licensed Professional Clinical Counselor (LPCC)	•	•	•
Licensed Professional Counselor Associate (LPCA)	• with supervision	• with supervision	•
Licensed Professional Art Therapist (LPAT)	•	•	•
Licensed Professional Art Therapist Associate (LPATA)	• with supervision	• with supervision	•
Licensed Marriage and Family Therapist (LMFT)	•	•	•
Marriage and Family Therapist Associate (MFTA)	• with supervision	• with supervision	•
Licensed Behavioral Analyst (LBA)	•		
Licensed Behavioral Analyst Associate (LABA)	• with supervision		
Physician	•	•	•
Psychiatrist	•	•	•
Advanced Practice Registered Nurse (APRN)	•	•	•

¹¹³ <https://newvista.org/blog/recognizing-mental-health-crisis>.

¹¹⁴ <https://apps.legislature.ky.gov/law/kar/titles/902/020/091/>.

¹¹⁵ <https://chfs.ky.gov/agencies/dms/dpo/bpb/Pages/cmhc.aspx>.

Practitioner Type	Medicaid State Plan	902 Kentucky Administrative Regulation 20:091-CMHC ¹¹⁴	CMHC Behavioral Health Services Manual ¹¹⁵
Psychiatric Resident			•
Resident Physician			•
Physician Assistant (PA)	•	•	
Peer Support Specialist (PSS)	•with supervision	•	•
Registered Nurse (RN)		•	• states "Nurse" does not specify licensure level
Psychiatric Registered Nurse (RN)	•	•	•
Professional Equivalent	• with supervision	•	•
Mental Health Associate	• with supervision		•
Licensed Clinical Alcohol and Drug Counselor (LCADC)	• provide services for recipients with SUD	•	•contingent upon approval from CMS
Licensed Clinical Alcohol and Drug Counselor Associate (LCADCA)	• provide services for recipients with SUD • With supervision	•	•contingent upon approval from CMS
Certified Alcohol and Drug Counselor (CADC)	• provide services for recipients with SUD • With supervision	•	•
Certified psychologist with autonomous functioning	•	•	•
Certified psychologist	•with supervision		•

902 KAR 20:430 lists the types of practitioners who can work at a BHSO as a behavioral health professional or a behavioral health professional under clinical supervision; further within the regulation is states a behavioral health professional; a behavioral health professional under clinical supervision; or an adult, family, or youth peer support specialist, as appropriate, working under the supervision of a behavioral health professional, can work as part of the MCT. Review of the Kentucky SPA, KARs, and the CMHC Behavioral Health Services Manual shows that there are some noted differences in the type of practitioner who can render MCI services.



MCI Services Providers

Profiles of Kentucky's current MCI services providers

MCI Services Providers

Kentucky's only Medicaid MCI services providers are CMHCs and BHSOs. Additionally, CMHCs operating as CCBHCs may also provide and bill for MCI services. This section outlines MCI service provider organizations, including individual practitioners, licensed organizations, and provider groups.



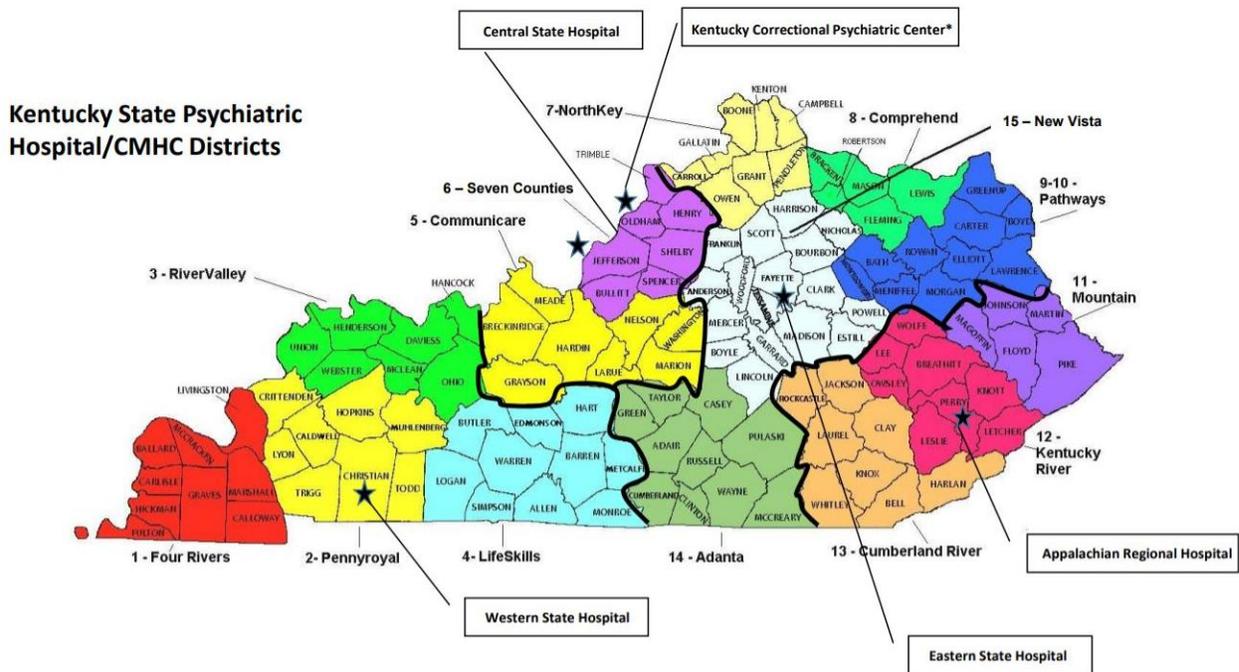
Kentucky CMHCs

Kentucky has 14 CMHCs that provide community-based behavioral health services to those needing services associated with mental health I/DD and/or substance abuse. In 1964, Kentucky passed the Community Mental Health Services Act which funded the construction of its CMHCs, making it the first Commonwealth/state to have a regional network of mental health organizations.¹¹⁶ Kentucky's CMHCs provide services through 14 regional boards or regions.¹¹⁷ The regional Mental Health and Intellectual Disabilities boards are private, non-profit organizations serving residents in designated multi-county regions. *Figure 18* shows the 15 CMHC regions which are aligned to counties and Kentucky state psychiatric hospitals. Note that Pathways serves Region 9 and Region 10.

¹¹⁶ <https://www.opencounseling.com/public-mental-health-ky#:~:text=Public%20mental%20health%20services%20in%20Kentucky%20are%20managed%20and%20overseen,a%20network%20of%2014%20CMHCs>.

¹¹⁷ <https://chfs.ky.gov/agencies/dms/dpo/bpb/Pages/cmhc.aspx>.

Figure 18. Kentucky CMHC Regions Map¹¹⁸



*KCPC provides forensic psychiatric services statewide

Currently, each of these 14 CMHCs has its own resource directory which identifies the resources available within the respective region. Often, these directories exist independently by county, and counties served within the same region may have access to a different array of resources depending on the size of the community, ability to designate resources, and/or awareness of a local resource champion to support development of resource directory. However, these directories may not always be updated on a regular basis. They may not be comprehensive in nature. They also may not consider resources that are outside the community as the best choice for some crisis callers. Additionally, each CMHC houses a Regional Prevention Center (RPC). The RPC is responsible for ensuring its community partners are aware of the various resources located within the county as a means of preventing and reducing behavioral health issues. The RPCs often create or update existing resource directories or assist community partners in doing so. Many of the directories that currently exist have not been updated recently or may not include a comprehensive listing of all resources, referral sources, and linkages available in a community.

DBHDID contracts with Kentucky’s 14 CMHCs to provide behavioral health services, including a crisis line/National Suicide Prevention Line (NSPL) answering, MCI services, and additional follow-up services as needed by the client. Required crisis services array identified in the contract between DBHDID and each CMHC includes the following:¹¹⁹

- Screening (e.g., telephonic screening and triage).

¹¹⁸ <https://dbhdid.ky.gov/cmhc/documents/RegionsMap.pdf>.

¹¹⁹ Kentucky 988 Implementation Plan, January 2022.

- Behavioral health crisis assessments, including involuntary hospitalization evaluations as defined in Kentucky Revised Statutes (KRS) 202A and KRS 645.
- Counseling and intervention to stabilize the situation (e.g., MCI services, residential crisis stabilization, crisis intervention, and crisis respite).
- Psychiatric consultation (e.g., psychiatrist, medical doctor, or APRN on call for consultation and medication management).
- Information and referral services to connect individuals and families with community resources (e.g., support for delivery of suicide prevention services by RPC staff).
- Observation and/or follow-up to ensure stabilization (e.g., 23-hour observation, telephonic/text/email follow-up to ensure continued stabilization).
- Therapeutic and supportive services to prevent, reduce, or eliminate the crisis situation (e.g., support delivery of community response services after suicide attempt by RPC staff, peer support, case management, emergency residential care, etc.).
- Coordination of transportation services for individuals needing an involuntary hospitalization (to and from the hospital).
- Safety planning for self-harm or suicide risk.
- Assessment and coordination of appropriate level of care for SUDs.

Kentucky CCBHCs

Section 223 of the Protecting Access to Medicare Act of 2014 outlines the creation of a demonstration program to implement CCBHCs and assess their effectiveness through the SAMHSA demonstration program. Eight states were selected to participate in the original demonstration program in December 2016. In August 2020, Kentucky and Michigan were selected as part of a two-state expansion of the demonstration as a result of the passage of the Coronavirus Aid, Relief, and Economic Security (CARES) Act. CCBHCs were developed to provide comprehensive quality care that is reimbursed through a prospective rate based on historical costs. The demonstration period is two years. The first demonstration year (DY) 1 for Kentucky is January 1, 2022 through December 31, 2022, while DY2 is January 1, 2023 through December 31, 2023.

Kentucky identified 4 CMHCs to participate in the demonstration as an additional provider type. Specifically, Pathways, NorthKey, Seven Counties and New Vista. A new provider type was established for use within the demonstration, Provider Type 16-CCBHC. The 4 CMHCs identified for participation in the demonstration are currently certified and enrolled as Provider Type 16 CCBHC. This is a specific provider type and separate and apart from operation as a CMHC (PT30). Kentucky expects that when a CMHC enrolls as a PT16 CCBHC, all outpatient services are provided under this provider type.

CCBHCs must provide crisis management services that are available and accessible 24-hours a day and must be delivered within three hours. They must also provide the following core services: crisis mental health services; screening, assessment, and diagnosis; outpatient mental health and SUD treatment; person-centered treatment planning; primary care screening and monitoring of key health indicators; targeted case management; psychiatric rehabilitation; peer support, including family and youth; and community-based mental health care for members of the armed forces and veterans

CCBHC Expansion Grants

There are also CMHCs in Kentucky that have received SAMHSA CCBHC expansion grants. SAMHSA expansion grants allow for the implementation of the CCBHC model by approved clinics. These expansion grants are separate and apart from the CCBHC Demonstration and the state provides no certification of grant recipients. SAMHSA assumes authority over all expansion grant activities in Kentucky.

CCBHCs grantees must provide crisis management services that are available and accessible 24-hours a day and must be delivered within three hours.¹²⁰ To classify as a CCBHC, a grantee must self-attest to the ability to provide the following core services: crisis mental health services; screening, assessment, and diagnosis; outpatient mental health and SUD treatment; person-centered treatment planning; primary care screening and monitoring of key health indicators; targeted case management; psychiatric rehabilitation; peer support, including family and youth; and community-based mental health care for members of the armed forces and veterans.¹²¹

A key difference between the expansion grantees and the demonstration participants is that only demonstration participants are certified by KDMS.

Kentucky BHSOs

In Kentucky, there are 158 BHSOs which are licensed entities under administrative regulation to provide behavioral health services. BHSOs operate under a scope of services to treat client needs of a mental health disorder, SUD or co-occurring mental health and SUD. BHSOs have three tiers in which they can enroll and provide services, as highlighted in the callout to the right side of this page.¹²²

All BHSOs must meet coverage provisions and requirements of 907 KAR 15:020 and 907 KAR 15:022.



BHSO Tier 1

Mental health services.

Licensed pursuant 902 KAR 20:430.

BHSO Tier 2

Outpatient services (including co-occurring disorders) for substance use treatment.

Licensed pursuant 908 KAR 1:370 and 908 KAR 1:374.

BHSO Tier 3

Residential services (including co-occurring disorders) for substance use treatment.

Licensed pursuant 908 KAR 1:370 and 908 KAR 1:372.

¹²⁰ https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf

¹²² <https://www.mathematica.org/publications/variation-in-services-offered-by-certified-community-behavioral-health-clinics-and-community-mental>.

¹²² 902 KAR 20:430.

Kentucky Medicaid classified BHSOs as provider type 03.¹²³ There are three BHSOs tiers, with only tiers one and two able to provide MCI services.

According to administrative legislation, BHSOs shall provide treatment to meet client needs, including one or more of the following:¹²⁴

- Screening.
- Assessment.
- Psychological testing.
- Crisis intervention.
- MCI services.
- Day treatment.
- Peer support.
- Intensive outpatient program services.
- Outpatient therapy (individual, group, and family).
- Collateral outpatient therapy.
- Service planning.
- Screening, brief intervention, and referral to treatment (SBIRT) for SUD.
- Assertive community treatment for SMI.
- Comprehensive community support services.
- Therapeutic rehabilitation program for SMI.
- Targeted case management services.
- Partial hospitalization.

CMHC MCI Service Provider Profiles

During the stakeholder engagement phase of the planning grant, all 14 of Kentucky's CMHCs representing the 15 regions were interviewed. The CMHC profiles presented below incorporate information gathered during engagement activities, research, policy information gathered, and documentation provided by stakeholders. This section provides detail on each CMHC in operation.

¹²³ <https://chfs.ky.gov/agencies/dms/DMSPProviderSummaries/BHSOPT03.pdf>.

¹²⁴ 902 KAR 20:430; <https://chfs.ky.gov/agencies/dms/provider/Pages/BHSO.aspx>.

Region 1 – Four Rivers Behavioral Health

As a CMHC serving Southwest Kentucky, Four Rivers provides children and adults with behavioral health, SUD, and I/DD services. Crisis prevention, intervention, and stabilization services are part of its core offerings including mobile crisis response, community supports, respite, and environmental assessments.¹²⁵

<p>Demographics</p> <ul style="list-style-type: none"> ▪ Nine Western Kentucky counties: Calloway, Marshall, Graves, Fulton, Hickman, Carlisle, Ballard, McCracken, and Livingston. ▪ Three outpatient office locations: Center for Adult Services (Paducah), Fuller Center (Mayfield), and Lakes Center (Murray). ▪ Employs 40 staff with 28 open positions listed. ▪ More than 456,400 individuals served annually via the Community Care Network, a five-CMHC collaboration (Regions 1, 2, 4, 5, and 13). ▪ In 2021, Four Rivers served 3,772 clients with SMI.¹²⁶ 	<p>Crisis Call Center</p> <ul style="list-style-type: none"> ▪ 1-800-273-8255. ▪ Current NSPL member. <p>Dispatch of MCI</p> <ul style="list-style-type: none"> ▪ Qualified mental health professional (QMHP) makes the level-of-care determination requesting dispatch of the MCT. ▪ MCT dispatch locations limited to local hospitals and jails. ▪ Response times vary: ED three hours, hospital partners (excluding ED) 24 hours, jail 12 hours. 	<p>Composition of MCT</p> <ul style="list-style-type: none"> ▪ MCT response consists of one clinician: LCSW, CSW, LPP, or LPCA. ▪ Quick response team (QRT) response to an SUD-related overdose crisis calls are selected from six staff members including clinicians, PSS, and law enforcement. ▪ Emergency response groups respond to local disasters (e.g., tornados) and consists of a three to four-person team including clinicians, PSS, and care coordinators.
<p>MCI Services</p> <ul style="list-style-type: none"> ▪ Telehealth MCI services offered for clients outside of partnering hospitals and jails. ▪ Risk assessment and outpatient referrals. ▪ Utilize a QRT for: SUD/OD response, connection to outpatient addiction treatment, referral to detox facility, connection to inpatient rehabilitation. ▪ Warm hand-offs to inpatient care including a safety plan. ▪ Ordering inpatient hospitalization, including admission to Western State Psychiatric Hospital. 	<p>Transportation</p> <ul style="list-style-type: none"> ▪ Relies on local law enforcement to transport individuals in crisis. ▪ The KORE QRTs use a Four Rivers agency vehicle for transporting clients to SUD treatment facility. <p>Crisis Stabilization and Follow-Up Care</p> <ul style="list-style-type: none"> ▪ Adult stabilization: Four Rivers has an eight-bed Crisis Stabilization Unit (CSU) in Mayfield, Kentucky. Most clients in the CSU are assessed over a 72-hour period.¹²⁷ ▪ Child stabilization: Four Rivers operates a Child Stabilization Unit providing a three-day evaluation for children and youth requiring more than outpatient treatment, but do not require full hospitalization. The CMHC maintains contracts with local private child care entities to provide overnight components during evaluation period, as needed.¹²⁸ ▪ Post-crisis stabilization follow-up includes scheduling for outpatient appointments at Four Rivers. 	

¹²⁵ <https://4rbh.org/>.

¹²⁶ <https://dbhdid.ky.gov/cmhc/datareports.aspx>.

¹²⁷ <https://4rbh.org/>.

¹²⁸ Ibid.



Region 2 – Pennyroyal

Established in 1967, Pennyroyal provides mental health, substance use, and I/DD services to Kentucky’s eight western counties. Emergent behavioral health crisis services are offered at all locations during the business hours of 8:30 a.m. to 4:00 p.m.¹²⁹

Demographics

- Eight Western Kentucky counties: Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd, and Trigg.
- Sixty locations and 35 programs.
- Employs 460 staff, with seven open positions listed.
- More than 456,400 individuals served annually via the Community Care Network, a five-CMHC collaboration (Regions 1, 2, 4, 5, and 13).

Crisis Call Center

- 1-270-882-9551 or 1-877-473-7766.
- RESPOND Crisis Line and Text available 24/7/365.
- Current NSPL member.
- Triage and assessment for care determination conducted via telehealth by a medical provider or QMHP.

Dispatch of MCI

- QMHP makes the level-of-care determination and request for MCT dispatch.
- MCI services deployed via telehealth for hospitals and jails.
- On-site MCI dispatch limited to designated safe places, after hours clinic, and crisis walk-ins.
- Use a Safe Alert mobile app to track dispatched team, using GPS for safety.

Composition of MCT

- Emergency services team: QMHPs take crisis calls via telehealth transferred from the call center.
- Crisis team: Provide on-site intervention. One-person team made up of either LCSW, LPCC, or MHA.
- Community crisis team: Respond to local disasters (e.g., severe weather, industrial accidents, fire). Offers psychological first aid response to schools, public centers, shelters, and areas of impact.

MCI Services

- All crisis call assessments are conducted via telehealth prior to MCT arriving on-scene to provide services.
- On-site MCI services vary and are person-based: screening, crisis planning, evaluation, and collaboration with natural supports, connections to next level-of-care determined.

Transportation

- MCT staff can transport clients if voluntary and deemed safe.
- MCT sometimes pays for a cab service.
- Law enforcement called for transport if necessary (i.e., involuntary hospitalization or safety risk).
- EMS transports to ED if medical concern is present.

Crisis Stabilization and Follow-Up Care

- Respite care for I/DD clients in need of stabilization.
- No CSUs in Region 2. Outpatient crisis stabilization for adults and children.
- Post-crisis follow-up: Care coordination is not a Medicaid-covered service and is not billable. Pennyroyal MCT members provide care coordination by referring clients to counseling and outpatient or advocacy services.

¹²⁹https://pennyroyalcenter.org/services/crisis_emergency_services/.

Region 3 – River Valley Behavioral Health

River Valley Behavioral Health (RVBH) offers a wide range of behavioral health services, substance use treatments, and I/DD services to adults, children, and families.¹³⁰ In addition, services related to prevention, housing, and employment are available for qualifying River Valley clients.¹³¹

In 2021, RVBH received the National Mental Health Corporations of America’s Best Practices Award for client satisfaction.¹³² In addition, RVBH’s population served includes 52.2 percent female, 45.5 percent male, and 1.5 percent transgender. The age makeup of RVBH’s service population across all programs includes: 20.4 percent age 16 to 25, 17.8 percent age 26 to 34, 14.8 percent age 35 to 44, 13.2 percent age 13 to 15, and 11.2 percent age 45 to 54. More than 14 percent of RVBH clients are under the age of 13. Only 8.2 percent of their clients were between the ages of 55 and 84 years old. No clients were in the 85 to 94-year old range. The ethnic background of clients served by RVBH is largely Non-Hispanic at 96 percent, with Hispanic making up four percent of the service population.¹³³

<p>Demographics</p> <ul style="list-style-type: none"> Seven counties served: Daviess, Hancock, Henderson, McLean, Ohio, Union, and Webster. Eleven locations, including outpatient clinics, CSU, behavioral health children’s hospital, and residential rehabilitation. Employs an estimated 600 staff, with 32 open positions listed. Affiliations with clinics in New Mexico, North Carolina, and Texas. 	<p>Crisis Call Center</p> <ul style="list-style-type: none"> 1-270-684-9466 or 1-800-433-7291. Available 24/7/365; chat/text options. Triage and assessment services; uses Columbia Suicide Severity Rating Scale. Current NSPL member. <p>Dispatch of MCI</p> <ul style="list-style-type: none"> Call center is the primary dispatch arm. Notifies the MCT Lead (LCSW) if in-person response is needed. MCI dispatched via telehealth if COVID-19 is a concern (i.e., recent exposure or positive test). Dispatch location is in person at the client’s location, including in home. GPS tracking is used to monitor safety of the MCT dispatch in the field. 	<p>Composition of MCT</p> <p>Consists of a clinician/QMHP, case manager, and PSS.</p>
<p>MCI Services</p> <ul style="list-style-type: none"> Telehealth MCI services are available upon request, or if COVID-19 is a concern. Full psychological screening and evaluation on site. Teams can respond to SUD-related crisis. If primary stressors are related to SDOH identified as the crisis trigger, RVBH can provide vouchers for food, assistance for social service support, and referral to short-term housing. 	<p>Transportation</p> <ul style="list-style-type: none"> Clients are transported in a RVBH agency vehicle for psychiatric hospitalization. RVBH agency vehicle will transport client to CSU if they (or natural supports) cannot transport themselves. <p>Crisis Stabilization and Follow-Up Care</p> <ul style="list-style-type: none"> Youth stabilization: Child CSU available for ages three to 18, psychiatric residential treatment facility nine-bed facility for boys 12 to 17. Residential chemical dependency (RCD) intensive outpatient program (IOP): 20 hours of weekly activities to ensure sober living. RVBH RCD-IOP available for 14 men; The Amethyst Center serves 16 women and six infants. Eight-bed residential CSU in Owensboro, Kentucky for adults 18 and older. Post-crisis follow-up: Initiated within seven days post-crisis. Adult case manager contacts regularly for check-ins and scheduling. 	

¹³⁰ <https://www.rvbh.com/about-us/>.

¹³¹ <https://www.rvbh.com/services-cat/crisis-emergency/>.

¹³² <https://www.rvbh.com/about-us/>.

¹³³ River Valley Behavioral Health Demographics Report, 02/16/2022.

Region 4 – Lifeskills

Lifeskills service offerings are mental health, addiction, intellectual disabilities, and crisis care. They offer a wide range of emergency mental health services to consumers in crisis with the goal to assist clients in their return to a pre-crisis level of functioning.¹³⁴ Lifeskills was awarded the National Institute of Mental Health-funded Consumer Crisis Response Grant to initiate peer support and consumer advocacy, supportive housing, in-school children’s services, and home-based services.¹³⁵

<p>Demographics</p> <ul style="list-style-type: none"> Ten South Central Kentucky counties: Allen, Barren, Butler, Edmondson, Hart, Logan, Metcalfe, Monroe, Simpson, and Warren. Twenty-six service locations. Employs 875 staff, with 66 open positions listed. 155,000 Medicaid-covered lives. More than 456,400 individuals served annually via the Community Care Network, a five-CMHC collaboration (Regions 1, 2, 4, 5, and 13). 	<p>Crisis Call Center</p> <ul style="list-style-type: none"> 1-270-843-4357 or 1-800-223-8913. Staff rotation: three shifts – business hours call staff, after hours weekdays, and a staff rotation for weekends and holidays. Call center staff makeup: CSW, MHA, LPA, LCC, LMFTA. Current NSPL member. <p>Dispatch of MCI</p> <ul style="list-style-type: none"> Lifeskills does not dispatch MCT in person for MCI services. Crisis call center staff initiate telehealth assessment if crisis intervention is needed. Virtual response to schools, EDs, police stations. 	<p>Composition of MCT</p> <p>Social workers, LPA, LPCC, and a LMFTA.</p>
<p>MCI Services</p> <ul style="list-style-type: none"> Services delivered via telehealth only. Thirty to 45-minute evaluation: screening for suicide/homicide risk, assess nature of crisis, psychiatric evaluation. Determine appropriate referrals: outpatient care, residential crisis placement (Lifeskills Adult RCSU and Child RCSU), SUD treatment referrals to outpatient care or inpatient rehabilitation or residential detox. 	<p>Transportation</p> <ul style="list-style-type: none"> Leverage natural supports and law enforcement. <p>Crisis Stabilization and Follow-Up Care</p> <ul style="list-style-type: none"> Post-crisis follow-up is not funded. Children’s crisis stabilization services currently include crisis assessment and recommendation of care, brief crisis stabilization for one to seven days, and intensive treatment (typically outpatient therapy session several days per week). 	

¹³⁴ <https://www.lifeskills.com/crisis>.

¹³⁵ Kentucky CMHC MCI Stakeholder Interview, February 2022.

Region 5 – Communicare

Communicare began operation in 1967 as a CMHC. Communicare offers a comprehensive care approach to provide accessible services for individuals with behavioral health, substance use, I/DD, and chemical dependency needs for adults and children.¹³⁶ This comprehensive care approach includes providing additional services such as prevention services and substance abuse transitional housing for women.¹³⁷

In 2021, Communicare was awarded \$2,855,492 by the Coronavirus Response and Relief Supplemental Appropriations Act for the support of its behavioral health services.¹³⁸

Communicare’s Central Kentucky catchment population was estimated to be 274,060, with a total population of youth (age 16 to 25) at 34,830.¹³⁹ In SFY2017, Communicare served 13,030 youth (age 16 to 25), including 892 who met the criteria of having either an SMI or SED.¹⁴⁰

<p>Demographics¹⁴¹</p> <ul style="list-style-type: none"> Eight Kentucky counties in the Lincoln Trail Region: Breckinridge, Mead, Grayson, Hardin, La Rue, Nelson, Marion, and Washington. More than 30 locations, including outpatient clinics, community habilitation, residential programs, crisis stabilization, alcohol and drug programs, and adult day training. Forty open staff positions listed. More than 456,400 individuals served annually via the Community Care Network, a five-CMHC collaboration (Regions 1, 2, 4, 5, and 13). 	<p>Crisis Call Center</p> <ul style="list-style-type: none"> 1-270-765-2605 or 1-800-641-4673. Calls received via the ACCESS Center Crisis Line or direct calls to a clinic department or manager. Current NSPL member. <p>Dispatch of MCI</p> <ul style="list-style-type: none"> Call center staff make the determination for MCI services dispatch. 	<p>Composition of MCT</p> <ul style="list-style-type: none"> One-person team for MCI services delivery unless acute care team (ACT) required. If individual in crisis is an existing client, Communicare looks to match a provider. LPCC, LPCA, LMFT, PA, or clinical psychiatrist. Nurses can be used as support. Peer supports are not currently in use. iHOPE is a multi-disciplinary team providing intensive therapeutic support for adolescents and young adults experiencing their first episode of psychosis.¹⁴²
<p>MCI Services</p> <ul style="list-style-type: none"> Telehealth available to the MCT for service delivery. Arrange for CSU and facilitate follow-up care plan if client cooperative. Coordinate with law enforcement if individual is not cooperative. Case manager helps with additional supports like housing and employment. Referral to Community Action, a non-profit providing social services. 	<p>Transportation</p> <ul style="list-style-type: none"> Leverage natural supports such as caregivers, family, and friends. Law enforcement. <p>Crisis Stabilization and Follow-Up Care</p> <ul style="list-style-type: none"> Post-crisis follow-up appointments made by MCT during MCI service delivery. Child CSU: A 12-bed 24-hour CSU is available for youth four to 18 years of age. Admitted youth receive a variety of interventions, such as individual and group therapy, nursing services, psychiatric evaluations, and medication management follow-up. Adult CSU: A 24-hour CSU is available for adults to help them during times of crisis. The targeted treatment approach is to connect the individual to community resources so they can return to their normal routine as quickly as possible. 	

¹³⁶ <https://www.communicare.org/why-communicare>.

¹³⁷ <https://www.samhsa.gov/grants-awards-by-state/KY/discretionary/2020/details>.

¹³⁸ <https://www.communicare.org/crisis>; Kentucky CMHC MCI Stakeholder Interview, February 2022.

¹³⁹ <https://www.samhsa.gov/grants-awards-by-state/KY/discretionary/2019/details>.

¹⁴⁰ <https://www.samhsa.gov/grants-awards-by-state/KY/discretionary/2019/details>.

¹⁴¹ *Ibid.*

¹⁴² <https://www.communicare.org/crisis>.

Region 6 – Seven Counties

Formerly known as Centerstone, Seven Counties offers a comprehensive range of mental health, substance abuse treatment and intellectual and developmental disabilities services in the region.¹⁴³ In FY 2019 and FY 2020, Seven Counties received grant money from SAMHSA to expand their services. According to the 2021 regional needs assessment for Seven Counties, “[t]he number of behavioral health professionals available to the population varies by county, with all of Seven Counties’ counties lacking adequate capacity except Jefferson County.”¹⁴⁴

Seven Counties’ service region is home to more than one million people, or 23 percent of the Commonwealth’s population.¹⁴⁵ Region 6 includes Louisville-metro, some of the state’s most densely populated and diverse locations which is made up of: 49 percent male, 51 percent female, 77 percent White, 18 percent African American, five percent Hispanic/Latino. Approximately 14 percent of the region live below the poverty rate and 10 percent lack a high school diploma/equivalent. Within the Seven Counties catchment, 22 percent of adults experience a mental health illness, 14 percent of children age two to 17 have an emotional/behavioral/developmental condition, and eight percent of adults and four percent of adolescents have an SUD.¹⁴⁶

Seven Counties has applied for nearly \$2.5 million in funding per project year from SAMSHA to reach the goal of serving an additional 500 individuals per year, to respond to clients within three hours 90 percent of the time, and to divert at least 80 percent of clients from hospitalization at the time of intervention.¹⁴⁷

Demographics

- Counties served: Bullitt, Henry, Jefferson, Oldham, Shelby, Spencer, and Trimble.
- Thirty locations, including outpatient offices, addiction services, I/DD division, drop-in center, and corporate offices.
- Eighty-five-plus unique programs: behavioral health, developmental disabilities, and drug/alcohol addictions.
- Serve 12,000-plus children per year with programs in more than 120 Jefferson County public schools.
- Employs more than 1,500 staff, with 247 open positions listed.
- Serves more than 34,000 individuals annually.

Crisis Call Center

- 1-502-589-4313 or 1-800-221-0446 (adult); 1-502-589-8070 or 1-800-432-4510 (children); 1-502-583-3951 (addiction help).
- Available 24/7/365, dedicated help line for adults, children, and SUD.
- QMHPs answer crisis calls through the children’s help line.
- Determine if call can be resolved telephonically, or if crisis intervention is needed. Crisis intervention can be done via telehealth or mobile response. Walk-in crisis clinic recommended for clients who can transport themselves immediately.
- Connections to active rescue/first responders if required.
- Current NSPL member.

Dispatch of MCI¹⁴⁸

- Call center staff make the determination for MCI dispatch.
- Clients who request telehealth crisis intervention services are increasing.
- Crisis clinic: Available for adults experiencing a mental health or substance abuse crisis Monday through Friday from 8:30 a.m. to 3:30 p.m. Services include crisis assessments and links to resources and a short-term follow-up for support.

Composition of MCT

- Multi-disciplinary team: two-plus-member team including behavioral health professionals, associates, and/or peer support.
- Deflection Program (via the DOVE Delegates) MCT services include crisis response staff and a peer support.
- Addiction response team, SUD-trained staff, and a peer support.

¹⁴³ <https://sevencounties.org/about/>

¹⁴⁴ Kentucky CHFS OHDA CCBHC Regional Needs Assessment: Seven Counties, May 2021.

¹⁴⁵ <https://www.samhsa.gov/grants-awards-by-state/KY/discretionary/2019/details>.

¹⁴⁶ Kentucky CHFS OHDA CCBHC Regional Needs Assessment: Seven Counties, May 2021.

¹⁴⁷ <https://www.samhsa.gov/grants-awards-by-state/KY/discretionary/2019/details>.

¹⁴⁸ <https://sevencounties.org/services/>.

MCI Services¹⁴⁹

- Telehealth services offered to client upon request.
- Conduct assessment, bridge to intake, warm hand-offs to outpatient or inpatient care.
- Provision of short-term services and supports as needed; bed placement for adult hospital stays and child placement.
- Safety plans that consider natural supports.
- Emergency services for children and families: provides acute child psychiatric services through 24 hours a day assessments, interventions, and referrals for children, adolescents, and families experiencing psychiatric emergencies.¹⁵⁰

Transportation

- Agency-provided transport for clients receiving response under the Deflection Program or addiction response.

Crisis Stabilization and Follow-Up Care

- Youth CSU: intensive short-term (up to seven days) inpatient program for children who need care outside of outpatient treatment. Can be utilized as a 23-hour stabilization unit.
- Adult Addiction Stabilization Unit: Intensive short-term stabilization unit primary for adults with SUD. Can be utilized as a 23 hour Stabilization Unit, recliners available for behavioral health crisis under the DOVE Delegate Deflection Program. Plan to expand on their Living Room Model that offers people experiencing a behavioral health crisis an alternative to hospitalization.
- Partnership with Wellspring for broader adult behavioral health stabilization.
- Crisis Prevention and Response Program: Offers person-centered, short-term response for I/DD and are experiencing a behavioral or psychiatric crisis.
- Follow-ups conducted immediately following post-crisis via the call center.

¹⁴⁹ [Ibid.](#)

¹⁵⁰ <https://sevencounties.org/children-families/>.

Region 7 – NorthKey

NorthKey began operation in 1966 as a CMHC and delivers research-driven mental health, substance use, and developmental disabilities services.¹⁵¹ NorthKey provides crisis services, outpatient individual/family/group therapy, case management, prevention services, and housing support for I/DD.¹⁵² Furthermore, in 2021 NorthKey received \$5 million from SAMHSA to address the COVID-19 impact on the Kentucky population as it related to the need for crisis support services.¹⁵³

In SFY2019, NorthKey served 37 percent of the estimated number of adults with a severe and persistent mental illness, and 42 percent of the estimated youth with serious emotional disabilities. NorthKey’s ratio of individuals per behavioral health professional is 741:1, which is higher than the state ratio of 494:1.¹⁵⁴

<p>Demographics</p> <ul style="list-style-type: none"> Eight counties served: Boone, Campbell, Gallatin, Grant, Kenton, Owen, and Pendleton. Fifteen locations, including outpatient, adult day training, and regional campuses. Employs more than 200 staff. Serves more than 14,000 individuals annually. 	<p>Crisis Call Center</p> <ul style="list-style-type: none"> 1-859-331-3292 or 1-877-331-3292. Call received via the ACCESS Center Crisis Line available 24/7/365. Triage and Columbia Suicide Severity Rating Scale for initial assessment. Callers are connected to a clinician to conduct an assessment and determine the approach or treatment needed. Referrals to crisis services are available in person at all locations during business hours for individuals needing crisis services. Video telehealth options are also available at select locations. Current NSPL member. <p>Dispatch of MCI</p> <ul style="list-style-type: none"> Safety assessment completed prior to on-site dispatch to determine site safety (e.g., pets, weapons, etc.). If it is deemed unsafe for MCT, NorthKey transfers response to police department CIT. Call center clinician makes the determination for MCI dispatch and arrange for crisis intervention and in-depth consultation. 	<p>Composition of MCT</p> <ul style="list-style-type: none"> On-site response typically includes one person, an LP, typically a therapist. Crisis case manager may assist the therapist with on-site response.
<p>MCI Services</p> <ul style="list-style-type: none"> All MCTs have the capability to connect via telehealth. Determination of level of care needed: outpatient services, inpatient treatment, or hospitalization. Referral to crisis medication clinic: at certain NorthKey locations, a crisis medication clinic is available for individuals referred by crisis stabilization clinicians. Crisis case manager connects in person or telephonically for care coordination and provision of supports like safe housing. 	<p>Transportation</p> <ul style="list-style-type: none"> Contracts with UberHealth. Work with natural supports. <p>Crisis Stabilization and Follow-Up Care</p> <ul style="list-style-type: none"> Post-crisis follow-up occurs within 24-hrs post-crisis. Crisis Stabilization Services: Available to children and families, adults and those with developmental disabilities. 	

¹⁵¹ <https://www.northkey.org/about-northkey/>.

¹⁵² <https://www.northkey.org/services/family-and-child-services/crisis-stabilization-services/>.

¹⁵³ <https://www.nkytribune.com/2021/10/northkey-community-care-gets-5million-federal-grant-to-address-emotional-mental-illness/>.

¹⁵⁴ Kentucky CHFS OHDA CCBHC Regional Needs Assessment: NorthKey, May 2021.

Region 8 – Comprehend

Comprehend has been in operation for more than 50 years. In 2020, the CMHC was awarded a \$300,000 grant by DBHDID, in partnership with the Kentucky Office of Drug Control Policy, to fund the expansion of treatment and recovery services for individuals with an OUD.¹⁵⁵ Comprehend intends to use the grant dollars to provide a women’s sober living facility, Harmony House, in Mason County.

Demographics

- Five counties served in the Buffalo Trace Region: Bracken, Robertson, Mason, Lewis, and Fleming.
- Eighteen locations.
- Programs: Comprehend Response and Information Center, child CSU, brown bag seminar series, 23-hour observation beds, transitional housing, emergency intervention fund, emergency preparedness efforts, and suicide prevention.
- Employs 170 staff, with 13 open positions listed.
- Partnerships: drug court, public school districts, juvenile justice, YMCA, law enforcement, emergency disaster, March of Dimes, probation and parole, and womens’ crisis centers.

Crisis Call Center

- 1-877-852-1523.
- Crisis call routing is dependant on time of day: business hours rings into central switchboard for intake; after hours rings into the Call Response Center to the ACT or on-call QMHP.
- Call takers determine if the ACT is needed. During business hours, crisis clients are directed to a walk-in crisis clinic.
- Not currently an NSPL member and does not have plans to onboard.

Dispatch of MCI

- After hours on-call QMHP triages calls flagged for physical crisis response, disposition for the ACT is made.
- On-site response limited to hospitals, local domestic violence shelters, jail, and police departments. Does not provide in-home response. Occassionally the ACT will respond on site (outside of designated locations) with law enforcement.

Composition of MCT

- Acute Care Team: One to two-person team. Primary delivery of emergency behavioral healthcare services. The team coordinates and oversees crisis stabilization-related services. Includes QMHP (psychologists, social workers, counselors, LMFT).
- Assertive Community Treatment (ACT) Team: includes client, team leader, case manager, PSS, counselor, psychiatrist, nurse, and vocational specialist.

MCI Services

- Crisis services are available via telehealth.
- Arrange for CSU and facilitate follow-up care plan if client cooperative.
- Coordinate with law enforcement if individual is not cooperative.
- Case manager helps with additional support: community action, supportive housing, and employment.
- Warm hand-offs: outpatient treatment, rehabilitation/withdrawal management facilities, and inpatient care.
- Goal is to rapidly respond, effectively screen, and provide early intervention to ensure continuum of care. Identifies services and alternatives to minimize distress. Provided in community setting by police, providers, hospitals, and community partners.
- ACT for clients with SMI: assists and supports with treatment, medication, housing, employment, and family stresses.

Transportation

- Police transport for involuntary commitments.
- EMS will occasionally provide transport to inpatient care.

Crisis Stabilization and Follow-Up Care

- Post-crisis follow-up calls made by crisis staff following crisis call (24 hours or next day). If referred for inpatient care, unit social worker conducts follow-up during discharge planning.
- Crisis stabilization services provided through multi-disciplinary team approach, emphasizing integrated care. Residential CSU provides short-term, more than 24-hour, stabilization services. Twenty-three hour CSU is no longer in use.
- Children’s CSU intervenes in crisis situations in which children are at risk or placement into a psychiatric hospital (intensive, short-term residential treatment). In addition to crisis intervention, the unit focuses on teaching children and families the skills to deal with future crises. Staff: psychiatrist, psychologist, social workers, counselors, and specialized residential staff.

¹⁵⁵ <https://comprehendinc.org/our-history>.

Region 9/10 – Pathways

Pathways began operating as a CMHC in 1967. Pathways offers a variety of behavioral health services including I/DD support services and SUD services.¹⁵⁶ According to the 2021 needs assessment for Pathways region, in FY 2019, the percentage of adults that Pathways served that had a severe and persistent mental illness, and youth with emotional disabilities exceeded the Commonwealth average.¹⁵⁷ Since 2016, there has been an increase in the number of mental health providers in the Pathways region.¹⁵⁸

<p>Demographics</p> <ul style="list-style-type: none"> Ten counties served: Bath, Boyd, Carter, Elliott, Greenup, Lawrence, Menifee, Montgomery, Morgan, and Rowan. More than 20 locations. Employs approximately 450 individuals, with 72 open positions listed. Serves more than 14,000 individuals annually. 	<p>Crisis Call Center</p> <ul style="list-style-type: none"> 1-606-324-1141 or 1-800-562-8909. Call Center available 24/7/365. Staff gather details for intake and submit orders for a telehealth assessment with the MCT. Majority of crisis calls come in from hospitals, police, social services, probation/parole, and schools. Referral for walk-ins for crisis services: walk-ins are assessed by a clinician to determine treatment plans. Current NSPL member. <p>Dispatch of MCI</p> <ul style="list-style-type: none"> Calls coming in from the behavioral units for involuntary hospitalization assessments are automatically triaged to the MCT for telehealth. Dispatch location limited to designated safe places (schools, hospitals, police stations, courthouses, probation/parole, and sometimes churches). MCT conducts a telehealth assessment prior to dispatching on site. 	<p>Composition of MCT</p> <ul style="list-style-type: none"> QRT: collaboration with law enforcement, medical care providers, and mental health providers to provide support within 24 to 72 hours to individuals experiencing a drug overdose during the "recovery window."
<p>MCI Services</p> <ul style="list-style-type: none"> Currently delivering MCI exclusively via telehealth. Crisis intervention includes de-escalation, full evaluation, and safety planning. MCT connects with call center for hospitalization needs, to facilitate referrals, and coordinate bed/placement. 	<p>Transportation</p> <ul style="list-style-type: none"> EMS does not transport behavioral health patients in Region 9/10. Call cab companies for transportation. Close relationship with local police departments who are willing to step in and fill transportation gaps. <p>Crisis Stabilization and Follow-Up Care</p> <ul style="list-style-type: none"> Walker House: a six-bed CSU for children six to 17 years old for short-term mental health treatment. Crisis and Residential Recovery Unit (CRRU): for clients 18-plus years of age that can live independently in/near Ashland and Mt. Sterling, Kentucky. CRRU offers a 28-day program with 15 hours of weekly individual therapy. Additional programs include group therapy, peer support services, and referral for long-term treatment as needed. Post-crisis follow-up conducted by the Help Line Call Center within 24 hours of stabilization. 	

¹⁵⁶ <https://www.pathways-ky.org/about>.

¹⁵⁷ <https://www.pathways-ky.org/crisis-services>.

¹⁵⁸ Kentucky CHFS OHDA CCBHC Regional Needs Assessment: Pathways, May 2021.

Region 11 – Mountain Comprehensive Care Center (MCCC)

The Mountain Comprehensive Care Center (MCCC) began operation in 1971 as a CMHC. MCCC offers a comprehensive care approach to provide services for behavioral health, substance use, and I/DD for adults and children.¹⁵⁹ This comprehensive care approach includes providing additional services, such as housing assistance for those in need and healing services for those who experienced interpersonal violence. In FY 2021, MCCC was awarded \$400,000 by SAMHSA to implement a zero suicide initiative for a project period of August 2020 through August 2025.¹⁶⁰ SAMHSA also awarded MCCC \$4 million under a CMHC grant to address COVID-19 impacts for the region as it related to the need for increased crisis support services.

Demographics

- Five Big Sandy/Appalachian counties served: Pike, Floyd, Martin, Johnson, and Magoffin.
- Twelve locations.
- Employs approximately 324 individuals, with more than 80 open positions listed.
- Serves more than 23,000 individuals annually.

Crisis Call Center

- 1-800-422-1060.
- Twenty-four-hour help line: the 24-hour help line is a toll-free crisis help line available 24/7/365. Mental health clinicians assist individuals during their time of crisis and assess the situation to determine the appropriate level of intervention.¹⁶¹
- Calls for MCI requests come in from eight contracted regional hospitals and three regional jails.
- Referrals to emergency walk-in services: available for individuals in crisis at all MCCC outpatient facilities during the business hours of Monday through Friday, 8:00 a.m. to 5:00 p.m.
- Current NSPL member.

Dispatch of MCI

- Crisis call center staff submits request for MCI response. Law enforcement is contacted to respond alongside MCT if there is an identified safety risk.
- Face-to-face response is limited to partnering hospitals' crisis calls. Does not offer in-home response. Telehealth is used to address gaps in crisis response.
- Single crisis evaluator responds to mobile crisis at requesting hospitals.

Composition of MCT

- Mixture of practitioners, fully licensed and/or supervised, used on the crisis response team: supervised MHA, on-call QMHP, CSW, LCSW, LPCC (limited use), LCADA (limited use). Not utilizing peers at this time.

MCI Services

- MCI services are delivered via telehealth to clients outside of hospital settings.
- Conducts face-to-face crisis evaluation, determines resolution, and schedules outpatient appointment for following day, placement for hospitalization, orders for involuntary hospitalization, and referrals to crisis walk-in for intake. Consultation is considered incomplete until final care decision is made.
- I/DD crisis response: for crisis calls that require I/DD-trained staff, the I/DD on call staff will assist in determining the most appropriate intervention for the situation.
- Assertive Community Treatment: mobile multi-disciplinary team that provides community-based outpatient services. ACT is available 24/7/365 and assists individuals with medication management, counseling peer support services, and more. An emphasis is placed on crisis intervention and preventing psychiatric hospitalizations.
- QRT used for crisis calls involving SUD.

Transportation

- Arranged by partnering hospitals.
- Sherrifs' office transports involuntary commitments.

Crisis Stabilization and Follow-Up Care

- Adult crisis stabilization is offered at Riverside in Prestonsburg, Kentucky and serves the MCCC region. The adult crisis stabilization service is open 24/7/365 and is an eight-bed residential program. Children's crisis stabilization is offered at Creekside and serves the MCCC region. It is a six-bed residential program located in Prestonsburg, Kentucky. The children's crisis stabilization service is available 24/7/365.
- Evaluators conduct post-crisis follow-up with patients 24 to 48 hours post-crisis or discharge from hospital.

¹⁵⁹ <https://www.mtcomp.org/programs>.

¹⁶⁰ <https://www.samhsa.gov/grants-awards-by-state/KY/discretionary/2021/details?page=1>.

¹⁶² <https://www.mtcomp.org/crisis>.

Region 12 – Kentucky River Community Care

Kentucky River Community Care (KRCC) is a CMHC serving Kentucky’s southeastern counties. The KRCC catchment population was estimated to be 105,732 in 2018, 11,771 of which were youth, age 16 to 25 years old.^{162,163} In SFY2017, KRCC served 1,143 youth between 16 and 25 years old, 308 of which met the criteria of having a severe SED or SMI.¹⁶⁴

<p>Demographics</p> <ul style="list-style-type: none"> Seven counties served: Breathitt, Knott, Lee, Leslie, Letcher, Perry, and Wolfe. Seven outpatient locations. Eighty open positions listed. Mobile crisis and community mental health efforts: MCI, emergency disaster response, specialized community response, QRTs, and CIT training for first responders. 	<p>Crisis Call Center</p> <ul style="list-style-type: none"> 1-800-262-7491. Staff rotation: three shifts – business hours call staff, after hours weekdays, and a staff rotation for weekends and holidays. Call center staff makeup: CSW, MHA, LPA, LPCC, and LMFTA. Current NSPL member. <p>Dispatch of MCI</p> <ul style="list-style-type: none"> Crisis call staff initiate orders for MCT dispatch. MCI telehealth dispatch for hospital settings and jails. 	<p>Composition of MCT</p> <ul style="list-style-type: none"> When MCT receives dispatch orders, they review client notes and form the team based on response needed. Team may be composed of QMHPs, supervised associates, peer support, and/or first responder. QRT (Breathitt County): peer support and therapist work closely with law enforcement and EMS on SUD crises.
<p>MCI Services</p> <ul style="list-style-type: none"> Telehealth used for clients in hospital and jail settings. MCT: provides on-site evaluation, treatment, and intervention. In-person MCI response to safe places unless police are involved or on scene. Disaster response: mental health trauma counselors perform community response after natural disaster or house fire. They work with first responders for on-site outreach. Specialized community response: on-site counseling to schools or workplace to provide in-person trauma counseling in response to “events” (like workplace accident or violent threat in school). 	<p>Transportation</p> <ul style="list-style-type: none"> Coordinate transport with law enforcement. KRCC staff can transport willing/voluntary clients deemed safe at the discretion of the MCT. <p>Crisis Stabilization and Follow-Up Care</p> <ul style="list-style-type: none"> Post-crisis referrals: case manager conducts follow-up and check-ins with client and natural supports during a seven-day window post-stabilization. QRT makes referrals to outpatient care for medication-assisted treatment (MAT) and/or inpatient withdrawal management or addiction treatment. Crossroads crisis center: 23-hour facility for adults and children. Evaluation, assessment, and de-escalation of crises with connection to community resources. Located in Hazard, Kentucky. The CSU is a short-term, voluntary eight-bed unit focused on crisis stabilization, but has limited availability. Ongoing peer support via recovery community center, peer-driven outpatient program for SUD/ODU/co-occurring (New Directions), peer-driven residential facility (Hickory Hills). 	

