

# **Kentucky's Community Mental Health System Is Expanding and Would Benefit From Better Planning and Reporting**

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## Foreword

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Robert Sherman  
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Legislative Research Commission  
Frankfort, Kentucky  
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## Summary

On November 18, 2005, the Program Review and Investigations Committee directed staff to review Kentucky's community mental health and mental retardation centers.

According to the report,

- Kentucky has a comprehensive system for planning services, but state and regional groups' estimates of costs to satisfy the demand for services are not used in developing the budget.
- The number of persons served by the centers and the number of services are increasing at a greater rate than inflation-adjusted revenue.
- Adjusted for inflation, state safety net funding for those who cannot pay for services has decreased in recent years. The total cost of regions' charity care could not be calculated, however.
- The system statewide appears to be stable in terms of providing current services to current populations. The system's capacity to expand services or serve larger populations is questionable, particularly in some regions.

## Structure and Planning

Federal law created the community mental health and mental retardation system in 1963. According to state law, a combination of cities and counties may establish a regional community mental health and mental retardation services program, which may be administered by a board. Kentucky has 14 regional mental health and mental retardation boards, which are required to provide services regardless of a person's ability to pay. Services are provided through community mental health centers in the 14 regions, which correspond approximately with the area development districts.



The secretary of the Cabinet for Health and Family Services has statutory authority for oversight of board operations and certain funding decisions. Authority is exercised by the Department for Mental Health and Mental Retardation Services.

Federal laws and regulations affect planning, service delivery, and measurement of outcomes. The Community Mental Health Services block grant is an example of a federal program passed through the department to the boards.

Federal and state laws require that planning for mental health, substance abuse, and mental retardation or other developmental disabilities services take place at both the statewide and regional levels.

At the state level, the plan and budget for community services is developed by the department and is incorporated in the budget request of the cabinet. The department's budget submission is prepared within federal and state funding restrictions, including amount of available funding and priority populations and services.

Among other entities, two commissions are involved in planning for behavioral health services. The Kentucky Commission on Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnoses (known as the 843 Commission) is required by state law to assess statewide needs and to develop a state plan for program development, funding, and efficient use of state funds for persons with mental illness, substance abuse problems, and dual diagnoses (both mental illness and substance abuse). The Kentucky Commission on Services and Supports for Individuals with Mental Retardation and Other Developmental Disabilities (known as the 144 Commission) is required by state law to assess state needs and to develop a state plan for program development, funding, and efficient use of state funds for persons with mental retardation and other developmental disabilities.

At the regional level, the boards are the major statutory planning authorities for community mental health, substance abuse, and mental retardation services for their populations.

In practice, the budgetary process does not incorporate long-term planning. The regional plans and budgets are developed in concert with the department. The department estimates the total funds that will be available for distribution to the regional boards during the upcoming fiscal year. Each board is notified of the amount the region may receive from each funding source passed through the department. The regional boards then develop an annual plan and budget based on these funding levels and other expected sources, which include Medicaid. Each board presents its plan and budget to the department for review and approval. Once the department's budget is enacted, the approved programs, services, and funding levels are incorporated into the contract between the department and each regional board.

**Recommendation 2.1.** If it is the intent of the General Assembly that the 843 Commission and the 144 Commission develop comprehensive plans for needed services and funding, then the General Assembly may wish to direct the commissions to present a plan to the governor and the Legislative Research Commission in sufficient time before each biennium so that the plan could be useful in the budgetary process. The plan should include specific population and service targets, funding needs, and measurable outcomes.

**Recommendation 2.2.** The General Assembly may consider merging the 843 Commission and the 144 Commission to identify needs, prepare a plan for services and associated funding, and identify expected outcomes for individuals with mental illness, substance abuse disorders, mental retardation and other developmental disabilities, and dual diagnoses. The General Assembly may consider requiring the combined commission to have a legislator and the secretary of the Cabinet for Health and Family Services as co-chairs.

If the commissions are merged, then recommendation 2.1 would apply to the combined commission.

**Recommendation 2.3.** Each regional board should develop a strategic plan that describes clearly set objectives, strategies and a timetable to implement them, and cost estimates. The board's plan should include expected outcomes and measurable indicators. The plans should be an integral part of statewide planning decisions.

### Consumers and Services

People who receive services from community centers include those with mental illness, substance abuse problems, and mental retardation and other developmental disabilities.