¹⁶² <https://www.krccnet.com/>.

¹⁶³ <https://www.samhsa.gov/grants-awards-by-state/KY/discretionary/2019/details>.

¹⁶⁴ Ibid.

Region 13 – Cumberland River Behavioral Health

Cumberland River Behavioral Health (CRBH) is a CMHC with more than 500 professionals providing mental health, I/DD, and substance use services in eight Southern Kentucky counties.

<p>Demographics</p> <ul style="list-style-type: none"> Eight Southern Kentucky counties served: Bell, Clay, Harlan, Jackson, Knox, Laurel, Rockcastle, and Whitley. Fifteen locations, including outpatient, community outreach, and residential centers. Employs approximately 500 individuals, with 44 open positions listed. More than 456,400 individuals served annually via the Community Care Network, a five-CMHC collaboration (Regions 1, 2, 4, 5, and 13). Partnerships with regional public school districts. 	<p>Crisis Call Center</p> <ul style="list-style-type: none"> 1-888-435-7761. Crisis line: 24/7/365 crisis line for children, families, and adults. Staff will listen to issues, provide support, and information regarding agency and community resources. American Sign Language (ASL) interpreter services are available via designated line; specific language accommodations (on individual basis).¹⁶⁵ Victims’ services hotline: for victims of sexual assault or abuse. 24/7/365 calls are answered by trained professionals and an advocate is dispatched to meet at the hospital if the assault happened recently and they choose to seek medical care.¹⁶⁶ Two clinicians available to answer crisis calls during business hours. If the two clinicians are busy, the call is routed to a staff member at the clinic. Crises are transferred to local law enforcement if a safety risk is identified, or in-person de-escalation is needed. Current NSPL member. <p>Dispatch of MCI</p> <ul style="list-style-type: none"> Clinician performs crisis intervention via telehealth. Cumberland River does not have current plans to respond in person. 	<p>Composition of MCT</p> <ul style="list-style-type: none"> Single clinician responds to crisis via telehealth: LPCA, LPCC, LCSW, and MHA. Virtual children’s MCT: team of trained professions that provide crisis intervention/ referral services. De-escalation is provided prior to assessment, followed by referral to the appropriate level of care. MCT available after 4:30 p.m. on weekdays and 24 hours on the weekends.¹⁶⁷
<p>MCI Services</p> <ul style="list-style-type: none"> MCI response via telehealth only. Crisis services are available at 10 outpatient locations, as well as the Haven House Adult CSU and the Turning Point Children’s CSU. Crisis evaluation and care determination made by MCT virtually. Coordination of outpatient services and inpatient placement, referrals as needed. 	<p>Transportation</p> <ul style="list-style-type: none"> Coordinate transport with local hospitals and law enforcement. If hospitalization is needed, call center will transfer for EMS transport. <p>Crisis Stabilization and Follow-Up Care</p> <ul style="list-style-type: none"> Post-crisis referrals: MCT follows up with client 24 hours post-crisis if care determination was outpatient care. MCT follows up with client within 10 business days if care determination was inpatient. Haven House Adult CSU and Turning Point Children’s CSU. 	

¹⁶⁵ <https://crbhky.org/>.

¹⁶⁶ [Ibid.](#)

¹⁶⁷ [Ibid.](#)



Region 14 – Adanta

Adanta is a CMHC serving the Cumberland Lake area. While Adanta does not offer MCI services, walk-in crisis services and outpatient crisis stabilization are offered in-house and through local partnerships. Current crisis services include crisis evaluations, I/DD crisis support, and referral to adult crisis stabilization.¹⁶⁸

Demographics	Crisis Call Center
<ul style="list-style-type: none"> ▪ Ten rural Kentucky counties served: Cumberland, Clinton, Wayne, McCreary, Pulaski, Russell, Adaire, Green, Taylor, and Casey. ▪ Eighteen locations, including outpatient, prevention center, and sexual assault resource center. ▪ Scope of services: outpatient mental health, outpatient substance use, Administrative Office of the Courts/specialty court (or drug court), case management, peer support, and comprehensive community support services. ▪ Employs approximately 265 individuals, with 110 open positions listed. ▪ Serves more than 5,000 individuals annually. 	<ul style="list-style-type: none"> ▪ NSPL crisis line (1-800-633-5599) available 24/7/365. Calls are answered by designated staff and 988/NSPL-trained call center staff. Call takers conduct the Columbia Suicide Rating Scale and either make referral to outpatient clinic for crisis appointment, connect to law enforcement if de-escalation is needed, or connect to EMS if an urgent need for hospitalization is identified. The call center is able to submit welfare check requests for law enforcement and can transfer to the 202A Evaluation Team (LPCC, LCSW, and case manager) for involuntary assessment. ▪ Current NSPL member.

While Adanta does not currently provide MCI services, it delivers services that could support MCI delivery in the future:

- **Assertive Community Treatment:** Community-based outreach and services provided for clients with SMI. Adanta staffs a four-person multi-disciplinary team that serves 18 clients with SMI.
- **Stabilization:** Upon discharge from hospitalization, the call center conducts outreach within three to seven business days. Since there is not a CSU in Region 14, adult stabilization services are offered in an outpatient setting via the Adanta Clinic. I/DD patients experiencing crisis are referred to respite care post-hospitalization. Case managers assist clients with social service supports on an ongoing basis. Adanta currently employs peer supports to assist with recovery and vocational support.
- **Community Programs:** Residents of the region can receive behavioral health supports through one of Adanta’s community programs which includes: early childhood mental health services, First Steps Early Intervention, supported employment, ACT, I/DD, and veterans’ services. Outside of the outpatient facilities, Adanta operates an adult sexual assault resource center and SKYHope Women’s Recovery facility.¹⁶⁹

¹⁶⁸ Adanta CMHC MCI Stakeholder Interview, March 2022.

¹⁶⁹ <http://www.adanta.org/index.php/client-information/client-services-guide>.



Region 15 – New Vista

New Vista began operation in 1966 as a CMHC. New Vista offers an integrated care approach to provide services in the areas in mental health, substance use, and I/DD for adults and children.¹⁷⁰ SAMHSA granted New Vista approximately \$2.56 million to address the COVID-19 impact on the Kentucky population as it related to the need for crisis support services.¹⁷¹

According to the 2021 regional needs assessment for New Vista, all New Vista counties except Fayette County lack adequate capacity for behavioral health professionals. The needs assessment also revealed that Kentuckians in the New Vista region received more Medicaid-funded behavioral health services in 2020 compared to 2019 across all providers including CMHC and non-CMHC providers.¹⁷²

New Vista received 71,500 calls to the regional help line, 266,348 visits to the New Vista website, 457,807 instances of service, served 2,912 clients with I/DD, served 3,324 clients with SUD, and served 12,181 clients with AMI.¹⁷³

Demographics	Crisis Call Center	Composition of MCT
<ul style="list-style-type: none"> ▪ Seventeen Kentucky counties served: Anderson, Bourbon, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harrison, Jessamine, Lincoln, Madison, Mercer, Nicholas, Powell, Scott, and Woodford. ▪ Fifty-two locations: I/DD access, child and family wellness center, birth to three years old developmental delay facility, outpatient clinics, residential SUD, iHOPE for SMI ACT, and The Drop-In Center for Homeless Services. ▪ Ninety-three programs, including mental health, substance use, I/DD, and prevention. ▪ Employs approximately 1,800 individuals and 281 licensed individuals, with 233 open positions listed. ▪ Serves more than 25,000 individuals annually. ▪ Partnerships with regions’ public school systems and Fayette County Detention Center. ▪ 2021 Annual Report: \$173.8 million budget. 	<ul style="list-style-type: none"> ▪ 1-800-928-8000. ▪ NSPL member. ▪ Emergency help line: Available 24/7/365 and allows for individuals in crisis to call and receive help from trained crisis counselors. ▪ Via the help line, crisis counselors recommend solutions for callers and develop a plan of action for those in mental health, substance use, and I/DD emergencies. ▪ Referral to crisis walk-in services are available at any New Vista location during office hours of 8:00 a.m. to 5:00 p.m. Monday through Friday. ▪ Agreements in place that enable police departments to bypass the emergency help line and directly request MCI services. ▪ Call Center transfers to Community Paramedicine Program (CPP) for MCI needs in the Lexington-area served. CPP is a local diversion program operated by EMS within Lexington. CPP’s partnership with New Vista supports diversion from the city’s hospital ED. <p style="text-align: center;">Dispatch of MCI</p> <ul style="list-style-type: none"> ▪ Call center staff identify need for MCI services and submit for dispatch. ▪ Most crisis calls are resolved within the call center: existing clients in crisis call to speak to an on-call psychiatrist. 	<ul style="list-style-type: none"> ▪ Rotation of QMHP, supervised associates, paraprofessional (peer), and case manager. Composition is dependent upon the nature of the crisis. ▪ Established partnership with Community Paramedicine Partnership (CPP): paramedic, social worker, and law enforcement.

MCI Services

Transportation

¹⁷⁰ <https://newvista.org/about/philosophy-care>.

¹⁷¹ <https://www.samhsa.gov/sites/default/files/covid19-programs-funded-samhsa-fy21.pdf>.

¹⁷² Kentucky CHFS OHDA CCBHC Regional Needs Assessment: New Vista, May 2021.

¹⁷³ <https://newvista.org/sites/default/files/New-Vista-AR-2021-Digital.pdf>.

- MCT has access to telehealth. Existing clients working with a New Vista provider may request crisis services via telehealth with their primary therapist.
 - Crisis team provides intervention services for adults and children experiencing crisis.
 - Immediate evaluation and crisis assessment, stabilization strategies and safety planning, short-term intensive crisis intervention, clinical consultation, and referral to acute behavioral healthcare treatment.
 - Emergency services for those with I/DD and those that are deaf and hard of hearing: intensive case managers are dispatched to provide intensive support to ensure individuals with I/DD receive proper and specialized treatment. For individuals that are deaf or hard of hearing and are in a crisis, they can call the 24-hour help line or email the help line for crisis support from a therapist who understands how to appropriately engage with those that are deaf and use ASL.¹⁷⁴
 - Community counseling outreach: grief drop-in services for schools experiencing traumatic events.
- EMS through CPP and law enforcement for involuntary hospitalization.
 - Creative solutions: leverage natural supports, gift cards, public transportation passes.

Crisis Stabilization and Follow-Up Care

- Region 15 does not have a CSU (24-plus hour) or a 23-hour stabilization unit.
- MCT follows up post-crisis within 24 hours for outpatient appointment scheduling if hospitalization or inpatient care was not required.
- MCT follows up post-stabilization upon discharge for outpatient scheduling.

¹⁷⁴ <https://newvista.org/emergency/emergency-services>.

BHSOs Providing MCI Services Over the Past Three Years

Medicaid claims data showed that over the past three SFYs, 2019 through 2021, only four BHSOs billed Medicaid for MCI services.¹⁷⁵ These organizations are Addiction Recovery Care (ARC), Omni Community Health, Ramey-Estep Homes, and Wellspring. In addition, these organizations participated in the MCI services planning grant stakeholder engagement activities.

ARC is a Tier 2 and Tier 3 BHSO operating in Eastern and Central Kentucky. ARC has a network of 36 licensed Commission on Accreditation of Rehabilitation Facilities (CARF) accredited addiction treatment centers offering a full continuum of care including withdrawal management, residential, transitional, intensive outpatient, outpatient, MAT, vocational rehabilitation, and job training.¹⁷⁶

Ramey-Estep Homes is a Tier 2 and 3 BHSO operating in Eastern Kentucky that provides services for youth and families. Ramey-Estep Homes provides adolescent residential treatment, therapeutic foster care, outpatient services, and addiction services. Since 1989, Ramey-Estep has served more than 2,000 young people through the adolescent residential treatment program. In 2020, Ramey-Estep expanded its residential programming to adult women with a specialization in SUD treatment. Ramey-Estep residential program provides a wide array of services to adolescents aged 12 to 17 years old. Youth residential services are provided through a therapeutic setting and incorporate consistent structure, education support, counseling services, skill development, and the development of supportive peer, adult, and therapeutic relationships. The program includes psycho-educational groups led by licensed professionals covering health issues and medical decisions, drug education, refusal skills, relapse prevention, and co-occurring problems. A 24/7 on-call number is available across services.^{177, 178}

Omni Community Health is a Tier 1 BHSO that was founded in 2014 and provides behavioral health services in Louisville.¹⁷⁹ Services provided include a family intervention treatment team, comprehensive diagnostic and evaluation services, individual, family, and couples therapy, group therapy, intensive outpatient program, comprehensive child and family treatment, case management, a continuous treatment team, and medication management and evaluation.¹⁸⁰

Wellspring is a Tier 1 BHSO headquartered in Louisville. Wellspring is involved throughout the MCI services continuum as a treatment provider, stabilization unit, and housing organization.¹⁸¹ Wellspring's programs include Perkins Supported Housing Program (PUSH), program for integrated care, and ACT. Their clients reported median income is \$17,000 per year.¹⁸²

¹⁷⁵ KDMS. Kentucky SFY 2019 – 2021 Data Query of Medicaid Crisis Intervention Claims for MCI services billed from 7/1/2018 to 6/30/2021, and paid as of 3/10/2022.

¹⁷⁶ <https://www.arccenters.com/>; Kentucky BHSO MCI Pre-Interview Questionnaire, February 2022.

¹⁷⁷ Kentucky BHSO MCI Pre-Interview Questionnaire, February 2022.

¹⁷⁸ <https://www.rameyestep.com/>.

¹⁷⁹ <https://www.theomnifamily.com/behavioral-health/>.

¹⁸⁰ <https://www.theomnifamily.com/behavioral-health/behavioral-health-services/>.

¹⁸¹ Kentucky MCI Roundtable: Housing Stakeholders, March 2022.

¹⁸² <https://wellspringky.org/>.



Current MCI Services Delivery Continuum

Kentucky's current system of MCI services delivered across the Commonwealth

Kentucky's Current MCI Services Delivery Continuum

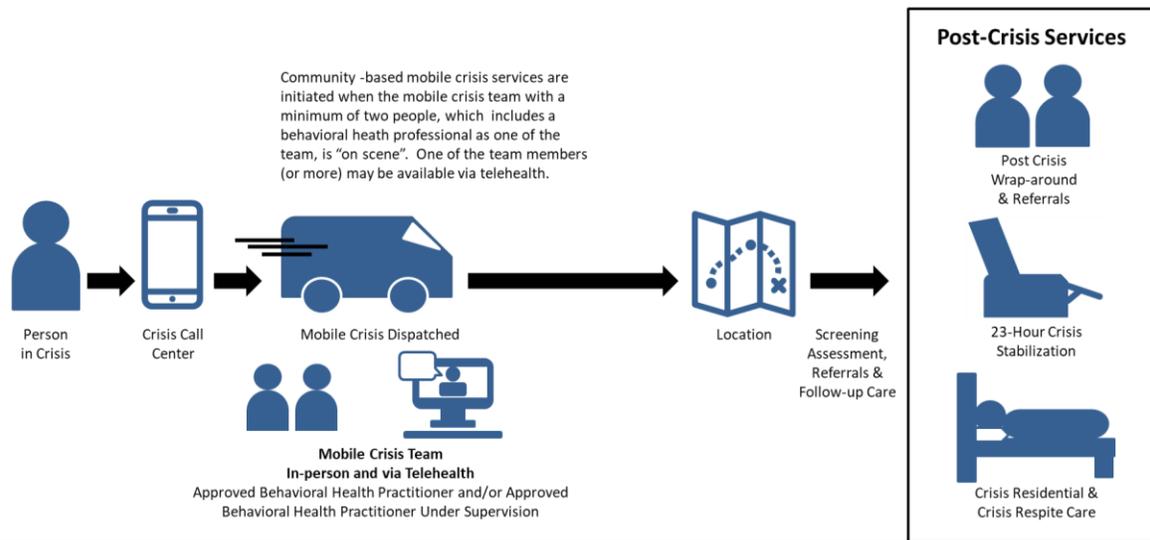
This section presents Kentucky's current operations of the end-to-end MCI services delivery continuum. SAMHSA defines the core elements of the service delivery continuum as Someone to Call – Crisis Call Center, Someone to Respond – MCT, Somewhere to Go – Crisis Stabilization.¹⁸³

An overview of Kentucky's current MCI services continuum is outlined in order of the crisis services processes as depicted in Figure 19.



Figure 19. MCI Services Continuum

Mobile Crisis Intervention Services Continuum



¹⁸³ Substance Abuse and Mental Health Services Administration, *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit*, Rockville, MD: Center Mental Health Services, 2020, <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>.

Crisis Call Centers in Kentucky

Kentucky's crisis call center services are provided by local and or regional dedicated crisis hotlines managed by the 14 CMHCs in all 15 regions and through all six of Kentucky's MCOs.

NSPL defines a crisis center as "*Crisis centers answer calls for the Lifeline, as well as local helplines, and offer other resources such as text, chat, or mobile services. Crisis centers also provide training and educational resources on suicide prevention and mental wellness. They are also a resource for mental health professionals seeking advice on best practices. All of the services a crisis center offers strengthens their local community and the state as a whole.*"¹⁸⁴

In July 2022, the 988 hotline will become the national dialing code for the NSPL, replacing the current phone number of 1-800-273-TALK.¹⁸⁵

CMHC Crisis Call Centers

Kentucky DBHDID contracts with 14 CMHCs to serve as the Commonwealth's public behavioral health safety net. The CMHCs are required to provide 24/7/365 crisis call services to screen and triage callers needing mental health, substance use, or I/DD services within the communities served by each CMHC.¹⁸⁶ The Commonwealth contracts with each CMHC to operate a local crisis line.

While each of the CMHCs staff a crisis call center, 13 of these organizations are accredited by the NSPL. This accreditation ensures NSPL requirements are met, increasing consistency in how local crisis lines operate. Currently, three CMHCs are in the process of onboarding to the NSPL. For the regions served by Comprehend, Pennyroyal is providing call center services. All 13 of the NSPL accredited CMHCs will utilize Vibrant for 988 call center technology, by June 30, 2022. All NSPL accredited call centers in the Commonwealth are collectively referred to as the Kentucky Lifeline.¹⁸⁷

Figure 20 presents a geographic breakdown of current NSPL call centers and the three CMHCs onboarding to the NSPL/988 platform—Communicare, NorthKey, and KRCC. Note that as of April 30, 2022 all call centers in the processing of onboarding to NSPL are now fully accredited.

¹⁸⁴ <https://suicidepreventionlifeline.org/our-crisis-centers/>.

¹⁸⁵ Kentucky 988 Implementation Plan, January 2022.

¹⁸⁶ Ibid.

¹⁸⁷ Ibid.

Figure 20. NSPL Call Centers¹⁸⁸

CMHCs must maintain a toll-free telephone crisis hotline with communicative capabilities for the deaf and hard of hearing and for individuals with behavioral health and/or I/DD. These hotlines operate 24/7/365 to screen and triage callers. The telephone numbers shall be prominently displayed at or near the top of the CMHC's website homepage.

The crisis hotline may be operated directly by the provider or under contract with another NSPL accredited crisis line. If the line is operated by another contracted agency, the line shall be marketed with the CMHC's name and provide behavioral health triage services.

CMHCs must staff hotlines with individuals who are appropriately trained and must document the training they receive. NSPL accredited centers must adhere to all NSPL requirements to maintain accreditation and maintain an 80 percent answer rate.¹⁸⁹

In addition to the CMHC crisis hotlines, national crisis lines are also available for the LGBTQ+ crises, veterans, and rural populations. These include the Trevor Project for LGBTQ+ youth, the Veterans Line, and the Farmers Crisis Center.¹⁹⁰

- **The Trevor Project Crisis Line for LGBTQ+ Youth (1-866-488-7386).** Kentucky g88 NSPL promotes the Trevor Project Crisis Line in their directory of crisis lines for targeted populations. The Trevor Project provides support for LGBTQ+ youth age 13 to 24. Immediate support is available 24/7/365 via call, text, and chat, and through a trained LGBTQ+ crisis counselor.¹⁹¹
- **Veterans Line (1-800-273-8255).** Across an 18-year period, 2001 through 2019, the average number of veteran suicides per day rose from 4.5 percent to 16.4 percent in 2001, to 17.2 percent in 2019.¹⁹² Kentucky g88 NSPL promotes the Veterans Crisis Line in their directory of crisis lines for targeted populations. Veterans, active military, and their family members or

¹⁸⁸ Ibid.

¹⁸⁹ Ibid.

¹⁹⁰ <https://dbhdid.ky.gov/dbh/documents/crisis-resources.pdf>.

¹⁹¹ <https://www.thetrevorproject.org/get-help/>.

¹⁹² <https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf>.

caregivers can call, text, or chat online. Support is offered 24/7/365 via staff trained and qualified to support veterans through a live connection.¹⁹³

- **Farmers Crisis Center (1-800-327-6243).** Provides a farm aid hotline to discuss assistance requests and to help famers experiencing a crisis.¹⁹⁴

As seen in *Figure 21*, Kentucky’s crisis call centers serve thousands of residents each month. Kentucky residents calling the NSPL, Spanish Language Line, and the Veteran’s Crisis Line are routed to the local/regional networks. From December 2020 to December 2021, Kentucky Lifeline received an average of 2,500 calls monthly from routed lines.



2021 Veterans Crisis Call Center Stats:

- More than 5.9 million calls.
- More than 239,000 texts.
- More than 704,000 chats.
- More than 1.1 million referrals to Veterans Administration (VA) suicide prevention coordinators.
- More than 220,000 dispatched of emergency services.

Figure 21. Kentucky Lifeline Calls Routed by Network¹⁹⁵

KY Lifeline Calls Routed by Network													
Network	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021
NSPL	1,663	1,589	1,500	1,642	1,700	1,858	1,770	2,088	1,981	1,921	2,132	2,049	1,947
Spanish	15	16	12	16	17	13	19	39	13	21	20	34	24
VA	713	816	707	706	663	617	546	739	690	631	657	509	542
Total	2,391	2,421	2,219	2,364	2,380	2,488	2,335	2,866	2,684	2,573	2,809	2,592	2,513

Figure 22 charts Kentucky’s in-state answer rate over time of all Kentucky Lifeline call centers. From January 2019 to March 2019, Kentucky’s in-state answer rate was 48 percent. From January 2021 to March 2021, the answer rate had increased to 72 percent. Recent data reported in the Kentucky 988 Implementation Plan demonstrates the in-state answer rate has increased further to 78 percent from April 2021 to June 2021.¹⁹⁶

¹⁹³ <https://www.veteranscrisisline.net/>.

¹⁹⁴ <https://www.farmaid.org/our-work/resources-for-farmers/online-request-for-assistance-form/>.

¹⁹⁵ Kentucky 988 Implementation Plan, January 2022.

¹⁹⁶ Ibid.

Figure 22. Kentucky's Call Center Metrics – January 2021 to June 2021¹⁹⁷

Center	Offered (Jan-Mar '21)	Answered In-State (Jan-Mar '21)	In-State Answer Rate (Jan-Mar '21)	Offered (Apr-Jun '21)	Answered In-State (Apr-Jun '21)	In-State Answer Rate (Apr-Jun '21)
Four Rivers	213	192	90%	241	183	76%
Pennyroyal	967	884	91%	917	900	98%
RiverValley	614	428	70%	701	437	62%
Lifeskills	199	183	92%	205	192	94%
Seven Counties	2030	1091	54%	1705	899	53%
Pathways	162	150	93%	209	197	94%
Mountain Comp.	129	109	84%	176	158	90%
Cumberland River	207	185	89%	241	220	91%
Adanta	188	166	88%	135	118	87%
New Vista	23	23	100%	1018	1003	99%
Total	4732	3411	72%	5548	4307	78%

Figure 23 shows the answer rate and answer speed of NSPL accredited call centers in November 2021.¹⁹⁸ Only two call centers had an answer rate lower than 80 percent. At the time, all NSPL call centers except for one had answer speed that met the 20 second target.

Figure 23. Kentucky's Call Center Metrics – November 2021¹⁹⁹

Region	Calls Offered	Calls Answered	Answer Rate	Answer Speed
Four Rivers	115	108	94%	18 seconds
Pennyroyal	395	377	95%	18 seconds
RiverValley	382	256	67%	17 seconds
LifeSkills	84	82	98%	7 seconds
Seven Counties	552	270	49%	38 seconds
Pathways	63	52	83%	13 seconds
Mountain	29	24	83%	20 seconds
Cumberland River	91	81	89%	16 seconds
Adanta	42	39	93%	3 seconds
New Vista	343	293	85%	18 seconds

From data reported on March 31, 2021, Kentucky had 24/7 primary hotline call center coverage for all 120 counties and 24/7 backup coverage for 37 counties. Since 2016, Kentucky has experienced a 48 percent uptick in call volume, shifting from approximately 13,000 calls per year to 19,442 calls for CY 2020. From 2019 to 2021, call volume in Kentucky increased overall by eight percent. Current volume

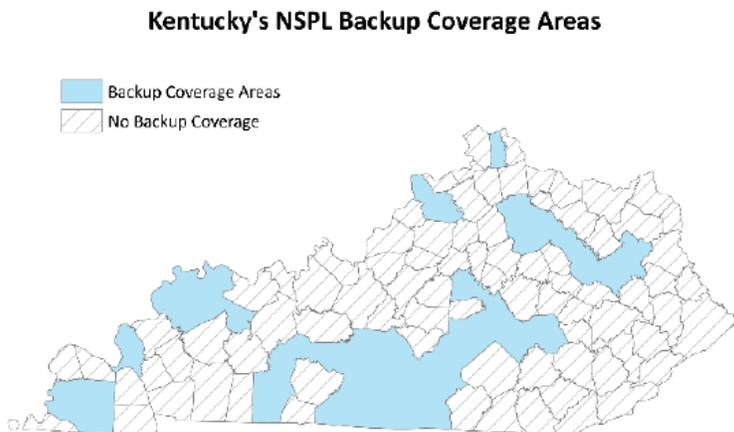
¹⁹⁷ Kentucky 988 Implementation Plan, January 2022.

¹⁹⁸ Kentucky 988 Capacity Infrastructure Grant – Project Narrative

¹⁹⁹ Ibid

for Kentucky’s Lifeline calls, chat, and text is provided in *Figure 24* and *Figure 25*²⁰⁰ Note Pennyroyal provides primary coverage for the region served by Comprehend.

*Figure 24. Kentucky’s NSPL Backup Coverage Areas*²⁰¹



*Figure 25. Kentucky County-Level Backup Coverage Gaps*²⁰²

• **Backup coverage gaps:** The following 83 counties currently do not have 24/7 backup coverage:

Anderson	Carter	Grayson	Lee	Montgomery	Scott
Ballard	Christian	Greenup	Leslie	Muhlenberg	Shelby
Bell	Clark	Hancock	Letcher	Nelson	Simpson
Boone	Clay	Hardin	Lewis	Ohio	Spencer
Boyd	Crittenden	Harlan	Lyon	Oldham	Taylor
Boyle	Daviess	Hopkins	Madison	Owen	Todd
Bracken	Estill	Jefferson	Magoffin	Owsley	Trigg
Breathitt	Fayette	Jessamine	Marion	Pendleton	Warren
Breckinridge	Fleming	Johnson	Marshall	Perry	Washington
Bullitt	Floyd	Knott	Martin	Pike	Wayne
Caldwell	Franklin	Knox	Mason	Powell	Whitley
Calloway	Fulton	Larue	McCracken	Pulaski	Wolfe
Campbell	Gallatin	Laurel	McCreary	Robertson	Woodford
Carroll	Grant	Lawrence	Meade	Rowan	

When Kentucky’s 988 Implementation Plan was finalized in January 2022, Kentucky only had one NSPL accredited center (Pennyroyal) with text/chat capability. Pennyroyal responds to both NSPL and non-NSPL chats and texts. RVBH has the capability to respond to chats and texts, but currently only responds to non-NSPL chats and texts. Based on data reported by Vibrant in August 2021, Kentucky residents generated 3,654 chats and 1,017 texts for the 13-month period, all of which were answered by Pennyroyal Center.²⁰³ Kentucky is currently not promoting additional centers becoming text and chat capable in an effort to avoid strain on existing resources answering NSPL/988 calls.²⁰⁴

²⁰⁰ Ibid.

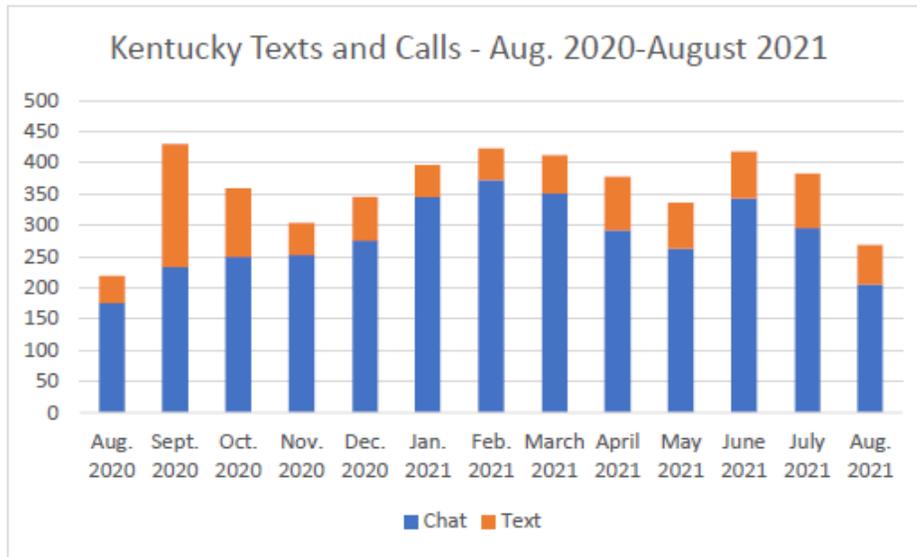
²⁰¹ Kentucky 988 Implementation Plan, January 2022.

²⁰² Ibid.

²⁰³ Ibid.

²⁰⁴ Ibid.

Figure 26. Kentucky Text and Chat Metrics²⁰⁵



From June 2021 information, eight of Kentucky’s 10 NSPL accredited crisis call centers, Four Rivers, Pennyroyal, Lifeskills, Pathways, MCCC, CRBH, Adanta, and New Vista, were answering 80 percent or more of the calls offered in each of their region. Five of these had an answer rate greater than 90 percent. In June 2021, two of the 10 accredited centers, RVBH and Seven Counties, had an answer rate below 80 percent. According to the Kentucky 988 Implementation Plan, both RVBH and Seven Counties receive additional funding to cover calls from counties which do not have accredited NSPL lines covering calls. Kentucky anticipates RVBH and Seven Counties to experience an increased answer rate post-implementation, as additional CMHCs onboard and improve capacity to accept calls in their respective regions.²⁰⁶

²⁰⁵ Kentucky 988 Implementation Plan, January 2022.

²⁰⁶ Ibid.

Figure 27. Kentucky Number of Calls Offered, Answered, and Answer Rate by Month²⁰⁷

Regions	Number of Calls Offered, Calls Answered and Answer Rate by Month			
	April 2021	May 2021	June 2021	
Four Rivers	Calls Offered	63	84	68
	Calls Answered	54	70	59
	Monthly Answer Rate	86%	83%	87%
Pennyroyal	Calls Offered	298	324	295
	Calls Answered	290	320	290
	Monthly Answer Rate	97%	99%	98%
RiverValley	Calls Offered	226	236	239
	Calls Answered	140	139	158
	Monthly Answer Rate	62%	59%	66%
LifeSkills	Calls Offered	64	70	71
	Calls Answered	56	66	70
	Monthly Answer Rate	88%	94%	99%
Seven Counties	Calls Offered	514	604	587
	Calls Answered	286	290	323
	Monthly Answer Rate	56%	48%	55%
Pathways	Calls Offered	63	68	78
	Calls Answered	60	65	72
	Monthly Answer Rate	95%	96%	92%
Mountain Comp	Calls Offered	66	45	65
	Calls Answered	56	42	60
	Monthly Answer Rate	85%	93%	92%
Cumberland River	Calls Offered	75	80	86
	Calls Answered	70	76	74
	Monthly Answer Rate	93%	95%	86%
Adanta	Calls Offered	43	58	34
	Calls Answered	38	52	28
	Monthly Answer Rate	88%	90%	82%
New Vista	Calls Offered	353	352	312
	Calls Answered	347	348	308
	Monthly Answer Rate	98%	99%	99%

All CMHCs responding to the CMHC Pre-Interview Questionnaire reported providing telephonic triage, de-escalation, suicide prevention, crisis assessment, and referral to outpatient services through their regional crisis call centers. Thirteen of the 14 responding CMHCs reported offering safety planning via their regional crisis call center. More than half of the CMHCs reported offering virtual counseling as a call center service.²⁰⁸

In *Table 5*, responding CMHCs report that every crisis call is answered. A combined 23 percent of responding CMHCs indicated their organization does not answer every crisis call. Fifteen percent were from CMHC crisis teams with conflicting selections,²⁰⁹ and eight percent were unique.

²⁰⁷ Kentucky 988 Implementation Plan, January 2022.

²⁰⁸ Kentucky CMHC MCI Pre-Interview Questionnaire, February 2022.

²⁰⁹ Conflicting selection (from the Pre-Interview Questionnaire) is noted when multiple members of the CMHC crisis team respond with differing or conflicting answers and information.

Table 5. CMHC Pre-Interview Questionnaire: Crisis Calls Answered

Calls Answered	Percentage of CMHCs
Every crisis call answered.	77%
Not every crisis call answered.	8%
Not every crisis call answered (conflicting responses).	15%

Table 6 presents CMHC responses to the question asking whether their organization has a current process for call warm hand-offs, ensuring the client is transferred to another team or provider, through the crisis call center. Sixty-nine percent of responding CMHCs indicated they do have a warm hand-off process in the call center, 15 percent of CMHCs responded they do not have a warm hand-off process in the call center, and 15 percent were unsure.

Table 6. CMHC Pre-Interview Questionnaire: Call Center Warm Hand-Offs

Warm Hand-Offs	Percentage of CMHCs
Yes there is a process for warm hand-offs.	69%
No, there is not a process for warm hand-offs.	15%
Unsure if the organization has a process for warm hand-offs.	15%

Table 7 shows which CMHCs currently have a process for the call center to notify the MCT of the resolution of the call. Seventy-seven percent of CMHCs reported that the call center is notified of resolution, eight percent of CMHCs reported that their CMHCs do not notify the call center of resolutions, and 14 percent responded that they were unsure.

Table 7. CMHC Pre-Interview Questionnaire: CMHC Call Center Notified of Resolution

Call Center Notified of Resolution	Percentage of CMHCs
Yes, the call center is notified of call resolution.	77%
No, the call center is not notified of call resolution.	8%
Unsure if the call center is notified of resolution.	14%

MCO Crisis Call Centers

In addition to CMHC crisis call centers, all six of Kentucky’s MCOs currently staff a crisis call center with a hotline available 24/7/365 for health plan network members. These MCOs are Anthem Blue Cross Blue Shield, Humana Healthy Horizons, Aetna Better Health, United Healthcare Community Plan, Passport Molina, and Wellcare. Contract obligations are examined further in the *MCO Contract Review* section of this report.

Humana distributes a “Where to Get Care” informational flyer with information for Medicaid members on what to do when their doctor is not available and where care is most appropriate with the intent to inform individuals on best-level-of-care to reduce ED utilization. The chart for appropriate level of care is a useful tool for individuals who are unsure if their condition/complaint warrants a primary care visit, virtual medicine visit, urgent care, or ED.²¹⁰ The flyer indicates that suicidal feelings require the individual to visit the ED, but it does not include information on the Commonwealth’s available behavioral health crisis services or crisis lines. The information presented in *Figure 28* was provided by Humana.



Kentucky MCO Humana Crisis Call Center Stats:

- Ninety-nine percent of calls are answered by the fourth ring.
- No incoming calls received a busy signal.
- Abandon rate at less than seven percent.
- System able to connect immediately to local suicide hotline and other crisis response systems.
- Patch capabilities to 911 emergency services.

Figure 28. Humana’s Where to Get Care Flyer (Snapshot)

Condition	Doctor’s (PCP’s) Office	Video Doctor Visit	Retail Clinic or Urgent Care Center*	Emergency Room
Screening for coronavirus (COVID-19)		X		
Severe conditions (e.g., headache, stomach pain, etc.)				X
Severe falls				X
Sinus infection	X	X	X	
Small cuts			X	
Strep throat	X	X	X	
Sudden chest pain or pressure, loss of consciousness, abdominal pain				X
Suicidal feelings				X
Trauma				X
Urgent cold or flu-like symptoms				X
Urinary burning	X	X	X	
Vomiting				X
Wheezing or shortness of breath				X

²¹⁰ Kentucky MCO Stakeholder Interview, February – March 2022.

Other MCOs operating crisis lines for their Medicaid members in Kentucky report similar standards for addressing behavioral health emergencies.²¹¹

Call Center Triage and Screening

Kentucky's CMHC and MCO crisis call centers serve as the point in the continuum for initial caller triage and screening. While the process within each CMHC varies, all 14 CMHCs reported that triage and screening are conducted telephonically with the objective to de-escalate, and if possible, resolve the situation over the phone. During triage, the objective of call center staff is to determine the level of risk faced by the individual in crisis and to assess the most appropriate response to meet the individual's needs. CMHCs use the Columbia Suicide Severity Rating Scale to determine risk of self-harm and safety screening to assess the individual's access to lethal means. If crisis response is needed, the call center conducts a warm hand-off to the MCT members. MCOs report a similar process; however, instead of a warm hand-off, there is the transfer from the MCO call center to contracted CMHCs.^{212, 213}

988 Implementation Planning

Upon implementation of the statewide 988, the Kentucky NSPL call centers will operate as a regional hub of contracted centers who ensure primary 24/7/365 coverage for crisis calls, chats, and texts in their regions. Collectively, the crisis call centers ensure no geographic area or time of day gaps exist in the state. The Kentucky 988 Implementation Plan cites that DBHDID will provide oversight for regional and statewide crisis call efforts.

Kentucky 988 has identified specific goals for post-implementation answer rates. According to the 988 Implementation Plan, upon launch, Kentucky's objective is to increase and maintain the Commonwealth's answer rates of at least 80 percent across the system, with a focus on the counties with the five lowest answer rates.²¹⁴

Kentucky's stated priority for 988 implementation is to build linkages between 911 and 988 centers, and to referral sources providing follow-up care for those experiencing a behavioral health crisis to ensure a smooth, warm hand-off within the MCI services continuum.²¹⁵ DBHDID expects that by the end of June 2023, crisis call volume in Kentucky will increase by nearly five-fold to 95,000 calls.²¹⁶ The expected call volume will require over 100 additional crisis call center positions in order to manage the anticipated call, text, and chat volume while meeting the answer rate, answer speed, and abandonment rate targets.

Kentucky 988 State Planning Team

The Kentucky 988 State Planning Team was formed in April 2021 to assess the current state of resources, referral sources, and linkages in preparation of 988 implementation.²¹⁷ The planning team was comprised of DBHDID program staff including the Prevention Branch Manager, Statewide Suicide

²¹¹ Kentucky MCO Stakeholder Interview, February–March 2022.

²¹² Kentucky CMHC MCI Stakeholder Interviews, February–March 2022.

²¹³ Kentucky MCO Stakeholder Interviews, February–March 2022.

²¹⁴ Ibid.

²¹⁵ Ibid.

²¹⁶ Kentucky 988 Capacity Infrastructure Grant – Project Narrative

²¹⁷ Kentucky 988 Implementation Plan, January 2022.

Prevention Coordinator, and RPC Liaison, as well as two CMHC crisis service directors and two RPC directors. The 988 State Planning Team is collecting crisis directories from across the Commonwealth in review of available resources for potential development of a comprehensive guide.

Kentucky 988 Coalition

The State Team developed a 988 Coalition that began April 2021. Kentucky's 988 Coalition is comprised of more than 70 key stakeholders representing state agencies, CMHCs and their crisis centers, representatives of 911 services in the state, those with lived and attempt experiences, coalitions, state representatives of national suicide prevention efforts, and others who play a role in ensuring capacity is in place for the 988 roll out. Members of the 988 Coalition helped to develop the plan for Kentucky's roll out of 988.

988 Crisis Staff Survey

Kentucky's CMHC crisis system staff completed a survey to inform identified needs related to resources and linkages. There were 72 responses to the survey.²¹⁸ They identified the top 10 reasons for calls: ²¹⁹

1. Depression.
2. Anxiety.
3. Suicide.
4. Relationship.
5. Stress.
6. Adolescent and youth adult.
7. Substance misuse.
8. Self-harm.
9. Housing assistance.
10. Grief.

Additionally, the 988 crisis staff survey respondents identified areas/populations perceived to be lacking crisis resources. Respondents indicated these are:

- Seniors.
- Domestic violence.
- Emotional abuse.
- Isolation.
- Sexual abuse, finances, LGBTQ+ specific, COVID-19, sexual assault, suicide loss, utility assistance, general needs, service members/veterans/their families (SMVF), bullying, school-related, gender identity, peer support, first responder, employee assistance, disaster related, eating disorders, deaf and hard of hearing, social media, gambling related, American

²¹⁸ Kentucky 988 Implementation Plan, January 2022.

²¹⁹ Ibid.

Indian/Alaskan Native specific, civil unrest, acute psychosis, and frequent callers with serious psychological or mental illness.²²⁰

988 Capacity Infrastructure Grant

SAMHSA awarded DBHDID \$1,163,404 for the period of April 30, 2022 to April 29, 2022 to support increased/retention of crisis call staffing to ensure 988 targets could be met.²²¹ The 988 targets include a 90 percent answer rate for all calls, texts and chats; answer time within 20 seconds, and having a call abandoned rate of less than five percent.²²² All Kentucky crisis centers that have NSPL accreditation will receive a percentage of the grant award equal to the percentage of calls generated from within their geographic region for the five-year period 2016-2020. As of April 30, 2022, 13 of the 14 CMHCs call centers are NSPL accredited. Goals of the grant include:²²³

- Expand capacity to respond to spikes in call volume.
- Facilitate communication between Lifeline and the call centers.
- Meet a 90% answer rate for the state, reducing calls that bounce to national back up site.
- Collaborate to align Lifeline KPIs with center outcomes.
- Oversee the development and implementation of a quality improvement plan.
- Ensure Veterans and their families are linked to the Veterans Crisis Line.
- Increase follow-up services provided to callers.
- Develop a plan to respond to chats and texts originating within the state by September 29, 2022.
- Develop a sustainability plan that maintains grant KPIs by March 20, 2023.
- Ensure crisis workers receive trainings on populations at high-risk for suicide

Mobile Crisis Team

The main objective of a MCTs is to reduce psychiatric hospitalizations, including hospitalizations that follow an ED admission, and unnecessary visits to the ED.²²⁴ Kentucky MCI services are provided by members of the MCT, which includes licensed behavioral health care professionals, supervised associates, peer supports, and case managers.²²⁵

Table 8 includes information from Kentucky's SFY2022 CMHC Annual Compilation documents and shows the number of full-time equivalent (FTEs) for crisis response by region.²²⁶

²²⁰ Ibid.

²²¹ Kentucky 988 Capacity Infrastructure Grant – Award Notice

²²² Kentucky 988 Capacity Infrastructure Grant – Project Narrative

²²³ Kentucky 988 Capacity Infrastructure Grant – Project Narrative

²²⁴ Substance Abuse and Mental Health Services Administration, *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies*, HHS Publication No. (SMA)-14-4848, Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014, <https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4848.pdf>.

²²⁵ Kentucky CMHC MCI Stakeholder Interviews, February–March 2022.

²²⁶ Kentucky CMHC Annual Crisis Services Compilation Documents, SFY2022.

Table 8. FTEs for Crisis Response by Region

Regions	1	2	3	4	5	6	7	8	10	11	12	13	14	15
Crisis Clinicians – Mobile	12	2	4	2	1	5	5	1	3	8	6	2	15	7
Crisis Clinicians – Office-Based	25	7.7	25	1.25	2	8.5	1	2	1	5	2	7	54	
Crisis Clinicians – CSU	4.5	0	2	5.5	2	2	0	1	11	12	1	6	1	0
Qualified professional in the area of intellectual disabilities	.25	1.2	0	0	3	0	1	0	1	0	0	2	1	3
Crisis Call Center Staff	4	11.5	9	2	6	5	0	3	3.5	8	4	3	14	11
Crisis Case Managers	8	6.35	2	0	1	5	4	0	0.5	0	0	3	41	0
Youth PSSs	2	0	2	1	1	0	0	0	2	1	0	0	0	2
Adult PSSs	0	2.3	3	1	1	8	0	0	16.5	1	0	2	1.5	4
Family PSSs	0	0	2	0	1	1	0	0	0	0	0	0	1	0
Community Support Associates	0	0	15	1	0	0	0	0	0	12.5	0	10	0	3.5
Prescribers	0.5	0.25	13	0.50	3	1	0	1	2	2	0	1	6	2.5
CSU Technicians	11	0	13	12.25	18	8	0	8	14.75	8	2	12	9	0

In SFY 2019, CMHCs were asked to report on their MCT availability. Twelve CMHCs recorded that their MCT is staffed during regular business hours of operation. The remaining two CMHCs only had an on-call MCT available during normal business hours. Five CMHC MCTs were staffed during evenings and weekends outside of business hours, and the remaining 10 CMHCs MCTs were available on-call during evening and weekend hours as seen in *Table 9*.²²⁷

Table 9. CMHC Staffed MCT vs On-Call (SFY2019)

Region	Business Hours Staffed MCT	Evenings/Weekends Staffed MCT	Business Hours On-Call MCT	Evenings/Weekends On-Call MCT
1	•			•
2	•	•		•
3	•			•
4	•	•		•
5	•			•

²²⁷ Kentucky CMHC Annual Crisis Services Compilation Documents, SFY2019.

Region	Business Hours Staffed MCT	Evenings/Weekends Staffed MCT	Business Hours On-Call MCT	Evenings/Weekends On-Call MCT
6	•	•		
7	•			•
8	•		•	•
9/10	•	•		
11			•	•
12	•	•		
13	•			•
14			•	•
15	•			•

The SFY2019 CMHC Annual Compilation documents allowed for CMHCs to respond with additional information on the composition of the MCT:²²⁸

- **Region 1 – Four Rivers:** The crisis director identified those that are to serve on the QMHP call by credentials, experience, and training. The individual must meet the minimal qualifications as defined by the State for a QMHP. Four Rivers uses experienced QMHP staff members as a “gatekeeper” or back-up resource for consultation as needed.
- **Region 11 – MCCC:** The MCT consists of the following members: program director, crisis coordinator, five licensed professional certified counselors, five LCSWs, two certified alcohol drug counselors, and seven mental health associates (MHAs) of social work/sociology/counseling.
- **Region 12 – KRCC:** The composition of the MCT varies depending on the location of the individual in need. Generally, the MCT is led by a mental health clinician in close communication with a crisis line staff member. Team members can include a police or EMS professional, community support associates, crisis staff (when indicated), and a behavioral support specialist.
- **Region 13 – CRBH:** Children’s crisis services have dedicated response teams. The team member to first respond to the person in crisis may be an unlicensed staff person but who has received training to be a first responder. These team members would then have access to an independently licensed mental health professional if needed. The I/DD crisis team follows the same model.



According to the SFY 2022 CMHC Annual Compilation Documents:

- Adult peer support available in 10 CMHCs, the remaining four CMHCs have limited access to peer support.
- Family peer supports are available in seven CMHCs; three CMHCs have limited access to family peers supports, and four CMHCs do not have any family peer supports.
- Youth peer supports are available in six CMHCs with limited access in one CMHC organization. Seven CMHCs do not have any youth peer support.

SFY2022 CMHC Annual Compilation Documents.

²²⁸Kentucky CMHC Annual Crisis Services Compilation Documents, SFY2019.

- **Region 15 – New Vista:** The New Vista MCT consists of six full-time clinicians, one case manager, and one team lead. The team consists of LPCCs, LCSWs, and one CSW in the process of completing supervision to become a LCSW.

I/DD MCTs

According to Kentucky’s DBHDID Crisis Coordinator Manual, the intensity and volume of I/DD crisis often necessitates involvement of additional community partners and systems alongside I/DD crisis responders. It is noted that these additions may not typically be considered part of the individual’s team or day-to-day care, but are called in to assist with specialized crisis response, intervention procedures, and safety. Community partners mentioned include law enforcement and other first responders, local hospital EDs, state psychiatric hospitals, psychiatrists, and court representatives.²²⁹

Use of PSSs

PSSs are certified paraprofessionals with lived experience.²³⁰ Kentucky currently allows for PSS to serve as one of the members of the MCT alongside a licensed behavioral health practitioner.²³¹

In 2019, all 14 of Kentucky’s CMHCs noted whether their organization offered peer support in crisis. Out of the 14 CMHCs, nine stated they do offer peer support in crisis, and five stated they did not offer peer support in crisis.²³²

CMHCs responding to the pre-interview questionnaire all employ PSSs but do not all permit them to serve within the MCT. *Table 10* outlines how Kentucky’s CMHCs currently use PSSs. Only 23 percent of responding CMHCs reported that PSSs serve as one of the members of the MCT.²³³

Table 10. Pre-Interview Questionnaire: Kentucky’s CMHC Peer Support Usage (2022)

Uses of Peer Supports within CMHC	Percentage
Peer supports serve as one of the two or more MCT members.	23%
They provide lived experience across several populations, including youth, parents, addiction recovery peers, and forensic peers, for maximum system impact.	100%
Teaching participants how to take an active role in their own services, the principles of recovery, the characteristics of peer-run, peer-directed support, and how to get the most from behavioral health services.	92%
Assisting providers to incorporate recovery principles into practice and teaching all stakeholders, particularly youth, recovery messaging to better address stigma, advocate for individuals living with behavioral health challenges, and educate family, friends, and the community.	92%

²²⁹ Kentucky DBHDID Crisis Coordinator Manual, FY2023.

²³⁰ "A peer support worker is someone with the lived experience of recovery from a mental health condition, substance use disorder, or both. They provide support to others experiencing similar challenges. They provide non-clinical, strengths-based support and are "experientially credentialed" by their own recovery journey." https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tac/peer-support-2017.pdf.

²³¹ Kentucky DBHDID Service Standards, 2016.

²³² Kentucky MCI State-Level Stakeholder Information Request, January 2022.

²³³ Kentucky CMHC MCI Pre-Interview Questionnaire, February 2022.

Uses of Peer Supports within CMHC	Percentage
Providing peer and family support in the community.	100%

Regions 9/10 – Pathways: provided additional information showing they employ a PSS, under supervision of the CSU team leaders, to provide social and emotional support, advocacy, and consumer resources to recipients of adult crisis services. In addition, PSSs are used to promote partnership between the participant and treatment team members. Pathways envisions PSSs as a critical support for assisting adults to “live their own lives and to direct their own recovery and wellness process.”²³⁴

Youth PSSs

The Commonwealth has a designation the Kentucky Youth Peer Support Specialist (KYPSS) for a transition-age youth or young adult with lived experience who is at least 18 years of age and not older than 35 years of age; who has an emotional, social, behavioral, and/or substance use disability; and who has or is currently receiving state-funded services related to the disability from at least one child-serving agency. KYPSSs can provide support to youth through various modalities and work towards enhancing youth involvement within the system of care.²³⁵

Other Crisis Support Teams in Use by CMHCs

As presented in the DBHDID CMHC Annual Compilation documents, MCTs may be a multi-disciplinary team, a co-response team CIT, an ACT, or a QRT.²³⁶

- **Region 1 – Four Rivers:** reported use of an emergency services team that provides MCI services in addition to other services like disaster response, workplace/trauma on-site counseling, and jail assessments.
- **Region 2 – Pennyroyal:** reported using two different types of teams for crisis response, an emergency services team and a crisis team. The emergency services team consists of QMHPs that conduct the initial assessment virtually to determine if crisis response is needed. The crisis team includes LCSWs, LPCCs, and/or MHAs and provides the MCI services.
- **Region 8 – Comprehend:** refers to their MCT as an ACT. The ACT manages emergency behavioral health needs in the region, oversees crisis walk-in clinics, work after-hours on-call, and perform “community consultations.” The team is responsible for off-site evaluations at jails, hospital EDs, and local hospital med-surgical floor and ICU.
- **Region 12 – KRCC:** CMHC includes its specialized community response efforts under its MCI umbrella. When community response is requested, KRCC sends an outreach counselor to school or the workplace to provide trauma counseling in response to an event (i.e., threat of violence in schools, sudden workplace injury resulting in death, sudden medical emergency, or death of a teacher in the classroom). KRCC also utilizes an emergency response team that is funded through a disaster grant and includes mental health trauma counselors in collaboration with local first responder agencies.

²³⁴ Kentucky CMHC Annual Crisis Services Compilation Documents, SFY2019.

²³⁵ <http://kypartnership.org/wp-content/uploads/2014/09/KYPSS-CCT-Application-April-2016.pdf>.

²³⁶ Kentucky CMHC MCI Stakeholder Interviews, February–March 2022.

Assertive Community Treatment Team

ACT is an evidence-based psychiatric rehabilitation practice which provides a comprehensive approach to service delivery for consumers with SMIs.²³⁷

ACT is a team-based approach to delivering comprehensive and flexible treatment and services.²³⁸ The goal is to provide a customized array of services to keep people out of the hospital and help them attain a life that is not driven by their illness. ACT serves individuals with severe and persistent symptoms of mental illness who also have frequent episodes that are difficult to manage. These individuals often have trouble taking care of their basic needs, protecting themselves, keeping safe and adequate housing, or staying employed. They have typically spent a lot of time in hospitals or are unhoused. They also tend to have high rates of co-occurring SUD and encounters with law enforcement. Principles of ACT include:²³⁹

- Services are targeted to a specific group of individuals with SMI.
- Rather than brokering services, treatment, support, and rehabilitation services, these are provided directly by the ACT.
- Team members share responsibility for the individuals served by the team.
- The staff-to-consumer ratio is small
- The range of treatments and services is comprehensive and flexible.
- Interventions are carried out in vivo²⁴⁰ rather than in hospital or clinic settings.
- There is no arbitrary time limit on receiving services.
- Treatment, support, and rehabilitation services are individualized.
- Services are available on a 24-hour basis.
- The team is assertive in engaging individuals in treatment and monitoring.

The ACT team must be comprised of at least four FTEs including 1.0 FTE therapist, 1.0 FTE case manager, 0.5 FTE PSS, 0.5 FTE nurse, and 1.0 FTE of the team's choosing with access to a prescriber.²⁴¹ The team size may vary from four to 10 people. Additional members may be brought in depending on the need. In addition to treatment and therapies, the ACT can provide assistance on daily activities like



ACT Programs in Kentucky include:

- Client-centered alternative intensive treatment Bluegrass.
- Specialized intensive case management – MCCC.

During stakeholder interviews, Comprehend and Adanta reported using an ACT to respond to existing clients with SMI receiving assertive community treatment.

Sources: <https://dbhdid.ky.gov/dbh/act.aspx>
CMHC Stakeholder Interviews February-March 2022.

²³⁷ Kentucky Medicaid State Plan Amendment (2019).

²³⁸ <https://dbhdid.ky.gov/dbh/act.aspx>.

²³⁹ *Ibid.*

²⁴⁰ In vivo services: Services delivered in the places and contexts where they are needed (SAMHSA)

²⁴¹ *Ibid.*

grocery shopping, cooking, purchasing and caring for clothing, using transportation, and social/family relationships.²⁴² Other services include:

- **Medical Services:** education to prevent health problems, medical screening, scheduling routine visits, linking people with medical providers for acute care, sex education, and counseling on reproductive health.
- **Family Services:** crisis management, counseling and education for family members, coordination with child welfare and family service agencies, and supporting people in carrying out their roles as parents.
- **Additional Services:** medication support, employment and housing assistance, entitlements, financial management, substance abuse treatment, and ongoing counseling/skills building.

Quick Response Teams (QRTs)

The QRT model is a multi-disciplinary team approach targeting overdose response and prevention. Many of the state's QRTs are funded by Kentucky's state opioid response grant, which is administered by the Kentucky Opioid Response Effort (KORE) within DBHDID, discussed later in the report.

As part of the KORE project, QRTs provide assertive outreach in communities across the state to engage people who experienced an overdose within 24 to 72 hours of the crisis event. They provide harm reduction (naloxone, fentanyl test strips), linkage to treatment/recovery services, and supportive wraparound services to the individual who experienced an overdose, family and friends, and community members. Outside of the KORE grant project, the QRT model is used to deploy MCI services in rural and urban settings and also provide engagement to communities with high rates of overdose and disparities.²⁴³

From an August 2021 report, KORE funds 12 teams that cover 33 counties and have served 1,423 individuals.²⁴⁴ Additional services bridge addiction services to care coordination:

- The clinical team includes PSSs (KORE staff, a minimum of six, full-time licensed/certified drug and alcohol specialists [KORE provides two]), independently licensed mental health professional and/or supervised associate with expertise in SUD (e.g., LCADCA, LPCCA, etc.), one part-time prescriber with Drug Enforcement Agency authorization, and one part-time nurse.



Quick Response Team in Practice

CMHCs reported using their own QRT for response to crisis related to SUD or co-occurring SUD:

- Four Rivers.
- MCCC.
- KRCC.
- Seven Counties operates a version of the QRT, but it is named Addiction Response Team, which coordinates with their addiction stabilization unit (ASU).

²⁴² [Ibid.](#)

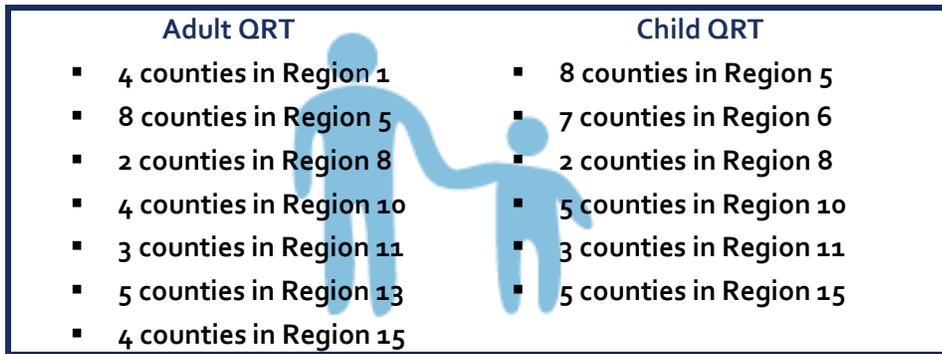
²⁴³ https://www.centerforhealthandjustice.org/chjweb/tertiary_page.aspx?id=109&title=Quick-Response-Teams:-Interdisciplinary-Overdose-Response-and-Prevention.

²⁴⁴ <https://chfs.ky.gov/agencies/dbhdid/Documents/AboutKORE.pdf>.

- The clinical team conducts emergent assessments using national care tools (American Society of Addiction Medicine) of individuals who had presented to the ED with overdose and were referred by a PSS or the clinician. The team then initiates medication for OUD (MOUD) (if necessary), followed by any needed psychological treatment, lab monitoring, and case management is arranged.
- The ASU serves as a triage center and delivers 24/7 stabilization services providing comprehensive and evidence-based screening and assessment, brief treatment, and specialty care directed in the behavioral health setting. ASU is intended to replace costly withdrawal management and/or ED visits. ASU is the crisis stabilization for addiction-specific presentations, diversion from higher levels of care, and re-entry into community-based recovery.

According to the SFY2022 CMHC Annual Compilation Documents in *Figure 29*, eight Kentucky CMHCs offer QRT. Adult QRT is available in seven of 14 CMHC regions. Child QRT is available in six regions.²⁴⁵

Figure 29. Adult and Child QRT



Co-Responder Model or CIT

The co-responder model is a type of crisis response team that includes a law enforcement officer or first responder on the MCT. The CIT is another approach to crisis response involving law enforcement officers who receive specialized training in behavioral health crisis, including addiction diversion. According to the pre-interview questionnaire, 23 percent of CMHCs consider law enforcement and first responders to be part of the multi-disciplinary team.²⁴⁶

²⁴⁵ Kentucky CMHC Annual Crisis Services Compilation Documents, SFY2022.

²⁴⁶ [https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-\(CIT\)-Programs](https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-(CIT)-Programs).

The Diversion Options: Voice and Empowerment (DOVE) Delegates initiative, presented in detail later in this report, uses a co-responder model for the MCTs and includes a member of the multi-disciplinary team, behavioral health professionals, and/or paraprofessionals responding to crisis with first responders. These firefighters, law enforcement, or emergency medical technicians are included as part of the two-person mobile crisis unit.²⁴⁷ The objectives of the CIT, a co-response model, are as follows:

- Makes connections between law enforcement, mental health providers, hospital emergency services, and individuals with mental illness and their families. Through collaborative community partnerships and intensive training, CIT improves communication, identifies mental health resources for those in crisis, and ensures officer and community safety.
- Divert individuals from arrest. CIT reduces arrests of people with mental illness and increases the likelihood that individuals will receive mental health services.
- Enable law enforcement to do their jobs more effectively. Those who complete CIT training have more tools to do their job safely and effectively, and reduce the time spent responding to a behavioral health call.

CIT is intended to be a community-based program that brings together law enforcement, mental health professionals, mental health advocates, and other partners to improve community responses to mental health crises. The team model emphasizes partnership and collaboration between law enforcement (and jails), behavioral health field workers, and other community-based supports. At the center of the model is law enforcement specialized training.²⁴⁸

Figure 30 shows Louisville Metro Police CIT monthly dispatches across all eight divisions in the Louisville Metro Area as an example. In December 2021, DOVE Delegates launched their Diversion Pilot in Louisville's fourth division.

²⁴⁷ Ibid.

²⁴⁸ Ibid.

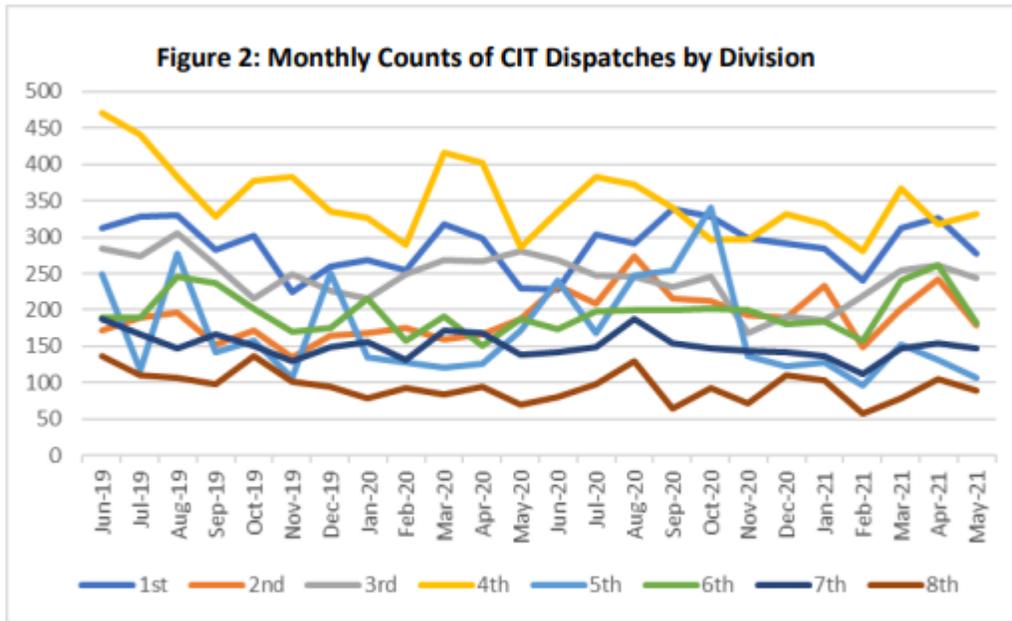


Co-Response in Practice

- Pathways reported recently receiving a grant for the implementation of a co-responder model in Mt. Sterling.
- KRCC CMHC works closely with local law enforcement and EMS on mobile crisis response to individuals with SUD and overdose. Co-response is utilized in Breathitt County.
- Seven Counties has plans for Phase 2 of their Deflection Program (in partnership with DOVE Delegates) which including a co-responder model for crisis cases deemed higher risk for physical harm, an estimated 28 percent of CIT dispatches.

CMHC Stakeholder Interviews February through March 2022; SFY2022 CMHC Compilation Documents.

Figure 30. DOVE Delegates CIT Dispatches, Monthly²⁴⁹



Kentucky’s CMHCs are involved with training their region’s police departments and sheriff’s offices on CIT. Regions report hosting or facilitating CIT on an annual or quarterly schedule.²⁵⁰

According to the SFY2022 CMHC Annual Compilation documents, 13 out of 14 CMHCs have CIT for adults, two of which provide coverage limited to certain locations/counties. Thirteen out of 14 regions have CIT for children, two of which provide coverage limited to certain location/counties within the Region. Region 13: CRBH is the only CMHC that does not currently have CIT.²⁵¹

Current MCI Services Delivery

In Kentucky, MCI services delivery varies by organization and is often dependent upon the type of crisis and the nature of the call.²⁵² While some CMHCs may consider delivery of MCI services to include activities performed by staff during the crisis call portion of the continuum, for purposes of the needs assessment, MCI services delivery was defined as those services provided to the client in crisis by the MCT.

MCI services begin at the time of dispatch of the MCT and end at the time the crisis is resolved at the scene, or when the individual is transported to another location for crisis stabilization or other post-crisis setting.

²⁴⁹ Louisville Metro Alternative Responder Model Research and Planning Final Report.” Louisville, Ky. University of Louisville Commonwealth Institute of Kentucky, September 2021. <https://louisvilleky.gov/mayor-greg-fischer/document/louisville-metro-alternative-responder-model-research-and-planning>.

²⁵⁰ Kentucky CMHC MCI Stakeholder Interviews, February through March 2022.

²⁵¹ Kentucky CMHC Annual Crisis Services Compilation Documents, SFY 2022.

²⁵² Kentucky CMHC MCI Stakeholder Interviews, February through March 2022.

While all 14 CMHC organization call centers make the request for MCT response to the individual in crisis, the dispatch location, safety procedures, and service delivery differ among each of the CMHCs.

MCT Dispatch

CMHC MCT Dispatch. Kentucky's CMHC dispatch procedures vary among the organizations and are dependent upon what type of response the MCT will be providing.²⁵³ While results from crisis triage and initial screening conducted by the crisis call centers typically result in the recommendation for dispatch of the MCT, the dispatch criteria is generally undefined, with the exception of criteria for the I/DD crisis scenarios.²⁵⁴ Various procedures of CMHCs include:

- Submit a request or order for MCI services by the call center.
- Determine the need for MCT dispatch by CMHC clinicians.²⁵⁵
- Connect a QMHP to the individual prior to response. (Two CMHCs do this).
- Utilize telehealth, or in some cases, consideration is given to send the individual or their caregiver a telehealth or Zoom link as dispatch of the MCT.

DBHDID I/DD MCT Dispatch. The Kentucky DBHDID I/DD Crisis Coordinator Manual defines crisis scenarios which require the dispatch of MCI services. The on-call, qualified I/DD crisis responder must be available through the crisis call center to receive initial referrals, triage the situation, and provide immediate response based on the appropriate triage level.

The I/DD crisis coordinator uses the Institute on Complex Disabilities Crisis Triage Codes to define the crisis and triage levels.²⁵⁶ The I/DD Crisis Coordinator Manual clearly states that crisis situations that are triggered at a three or four triage level require immediate in-person intervention. Crisis events that triage at a one or two level may include immediate assistance in person or by phone with the addition of in-person follow-up and debriefing.²⁵⁷

MCI Services Delivery Methods

The 907 KAR 1:044 defines MCI services in the CMHC Services Manual as: *"Mobile Crisis services shall be a multi-disciplinary team-based intervention provided face-to-face in a home or in a community setting that ensures access to mental health and substance used disorder services and supports to reduce symptoms or harm or to safely transition persons in acute crises to the appropriate and least restrictive level of care. Mobile Crisis services shall also involve all services and supports necessary to provide*

²⁵³ Kentucky CMHC MCI Stakeholder Interviews, February through March 2022.

²⁵⁴ Ibid.

²⁵⁵ Kentucky MCI State-Level Stakeholder Information Request, January 2022.

²⁵⁶ Kentucky DBHDID Crisis Coordinator Manual, FY 2023.

²⁵⁷ Ibid.

integrated crisis prevention, assessment and disposition, intervention, continuity of care recommendations, and follow-up services.²⁵⁸

- Face to face [is defined as] occurring in person, or if authorized by 907 KAR 3:170, via real-time, electronic communication that involves two-way interactive video and audio communication.²⁵⁹
- Crisis Intervention Services shall be a therapeutic intervention provided for a purpose of immediately reducing or eliminating risk of physical or emotional harm to the recipient, or others. This service shall be provided as an immediate relief to the presenting problem or threat. It shall be followed by non-crisis service referral as appropriate. It shall be provided in a face-to-face, one-on-one encounter between the provider and the recipient.²⁶⁰



View of MCT in the Community

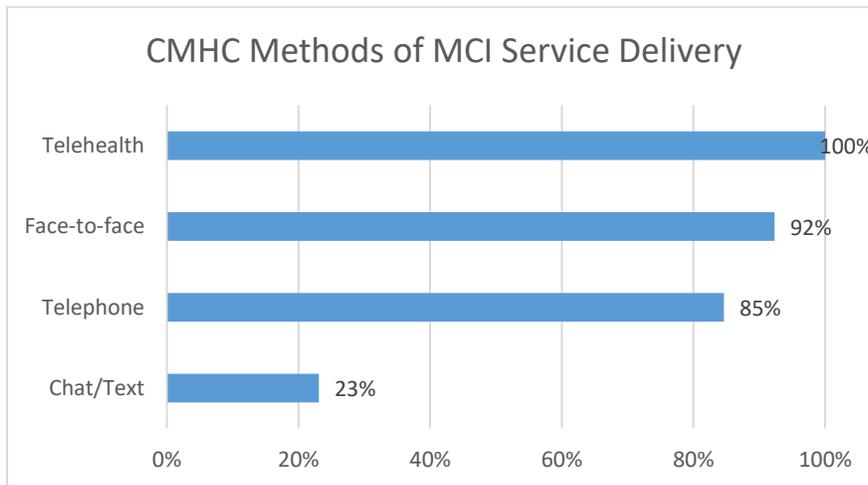
“Kentucky’s mobile crisis teams aren’t really ‘mobile.’ They won’t respond at the individual’s location unless it’s a designated “safe location” like hospital, school, or courthouse. Or they want to do telehealth for crisis intervention, but without street outreach teams, how would the unhoused connect?”

— *Housing Representative Roundtable*

Based on stakeholder input, once it is determined that MCI services are needed and the MCT is dispatched, CMHCs vary in their use of service delivery methods. Based on the pre-interview questionnaire in Figure 31, all responding CMHCs use telehealth, whereas 92 percent noted they engage with the client face to face. It should be noted that the definition of face to face was not explicit.

During interviews with CMHCs, several organizations stated that face-to-face MCI service delivery was provided via telehealth or via telephone only.

Figure 31. CMHC Pre-Interview Questionnaire: CMHC Methods of MCI Delivery



²⁵⁸ 907 KAR 1:044.

²⁵⁹ Ibid.

²⁶⁰ Ibid.

CMHC MCI Services Delivery Methods

Notable MCI services delivery methods by CMHC are stated below:

- **Region 1 – Four Rivers:** MCT provides in-person response to jails and hospitals with contracts in place. Other MCI responses are conducted via telehealth.
- **Region 2 – Pennyroyal:** The CMHC contracts with hospitals and jails for telehealth MCI services. In-person delivery of MCI service is limited to a safe place such as a centralized official location. The CMHC also provides in-person MCI services at the after-hours clinic.
- **Region 3 – RVBH:** MCT provides in-person MCI services unless telehealth is requested by the client. MCT will meet in their home, McDonald's parking lots, or a designated safe place in the community. Telehealth is used if COVID-19 is a concern and the individual states they have recently been infected or exposed.
- **Region 4 – LifeSkills:** Since COVID-19, all MCI services are conducted via telehealth with no in-person option. Prior to COVID-19, MCI services were conducted in person within the community, but only at designated safe places. If the MCI service was occurring in home outside of the designated safe environment, they would rely on law enforcement or EMS to address safety issues.
- **Region 5 – Communicare:** There is no formal process in place for dispatch. MCT dispatch and composition is entirely dependent upon the situation and the nature on the crisis call. Most MCI service response is a one-person team, but may deploy a larger ACT if necessary.
- **Region 6 – Seven Counties:** In-person MCI response into the community is mostly available. Most calls received now request telehealth instead of in person. Seven Counties stated most crises do not require in person response. They will provide telehealth if the person has been exposed or infected with COVID-19.
- **Region 7 – NorthKey:** In-person MCI response after a telephonic home safety assessment is conducted and deems the individual and site are safe to respond. If deemed unsafe, they will contact law enforcement to assess the location prior to dispatch.
- **Region 8 – Comprehend:** In-person MCI response is limited to certain locations, such as hospitals, domestic violence shelters, jail, and police departments. Exceptions are made if the MCT can co-respond with law enforcement or if law enforcement is able to check the scene for safety prior to MCT response. In these exceptions, the MCT will provide in-home response.
- **Region 9/10 – Pathways:** Does not provide MCI services in person at an individual's home, but they will provide MCI services at a designated safe place which is defined as schools, hospitals, police departments, court houses, churches, or probation/parole offices. If a call comes in from a rural/remote location and commute time or staffing is a concern, they will conduct crisis response via telehealth. Crisis response to personal care homes is conducted via telehealth.
- **Region 11 – MCCC:** In-person MCI response is only provided to hospitals. All other MCT response is performed via telehealth. If a safety risk is identified by the call center, the staff then transfers the crisis response to law enforcement. If a co-morbidity is identified by the call center, they then transfer it to EMS.
- **Region 12 – KRCC:** In-person MCI services are provided at a safe places unless accompanied by law enforcement, the site was deemed safe by law enforcement, or a law enforcement car is at the site for backup. MCI response to hospitals and jails is done via telehealth.

- **Region 13 – CRBH:** Provides MCI response via telehealth only. MCT does not respond in person at this time since the COVID-19 PHE, but is expecting to restart in-person MCI service delivery in the future. The CMHC stated that the region is too large to provide in-person MCI services efficiently or consistently.
- **Region 14 – Adanta:** Does not provide MCI services. The CMHC performs virtual 202A evaluations, or makes referrals for the client to go to a walk-in crisis clinic.
- **Region 15 – New Vista:** Provides in-person MCI response. Some schools, jails, and EDs have moved to telehealth delivery of MCI services due to COVID-19. If the service location is in Lexington, the MCI response is transferred to CPP. The organization also provides MCI response via telehealth upon the client’s request.

Walk-in Services

CMHCs were asked, “Are walk-ins considered a mobile crisis service by your organization?” Twenty-one percent of CMHCs currently consider walk-ins a mobile crisis service. Fifty-five percent of CMHCs currently do not consider walk-ins a MCI service, and 24 percent were unsure.²⁶¹

The reference to walk-ins relates to behavioral health urgent care or after-hours crisis clinics. Stakeholders reported if the call center determines the client in crisis to be capable to safely transport themselves, they might be referred to the clinic for a walk-in crisis appointment or after-hours crisis evaluation at the region’s CSU.²⁶²

Meeting Individuals Where They Are In the Community

From the pre-interview questionnaire, CMHCs reported whether their organizations’ MCT members provided MCI services at the location where the individual was experiencing a behavioral health crisis, such as their home, workplace, or other community location. Only 38 percent of responding CMHCs stated they meet the individual at their location in the community.

Based on interviews with CMHCs, stakeholders reported the following:

- One CMHC currently does not perform MCI services.
- One CMHC delivers MCI services at the individual’s home or wherever the individual in crisis is located.
- Two CMHCs reported flexibility of dispatch location at the discretion of the MCT and crisis staff, but primarily respond to designated safe places.
- Five CMHCs reported only dispatching in-person response to designated safe places (i.e., hospitals, schools, jails).
- Five CMHCs reported current MCI services delivery is provided exclusively via telehealth.
- All reported that response times for MCI varied from estimated 30 minutes to 24 hours.

²⁶¹ Kentucky CMHC MCI Pre-Interview Questionnaire, February 2022.

²⁶² Kentucky CMHC MCI Stakeholder Interviews, February through March 2022.

According to the SFY 2022 CMHC Annual Compilation documents, KRCC defines when a mobile crisis response warrants an in-person response as follows: "A *mobile crisis response is provided for individuals who are believed to have acute mental health symptoms, those who are experiencing suicidal or homicidal ideation, or those who are demonstrating behavior that is markedly different from their baseline. KRCC provides mobile crisis intervention to a limited list of sites including hospital emergency departments, schools, and partnering community settings like nursing homes and staffed housing facilities.*"²⁶³

Collection of Insurance Information

Providers understand it is most important to treat the individual and mitigate the crisis they are going through before gathering insurance or payment information. Once the individual is stabilized or able to provide insurance information, providers use different strategies to gather the information. These methods include:

- Using previously gathered information for payments when possible, as the CMHCs see many of the same patients.
- Providing the services without being reimbursed if insurance information is not gathered.
- Gathering payment information during the initial call (Region 2 – Pennyroyal).
- Gathering payment information during intake or in the field using iPads when they have connectivity (Region 5 – Communicare).
- Ensuring verbal consent is obtained first to treat patient and obtain payer information later and typically only if there are follow-up services. Most payer information is obtained during follow-up services (Region 15: New Vista).

Obtaining Consent for Treatment

In stakeholder interviews, it was noted that gathering consent for treatment from persons in crisis is accomplished in multiple ways. When a patient is in crisis, it can be difficult to get consent in a traditional manner, and many CMHCs rely upon verbal consent.

- The majority of CMHCs obtain verbal consent when treating a patient in a crisis.
- If the CMHC or provider will be treating the patient for more than 24 hours, or the patient will be referred to follow-up services, then written consent is obtained.
- Many CMHCs gather consents via paper, but electronic methods are also used.
- When providing telehealth services, DocuSign or other remote solutions are used to receive written consent.
- Twelve out of the 14 CMHCs are connected to Kentucky Health Information Exchange. Region 2 – Pennyroyal utilizes verbal consents for one-time emergencies.
- Region 15 – New Vista gathers written consent when possible, but uses verbal consent when not. Follow-up services always require written consent.

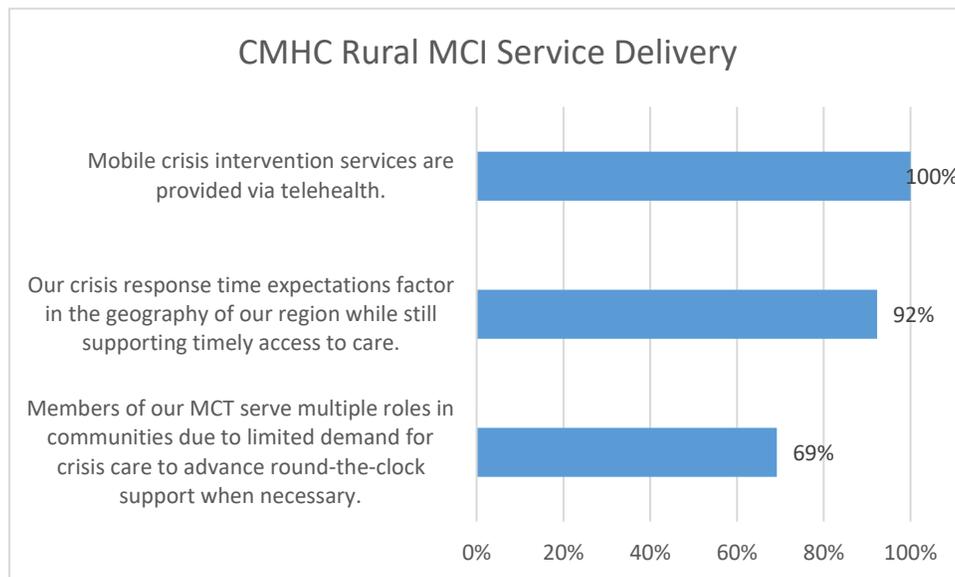
²⁶³ Kentucky CMHC Annual Crisis Services Compilation Documents, SFY 2022.

MCI Services Delivery in Rural Communities

A significant portion of Kentucky is considered rural and is reflected in the findings of this needs assessment report.²⁶⁴ It is noted that CMHCs that serve urban areas must also be prepared to serve individuals living in rural areas.

Figure 32 shows CMHC responses to the pre-interview questionnaire regarding different delivery tactics that are used by CMHCs to better serve rural areas. All of the CMHCs stated they have telehealth capabilities for MCI services, 92 percent of CMHCs factor in the geography to ensure timely access to care, and 69 percent of CMHCs have members of the MCT serve multiple roles due to limited demand for crisis care in the regions in which they provide services. Note that many CMHCs with telehealth capabilities also provide in-person services as described in this herein report.

Figure 32. CMHC Pre-Interview Questionnaire: CMHC Rural MCI Delivery



CMHC stakeholders stated that providing care in rural areas can be very difficult due in part to the geography and size of the CMHC region. It may take as long as 2.5 hours to arrive at the individual's location.

During the interviews, staffing issues were commonly cited by stakeholders as a challenge in meeting MCI services delivery needs. While workforce shortages were more prominent in rural areas, staffing issues also required members of the MCT to serve in multiple roles within the CMHC.

²⁶⁴ <https://chfs.ky.gov/agencies/dph/dpqi/hcab/hcabdocs/pconeeds.docx>.

Serving Specialized Populations

Stakeholders reported that specific populations such as individuals with I/DD, children and youth, and individuals struggling with substance abuse may require specialized MCI services.²⁶⁵ Additionally, CMHCs must be able to address cultural and linguistic needs of the community. CMHCs were asked whether they have established protocols or policies to address such needs. As shown in

Table 11, 85 percent of CMHCs stated they provide access to translation services 24/7/365. In addition, 62 percent of CMHCs have required their MCT undergo training pertaining to cultural issues and utilize cultural competency for quality improvement.

Table 11. CMHC Pre-Interview Questionnaire: CMHC Cultural and Linguistic Strategies

Cultural and Linguistic Strategies	Percentage of CMHCs
MCI services provide access to 24/7/365 translation services for individuals in crisis who speak non-threshold languages and are unable to receive effective services in English.	85%
Established policies to ensure staff understand: refer and call client by correct name, even if different than on birth certificate or ID card.	69%
Established policies to ensure staff understand: the medical record can correctly indicate gender identity and name.	64%
MCI services providers undergo training in cultural issues and utilize an annual measure of cultural competency as a component of their quality improvement.	62%
Established policies to ensure staff understand: the importance of asking clients about their correct pronouns.	62%
Established policies to ensuring MCI services providers can identify culturally-specific resources available in the community for continued behavioral health care needs, as well as provision of social support and be able to facilitate ongoing connection and coordination of care for populations who need and prefer such services.	56%
Established policies to ensure staff understand: they ensure client confidentiality and respect to the degree to which the client wishes to be "out."	53%
MCI services providers have access to information necessary to support working with immigrant and refugee populations that might be prevalent in the region or community.	23%
MCI services provide adequate, regular, and on-call bilingual crisis staff to serve individuals and families who speak a threshold language other than English, including ASL, 24/7/365 in all levels of care.	15%

²⁶⁵ Summation of the Stakeholder Roundtables: Adult and Aging Roundtable, Youth Roundtable, I/DD Roundtable, Housing Roundtable, and BHSO/SUD Provider Engagement, February through March 2022.

Crisis Services for I/DD

Kentucky DBHDID defines I/DD crisis services in their Crisis Coordinator Manual below:²⁶⁶

- **Crisis Service Plan:** *"a person-centered and specific plan or action for the implementation of recommendations made by the individual and care team to manage potential future crises. Recommendations are based on in-the-field debriefing."*
- **Crisis/Emergency Response Plan:** *"created for individuals who have experienced a crisis episode with risk of reoccurrence. The objective is to identify early warning signs, triggers, and de-escalation strategies for early intervention. Outlines the who, what, when, how long, and how often."*
- **Safety Plan:** *"intended to prevent self-injurious behavior (SIB) for those at risk. Safety plans are developed by mental health professionals and includes coping strategies for reduction of symptoms."*
- **Debriefing:** *"occurs after safety of the individual is no longer a concern (return to calm). Meeting between the individual who experienced crisis and their response team to identify contributions to crisis and effective interventions."*



Challenges Related to Populations Served

"I am concerned that there aren't appropriate MCI services for persons with I/DD concerns in addition to mental health and SUD presenting problems. Crisis services for the I/DD population seem to be lacking."

— Department-Level Response

CMHC crisis line staff are trained to identify individuals with I/DD experiencing a behavioral health crisis and provide referral to the designated I/DD crisis team, as well as additional behavioral health service information.²⁶⁷ After the identification of an I/DD crisis and referral for crisis team response, CMHCs provide specialized I/DD MCI services as specified in their contracts with the State. All 14 CMHCs are required by contract with DBHDID to provide the following MCI services for their I/DD population:²⁶⁸

- Debriefing.
- Development of behavior intervention strategies.
- Environmental assessment.
- Functional assessment.
- Mobile crisis.
- Person-centered planning.
- Technical assistance and resource linkage.²⁶⁹
- Transportation.

²⁶⁶ Kentucky DBHDID Crisis Coordinator Manual, FY 2023.

²⁶⁷ Ibid.

²⁶⁸ Kentucky CMHC Annual Crisis Services Compilation Documents, SFY 2022.

²⁶⁹ A time-limited service in which participants are referred or linked to needed community information, resources, programs/services, and/or other supports, including specific information on how to apply for any applicable programs, health benefits, grants, or Medicaid waiver programs.

- Prevention services.
- Medical care evaluations.

Region 13 – CRBH has an I/DD Crisis Response and Prevention Program that supports individuals with I/DD who are experiencing an acute, immediate behavioral and/or psychiatric crisis. Parameters of the program are outlined in *Table 12*.

Table 12. Kentucky's CRBH CMHC I/DD Crisis Response and Prevention Program

Kentucky's CRBH CMHC I/DD Crisis Response and Prevention Program²⁷⁰ <i>Available to individuals with an I/DD diagnosis</i>	
1.	<p>Mobile Crisis: Mobile crisis is the immediate in-home or community response to assess for acute service needs, to assist with acute symptom reduction, and if necessary, to ensure the person in crisis safely transitions to appropriate crisis stabilization services. These services are available 24/7/365. CRBH uses a team approach to meeting the needs of the recipient. This service is provided in duration of less than 24 hours and is not an overnight service.</p>
2.	<p>Debriefing: Analysis of the situation, subsequent to assistance by the regional I/DD crisis team for managing a crisis, identifying things such as: what is known, was the crisis plan or participant summary followed, if not, why, does the plan address the issue, have staff been adequately trained, what were the triggers, antecedents, destabilizing factors present, environmental factors, further assessments needed, medications recently changed or improperly administered, other issues, and subsequent recommendations and intensive planning to help prevent further incidents/crises. Debriefing may consist of multiple meetings to resolve an issue and should be conducted at all triage levels. An action plan should be developed to include responsible parties and dates to complete tasks, and may include periodic assessment of progress and training of staff to implement behavioral strategies and environmental changes.</p>
3.	<p>PCP: At critical moments, when community living may be threatened, it may be necessary to assist and guide an individual in crisis and his or her person-centered team in the identification of how strengths, capacities, desires, choices, and opportunities can be best utilized in defining and pursuing a meaningful life. PCP helps to assess and mitigate risk while determining what is important to and for the participant. It considers options available through Medicaid, a Medicaid waiver program, the Office of Vocational Rehabilitation, natural supports, and other resources. It maximizes community inclusion and generates action steps that can be taken immediately toward a better life. Family, guardian (if applicable), friends, and care service professionals are included in planning, as designated by the participant. PCP ensures services are delivered in a respectful manner and plans include insight into how to assess the quality of services being provided.</p>
4.	<p>Technical Assistance/Resource Linkage: A time-limited service in which participants are referred or linked to needed community information, resources, programs/services, other supports, including specific information on how to apply for any applicable programs, health benefits, grants, or Medicaid waiver programs.</p>
5.	<p>Prevention Services: The goal of prevention is to prevent the onset of disease and/or to mitigate the effects once diagnosed, this includes services such as screening tests for issues such as depression, alcohol or drug abuse, health conditions such as diabetes, obesity, or sexually-transmitted diseases, but can also be health monitoring, counseling and education, exams, shots, and other lab tests and screening.</p>

²⁷⁰ <https://crbhky.org/>.

Kentucky's CRBH CMHC I/DD Crisis Response and Prevention Program²⁷⁰

Available to individuals with an I/DD diagnosis

6. **Crisis Respite:** Crisis respite provides short-term relief (up to two weeks) for the individual and caregivers to prevent a crisis or assist in the de-escalation of a current crisis. Respite may be provided in a residential setting or on an hourly basis.
7. **Psychological Assessment:** Psychological assessments are provided to assist in the prevention of crisis for an individual. Psychological assessments are a way of testing people about their behavior, personality, and capabilities to draw conclusions using combinations of techniques. The purpose behind modern psychological evaluation is to try and pinpoint what is happening in someone's psychological life that may be inhibiting their ability to behave or feel in more appropriate or constructive way.
8. **Environmental Assessment:** Field-based assessments of the environment to determine what environmental factors may contribute to the occurrence or recurrence of a crisis. May include: physical/biological factors, physical surroundings, social practices and knowledge, technological adaptations and physical arrangements, culture, people and institutions with whom they interact, and other living (i.e., pets) and/or non-living things. Also consider how environmental factors are impacted by the crisis to identify potential risks to a participant's health and safety.
9. **Functional Assessment:** Functional assessments are used to help prevent crisis by the examination of the relationships between stimuli and responses for an individual. To establish the function of a behavior, one typically examines the four-term contingency first by identifying the motivating operations, then identifying the antecedent or trigger of the behavior, identifying the behavior itself as it has been operationalized, and identifying the consequence of the behavior which continues to maintain it.
10. **Development of Behavior Support Plan:** The utilization of evidenced-based practices and best practices in behavioral techniques, interventions, and methods to assist a person with significant, intensive challenges which interfere with activities of daily living, social interaction, or work. Evidenced-based practices or best practices regarding treatment of a behavioral health condition shall be the primary support if supplemental behavioral interventions are needed. Positive behavior support plans are developed with the individual and the individual's person-centered team and are related to goals of interventions, such as greater participation in activities, and/or enhanced coping or social skills. It is clearly based on the information provided, data collected, and recommendations from the functional assessment.
11. **Transportation:** Transportation services are provided on a short-term basis to ensure access to services and supports to prevent or de-escalate a crisis. These services can be agency-provided or provide funding for this to be provided by an outside source. This is only provided when transportation is not otherwise available through natural supports or a Medicaid program.
12. **Medical Care/Evaluations:** Supports to address acute or longstanding medical or related conditions that are interfering with the individual's stability in the community, to ultimately provide relief to the individual being served, and to provide additional information in the identification of the nature of supports needed.

Region 5 – Communicare maintains a position for an I/DD crisis coordinator within their crisis call center 24/7/365. Follow-ups for crises related to I/DD are completed by an I/DD crisis coordinator directly with the referring party. The crisis coordinator can arrange a face-to-face service, as needed, 24/7/365. Communicare's I/DD crisis coordinator position received specialized training related to I/DD crisis, completes all required state general fund I/DD training, and qualifies as an MHA.²⁷¹

²⁷¹ Kentucky CMHC Annual Crisis Services Compilation Documents, SFY 2020.

Crisis Services for Children and Youth

During the youth roundtable stakeholder engagement event, stakeholders stated that much of the same MCI services delivered to adults are also delivered to children/youth, but children/youth have limited stabilization and hospitalization placement options.²⁷²

- Youth in crisis may not meet the criteria for placement if they have a history of aggressive behavior.
- Sometimes youth are inappropriately placed in juvenile detention when aggressive behavioral health issues are present.
- Crisis calls from juvenile detention may be triaged for MCI services with a lower priority, as these centers are deemed “safe environments” with reduced risk of harm to the individual.
- Most CMHCs delivering MCI services will not conduct an assessment on children and youth in crisis unless they present in person.
- During the youth roundtable, stakeholders noted that MCI services are less likely to be delivered via telehealth for children and youth.
- MCTs and other staff designated to serve children and youth often have limited availability outside of regular business hours.
- There is less availability of post-crisis services and psychiatric beds for youth when compared to adults, especially in rural communities.

Stakeholders maintained that schools are at the center of the MCI care continuum for children and youth. They stated that teachers, school counselors, administrators, school health program nurses, peer leaders, and resource officers can sometimes recognize signs of behavioral health issues, trauma, and substance use, and, if trained, can identify at-risk children in need of additional attention and crisis prevention.²⁷³



Specialized Alternatives for Families and Youth (SAFY) Kentucky Private Foster Care Agency

- The TFC Behavioral Health Program in Lexington, Kentucky offers a wide range of behavioral health supports for children in private placement. Services include: cognitive behavioral therapy, art therapy, group therapy, trauma counseling.
- Independent living (housing offered to youth in transition). Developed to address that 26 percent of young people aged out of foster care in the U.S. experience a period or more of homelessness, one-third lacked a high school diploma, and only one-half will be employed by age 24. Provided to older youth with a focus on emotional health, educational services, job training, financial literacy, and life skills. Supports include housing assistance, transportation, furnishings, and food.

*TFC Agency: SAFY Kentucky
<https://www.safy.org/kentucky/> Locations: Bowling Green, Elizabethtown, Lexington, Louisville, Northern Kentucky, Somerset.*

²⁷² Kentucky MCI Roundtable: Youth Stakeholders, February 2022; Kentucky MCI State-Level Stakeholder Information Request, January 2022.

²⁷³ Kentucky MCI Roundtable: Youth Stakeholders, February 2022.

Therapeutic Foster Care (TFC). The TFC model is an out-of-home care by foster parents with specialized training to care for a wide variety of children and adolescents, usually those with significant emotional, behavioral, or social issues, or medical needs. These programs are designed to provide safe and nurturing care to child or youth in a structured home environment instead of traditional foster care and a cost-effective alternative to residential treatment. Foster parents in the program receive additional supports and services.²⁷⁴

The TFC model includes trauma-informed care services, training, case management, and 24/7 crisis intervention for children living with kin, and aims to remove barriers to meeting the needs of children in placement.

Youth PSSs are often used in behavioral health care delivery to children in foster care. Many established programs use youth PSSs with lived experience in the foster care system and can be beneficial when applied to support youth in transition out of the system, as they are at increased risk of incarceration, homelessness, and in many cases (as reported by stakeholders) end up going back to the environment they were once taken from and subjected to abuse and SUD.²⁷⁵

Project AWARE. Project AWARE is five-year grant project through the Kentucky Department of Education with funds from SAMHSA. The learning collaborative component is led by the University of Kentucky Center on Trauma and Children.²⁷⁶ Project AWARE:

- Provides leadership through state and local management teams.
- Develops standards of culturally- and linguistically-appropriate mental health services.
- Provides youth mental health first aid training.
- Implements positive behavioral intervention supports.
- Develops and implements a behavioral health referral system.

Project AWARE's learning collaborative provides education and training to staff interested in becoming better equipped to recognize trauma and address crisis. The goal is to increase awareness, decrease bullying that may lead to increased crisis risk, and provide support to students in need.²⁷⁷



Challenges Related to Populations Served

"For juveniles, I believe there is a trend to 'blackball' youth that have been placed before and were problematic. Youth that are actively suicidal are not being given services. Youth being deemed 'too acute' for an acute care setting."

— Department-Level Response

²⁷⁴ <https://www.childwelfare.gov/topics/outofhome/foster-care/treat-foster/>.

²⁷⁵ Kentucky Foster Care MCI Stakeholder Interview, March 2022.

²⁷⁶ <https://apps.legislature.ky.gov/CommitteeDocuments/7/11950/Jun%203%202019%20KDE%20KY%20Project%20AWARE%20Logic%20Model.pdf>.

²⁷⁷ Kentucky DOE MCI Stakeholder Interview, March 2022.

Crisis Services for Individuals with SUD

KORE currently funds QRTs providing community-based response to SUD-related crisis across Kentucky in areas identified for having high rates of SUD/ODU and overdoses. The teams receive data regarding overdoses in their service area and the QRT performs a follow-up visit within 24 to 72 hours of the overdose event to provide harm reduction resources, linkage and referral to services and supports, counseling, and treatment information. The QRTs' objective has been to successfully engage individuals who would not typically attend or seek to attend services in brick and mortar (e.g., African American, indigenous, people of color community, and unhoused).²⁷⁸

Harm reduction is a set of practical strategies that reduces negative consequences associated with SUD.²⁷⁹ Harm reduction tactics are central to MCI services delivery for clients with SUD, as these tactics can prevent future SUD-related crisis episodes and reduce overdose rates. Kentucky's SUD/ODU crisis responders, including the QRTs, provide services outside of the general MCI services continuum, and include:²⁸⁰

- Administration of naloxone. Each member on the QRT carries naloxone²⁸¹ to crisis response sites.²⁸²
- Linkage and information on local syringe service programs (SSPs) provided by QRTs, if available in the region.²⁸³
- Follow-ups for MOUD, including referrals for MAT.²⁸⁴
- Referrals to licensed residential and intensive outpatient treatment, and includes ongoing peer support.²⁸⁵

Crisis Services for Unhoused Individuals

In 1994, Congress established the Education and Prevention Services to Reduce Sexual Abuse of Runaway, Homeless, and Street Youth Program through the Violence Against Women Act of the Violent Crime Control and Law Enforcement Act (Public Law 103-322). The legislation funds street-based outreach and education for runaway and homeless youth and is funded by the Family and Youth Services Bureau.²⁸⁶

Street outreach programs collaborate with agencies and organizations to treat the at-risk unhoused population by providing the following services:^{287, 288}

- Street-based education and outreach.

²⁷⁸ Kentucky MCI State-Level Stakeholder Information Request, January 2022.

²⁷⁹ <https://chfs.ky.gov/agencies/dbhdid/Documents/AboutKORE.pdf>.

²⁸⁰ Kentucky CMHC MCI Stakeholder Interviews, February through March 2022.

²⁸¹ Naloxone (one brand is "Narcan") is a safe medication that reverses opioid overdose by attaching to opioid receptors in the brain and blocking the effects of opioids. This allows an individual to resume breathing.

²⁸² QRT Meeting, February 2022.

²⁸³ <https://chfs.ky.gov/agencies/dbhdid/Documents/AboutKORE.pdf>.

²⁸⁴ Ibid.

²⁸⁵ Kentucky MCI Roundtable: SUD Stakeholders, February 2022.

²⁸⁶ <https://www.acf.hhs.gov/fysb/fact-sheet/street-outreach-program-fact-sheet>.

²⁸⁷ Ibid.

²⁸⁸ Kentucky MCI Roundtable: Housing Stakeholders, March 2022.

- Access to emergency shelter.
- Individual assessments.
- Trauma-informed treatment and counseling.
- Harm reduction.
- Crisis Intervention.
- Follow-up support.