The number of people receiving services from the centers and the number of services they receive are increasing. In fiscal year 2005, the centers served more than 160,000 unique individuals statewide. This is an increase of more than 20,000—almost 17 percent—from four years before. The services provided to these individuals increased by almost 28 percent over the same four-year period, an increase from approximately 14 million services to approximately 18 million services in 2005.

Over the four-year period, on average, mental health services constituted 41.6 percent, substance abuse services constituted 6.5 percent, and mental retardation and other developmental disabilities services constituted 36 percent of total services provided.

The mix of consumer types remained relatively stable over recent years. On average, persons with a mental health diagnosis were almost 78 percent of the service population during this period. Persons with a primary diagnosis of substance abuse constituted approximately 15 percent, and persons with a primary diagnosis of mental retardation or other developmental disabilities constituted more than 2 percent of the service population.

In recent years, personal referrals, which are self-referrals, have averaged almost 40 percent of consumers. Approximately 17 percent of referrals were by agencies. Almost 14 percent of referrals were by the judicial system.

In an average year over the period from fiscal year 2001 to 2005, 3.7 percent of Kentuckians received services at one of the centers. The percentages receiving services varied significantly by region. In four regions in eastern Kentucky, more than 6 percent of residents, on average, received services each year. In general, a higher regional poverty rate and a higher rate of uninsured individuals correlate to a larger share of the population accessing community services.

### Funding

Total revenue and support, adjusted for inflation to reflect 2001 dollars, has increased by 8.9 percent, from \$312 million to \$339 million from fiscal year 2001 to 2005.

From fiscal year 2002 to fiscal year 2005, on average, 54 percent of revenue came from the federal government, and 32 percent came from state government sources. Charges to patients comprised approximately 7 percent of revenue.

Federal revenue to the centers comes from the Medicaid program, the Community Mental Health Services block grant, the Substance Abuse Prevention and Treatment block grant, and various grants from other federal agencies. On average, Medicaid provides nearly 80 percent of federal funding.

State revenue from the Department for Mental Health and Mental Retardation Services represents 81 percent of centers' state revenue. The remaining 19 percent comes from other agencies, such as the Department for Community Based Services.

The centers are required by statute to provide services regardless of a person's ability to pay. The charity allowance is the amount an indigent person is not required to pay and is determined on an income-related sliding fee schedule unique to each region. The statewide community care support allocation for fiscal year 2006 is \$3 million less than the average charity allowance over the previous five years. This should not be interpreted to mean that an additional \$3 million in community care support funding is needed because the regions do not define and report charity allowances consistently.

**Recommendation 4.1.** The Department for Mental Health and Mental Retardation Services should develop a standardized method to calculate charity allowances. The department should require the boards to use that method and report annually, in conjunction with their annual financial statement audit, a separate schedule of charity allowances. The boards' independent auditors should be required to certify that the charity allowances are reported in accordance with the department's instructions.

## **Consumer Outcomes and Other Performance Measures**

Assessing consumer outcomes is difficult, in part because of a lack of consensus on the performance to be measured and how it should be measured. In recent years, consumer outcomes in Kentucky have been similar to the average outcomes of other reporting states. For example, for the mental health outcome “Increased/retained employment,” Kentucky reported 20.0 percent of adult consumers as employed in 2004, compared to 21.3 percent in all reporting states.

The contracts between the department and the boards require the centers to collect consumer outcome data using multiple tools. Department staff have visited each region to obtain information about best practices planned, adopted, and/or sustained in specific program areas. Best practices have been incorporated in the contracts between the department and the boards. The contracts include incentive funding provisions that require centers to demonstrate the use of certain practices to earn a portion of state general funds.



## Chapter 1

### Overview and Major Conclusions

On November 18, 2005, the Program Review and Investigations Committee directed staff to review Kentucky's community mental health and mental retardation centers.

### Objectives and Overview of the Report

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The study's objectives were to describe the centers' mission, activities, and resources; analyze needs assessment and services; and examine the processes of treatment, monitoring, and outcome evaluation.

The study had three major objectives:

1. Describe the community mental health and mental retardation centers' mission, activities, and available personnel and financial resources.
2. Analyze how the centers determine consumers' needs and what procedures are used to satisfy those needs.
3. Examine the processes of treatment, monitoring, and outcome evaluation.

This report consists of five chapters. Chapter 1 provides an overview of the report and describes the study's research methods and major conclusions.

Chapter 2 provides an overview of federal and state legal and administrative requirements, including the budgetary process.

Chapter 3 describes characteristics of individuals who receive services from the centers and the types of services they receive. Because this report focuses on administrative functions, staff did not describe the variety of individual clinical diagnoses. Instead, broad categories were analyzed.

Chapter 4 covers funding of the services provided by the centers. Services by program area (mental health, substance abuse, mental retardation and developmental disabilities, and others) are discussed. Funding from different payers, levels of government, and other sources is examined.

Chapter 5 provides an overview of consumer advocacy groups that assist in planning for services and improving consumer outcomes. The chapter also includes information on a pilot project to decrease psychiatric hospital admissions, as well as consumer outcome measures and state performance indicators.

Appendices A to I provide more detailed information on selected topics from the report. Appendix J is the Department for Mental Health and Mental Retardation Services' response to the report. Appendix K is the Kentucky Association of Regional Programs' response.

### **How This Study Was Conducted**

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Program Review staff visited each regional board, interviewed board members and employees, and toured direct-care sites and talked with consumers. Staff also reviewed documentation obtained from the boards.

This study had a broad scope. Kentucky has 14 regional mental health and mental retardation boards, each of which is a nonprofit corporation authorized by KRS Chapter 210. Program Review staff visited each region and interviewed board employees. When practical, staff interviewed board members, talked with consumers, and toured direct-care sites. Staff obtained information from each regional center based on a standardized list of questions. Staff reviewed the boards' audited financial statements and cost reports. Staff attended meetings of the Kentucky Association of Regional Programs, the professional association for center administrators, and interviewed association staff.

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Program Review staff reviewed laws and regulations and obtained information from state agency staff and Web sites. Staff also obtained information from consumer groups.

Statutory oversight of the programs and services provided by the boards rests with the secretary of the Cabinet for Health and Family Services and is exercised by the Department for Mental Health and Mental Retardation Services. A review of applicable statutes and regulations helped frame the scope of this study. The cabinet secretary and departmental staff were interviewed, and documentation was obtained from the department. Much of the information consisted of data submitted by the regional board staffs. Other information consisted of financial and related information developed at the departmental level. Staff reviewed contracts, annual plans and budgets, and associated documentation and information on Web sites. Staff obtained information from other state agencies involved in the operation of regional programs, including the Kentucky Council on Developmental Disabilities, and the Cabinet for Health and Family Services' Office of Inspector General and Office of Health Policy, Certificate of Need. Because of issues related to centers' ability to obtain qualified staff, Program Review staff interviewed personnel and obtained information from the Council on Postsecondary Education and the Kentucky Association of Independent Colleges and Universities.

The department receives federal block grant funds to serve persons with mental health and substance abuse problems. The associated federal laws and regulations drive much of the program planning and service delivery in the Commonwealth by specifying priority

populations and required services. The planning for, delivery of, and funding of services at the state and local levels often are driven by planning initiatives at the federal level. A review of applicable federal initiatives and related laws and regulations helped frame the scope of this study.

Individual consumers of services and board members and staff of consumer organizations were interviewed for their perspectives on regional services. “Consumers” are the people who use the services provided by the regional programs. “Services” consist of either the time a professional, such as a psychologist or social worker, spends with a consumer or the professional time associated with providing other services to or on behalf of a consumer, such as case management.

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Program Review staff attended meetings and interviewed members and staff of statutorily required planning groups.

Many groups are required by statute to participate in planning for services. Program Review staff attended meetings of two of those groups: the Kentucky Mental Health Services Planning Council and the Kentucky Commission on Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnoses. Members and staff of the two groups were interviewed, as were members and staff of the Kentucky Commission on Services and Supports for Individuals with Mental Retardation and Other Developmental Disabilities.

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Program Review staff interviewed members and staff of advocacy groups.

Advocacy groups play a role in advising the state and the regional boards on community needs. Program Review staff interviewed members and/or staff of NAMI Kentucky, the state affiliate of the National Alliance for the Mentally Ill. Staff also interviewed members and staff of the Kentucky Consumer Advocate Network and the Kentucky Mental Health Coalition. An individual long-time consumer advocate not affiliated with these groups was interviewed. Staff obtained additional information by reviewing Web sites of these and related organizations, such as the Arc of Kentucky, which advocates for persons with mental retardation.