In Kentucky, street outreach programs perform crisis assessments and services to homeless individuals. Stakeholders acknowledged the potential collaboration between providers of street outreach, Housing and Urban Development (HUD) housing coordinators, and providers of MCI services. In the traditional setting, the challenge is provider willingness and limited availability to treat homeless populations in the community.

Stakeholders reported that serving unhoused individuals requires an in-person, in-the-field response. This population does not generally have access to a phone or technology to dial a crisis line, and thus, a staffed street outreach team is critical to ensure Kentuckians living on the streets have access to behavioral health services available to them.²⁸⁹

MCT Member Personal Safety Considerations

CMHCs employ several strategies to ensure the safety of their MCT members. These strategies are shown in *Table 13*. Ninety-two percent of CMHCs review available client information prior to meeting with them. Five CMHCs stated they currently provide services only via telehealth in part due to safety concerns, and the use of telehealth eliminates risk for the MCT. Ninety-two percent of CMHC pre-interview questionnaire respondents stated that reviewing available information prior to the visit is helpful to ensuring the safety of their MCT members. Other strategies regarding safety are listed in the table below.

Table 13. CMHC Pre-Interview Questionnaire: CMHC Strategies to Ensure Safety of MCT

Strategies to Ensure Safety of Mobile Crisis Team Members	Percentage of CMHCs
Reviewing available background data before meeting with the client.	92%
Limiting shift length to <12 hours.	62%
Structured protocol for assessing environment safety on scene.	54%
Structured protocol for assessing level of agitation/violence risk.	54%
Structured protocol for assessing environment safety on scene.	38%
Required two-person response.	31%
Daily vehicle/equipment inspection.	31%

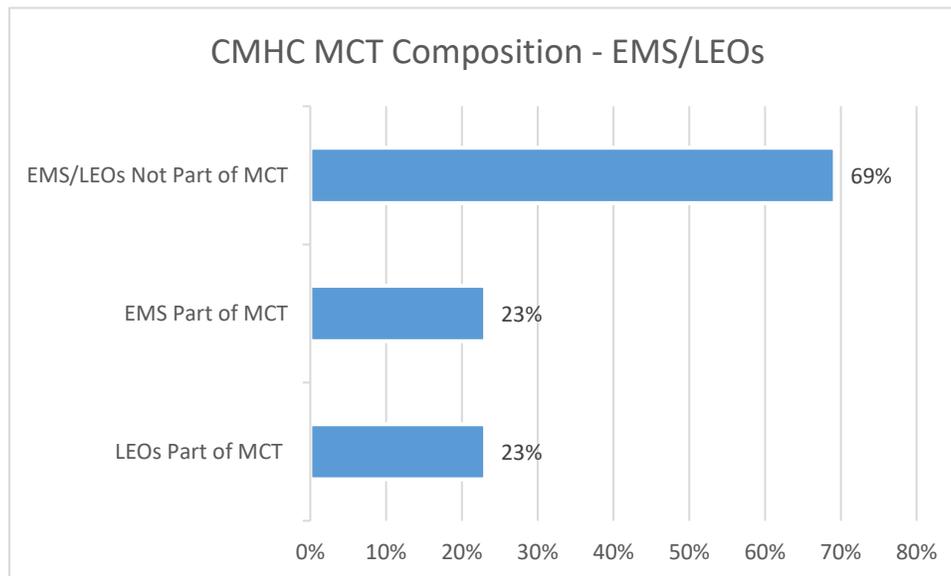
²⁸⁹ Ibid.

Stakeholders report concern for in-person MCI response in rural and remote areas of Kentucky. In particular, stakeholders serving Eastern Kentucky cite the remoteness of the area as a major concern for the safety of its response team. Concerns ranged from late night, in-person crisis response to navigating difficult roadways to limited cell reception in certain areas. CMHCs expressing these safety concerns currently use telehealth as an alternative response to clients in remote areas of the Commonwealth.²⁹⁰

Law Enforcement and First Responder Involvement

While most CMHCs do not consider EMS or law enforcement to be part of the MCT, many do have formal agreements with them to ensure safety for the MCT member, as well as the individual in crisis, as seen in *Figure 33*. Some CMHCs (Four Rivers Behavioral Health, RVBH, Lifeskills, Seven Counties, KRCC, CRBH, and New Vista) have current memorandums of understanding (MOUs) with law enforcement and first responders. Kentucky's Region 8 CMHC, Comprehend, works with local CITs through partnerships with law enforcement agencies.²⁹¹ *Figure 34* shows the percentage of CMHCs with an MOU or formal agreement with EMS and/or law enforcement.

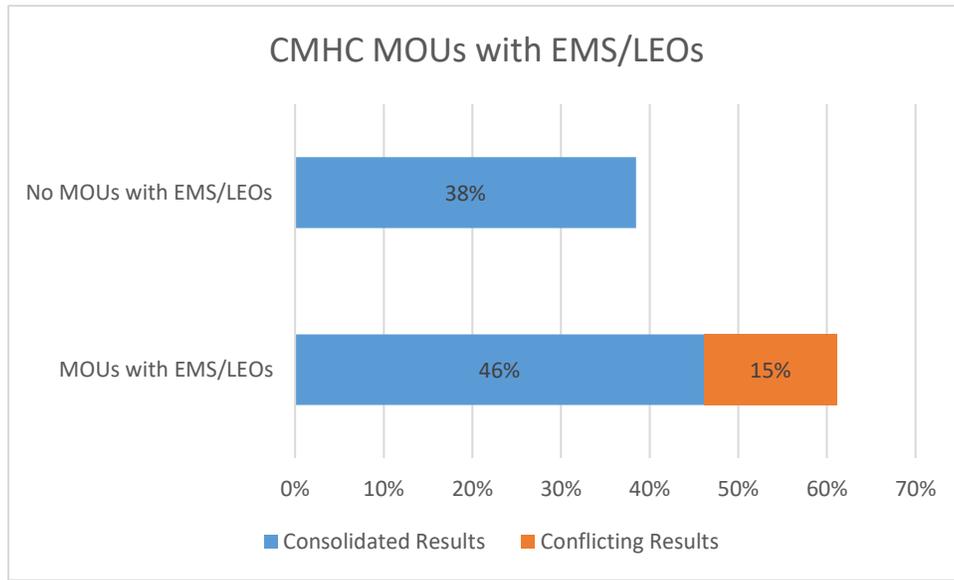
Figure 33. CMHC Pre-Interview Questionnaire: CMHC MCT Composition – EMS/Law Enforcement



²⁹⁰ Kentucky CMHC MCI Stakeholder Interviews, February through March, 2022.

²⁹¹ CMHC MCI Pre-Interview Questionnaire, February 2022.

Figure 34. CMHC Pre-Interview Questionnaire: CMHC MOUs with EMS/Law Enforcement



CMHCs noted that strong partnerships and collaboration with law enforcement is critical for regional behavioral health crisis response. Stakeholders further stated that while police should remain part of the process, their presence can increase the intensity and severity of the crisis for the individual in need of intervention.

MCI Services-Related Transportation

Limited transportation options present a challenge in Kentucky’s current MCI services continuum. During the key informant interviews, all CMHCs mentioned that their region’s EMS will not accept or transport behavioral health patients unless there is also a co-occurring medical emergency. This barrier is felt most with the children and youth populations, as many hospitals have requirements for youth transport in order to receive inpatient care.

Transportation barriers limit an individual’s ability to access other behavioral health services and community supports that could reduce the likelihood for future crises. Individuals with limited transportation options to regular behavioral health care may lead to unaddressed behavioral health needs that escalate to crisis. Increased calls for MCI services due to limited self-transportation options can place a strain on a CMHC, which translates to longer wait times for MCT response and potentially increased reliance on EMS.²⁹²



Transportation

“Transportation is one of the most important services needed in Kentucky. If law enforcement isn’t involved, then there isn’t an alternative in a majority of locations. While there are some Medicaid-contracted transportation programs around the state, there aren’t any services provided in the evenings or in crisis situations.”

— *DBHDID Information Request*

²⁹² Aetna Response to Information Request, February 2022.

Non-Emergency Medical Transportation (NEMT)

Kentucky currently does not have specific laws or regulations referring directly to the transportation of a recipient during or after an MCI services delivery. There are two existing administrative regulations that cover NEMT broadly, but neither regulation specifically points to NEMT during or after an MCI services event.

907 KAR 3:066 outlines the following requirements for NEMT: a) the recipient is traveling to or from a Medicaid-covered service; b) the service is determined to be of medical necessity; and c) free transportation is not available. This regulation could allow NEMT services following an MCI services visit if the recipient who is transferred meets those three requirements. 907 KAR 3:130 discusses whether a service is a medical necessity.

907 KAR 1:060 includes requirements for NEMT and distinguishes whether the transportation occurs in the medical service area, the member's county of residence, or a bordering county. The minimum requirements for transportation inside the Medicaid member's medical service area are the following three items:

- Medicaid members' medical condition requires transport by a stretcher.
- Medicaid member is traveling to or from a Medicaid-covered service.
- The service is the least expensive available transportation for the recipient's needs.

However, if the crisis does not occur in the Medicaid member's county or a bordering county, it could mean this regulation would not cover NEMT after a crisis. The regulation addresses what occurs should the NEMT service be provided outside the medical service area. The three items discussed previously must be met. In addition, the regulation requires that the medical service required by the Medicaid member is not available in the medical service area, and a physician must refer the Medicaid member.

Federal regulation 42 Code of Federal Regulations 431.53 mandates that each state which receives federal funds for their Medicaid program provide necessary transportation for Medicaid members to and from providers. Nothing in the scope of services described in these regulations excludes the Medicaid member seeking crisis or behavioral health services. KDMS contracts with the Kentucky Transportation Cabinet to provide NEMT to Medicaid-eligible recipients through contracts with transportation brokers or providers. This is in accordance with applicable sections of KRS Chapter 281 and 907 KAR 3:066. NEMT services are available through the Human Service Transportation Delivery (HSTD) program, a regional brokerage system.²⁹³ Depending on a Medicaid member's medical needs, transportation is provided by taxi, van, bus, or public transit.²⁹⁴

The KDMS website explains that NEMT "is for Medicaid members who do not have access to free transportation that suits their medical needs" (as required in 907 KAR 3:066) and provides a link to the HSTD program,²⁹⁵ which lists eight transportation providers for the 15 regions. Transportation must be scheduled by calling providers during office hours in advance of the travel time (provider requirements

²⁹³ <https://transportation.ky.gov/TransportationDelivery/Pages/default.aspx>.

²⁹⁴ <https://chfs.ky.gov/agencies/dms/provider/Pages/nemt.aspx>.

²⁹⁵ Ibid.

range from 24 to 72 hours ahead). Some providers specify exceptions to advance scheduling, offering after-hours paging for urgent needs.^{296, 297}

Responses to a request for information noted that Medicaid can transport MCI services Medicaid members to stabilization locations, but respondents were unaware of the use of this service (how frequent Medicaid members' transportation needs were met, or how the transportation was provided).²⁹⁸

Law enforcement is also involved in Medicaid members' transportation. Kentucky's DBHDID Form 113D Emergency Services Planning and Implementation Report includes reimbursement for law enforcement providers for transportation of Medicaid members to and from hospitals and/or CSUs.²⁹⁹ According to data reported for SFY 2020, CMHCs reimbursed law enforcement agencies for:³⁰⁰

- 5,726 adult transports.
- 357 child transports.
- 6,871 evaluations to adults pursuant to adult court-ordered petition.
- 245 evaluations to children pursuant to adult court-ordered petition.
- 5,299 evaluations to adults pursuant in a warrantless arrest/uniform citation.
- 620 evaluations to children at risk of justice involvement but did not have a signed court petition.

Kentucky's Statute 202A.0813 includes transportation and examination of petition respondent for court-ordered evaluations:³⁰¹

The court may order that the sheriff of the county or a peace officer transport the respondent to a hospital or site designated by the cabinet so the respondent shall be examined without unnecessary delay by a QMHP. The sheriff or peace officer may authorize, upon agreement of a person authorized by the peace officer, the cabinet, a private agency on contract with the cabinet, or an ambulance service designated by the cabinet to transport the person to a hospital or site designated by the cabinet.

- When the court is authorized to issue an order that the respondent be transported to a hospital or site designated by the cabinet for examination, the court may issue a summons.
- A summons so issued shall be directed to the respondent and shall command the respondent to appear at a time and place specified in the summons, where the respondent shall be examined by a QMHP.
- If a respondent who has been summoned fails to appear for the examination, the court may order that the sheriff of the county or a peace officer transport the respondent to a hospital or site designated by the cabinet for the purpose of an examination.

²⁹⁶ <https://transportation.ky.gov/TransportationDelivery/Pages/Human-Services-Transportation.aspx>.

²⁹⁷ <https://www.ridertec.org/services/hstd-medicaid-broker>.

²⁹⁸ Kentucky State-Level Stakeholder Information Request, January 2022.

²⁹⁹ Kentucky State-Level Stakeholder Information Request, documentation received from stakeholders.

³⁰⁰ Kentucky State-Level Stakeholder Information Request, January 2022.

³⁰¹ <https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=46748>.

Current Transportation Process within MCI Services Continuum

CMHCs reported that transportation may often require the MCT and case managers to use creative solutions to coordinate transportation when and if situations warrant transition to other locations. Such solutions may include, but are not limited to: public transportation passes, gas reimbursement, and/or gift cards as a strategy they employ to fill the non-emergent transportation gap.

Through engagement for this needs assessment, stakeholders reported that EMS agencies in their region will not transport behavioral health clients as they are not deemed to be medical emergencies. However, in 2022, the Kentucky Board of EMS reported that most EMS transfers in Kentucky are not emergency-related, and 85 percent of all transfers were categorized as non-emergent.³⁰²

The SFY 2022 CMHC Annual Compilation Documents reports that eight out of 14 CMHCs include transportation services in their adult crisis array. Two of these eight provide coverage limited to certain counties/locations. Seven out of 14 CMHCs include transportation in their child crisis array, with one CMHC providing coverage limited to certain counties/locations.³⁰³

CMHC responses to the pre-interview questionnaires and feedback collected during the key informant interviews indicates:³⁰⁴

- All 14 CMHC regions report reliance on natural supports for transportation.
- One CMHC contracts with Uber Health.
- Three CMHCs provide transportation for clients deemed willing and non-violent, but safety concerns remain a challenge.
- One CMHC reported providing transportation for individuals in SUD crisis to withdrawal facilities.
- All CMHCs rely on law enforcement for transportation of clients with a 202A.
- ARC (BHSO) uses PSSs to transport willing clients to treatment.

Crisis Stabilization and Post-Crisis Supports

By design, hospital EDs are not set up to adequately treat mental illness due to provider time constraints and environmental factors that may escalate a behavioral health crisis. Since emergency room physicians do not specialize in mental health or addiction, they will often treat medical symptoms rather than the underlying mental and emotional causes of a person's condition. As a result, the cause of crisis is often left unaddressed, and the patient is discharged at risk for repeat crisis.³⁰⁵

Crisis respite and residential services are intended to help a person stabilize, resolve problems, and connect with possible sources of ongoing support. Crisis stabilization services may include physical and psychiatric assessment, daily living skills training, social activities, counseling, treatment planning, and

³⁰² <https://www.wymt.com/2022/01/21/ems-hospital-association-odds-over-proposed-ky-house-bill/>.

³⁰³ Kentucky CMHC Annual Crisis Services Compilation Documents, SFY2022.

³⁰⁴ Kentucky CMHC MCI Pre-Interview Questionnaire, February 2022.

³⁰⁵ Ibid.

connecting to services. Residential crisis services can either be an alternative to hospitalization or a step-down setting upon leaving a hospital.

Table 14 lists the various crisis stabilization and post-crisis stabilization services provided by CMHCs based on their response to the pre-interview questionnaire.³⁰⁶ Ninety-two percent of CMHCs provide post-crisis follow-up and drug and alcohol services. However, only 31 percent of CMHCs provide respite. Having full service offerings at all CMHCs would help to ensure a full MCI service continuum.



Crisis Stabilization

“Immediate placement is often not available as we do not have specialized homes or facilities to accept these individuals and it can take time to find a provider to assist. Many CSUs will not accept I/DD population even when they are experiencing a behavioral health crisis.”

— Information Request Response

Table 14. Pre-Interview Questionnaire: CMHCs Providing Stabilization and Post-Crisis Services

Crisis Stabilization and Post-Crisis Stabilization Services	Percentage of CMHCs	Gaps for CMHCs
Respite	31%	R1, R2, R3, R5, R7, R11, R12, R13, R15
Residential crisis stabilization	77%	R3, R7, R15
MAT	77%	R1, R8, R13
Post-crisis follow-up	92%	R1
Housing support	85%	R1, R13
Vocational support	85%	R1, R13
Social services (food, Medicaid, etc.)	69%	R1, R4, R5, R13
Drug and alcohol	92%	R1

CSUs

CSUs are important facilities for the behavioral health community and provide crisis stabilization services to people in need of urgent care related to mental illnesses, SUDs, or both. CSUs can look different from one jurisdiction to the next. CSUs provide a better alternative to an ED for people experiencing a mental health crisis. These units are a cost-efficient alternative and can reduce incarceration and hospitalization costs.³⁰⁷

The Kentucky Medicaid SPA defines residential crisis stabilization as: “Residential Crisis Stabilization services are provided in Crisis Stabilization Units. CSUs are community-based, residential programs that offer an array of services including screening; assessment; treatment planning; individual, group, and family therapy; and peer support in order to stabilize a crisis and divert the individual from a higher level of care. Crisis Stabilization Units are not part of a hospital. They are used when individuals in a behavioral health emergency cannot be safely accommodated within the community, are not in need of hospitalization, but need overnight care.”

³⁰⁶ Ibid.

³⁰⁷ <https://csgjusticecenter.org/publications/tips-for-successfully-implementing-crisis-stabilization-units/#:~:text=What%20is%20a%20Crisis%20Stabilization,one%20jurisdiction%20to%20the%20next.>

Ten out of the 14 CMHCs operate a CSU for adults as seen in *Table 15*. Of the 10 CMHCs operating a CSU, all provide CSU services for adults with acquired brain injuries and adults with I/DD. Three out of the 10 CMHCs operate CSU for adults with SUD, actively using or under the influence, and five out of 10 provide CSU for adults with SUD in withdrawal/detox.

Table 15. CMHCs Operating Adult CSUs (SFY 2019 Kentucky Annual Compilation Documents)

Regions	1	2	3	4	5	6	7	8	9/10	11	12	13	14	15
Region has an adult CSU	•		•	•	•				•	•		•	•	•
Adults with acquired brain injuries	•		•	•	•				•	•	•	•	•	•
Adults with I/DD	•		•	•	•				•	•	•	•		•
Adults who are under the influence of substances or alcohol			•								•	•		
Adults who are withdrawing/detoxing from alcohol or substances				•	•					•	•	•		

Among Kentucky's CMHCs, eight out of 14 operate a CSU for children as seen in *Table 16*. Of these eight, seven provide CSUs for children with acquired brain injuries and children with I/DD. Four out of the eight CMHCs operate CSUs for children with SUD, actively using or under the influence, and two out of 10 provide CSUs for children with SUD in withdrawal/detox.

Table 16. CMHCs Operating Children's CSUs (SFY 2019 Kentucky Annual Compilation Documents)

Regions	1	2	3	4	5	6	7	8	9/10	11	12	13	14	15
Region has a children's CSU				•	•	•		•	•	•	•	•		
Children with acquired brain injuries					•	•		•	•	•	•	•		
Children with I/DD					•	•		•	•	•	•	•		
Children who are under the influence of substances or alcohol						•				•	•	•		
Children who are withdrawing/detoxing from alcohol or substances					•							•		

Wellspring BHSO CSU assists adults experiencing acute psychiatric episodes and helps them achieve stabilization and avoid hospitalization. Two CSU sites, Samuel B. Todd Center and the David J. Block Center, provide 16 stabilization beds. Units provide clients with intensive treatment, close monitoring

with high levels of staff support, and medications prescribed by a psychiatrist. Both units are staffed 24/7/365.³⁰⁸

According to the SFY2022 Kentucky Annual CMHC Compilation Documents, 13 out of 14 CMHCs offer follow-up support and outreach in the adult crisis services array. Follow-up support and outreach is not a listed service in the children’s crisis array. For children, emergency residential crisis care is available through a TFC home is offered in one CMHC, Region 6 – Seven Counties.³⁰⁹

23-Hour Crisis Receiving and Stabilization Programs

Twenty-three-hour crisis stabilization services are designed for short-term observation for persons in need of brief intensive treatment in a safe environment that is less restrictive than a hospital.³¹⁰

According to the SFY 2022 Kentucky Annual CMHC Compilation Documents, the availability of 23-hour crisis stabilization services is limited to non-existent. Stakeholders confirmed this throughout CMHC interviews.

- KRCC operates an adult 23-hour CSU in Hazard with limited coverage for select counties.³¹¹
- RVBH operates an adult 23-hour CSU available in Region 3 with limited coverage for select counties.³¹²
- Pathways has a 23-hour CSU in Morehead, but the facility is currently unused.³¹³
- Seven Counties operates a 23-hour ASU designated for SUD-related crises. Seven Counties currently uses the ASU for short-term behavioral health stabilization of individuals diverted in the DOVE Delegates program. Plans to expand this unit to broad short-term adult crisis stabilization for individuals across the region are underway.³¹⁴
- Short-term 23-hour crisis stabilization services are not listed in the children’s crisis array.³¹⁵
- Stakeholders reported that the operation of 23-hour stabilization units has declined in Kentucky’s CMHCs due to staffing limitations and budget constraints.³¹⁶

Crisis Respite

Crisis respite centers and apartments provide 24-hour observation and support by crisis workers or trained volunteers until a person is stabilized and connected with other supports. In some locations, PSSs provide encouragement, support, assistance, and role models in a non-threatening atmosphere.

The SFY 2022 Kentucky Annual CMHC Compilation Documents list emergency respite in the children’s crisis services array. Emergency respite for children is offered in four CMHCs, three of which have

³⁰⁸ Kentucky MCI Roundtable: Housing Stakeholders, March 2022.

³⁰⁹ Kentucky CMHC Annual Crisis Services Compilation Documents, SFY 2022.

³¹⁰ Ibid.

³¹¹ Ibid.

³¹² Ibid.

³¹³ Kentucky CMHC MCI Stakeholder Interviews, February through March 2022.

³¹⁴ Ibid.

³¹⁵ Kentucky CMHC Annual Crisis Services Compilation Documents, SFY 2022.

³¹⁶ Kentucky CMHC MCI Stakeholder Interviews, February through March 2022.

coverage limited to select counties/locations.³¹⁷ Some example respite services offered within the Commonwealth are listed below.

First Steps (Seven Counties) is an early intervention system in Kentucky, offering services to children with developmental disabilities from birth to three years old. Services are offered through Kentucky community agencies. First Steps creates an individualized family service plan that determines the need for respite care for children up to three years old. Providers of these respite service must be enrolled under the First Steps respite program, led by Seven Counties. The objective of early respite care for I/DD children is to provide the family relief from care of the child to strengthen the family's ability to address the child's developmental needs.^{318, 319}



Crisis Respite Definition

Crisis respite provides short-term relief, for up to two weeks, for the individual and caregivers in order to prevent a crisis or assist in the de-escalation of a current crisis. Respite may be provided in a residential setting or on an hourly basis. (www.CRBHKY.org)

CMHCs Respite Services for Children and Youth

- Lifeskills offers brief respite for children experiencing a crisis situation in order to allow the situation to settle and to observe and assess the situation to determine recommendations for aftercare with the child's family. Crisis stabilization respite for children is available for one to seven days.³²⁰
- Communicare, Seven Counties, Comprehend, Pathways, and MCCC currently offer emergency respite services for children with and without I/DD.³²¹
- NorthKey staff provide referrals to respite care for children with I/DD.

CMHCs Respite Services for Adults with I/DD

- NorthKey's adult crisis respite program receives funding support through local, state, and federal grants. Medicaid and Medicare also serve as a primary payer for respite services.³²²
- Communicare offers emergency respite services for adults with I/DD.³²³
- Pathways offers crisis respite care for adults and I/DD stabilization.

CMHC Adult Respite Services

- KRCC, Seven Counties, and Comprehend offer adult emergency respite care.³²⁴
- Seven Counties has a residential care program with emergency apartments when available.

³¹⁷ Kentucky CMHC Annual Crisis Services Compilation Documents, SFY 2022.

³¹⁸ <https://resources.hdiuky.org/resource/respite-care/>.

³¹⁹ <https://apps.legislature.ky.gov/law/kar/titles/902/030/160/>.

³²⁰ Kentucky CMHC MCI Stakeholder Interview, February 2022.

³²¹ <https://dbhdid.ky.gov/dbh/documents/crisis-services.pdf>.

³²² <https://www.northkey.org/services/developmental-disabilities-services/respite-care/>.

³²³ <https://dbhdid.ky.gov/dbh/documents/crisis-services.pdf>.

³²⁴ [Ibid.](#)

- RVBH operates residential care and support for adults with SMI, and can provide emergency apartments when available.³²⁵

BHSO Respite Services

- Welcome House currently offers respite housing for women and children. Welcome House is piloting a new respite program which expands the current respite housing to a broader population.³²⁶

Housing Services

The pre-interview questionnaire asked about two client-related barriers. Eighty-five percent of the CMHCs stated that limited availability for stable housing was a barrier, and 77 percent stated that limited availability of social supports leading to repeat crisis as a barrier. The majority of CMHCs stated that post-crisis and stabilization supports are a barrier.

In the SFY2021 Kentucky Annual CMHC Compilation Documents, the CMHCs were asked whether they had access to emergency housing. Eleven of the 14 CMHCs stated they do have access to emergency housing.

Example housing services offered within the Commonwealth are listed below.

Wellspring supports the evidence-based practice of housing first by providing adults with SMI access to housing. Wellspring's programs combine housing with additional support services to help individuals achieve stability after experiencing homelessness, hospitalization, or incarceration. Wellspring's PUSH provides high-level targeted case management assistance for people in need of intensive mental health services and support. The program uses case management, peer support, personalized therapy, and customized resources based on the individual's need.³²⁷

Welcome House offers a housing continuum of services in Northern Kentucky and initially operated an emergency shelter before expanding its mission to include a holistic approach to end homelessness. Three main service areas are housing, service coordination, outreach, and stability. In Welcome House's service area, 61 percent of families in Kenton County are headed by single women with children under the age of five years old.^{328, 329}

The Drop-In Center (New Vista) operates under New Vista's CCBHC grant in Richmond, Kentucky. The center is a peer-led program, a designated safe place, for adults experiencing mental illness, SUDs, and/or homelessness. Peers connect clients to therapy services, employment and vocational supports, housing, and case management. Clients are able to drop-in and shower on site at no charge. Currently, the Drop-In Center is open Monday through Friday, 8:00 a.m. to 12:00 p.m., and 1:00 p.m. to 4:00 p.m.³³⁰

³²⁵ Kentucky CMHC MCI Stakeholder Interview, February 2022.

³²⁶ Kentucky MCI Roundtable: Housing Stakeholders, March 2022.

³²⁷ <https://www.wellspringky.org/>.

³²⁸ <https://www.welcomehouseky.org/programs-services/>.

³²⁹ Kentucky MCI Roundtable: Housing Stakeholders, March 2022.

³³⁰ <https://newvista.org/new-drop-center-and-therapeutic-rehabilitation-program-open-richmond>.

Kentucky's Housing Authority relies on CMHCs to coordinate behavioral health needs. Stakeholders stated there is a critical shortage of housing supports in rural Kentucky with most counties considered rural and/or have limited HUD coverage.³³¹

Community Partnerships

Partnerships and collaborations are essential throughout the MCI service continuum. When the level-of-care need is determined by the MCT, warm hand-offs to community partner facilities, such as hospitals, inpatient rehabilitation, and SUD detox/sobering take place.

Based on the pre-interview questionnaire, CMHCs reported maintaining formal agreements with local services as seen in *Table 17*. It should be noted that during CMHC interviews, stakeholders cited circumstances where informal partnerships existed with various potential community partners.

Table 17. CMHC Pre-Interview Questionnaire: CMHC Local Services with Formal Agreements

Local Services with Formal Agreements	Percentage of CMHCs
Outpatient behavioral health services (e.g., case management, medication support, etc.)	77%
Behavioral health crisis facility (e.g., residential, respite, stabilization utilization, etc.)	62%
Substance use withdrawal management/sobering	46%
Psychiatric emergency services (e.g., CPEP, EmPATH unit, etc.)	38%
Inpatient psychiatry	54%

Kentucky's Pilot Programs and Grant-Funded Initiatives

Kentucky Opioid Response Effort (KORE). KORE is led by the Kentucky DBHDID. KORE is a program that seeks to expand and sustain an equitable recovery center system of care in Kentucky and reduce opioid-related overdose deaths by increasing access to evidence-based prevention, reduction, treatment, and recovery methods.³³²

KORE receives federal funding from SAMHSA. KORE supports and implements a variety of harm reduction and prevention programs and interventions, such as syringe service programs (SSPs), after school K-12 drug use prevention programs, and distribution of free naloxone throughout Kentucky. Since 2018, KORE has supported the treatment of more than 28,625 Kentuckians through its initiatives. KORE oversees service treatment in rural and urban areas throughout Kentucky with an emphasis on areas with high rates of overdose cases, and areas that lack access to effective treatment for opioid misuse. KORE funds 12 mobile teams known as QRTs which currently cover 33 counties in Kentucky. The QRTs provide overdose follow-up services for survivors and their families. The budget for each QRT is \$110,000 to \$200,000. The budget for each QRT is used to support a variety of operations and

³³¹ Kentucky MCI Roundtable: Housing Stakeholders, March 2022.

³³² <https://chfs.ky.gov/agencies/dbhdid/Documents/AboutKORE.pdf>.

implementation costs such as the cost for PSSs, first responders (e.g., EMS, etc.), travel expenses, outreach and engagement supplies, marketing, naloxone, fentanyl test strips, and more. In order to support the recovery of individuals with opioid misuse addictions, KORE supports a variety of services that help these individuals seek job training, employment, and recovery housing.³³³

DOVE Delegates. The DOVE Delegate model in Louisville, Kentucky is a new pilot program implemented on March 21, 2022.

The program seeks to deflect a percentage of calls entering the 911 system to a non-police response focused on problem-solving, de-escalation, and referral to appropriate community services. Calls made to 911 that are identified as needing assistance from a CIT are transferred to the behavioral health hub at the MetroSafe 911 call center for further triage.³³⁴ In lieu of sending law enforcement to people in crisis who do not carry a risk of violence, the DOVE Delegate program sends a team of community responders trained in crisis intervention to assist that individual. The DOVE Delegate program also provides de-escalation techniques over the phone to assist the individual in crisis without having to travel to the individual.

The DOVE Delegate program is offered to adults age 18 and older who are experiencing, or at risk of experiencing, a behavioral health crisis. An analysis of research and stakeholder communications noted that there were 40,000 911 calls and 29,000 (72 percent) of them could have been diverted to other community resources.³³⁵

The Seven Counties Deflection program is a component of the DOVE Delegates Diversion Pilot. When crisis calls are received through the deflection program, the operator, trained in behavioral health crisis care, engages the individuals and makes a request for MCT dispatch if the need is determined.³³⁶

Under the DOVE Delegates alternative model, deflection is defined as “an event (that) involved one or more CIT classifications but did not indicate an issue that is considered potentially high risk for physical harm.”³³⁷ Calls meeting the deflection criteria are passed through to the Seven Counties Deflection Response Team, via the process mentioned above. Throughout the eight divisions in the Louisville area, 72 percent of all CIT dispatches between 2019 and 2021 were labeled deflection.³³⁸

Figure 35. Seven Counties Deflection Classifications by Year

Table 7: CIT Classifications by Year					
Division	2019	2020	2021	Total	Avg. Events Per Day
Deflection	9,039	14,438	5,611	29,088	40.23
Higher-Risk	3,298	5,676	2,380	11,354	15.70
Total	12,346	20,128	7,996	40,470	55.98

³³³ Ibid.

³³⁴ <https://louisvilleky.gov/mayor-greg-fischer/document/louisville-metro-alternative-responder-model-research-and-planning>.

³³⁵ Ibid.

³³⁶ Kentucky CMHC MCI Stakeholder Interview, February through March, 2022.

³³⁷ U of L, Commonwealth Institute of Kentucky, *Louisville Metro Alternative Responder Model Research and Planning Final Report*, 2021: 25.

³³⁸ Ibid.

The next phase of the Seven Counties Deflection program is to implement a co-responder model for instances where a safety threat is identified (violence or weapons). Additionally, the Deflection Team for Prevention could be leveraged or expanded for housing and employment.

Lyon County Diversion for SUD. Badges of Hope is an alliance between law enforcement and rehabilitation facilities in Lyon County, Kentucky. The partnership aims to present a united front for individuals experiencing SUD. An individual can call the Lyon County Sheriff's Department and voluntarily request help for their SUD. Once a call is taken, the sheriff's office will send a deputy to transport the individual to a treatment center in the Badges of Hope program. If the individual is uninsured, they will automatically receive assistance through the partnership, and treatment is provided at no cost. The mission is to provide rehabilitation instead of jail.^{339, 340}

CPP. The Kentucky Board of EMS first implemented the CPP for mobile integrated health in 2016.³⁴¹ The CPP is available for children and adults. The program allows its individuals to receive at-home care by a trained EMS healthcare worker which frees up hospital beds and allows for other healthcare professionals to use the resources elsewhere, which in turn, helps to reduce healthcare costs. Other first responders such as firefighters can call on the support of the CPP when they are faced with non-emergent medical situations that do not require an ambulance.³⁴²

The CPP follows a multi-disciplinary model which allows the program to find needed resources for the vulnerable populations being served by the team after thorough assessments.³⁴³ Since the implementation of the CPP in Lexington, there has been a significant decrease in EMS responses, 6.5 percent from 2017 to 2019. Through providing at-home care for non-emergent medical situations, the CPP has been able to reduce the number of patients in hospital EDs and number of readmissions after a patient is discharged.

New Vista works closely with CPP. If a crisis call comes in requiring mobile response within CPP jurisdiction, New Vista patches through to EMS for mobile crisis referral.

Kentucky Crisis Care Transformation Initiative. DBHDID received Transformation Transfer Initiative (TTI) funds from SAMHSA to: 1) support installation and initial implementation of a rural community paramedicine crisis response model that will expand the role of paramedics and emergency medical technicians (EMTs) as first responders in a behavioral health crisis and 2) improve implementation of evidence-based programs (EBPs) among existing behavioral health crisis staff to improve client outcomes, particularly for families, children, adolescents and transition-age youth.³⁴⁴ DBHDID will collaborate with Perry County EMS to support the initial implementation of the pilot that will allow paramedics and EMTs to operate in expanded roles during behavioral health crises in collaboration with a behavioral health clinician and/or PSS. Additionally, DBHDID will collaborate with the CMHCs to ensure that its workforce is trained in EBPs.

³³⁹ Kentucky MCI Stakeholder Lyon County Law Enforcement Interview, March 2022.

³⁴⁰ <https://www.lyonsheriff.com/badges-of-hope.html>.

³⁴¹ https://kbems.kctcs.edu/education/YearsData_073117.pdf.

³⁴² <https://www.lexingtonky.gov/news/11-11-2019/hospitals-provide-funds-community-paramedicine-program>.

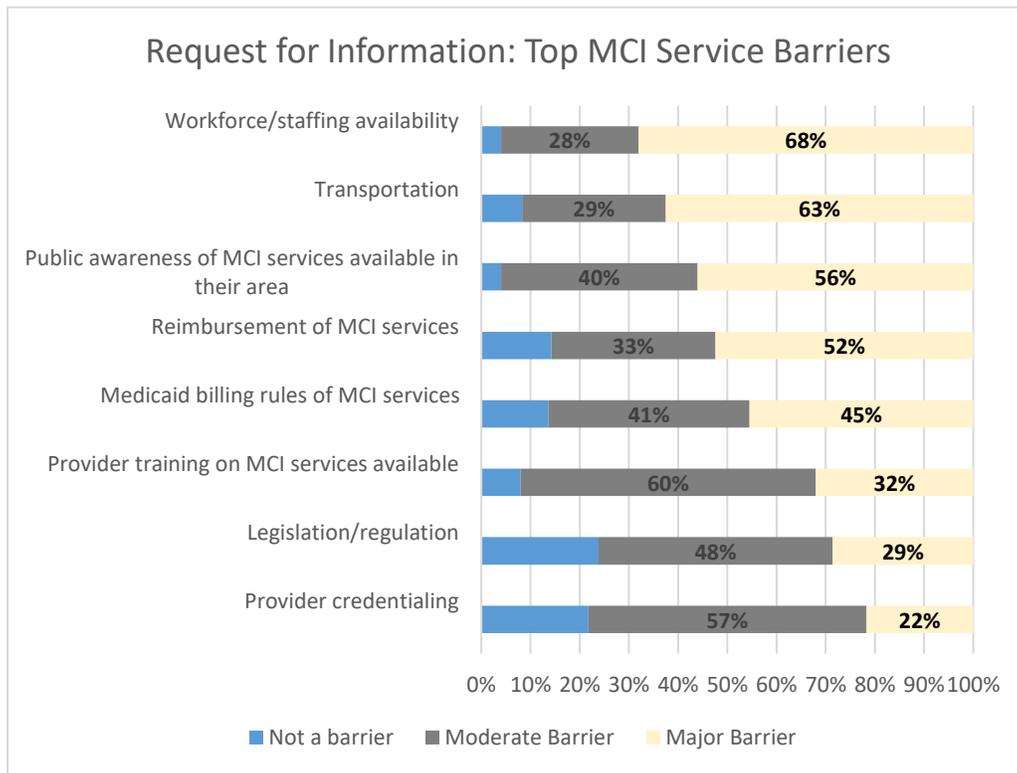
³⁴³ <https://www.allisonigibsonphd.com/cpp>.

³⁴⁴ Kentucky Crisis Care Transformation Initiative Application, November 2021

Barriers and Challenges Delivering MCI Services in Kentucky

Figure 36 lists the top MCI services barriers from the responses to the request for information which asked critical KDMS, DBHDID, other state agencies, and select community stakeholders for input about the current MCI environment. The top two barriers for MCI services were workforce/staffing availability at 68 percent of respondents stating that it was a major barrier, and transportation with 63 percent of respondents stating it was a major barrier. Respondents indicated that other significant barriers were public awareness of MCI services, and reimbursement of MCI services. All of these barriers align with communications received during stakeholder interviews, roundtables, and pre-interview questionnaires.

Figure 36. State-Level Request for Information: Top MCI Service Barriers



The CMHCs were asked to select the top three barriers related to MCI services (Figure 37). The top barriers identified from the pre-interview questionnaire included: limited availability of services and supports for individuals with memory issues at 62 percent of respondents; limited availability of cultural and linguistic-related services and supports at 54 percent; limited availability of services and supports for people with co-occurring disabilities at 46 percent; and limited availability of services for children, youth, and families at 46 percent. The findings from the questionnaire align with communications by stakeholders during interviews with CMHCs, which indicated there are limited services available for populations that have specialized needs such as children, individuals with co-occurring disabilities, and those with memory issues.

Figure 37. CMHC Pre-Interview Questionnaire: CMHC Top Barriers Related to Services

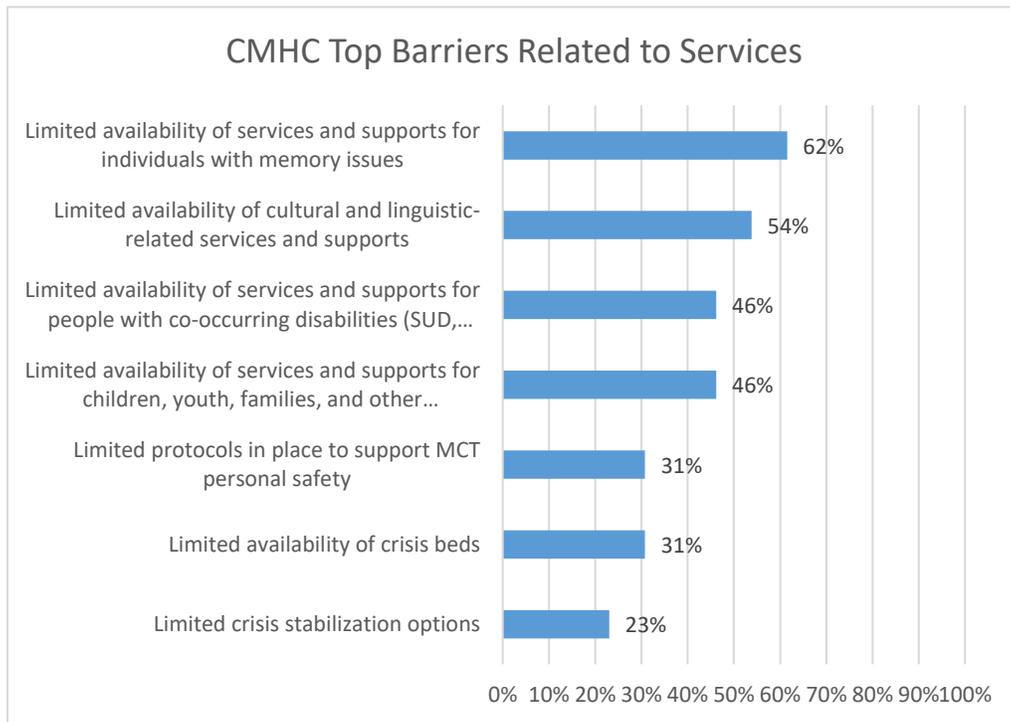


Table 18 shows the top barriers as indicated by the CMHC pre-interview questionnaire results, as it relates to timing. Of note, 54 percent of CMHCs stated that MCT response time can be delayed because of the large geography of the region. This concern aligns with the other barriers noted for rural regions.³⁴⁵ The service delivery time-related barriers were echoed throughout the engagement, particularly as they related to MCT responses in geographically large areas.

Table 18. CMHC Pre-Interview Questionnaire: CMHC Top Barriers Related to Service Delivery Timing

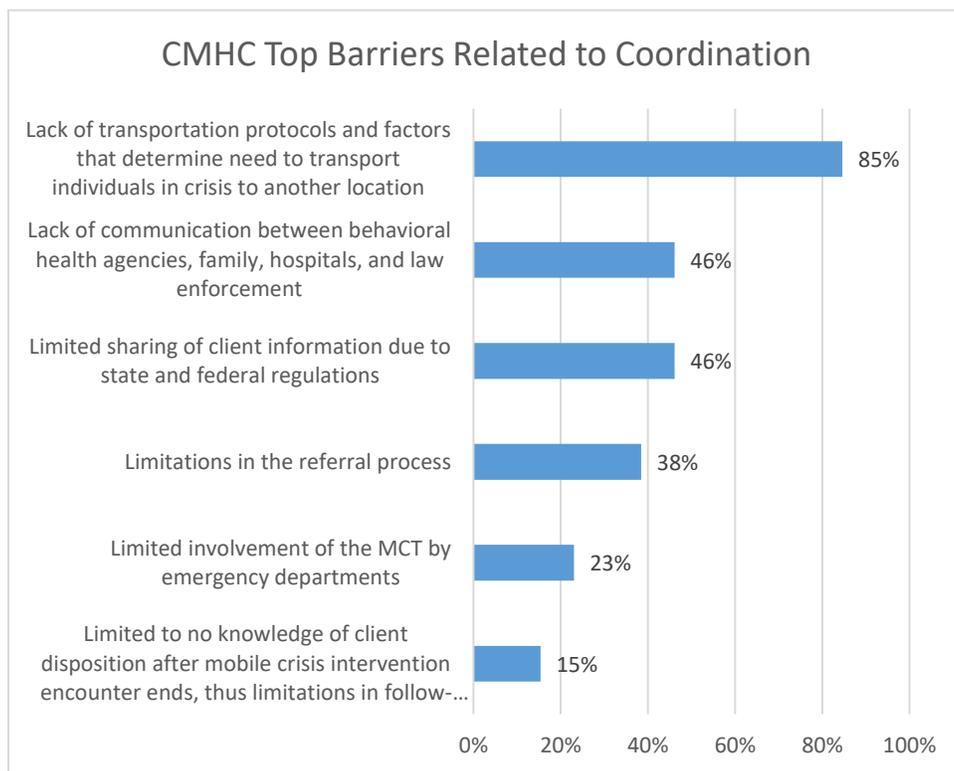
Service Delivery Time-Related Barriers	Percentage of CMHCs
Delays in MCT response time due to size of the region or coverage areas.	54%

³⁴⁵ Kentucky CMHC MCI Pre-Interview Questionnaire, February through March 2022.

Service Delivery Time-Related Barriers	Percentage of CMHCs
Delays in scheduling follow-up care.	54%
Delays in issuing referrals.	23%

Figure 38 shows the top barriers relating to coordination. In the pre-interview questionnaire, CMHC stakeholders reported their top barriers to be transportation at 85 percent, lack of communication between providers, family, and community partners at 46 percent, and limited sharing of client information at 45 percent. These findings are consistent with information presented earlier, that transportation is a critical barrier and needs to be addressed to ensure comprehensive MCI service delivery.

Figure 38. CMHC Pre-Interview Questionnaire: CMHC Top Barriers Related to Coordination



Marketing and Awareness

During several stakeholder events, including a large-format BHSO roundtable, adult/aging roundtable, and children/youth roundtable, participants reported limited awareness of available MCI services within Kentucky. Stakeholders expressed concern that if providers are not aware of MCI services, then patients/clients are likely to be unaware as well.

- There is a general lack of awareness regarding available crisis supports among youth, parents, caregivers, and day-to-day supports (e.g., teachers).^{346, 347}
- Stigma often restricts casual discussions concerning mental health issues, particularly affecting children and youth.³⁴⁸
- ED staff tend to stigmatize behavioral health crisis, broader mental illness, and SUD. Individuals in crisis report to advocates that when in the ED, they hear a lot of “they shouldn’t be in the ED,” or “this isn’t an emergency.”³⁴⁹

Table 19 lists the marketing methods the CMHCs use to promote MCI services. All CMHCs have a website, and all but one CMHC use social media to help spread awareness of MCI services.

Through the interviews with stakeholders, they communicated that it appears there is an opportunity to market MCI services to other providers, EMS, law enforcement, and individuals. KDMS also has the opportunity to spread awareness of how to provide or bill for MCI services as there is limited information on what truly are MCI services.

Table 19. CMHC Pre-Interview: CMHC Marketing Methods

Marketing Methods	Percentage of CMHCs
Website	100%
Social media	92%

³⁴⁶ Kentucky MCI Roundtable: Youth Stakeholders, February 2022.

³⁴⁷ Kentucky MCI State-Level Stakeholder Information Request, January 2022.

³⁴⁸ Kentucky MCI Roundtable: Youth Stakeholders, February 2022.

³⁴⁹ Kentucky MCI Roundtable: Adults/Seniors Stakeholders, February 2022.



Awareness

“Families don’t like to talk about the mental health struggles their child experiences. Kids don’t feel comfortable expressing concerns about their mental health, and pediatricians struggle to approach the topic at regular appointments. Mom’s chat ‘over the fence’ about ear infections and strep but not about mental illness.”

— *Children’s Mental Health Provider*



Awareness

“There’s a need to conduct community outreach to educate community members, schools, police, and other first responders about mobile crisis. Kentucky <should> engage in a public information campaign that gets the word out to community agencies, public and private, as well as the general public. This is a must for a well-functioning service entry process.”

— *MCO Representative*

Marketing Methods	Percentage of CMHCs
Appointment cards	85%
Flyers	54%
Traditional media advertisements	38%

Kentucky's 988 State Planning Team released marketing and communication goals in their 988 Implementation Plan, published in January 2022. Specific supports for promotion of the 988 crisis line include: building relationships with local media and advertising agencies, advocating for captioning and messaging available, culturally-appropriate response to English to speakers of other languages and sign language users, and sharing messaging via social media and other channels. By June 30, 2022, the 988 State Planning Team will have a written plan in place identifying audiences, resources, channels, and other elements to disseminate national-level public messaging.³⁵⁰

³⁵⁰ Kentucky 988 Implementation Plan, January 2022.



Current MCI Services Provider Network, Reimbursement, and Member Utilization



CHFS
KENTUCKY
Cabinet for Health and
Family Services

Current MCI Services Provider Network, Reimbursement, and Medicaid Member Utilization

Medicaid-Enrolled Behavioral Health Providers

Kentucky Medicaid requires all services for MCI be provided through a CMHC or a BHSO. There are 14 CMHCs in Kentucky, and 158 BHSOs. CMHCs designated as CCBHCs may also provide MCI services, and they are included in the count of CMHCs.³⁵¹



To provide MCI services that can be billed to Medicaid by the above organizations, a provider must be enrolled in the Medicaid program as one of the following types of providers listed in *Table 20*. Other providers may also deliver MCI services, but they must be provided under the supervision of the provider types listed below. *Table 4* in this report identifies these other provider types. Further, the number of Medicaid-enrolled providers reflects the number enrolled in Medicaid overall. Each of the six MCOs in Kentucky has its own network of providers, so the number of providers available to serve the Medicaid population may differ based on enrollment in a particular MCO. All MCO providers, however, must be enrolled in the Medicaid program.

Table 20. Number of Medicaid Enrolled Behavioral Health Providers by Provider Type

Provider Type	# Medicaid Enrolled Providers ³⁵²
LBA	328
LCADC	171
LCSW	1,612
LMFT	249
LPAT	40
LPCC	1,520
LPP	80

³⁵¹ KDMS. MMIS Medicaid Provider Enrollment Data. 3/10/2022.

³⁵² Ibid.

Provider Type	# Medicaid Enrolled Providers ³⁵²
LP	308
Psychiatrist	316
TOTAL	5,144

Note: For all counts of Medicaid-enrolled behavioral health providers in this report, the counts include only the billing providers and do not include non-licensed or other providers who bill under the supervision of billing providers. Regarding the count of behavioral health multi-specialty groups, individual providers within groups may also provide services in areas other than their group setting.

As of March 2022, considering the counts of providers listed above, there are 1.6 million Medicaid members, or 2.9 Medicaid-enrolled behavioral health providers per 1,000 Medicaid members.³⁵³ However, as shown in Table 21 below, the ratio of behavioral health providers to Medicaid members varies across the various CMHC regions. Regions 6 and 15, the most populous urban centers in Kentucky (include Lexington and Louisville), have a higher ratio of providers to Medicaid members than the state average ratio. The Medicaid-enrolled provider-to-member ratios in Regions 1, 2, 8, 12, and 13 are well below the state average of 2.9 Medicaid-enrolled providers per 1,000 Medicaid members. These regions with lower ratios are typically more rural and are not near a large urban center.

Of note, there are 12 counties that do not have any billing Medicaid behavioral health providers with a physical location in the corresponding county. These counties are within Region 1: Carlisle, Fulton, Hickman, and Livingston counties; within Region 2: Crittenden County; within Region 3: Hancock and McLean counties; within Region 6: Henry and Trimble counties; within Region 8: Bracken and Robertson counties; and within Region 12: Owsley County. As described above, there may be other behavioral health supports within the community that support Medicaid members but who do not bill directly, such as peer supports. These providers are not accounted for in the ratio.

Table 21. Ratio of Medicaid-Enrolled Behavioral Health Providers to 1,000 Medicaid Members by CMHC Region

CMHC Region	# of Medicaid Enrolled Providers Per 1,000 Medicaid Members
Region 1 – Four Rivers	1.7
Region 2 – Pennyroyal	1.7
Region 3 – RVBH	2.4
Region 4 – Lifeskills	2.5
Region 5 – Communicare	2.6
Region 6 – Seven Counties	4.3
Region 7 - NorthKey	2.9
Region 8 – Comprehend	1.6
Region 9/10 – Pathways	2.6
Region 11 – MCCC	2.9
Region 12 – KRCC	1.9
Region 13 – CRBH	1.4
Region 14 – Adanta	2.5
Region 15 – New Vista	3.4
State Average	2.9

³⁵³ There are 1,461,656 members enrolled in Medicaid Managed care plans. These plans contract with providers to establish their own network of providers, so the ratio of Medicaid members to licensed behavioral health providers may be overstated for Medicaid managed care members.

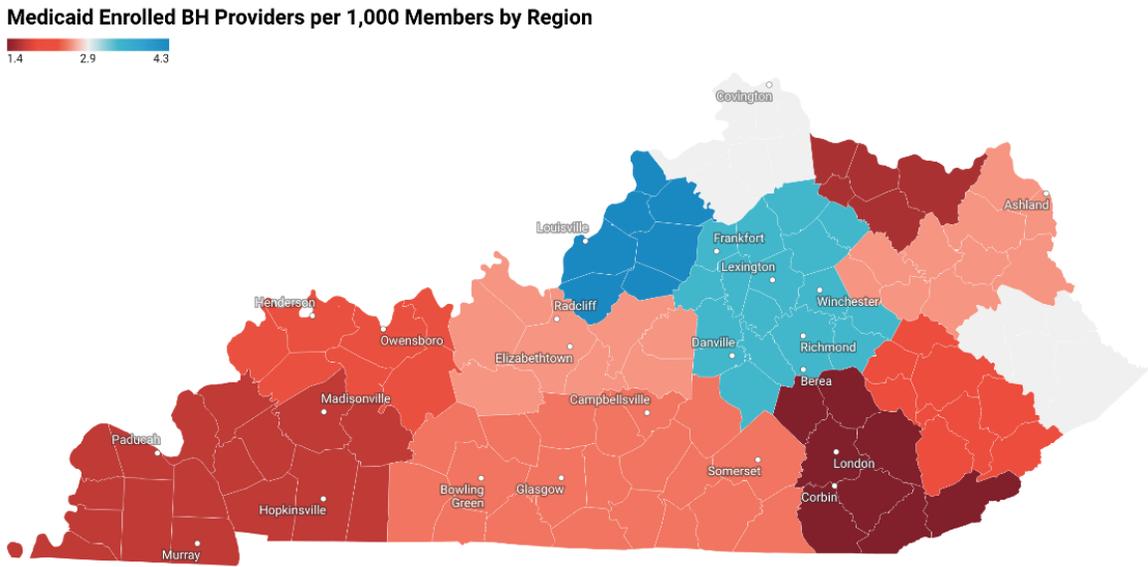
Note: Providers were assigned to counties based on the zip code of the practice location. In cases where a provider's zip code spans multiple counties, the county representing the geographic area most covered by the zip code is used for grouping purposes. Counties were then assigned to the CMHC region based on the DBHDID region map.³⁵⁴

Note: Medicaid-enrolled behavioral health providers only include the billing providers and are not fully inclusive of all capacity as non-licensed or other providers who bill under the supervision of billing providers is not included.

Each CMHC provides community services in its designated multi-county region as shown in Table 22.

Figure 39 shows the ratio of Medicaid-enrolled behavioral health providers per 1,000 Medicaid members by CMHC region.

Figure 39: Ratio of Medicaid Enrolled Behavioral Health Providers per 1,000 Medicaid Members by CMHC Region



Note: For all counts of Medicaid-enrolled behavioral health providers in this report, the counts include only the billing providers and do not include non-licensed or other providers who bill under the supervision of billing providers.

Provider Billing for MCI Services

Medicaid MCI services are billed with Healthcare Common Procedure Coding System (HCPCS) code S9484, "crisis intervention mental health services, per hour."³⁵⁵ While eight out of the 14 CMHCs were paid for S9484, up to four BHSOs were paid for these services, as shown in Table 22.³⁵⁶

³⁵⁴ "Kentucky State Psychiatric Hospital/CMHC Districts." Department for Behavioral Health, Developmental and Intellectual Disabilities, <https://dbhdid.ky.gov/cmhc/documents/RegionsMap.pdf>.

³⁵⁵ <https://hcpcs.codes/s-codes/S9484/>.

³⁵⁶ KDMS. Kentucky SFY 2019 – 2021 Data Query of Medicaid Crisis Intervention Claims for MCI services billed from 7/1/2018 to 6/30/2021, and paid as of 3/10/2022.

Table 22. Listing of Providers who Billed for MCI Services for SFY 2019 – 2021

CMHCs Billing for S9484 Services	BHSOs Billing for S9484 Services
<ul style="list-style-type: none"> ▪ Comprehend ▪ Four Rivers Behavioral Health ▪ KRCC ▪ Lifeskills ▪ MCCC ▪ Pennyroyal ▪ Seven Counties. ▪ The Adanta Group 	<ul style="list-style-type: none"> ▪ ARC ▪ Ramey-Estep Homes ▪ Omni Community Health ▪ Wellspring

Total payments for MCI services were modest: the CMHCs and BHSOs were paid approximately \$943,000 for MCI (S9484) services during SFY 2019 – 2021 as shown in Table 23.³⁵⁷ SFY 2021 claims data were incurred through June 30, 2021. The two providers receiving the largest payments for MCI services were KRCC and Pennyroyal Center.³⁵⁸

Table 23. Providers that Billed MCI Services with Expenditures for SFY 2019 – 2021

Provider Type	Number of Providers Enrolled in Kentucky Medicaid ³⁵⁹	Number That Billed for Mobile Crisis Intervention	Percentage of Providers Billing for MCI	Total Mobile Crisis Services Expenditures
CMHC	14	8	57%	\$ 891,132
BHSO	158	4	3%	\$ 52,081
Total	-	-	-	\$ 943,213

Note that for SFY 2021, claims data may not be complete due to claims lag/runout.

Table 24 summarizes the CMHC billings and payments of HCPS code S9484 for SFY2020. Pennyroyal and KRCC received the highest share of payments to CMHCs billing S9484, together the CMHCs received nearly 90 percent of the statewide mobile crisis payments.

Table 24. CMHCs that Received Payments for Mobile Crisis (S9484)³⁶⁰

Provider	Units Billed (FFS and MCO)	Units Allowed (FFS and MCO)	Total of FFS, MCO, Copays	Percentage of Payments to Total
Comprehend Inc	121	79	\$7,377	2.7%
Four Rivers Behavioral Health	2	2	\$208	0.1%
Kentucky River Comm Care	1,547	1,298	\$117,410	42.5%

³⁵⁷ Kentucky SFY 2019 – 2021 Data Query of Medicaid Crisis Intervention Claims for MCI services billed from 7/1/2018 to 6/30/2021, and paid as of 3/10/2022.

³⁵⁸ Kentucky SFY 2019 – 2021 Data Query of Medicaid Crisis Intervention Claims.

³⁵⁹ KDMS. MMIS Medicaid Provider Enrollment Data. 3/10/2022.

³⁶⁰ Kentucky SFY 2020 Medicaid Claims Data

Provider	Units Billed (FFS and MCO)	Units Allowed (FFS and MCO)	Total of FFS, MCO, Copays	Percentage of Payments to Total
Lake Cumberland Comp Care	25	21	\$1,892	0.7%
Lifeskills Inc	106	89	\$9,705	3.5%
Mountain Comprehensive Care Ctr	181	150	\$12,286	4.4%
Pennyroyal Center	1,734	1,335	\$126,967	45.9%
Seven Counties Services, Inc.	7	5	\$584	0.2%
Total	3,723	2,979	\$276,429	100%

MCOs paid for about 97 percent of the \$943,000 in expenditures to these providers, as shown in Table 25, and about 92 percent of all these expenditures were made for CMHC services.³⁶¹ Less than three percent of MCI expenditures were paid through FFS payments to CMHCs or BHSOs.

Table 25. MCI Service Expenditures by Billing Provider and Payer for SFY 2019 – 2021

Provider Type	Expenditures for MCI Services			MCI Expenditures Paid by MCOs and FFS		
	FFS	MCOs	Total	FFS	MCOs	Total
CMHC	\$ 24,287	\$ 866,845	\$ 891,132	2.6%	91.9%	94.5%
BHSO	\$ 689	\$ 51,392	\$ 52,081	0.1%	5.4%	5.5%
Total	\$ 24,976	\$ 918,237	\$ 943,213	2.6%	97.4%	100.0%

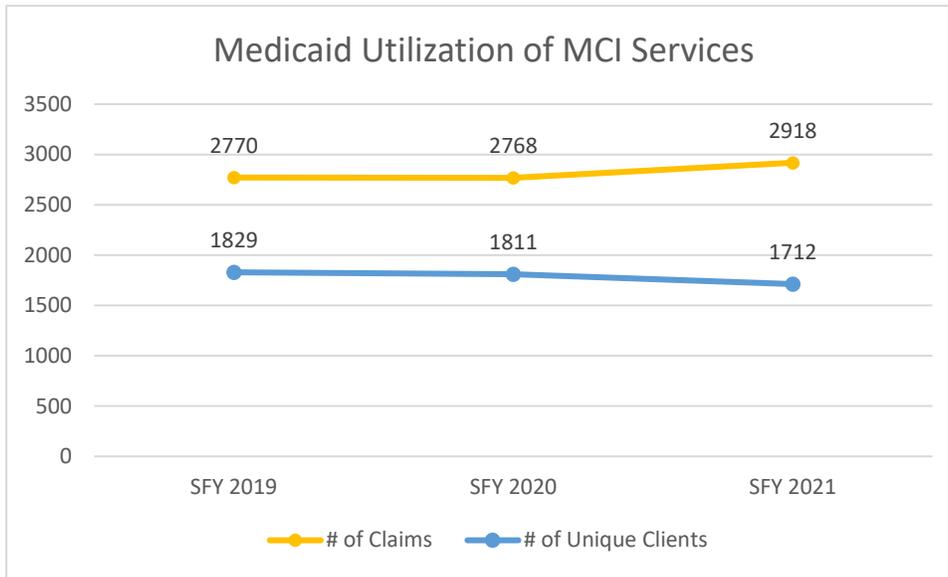
Kentucky Medicaid Member MCI Services Utilization

The \$943,213 total expenditures represent MCI services provided to 5,352 Medicaid members, and for a total of 8,456 paid claims.³⁶² The number of MCI service claims paid varied from 2,770 to 2,918 for SFY2019 to SFY2021 (Figure 40). The number of unique MCI clients dropped from 1,829 to 1,712 over the same time period.

³⁶¹ Kentucky SFY 2019 – 2021 Data Query of Medicaid Crisis Intervention Claims.

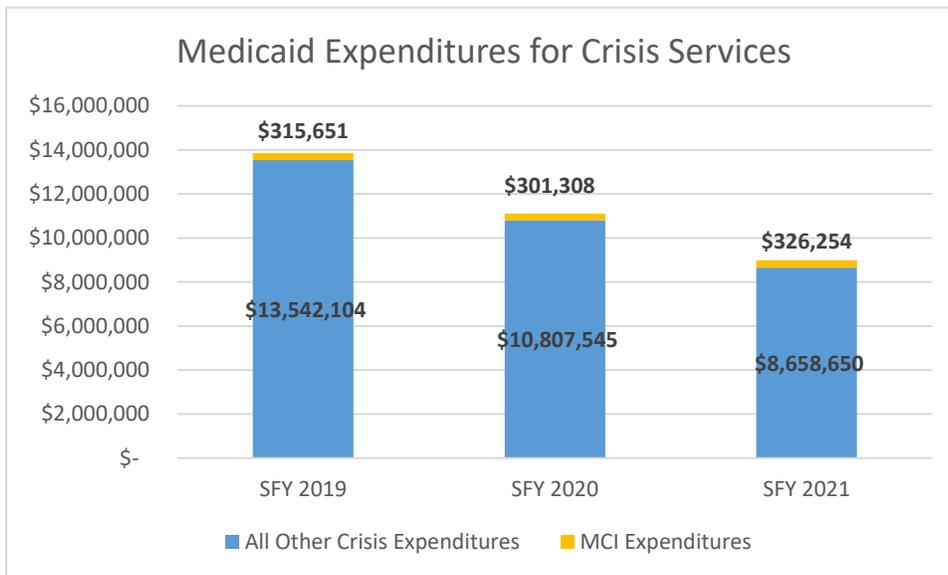
³⁶² Kentucky SFY 2019 – 2021 Data Query of Medicaid Crisis Intervention Claims.

Figure 40. MCI Services by Claims Paid and Unique Clients from SFY 2019 – 2021



MCI services are a very small percent of total crisis intervention services for which Kentucky Medicaid pays. Medicaid paid a total of \$33,951,512 for all MCI services, and less than three percent, or \$943,213, was paid for MCI services. Figure 41 shows the expenditures for all Medicaid crisis services from SFY 2019 – 2021, and MCI services as a part of those.

Figure 41. Crisis and MCI Services Expenditures by SFY 2019 – 2021



Current Funding Structure

Medicaid MCI services are provided through SPA benefits and are matched with federal dollars paid as Medicaid fee schedule payments in the FFS program for state plan services, and as payments made to the MCOs who pay providers on a negotiated FFS basis.

Funding for MCI services in Kentucky comes from a number of sources, depending on whether the individual receiving the service is eligible for Medicaid or not. Medicaid expenditures for MCI services are approximately \$943,213 for SFY 2019 – 2021. Based on an average federal matching percentage rate of 72 percent (pre-COVID-19), Kentucky general fund expenditures for MCI services for this three-year period were \$264,100.³⁶³

Effective January 1, 2022, Kentucky Medicaid began participating in the Protecting Access to Medicare Act CCBHC demonstration and four CMHCs have been provisionally certified as CCBHCs.³⁶⁴ KDMS receives an enhanced federal medical assistance program (FMAP) rate of approximately 80 percent for the two-year demonstration period. The 24/7 MCI services are a required service for CCBHCs, and therefore, KDMS will receive the enhanced FMAP for CCBHC MCI services billed during 2022 and 2023.

Throughout the U.S. and in Kentucky, crisis programs are also funded through the VA, grant and contract monies from SAMHSA, and community health center funding from the Health Resources and Services Administration (HRSA). Private insurance benefit packages generally do not include MCI.³⁶⁵ In Kentucky, DBHDID administers grant funding from various sources. For example, DBHDID currently provides approximately \$8.8 million to CMHCs to fund crisis services, which includes a limited amount of dollars for MCI services and crisis call centers. DBHDID is also administering funding that was distributed to CMHCs due to the PHE, some of which may be used to cover expenditures for MCI services.³⁶⁶ It will administer an additional \$5.2 million designated for crisis services in the upcoming years using emergency discretionary funding from SAMHSA.³⁶⁷

House Bill 1 from the 2022 Kentucky legislative session outlines the state biennial budget and was finalized on April 13, 2022. It appropriated \$19.6 million in general funds for MCI service expansion and the 988 suicide hotline. The funding amount is \$6,170,700 for state fiscal year 2022-2023 and \$13,437,000 for state fiscal year 2023-2024.³⁶⁸ Provider Reimbursement and Rates

CMHCs may bill in one-hour increments in accordance with the CMHC reimbursement regulation, 907 KAR 1:045, as well as the CMHC Mental Health Substance Abuse Codes and Units of Service using

³⁶³ Kentucky SFY 2019 – 2021 Data Query of Medicaid Crisis Intervention Claims. Effective 1/1/2020 a 6% enhanced FMAP was given due to the PHE, however, is expected to end once the PHE is over.

³⁶⁴ Dunlap, Susan. "Kentucky to Expand, Improve Behavioral Health Treatment Services." *Kentucky.gov*, 21 Aug. 2020, <https://kentucky.gov/Pages/Activity-stream.aspx?n=CHFS&prid=284>.

³⁶⁵ Gordon, Stuart Yale. "Building State Capacity to Address Behavioral Health Needs through Crisis Services and Early Intervention." *Milbank Memorial Fund*, 10 Dec. 2020, <https://www.milbank.org/publications/building-state-capacity-to-address-behavioral-health-needs-through-crisis-services-and-early-intervention/>.

³⁶⁶ Consolidated Appropriations Act, COVID Mental Health Block Grant, American Rescue Plan Act block grant.

³⁶⁷ Kentucky 988 Implementation Plan, January 2022.

³⁶⁸ "House Bill 1." *Kentucky General Assembly*, <https://apps.legislature.ky.gov/record/22rs/hb1.html>.

HCPCS code S9484.^{369, 370} BHSOs may bill in one-hour increments in accordance with the Kentucky Medicaid Fee-for-Service Behavioral Health & Substance Abuse Services Outpatient Fee Schedule using HCPCS code S9484.³⁷¹ Through stakeholder engagement, KDMS policy staff indicated that a provider may round up to one hour if at least 53 minutes were spent with the client.³⁷²

In accordance with the CMHC services manual, 2015 edition, MCI services may not be billed for a duration that exceeds 24 hours and is not considered an overnight service. Services must be provided in a setting outside of the provider's office and be face-to-face in a home or community setting.³⁷³ Additionally, MCI services must be available 24/7/365, be based on a multi-disciplinary team, and the team must have access to a board certified or board-eligible psychiatrist at all times. BHSOs must follow the same MCI services restrictions in accordance with their appropriate regulation. In order to avoid duplication of services for members receiving assertive community treatment, which is a bundled service that can include MCI services, the provider may not bill separately for MCI services.³⁷⁴

The method for paying providers for MCI services, as well as payment amounts, varies based on the type of provider, as shown in *Table 26*.

Table 26. MCI Payment Methodology and Fee Schedule by Provider Type

Provider Type	Payor (FFS vs Managed Care)	Methodology	Reimbursement Description	MCI Services Rates
BHSO	FFS	Fee schedule ³⁷⁵	Kentucky Medicaid Behavioral Health Outpatient Fee Schedule (1/1/2022)	Per one hour: <ul style="list-style-type: none"> • Certified Alcohol and Drug Counselor - \$43.11 • LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA - \$60.28 • LPP, CPsy w/Auto Func, LCSW, LPCC, LMFT, LPAT, LBA, LCADC - \$68.88 • APRN, Licensed Clinical Psychologist, PA - \$73.20 • Psychiatrist, MD/DO - \$86.21
	MCO	Negotiated	Negotiated	N/A

³⁶⁹ "907 KAR 1:045. Reimbursement Provisions and Requirements Regarding Community Mental Health Center Services." *Kentucky Administrative Regulations*, <https://apps.legislature.ky.gov/law/kar/titles/907/001/045/>.

³⁷⁰ "CMHC Mental Health Substance Abuse Fee Schedule For Reference Only." *Department for Medicaid Services*, <https://chfs.ky.gov/agencies/dms/DMSFeeRateSchedules/CMHCfeeschedule2020april.pdf>.

³⁷¹ "KY Medicaid Fee-for-Service Behavioral Health & Substance Abuse Services Outpatient (Non-Facility) Fee Schedule." *Department for Medicaid Services*, <https://chfs.ky.gov/agencies/dms/DMSFeeRateSchedules/BHOutpatientFFS2022.pdf>.

³⁷² MCI Framework, Work Group #2.

³⁷³ "Community Mental Health Center Behavioral Health Services Manual (May 2015)." *Department for Medicaid Services*, <https://chfs.ky.gov/agencies/dms/dpo/bpb/Documents/CLEANCMHCBHMANUALARRS43015.pdf>.

³⁷⁴ "907 KAR 15:020. Coverage Provisions and Requirements Regarding Services Provided by Behavioral Health Services Organizations for Mental Health Treatment." *Kentucky General Assembly*, <https://apps.legislature.ky.gov/law/kar/titles/907/015/020/>.

³⁷⁵ "KY Medicaid Fee-for-Service Behavioral Health & Substance Abuse Services Outpatient (Non-Facility) Fee Schedule." *Department for Medicaid Services*, <https://chfs.ky.gov/agencies/dms/DMSFeeRateSchedules/BHOutpatientFFS2022.pdf>.

Provider Type	Payor (FFS vs Managed Care)	Methodology	Reimbursement Description	MCI Services Rates
CMHC	FFS	Cost settlement ³⁷⁶	MCI services for FFS is cost settled annually through cost report reviews.	Provider-specific, cost-based
	MCO	CMHC Mental Health Substance Abuse Codes and Units of Service ³⁷⁷ or negotiated rate	Negotiated rates. KDMS no longer publishes a fee schedule, but providers may negotiate with the MCOs using the April 2020 fee schedule.	Per 1 hour: <ul style="list-style-type: none"> \$53.89 to \$256.40, varies based on the billing provider and on the licensed provider performing the service. CMHCs and MCOs may negotiate rates that vary from the historic fee schedule.
CCBHC	FFS	Provider-specific PPS rate	Prospective bundled all-inclusive rate. Medicaid FFS will pay the prospective rate for any eligible daily visit. One encounter per day limit.	Range of \$220 to \$300
	MCO	Fee schedule or negotiated rates	MCO pays floor based on Medicaid fee schedule, or a negotiated rate; Medicaid pays wrap up to the PPS. The Medicaid wrap payment is limited to one PPS per day, regardless of services.	Range of \$220 to \$300

³⁷⁶ "907 KAR 1:045. Reimbursement Provisions and Requirements Regarding Community Mental Health Center Services." *Kentucky Administrative Regulations*, <https://apps.legislature.ky.gov/law/kar/titles/907/001/045/>.

³⁷⁷ "CMHC Mental Health Substance Abuse Fee Schedule For Reference Only." *Department for Medicaid Services*, <https://chfs.ky.gov/agencies/dms/DMSFeeRateSchedules/CMHCfeeschedule2020april.pdf>.

Comparison to Other States' Approaches to Paying for MCI Services

As described earlier, Kentucky Medicaid requires providers to bill for MCI services using S9484. The HCPCS identifies several modifiers that could be used with this code, but Kentucky does not use them. Other state Medicaid programs vary in their approaches as to how MCI services should be reported and paid. For example, they may:

- Vary in their use of per diem and per 15-minute increment rates.
- Allow billing for a MCI follow-up service.
- Use H2011, "crisis intervention services, per 15 minutes," mostly with modifier HT to designate team services.³⁷⁸
- Use both S9485 (per diem) and S9486 (per hour), and S9484 for MCI services response follow-up.
- Use other codes in addition to H2011 (e.g., H2000), "comprehensive, multi-disciplinary evaluation."
- Use modifiers to identify the number and types of professionals delivering a service and structure their fee schedules based on these designations.
- Pay for H0030 (behavioral health hotline).
- Vary rates based on geography.
- Pay for telehealth, but with a reduced fee schedule.

Research generally does not indicate the source of information used for developing the fee schedule for other states, although states often use cost reports and cost settlement to develop rates for CMHCs, and their professional fee schedule to develop professional services rates (e.g., for psychiatrists, nurses, counselors, etc.). This is the approach that Kentucky uses for physician and other professional services; however, the MCI services codes and fee amounts are not found on the Medicare fee schedule.³⁷⁹ There is no written documentation regarding the rate development methodology.

Examples of rates and methodologies for other states are outlined below in *Table 27*.

Table 27. Other State MCI Billing Methodologies

State	Billing Methodologies	Rates
Arizona ³⁸⁰	<ul style="list-style-type: none"> • Uses H2011 with modifier HT for MCI services. • Pays for the behavioral health hotline with H0030, and has a separate modifier HO to designate master's level individual and HN for bachelor's level. 	<ul style="list-style-type: none"> • H2011- \$71.88 FFS fee schedule, \$51.34 for MCO fee schedule.

³⁷⁸ This is consistent with SAMSHA guidelines. SAMSHA states that the HT modifier can be used with this code to denote a multidisciplinary team if codes are used for multiple crisis delivery modalities. <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>.

³⁷⁹ "907 KAR 15:015. Reimbursement Provisions and Requirements for Behavioral Health Services Provided by Individual Approved Behavioral Health Practitioners, Behavioral Health Provider Groups, or Behavioral Health Multi-Specialty Groups." *Kentucky General Assembly*, <https://apps.legislature.ky.gov/law/kar/titles/907/015/015/>.

³⁸⁰ "Behavioral Health FFS Rates & Codes." *Arizona Health Care Cost Containment System*, <https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/BehavioralHealthrates.html?id=Outpatient>.

State	Billing Methodologies	Rates
		<ul style="list-style-type: none"> • H0030 - Modifier HN= \$28.52, modifier HO = \$41.46. FFS and MCO fee schedule are the same.
Nevada ³⁸¹	<ul style="list-style-type: none"> • H2011 only with modifiers GT (telehealth) HT (multi-disciplinary team), or no modifier. • Supports telehealth at a reduced rate. • Mobile response may be a single person or a team. 	<ul style="list-style-type: none"> • Telehealth - \$12.17. • Mobile response (single) - \$21.71. • Mobile response (team) - \$34.22.
New York ³⁸²	<ul style="list-style-type: none"> • Uses both H2011 and S9485 with modifiers. • H2011 is billed in 15-minute increments; it covers the initial response and is also used for crisis follow-up. • Pays for telehealth services. • Rates for H2011 vary based on who is providing services (one person, one person unlicensed peer support professional, and two-person response, with one unlicensed). • Per diem rate for S9484 requires three hours of face-to-face contact, and rates vary depending on number of people providing service and license status. • Rates differ based on geography. 	<ul style="list-style-type: none"> • 15-minute codes range from \$80.74 to \$181.44 for crisis response; \$25.23 to \$103.95 for crisis follow-up. • Per diems range from \$986.19 to \$2,177.28.
North Carolina ³⁸³	<ul style="list-style-type: none"> • H2011. • Fee schedule sets a rate floor for MCOs. 	<ul style="list-style-type: none"> • \$90.00 for 15 minutes.
Ohio ³⁸⁴	<ul style="list-style-type: none"> • Uses both S9484 and S9485. • Rates vary based on the number of providers delivering the service. • Rates vary based on status of practitioner (i.e., licensed, unlicensed, and peer support). • S9484 is billed per hour; S9485 is billed per diem. • Ohio Administrative Code Section 5160-27-12 describes behavioral health crisis intervention provided by unlicensed practitioners.³⁸⁵ • The Ohio Department of Medicaid, managed care is redesigning behavioral health services, and in February 2021, were reviewing policy changes for youth services from the mobile response and stabilization services workgroup.³⁸⁶ 	<ul style="list-style-type: none"> • Ohio has implemented rates that will be effective 7/1/2022 for S9484 Crisis Mobile Response Follow-Up per Hour, and S9485 Crisis Mobile Response Follow-Up Per Diem. • S9484 - \$102.89 - \$139.92. • S9485 - \$365.55-\$476.64.

³⁸¹ "Fee Schedules." Nevada Department of Health and Human Services Division of Health Care Financing and Policy, <https://dhcfp.nv.gov/Resources/Rates/FeeSchedules/>.

³⁸² "Medicaid Reimbursement Rates." New York State Office of Mental Health, https://omh.ny.gov/omhweb/medicaid_reimbursement/.

³⁸³ "State Plan Amendment." State of North Carolina Department of Health and Human Services, <https://medicaid.ncdhhs.gov/media/10210/open>.

³⁸⁴ "Community Behavioral Health Services Medicaid Fee Schedule." Ohio Laws and Administrative Rules, https://codes.ohio.gov/assets/laws/administrative-code/pdfs/5160/01/5160-1-60_PH_FF_A_APP1_20211215_1151.pdf.

³⁸⁵ "Section 5160-27-12 - Behavioral Health Crisis Intervention Provided by Unlicensed Practitioners." CaseText, Ohio Administrative Code, <https://casetext.com/regulation/ohio-administrative-code/title-5160-ohio-department-of-medicaid/chapter-5160-27-community-mental-health-agency-services/section-5160-27-12-behavioral-health-crisis-intervention-provided-by-unlicensed-practitioners>.

³⁸⁶ "Mobile Response and Stabilization Services Workgroup Meeting." Ohio Department of Medicaid, https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/a366a46d-352e-42a5-b945-3a8c5d4bcdo6/OhioRISE_Second+MRSS+Workgroup_2021.02.09.pdf?MOD=AJPERES&CVID=nudVntX.

State	Billing Methodologies	Rates
Utah ³⁸⁷	<ul style="list-style-type: none"> H2000 Comprehensive Multi-Disciplinary Evaluation. Medicaid provider manual states that team must include at least two individuals and only one unit of service per day can be billed. Utah's SPA Transmittal #20-0012 allows a bundled payment methodology for rehabilitative mental health services when provided in crisis receiving centers, including Mobile Crisis Outreach Teams. 	<ul style="list-style-type: none"> \$356.02 per event.
Virginia ³⁸⁸	<ul style="list-style-type: none"> H2011 only. Rates vary by geography (two regions). 	<ul style="list-style-type: none"> N. VA - \$31.06. Rest of state - \$27.02.

CMHC Reported MCI Services Billing-Related Barriers

CMHCs reported a number of issues, summarized here, related to billing and reimbursement during stakeholder interviews and stated that Medicaid should further support MCI by defining services, including telehealth, and develop new rates and billing processes to encourage statewide access to services. Specific comments include:

Region 2 – Pennyroyal

- Regarding S9484 – “If they have Medicaid, then we would bill Medicaid. If they have Medicare, or a third party/private, we don’t bill their insurance because it’s not billable to their insurance. We have block grant funding from DBHDID that support crisis continuum services.”
- Billing Barriers – “H2011 is per 15 minutes, whereas, mobile crisis is a flat rate for the service. A lot of times you spend a lot more time with the individual that you’re going to get reimbursed for. So, if you ended up being with somebody for two or three hours, you’re not really getting reimbursed for that. And with mobile crisis, you’re only billing for direct service time. And if you’re evaluating somebody, and you’re trying to get them to the hospital, there’s a lot of time lost there. So, the whole process may have taken you three hours but you only get to bill one hour.”

Region 14 – Adanta

- “Regardless of the crisis code that we bill, it’s not sufficient to cover the costs. As a CMHC, our Medicaid reimbursement rates have been frozen for over 20 years, we’re operating on 20-plus-year old rates. And so, in many instances, these rates don’t even cover the cost for us to do the service. We bring this up on every conversation had with legislators. And so, you know it’s the reason why staffing is a barrier. It’s hard to recruit staff when we’re getting paid on rates calculated in 1998.”

³⁸⁷ “Utah Medicaid Provider Manual - Rehabilitative Mental Health and Substance Use Disorder Services.” *Utah Division of Medicaid and Health Financing*, <https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Rehabilitative%20Mental%20Health%20And%20Substance%20Use%20Disorder%20Services/Archive/2019/>; <https://health.utah.gov/stplan/lookup/CoverageLookup.php>.

³⁸⁸ “Procedure Fee Files & CPT Codes.” *DMAS - Department of Medical Assistance Services*, <https://www.dmas.virginia.gov/providers/procedure-fee-files-cpt-codes/>.

Region 11 – MCCC

- “There is a mobile crisis code. I’m not entirely sure what it is, but we only use it for walk-ins to our after-hours clinic. So, that’s the only time we actually bill mobile crisis services.” Mountain Comprehensive only performs MCI response to hospitals not at the location of individual in crisis or other non-facility areas in the community. The CMHC has contracts with hospitals where the hospital pays the CMHC a fee for their response and there is no billing for the MCI service.

Region 5 – Communicare

- Communicare stated that they are not billing mobile crisis services because they do not receive insurance information from the client in crisis; however, they do have practices to ensure billing is performed for follow-up services.

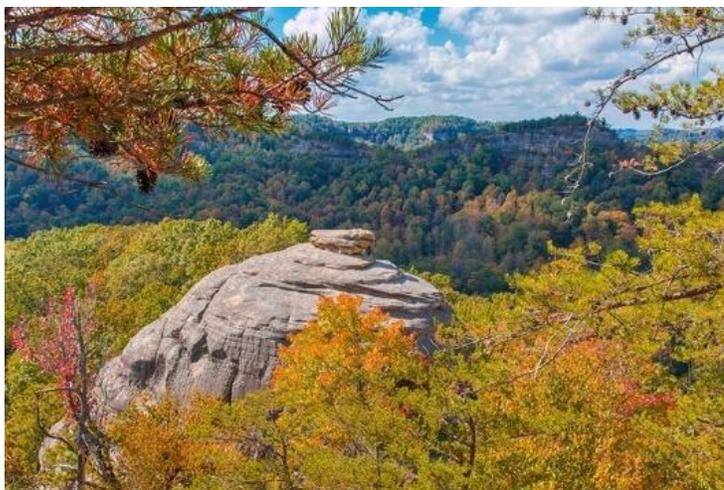
CMHCs also noted that there is a workforce shortage which makes it critical to provide a clear MCI service definition and more specificity is needed regarding what providers can provide MCI services, and training regarding MCI services. CMHCs also requested that private insurers should be included in discussions about crisis services.



Workforce Shortages, Development and Provider Training

Workforce Shortages, Development, and Provider Training

MCI services providers in Kentucky face widespread staffing shortages due to funding and regional healthcare workforce retention issues. Limited funding can decrease workforce retention and restrict recruitment efforts. CMHCs reported limited availability of existing staff, high numbers of open positions, and local workforce shortages that impact their crisis response systems.³⁸⁹



Workforce Shortages

Health Professional Shortage Areas (HPSAs), designated geographies with deficiencies in primary, dental, and mental health providers, contribute to adverse health status outcomes. According to 2019 HPSA designations, mental health care shortages are found in all counties in Kentucky and encompass the entirety of the county (Figure 4.2).³⁹⁰

Figure 4.2. Health Professional Shortage Areas



Kentucky's workforce shortage impacts CMHCs' ability to provide MCI services. Nationally, the top 10 percent of U.S. counties have a ratio of 310 individuals per every one behavioral health professional. In

³⁸⁹ Kentucky CMHC MCI Stakeholder Interview, February 2022; Kentucky CMHC MCI Stakeholder Interview, March 2022.

³⁹⁰ <https://www.ruralhealthinfo.org/charts/7?state=KY>

Kentucky, the reported ratio is 494:1, individuals to behavioral health professional. Counties in northern Kentucky report an even larger divide, 741 individuals to every one behavioral health professional.³⁹¹

Throughout the engagement, CMHC representatives cited maintaining sufficient staffing as a major concern, as shown in *Figure 43*. In the pre-interview questionnaire, the responding CMHCs selected “lack of staff to fill key positions in all shifts” as the top barrier related to resources. Other critical resource barriers include funding for specific provider roles, funding of transportation, and the need for on-call staff.³⁹²

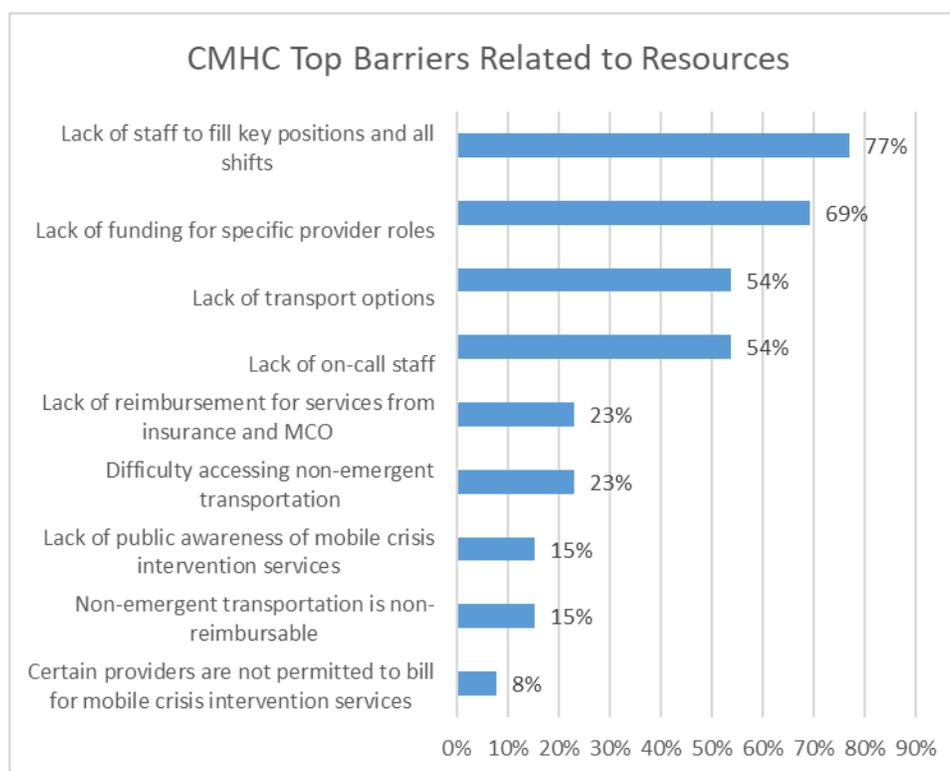


Children's Mental Health Staffing Concern

“Not only is there a workforce shortage, but there’s also the issue of children’s mental health professionals, including psychiatrists, aging near or past the age of retirement. The question is what happens when this population retires, considering the existing shortage. Some kids struggle to relate and share with someone 40 years older than them.”

— Youth Roundtable February 2022

Figure 43. CMHC Pre-Interview Questionnaire: CMHC Top Barriers Related to Resources



Note: There were no responses in the questionnaire that identified the following options: limited crisis assessment training for providers, limited ability of providers to handle a client’s risk of suicide, and limited information available regarding billing for MCI services.

³⁹¹ Kentucky CHFS OHDA CCBHC Regional Needs Assessment, May 2021.

³⁹² Kentucky CMHC MCI Pre-Interview Questionnaire, February 2022.

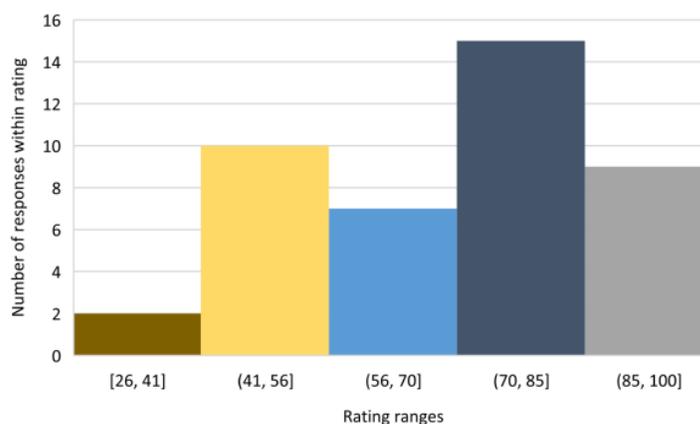
Both the MCO representatives and responses to the state-level information request echoed sentiments reported by Kentucky’s CMHCs:

- Multi-disciplinary teams are not in practice in many regions due to workforce shortages and retention issues. Using a single behavioral health professional to perform on-site MCI services raises questions about safety.³⁹³
- There is a shortage of psychiatrists to fulfill the 24/7 access requirement outlined in regulations, which strains the system.³⁹⁴

Behavioral Health Workforce Retention in Kentucky

In a National Workforce Retention Request for Information survey³⁹⁵ distributed in 2021 to treatment coordinators and women’s services coordinators, 43 states responded with a 1 to 100 rating of SUD staff retention difficulty. Figure 44 shows that Kentucky is rated at 70 to 85 retention difficulty. Additionally, the respondents reported that lack of funding to support staff (38 percent) and the resultant low compensation and benefits (23 percent) are key barriers inhibiting retention of staff.

Figure 44. State Rating of Level of Difficulty Retaining Staff (N=43)



³⁹³ Kentucky MCI State-Level Stakeholder Information Request, January 2022.

³⁹⁴ Kentucky MCO Stakeholder Interview, February – March 2022.

³⁹⁵ Treatment Coordinators and Women’s Services Coordinators: Request for Information, Workforce Retention, March 2021.



Workforce Shortages

“The U.S. simply does not have enough trained professionals to provide in-person support to everyone who needs it. (And, because of ongoing stigma, work and family schedules and other barriers to entry, a member told to seek mental healthcare may never make the outreach needed to pair up with a practitioner anyway.) A 2018 survey cosponsored by the National Council for Behavioral Health reported that 42% of respondents cited cost and poor insurance coverage as key barriers to accessing mental healthcare. A study of more than 36,000 people found that this was true of: 62% of people with mood disorders, 76% of people with anxiety, 81% of people with SUD. The American Psychological Association estimates that for everyone who needs support to have it, we’d need to add 25,080 psychologists by 2030 – and those estimates were made in 2018. When it comes to psychiatrists, more than half of U.S. counties don’t have one.”

— SilverCloud Health White Paper



Kentucky is currently facing a dire workforce issue as a result of the state's increasing addiction rates in recent years. Employers throughout Kentucky report experiencing impacts and struggles to recruit and retain employees as a result of the state's addiction. In response to current opioid epidemic and resulting statewide workforce retention challenges, the Kentucky Chamber Workforce Center and the Kentucky Comeback initiative came together to form a Workforce Recovery Program:³⁹⁶

- Kentucky Transformational Employment Program provides a pathway for businesses and employers to help more Kentuckians reach long-term recovery and fair employment.
- Education Series for Partnering Businesses aimed to "shift the cultural mindset," address stigma, identify and navigate mental health in the workplace, and provide baseline knowledge around disclosure.
- Members within the task force are: Seven Counties (CMHC), New Vista (CMHC), Aetna of Kentucky (MCO), Anthem BCBS of Kentucky (MCO), and Addiction Recovery Care/ARC (BHSO).

Behavioral Health Workforce Development

While stakeholders reported staffing barriers, workforce recruitment and development efforts were also limited due to funding and budgetary restrictions. State-level stakeholders stated that Medicaid reimbursement does not cover employee cost.³⁹⁷

Kentucky's expansion CCBHC grantees reported they were able to mitigate staffing barriers using the additional grant funding they received as part of their participation in the CCBHC program, including increased rates and/or increased discretionary funds.³⁹⁸ CCBHCs receiving expansion grants do not receive the enhanced prospective payment system (PPS) rate for funding, and instead receive up to \$2 million annually for a two-year period.³⁹⁹ Stakeholders reported that funding made available via the CCBHC model increased provider capacity, workforce development, and staff retention.

Within the bounds of state licensure and certification regulations, CCBHC staffing includes Medicaid-enrolled providers who adequately address the needs of the consumer population served. Credentialed, certified, and licensed professionals with adequate training in person-centered, family-centered, trauma-informed, culturally competent, and recovery-oriented care are included in the programmatic requirements for staffing. The statute states "staffing requirements, including criteria that staff have diverse disciplinary backgrounds, have necessary state-required license and accreditation, and are culturally and linguistically trained to serve the needs of the clinic's patient population."^{400, 401}

SAMHSA recognizes professional shortages exist for many behavioral health providers and provides guidelines for CCBHCs operating in shortage regions. To address shortages and develop the workforce, some services may be provided using a designated collaborating organization (DCO) as needed. CCBHC

³⁹⁶ <https://www.kychamber.com/workforcerecovery>.

³⁹⁷ Kentucky MCI State-Level Stakeholder Information Request, January 2022

³⁹⁸ CMHC interviews February through March 2022.

³⁹⁹ The Quadruple Aim: Workforce and Service Delivery within CCBHCs (National Council for Behavioral Health, 2019). https://www.behavioralhealthworkforce.org/wp-content/uploads/2019/10/NC-CCBHC_Full-Report.pdf.

⁴⁰⁰ https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf.

⁴⁰¹ Section 223 (a)(2)(A) of PAMA

organizations comprised of multiple clinics may share providers across clinics or sites. Telehealth and online or virtual medicine can be utilized by CCBHCs to alleviate shortages and staffing limitations.⁴⁰²

CMHCs reported promoting use of telehealth/ telemedicine, in-house wellness programs, and comprehensive benefits as a means to recruit new crisis response staff; however, stakeholders also note that recruitment efforts are limited due to regional shortages and funding.⁴⁰³

- Five out of 14 CMHCs mentioned staff wellness programs as an added benefit.
- CMHCs are addressing workplace burnout by providing staff trauma counseling (when necessary), team debriefing, department counseling, and/or staffing swaps and rotations.
- CMHCs are leveraging telehealth as a recruitment tool. Promoting technology use enables them to hire new staff from outside their regions or even out of state.
- New Vista (Region 15) offers employees a benefits package including: health, dental, and vision insurance, paid time off, five percent match for 401k retirement plan contributions, paid life insurance, tuition reimbursement, clinical supervision, and an employee wellness program.⁴⁰⁴

⁴⁰² https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf.

⁴⁰³ https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf; Kentucky CMHC MCI Stakeholder Interview, February 2022.

⁴⁰⁴ <https://newvista.org>.

Provider Training

Kentucky's MCI services providers reported training staff in behavioral health crisis intervention.⁴⁰⁵ All CMHCs provide their staff with behavioral health crisis intervention-related trainings and each region has its own curriculum. CMHCs and BHSOs reported offering crisis trainings quarterly, yearly, and/or as needed for continuing education. Stakeholders mentioned active use of standardized trainings for providers.⁴⁰⁶

The following are trainings associated with specific CMHC/CCBHC organizations:⁴⁰⁷

- RVBH (Region 3) – RVBH has a specialized advocacy training program including population-specific training for farmers' behavioral health and veteran cultural awareness.
- Seven Counties (Region 6) – Seven Counties has a special training for PSS centered on warm hand-offs.
- Comprehend (Region 8) – Comprehend administers a required exam at the conclusion of on-boarding for Crisis Staff.
- MCCC (Region 11) – MCCC's new crisis staff members shadow the MCT for up to a month.
- CRBH (Region 13) – CRBH requires a three-month skills training program during onboarding of new crisis staff.
- New Vista (Region 15) – New Vista offers ongoing cultural competency training for staff, as well as on-demand refresher courses for practices like Motivational Interviewing.
- Kentucky's CMHCs that are also operating as CCBHCs are required to offer crisis training to all staff members. These requirements include trauma-informed care, addressing needs of individuals with SED/SMI, cultural and linguistic competency, behavioral health integration, peer support, and suicide intervention.

Table 28 displays the trainings required for MCTs as selected by respondents to the CMHC pre-interview questionnaire. Of note, all CMHCs require training for trauma-informed care, privacy and confidentiality, and suicide assessment or suicide screening. However, just over half of respondents require Race, Ethnicity, Language, and Disability (REALD), Culturally and Linguistically Appropriate



CCBHC Training Requirements

- Training in person-centered, family-centered, trauma-informed, culturally competent, and recovery-oriented care.
- Staff individuals with expertise in addressing the needs of children and adolescents with SED and adults with SMI.
- Culturally and linguistically competent requirements: culture, age, gender identity, sexual orientation, military/veterans' culture, spiritual beliefs, and socioeconomic status.
- Primary care and behavioral health integration.
- Risk assessment, suicide prevention, and suicide response.
- Understand the roles of families and peers.

⁴⁰⁵ Kentucky CMHC MCI Stakeholder Interview, February 2022; Kentucky CMHC MCI Stakeholder Interview, March 2022; Kentucky BHSO MCI Stakeholder Interview, February 2022.

⁴⁰⁶ Kentucky CMHC MCI Stakeholder Interview, February 2022; Kentucky CMHC MCI Stakeholder Interview.

⁴⁰⁷ Kentucky CMHC MCI Stakeholder Interview, February 2022; Kentucky CMHC MCI Stakeholder Interview.

Services, and Sexual Orientation and Gender Identity (SOGI) training. While safety was a commonly cited concern among CMHCs, only 85 percent of responding CMHCs stated that they have training for MCT members on safety standards, and 31 percent provided training on Counseling Access to Lethal Means (CALM). Additionally, results from the pre-interview questionnaire concluded that Kentucky's CMHCs do not consistently offer trainings on I/DD, peer support, or co-occurring disorders.⁴⁰⁸ Note that there may be additional trainings conducted by CMHCs that were not captured in the pre-interview questionnaire.