The Program Review and Investigations Committee previously has studied the centers’ operations and finances. Staff reviewed the prior reports for issues that would be significant to this study’s objectives. Staff also reviewed audit reports from Kentucky’s Auditor of Public Accounts, reports of other states, reports of the U.S. Government Accountability Office, and research reports on issues related to study objectives.

## Major Conclusions

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This report has five major conclusions.

1. Kentucky has a comprehensive system for planning services. However, development of the budget does not make use of state and regional estimates of what is needed to satisfy the demand for services.
2. The centers are providing more services to more people, particularly in regions with high poverty and uninsured rates.
3. The "safety net" requirement is that the centers provide services regardless of a person's ability to pay. State safety net funding has decreased in recent years.
4. The total cost of charity care is unknown.
5. The system statewide appears to be stable in terms of providing current services to current populations. The system's capacity to expand services or serve larger populations is questionable, particularly in some regions.

This report has five major conclusions.

1. Kentucky has a comprehensive system for planning services but is not taking advantage of the work of all partners. State and regional groups develop cost estimates to satisfy the demand for services, but the estimates are not used in developing the budget.
2. From fiscal year 2001 through fiscal year 2005, the number of persons served by the centers increased by almost 17 percent, and the number of services increased by almost 28 percent. Revenue, adjusted for inflation, increased less than 9 percent. In general, higher regional poverty and uninsured rates correlate to a larger percentage of the population receiving services.
3. The centers are required to provide services regardless of a person's ability to pay. This requirement is referred to as the "safety net." The safety net implies that the centers are providing charity care to persons who cannot afford to pay. Adjusted for inflation, community care support, the state safety net funding, has decreased in recent years.
4. However, the total cost of charity care is unknown. Staff were unable to calculate the cost because of different interpretations of what constitutes a charity allowance and different accounting systems among regions.
5. Staff analysis of financial results shows great variation among regions. The system statewide appears to be stable in terms of providing current services to current populations. The system's capacity to expand services or serve larger populations is questionable, particularly in some regions.

## Chapter 2

### Kentucky's Regional and State Structure

This chapter provides an overview of federal and state legal requirements for community services to persons with mental illness, substance abuse problems, and mental retardation and other developmental disabilities. Legally required planning groups and others are described.

#### The Regional Board Structure Is Established in Statute

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Kentucky's has 14 regional mental health and mental retardation boards. The regions approximate the area development districts.

Kentucky has 14 regional mental health and mental retardation boards. As shown in Figure 2.A, the 14 regions approximate the area development districts.<sup>1</sup> All regions and surrounding states are shown to emphasize that the regions compete with each other and with other states for resources, including funding and staff. The only region that does not border another state is Bluegrass, which borders eight other regions.

**Figure 2.A**  
**Kentucky's Regional Mental Health and Mental Retardation Boards**



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<sup>1</sup> Livingston County is in the Pennyroyal Area Development District but in the Four Rivers region. The Pathways region encompasses two area development districts.

KRS 210.430 authorizes each board to apply for financial assistance by submitting annually to the secretary of the Cabinet for Health and Family Services its plan, budget, and board membership for the next fiscal year. Eligibility for a state grant or other fund allocation from the cabinet depends on approval of the secretary. In addition, the board's composition must reasonably represent the groups listed in KRS 210.380.

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Federal law created the community mental health and mental retardation system in 1963.

Kentucky's community mental health and mental retardation system was created in large part by the federal Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. The law funded the construction of facilities for treatment of mental health and mental retardation and established a commitment for services to be provided in local communities. Subsequent federal legislation provided staffing grants for the regional centers. Although much of the original legislation has been amended or superseded, it established the regional basis for community services.

In 1964, Governor Edward T. Breathitt established the Kentucky Mental Health Planning Commission, which presented *Pattern for Change in Kentucky Mental Health Programs and Services* to the governor and General Assembly in 1966. The report incorporated recommendations from the Kentucky Mental Retardation Planning Commission, which performed a similar study under a grant from the U.S. Public Health Service. The central recommendation of the mental health planning commission report was that the Kentucky Department of Mental Health implement a state program to stimulate greater responsibility of Kentucky's citizens at the community level for mental health and mental retardation services through the creation of regional mental health and mental retardation boards of citizens.