Table 28. CMHC Pre-Interview Questionnaire: CMHC Trainings Required for MCT

Training Required for MCT Members	Percentage of CMHCs
Trauma-Informed Care	100%
Client/Patient Rights	100%
Privacy and Confidentiality	100%
Overview of Suicide Assessment/Overview of Suicide Screening	100%
Duty to Warn	92%
Crisis De-Escalation, Crisis Management, Conflict Management	85%
Safety Standards	85%
Research-Based Practices	85%
Suicide Severity Rating Scale	85%
Crisis Support/Counseling	85%
Harm Reduction	77%
I/DD	77%
Behavioral Health/SUDs and Associated Medical Conditions and Care	62%
First Aid Refresher	62%
Identifying and Preventing Abuse and Neglect	62%
REALD and SOGI Awareness, Competency, and Responsiveness	54%
Emergency Preparedness	54%
Law Enforcement and ED Interface	46%
Co-Occurring Complexities; Signs of Withdrawal and Suicidal Tendencies in Individuals with SUD	46%
Therapeutic Communication	46%
Peer Support Training	38%
Monitoring and Evaluation	38%
Treatment Considerations for Children and Adolescents	31%
CALM	31%
Environmental Interventions and Crisis Stabilization	31%
Information, Liaison, Advocacy and Consultation/Collaboration	31%
Training relative to intellectual disabilities (including differentiating between behavioral and psychiatric symptoms, cross system crisis planning, system of support)	31%
Comprehensive Crisis Management/Comparable Program	31%
Disaster Mental Health Intervention	31%
Physical Disabilities	23%
Age-Appropriate Developmental Principles and Early Periodic Screening, Diagnosis, and Treatment Requirements for Children and Adolescents	23%

⁴⁰⁸ Kentucky CMHC MCI Pre-Interview Questionnaire, February 2022.

Training Required for MCT Members	Percentage of CMHCs
Overview of Psychopharmacology	15%

CMHC Crisis Team Trainings

Throughout stakeholder engagement activities, CMHC organizations stated that they consistently use a number of trainings for new hire onboarding and ongoing education of the behavioral health crisis staff.⁴⁰⁹

Trauma-Informed Care:⁴¹⁰ The concept was developed out of research on ACE and the conclusion that an individual's experience of trauma impacts every area of human functioning (physical, mental, behavioral, social, and spiritual). The study evaluated individuals with behavioral health diagnoses and found nearly two-thirds of the participants reported at least one ACE of physical and/or sexual abuse, neglect, or family dysfunction. Evidence-based models centered on the incorporation of trauma experiences into behavioral health assessment and treatment. Practice designed for specific populations, types of trauma, and behavioral health manifestations.

Motivational Interviewing (MI): This is an evidence-based training and communication approach to behavior change. MI focuses on building rapport in the initial stages of the counseling relationship. The training includes the identification, examination, and resolution of ambivalence about changing behavior and includes three "essential elements:" conversation about change (counseling, therapy, consultation); collaboration (person-centered, partnership, honors autonomy); and evocation (seeking to



Region 9/10 Training Requirements

According to SFY2019 Kentucky Annual CMHC Compilation Documents, Region 9/10 requires up to 40 hours of crisis training for all crisis staff which includes the following modules:

- Introduction to 40-Hour Crisis Training.
- Direct Support and Crisis Intervention.
- Crisis Intervention and Risk Assessment.
- Suicide, Question, Persuade, Refer, and the Suicidal Caller.
- Rape Crisis.
- Abuse and Neglect.
- Mental Health Diagnosis (MH DX)- Overview of Frequently Seen Diagnosis and Symptoms.
- Addictions: Module 1, Unit 1 – Intro to Addiction.
- Addictions: Module 1, Unit 2 – Twelve Steps Groups and Steps – What Are They.
- Pathways Hospitalization/Crisis Contact.
- Kentucky Mental Health Hospitalization Act.
- Evidence-Based Practices for Treating Individuals Experiencing Trauma and/or Post-Traumatic Stress Disorder (PTSD) – Part 1.
- Domestic Violence Part 1 and 2.
- MI.
- Cultural Diversity.
- Addictions: Module 1, Unit 3 – Relapse Prevention.
- Addictions: Effective Discharge Planning.
- Addictions: Suicide and SUDs.
- Addictions: Medically-Assisted Recovery.
- Crisis medication training.
- CPI.
- Creating Cultures of Trauma-Informed Care.

⁴⁰⁹ CMHC Interviews February through March 2022.

⁴¹⁰ <https://www.thenationalcouncil.org/areas-of-expertise/trauma-informed-behavioral-healthcare/>.

call forth the person's own motivation and commitment). Eight out of 14 CMHCs employ a certified instructor to train staff on the practice of MI.⁴¹¹

Assessing and Managing Suicide Risk (AMSR): Core objectives of this effort include provider training on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk; adopt, disseminate, and implement guidelines for the assessment of suicide risk among persons receiving care in all settings. Ten out of 14 CMHCs employ certified instructors for the practice of AMSR, and report offering staff trainings in outpatient settings, inpatient care, and SUD treatment environments.⁴¹²

Collaborative Assessment and Management of Suicidality (CAMS): This is a program of evidence-based training and treatment modality intended for behavioral health professionals across settings to assess suicide risk and manage at-risk populations. RVBH and NorthKey employ certified instructors that train staff on the use of CAMS.⁴¹³

Mental Health First Aid and Youth Mental Health First Aid: This is a national skills-based training program designed to teach participants how to recognize and respond to signs and symptoms of mental health and substance use challenges. Much like cardiopulmonary resuscitation training, participants are not limited to healthcare professionals. Programs include adult, youth, workplaces, and teens. Additionally, specialized, population-specific trainings are available to older adults, veterans, fire/EMS, public safety, higher education, rural communities, schools, and faith/spiritual communities. Kentucky's CMHCs and BHSOs reported training staff in mental health first aid. Sixty-two percent of CMHCs responding to the pre-interview questionnaire require mental health first aid refreshers for members of the MCT.⁴¹⁴

Common Trainings on Treatment Modalities: In addition to MCI services training, CMHC staff receive training on the following treatment modalities.⁴¹⁵

- **Accelerated Resolution Treatment (ART):** Evidence-based psychotherapy for rapid recovery centered on reprogramming how the brain stores traumatic memories and imagery. Treatment methodology used for PTSD, depression, grief, phobias, anxiety, and addiction.⁴¹⁶
- **Cognitive Behavior Therapy (CBT):** Evidence-based psychological treatment involving efforts to change thinking patterns and identified problem behaviors. CBT is widely used to treat a range of diagnoses including depression, anxiety, SUD, eating disorders, and SMI.⁴¹⁷
- **Dialectical Behavioral Therapy (DBT):** Evidence-based treatment includes four modes: individual psychotherapy, skills training, in-the-moment phone coaching, and the use of consultation teams. DBT typically incorporates individual and group counseling, case management, and crisis prevention strategies (mindfulness, distress tolerance, and emotional regulation). The training was originally intended to treat individuals with borderline personality

⁴¹¹ Kentucky CMHC Annual Crisis Services Compilation Documents, SFY2022;

https://www.umass.edu/studentlife/sites/default/files/documents/pdf/Motivational_Interviewing_Definition_Principles_Approach.pdf.

⁴¹² Kentucky CMHC Annual Crisis Services Compilation Documents, SFY2022; <https://www.sprc.org/resources-programs/assessing-and-managing-suicide-risk-core-competencies-mental-health-professionals>.

⁴¹³ Kentucky CMHC Annual Crisis Services Compilation Documents, SFY2022; <https://cams-care.com/training/>.

⁴¹⁴ Kentucky CMHC MCI Pre-Interview Questionnaire, February 2022; <https://www.mentalhealthfirstaid.org/>.

⁴¹⁵ CMHC Stakeholder Interviews January through March 2022.

⁴¹⁶ <https://arthrapyinternational.org/>.

⁴¹⁷ <https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral>.

disorder and has been widely adapted for other diagnoses and individuals at high risk of suicide. RVBH and KRCC employ a certified instructor to train staff on the practice of DBT.⁴¹⁸

Other Behavioral Health Crisis Care Training Programs in Kentucky

There are a number of other training programs related to behavioral health crisis care in Kentucky.

Crisis Intervention Training (CIT) for Law Enforcement and First Responders: Crisis intervention training is a specialized training program for law enforcement officers and first responders. The objective of this training is to train law enforcement officers and first responders to effectively respond to individuals who may have mental illness, SUD, I/DD, or dual diagnosis. The training is intended to reduce injuries, inappropriate incarceration, and liability, while improving risk management practices. Kentucky Statute 210.365 outlines the crisis intervention training curriculum. Requirements are:⁴¹⁹

- Introduction to CITs.
- Identification and recognition of behavioral health diagnoses.
- Interviewing and assessing a person who may have behavioral health diagnoses.
- Identification and common side effects of psychotropic medications.
- Suicide prevention.
- Options for treatment and community resources.
- Voluntary and involuntary processes for hospitalization.
- Hostage or other negotiations with a person with behavioral health diagnoses.

Stakeholders identified gaps in the crisis intervention training curriculum. For instance, law enforcement representatives and advocates noted that the training did not include autism spectrum disorder (and broader neurodiversity and sensory disorders).^{420, 421} Advocates in the roundtable events stated that curriculum for I/DD needed to be enhanced or expanded within the crisis intervention training, as many officers still struggle with I/DD crisis scenarios, and the I/DD population often ends up in the justice system.⁴²²

KORE Program Training. KORE partners with the Opioid Response Network to provide training and technical assistance to improve equitable access to services. KORE led Kentucky participation in a National Governor's Association (NGA) Learning Collaborative that aimed to address racial health disparities, focusing specifically on gaps in SUD services.⁴²³

- Provider trainings include ASAM multi-dimensional assessment, tobacco cessation for pregnant persons, DATA 2000 waiver training for buprenorphine prescribing, and AMSR training for substance use providers.

⁴¹⁸ Kentucky CMHC Annual Crisis Services Compilation Documents, SFY2022.

⁴¹⁹ <https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=51247>.

⁴²⁰ Law Enforcement Interview March 2022.

⁴²¹ Adult and Youth Roundtables February 2022.

⁴²² I/DD Roundtable February 2022.

⁴²³ <https://chfs.ky.gov/agencies/dbhdid/Documents/AboutKORE.pdf>.

- PSSs and supervisors receive training in person-centered recovery planning. Specialized peers are hired and trained for service members/veterans/their families. These peers can go on to work on MCTs, crisis treatment facilities, hospitals, clinics, and/or domestic violence shelters.

Peer Support Academy. Interviewed BHSOs reported using the Peer Support Academy to train members of the MCT.⁴²⁴ The Peer Support Academy is a state and national certification training module for PSSs. They offer self-paced online learning combined with four face-to-face weekend classes. The 68-hour continuing education units (CEU) certification program covers the following:⁴²⁵

- Recovery Coaching.
- Coaching Skills.
- Utilizing the Client’s Strengths and Assets.
- eCoaching and Documentation Skills.
- Client Advocacy.
- Cultural Competency.
- Care Coordination.
- Crisis Management (includes approaches to non-violent crisis intervention, identification of triggers, and techniques to calm clients in a crisis situation).
- Overview of Addiction and Recovery Stages.
- MI.
- Pharmacology and Addictions.
- Ethics of Recovery Coaching and Professional Ethics and Boundaries.
- Mental Health and Dual Issues in Coaching.
- Importance of Resiliency.
- Not included in the required curriculum but offered as training webinars: Screening, Brief Intervention and Referral to Treatment (SBIRT) and human immunodeficiency virus (HIV)/blood borne pathogens.

The Peer Support Academy offers a 42-hour CEU sub-specialized PSS certification focused on forensic peer support. Forensic peers work to remove barriers and obstacles by serving as a personal guide and role model to people with criminal justice involvement. The sequential intercept model is central to the PSS engagement training for application across the criminal justice continuum.⁴²⁶

Project ECHO in Kentucky

Project Extension for Community Healthcare Outcomes (ECHO) is a lifelong learning and guided practice model that revolutionizes medical education and exponentially increases workforce capacity to provide best practice specialty care and reduce health disparities. The heart of the ECHO model is its hub-and-

⁴²⁴ Kentucky BHSO MCI Stakeholder Interview, February 2022.

⁴²⁵ <https://www.peersupports.academy/>

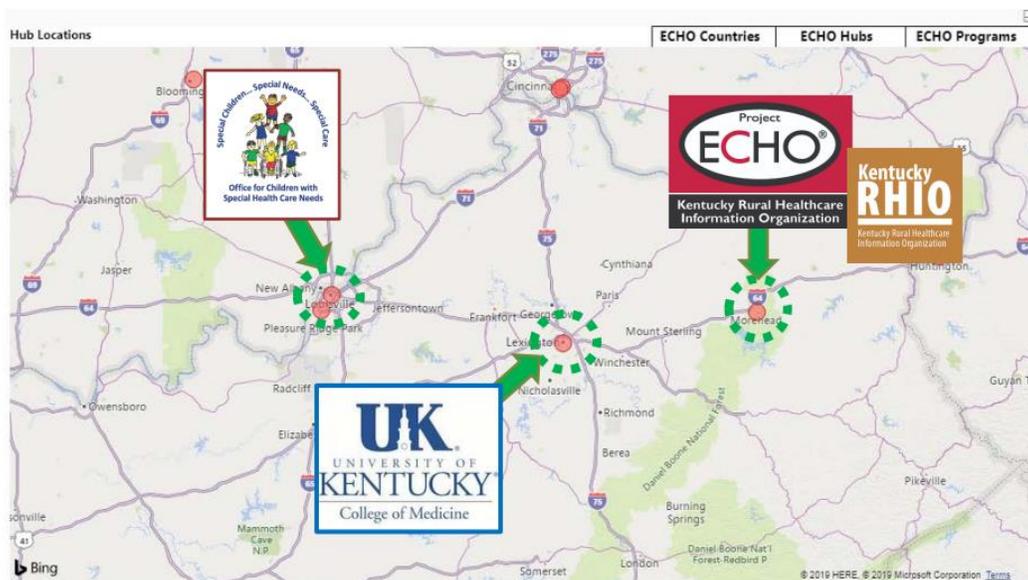
⁴²⁶ <https://www.peersupports.academy/forensicpeersupport>

spoke knowledge-sharing networks, led by expert teams who use tele-mentoring to conduct virtual clinics with community providers.⁴²⁷ Nearly a decade ago, Project ECHO began an initiative to integrate behavioral health care with primary care, by bringing behavioral health expertise into primary care settings. This expands access for individuals with mental health and addiction issues.⁴²⁸

Kentucky has leveraged Project ECHO programs to build workforce capacity and increase access to care. Kentucky's Cabinet for Health and Family Services (CHFS) ECHO programs address behavioral health and other issues in primary care (Figure 45):

- Office for children with special needs (centered in Louisville) program focuses on children with autism spectrum disorders.
- University of Kentucky College of Medicine program focuses on treating individuals with Hepatitis-C.⁴²⁹
- Kentucky Rural Healthcare Information Organization in Morehead, program focus on Opioid Addiction Prevention & Treatment Project ECHO. The program aims to extend specialty care knowledge into the primary care setting so that primary care physicians can give their patients improved care in their own communities, without the need for a specialist referral. It is HRSA funded, with 12 sessions, including MAT.⁴³⁰

Figure 45. Project ECHO Locations



The following are additional Project ECHO programs in Kentucky:

⁴²⁷ <https://www.wvctsi.org/programs/community-engagement-outreach/project-echo/>

⁴²⁸ <https://www.healthaffairs.org/doi/10.1377/forefront.20130708.032887/full/>

⁴²⁹ <https://ruralhealth.med.uky.edu/sites/default/files/ECHO%20Projects%20in%20KY-Nicole%20Winkleman%20v%20Alexander%20Jens%20Rosenau.pdf>.

⁴³⁰ <https://krhio.org/project-echo/>.

- The University of Kentucky Human Development Institute is holding a Supporting Children of the Opioid Epidemic project (Project SCOPE) ECHO series to build capacity of providers serving children, birth to five years old, with neonatal abstinence syndrome and other SUDs, as well as their families.⁴³¹
- The Republic Bank Foundation Optimal Aging Clinic at the University of Louisville Trager Institute offers a Project ECHO approach to build a community to learn how to better treat and improve the quality of life for older adults in Kentucky. Continuing education opportunities are planned.⁴³²
- The University of Louisville Center for Research in Infectious Diseases offers a certificate of completion and continuing education credits (e.g., continuing medical education, continuing professional education, and continuing nurse education) for each session.⁴³³
- In response to the need for more accessible palliative care education and training in the community, it was reported in 2018 that Hosparus Health has partnered with the University of New Mexico to bring Project ECHO to communities across Kentucky and Indiana.⁴³⁴

⁴³¹ <https://hdi.uky.edu/project-scope>.

⁴³² <https://www.tragerinstitute.org/project-echo>.

⁴³³ <https://www.ceridlouisville.org/projectechoabout>.

⁴³⁴ <https://hosparushealth.org/blog/hosparus-health-launches-project-echo-clinic-to-increase-access-to-palliative-care-education/>.



Current MCI Technology-Related Landscape



Current MCI Technology-Related Landscape

Technology in the MCI Services Response System

Core technologies required to support the MCI services continuum are:⁴³⁵

- Call/text routing and handling including caller ID.
- Crisis call/case management, including disposition status tracking.
- Mobile team dispatch routing and tracking, including GPS.
- Bed registry.
- Twenty-four-hour availability outpatient care appointment scheduling.
- Performance dashboards and reporting.



Additionally, telehealth can be used to support staffing needs and increase anytime access to psychiatrists, psychiatric nurse practitioners, and other licensed professionals in the field in both urban and rural communities.⁴³⁶

There are other technology infrastructure components that can support the behavioral health system of care. EHRs allow for streamlined health data collection in a digital format that is more easily and securely shared with other members of the care team for improved clinical decision-making. A health information exchange (HIE) can increase provider access to important historical health information to improve clinical decision making and can be used as a secure means of sending and receiving health data between systems for care coordination purposes and to increase behavioral health integration. HIEs can offer event notification services, which can alert providers that have an established relationship to their patients when they are seen in the ED or discharged from a hospital to further support care coordination and transitions. HIEs offer the infrastructure to close the loop on referrals to specialists, including behavioral health providers, which can be enhanced to include community services referral management to address SDOH issues.

⁴³⁵ SAMHSA. National Guidelines for Behavioral Health Crisis Care. 2020.

⁴³⁶ Ibid.

The project team reviewed the Final g88 Implementation Plan and spoke with stakeholders directly during interviews and workgroups to assess the current state of technology and information systems in use to support the core elements of the MCI service delivery continuum. The aim was to identify the information system and infrastructure changes necessary to support data-driven decisions related to quality, sustainability, and expansion of community MCI services.

Current State of Technology for MCI Services in Kentucky

Call Center Technology

Kentucky has increased statewide coverage of NSPL calls and achieved 24/7 coverage for all 120 counties as of March 31, 2021, which coincides with a 48 percent increase in initiated call volume since 2016.⁴³⁷ However, NSPL call centers operate independently.

The g88 implementation planning process included an analysis of CMHC call center technology.⁴³⁸ Information collected from CMHC call center directors included the following, and was confirmed during the subsequent stakeholder engagement effort to inform the needs assessment:

- They use a variety of telephone and call system hardware and software to do their jobs.
- Systems included both server-based and cloud-based systems.
- Few CMHCs have routing software or referral management systems.
- Various systems were in use for call documentation and database management, including EHRs, such as Netsmart Avatar, or iCarol, an agency development software, and Cisco.
- Four CMHCs reported manual processes, such as use of Microsoft Excel spreadsheets, paper logs, or hand counting as a means data collection and management.
- The systems have limited ability to talk to each other and local 911 public-safety answering points.
- All centers report that data collection and analysis is problematic, and they use a variety of methods to collect data, such as paper logs, spreadsheets, EHRs, and call center software.
- The State has limited resources to respond to texts and chats that originate in the Commonwealth.



Staffing Impact

Thirty percent of crisis center respondents to a 2021 landscape analysis indicated they could maintain a 90 percent answer rate with a 30 percent increase in volume at current staffing levels.

Sixty percent said they could cover the volume increase with additional staffing.

⁴³⁷ DBHDID Final g88 Implementation Plan.

⁴³⁸ DBHDID Final g88 Implementation Plan.

- Eighty-three counties do not have 24/7 back-up coverage for calls.
- There is one NSPL accredited center that has text/chat capabilities.

Connectivity and GPS Technology

Kentucky is mainly rural, which is a challenge to accessing healthcare services. Ninety-two percent of CMHCs responding to the pre-interview questionnaire stated they have wireless tablets or computers they can use in the field. However, utilization is currently low due to the COVID-19 pandemic, which has limited in-person services resulting in a significant reliance in telehealth.



Wireless Technology

Ninety-two percent of CMHCs have wireless tablets or computers that can be used in the field.

CMHCs stakeholders reported that:

- There are connectivity issues when providing in-person MCI services, making it difficult to access client information or even place a cellular phone call for additional support.
- Connectivity issues create safety concerns for staff as they serve clients in rural areas. As a result, MCI services providers may be hesitant to provide in-person services even after the COVID-19 pandemic subsides and PHE ends.
- One CMHC noted that it uses an application through their iPads called Safe Alert for emergencies or safety issues while in the field. This service allows for GPS tracking of the MCT to ensure personal safety.
- There is a need for greater system and broadband connectivity, including GPS tracking, to improve MCI services delivery. KDMS representatives also reported this sentiment.

Bed Registry

A statewide bed registry provides access to real-time data related to the availability of crisis stabilization beds and inpatient and outpatient appointments in behavioral health settings. However, only one CMHC stated in the pre-interview questionnaire that it has access to a real-time regional bed registry to locate availability.

Kentucky operates a public facing website, Find Help Now Kentucky,⁴³⁹ which is used to find an addiction treatment facility that is accepting patients by location, type of treatment, and payment. Find Help Now Kentucky was created



Lack of Comprehensive Bed Registry

A comprehensive bed registry does not currently exist in Kentucky. CMHCs rely on phone calls and emails to locate bed availability for mental health crisis that does not pertain to a substance use crisis.

⁴³⁹ www.findhelpnowky.org.

by the Kentucky Injury Prevention and Research Center (KIPRC) on behalf of the Kentucky Department for Public Health and in partnership with the Kentucky Office of Drug Control Policy, DBHDID, and Operation Unite. The website can be used by both patients and providers. Participation by providers is voluntary and there are no fees for the provider to be listed. One CMHC noted this was a helpful tool.

Currently, KIPRC is working under contract in conjunction with the Kentucky 988 State Planning Team to update the Find Help Now Kentucky website further. The update will include:

- Additional SUD and mental health provider information at the local level.
- Ability for providers to voluntarily update bed and appointment availability on a daily basis.
- An outreach specialist to assist with onboarding providers and support the availability updates if providers have not been responsive to automated update requests.

Stakeholders reported the following:

- Many manual processes were used to check availability from the various state and private hospitals and other mental health providers.
- Individual phone calls or emails to the appropriate facilities were commonly used, and they were noted as being time consuming and inefficient.
- Appalachian Regional Healthcare, which has 12 service locations within Kentucky, does send out regular bed availability emails every day.⁴⁴⁰
- Two CMHCs reported receiving bed availability by emails, which can be shared with acute care staff.

Telehealth

KDMS has the responsibility to administer the Medicaid program, and this includes requirements of telehealth services as required by KRS 205.5591. Recently, the 907 KAR 3:170 regulation was amended to better align with federal requirements for telehealth and defines in-person services as not via telehealth.⁴⁴¹ As defined by the regulation, telehealth service shall be reimbursable if they are:

- Appropriate and safe to be delivered via the telecommunication technology used. Whether a service is appropriate shall include any requirements and descriptions relating to a department-utilized procedure code.
- Not prohibited by the licensing board of the telehealth care provider delivering or supervising the service.
- Provided by a telehealth care provider.

Reimbursement of remote patient monitoring was also added to the regulation. This includes behavioral health multi-specialty groups, BHSOs, residential CSUs, chemical dependency treatment centers, CMHCs, and CCBHCs as providers who can conduct remote patient monitoring services.

According to information collected from stakeholders:

⁴⁴⁰ <https://www.arh.org/clinics/>.

⁴⁴¹ <https://apps.legislature.ky.gov/law/kar/titles/907/003/170/REG/>.

- Supervision and training processes are in place and centers have advanced significantly over the past 21 months in the delivery of crisis services via telehealth.⁴⁴²
- CMHCs stated they use typical virtual meeting platforms such as Zoom to interact with the client, and some cited the use of DocuSign to receive signed consents remotely. No barriers were reported regarding these platforms.
- Many of the CMHCs are only providing MCI services via telehealth in response to the pandemic but expect to continue this practice despite pandemic status.
- Not all CMHCs stated how they obtained patient consents remotely, but it was mentioned as a concern by several KDMS and DBHDID stakeholders in separate meetings.



MCI Telehealth

All CMHCs use telehealth for MCI services to address travel issues, safety concerns, and/or staffing availability.

Electronic Referral Systems and Appointment Scheduling

All CMHCs assist clients with additional provider or service referrals after receiving crisis care. EHRs enable easier management of patient data, lab and prescription processing, and access to medical history. All CMHCs stated they use an EHR system which was confirmed by the CMHC pre-interview questionnaire as shown in *Table 29*.

Fifteen percent of CMHC respondents indicate their organization's EHR is integrated with other technology systems, and 31 percent of respondents' EHR is integrated with an HIE.

Stakeholders from CMHCs also reported:

- There were no specific issues with utilizing the EHR system for MCI services but ensuring the most up-to date patient information accessibility is critical.
- Accessing patient information through their EHR system in the field can be difficult because of internet availability issues throughout the Commonwealth.

Table 29. CMHC Pre-Interview Questionnaire: CMHC EHR Usage

CMHC EHR Usage	% of CMHCs
Has an EHR	100%
EHR is integrated with other behavioral health systems	15%
EHR is integrated with an HIE	31%

For larger health systems especially, an electronic referral management system is also used to further streamline and enhance patient referrals. An electronic referral management system can link to other EHR systems, produce referral analytics, and enable patient data exchange to close the loop on the referral visit. An electronic outpatient scheduling system can automate aspects of the scheduling processing but lacks functionality for care coordination. Data from the pre-interview questionnaire

⁴⁴² Kentucky DBHDID Final 988 Implementation Plan, January 2022.

show that 15 percent of CMHCs use an electronic referral system, and 62 percent use an electronic outpatient scheduling system for follow-up appointments if additional services are to be provided by the CMHC (Table 30).

Table 30. CMHC Pre-Interview Questionnaire: CMHC Referral and Scheduling Systems

CMHC Referral and Scheduling Systems	% of CMHCs
Electronic referral system	15%
Electronic Outpatient scheduling system for follow-up appointments	62%

According to the interviews with the CMHCs, most referrals for follow-up and specialty care are performed using the following sources or processes:

- Reliance upon local community resources through existing relationships.
- Providing the patient with a list of resources for follow-up services.
- Assisting the patient with the initial follow-up services through calls or emails when possible.
- Using Find Help Now Kentucky online resource tool to identify treatment or recovery services (one CMHC uses).
- Using a regional bed registry (one CMHC uses).

Referrals may also be necessary for community resources and social services to address SDOH issues that are identified during the clinical encounter. Kentucky Kynect⁴⁴³ lists community programs and services available to assist with food insecurity, housing concerns, childcare, and others.⁴⁴⁴ Kynect was reintroduced in November 2021 as a health insurance online shop with the resource component being supported in partnership by the Kentucky United Way.⁴⁴⁵ During stakeholder engagement, the CMHCs and providers did not mention utilizing Kynect resources.

KHIE

KHIE is the single statewide HIE in the Commonwealth. KHIE is administered by the Division of Kentucky Electronic Health Information within CHFS and is supported by the Office of Administrative and Technology Services. This relationship allows for easier collaboration and coordination between the HIE and KDMS.

KHIE is connected to over 100 hospitals and over 26,000 ambulatory healthcare locations. Key features of KHIE include:⁴⁴⁶

- Patient information integration into provider EHRs.
- Access to patient information through the KHIE portal for those participants who do not have integration through their EHR.

⁴⁴³ www.kynect.ky.gov.

⁴⁴⁴ <https://chfs.ky.gov/agencies/dms/Pages/kynectres.aspx>.

⁴⁴⁵ <https://www.courier-journal.com/story/news/local/2021/10/08/kentuckys-health-care-shop-kynect-returning-what-means-you/6018396001/>.

⁴⁴⁶ <https://khie.ky.gov/Pages/index.aspx>.

- Integration to more than 10,000 provider, payer, and community-based organizations through Kynect resources, which is a community resource portal to help address SDOH. This includes taking patient-completed self-assessments or guided assessments and integrating that information into the KHIE patient record which can be shared with any participating provider.
- Event notification systems that alert providers to patient transitions of care, such as ED visits, hospitalizations, and discharges.
- Connectivity to the national eHealth Exchange which enables KHIE to share and receive patient health information outside of Kentucky.
- Connectivity to correctional facility clinics including Commonwealth and county jails in Lexington, Louisville, and Northern Kentucky.
- Direct data entry for several communicable diseases such as COVID-19, sexually transmitted diseases (STDs), multi-drug-resistant organisms, perinatal hepatitis, and child hepatitis.
- From the KHIE interview conducted, the organization's current priorities are to increase utilization of services and to improve quality of the data.



MCI and HIE

Twelve out of the 14 CMHCs are participants with KHIE, but only one CMHC stated that it uses information from KHIE for MCI services.

Regarding sharing patient information through KHIE, there are different consent requirements depending on the information type.

- An opt-out consent model for health information being shared through KHIE.
- KHIE requires the patient to opt-in, provide written consent, and update the consent request every six months for information that falls under 42 CFR Part 2.⁴⁴⁷

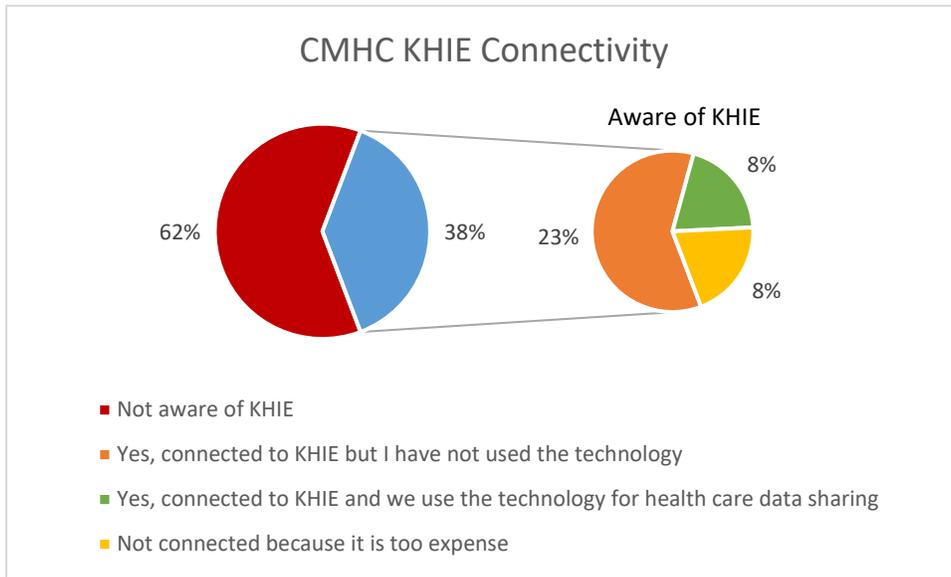
According to the most recent KHIE participant list, 12 of the 14 CMHCs are participants with the HIE.⁴⁴⁸ Despite the high participant rate of the CMHCs, not many individuals who were engaged through the MCI services stakeholder activities were aware of KHIE, which may be related to how the data is integrated into existing systems. When an EHR system is fully integrated with an HIE, data moves seamlessly without the need to interact with the HIE directly. According to KHIE, there is integration with Region 9/10's Netsmart EHR system. Other CMHC EHRs may have integration with KHIE, but ensuring staff are aware of this and trained to use it is critical.

Figure 46 shows the results of the pre-interview questionnaire regarding KHIE connectivity. Of the respondents from 13 CMHCs, 62 percent were unaware of KHIE. Comparatively, 23 percent of respondents stated their organization was connected to KHIE, but they were not using the information. One CMHC respondent indicated they use KHIE for health care data sharing as it relates to MCI services. During interviews, one CMHC reported integration with KHIE was not a smooth process, and another stated that KHIE is not being used by crisis teams.

⁴⁴⁷ <https://khie.ky.gov/Resources/Pages/KHIE-Consent-Model.aspx>.

⁴⁴⁸ <https://khie.ky.gov/Participants/Pages/All-KHIE-Participants.aspx>.

Figure 4.6. CMHC Pre-Interview Questionnaire: CMHC KHIE Connectivity



Recommendations



KENTUCKY
Cabinet *for* Health and
Family Services

Recommendations

There are successful elements of MCI services operating regionally in Kentucky, yet many stakeholders identified barriers and challenges in the provision of MCI services. These elements will provide a foundation for the development of a statewide MCI services model providing mobile crisis services for anyone, anywhere, and at anytime.

To develop such a model, the following details an initial set of recommendations for KDMS, sister agencies, and community partners to consider during the strategic planning phase of the planning grant project.

MCI Service Policy Design and Communication Needs

Ambiguous Definitions of Behavioral Health Crisis and Mobile Crisis Intervention Services

Both MCI service providers and stakeholders from Kentucky's Medicaid MCOs have expressed the need for clear definitions of behavioral health crisis and mobile crisis intervention services. Unclear or inconsistent definitions of MCI services have led to provider confusion and inconsistencies in service delivery.⁴⁴⁹

Recommendation: All definitions of MCI services in Kentucky regulations and the Medicaid SPA should align with national best practices regarding the core elements of a crisis system. While not necessary for all documents to be identical in their specific details, each policy and regulation should present clear direction regarding the fundamental aspects and minimum requirements of MCI service delivery such as service availability, compositions of the MCT, service delivery methods, use of telehealth, and other key areas.

Kentucky should establish a statewide definition of MCI services and behavioral health crisis that is clear and consistent across agencies, provider organizations, payers, and also aligns with Section 9813 of ARPA to qualify for the enhanced matching rate and ensure mobilization of crisis response services is delivered appropriately, timely, efficiently, and consistently across Kentucky.

Recommendation: Address crisis scenarios that may not qualify as behavioral health crisis. Kentucky's stakeholders reported confusion around "who" responds to crises relating to age-related cognitive impairment, such as dementia. For example, CMHC crisis responders reported frequent instances of being dispatched to hospital EDs to evaluate patients in behavioral health crisis only to discover the individual actually has dementia. Age-related cognitive impairments necessitate different de-escalation techniques, differing from behavioral health crisis.

⁴⁴⁹ Kentucky MCO Stakeholder Interview, February – March 2022

Resources

Examples of definitions of behavioral health crisis include the following:

- **NAMI:** A “mental health crisis” is any situation in which a person’s behavior puts them at risk of hurting themselves or others and/or prevents them from being able to care for themselves or function effectively in the community.⁴⁵⁰
- **Tennessee:** A behavioral health crisis is defined as any intense behavioral, emotional, or psychiatric situation perceived to be a crisis by the individual experiencing the crisis, family, or others who closely observe the individual which left untreated, could result in an emergency situation in the placement of the person in a more restrictive, less clinically appropriate setting, including but not limited to, inpatient hospitalization or at the very least, significantly reduced levels of functioning in primary activities of daily living.⁴⁵¹
- **Arizona:** A crisis is defined by the person going through it. If a situation exceeds a person's coping skills, then they are considered to be in crisis.⁴⁵²
- **Mississippi:** A mental health crisis is any situation in which someone’s behavior puts them at risk of becoming unable to properly provide self-care, of functioning in the community, or maybe even of hurting themselves.⁴⁵³
- **SAMHSA Guidelines:** To identify crises accurately requires a much more nuanced understanding and a perspective that looks beyond whether an individual is dangerous or immediate psychiatric hospitalization is indicated. While behaviors that represent an imminent danger certainly indicate the need for some sort of an emergency response, these behaviors may well be the culmination of a crisis episode, rather than the episode in its entirety. Situations involving mental health crises may follow trajectories that include intense feelings of personal distress (e.g., anxiety, depression, anger, panic, hopelessness), obvious changes in functioning (e.g., neglect of personal hygiene, unusual behavior) or catastrophic life events (e.g., disruptions in personal relationships, support systems or living arrangements; loss of autonomy or parental rights; victimization or natural disasters).⁴⁵⁴

Provider Understanding of Rendering Practitioners and Composition of the MCT Varies

While Kentucky’s CMHCs currently employ providers able to render MCI services within the Kentucky SPA, stakeholders do not have a common understanding of 1) who can render MCI 2) who can bill for the services and 3) the composition of a multi-disciplinary team.

The listing of provider types who can serve as part of a MCI team is defined in the Kentucky State Plan, KAR regulations and the CMHC Behavioral Health Services Manual. However, the listing of rendering providers is not consistent across agency policies. For example, the licensed behavioral analyst, who

⁴⁵⁰ <https://www.nami.org/Support-Education/Publications-Reports/Guides/Navigating-a-Mental-Health-Crisis/Navigating-A-Mental-Health-Crisis.pdf>

⁴⁵¹ Tennessee Department of Mental Health and Substance Abuse Services Office of Crisis Services and Suicide Prevention Minimal Standards of Care (2017).

⁴⁵² <https://www.vera.org/behavioral-health-crisis-alternatives/robust-crisis-care-and-diverting-911-calls-to-crisis-lines>.

⁴⁵³ <http://www.dmh.ms.gov/service-options/crisis-services/>.

⁴⁵⁴ <https://store.samhsa.gov/sites/default/files/d7/priv/sma09-4427.pdf>.

can provider services under supervision, is listed as a rendering provider under the State Plan but is not listed in the CMHC Behavioral Health Services Manual or the 902 KAR Regulation 20:091.

Recommendation: Align policies and revise state-issued MCI materials. Evaluate the language included in the KAR, State Plan, and resource materials such as the CMHC provider manual. The listing of professionals and paraprofessionals who can provide MCI services should be aligned across all materials to reduce confusion of roles and responsibilities of MCI team members. The following are examples of conflicting information found:

- The DBHDID CMHC manual expressly lists Psychiatric Resident and Resident Physician as providers, while these provider types are not specifically listed in the state plan or KAR as mobile crisis providers.
- The State Plan lists LBA and LABA as rendering practitioners for MCI services under a licensing organization; however, these two provider types are not listed in the KAR or CMHC provider manual.
- MCOs stakeholders noted that contracted providers claimed that the limiting factor in the provision of MCI services is the requirement for “access to a psychiatrist 24/7/365”. The State could update policy language in rendering provider type regulations to include Psychiatric Nurse Practitioner.

Recommendation: Develop an MCI Services Toolkit for CMHCs and BHSOs. Adapt CMHC guidelines for BHSOs, promote trainings for crisis providers in BHSOs, consider the creation of a workgroup that meets in regularly to provide a collaborative environment for knowledge exchange and to promote MCI services delivery. The toolkit should include best practices for composition of the MCT and guidelines for billing and reimbursement.

Resources

The following are examples of provider types that can be included in an aligned set of policies identifying the potential members within the MCT and communicating such guidelines to the providers and provider organizations:⁴⁵⁵

- **Crisis Clinicians:** Skilled in doing initial triage, crisis assessment, provisional diagnosis, crisis planning, and crisis intervention. They are commonly master’s level clinicians from any discipline, frequently LPCCs or LMFTs, but in some settings may be bachelor’s level crisis clinicians with training and supervision that qualifies them to perform crisis intervention and crisis care management. Clinicians can also begin short-term, crisis focused, and motivational treatments.
- **Psychiatric Care Providers:** The crisis team has psychiatric care providers available on-site or on call who can initiate medication treatment if needed. These clinicians can be MDs, doctors of osteopathy, APRNs, nurse practitioners, or PAs, depending on state licensure and regulations, and can distinguish between the need for emergency treatment, urgent treatment, and ongoing care.
- **Nursing:** Essential to oversee medical screening and evaluation, provide and monitor medications, and interface with nursing personnel at referring and receiving programs.

⁴⁵⁵ https://www.thenationalcouncil.org/wp-content/uploads/2022/02/042721_GAP_CrisisReport.pdf

Depending on the type and intensity of services, during any shift, nursing may be on-site or on call and may involve RNs or licensed vocational nurses/LPNs. There also needs to be an individual designated as a nursing supervisor, who will be on-site or off-site depending on the number of nursing staff or extent of nursing coverage.

- **Social Worker:** Social workers, LMFTs, or other clinicians trained in family engagement can gather historical information, family, and social contacts and begin linkage to other services and care in the community.
- **SUD Clinician:** There are team members who are certified or licensed SUD specialists and/or individuals who have SUD experience. These team members support the ability of all team members to work with individuals with SUD/COD in crisis.
- **Peer Specialists:** Peer specialists are essential team members who specialize in welcoming and engaging clients, helping educate clients about crisis program services, and process and facilitating community transitions as community bridges. Georgia uses specialized initiatives to focus on training in peer services with emphasis placed on “lived experience” across several specializations, including youth, parents, addiction, and recovery to generate maximum benefit to the overall crisis system input.⁴⁵⁶

Provider Awareness of MCI Services and Reimbursement-Related Concerns Result in Varying Billing Practices

Stakeholders expressed concern about the definition of MCI services, billing codes used, and billing policies. Some of the provider stakeholders interviewed, reported minimal awareness of mobile crisis services and supports in communities throughout Kentucky. It was stated by stakeholders that the mobile crisis codes are underutilized due to confusion around the definition of MCI and limited billing guidance.⁴⁵⁷

- Advocates and providers feel teachers and coaches should have an understanding of who to call if a child is in crisis.
- Parents and caregivers should have the crisis phone number readily available.
- Pediatricians and primary care providers need a directory of crisis supports and some knowledge around how they can respond in a crisis.
- Private practice counselors, therapists, and psychologists who work with children should have basic training around response in behavioral health crisis and have a readily available directory for crisis supports.
- MCOs recognize MCI is underutilized partly due to provider awareness and state-led billing and reimbursement guidance.

Other states vary in their policies for assigning codes for MCI services and provider billing, but SAMHSA recommends the use of H2011, with the modifier HT to indicate multi-disciplinary teams, and which

⁴⁵⁶ Gordon, Stuart Y. Building State Capacity to Address Behavioral Health Needs Through Crisis Services and Early Intervention. Milbank Memorial Fund Issue Brief. November 2020.

⁴⁵⁷ Kentucky MCI Roundtable: Youth Stakeholders, February 2022; Kentucky CMHC MCI Stakeholder Interview, February 2022; Kentucky MCI Roundtable: BHSO Stakeholders, February 2022; Kentucky MCI State-Level Stakeholder Information Request, January 2022.

allows for billing for MCI for each 15-minute interval of services.⁴⁵⁸ This approach is also endorsed by Crisis Now and was favorably viewed by some stakeholders.⁴⁵⁹

Recommendation: Medicaid should review best practices, and SAMHSA recommendations, about the definition of services, the providers who can deliver services, and the coding to be used for services. Consider moving to billing using the more common H2011 and allow billing in 15-minute increments. If feasible, develop a code for MCI follow up services. Should this recommendation move forward, Kentucky's related agencies should work together to develop an approach that is consistent across payers.

Provider billing practices for MCI services varies significantly and many are not using mobile crisis-related billing codes. Based on MMIS paid claims information, it appears that not all CMHCs are billing for MCI services, and almost no BHSOs are billing for MCI services. Further, Medicaid paid claims data indicates that there is relatively low utilization of and expenditures for MCI services. Stakeholders indicated that they do not bill Medicaid for MCI services for various reasons including:

- Cannot determine Medicaid eligibility status.
- Do not understand when the MCI code should be used, and so do not bill for MCI services.
- May be providing MCI services through contracts with hospitals (related to CMHCs), so these CMHCs also do not bill for services.

Several stakeholders expressed concern that community members, providers, schools, law enforcement, and other first responders do not know about the MCI services available. This lack of knowledge could also contribute to reported low utilization of services.

Recommendation: The Department should develop a plan to outreach to community members, providers, schools, law enforcement, and other first responders to increase awareness of MCI services funded by Medicaid. As new policies and rules related to MCI evolve, Kentucky Medicaid and its MCOs should:

- Work with MCOs and CMHCs to quantify the number of MCI services provided to individuals, and the number of follow-up services to each individual. Regularly survey BHSOs, if these providers will continue as providers of MCI services, to determine why they are not providing MCI services.
- Work to develop procedures that allow KDMS to record not only the billing provider, but providers who are not directly billing for MCI services, such as nurse practitioners and peer support professionals. Work with MCOs to capture all relevant provider and billing information.
- Work with MCOs to develop and implement an approach to support providers to identify Medicaid-eligible beneficiaries so that providers may bill Medicaid. MCOs should work to identify challenges and determine why there is no follow-up to determine potential for billing. KDMS should also work with MCOs to develop strategies to collect the payer source during follow-up services to maximize federal funding.

⁴⁵⁸ <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

⁴⁵⁹ National Action Alliance for Suicide Prevention: Crisis Services Task Force. (2016). Crisis now: Transforming services is within our reach. Washington, DC: Education Development Center, Inc.

- Educate providers through various media (webinars, provider bulletins, websites, etc.) about what MCI services can be billed and the approach for billing for MCI services. Update relevant parties when any changes to current policy are made. Because almost all of the MCI services are paid through the MCOs, MCOs should work to determine what information providers need to bill and address billing and policy issues.
- Monitor data from MCI providers to assess whether service utilization is improving. With the implementation of g88, it is likely that there will be growing utilization of MCI services, and KDMS should obtain information from MCOs to monitor utilization, and address potential barriers and challenges as they emerge.

Establish or Enhance Core Elements of Kentucky's MCI Service Delivery

Need to Establish a Comprehensive Governance Structure to Implement Kentucky's MCI Services Model

Recommendation: Establish a cross-system of agencies, provider entities, health plans, and community organizations that support an on-going governance committee. This group of stakeholders will be responsible for creating the guiding principles related to the oversight and evolution of the mobile crisis system to best serve the needs of the State. Also, the governance body will develop and maintain a process for ongoing performance monitoring and evaluation. The system could include the following:

- When transitioning from planning to implementation of Kentucky's MCI Model, it will be critical to continue with a cross-system, partnership-based governance group that is expanded to include representation from law enforcement and first responders, in addition to the current representation of agencies, health plans, mental health and SUD experts, education administrators, and school counselors with a shared mission and defined goals for the mobile crisis service delivery system.
- The cross-system group within the governance structure may be part of an existing behavioral health crisis coalition or oversight entity. The existing behavioral health group may also have regular meetings with cross-system partners to review, discuss and make decisions regarding the end-to-end MCI service continuum – the initial crisis response through to treatment and supportive services. The topics will focus on the key areas necessary to apply the planning grant outcomes and implement the statewide MCI services model. Such topics will include, for example, the use of telehealth with in-person service, conditions to dispatch of a mobile crisis team, use of protocols for the role of law enforcement and other first responders, exploration of the possibility of using KHIE as a shared data exchange to provide connections for referrals and post-crisis care, transportation, and short-term crisis stabilization.
- The governance structure will foster a collaborative environment enabling Kentucky's organizations that are involved in providing direct mobile crisis response to engage in a "knowledge exchange." These meetings should include CMHCs, BHSOs, community response groups, and public and private stakeholders. The governance group may host the sessions and prepare topics for discussion that facilitate "lessons learned" and encourage exploration regarding addressing barriers, health equity, and reproducing or scaling successes.

Resources⁴⁶⁰

On example of cross-system cooperation includes the following:

- **Vermont:** Since 2017, the Vermont Department of Mental Health had been working with several agencies and departments to explore mobile response and support services (MRSS) for the child, youth, and family system of care. To provide ongoing oversight and assessment of progress, the Vermont Agencies of Human Services convened a “Mobile Crisis Think Tank” in June 2018. This interagency team, included representation from community providers, advocates, and consumers to discuss current status of mobile crisis and stabilization, as well as opportunities for improvement in serving children, youth, and families.⁴⁶¹

Recommendation: Standardized mobile crisis procedures. MCI service delivery currently varies across Kentucky’s providers. Providers are seeking clear, universal guidance to delivery MCI services without being restricted and/or limited. The standardized procedure should match Kentucky’s new MCI Model while providing best practices for crisis intervention process and service definition practices (e.g., what defines a behavioral health crisis, what triggers dispatch, window of time for follow-ups, etc.).

Resources

On example of standardization includes the following:

- **Florida:** The Florida state code defines the “no-wrong-door” model as the model for the delivery of acute care services to persons who have mental health or SUD, or both, which optimizes access to care, regardless of the entry point to the behavioral health care system.⁴⁶²

Recommendation: Evaluate available quality measure reporting. Since national quality measures for MCI services do not exist, KDMS and its partners should assess current available quality measure reporting to determine applicability to MCI services. For example, EQRO annual reporting regarding MCO performance, CMHC reporting to DBHDID, and CCBHC demonstration reporting may provide quality measures that Kentucky can use to evaluate how the MCI Model is performing. It may also be possible to modify or focus those quality measures specifically on the MCI Model performance.

Recommendation: Develop a comprehensive list of process measures to assess the MCI Model. Process measures document the intervention performed. The State already has in place process measures to evaluate crisis call center measures. It is recommended the State also implements process measures to evaluate MCI model performance. SAMHSA, in its National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit, recommends the following measures⁴⁶³:

- Number served per eight-hour shift.
- Average response time.

⁴⁶⁰

https://www.nasmhpd.org/sites/default/files/The%20National%20Guidelines%20for%20Crisis%20Care_A%20Best%20Practice%20Toolkit.pdf

⁴⁶¹ Vermont Agency of Human Services, MRSS Team. (August 2019). Making the Case for Mobile Response in Vermont – Child, Youth and Family System of Care.

⁴⁶² Florida Statute Section 394.4523(1)(d), F.S.

⁴⁶³ <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

- Percentage of calls responded to within one hour.
- Percentage of calls responded to within two hours.
- Longest response time.
- Percentage of mobile crisis responses resolved in the community.

Recommendation: Select meaningful outcome measures to monitor MCI services. Outcome measures assess the outcome of the intervention performed. It is recommended the State, in addition to monitoring of process measures, also selects meaningful outcome measures to support ongoing monitoring and evaluation of the MCI model.

Resources⁴⁶⁴

The following are suggested minimum data standards for collection and reporting:

Crisis Call Center Services

- Call Volume.
- Average speed of answer average delay.
- Average length of call.
- Call abandonment rate.
- Percent of calls resolved by phone.
- Number of mobile teams dispatched.
- Number of individuals connected to a crisis or hospital bed.
- Number of first responder-initiated calls connected to care.

Crisis Mobile Services

- Number served per eight-hour shift.
- Average response time.
- Percent of calls responded to within one hour, two hours, etc. Longest response time.
- Percent of mobile crisis responses resolved in the community at the scene, via arrest, transport to crisis stabilization, transport to ED, or transport to home.

Crisis Receiving and Stabilization

- Number served (eg., measure of individuals served per chair daily).
- Percent of referrals accepted.
- Percent of referrals from law enforcement (e.g., hospital and jail diversions).
- Law enforcement drop-off time.

⁴⁶⁴

https://www.nasmhpd.org/sites/default/files/The%20National%20Guidelines%20for%20Crisis%20Care_A%20Best%20Practice%20Toolkit.pdf

- Percent of referrals from all first responders.
- Average length of stay.
- Percent discharged to the community.
- Percent of involuntary commitment referrals converted to voluntary.
- Percent not referred to ED for medical care.
- Readmission rate.
- Percent completing an outpatient follow-up visit after discharge.
- Total cost of care for crisis episode.
- Guest service satisfaction.
- Percent of individuals reporting improvement in ability to manage future crisis.

Other Metrics

Other meaningful metrics to establish benchmarks and monitor performance using the following metrics:

- Location of where intervention occurs.
- Time of day intervention occurs
- When the intervention occurs within the course of the crisis episode.
- The familiarity of the MCT team member with the individual or with the type of problem experienced by the individual.
- MCT team member training relating to crisis services.
- Performance metrics associated with mobile crisis intervention associated with youth under the age of 21.
- Occupancy rate of crisis stabilization units (90% required).
- Denial rate (no more than 10%).
- Length of stay (average of seven calendar days or less).
- Diversion Rate (50% of individuals who present to walk-in centers or temporary observation units and are treated in <24hrs and no longer require inpatient admission to a crisis unit or hospital).

Transportation Continues to be a Major Concern and Obstacle to Short-Term Crisis Stabilization for Persons Experiencing a Behavioral Health Crisis.

Stakeholders reported EMS providers might be unwilling to transport behavioral health clients. CMHCs address transportation barriers through collaboration with “natural supports” (client’s family, caregiver, friends, etc.), provision of public transit passes, gas reimbursement, and gift cards. One CMHC currently partners with UberHealth, but this service is unavailable in the rural regions of the Commonwealth.

Rural CMHCs stated that they often rely on their law enforcement partners to transport a client after a crisis encounter.

Recommendation: Review and amend Kentucky NEMT regulations. Educate all relevant stakeholders (including brokers and providers) to the fact that Medicaid beneficiaries receiving MCI services are eligible for NEMT services.

Recommendation: Clarify the EMS role in providing transportation for clients of CMHCs, and follow-up with clear marketing material and training. At the same time, promote Human Service Transportation Delivery (HSTD) transportation services.

Recommendation: Modify Kentucky’s Medicaid SPA transportation-related provisions based upon Nevada’s SPA (NV-21-005), which defines three types of transportation services (EMT, non-emergency secure behavioral health transport, and NEMT). Also review Nevada’s parallel laws and regulations. Of particular interest to Kentucky because of the reference to crisis, is the definition of non-emergency secure behavioral health transport services as the use of a motor vehicle, other than an ambulance or other emergency response vehicle, that is specifically designed, equipped, and staffed by an accredited agent to transport a person alleged to be in a mental health crisis or other behavioral health condition, including those individuals placed on a legal hold.⁴⁶⁵

Resources

Examples of transportation options in other states include the following:

- **Minnesota.** Consider Minnesota’s NEMT services, which establish the category of “protected transportation.”⁴⁶⁶ Protected vehicles are not ambulances or police cars, but vehicles that include safety locks, video recorders, and transparent partitions between passengers and drivers. The state’s guidelines include a link to an assessment form, which ascertains that the beneficiary requires a protected level of transportation, and numerous references to crisis providers.⁴⁶⁷

Recommendation: Consider expanding the DMS Memorandum of Agreement (MOA) with the Kentucky Transportation Cabinet to include transportation network companies (TNCs), such as Lyft and Uber, for ridesharing. Studies found patients using rideshare-based NEMT had fewer missed primary care appointments, a lower average wait time, a higher rate of on-time pickup compared to those using other types of NEMT, and lower costs. Although some regions of the state will not have rideshare capabilities, the regions that do could benefit. Currently, at least ten states include rideshare as a NEMT provider.⁴⁶⁸ Georgia’s Medicaid state plan amendment (GA-21-0015) was approved in March 2022 and attests that TNCs, and others meet Medicaid’s transportation requirements.⁴⁶⁹ It is noteworthy that Georgia expanded to include TNCs. Since 1997, the Georgia Department of

⁴⁶⁵ <https://www.medicaid.gov/Medicaid/spa/downloads/NV-21-0015>

⁴⁶⁶ <https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MN/MN-16-14.pdf>

⁴⁶⁷ https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-288176.

⁴⁶⁸ <https://www.rand.org/blog/2020/05/non-emergency-medical-transportation-in-the-time-of.html>

⁴⁶⁹ <https://www.medicaid.gov/medicaid/spa/downloads/GA-21-0015.pdf>

Community Health has a regional transportation brokerage program to serve its Medicaid clients. Two private brokers—LogistiCare and Southeasterns—have managed NEMT services in the state’s five regions since the inception of the program.⁴⁷⁰

Minimal Availability of Short-Term Crisis Stabilization Facilities, 23-Hours or Less

Twenty-three hour CSUs in Kentucky are limited to addiction stabilization with the recent exception of recent changes at one CMHC. CMHCs expressed concern that their regions’ short-term stabilization units (less than 24 hours) have closed over the past several years, largely due to underutilization and lack of funding.⁴⁷¹

Recommendation: Implement the Living Room Model (23-hour Crisis Stabilization Units). The Living Room Model is designed to reduce mental health emergency room visits. These facilities are comprised of small units, and are open to the public, catering to clients who need help due to behavioral health concerns. The Living Room Model provides counseling, monitoring, and medication management through a staff of mental health clinicians and social workers who can address the needs of a smaller number of clients.⁴⁷² The Commonwealth should evaluate current short-term stabilization units in operation throughout Kentucky and examine current system capacity, including how service needs could be addressed by the implementation of the Living Room Model. Apply the governance structure, including CMHCs, housing organizations, and other relevant stakeholders to identify needs from a policy and funding perspective.

Recommendation: Adoption of Peer-Operated Respite. Stakeholders in the adult roundtable recognized how peer supports add value to crisis services and stabilization and imagine peer respite playing an affordable role in Kentucky’s post-crisis service array. Kentucky should also explore the potential impacts of peer-operated respite for youth peer-run respites are crisis alternatives with intended outcome to divert hospitalization. Staffed and operated by PSSs who have professional training in providing crisis support to build mutual, trusting relationships. Centers are typically located in a house in a residential neighborhood providing a safe, homelike environment for people to overcome crisis. They should:

- Function at the intersection of the consumer/independent living movement and the professional behavioral health system.
- Provide restful, voluntary sanctuary for people in crisis, which is preferred by guests and increasingly valued in service systems.

Ideally, there should be one respite alternative in every crisis care system.

Resources:

- **Nebraska:** Keya House is for adults with mental health and/or SUD who are 19 years or older. Residents can stay, free of charge, for up to five days or under 24 hrs. Staffed 24/7/365 entirely with PSSs, with varying “lived experience”. Guests are able to come and go as needed, attend

⁴⁷⁰ https://onlinepubs.trb.org/onlinepubs/tcrp/tcrp_rpt_202_companion.pdf

⁴⁷¹ Kentucky CMHC MCI Stakeholder Interview, February 2022; Kentucky CMHC MCI Stakeholder Interview, March 2022.

⁴⁷² <https://www.nami.org/Blogs/NAMI-Blog/September-2020/Responding-to-Crisis-The-Crisis-Living-Room>

to work/school, or visit with friends.⁴⁷³ The average cost to run Keya House is approximately \$284 per day, compared to higher levels of care which can exceed \$1200 per day (excluding emergency personnel).⁴⁷⁴ Since August 2017, guests reported: Keya helped them avoid crisis centers and/or ED (90%); staff used language that was “nonjudgmental” (95%); staff and guests were respected equally (95%); staff was always available to talk (95%); and guests felt comfortable throughout their stay (94%).⁴⁷⁵

Challenges to Rural Communities and Specialized Populations

Rural Regions Face Unique Challenges in Providing an MCI Response in the Community

The majority of the Commonwealth is considered rural. Rural location poses travel and broadband access challenges that limit the mobile crisis team to in-person response to an individual in crisis in a timely manner.

Recommendation: Consider a co-response model in rural regions of Kentucky that have limited behavioral health resources. In regions with limited resources and expansive service geography, CMHCs may consider establishing formal partnerships with local law enforcement offices and first responder agencies based upon specific protocols and required trainings.

Recommendation: Leverage community organizations and partnerships for new roles in the delivery of crisis care. CMHCs should explore current partnerships and host future trainings for how non-clinical staff at community organizations can respond to individuals receiving their care in crisis.

Resources

The following are suggestions for MCI in rural areas:

- SAMHSA: Crisis Services in Rural Communities⁴⁷⁶ and Development of Cross-System Partnerships⁴⁷⁷
 - ♦ Learning how other first responder services like law enforcement, fire, and emergency medical services operate in the area.
 - ♦ Leveraging existing first responder transportation systems to offer access to care in a manner that aligns with emergency medical services in the area.
 - ♦ Incorporating technology such as telehealth to offer greater access to limited licensed professional resources.

⁴⁷³ <https://mha-ne.org/programs-services/keya.html>

⁴⁷⁴ [Ibid](#)

⁴⁷⁵ [Ibid](#)

⁴⁷⁶ <https://store.samhsa.gov/sites/default/files/d7/priv/pep19-crisis-rural.pdf>

⁴⁷⁷ https://csgjusticecenter.org/wp-content/uploads/2021/04/Field-Notes-Mobile-Crisis-Team_508FINAL34.pdf

- ♦ Developing crisis response teams with members who serve multiple roles in communities with limited demand for crisis care to advance around the clock support, when called-upon.
 - ♦ Establishing rural reimbursement rates for services that support the development of adequate crisis care in the area.
 - ♦ Creating crisis service response time expectations that consider the geography of the region while still supporting timely access to care
 - ♦ Assemble a planning team to determine if a mobile crisis team fits the jurisdiction's needs. This team should consist of law enforcement representatives, mental health and SUD experts, agencies that serve people in the criminal justice system, people impacted by these systems, and community leaders and advocates.
 - ♦ Establish a shared mission and define goals for the mobile crisis team.
 - ♦ Outline clear roles, responsibilities, and processes through memorandums and agreements.
- **Connecticut:** Initial response time is within 45 minutes. In SFY 2018, 86% of all mobile responses were achieved within the 45-minute mark with a median response time of 30 minutes.
 - **Rural Nevada Mobile Crisis Response Team:** Rural clinician intervenes via telehealth and case manager from the rural community responds in-person or via phone.
 - **New Jersey:** Response time is within 60 minutes.
 - **Oklahoma:** After triage, if determined to be an emergency, response time is within one hour. If non-emergency, response time is within 24 hours.

At-Risk Populations Face Barriers to Receiving Crisis Services

Stakeholders expressed concern regarding limited availability of crisis services and supports for youth (including justice-involved and those in foster care), the homeless and individuals facing housing instability, LGBTQ+, hearing and vision impaired, and individuals with I/DD.

Recommendation: CMHCs should increase their collaboration with housing organizations and shelters to address gaps in crisis response to the unhoused population. Since CMHCs face staffing shortages, they should look to local housing organizations, shelters, and non-profit groups focused on serving the unhoused population for support. Stakeholders identified the need for teams “on the street,” building rapport with unhoused individuals and screening for mental health needs, crisis prevention, and crisis intervention. CMHCs may serve as the training hub for non-profit community workers to learn how to build rapport and discuss behavioral health needs. Understanding that these community workers will likely not meet requirements for rendering mobile crisis services, CMHCs could instead educate them about how to identify needs and provide resources and referrals to supports.

Recommendation: Develop a directory of crisis providers and special population supports. Planning for MCI services should consider the wider health and social needs of the population. This is particularly important for mental health and SUD treatment services, who frequently need to collaborate with a range of social and health care agencies and community organizations to coordinate

care for the individuals and families they treat. Positive outcomes in mental health depend upon a broad range of factors, including the physical health of individuals, social circumstances, employment, and family relations.⁴⁷⁸

Recommendation: Ensure MCI services address the needs of individuals with cultural and linguistic needs. The continuum of crisis response should account for cultural and linguistic needs. DMS may consider requiring MCOs demonstrate availability of supports in their provider networks as outlined below:

- Access for individuals who speak threshold languages.
- Access for individuals who speak non-threshold languages.
- Access for individuals from of all races and ethnicities.
- Access and intervention for documented and undocumented immigrants.
- Access and interventions for individuals who identify as transgender or gender non-confirming.

Recommendation: Leverage community organizations and partnerships for the delivery of specialized crisis care to at risk populations. CMHCs should explore current partnerships and host trainings for how non-clinical staff at these community organizations can respond to individuals under their care in crisis. CMHCs should host Mental Health First Aid trainings for members of community organizations.

Resources

The following are examples of other states' regarding at-risk populations:

- **Texas:** Currently invests \$8 billion biennially at the state-level through general revenue (Medicaid), and local and federal dollars to increase access to behavioral health services provided by multiple agencies. Included in this funding is the provision of Mental Health First Aid to state employees. Since SFY2014, Texas has trained nearly 24,000 school district employees; 3,000 HHS employees; and more than 17,000 community members.⁴⁷⁹
- **Florida:** The Jacksonville Hospital Collaborative consists of five health systems across Northeast Florida. Since adoption of the Mental Health First Aid program, the Collaborative has trained more than 3,400 staff and certified more than 60 instructors. As a result of the hospital system's success, the training program was adopted by the Jacksonville Sherriff's Office, which committed to training 3,000 of its employees, including officers.⁴⁸⁰

Diversity Training to Drive Equitable Service Delivery and Reduce Behavioral Health Stigma

Current crisis intervention training for law enforcement and first responders does not include autism spectrum disorder or other neurodivergent and sensory disorders. CMHC stakeholders also expressed a

⁴⁷⁸ Glover, 1996; Thornicroft, De Salvia & Tansella. 1993.

⁴⁷⁹ <https://www.mentalhealthfirstaid.org/case-studies/texas-health-human-services-commission-behavioral-health-division/>

⁴⁸⁰ <https://www.mentalhealthfirstaid.org/case-studies/jacksonville-hospital-collaborative/>

need to increase staff trainings and targeted supports for LGBTQ+ and cultural and linguistic minorities.

Recommendation: Increase coordination with behavioral health providers from diverse backgrounds around Culturally and Linguistically Appropriate Services (CLAS). Licensed organizations such as CMHCs may provide mechanisms and effect change to train key MCT members.

- Adoption of Person-First language may ensure equitable services are delivered and reduce stigmatization of behavioral and mental health conditions, which is a known barrier to seeking services.
- Crisis system providers are expected to have the ability to identify culturally specific resources available in the community for continuing behavioral health care needs as well as provision of social support and be able to facilitate ongoing connection and coordination of care for populations who need and prefer such services.

Recommendation: Work to revise the current crisis intervention training curriculum statute to include considerations for autism spectrum disorder (ASD), neurodivergent disorders (i.e., ADHD, Tourette's, OCD), sensory processing disorders (SPD), and expand upon current curriculum regarding I/DD, at-risk populations (i.e., LGBTQ+ youth), health disparities, and individuals with cultural and linguistic differences. Revisions of curriculum should consider the SAMSHA definitions of cultural and linguistic competence.

To be culturally competent, systems and organizations are required to:

- Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively with people of diverse backgrounds.
- Have the capacity to value diversity, conduct self-assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge, and adapt to the diversity and cultural contexts of the communities they serve.

To be linguistically competent systems and organizations must:

- Have the capacity to communicate effectively and convey information in a manner that is easily understood by diverse audiences, including persons of limited English proficiency, those with low literacy skills, and individuals with other communication challenges
- Have policies, structures, practices, procedures, and dedicated resources to support the linguistic needs of diverse populations⁴⁸¹

Resources

Examples of states and organizations working to improve health inequity include:

- **Pennsylvania:** Pennsylvania's Department of Behavioral Health and Intellectual (dis)Ability Services (DBHIDS) has a public-facing Person-First Initiative guidelines with the stated purpose to address behavioral health system word association, aimed to increase inclusivity and decrease stigma.⁴⁸²

⁴⁸¹ <https://www.samhsa.gov/sites/default/files/lgbtqi2-s-practice-brief.pdf>

⁴⁸² <https://dbhids.org/wp-content/uploads/2015/09/Person-First-Initiative-Guidelines.pdf>

- **Oregon:** The Oregon Health Authority established a strategic goal to eliminate health inequities. A component of this strategic goal is to support “data justice by making changes that recognize and value community-led approaches to data. Part of this includes the standardized terminology used to address diverse minorities: Race, Ethnicity, Language or Disability (REALD) or Sexual Orientation or Gender Identity (SOGI).⁴⁸³
- **The Trevor Project:** The Trevor Project has published trainings specific to At-Risk LGBTQ+ youth, SUD in LGBTQ+ individuals, and treatment of transgender and non-binary individuals. Education should result in practice change like use of preferred pronouns and chosen name.
- **US Department of Health and Human Services (HHS):** HHS makes available a 5.5 hour course for behavioral health professionals called “Think Cultural Health” with the objective to improve quality of care provided to clients from diverse backgrounds. “Think Cultural Health” is an approved continuing medical education credit for counselors, nurses, psychologists, psychiatrists, and social workers. Support staff can still take the course and earn a Statement of Participation upon completion. The course includes an introduction to cultural and linguistic competency, self-awareness, cultural identity, and CLAS.⁴⁸⁴ Training should result in practice change including the adoption of guidelines for cultural and linguistic competence and the incorporation of CLAS in mobile crisis intervention service delivery.
- **Additional Organizations Addressing Health Disparities:** Trainings consider root causes of health inequities, including racism and other structural determinants of health, and include, the American Medical Association (AMA) series of CME modules for medical professionals on SDOH, Harvard Medical School “Advancing Health Equity: Skills for Health Care Providers.”⁴⁸⁵ The National Council hosts a list of public staff trainings/webinars/resources on Implicit Bias.⁴⁸⁶ Increased education on health disparities should result in practice change including the documentation and identification of SDOH and increased provider awareness of community resources that can address the SDOH needs of their clients.

Opportunities to Enhance MCI Service Delivery Infrastructure

MCI Service Related Data is Fragmented, Presenting an Incomplete Picture of Member Utilization, Provider Capacity, and Reimbursement

A number of overarching issues emerged from the analysis of current MCI services related to reimbursement and funding including:

- Relatively low utilization or billing of MCI services especially as a percent of total crisis services.
- Stakeholder concern about the definition of MCI services and who can provide the service.

⁴⁸³ <https://www.oregon.gov/oha/OEI/Pages/Demographics.aspx>

⁴⁸⁴ <https://thinkculturalhealth.hhs.gov/education/behavioral-health>

⁴⁸⁵ <https://pll.harvard.edu/course/advancing-health-equity-skills-health-care-providers?delta=0>

⁴⁸⁶ <https://www.thenationalcouncil.org/resources/addressing-health-equity-and-racial-justice/>

- Issues with how MCI services are reported.
- Stakeholder concerns about billing policies, reimbursement rates, and payment levels.
- Different payment methods and rates that vary across Medicaid and DBHDID.

These issues concerns suggest a need for a more coordinated statewide delivery and financing of MCI services. This need is fueled by the increase in demand for crisis intervention services that will likely arise from the implementation of 988. Funding options for crisis team responses may include⁴⁸⁷:

- Medicaid waivers.
- Enhanced matching rates for MCI.
- CCBHC demonstration/state plan services.
- CCBHC expansion grants.
- Block grants (Community Mental Health Services, Substance Abuse Prevention and Treatment, SAMSHA grants/988 appropriations, 998 mobile phone fees).

Recommendation: Address MCI service delivery and financing through a coordinated effort across payers, and funded through a braided funding approach, to include all payer sources and grants. MCI services would be available to anyone, regardless of payer coverage.

The full continuum of crisis services cannot be supported solely by Medicaid.⁴⁸⁸ Under a coordinated model, KDMS and its sister agencies such as DBHDID (referred to as the Departments below) would leverage funding from all available sources and potentially improve the portion of MCI services that are matched with federal dollars. A collaborative funding approach would promote coordination of care among multiple agencies, and more efficiently fund services. An important first step in the implementation of this recommendation is to clearly identify what DBHDID, 988, and existing Medicaid dollars are earmarked for MCI services to ensure funds are not duplicated among the services. The Departments should also identify crisis call center costs available for 50 percent match on administrative claiming, to the extent these are allowable.

This approach requires that KDMS and DBHDID work together to define MCI services, evaluate the existing array of MCI services, identify mobile crisis staffing and competency levels, a common group of providers that can bill for MCI services such as CMHCs, consider expanding the use of peer supports as recommended by SAMHSA, develop common billing policies, and potentially develop common fee schedules, for at least state-funded services.⁴⁸⁹ KDMS and sister agencies should design the rate methodology to meet the criteria of the enhanced FMAP for MCI services, and identify crisis call center

⁴⁸⁷ https://crisisnow.com/wp-content/uploads/2022/03/20220302_OverviewOfCrisisFundingSources.pdf

⁴⁸⁸ <https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-2-Access-to-Mental-Health-Services-for-Adults-Covered-by-Medicaid.pdf>

⁴⁸⁹ The ARPA legislation allows states to offer qualifying community-based mobile crisis intervention services without regard to Medicaid requirements that pertain to choice of provider or written agreement for services. This permits states to enter into selective contracts with providers of mobile crisis services and allows those providers to provide services without formal intake processes. Procurement processes allow state and local governments to select the provider or providers who can best meet the needs of their residents. Contracting requirements are essential in detailing expectations of services and specifying anticipated outcomes with key performance indicators. Such contracts are the vehicles by which states can develop measurable performance criteria and drive continuous quality improvement.

<https://www.congress.gov/bill/117th-congress/house-bill/1319/text>; <https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-2-Access-to-Mental-Health-Services-for-Adults-Covered-by-Medicaid.pdf>

costs that can be matched 50 percent by administrative claiming. KDMS and sister agencies should also define quality measures and improved outcomes that are expected to result from this redesign. State agencies should work with private health plans and other stakeholders as needed to refine the service design.

Resources

Examples of delivery and finance coordination includes the following:

- **Arizona.** The crisis system is operated by its Medicaid agency and administered by three Regional Behavioral Health Associations (RBHAs). They braid county and state funding with capitated per member per month Medicaid (1115 waiver) funding that is based on service utilization. This is used to pay their capitated behavioral health organizations to provide and oversee crisis response services. This funding structure allows Arizona to provide crisis services for a minimum of 24 hours for individuals enrolled in Medicaid and 72 hours for individuals not receiving Medicaid benefits.
- **Washington.** They fund behavioral health administrative service organizations (BH-ASOs) with block grants and general funds and requires that MCOs contract with the BH-ASO to ensure funding for crisis services for their enrollees. BH-ASOs and MCOs usually set a capitation rate for payment for all enrollees.
- **Georgia Department of Behavioral and Developmental Disabilities.** This agency supports its crisis call center and mobile crisis services through Medicaid administrative claiming. Through this option, CMS allows states to claim up to 50 percent of expenditures necessary to administer the state plan and execute activities for Medicaid enrollees. Georgia designated a formal protocol for assessing the Medicaid penetration rate. In order to access administrative matching for crisis call centers, a state must justify in a reasonable manner how many callers are Medicaid beneficiaries in order to properly allocate costs to Medicaid.

This recommendation requires significant time and resources for development. As planning is underway, or if this recommendation is not adopted, there are additional findings that can be addressed through other recommendations. However, if this recommendation is adopted, then KDMS should work with DBHDID to resolve many of these issues. Even if this recommendation is not adopted, a set of common policies, procedures, etc., would reduce administrative burden placed on providers who are billing for MCI services.

Behavioral Health Professional Shortages Necessitate Workforce Development Strategies

Stakeholders discussed workforce issues in general, and that there is a healthcare work force shortage in Kentucky that is making it difficult to provide MCI services. However, based on available data it is not possible to determine the extent to which any workforce challenges affect the availability of MCI services.

Recommendation: Determine optimal staffing and staffing competency models and develop workforce strategies that implement those. Several stakeholders also discussed creating more positions for peer support professionals to support the MCI team. As KDMS collects more information

about the provider network, it should consider if and how additional peer support services could be included in MCI delivery.

Steps for this recommendation could include:

- As the Commonwealth begins its design of the new MCI services policy, consider creation of a MCI provider taskforce that can quantify the need for MCI MCOs to determine best practices across the state in recruiting providers.
- KDMS should consider better tracking of MCI service data in order to better understand needed capacity.
- KDMS should consider whether the CCBHC option is achieving desired outcomes after the two-year demonstration and expansion of this option through a state plan amendment will improve availability to and use of MCI services.
- KDMS should consider workforce development related to behavioral health statewide. Developing the provider network for MCI cannot be done without consideration of other behavioral health workforce needs related to the continuum of care.

Recommendation: Continue to invest in behavioral health workforce recruitment and retention strategies. In order to increase workforce capacity, the state should consider, in addition to the financial incentives, other avenues for incentivizing providers.

Resources

The following are example recruitment and retention strategies:

- **Training.** New Jersey offers no-cost initial CADAC and peer training. Additionally, New Jersey reimburses peer support specialists for certification and testing costs.⁴⁹⁰
- **Tuition assistance.** Georgia has a medical education program that is designed to increase the number of doctors serving rural communities. Augusta University offers a specialized accelerated program to medical students who commit to practice in rural Georgia for six years. Students in the program benefit by a three-year, shorter medical school, a three-year primary care residency in Georgia, and free medical school tuition. In 2019, Georgia state legislature included \$500,000 in the budget for next fiscal year for the program's administration. It was estimated that if the program cost the state \$20 million a year by 2028, simply putting 48 doctors into rural underserved areas would yield an economic benefit to the state of more than \$340 million.^{491, 492}
- **Student loan repayment program.** The Behavioral Health Workforce Research Center (BHWRC) at the University of Michigan conducted interviews nationwide with 75 state experts and reported that scholarship and loan repayment programs were perceived as the most effective strategy for provider recruitment.⁴⁹³ The Florida Department of Health and a partner advertise and distribute information from the National Health Service Corps program. This is a

⁴⁹⁰ Stakeholder Information Received, Workforce Development, February 2021.

⁴⁹¹ <https://www.augustachronicle.com/news/20190504/medical-college-of-georgia-changes-aim-to-get-more-doctors-to-rural-ar>.

⁴⁹² <https://www.augusta.edu/mcg/fammed/residents/facilities/rural.php>.

⁴⁹³ The Behavioral Health Workforce in Rural America: Developing a National Recruitment Strategy, 2020.

program that provides scholarships or loan repayment for primary care physicians and other health care providers (nurse practitioners, physician assistants, dentists and hygienists, mental health professionals and certified nurse midwives) who agree to serve a minimum of two years in a federally designated HPSA.⁴⁹⁴

- **Relocation assistance.** In Oregon, legislation was introduced in 2021 to incentivize mental health professionals to provide services, especially in rural and underserved areas. Incentives include a state loan repayment program; student loan repayments; stipends; financial incentives for treatment providers to offer services in underserved areas; relocation assistance for treatment professionals moving to rural, frontier, or other underserved areas; educational opportunities; and direct financial support for telemedicine equipment and training.⁴⁹⁵ The current status of this bill is it is under committee review at the end of the 2021 legislative session.
- **Recognition and Rewards Program.** Provide mobile crisis staff and behavioral health providers who adhere to schedules and remain adherent with recognition and/or appropriate, allowable rewards in order to motivate others to follow.

Need To Consider Revising Payment Methodologies and Reimbursement Rates

Evaluate current rate structure and determine if rates and methodologies should be revised to better fit market needs. A direct comparison of KDMS Medicaid fee schedule rates and payment amounts to those of other states is difficult because states' policies regarding codes to bill, units to bill, etc., vary. Many states contract with MCOs, which do not publish their rates. However, a review of KDMS rates indicates that rates also vary based on provider. Some rates are based on reported costs, and others based on methodologies that are not documented. Rates for some providers are not updated. For example, the fee schedule for CMHCs is updated annually based on submitted cost reports, but these new rates apply only to the fee for service program. Several stakeholders expressed concern about low payment rates and rate adequacy, e.g., rates are not updated frequently, payment for direct service time does not include cost of time spent with the individual, etc.

Recommendation: KDMS Medicaid should consider developing a new rate methodology based on any revised definitions of units of service, HCPCS codes, and other billing requirements. This methodology should consider wage information, staffing ratios, and other market data that reflects current cost experience of providers, follow up services, etc. KDMS and DBHDID may want to work together to create a common methodology to create more consistency for providers.

Steps to implement this recommendation could include:

- Allowing for 15-minute increments to be billed may potentially address some of the challenges viewed by providers related to insufficient funding of MCI services. KDMS may also want to consider adopting codes for follow up visits.
- Braided funding as described above can address the challenges faced by states in developing payment methodologies for MCI services, because provider costs for outreach and team

⁴⁹⁴ Stakeholder Information Received, Workforce Development, February 2021.

⁴⁹⁵ <https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2361/Introduced>.

supervision costs may not be coverable under the Medicaid State Plan. Braided funding may support some of these costs, but CMS guidance is needed to address a process for doing so.⁴⁹⁶

Explore the Role of Law Enforcement and First Responders to Develop Specific Protocols for their Involvement During Delivery of MCI Services by the MCT.

Rural regions tend to rely on close partnerships with their local law enforcement agencies to help with intervention when the MCT is unable to respond in-person. CMHCs using co-response, CIT, and QRT, in addition to MCT report success in meeting crisis response requirements.

Recommendation: Evaluate potential implementation of co-location in communities with high volume of behavioral health-related 911 calls. After the analysis of Kentucky's 911 Run Cards, used by 911 operators to route in-coming calls, KDMS and its partners may consider review for regional and/or local trends within police jurisdictions to collaboratively develop first responder involvement coordination protocols.

Resources

The following are examples supporting this recommendation:

Arizona and Texas⁴⁹⁷

- Worked to improve coordination between 911 and behavioral health crisis responders. Many behavioral health calls that come through 911 are not from people in behavioral health crisis but are from a 3rd party individual observing "strange behaviors". In these scenarios the caller is not at risk, but the individual being referred to often has a quality of life or behavioral health need. These calls can be difficult to route to a crisis call center for mobile response, but co-location enables crisis call counselors to work with police and 911 operators in the determination of response needed.
- Co-location programs can address workforce barriers (shortages, availability concerns, etc.) in those deflected calls allow police, fire, and EMS to remain focused within their scope of work.
- More timely police diversion and MCT response.
- Co-location and cooperation also reduce stigma: By virtue of working closely together, police, first responders, and 911 operators increase their understanding of behavioral health crisis. In Austin, TX, 911 operators and police reported a natural adoption of Person-First language as a result of working closely with Crisis Call Counselors.

⁴⁹⁶ <https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-2-Access-to-Mental-Health-Services-for-Adults-Covered-by-Medicaid.pdf>

⁴⁹⁷ <https://talk.crisisnow.com/how-co-location-at-911-call-centers-strengthens-behavioral-health-connectivity-whether-in-person-or-virtual/>

Kentucky's Current Technology Infrastructure is Underutilized to Support MCI Services

The current MCI service-related system is fragmented and relies heavily on manual processes and/or soloed provider EHR. Technology – GPS-enabled mobile dispatch, real-time bed registry and coordination, centralized outpatient appointment scheduling, and performance dashboards, all of which are limited in use or non-existent in Kentucky—is a critical component of the MCI services system.

The call center system is fragmented and unable to meet increasing demands. CMHCs rely on manual processes for data collection, and only a few have routing software or referral management systems.

- Thirty % of crisis center respondents to a 2021 landscape analysis indicated they could maintain a 90% answer rate with a 30% increase in volume at current staffing levels.
- CMHCs that responded to questionnaires report that data collection and analysis is problematic, and they use a variety of methods to collect data, such as paper logs, spreadsheets, electronic health records, and call center software.
- Providers use a variety of telephone and call system hardware and software.

GPS technology is widely unavailable, but the use of GPS is critical to ensure safety. Only one CMHC reported use of an iPad application that allows for tracking of the MCT.

- CMHCs reported that connectivity issues create safety concerns, and staff are hesitant to provide in-person services in rural areas.
- Nearly all providers expressed significant concerns regarding MCT safety while in the field.
- 92% of CMHCs have tables or computers that can be used in the field.
- Cell phone coverage was cited as a barrier.

There is no statewide, comprehensive bed registry. Instead, CMHCs reported that they receive email lists of available beds.

- Most CMHCs rely upon manual processes such as phone calls or emails for bed availability or referrals.
- The process to assess bed availability and process referrals is time consuming and inefficient.
- Find Help Now KY is a valuable resource for CMHCs to locate addiction treatment facilities with availability.

Telehealth is widely used, but broadband is still an issue.

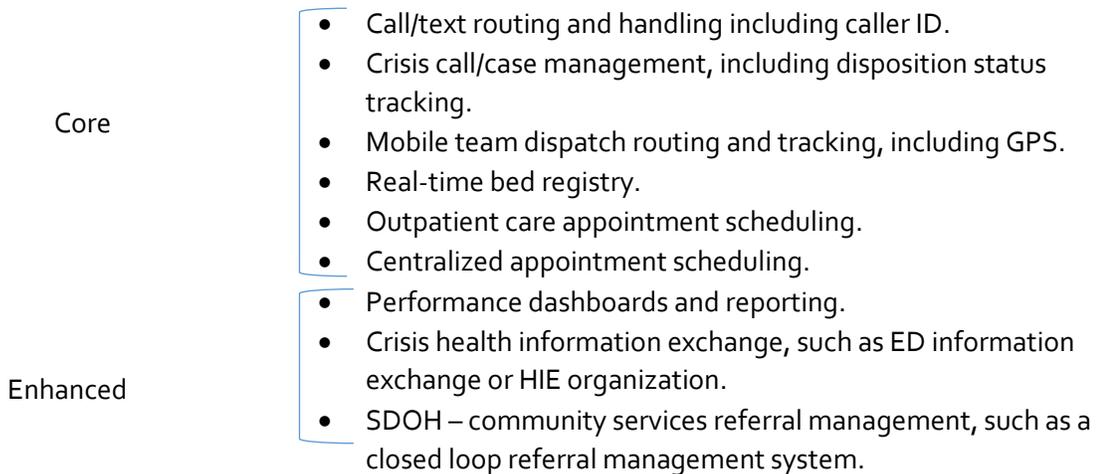
- All CMHCs rely upon telehealth for some of their MCI service delivery and many strictly use telehealth only to combat long distance travels, safety concerns, and staffing availability.
- Connectivity across the state and especially in rural areas is a major barrier for providing MCI services as this create issues for staff safety and reduces the availability to access patient information in the field.

Kynect and KHIE are existing resources that can help streamline data sharing and referrals to community resources, but both are underutilized.

- Kynect is an available social serve and community resource listing, but none of the stakeholder’s reported utilization.
- KHIE is connected to 12 of the 14 CMHCs but many MCTs are not aware of its capabilities or are not able to utilize the information from the system.
- 23% of CMHCs were connected to KHIE but weren’t using the system.

Recommendation: Kentucky authorities should conduct a robust technology assessment of the current system. KDMS should perform a technology assessment to illustrate the current assets and initiatives, such as FindHelpNowKY.org, and gaps within the MCI technology infrastructure. The technology assessment should include a crosswalk of current system components against national best practices, core elements of an Air Traffic Control (ATC) qualified crisis system, as well as key features cited as necessary among 988 stakeholders as outlined below.

In general, there are several technology platforms that can support the system of mobile crisis care. When these systems are integrated, the resulting infrastructure creates a cohesive crisis response system:



The following are examples of technology which should be considered:

- **According to the SAMHSA National Guidelines for Behavioral Health Crisis Care, technology is a critical component of the MCI services system.** This includes GPS-enabled mobile team dispatch, real-time bed registry and coordination, centralized outpatient appointment scheduling and performance dashboards that support air traffic control-type functioning in the crisis system have an important role in a crisis response system of care.⁴⁹⁸
- **Bed Registry.** A bed registry can serve as a single-point, real-time crisis services locator to enable behavioral health providers and/or law enforcement to quality assess 23 hour stabilization and inpatient capacity at crisis facilities, including locations, services available, and direct contact information.

⁴⁹⁸ Substance Abuse and Mental Health Services Administration (SAMHSA). National Guidelines for Behavioral Health Crisis Care. 2020.

- GPS-Technology.** Implementing real-time GPS technology in partnership with the regional crisis call center hub can support efficient connections to needed resources and tracking of engagement; and scheduling outpatient follow-up appointments and services to connect to ongoing care and home and community-based services and supports.⁴⁹⁹ GPS technology linked to the crisis hotline can be used to track mobile crisis teams to ensure direct communication between team members in the field and the call center. This can improve coordination of care and increase patient safety by allowing the call center to identify the closest team available for response and reduce the amount of time to reach an individual in crisis. Additionally, often times when mobile crisis teams are in the field, internet may not be available. Connecting the call center to the mobile response team’s cellular-enabled GPS can allow call center staff to assist with directions. In combination with caller-ID technology, GPS can be used to quickly identify the individual in crisis if the caller is using cellular service. Crisis hotlines can combine the use GPS technology to identify the location of an individual in crisis, and with the use of a behavioral health bed registry, they can identify the nearest available crisis stabilization bed to meet the caller’s needs and improve care coordination.
- Text and Chat.** Text and chat options to engage with crisis response resources are critical to increasing engagement by entire communities, especially youth.
- Telehealth.** Additionally, telehealth offers an opportunity to establish greater efficiencies in accessing licensed and/or credentialed clinicians, psychiatrists, and psychiatric nurse practitioners both in rural and urban communities.⁵⁰⁰ Economic disparities and technology disparities can cause issue for individuals seeking mental health services.⁵⁰¹ Communities of color and lower-income populations have worse mental health outcomes while also having lower technology literacy. This can compound the problem as providers continue to shift more services to telehealth. However, some individuals and communities of color may be more comfortable in receiving services at home rather than in a facility.

Telehealth helps to alleviate provider concerns related to travel distances, safety, and staffing availability but it is critical that patients receive the services in a manner that is helpful to their need. From a patient perspective there may be a need for a provider to visit them in person to assist with their crisis. Additionally, some stakeholders have cited internet connectivity issues throughout Kentucky. An individual may not have access to the necessary internet bandwidth at their home to utilize telehealth or cannot travel to a location that has the needed access.

- Air Traffic Control Model.** The National Alliance for Suicide Prevention’s Crisis Service Task Force also recommends an “air traffic control” (ATC) model for MCI services, which brings big data to crisis care and provides the ability of real-time coordination of services.⁵⁰² ATC focuses of valuable real-time and technology-driven coordination to reduce the incidence of suicide by individuals in crisis. This model was designed as an effort to reduce scenarios in which individuals “fall through the cracks” due to gaps in real-time coordination of crisis and ongoing services, and lack of linked flexible services specific to crisis response (mobile crisis and crisis stabilization facilities).

⁴⁹⁹ SHO# 21-008. Medicaid Guidance on the Scope and Payments for Qualifying Community-Based Mobile Crisis Intervention Services. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf>

⁵⁰⁰ Ibid.

⁵⁰¹ <https://www.nashp.org/states-focus-on-behavioral-health-as-they-consider-the-future-of-telehealth/>

⁵⁰² National Action Alliance for Suicide Prevention: Crisis Services Task Force. (2016). Crisis now: Transforming services is within our reach. Washington, DC: Education Development Center, Inc.

ATC model is used within integrated crisis call centers to create a professional framework for all levels of crisis services. This creates a hub for effective deployment of mobile crisis and ensures timely and appropriate access to facility services like stabilization and respite. The aims of the ATC Model in Crisis Care are to always know where an individual in crisis is and verify that the hand-off has occurred to the next service provider.

The ideal system would provide the following:

- **Status Disposition for Intensive Referrals.** Shared tracking of the status and disposition of linkage/referrals for individuals needing intensive service levels, including requirements for service approval and transport, shared protocols for medical clearance algorithms, and data on speed of accessibility (average minutes until disposition) are essential to a successful and well implemented crisis system.⁵⁰³ Programs can take advantage of sophisticated software to help crisis professionals assess and engage those at risk and track individuals throughout the process, including where they are, how long they have been waiting, and what specifically is needed to advance them to service linkage.
- **24/7 Outpatient Scheduling.** Crisis staff should be able to schedule intake and outpatient appointments for individuals in crisis with providers across Kentucky, while providing data on speed of accessibility (average business days until appointment).⁵⁰⁴
- **Shared Bed Registry.** Intensive Services Bed Census is required, showing the availability of beds in crisis stabilization programs and 23-hour observation beds, as well as in private psychiatric hospitals, with interactive two-way exchange (individual referral editor, inventory/through-put status board).⁵⁰⁵ Kentucky's CMHCs currently locate bed/facility placement manually by calling facilities one-by-one and/or consulting Kentucky Help Now for web-based SUD bed availability.
- **GPS-enabled Mobile Crisis Dispatch.** Mobile crisis teams should use GPS-enabled tablets or smart phones to determine the closest available teams, track response times, and ensure clinician safety quickly and efficiently. Additionally, the MCT can send out an "SOS" notification to the Call Center if there is a safety concern.
- **Real-Time Performance Outcomes Dashboards.** Outwardly facing performance reports should accurately measure a variety of metrics such as call volume, number of referrals, time-to-answer, abandonment rates, and service accessibility performance. When implemented in real time, the public transparency provides an extra layer of urgency and accountability.⁵⁰⁶

Resources

The following are examples of technology practices to be considered:

- **Arizona.** The Arizona Health Care Cost Containment System, Arizona's Medicaid agency, utilizes RBHAs to serve foster care children, members enrolled with DES/DDD, and individuals with SMI.

⁵⁰³ Ibid

⁵⁰⁴ Ibid

⁵⁰⁵ Ibid

⁵⁰⁶ National Action Alliance for Suicide Prevention: Crisis Services Task Force. (2016). Crisis now: Transforming services is within our reach. Washington, DC: Education Development Center, Inc.

- ♦ **Call Center Monitoring.** Related to call measures, the crisis line must be answered within three rings, with a call abandonment rate of less than three percent. Crisis lines must provide telephone support to callers to the crisis response line including a follow-up call within 72 hours to make sure the caller is stabilized.
 - ♦ **GPS-enabled Technology.** GPS tracking is available for all crisis mobile team workers through the Solari solution that enables tracking of the MCT for safety and to ensure efficiency when being dispatched (L.A. Fitzpatrick, personal communication, 3/9/2022). Additional safety measures include "triage for dangerous incidents including weapons searches, escalation protocols to ensure law enforcement is quickly dispatched when needed, and joint dispatching efforts of first responders and crisis teams.
 - ♦ **MCT Metrics.** According to one Arizona's MCT providers, the following items are tracked in monthly reports: dispatches completed, response time, referral sources, and dispositions with breakouts by adults, youth, I/DD, and by provider types.
- **Georgia.** Post-Hurricane Katrina, Georgia DBHDD expanded its Single Point of Entry into a statewide program for all 159 counties with 24/7 scheduling, online dashboards, and advanced analytics. In January 2019, the program launched Youth Services. Georgia Crisis and Access Line (GCAL) utilizes technology and web interfaced to support the full ATC model that brings big data to crisis care and provides ability of real-time coordination. GCAL offers text and chat features, crisis services are available through a mobile app (myGCAL), and offers Spanish language services.⁵⁰⁷ Resources listed in the NAMI directory include GCAL but also note other crisis lines in the state or national partners (veterans crisis line, national runaway safe line, parent hotline, Trevor Project lifeline, Georgia DFCS Central Child Abuse Intake, Georgia Coalition Against Domestic Violence Hotline, Georgia Elder Abuse Hotline⁵⁰⁸ Foundational elements of the Georgia mobile crisis response system are:
 - ♦ 24/7/365 Mobile Crisis Dispatch for all State Funded DBHDD MCR Teams
 - ♦ 24/7/365 Single Point of Entry for State Contracted Inpatient Beds
 - ♦ 24/7/365 Preferred Point of Entry for Crisis Stabilization Units and State Hospitals
 - ♦ 24/7/365 Initial Authorization for CSU, State Hospital, and State Contracted Inpatient Bed Admissions
 - **Tennessee.**
 - ♦ **Crisis Call Centers.** Crisis call centers are required to follow specific requirements regarding tracking and measuring calls and related response. For example, a log or EHR report of all contacts with crisis telephone services must be maintained by the crisis service provider and include: the name of the caller, client's date of birth, social security number, gender, race/ethnicity, the name of the crisis telephone worker, the time and duration of the call, time of face-to-face dispatch, if applicable, and final disposition of the call. Call documentation shall include a description of the presenting problem. If some of the information cannot be obtained from the caller that is okay. Call centers must meet the following:

⁵⁰⁷ <https://www.georgiacollaborative.com/providers/georgia-crisis-and-access-line-gcal/>

⁵⁰⁸ <https://namiga.org/resources/crisis-info-2/>

- Answer within five rings and/or 30 seconds (or will be routed to the State’s appointed managing entity).
 - Calls shall not remain in queue for longer than three minutes.
 - Centers will only place caller on hold with caller permission and check back every minute.
 - Discounted call abandonment rate will not exceed more than 5% of total volume of calls.
 - Interpreter services can be accessed by utilizing the language line, hiring multi-lingual staff persons, or making arrangements to purchase behavioral health interpreter services
 - Crisis staff shall be aware of available resources within the community when a request is made for a culturally competent provider.
 - Face-to-face assessments will occur within 2 hours from the time of the call for assistance at least 90% of the time, never to exceed 4 hours.
- **Bed Registry.** In 2019, Tennessee was one of 23 states that received funding from SAMHSA via the TTI to establish or expand comprehensive psychiatric crisis bed registry systems.⁵⁰⁹ The Tennessee’s Health Department’s Office of Emergency Preparedness oversees the Hospital Resource Tracking System (HRTS) which lists bed registry availability of 49 inpatient health facilities including those who provide mental health services.⁵¹⁰ HRTS was launched in 2006 and has been updated several times to improve usability and there have been initiatives to encourage hospital participation to ensure information is updated consistently. Recently, HRTS has been developing connectivity between state hospital EHR systems to automatically update bed availability in real-time. This will reduce the reliance upon daily manual updates. Additionally, HRTS is in the process of implementing a Patient Bed Matching System (PBMS) to support electronic referrals for behavioral health beds. Both the real-time availability and PBMS is expected to be completed in 2022. Participation in HRTS is voluntary but it is accessible to MCTs, crisis stabilization units, hospital EDs, and psychiatric units in hospitals.
 - **Colorado and New Mexico.**
 - ◆ **Crisis Text Lines.** In Colorado, when someone engages with their text line, they will receive a response from a live person. Reports indicate that it can cost three times as much to implement a crisis text line when compared to the cost to implement a voice only crisis hotline due to the additional human resources required to respond to the texts.⁵¹¹ To avoid this additional cost, yet still reach youth and young adults in need of crisis services, New Mexico launched an asynchronous crisis text line, meaning that instead of relying on humans to respond to texts, a bot responds and is able to connect

⁵⁰⁹ <https://www.nasmhpd.org/content/tti-2019-bed-registry-project-fact-sheets-and-full-report>

⁵¹⁰ https://www.nasmhpd.org/sites/default/files/Tennessee_BedRegistry.pdf

⁵¹¹ Neylon, K.A. (2020). Using Technology to Improve the Delivery of Behavioral Health Crisis Services in the United States. Alexandria, VA: National Association of State Mental Health Program Directors.

individuals to appropriate levels of crisis care.⁵¹² Several other states, including Maine, South Dakota, New York, Utah, and Connecticut offer access to crisis call centers via text or chat options. Access to online chat functions are made available on a state crisis hotline website.

- **Expansion of FindHelpNowKY.org.** Currently, KIPRC is working on contract in conjunction with DBHDID and the Kentucky 988 project team to update the FindHelpNowKY.org website further to ensure that community-level resource information is available to all crisis call takers. The FindHelpNowKY.org website will be integrated into the current website. Once the unified platform is developed, the state will analyze cost and feasibility of integrating the website. The update will include:
 - ♦ Additional SUD and mental health provider information at the local level.
 - ♦ Ability for providers to voluntarily update bed and appointment availability on a daily basis.
 - ♦ An outreach specialist to assist in onboarding providers and support the availability updates if providers have not been responsive to automated update requests.

Call center features recommended by Kentucky 988 stakeholders:

- A mechanism for measuring call taker wellness.
- Resources to serve clients who are deaf or hard of hearing, such as qualified interpreters, on-video interpreting, etc.
- Abandoned call distinguished from unanswered calls.;
- A list of potential dispositions for the call that the call taker may select.
- List of potential referrals provided.
- Language preference (e.g., American Sign Language, preferred interpreters).

Recommendation: Kentucky authorities should create a technical and operational plan to address the needs identified in the technology assessment.

This suggested technical and operational plan should include challenges, technical requirements, and specifications in order to inform a request for proposal process to secure an appropriate vendor (or vendors) to provide the software solutions necessary to support a comprehensive MCI services infrastructure that meets best practice standards. The plan should address, at a minimum:

- Data access, management, and flow.
- Data governance, privacy, and security.
- Potential software vendors to meet the need.
- Feasibility analysis.
- Estimated costs and funding strategies.