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The recommendation for community programs was implemented in KRS Chapter 210.

This recommendation was adopted in KRS Chapter 210. KRS 210.370 describes how regional mental health and mental retardation boards can be established. A combination of cities and counties may establish a regional community mental health and mental retardation services program. The program may be administered by a community mental health and mental retardation board.

In this report, the term "board" refers to the nonprofit corporation and/or the members of the board of directors of the individual nonprofit corporations. The term "center" refers to the administration and staff employed by the boards and the programs they administer.

KRS 210.380 ensures the creation of local boards of citizens. Board membership is required to be representative of the elected chief executives of county governments; local health departments; medical societies; county welfare boards; hospital boards; lay associations concerned with mental health and mental retardation; labor, business, and civic groups; and the general public.

According to KRS 210.400, the duties of the board are to

- review and evaluate mental health and mental retardation services provided pursuant to KRS 210.370 to 210.460 and report thereon to the cabinet secretary, the administrator of the program, and, when indicated, the public, with recommendations for additional services and facilities;
- recruit and promote local financial support for the program from private sources such as community chests, business, industrial and private foundations, voluntary agencies, and other lawful sources, and promote public support for municipal and county appropriations;
- promote, arrange, and implement working agreements with other social service agencies, both public and private, and with other educational and judicial agencies;
- adopt and implement policies to stimulate effective community relations;
- be responsible for the development and approval of an annual plan and budget;
- act as the administrative authority of the community mental health and mental retardation program; and
- oversee and be responsible for the management of the program in accordance with the plan and budget adopted by the board and the policies and regulations issued under KRS 210.370 to 210.480 by the cabinet secretary.

### **The Cabinet for Health and Family Services Oversees Funding and Program Services**

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The authority for oversight of board operations is exercised by the Department for Mental Health and Mental Retardation Services.

The statutory authority for oversight of board operations and certain funding decisions rests with the secretary of the Cabinet for Health and Family Services. That authority is exercised by the Department for Mental Health and Mental Retardation Services. KRS 210.410 authorizes the secretary to make state grants and other fund allocations from the cabinet to help the boards provide at least the following services: inpatient, outpatient, partial hospitalization or psychosocial rehabilitation, emergency, consultation and education, and mental retardation.

The state formula for paying the boards for services is introduced in KRS 210.440. At the beginning of each fiscal year, the secretary is required to allocate available funds to the boards in accordance with their approved plans and budgets. The secretary must review operations, budgets, and expenditures of the centers and may reallocate or withdraw funds from centers based on the results of the review. KRS 210.440 is implemented in 908 KAR 2:050, *Formula for allocation of funds*. The funding formula is discussed in more detail in Chapter 4.

KRS 210.450 describes additional duties of the secretary that include but are not limited to:

- promulgating policies and regulations governing eligibility of centers to receive state grants and other fund allocations from the cabinet;
- governing eligibility for service so that no person is denied service on the basis of race, color, creed, or inability to pay;
- providing for establishment of fee schedules based on ability to pay;
- regulating fees without regard to ability to pay for diagnostic services for anyone referred by the courts, schools, or public and private health and welfare agencies;
- governing financial record keeping; and
- providing for financial and program reporting requirements.

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The regional programs are required to provide services to all persons regardless of their ability to pay.

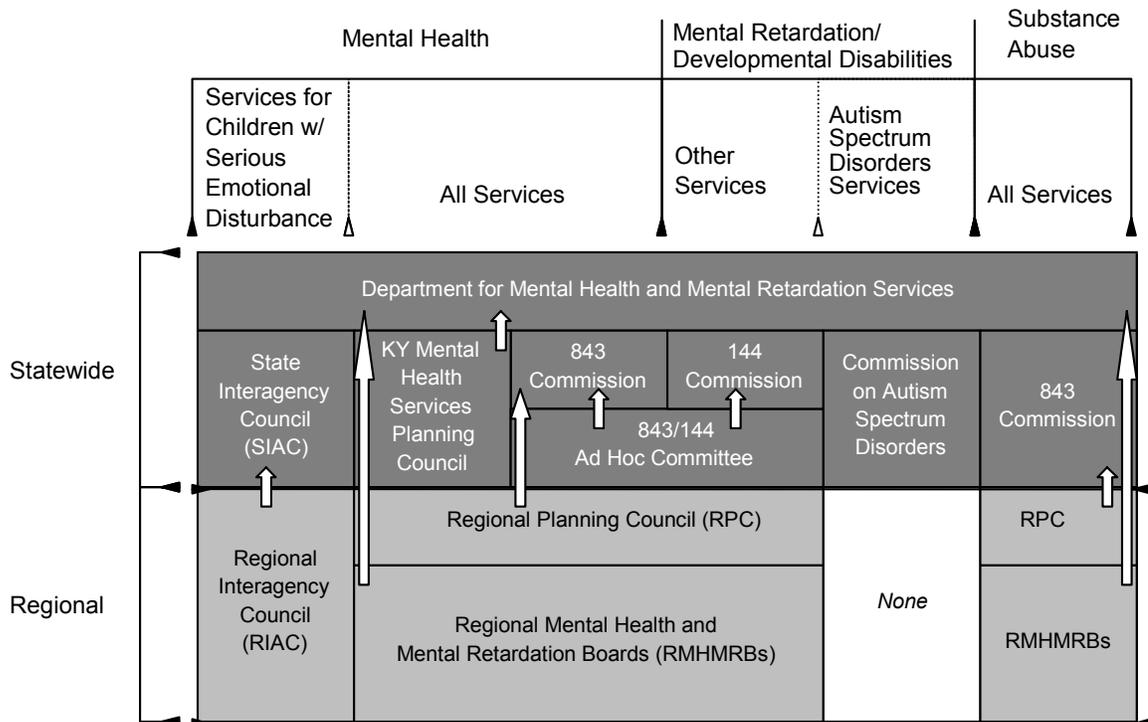
The requirement for the regional boards to provide services regardless of a person's ability to pay is referred to in this study as the "safety net." Chapter 4 explains that safety net funding, adjusted for inflation, has decreased in recent years.

Federal program laws and regulations affect the planning, service delivery, and outcomes measurement of the state and the centers. An example of a federal program passed through the department to the centers is the Community Mental Health Services block grant. It authorizes centers to provide mental health services to adults with severe mental illness and children with serious emotional disturbance, including programs on child mental health, psychosocial rehabilitation, peer support, and consumer-directed programs. Illnesses covered by the grant include schizophrenia, bipolar disorder, and severe depression. The Substance Abuse Prevention and Treatment block grant is another example. It authorizes centers to provide prevention, treatment, and rehabilitation services to persons with alcohol and drug abuse problems. At least 20 percent of the grant funds must be spent for educational activities. At least 10 percent of base expenditures from 1994 must be spent on services to pregnant women and women with dependent children.

### Many Groups Are Involved in Planning for Services

Federal and state laws require that planning for mental health, substance abuse, and mental retardation or other developmental disabilities services take place at both the statewide and regional levels. Figure 2.B shows the program planning relationships.

**Figure 2.B**  
**Statutory Planning Entities by Level of Planning,**  
**Organizational Hierarchy, and Program Area of Responsibility**



Source: Developed by Program Review staff from requirements in Kentucky Revised Statutes.

The state plan and budget for community services is part of the executive branch budget process.

At the state level, the plan and budget for community services is developed by the department and is incorporated in the budget request of the cabinet. The department’s budget submission is prepared within federal and state funding restrictions, including the amount of available funding and priority populations and services. The department’s plan and budget for mental health services incorporates the Kentucky Mental Health Services Planning Council’s recommendations for use of the Community Mental Health Services block grant. The council is required by the block grant provisions to be established and to provide input on services funded by the grant.

Other statutory groups at the statewide level are involved in planning for behavioral health services but have a less formal

impact on the department's budget request. These groups include the Kentucky Commission on Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnoses; the Kentucky Commission on Services and Supports for Individuals with Mental Retardation and Other Developmental Disabilities; the State Interagency Council for Services to Children with Emotional Disabilities; and the Commission on Autism Spectrum Disorders. Regional board staff actively participate in all these groups.

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The Department for Mental Health and Mental Retardation Services has authority over planning, funding, and service delivery for mental health, substance abuse, and mental retardation services.

Each statewide statutory planning authority is introduced below in terms of the scope of its planning responsibilities. More detail is provided in Appendix A.