⁵¹² <https://www.nasmhpd.org/sites/default/files/2020paper3.pdf>

Once a more established definition of MCI services is established, KDMS should evaluate what existing data collection methods or dashboards could be utilized. Once a determination is made on the solution, then KDMS should determine what specific measures should be tracked based upon accessible data to ensure the proper administering of MCI services. Specific targets for the measures should not be established until baseline data is gathered as existing data on MCI services is not accurate or all encompassing.

Recommendation: Kentucky authorities may explore how to best leverage available federal funding for MCI technology infrastructure needs.

CMS is committed to assisting states with procurement or development of technology systems that support mobile crisis services. On December 28, 2021, CMS released SHO Letter #21-008 Re: Medicaid Guidance on the Scope and Payments for Qualifying Community-Based Mobile Crisis Intervention Services.⁵¹³ The letter describes that State Medicaid Agencies IT System costs may be eligible for enhanced federal financial participation (FFP), which allows 90/10 enhanced match for the design, development, and implementation of Medicaid Enterprise Systems initiatives that contribute to the economic and efficient operation of the program, including technology supporting implementation of crisis call centers, community-based mobile crisis intervention services, and crisis stabilization centers, including the maintenance and operations of these services.⁵¹⁴

The letter offers these examples of costs that may be eligible for the enhanced match:

- Systems in support of establishing and/or improving crisis call centers that can enable Medicaid beneficiaries to access mobile crisis teams.
- Systems integration activities in support of the g88 activities.
- Providing cell phones or iPads to state staffed mobile crisis teams to facilitate telehealth services with a clinician at another location during a crisis intervention.
- Developing and implementing software applications to facilitate communication between crisis call centers and mobile crisis providers and supervisory clinicians with mobile crisis team staff.
- Implementing text and chat technologies that many beneficiaries, including youth, may be more comfortable using as part of the services offered by crisis call centers.
- Implementing accessible technologies for individuals with disabilities.

Specific projects that may qualify include:

- Implementation of real-time GPS technology.
- Implementation or expansion of a statewide bed registry.
- Integration of other data sources, such as state systems or a health information exchange.

⁵¹³ SHO# 21-008. Medicaid Guidance on the Scope and Payments for Qualifying Community-Based Mobile Crisis Intervention Services. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf>

⁵¹⁴ When securing MES funding, it may be necessary for KDMS to meet outcome-based certification for certain technology implementations or define outcome measures to track the impact or progress of the implementation. This may be subject to cost allocation if the solution will be used by non-Medicaid members or providers. Costs associated to supporting non-Medicaid members may need to be passed on to the appropriate providers or organization utilizing the system. States are encouraged to work with CMS directly on funding and cost allocation proposals.

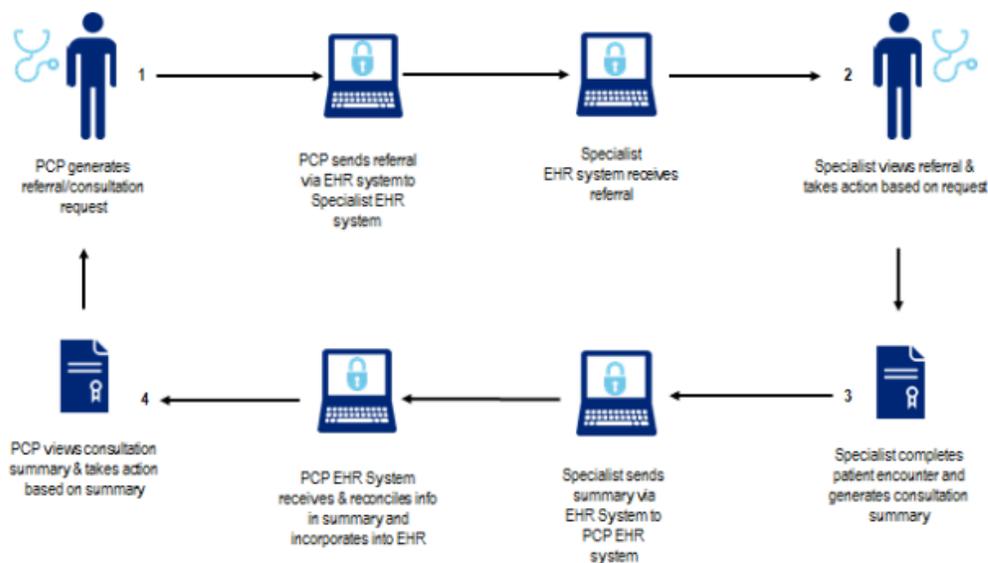
Recommendation: Kentucky authorities should assess the broader landscape of technology availability and data sharing across the behavioral and physical health continuum of care, namely the use of EHRs and HIE, and identify potential use cases that leverage existing infrastructure to expand the MCI system of care.

As use cases are identified, workgroups should be formed to develop data use and information-sharing agreements to ensure that information can be legally shared and implementation best practices, and to explore the possibility of creating a shared database.

Awareness of KHIE among CMHCs and utilization of the HIE for MCI services is low, however, the majority of CMHCs are connected. There may be an opportunity for additional discussion with the CMHCs’ CIOs or other IT contacts to understand what data sources are integrated into the patient records today and identify other ways in which the statewide HIE infrastructure can be leveraged for crisis response. It may also be beneficial for CMHC MCTs to receive training on how to use KHIE information through the KHIE portal as this may be another access point.

Often times mobile crisis call centers and behavioral health providers use different case management systems and EHRs, which can limit data exchange. HIE is a useful tool to enable basic data sharing to inform the referral process. Closing the loop on a referral involves the sending provider receiving a report from the receiving provider after completion of the visit that resulted from the referral. This has long been a common practice in clinics, with specialists faxing encounter reports to the PCP after they see one of the PCP’s patients. This is important for care coordination and ensures the patient will receive any necessary follow-up care. However, it has always been a time-consuming process because it requires printing, faxing, and scanning, and it does not involve the exchange of discrete data. Additionally, upwards of 50% of referrals are incomplete, and that may be due to missing information, misdirected referrals, or faulty communication.

Figure 47. Closing the Loop on Referrals in Primary and Specialty Care



The need to close the loop on referrals expands beyond coordination between physical, mental, and behavioral health providers, but also outside agencies that provide support programs within the community to address social needs or other factors that contribute to poor health outcomes.

A closed-loop referral management system can provide a way for healthcare providers to refer patients and send patient information to community-based organizations that can help serve a client's needs that fall outside of the clinical workflow. The community-based organization or agency can then use the system, much like what is outlined above, to confirm that the referral was completed and share an outcome.

Resources

States are leveraging HIE infrastructure to support behavioral health and crisis response in various ways:

- **Arizona** Medicaid Agency (AHCCCS) has partnered with the statewide HIE, 2-1-1 Arizona, and the Crisis Response Network to create a statewide close-loop referral system that is integrated with the statewide HIE, Contexture. The system supports the state's Whole Person Care Initiative, which focuses on the role social risk factors play in influencing individual health outcomes. The system's resource directory is informed by Arizona 2-1-1, which includes services related to food insecurity, homelessness, health care and mental health services, and rent and utility assistance programs- as examples. RBHAs should participate in a data and information sharing system, connecting crisis providers and member physicians through a health information exchange such as Arizona's statewide HIE, Contexture (formerly Health Current).⁵¹⁵ RBHAs could also utilize the AHCCCS-Approved Statewide Closed-Loop Referral System (CLRS) that is operated by Contexture and actively promote provider network utilization of the CLRS to properly refer members to Community Based Organizations providing services addressing social risk factors of health. The CLRS is "designed to connect healthcare and community service providers to streamline the referral process, foster easier access to vital services and provide confirmation when social services are delivered."⁵¹⁶
- **Rhode Island and Arizona** have used their existing health information exchange networks to support statewide bed registries as hospitals are often already connected and sending data to the HIE.
- **Washington DC** has legislatively mandated participation with the HIE as a part of certification requirements for crisis service providers under the 1115 Behavioral Health Transformation Program.

Recommendation: Kentucky authorities should assess and evaluate current broadband availability in areas of greatest need, and work with the Kentucky Broadband Initiative to explore ways of accelerating broadband availability.

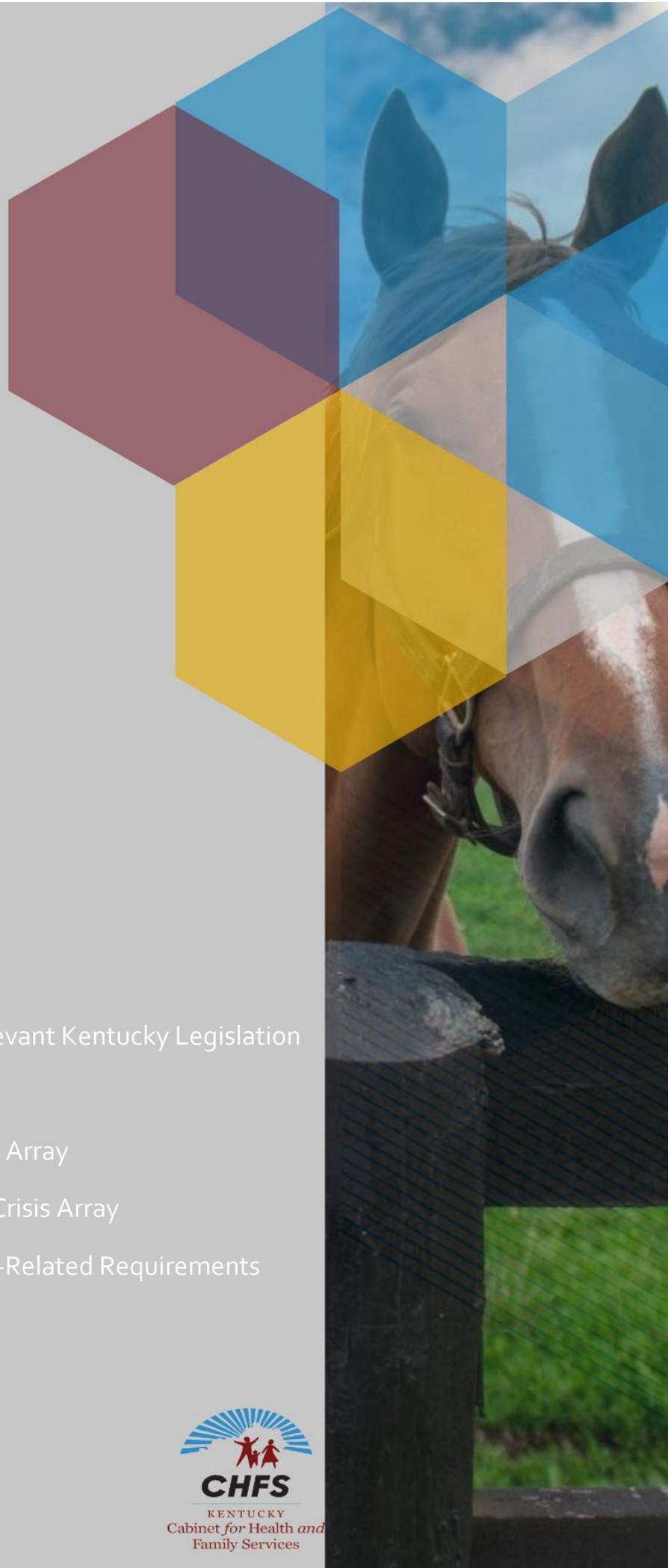
The rural areas and the natural topography of Kentucky makes it difficult to ensure that MCTs have coverage at all times to support telehealth expansion for both patients and providers, as well as supporting GPS-enabled MCI services in the field. Kentucky authorities should ensure ongoing

⁵¹⁵ <https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/behavioralhealth.html>

⁵¹⁶ <https://healthcurrent.org/sdoh/>

stakeholder engagement, establishment of a policy framework that creates goals and direction, planning and capacity building, funding strategies and operations, and program evaluation as part of a robust broadband expansion program.⁵¹⁷

⁵¹⁷ How States are Expanding Broadband Access. Pew Research. February 27, 2020.



Appendix

Appendix A: Acronym List

Appendix B: Information Resources

Appendix C: Stakeholder Statistics

Appendix D: Grants Appendix E: MCI Relevant Kentucky Legislation

Appendix F: Data Sources

Appendix G: Kentucky CMHC Adult Crisis Array

Appendix H: Kentucky CMHC Children's Crisis Array

Appendix I: Kentucky MCO Contract MCI-Related Requirements

Appendix J: Glossary

Appendix A: Acronym List

Acronym	Term
ACE	Adverse Childhood Experiences
ACT	Acute Care Team
ACT	Assertive Community Treatment
AMI	Any Mental Illness
AMSR	Assessing and Managing Suicide Risk
AOC	Administrative Office of the Courts
APRN	Advanced Practice Registered Nurse
ARC	Addiction Recovery Act
ARPA	American Rescue Plan Act
ART	Accelerated Resolution Therapy
ASAM	American Society of Addiction Medicine
ASIST	Applied Suicide Intervention Skills Training
ASL	American Sign Language
ASU	Addiction Stabilization Unit
BCBS	Blue Cross Blue Shield
BH	Behavioral Health
BHSO	Behavioral Health Services Organization
BIPOC	Black, Indigenous, and People of Color
BRFSS	Behavioral Risk Factor Surveillance System
CADC	Certified Alcohol and Drug Counselor
CAHOOTS	Crisis Assistance Helping Out On The Streets Program
CALM	Counseling Access to Lethal Means
CAMS	Collaborative Assessment and Management of Suicidality
CARF	Commission on Accreditation of Rehabilitation Facilities
CBT	Cognitive Behavioral Therapy
CCAIT	Client-Centered Alternative Intensive Treatment
CCBHC	Certified Community Behavioral Health Clinic
CEU	Continuing Education Unit
CHFS	Cabinet for Health and Family Services
CHIP	Children's Health Insurance Program
CIT	Crisis Intervention Team
CLAS	Culturally and Linguistically Appropriate Services
CME	Continuing Medical Education
CMHC	Community Mental Health Clinic
CMS	Centers for Medicare & Medicaid Services
CNE	Continuing Nursing Education
COD	Co-Occurring Disorders
CPE	Continuing Professional Education
CPEP	Comprehensive Psychiatric Emergency Program

Acronym	Term
CPP	Community Paramedicine Program
CRBH	Cumberland River Behavioral Health
CRRU	Crisis & Residential Recovery Unit
CSU	Crisis Stabilization Unit
CSW	Certified Social Worker
CT-SP	Cognitive Therapy for Suicide Prevention
CY	Calendar Year
DAIL	Department for Aging and Independent Living
DBHDID	Department for Behavioral Health, Developmental and Intellectual Disabilities
DBT	Dialectical Behavior Therapy
DCBS	Department for Community Based Services
DDE	Direct Data Entry
DDID	Division of Developmental and Intellectual Disabilities
DEA	Drug Enforcement Administration
DID	Developmental and Intellectual Disabilities
DJJ	Department of Juvenile Justice
DMS	Department of Medicaid Services
DOC	Department of Corrections
DOVE	Diversion Options:Voice and Empowerment Delegates
DPH	Department of Public Health
ECHO	Extension for Community Healthcare Outcomes
ED	Emergency Department
EHR	Electronic Health Record
EmPATH	Emergency Psychiatric Assessment, Treatment, and Healing
EMS	Emergency Medical Services
ENS	Event Notification Systems
EQRO	External Quality Review Organization
ESOL	English to Speakers of Languages
FFS	Fee for Service
FMAP	Federal Medical Assistance Program
FMD	Frequent Mental Distress
FTE	Full-Time Equivalent
FYSB	Family and Youth Services Bureau
GPS	Global Positioning System
HCBS	Home and Community-Based Services
HCPCS	Healthcare Common Procedure Coding System
HIE	Health Information Exchange
HPSA	Health Professional Shortage Areas
HRSA	Health Resources and Services Administration
HSTD	Human Service Transportation Delivery
HUD	Housing and Urban Development
ICU	Intensive Care Unit

Acronym	Term
I/DD	Intellectual and Developmental Disabilities
IEP	Individual Education Program
IOP	Intensive Outpatient Program
IT	Information Technology
KAR	Kentucky Administrative Regulations
KARP	Kentucky Association of Regional Programs
KDMS	Kentucky Department of Medicaid Services
KHA	Kentucky Hospital Association
KHC	Kentucky Housing Corporation
KHIE	Kentucky Health Information Exchange
KIPRC	Kentucky Injury Prevention and Research Center
KORE	Kentucky Opioid Response Effort Grant
KRCC	Kentucky River Community Care
KRS	Kentucky Revised Statutes
KTEP	Kentucky Transformational Employment Program
KY	Kentucky
KYPSS	Kentucky Youth Peer Support Specialist
LABA	Licensed Assistant Behavioral Analyst
LBA	Licensed Behavioral Analyst
LCADC	Licensed Clinical Alcohol and Drug Counselor
LCADCA	Licensed Clinical Alcohol and Drug Counselor Associate
LCC	Lutheran Church Charities
LCSW	Licensed Clinical Social Worker
LEO	Law Enforcement Officer
LEO	Limited Emergency Operation
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Queer, Questioning
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersexed
LLC	Limited Liability Company
LMFT	Licensed Marriage and Family Therapist
LMFTA	Licensed Marriage and Family Therapist Associate
LP	Licensed Psychologist
LPA	Licensed Psychologist Associate
LPAT	Licensed Professional Art Therapist
LPATA	Licensed Professional Art Therapist Associate
LPCC	Licensed Professional Clinical Counselor
LPCCA	Licensed Professional Clinical Counselor Associate
LPP	Licensed Psychological Practitioner
MAT	Medication-Assisted Treatment
MCCC	Mountain Comprehensive Care Center
MCI	Mobile Crisis Intervention
MCO	Managed Care Organization
MCT	Mobile Crisis Team
MDE	Major Depressive Episode

Acronym	Term
MFTA	Marriage and Family Therapist Associate
MHA	Mental Health America
MHID	Mental Health or Individuals with an Intellectual Disability
MI	Motivational Interviewing
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
MOUD	Medication for Opioid Use Disorder
NAMI	National Alliance on Mental Illness
NEMT	Non-Emergent Medical Transport
NIMH	National Institute of Mental Health
NSDUH	National Survey Drug Use and Health
NSPL	National Suicide Prevention Line
OFS	Omni Family of Services
ODD	Opioid Use Disorder
PA	Physician's Assistant
PAMA	Protecting Access to Medicare Act
PBIS	Positive Behavioral Intervention Services
PCP	Patient-Centered Planning
PHE	Public Health Emergency
PPS	Prospective Payment System
PRTF	Psychiatric Residential Treatment Facility
PSAP	Public-Safety Answering Point
PSS	Peer Support Specialist
PT	Provider Type
PUSH	Perkins Supported Housing Program
QMHP	Qualified Mental Health Professional
QPR	Question, Persuade, Refer
QRT	Quick Response Team
RCD	Residential Chemical Dependency
RCSU	Residential Crisis Stabilization Unit
REALD	Race, Ethnicity, Language, and Disability
RFI	Request for Information
RN	Registered Nurse
RPC	Regional Prevention Center
RVBH	River Valley Behavioral Health
SAFY	Specialized Alternatives for Families and Youth
SAMHSA	Substance Abuse and Mental Health Services Administrations
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDOH	Social Determinants of Health
SED	Serious Emotional Disturbance
SFY	State Fiscal Year
SHO	State Health Officer
SIB	Self-Injurious Behavior

Acronym	Term
SICM	Specialized Intensive Case Management
SIPS	Structured Interview for Psychosis Risk Syndromes
SMI	Serious Mental Illness
SMVF	Service Members/Veterans/Their Families
SOGI	Sexual Orientation and Gender Identity
SPA	State Plan Amendment
SPARS	Performance Accountability and Reporting System
SSP	Syringe Service Program
SUD	Substance Use Disorder
TAC	Technical Assistance Collaborative
TFC	Therapeutic Foster Care
TIC	Trauma Informed Care
VA	Veteran's Association

Appendix B: Information Resources

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Appendix C: Stakeholder Statistics

Appendix C.1: Stakeholder Engagement Summary

Stakeholder Engagement Method	Events Held	Unique Attendees / Responses
Request for information	NA	29
Pre-interview questionnaires – 13 CMHCs represented	NA	32
All interviews	29	81
CMHC interviews	14	47
MCO interviews	6	15
Other interviews	9	19
Roundtables – 29 organizations represented	5	35

Appendix C.2: Summary of Interviews Conducted

Interview Type	Interviews Conducted	Unique Stakeholders
CMHC	14	47
MCOs	6	15
CMHC Experts	1	2
BHSO Small Group Interview	1	7
EMS	2	2
LEO	2	2
KDE	1	3
Foster Care	1	2
KHIE	1	1

Appendix C.3: Summary of Roundtable Events

Roundtable	Unique Organizations	Unique Stakeholders
Roundtable: Youth	4	4
Roundtable: Adults	2	2
Roundtable: I/DD	16	19
Roundtable: SUD/Non-billed BHSOs	4	5
Roundtable: Housing	3	5

Appendix C.4: List of Participating Organizations by Mode of Engagement

Organization	Interview Participants	Roundtable Participants	Pre-Interview Questionnaire Responses	Request for Information Responses
CMHCs				
CMHC Region 1: Four Rivers	2	1	2	
CMHC Region 2: PennyRoyal	3	1	2	
CMHC Region 3: Rivervalley	3	1	1	
CMHC Region 4: Lifeskills	2	1	3	
CMHC Region 5: Communicare	6		5	
CMHC Region 6: Seven Counties	5	5	4	
CMHC Region 7: NorthKey	4		2	
CMHC Region 8: Comprehend	1		1	
CMHC Region 9/10: Pathways	4	2	3	
CMHC Region 11: Mountain Comprehensive Care	3		3	
CMHC Region 12: Kentucky River Community Care	3	1	4	
CMHC Region 13: Cumberland River Behavioral Health	2	2	2	
CMHC Region 14: Adanta	3	3		
CMHC Region 15: New Vista	6	2		
MCOs				
Aetna Better Health of KY	2			1
Anthem BlueCross BlueShield	1			
Healthy Human Horizons	3			
Passport Health Plan/Molina	2			
UnitedHealthcare Community Plan of KY	1			
Wellcare of KY	6			
Commonwealth-Level Organizations				
AOC				5
CHFS	1			1
DBHDID*		1		7
DCBS				2
DJJ				4
DOC				1
KDMS*				5
Behavioral Health Organizations and Other Community Organizations				
Advocacy Action Network		1		
ARC	4			
Children's Alliance		1		

Organization	Interview Participants	Roundtable Participants	Pre-Interview Questionnaire Responses	Request for Information Responses
Frontier Health		1		
KARP Association Mental Health Centers	1			
Kentucky Health Resource Alliance	1			
Kentucky State Police	1	1		
Kentucky Voices for Health		1		
Kentucky Youth Advocates		1		
KY Housing Authority		2		
Lexington Fire Department	1			2
Mental Health of America-Kentucky		2		
Omni Community Health	1			
Operation Unite		1		
Perry County Ambulatory Authority				1
Ramey Estep Homes	1			
UofL Health Peace Hospital		2		
Welcome House of KY		2		
Wellfront Readiness Solutions		1		
Wellspring	1	1		

*KDMS and DBHDID were active throughout the entire project and were engaged on a regular-basis outside of the regular stakeholder engagement activities. KDMS joined all interviews and roundtables.

Appendix D: Grants

Appendix D.1: Garrett Lee Smith (GLS) Campus Suicide Prevention Grant

Grantee: UNIVERSITY OF KENTUCKY

Program: Garrett Lee Smith (GLS) Campus Suicide Prevention Grant

City: LEXINGTON

State: KY

Grant Award Number: 1 H79 SM084013-01

Congressional District: 6

FY 2021 Funding: \$101,967

Project Period: 2021/09/30 - 2024/09/29

University of Kentucky: Connecting and Networking for Suicide Prevention (UK-CAN) will create a new network at the University of Kentucky to decrease suicide attempts and deaths, increase help-seeking, and decrease stigma around mental health concerns on campus. This innovative project brings together expertise from across campus and is led by a team with substantial national experience in suicide prevention. UK-CAN is a new initiative that aims to reduce suicides by: 1) Increasing network infrastructure; 2) Increasing training to respond effectively to students with mental and substance use disorders; 3) Increasing voluntary screening and assessment; 4) Providing outreach services to inform college students about available services; 5) Promoting linkage to hotlines and 6) Training campus and community clinicians in evidence-based practices. UK is the land-grant flagship university in the Commonwealth of Kentucky with an enrollment of more than 31,000 students. This project will serve all students at UK with special emphasis on those seeking mental health treatment, first-year students, veterans, diverse students and students in specific units such as Engineering, Nursing, Social Work and Agriculture. Online pathways will be developed to highlight wellness and mental health events, and guide students through completing these pathways. At least 1,000 students, faculty and staff will receive training each year with support from this project -- including a variety of gatekeeper approaches and evidence-based training for practicing clinicians and those in training. Campus infrastructure developed and further refined will strengthen continuity between units and collaboration in times of crises. UK: CAN will operate with the support of a wide array of campus partners and university administration at the highest levels. Through Connecting and Networking, our campus will see more students connected to university resources and each other, and a broad-based network of support for those at risk of suicide.

Appendix D.2: Mental Health Awareness Training Grants

Grantee: MENTAL HEALTH AMERICA OF NORTHERN KENTUCKY AND SOUTHWEST OHIO, INC

Program: Mental Health Awareness Training Grants

City: COVINGTON

State: KY

Grant Award Number: 1 H79 SM084432-01

Congressional District: 4

FY 2021 Funding: \$125,000

Project Period: 2021/09/30 - 2026/09/29

Mental Health America of Northern Kentucky & Southwest Ohio (MHA) will launch "MHFA for High Risk Populations", a five-year project using the evidenced based practice, Mental Health First Aid (MHFA), for the target population: Active military, veterans, first responders and other high-risk frontline professionals and their family members. The geographic region will be throughout Southwest Ohio (Brown, Butler, Champagne, Clark, Clermont, Clinton, Green, Hamilton, Highland, Logan, Montgomery, Preble and Warren Counties) and Northern Kentucky (Boone, Campbell, Carroll, Gallatin, Grant, Kenton, Owen, and Pendleton Counties). Project goals are: increase the number of active military (and their families), veterans (and their families) and first responders who receive mental health awareness training so that trainees increase their capacity to address their own mental health needs, the needs of veterans and first responders and the needs of those with whom they come into contact; increase help-seeking behaviors and access to resources by establishing or strengthening linkages between active military (and their families, veteran (and their families), and first responders and community based mental health and prevention services; and increase the capacity of the region's ability to provide MHFA as an affordable and accessible training. Project objectives are: conduct outreach and promotions to attract a minimum of 600 individuals annually (or 3,000 over the life of the grant) from the target populations to register for and complete MHAT training; equip 600 individuals annually (or 3,000 over the life of the grant) from the target population with MHAT (Mental Health First Aid or Youth Mental Health First Aid- Fire/EMS/Veteran/Public Safety Services Modules); assist a minimum of 200 people annually experiencing risks of depression, anxiety, suicidal ideation or other mental health or substance abuse crises with access to information and linkages through the Help for Heroes helpline or MHA's information and referral service (totaling 1,000 through the life of the grant); connect with community based mental health and prevention services twice annually throughout the life of the grant to review linkages, revise, and maintain a standard guide to mental health and prevention services (including tool kit for first aiders); certify 2 new instructors in MHFA annually throughout the life of the grant; provide 6 instructors with the Fire/EMS, Veteran, and Public Safety Services module training; educate regional stakeholders on target population need for MHAT through participation in a minimum of 12 stakeholder meetings/trainings/conferences, etc. annually throughout the life of the grant; and update the MHFA Sustainability Plan, first drafted through AWARE-C and

revised through the Ohio Statewide MHFA Collaborative effort once annually throughout the life of the grant.

Appendix D.3: Project AWARE

Grantee: KENTUCKY STATE DEPARTMENT OF EDUCATION

Program: Project AWARE

City: FRANKFORT

State: KY

Grant Award Number: 1 H79 SM081958-01

Congressional District: 6

FY 2019 Funding: \$1,800,000

Project Period: 2019/04/30 - 2024/04/29

The purpose of the Kentucky AWARE 2018 project is to increase awareness of mental health issues among school-age youth and to support school personnel, parents, and other adults who interact with youth to identify, respond, and refer youth and their families to needed services. In the latest Kids Count Data Book, Kentucky ranks 37th nationally in overall child wellbeing, a drop from last year's ranking of 34th. Youth in the 3 partner LEAs present with a variety of needs for social and emotional learning, mental health and trauma informed care. All have more than 45% of students receiving free or reduced lunch, rates of out-of-home care are the highest in history, and rates of court and juvenile justice involvement are concerning. The 3 AWARE LEAs, Warren, Bullitt and Henderson, are among Kentucky's largest districts. Like most of Kentucky, these LEAs contain largely rural to suburban-rural populations. Two of the three LEAs are located in areas designated by HRSA as having a shortage of mental health professionals. In collaboration with statewide efforts under AWARE, the 3 LEAs are taking steps to align school mental health supports and processes with existing school wide PBIS (Positive Behavioral Interventions and Supports) practices, and are committed to implementing trauma informed practices, Youth Mental Health First Aid training for school adults, and improving social emotional skills for all students. Kentucky AWARE will serve 37,556 students annually through universal, targeted, and direct interventions. Through the provision of training and other supports, the project will impact 375 school administrators, 3292 school staff, and over 1000 parents and community members. Goal 1: Increase the mental health (MH) awareness & literacy of school staff & administrators, parents, agency partners, & community members who interact with school-aged youth by training individuals to respond effectively to youth MH needs Goal 2: Increase statewide capacity and sustainability of the school and behavioral health treatment workforces to implement and integrate trauma-informed principles into practice. Goal 3: Increase access to evidence-based, culturally competent, and developmentally appropriate community- and school-based behavioral health services and supports in each partner LEA. Goal 4: Enhance resiliency among school-age youth by integrating and implementing social-emotional learning skills into the general education curricula and increase family and student engagement. Goal 5: Increase access and use of school-based MH promotion,

prevention, early intervention, and treatment strategies by creating or enhancing a proactive multi-tiered system of support (MTSS) in schools, which integrates academic, positive behavior and MH supports to meet the needs of students.

Appendix E: MCI Relevant Kentucky Legislation

Appendix E.1: Pending Legislation

KY House Bill 373 “an act relating to mental health and making an appropriation therefor” – This slight partisan bill (Democrat 10-4) was introduced January 26, 2022. If passed it will establish a 988 mental health crisis hotline, board and membership. If passed it will also create restricted funding and establish a 988 service charge. *HB 373 was returned to Appropriations & Revue on 3/14/22 and is currently pending House Appropriations and Revenue Committee. Progression at 25%.*⁵¹⁸

Kentucky House Bill 645 “An act relating to mobile crisis services”: This proposed bill with 93-7 support in the House is currently being considered. If passed, it was create a mobile crisis loan fund for CMHCs with certain requirements and repayment terms. The proposed funding is \$2.8 million for 2022-2023 and \$3 million for 2023-2024. *HB645 was introduced to Health & Welfare on 3/16/22.*⁵¹⁹

Appendix E.2: Current Legislation

Kentucky School Safety and Resiliency Act: The Kentucky General Assembly passed the School Safety and Resiliency Act (Senate Bill 1, SB1) in 2019. Requires that all school districts must have at least one mental health professional for every 1,500 students by July 2021, with the ultimate goal of at least one provider per 250 students. In 2020, Kentucky state government allocated \$7.4 million from its annual budget to the hiring of school-based mental health providers.⁵²⁰ Training Requirements in the bill include: suicide prevention training, trauma-informed approaches to education, school counselors, and student-involved trauma.^{521 522}

State Senate Bill 42 “An act relating to student health and safety”: Requires hotline information for suicide prevention, sexual assault, and domestic violence on school-issued student IDs for public schools and public universities in Kentucky. This change is required for grades 6-12 and Kentucky-university students. Inspiration for SB42 was the statistic provided by the American Foundation for Suicide Prevention: suicide is the second leading cause of death for Kentuckians aged 15-34 and every 12 hours someone in Kentucky loses their life to suicide. *Signed into legislation by the Governor on 3/27/2020*^{523 524}

⁵¹⁸ <https://legiscan.com/KY/bill/HB373/2022>.

⁵¹⁹ <https://apps.legislature.ky.gov/record/22RS/hb645.html>.

⁵²⁰ Mental Health Technology Transfer Center Network (MHTTC): Recruitment and Retention of School Mental Health Providers (Southeast HHS Region 4) [file:///C:/Users/Afarrugia/Downloads/SchoolMHWorkforceReport_2021%20\(1\).pdf](file:///C:/Users/Afarrugia/Downloads/SchoolMHWorkforceReport_2021%20(1).pdf).

⁵²¹ [https://education.ky.gov/school/sdfs/Pages/School-Safety-and-Resiliency-Act-\(Senate-Bill,-2019\).aspx](https://education.ky.gov/school/sdfs/Pages/School-Safety-and-Resiliency-Act-(Senate-Bill,-2019).aspx).

⁵²² <https://apps.legislature.ky.gov/recorddocuments/bill/19RS/sb1/bill.pdf>.

⁵²³ Youth Roundtable and DOE Interview February through Mar2022.

⁵²⁴ <https://apps.legislature.ky.gov/record/20rs/sb42.html>.

Kentucky House Bill 352 “An act relating to appropriation measures...”: HB352 was introduced to the House in January 2020. If passed, HB 352 would allocate additional funds to establish or expand school mental health programs. *Delivered to Secretary of State 4/15/2020.* ⁵²⁵

⁵²⁵ <https://apps.legislature.ky.gov/record/20rs/hb352.html>

Appendix F: Data Sources

Data	Data Type(s)	Source
Aetna Behavioral Health Hotline Service Performance Indicators	Crisis hotline information	Aetna
America's Health Rankings, National Mental Health Providers, as of March 25, 2022	Mental health providers per capita, ranked by state	America Health Rankings
Anthem Behavioral Health Population Management Metrics	Behavioral performance and cost metrics	Anthem
CMHC and CCBHC Cost reports	Cost report data	KDMS
CMHC Mental Health Substance Abuse Codes and Units of Service	Fee schedule	KDMS
DBHDID Emergency Transportation Data	Staff positions dedicated to crisis services	DBHDID
HRSA Data by Geography, Kentucky, Shortage Areas, as of March 25, 2022	County level health shortage areas	HRSA
Humana Health Plan Network Adequacy and Geo Mapping Data	Behavioral health provider information	Humana
Kentucky Data Warehouse Monthly Membership Counts by County, Run Date 2/8/2022	Medicaid membership counts	KDMS
Kentucky Medicaid FFS Behavioral Health & Substance Abuse Services Outpatient Fee Schedule	Fee schedule	KDMS
MCO Quality Reports	Crisis hotline information	KDMS
Medicaid Provider Enrollment Data provided by KDMS to Myers and Stauffer on 3/10/2022	Aggregate and ZIP-code level data	KDMS MMIS
Regional Boards for Mental Health or Individuals With an I/DD	County assignments of CMHC regions	KDMS
SFY 2019 – 2021 Data Query of MCI Claims	Summary level claim and expenditure totals for KDMS identified crisis codes	KDMS MMIS

Appendix G: Kentucky CMHC Adult Crisis Array

SFY 2022 Kentucky Community Mental Health Center

Adult Crisis Services Array

● = Service is available in every county in the CMHC Region as a service element of the CMHC's emergency services program.

○ = Service is available in one or more counties in the CMHC Region as a service element of the CMHC's emergency services program.

Region	1	2	3	4	5	6	7	8	10	11	12	13	14	15	
Clinical Services															
Number of counties in which agency has an outpatient office, CSU, or other office space to provide crisis services.	● 9 of 9	○ 4 of 8	○ 6 of 7	● 10 of 10	● 8 of 8	○ 6 of 7	● 8 of 8	● 5 of 5	● 10 of 10	● 5 of 5	● 8 of 8	● 8 of 8	● 10 of 10	○ 13 of 17	○ 17
Crisis Assessment via Telehealth (# counties)	9	8	7	10	8	7	8	5	10	5	8	8	10	17	
Crisis Intervention (Walk-In After Business Hours)	○	○	○	○	○	○		○	○	○	○	○	○		
Crisis Intervention (Walk-In During Business Hours)	●	○	○	●	●	●	●	●	●	●	●	●	○	○	
Follow-Up, Outreach and Support	●	●	○	●	●	●	●	●	●	●	●	●	●	●	
Intensive Outpatient Crisis Counseling		●			●	●	●	●	○	●	○	○	●	●	
Safety Planning for Suicide Risk	●	●	○	●	●	●	●	●	●	●	●	●	●	●	
Withdrawal Management	○			○	○	●			●		●	○			

Region	1	2	3	4	5	6	7	8	10	11	12	13	14	15
23-Hour Crisis Observation (Living Room Model)											○			
Community-Based Services														
Crisis Case Management	●	●	○		●	●	●	●			●	●	●	●
Mobile Crisis Services	●	●	●	●	●	●	●	●	●	●	●	●	○	●
Quick Response Team (# counties)	4				8			2	4	3		5		4
Transportation Services					●	○	●	●	●		●	●		○
Diversion from the Justice System														
Commitment Hearing Attendance					○	○					●			
Criminal Justice Drop-off Site(s)			○		○	○		○	○		○			○
Crisis Intervention Team (CIT)	○	●	●	●	●	●	●	●	○	●	●		○	●
Involuntary Hospitalization Evaluations	●	●	○	●	●	○	●	●	●	●	●	●	○	●
I/DD Crisis Prevention and Intervention														
Crisis Respite	All listed services are required to be included in the CMHC crisis services array.													
Debriefing														
Development of Behavior Intervention Strategies														
Environmental Assessment														
Functional Assessment														
Mobile Crisis														
Person-Centered Planning														

Region	1	2	3	4	5	6	7	8	10	11	12	13	14	15
Technical Assistance and Resource Linkage														
Transportation														
Prevention Services														
Medical Care/Evaluations														
Medical Services														
Medical Evaluation by Physician or APRN within 24 Hours or Next Business Day		○	●		●	○	○	○	●	○	●	○		○
Partial Hospitalization			○					○						
Psychiatric Evaluation and/or Medication Management within 24 Hours or Next Business Day (# counties)	3	4	7	10	8	7	1	5	10	5	8	8	10	●
Ready Access to a Physical Health Consultation		○	●	●	●	○	○	●	○	●	●	○		○
Ready Access to a Psychiatric Consultation	●	●	●	●	●	○	●	●	●	●	●	○	●	●
Peer Support														
Adult Peer Support	●	●	●	●	●	○	●	●	●	●	●	○	○	○
Family Peer Support			●	●	●	○	●	●	●	●		○	○	
Youth Peer Support	●		●	●	●				●	●		○		
Residential Crisis Stabilization														
Emergency Residential Crisis Care in an Emergency Apartment				○	○									○
Emergency Residential Crisis Care in a Personal Care Home		○								○				

Region	1	2	3	4	5	6	7	8	10	11	12	13	14	15
Emergency Residential Crisis Care in a Private/Contracted CSU								●						
Emergency Respite								●	○		○			
Residential Crisis Stabilization Unit	○		○	○	○				○	○	○	○	○	
23-Hour Beds			○								○			
Call Center Services														
Telephone Crisis Contact (Brief)	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Telephone Crisis Counseling (Brief)	●		●	●	●	●	●	●	●	●	●	●	●	●
Telephone Crisis Counseling (Extended)	●		●	○	●	●	●	●	●		●	●		●
Virtual Crisis Support - Text		●	●					●	●					
Virtual Crisis Support - Email			●		●						●			●
Virtual Crisis Support - Chat		●	●						●		●			
Warm Line	○	●	●		●				●		●	●	●	
Other Crisis Services														
Other, Please Describe: Crisis Outreach Team														○
Other, Please Describe:														
Other, Please Describe:														
Other, Please Describe:														

Appendix H: Kentucky CMHC Children's Crisis Array

SFY 2022 Kentucky Community Mental Health Center Children's Crisis Services Array

● = Service is available in every county in the CMHC Region as service element of the CMHC's emergency services program.

○ = Service is available in one or more counties in the CMHC Region as a service element of the CMHC's emergency services program.

Region	1	2	3	4	5	6	7	8	10	11	12	13	14	15	
Clinical Services															
Number of Counties in which the agency has an outpatient office, CSU or other office space to provide crisis services.	● 9 of 9	○ 4 of 8	○ 6 of 7	● 10 of 10	● 8 of 8	● 7 of 7	● 8 of 8	● 5 of 5	● 10 of 10	● 5 of 5	● 8 of 8	● 8 of 8	○ 9 of 10	○ 13 of 17	
Crisis Assessment via Telehealth (# counties)	9	8	6	10	8	7	8	5	10	5	8	8	10	17	
Crisis Intervention (Walk-In After Business Hours)	○	○	○	○	○	●		○	○	○	○	○	●		
Crisis Intervention (Walk-In During Business Hours)	○	○	○	●	●	●	●	●	●	●	●	●	●	○	
Intensive Outpatient Crisis Counseling		●	○		●	●	●	●	○	●			●	●	
Safety Planning for Suicide Risk	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Withdrawal Management															
Community-Based Services															
Crisis Case Management	●	●	●		●	●	●	●			●	●	●	●	
Intensive In-Home Services			●			●			●	●	●		●	●	

Region	1	2	3	4	5	6	7	8	10	11	12	13	14	15
Mobile Crisis	●	●	●	●	○	●	●	●	●	●	●	●	●	●
Quick Response Team (# counties)					8	7		2	5	3				5
Transportation Services					●	●	●	●	●		●	●		○
Diversion from the Justice System														
Commitment Hearing Attendance						●					●		○	
Criminal Justice Drop-off Site(s)			○		○	○		○			○			○
Crisis Intervention Team (CIT)	○	●	●	●	●	●	●	●	○	●	●		●	●
Involuntary Hospitalization Evaluations	○	●	○	●	●	●	●	●	●	●	●	●	○	●
I/DD Crisis Prevention and Intervention														
Crisis Respite	All listed services are required to be included in the CMHC crisis services array.													
Debriefing														
Development of Behavior Intervention Strategies (Behavior Support Plan)														
Environmental Assessment														
Functional Assessment														
Mobile Crisis														
Person-Centered Planning														
Technical Assistance/ Resource Linkage														
Transportation														
Prevention Services														
Medical Care/Evaluations														



Region	1	2	3	4	5	6	7	8	10	11	12	13	14	15
Medical Services														
Medical Evaluation by a Physician or APRN within 24 Hours or Next Business Day			●	○	●			○	●	○	●	○		○
Partial Hospitalization			○											
Psychiatric Evaluation and/or Medication Management within 24 Hour or Next Business Day (# counties)	3	4	7	10	8	7	1	5	10	5	8	8	10	17
Ready Access to a Physical Health Consultation			●	●	○	●		●	○	●	●			○
Ready Access to a Psychiatric Consultation	●	●	●	●	●	●	●	●	●	●	●	○	●	●
Peer Support														
Family Peer Support			●	●	●	●	●	●	●		●	○	○	
Youth Peer Support	●		●	●	●	●			●	●	●	○		○
Residential Crisis Stabilization														
Emergency Residential Crisis Care in a Private/Contracted CSU														
Emerg Residential Crisis Care in a Therapeutic Foster Care Home						●								
Emergency Respite				○	●			○	○					
Residential Crisis Stabilization Unit				○	○	○		○	○	○		○	●	
23-Hour Beds														
Call Center Services														
Telephone Crisis Contact (Brief)	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Telephone Crisis Counseling (Brief)	●		●	●	●	●	●	●	●	●	●	●	●	●
Telephone Crisis Counseling (Extended)	●		●	○	●	●	●	●	●		●	●		●

Region	1	2	3	4	5	6	7	8	10	11	12	13	14	15
Virtual Crisis Support - Text		●	●					●	●		●			
Virtual Crisis Support - Email			●		●						●			●
Virtual Crisis Support - Chat			●						●		●			
Warm Line		●	●		●	●			●		●	●	●	
Other Crisis Services														
Other, Please Describe: Crisis Outreach Team														○

Appendix I: Kentucky MCO Contract MCI-Related Requirements

KDMS has entered into new managed care contracts beginning in 2021 to provide healthcare services to Kentuckians who meet eligibility requirements for Medicaid. The contracts have been submitted to the Centers for Medicare & Medicaid Services for approval. The contracts and amendments for 2021 to 2024 for the six MCOs are located here: <https://chfs.ky.gov/agencies/dms/dpqq/Pages/mco-contracts.aspx>.

Each MCO contract with the Commonwealth was evaluated to determine the language included for MCI services. This section provides an overview of our findings, as well as recommendations for state consideration.

Myers and Stauffer found each MCO contract with the Commonwealth had standard language for crisis and mobile crisis services. Language included in the scope of work includes the following: the Contractor shall maintain a comprehensive network of behavioral health and substance abuse providers to provide outpatient (including intensive home services), intensive outpatient, substance abuse residential, case management, mobile crisis, residential crisis stabilization, assertive community treatment, and peer support services, as follows:

- Psychiatrists, psychologists, and LCSWs.
- LPCCs, LMFTs, LPPs, and LCADCs.
- Targeted case managers and certified family, youth and peer support providers.
- Behavioral health multi-specialty groups and BHSOs.
- Chemical dependency treatment centers.
- Psychiatric residential treatment facilities and residential crisis stabilization units (RCSUs).
- CMHCs.
- Multi-therapy agencies providing physical, speech and occupational therapies, which include comprehensive outpatient rehabilitation facilities, special health clinics, mobile health services, rehabilitation agencies and adult day health centers.
- Other independently licensed behavioral health professionals.

In addition to the language above, each contract also states that the contractor must provide services according to statute or administrative regulations, specifically RCSU services according to 907 KAR 15:075.

Furthermore, Aetna, which is the contractor managing the Supporting Kentucky Youth (SKY) program which serves all youth in Kentucky's child welfare and juvenile justice systems, has language on providing MCI services to Medicaid members. The SKY section of the Aetna contract also contains the following call center language not found in the other contracts "The SKY Contractor's call center job descriptions must detail the level and type of training related to Crisis calls, including how personnel are trained to recognize callers in Crisis and then manage triage. The SKY Contractor must have an

operational process through which emergency and Crisis calls are prioritized over routine calls, protocols that support warm transfers and technology that enables direct telephonic/computer connectivity to emergent and Crisis Intervention Services.”

Appendix J: Glossary

Term	Definition
Adverse Childhood Experience (ACE)	Potentially traumatic events that occur in childhood. Events may include violence, abuse, and growing up in a family with mental health or substance use problems. Toxic stress from ACEs can change brain development and affect how the body responds to stress, potentially leading to chronic health problems, mental illness, and substance misuse in adulthood. (CDC)
Any Mental Illness (AMI)	A mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment.
Behavioral Health	A state of mental/emotional being and/or choices and actions that affect wellness.
Behavioral Health Condition	An umbrella term for substance use disorders, addiction, and mental health conditions.
Cognitive Impairment	Experiencing difficulty with cognition. Examples include having trouble paying attention, thinking clearly, or remembering new information.
Continuum of Care	An integrated system of care that guides and tracks a person over time through a comprehensive array of health services appropriate to the individual's need. A continuum of care may include prevention, early intervention, treatment, continuing care, and recovery support.
Co-Occurring Disorder (COD)	The co-existence of both a mental illness and a substance use disorder or presence of multiple mental health diagnoses.
Crisis Case Management	Assistance and advocacy to access behavioral health, educational, vocational, legal, income, and other support programs that are essential to stabilizing an individual experiencing a behavioral health crisis.
Debriefing	A process that occurs after safety of the individual is no longer a concern and calm has been returned following a crisis event. The individual and their team meets to identify what may have contributed to or caused the crisis, and which interventions used were effective or ineffective.
Developmental Disability	Physical and/or mental impairments that begin before age 22, are likely to continue indefinitely, and result in substantial functional limitations in at least three of the following key areas: self-care (dressing, bathing, eating, and other daily tasks learning); walking/moving around; self-direction; independent living; economic self-sufficiency; and language.
Dual-Diagnoses	Having a mental health disorder and an SUD at the same time.
Evidence-Based Practice	Treatments that are supported by clinical research.
Frequent Mental Distress (FMD)	Defined as 14 or more self-reported mentally unhealthy days in the past 30 days. Associated with adverse health behaviors, increased use of health services, mental disorders (e.g. major depressive disorder), chronic diseases, and functional limitations. Also known as, Frequent Emotional Distress or Poor Mental Health Days.

Term	Definition
Intellectual Disability	A disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 18.
Intervention	An action intended to help treat or cure a condition.
Major Depressive Episode (MDE)	A period of two weeks or longer in which a person experiences certain symptoms of major depression.
Mental Health Condition	Patterns in moods, thinking, or behaviors that can affect daily functioning.
Natural Support	May include immediate family, extended family, friends, faith communities, neighbors, mentors at work or school, or acquaintances who play an encouraging role in an individual's life.
Neurodivergent	Refers to an individual who has a less typical cognitive variation such as Autism, ADHD, Dyslexia, Dyspraxia, etc.
Neurodiversity	A recognition that not all brains think or feel in the same way, and that these differences are natural variations in the human genome. A group of people are neurodiversity, an individual is not.
Peer	Refers to someone who shares the experience of living with a psychiatric disorder and/or addiction.
Peer Support	Process of giving and receiving encouragement and assistance to achieve long-term recovery. Offers emotional support, shares knowledge, teaches skills, provides practical assistance, and connects people with resources, opportunities, and communities of support.
Serious Emotional Disturbance (SED)	Persons under the age of 18, who have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-V, that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.
Serious Mental illness (SMI)	A mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI.
Trauma-Informed Care	A trauma-informed approach to care "realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved in the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization." The six key principles of a trauma-informed approach include: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical and gender issues.
Triage	Process of assigning a priority level to determine the urgency and type of response required to a crisis situation.