- The Kentucky Mental Health Services Planning Council is required by federal law for any state that receives Community Mental Health Services block grant funds. Council members include consumers, family members, consumer organizations, providers, and state agencies. The council is responsible for reviewing plans for allocation of mental health services statewide and recommending modification of such plans; monitoring, reviewing, and evaluating the allocation and adequacy of mental health services in the state; and playing a role in improving mental health services in the state.
- The Department for Mental Health and Mental Retardation Services exercises the authority for planning, funding, and service delivery for mental health, substance abuse, and mental retardation services. The department's responsibility includes community services as well as inpatient and other residential care at the state-owned and state-contracted psychiatric hospitals, nursing facilities, substance abuse treatment facilities, and intermediate care facilities for persons with mental retardation and other developmental disabilities.
- The Kentucky Commission on Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnoses (also known as the 843 Commission) is required by KRS Chapter 210 to assess statewide needs and to develop a state plan for program development, funding, and efficient use of state funds for persons with mental illness, substance abuse problems, and dual diagnoses (both mental illness and substance abuse). The commission's responsibility includes community services and inpatient and residential care and encompasses coordination of services and funding across agencies and funding sources.
- The Kentucky Commission on Services and Supports for Individuals with Mental Retardation and Other Developmental Disabilities (also known as the 144 Commission) is required by KRS Chapter 210 to assess state needs and to develop a state plan for program development, funding, and efficient use of

state funds for persons with mental retardation and other developmental disabilities. The commission's responsibility includes community services and residential care in intermediate care facilities for persons with mental retardation and other developmental disabilities. Inherent in this responsibility is coordination of services and funding across agencies and funding sources.

- The State Interagency Council for Services to Children with Emotional Disabilities is a statewide group composed of officers of state agencies that offer services to children and their parents. The council's efforts are limited to services for children with serious emotional disturbance.
- The Kentucky Commission on Autism Spectrum Disorders is required by statute to, among other things, develop a plan to identify persons with such disorders, assess their needs, and identify appropriate funding sources.

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The regional boards are the major statutory planning authorities for community services.

At the regional level, the boards are the major statutory planning authorities for community mental health, substance abuse, and mental retardation services for their populations. Other entities are involved in both community and inpatient or other residential care services for specific populations. The requirements imposed on the boards and their programs result in significant statutory administrative burdens not imposed on private providers. Each regional statutory planning authority is briefly described below in terms of the scope of its planning responsibilities. More detail is provided in Appendix A.

- The regional boards are the only entities in the state with the sole statutory responsibility for providing services in the community. The boards and their programs, implemented by the centers, are responsible for community services to persons with mental illness, substance abuse problems, and mental retardation or other developmental disabilities. They are required by statute to present to the department an annual plan and budget for community services.
- Regional boards are required to convene regional planning councils to assess regional needs and recommend a regional strategic plan. The councils' scope includes community and inpatient and other residential care needs for persons with mental illness, substance abuse disorders, and dual diagnoses. Regional planning councils report directly to the 843 Commission. Regional board staff are active participants in these councils.
- The regional interagency councils provide for regional participation in the planning and service coordination among agencies that serve children with serious emotional

disturbance. Councils are required by statute to be established in each region of the state and to be chaired by a representative of the Department for Community Based Services. The regional councils' responsibilities include reviewing case histories of children and identifying and providing appropriate services. The regional councils report their results to the state council. Regional board staff are active participants in these councils.

### **Budgetary Processes Do Not Incorporate Long-term Planning**

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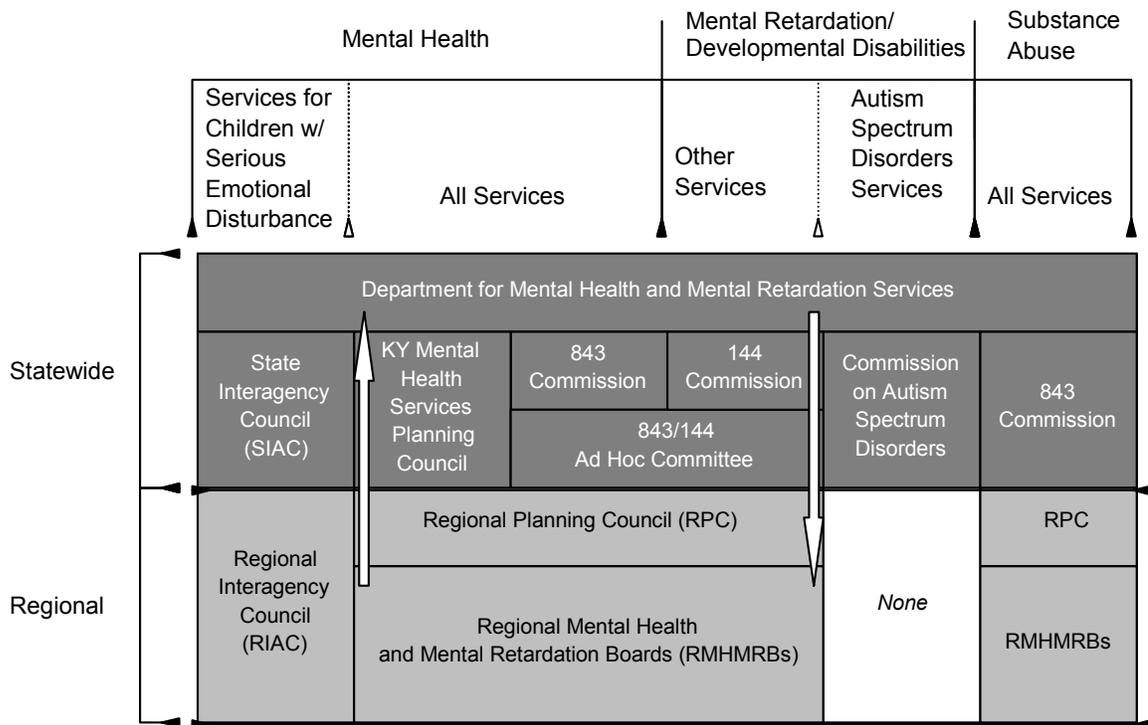
The state budgetary process does not provide sufficient opportunity for regional funding needs to be addressed.

Figure 2.B showed entities at the state and regional levels with statutory planning duties related to specific populations who receive mental health, substance abuse, and mental retardation and other developmental disabilities services from the regional centers. Although these entities were created to plan programs and services for consumers, the related plans cannot be implemented without adequate funding. The duties associated with these entities indicate that most of them are required to identify funding needs and develop funding strategies. However, the state budgetary process does not provide sufficient opportunity for the identified regional funding needs to be addressed.

Figure 2.C illustrates that the only planning entities directly involved in the budgetary process for community services are the regional boards and the department.

The regional plans and budgets are developed in concert with the department. Early in each calendar year, the department estimates the total funds that will be available for distribution to the regional boards during the upcoming fiscal year. Department staff send a letter to each board specifying the amount the region may receive from each funding source passed through the department. The regional boards then develop an annual plan and budget based on these funding levels and other expected sources, which include Medicaid. Each board presents its plan and budget to the department for review and approval. Once the department's budget is enacted, the department sends a second letter to the boards outlining their approved funding levels and any new fiscal or programmatic requirements. The approved programs, services, and funding levels are incorporated into the contract between the department and each regional board. The method of budget approval requires the boards to work within state budgetary constraints.

**Figure 2.C**  
**Statutory Planning Entities by Level**  
**of Planning and Budget Responsibility**



Source: Developed by Program Review staff from requirements in Kentucky Revised Statutes.

The statutory planning authorities of the different entities are designed to produce plans and identify funding needs for various purposes. For example, the 843 Commission is required to identify funding needs and develop a comprehensive state plan to guide funding and the use of state resources for all services to persons with mental illness, substance abuse problems, and dual diagnoses, including inpatient and residential care. Table 2.1 shows the members of the 843 Commission and the stakeholders they represent.

**Table 2.1**  
**Members of the 843 Commission and Their Representation**

<b>Statutorily Required Member</b>	<b>Stakeholder Representation</b>
Secretary of the Cabinet for Health and Family Services	Executive Branch
Secretary of the Justice and Public Safety Cabinet	Executive Branch
Commissioner of the Department for Mental Health and Mental Retardation Services	Executive Branch
Commissioner of the Department for Medicaid Services	Executive Branch
Commissioner of the Department of Corrections	Executive Branch
Commissioner of the Department of Juvenile Justice	Executive Branch
Commissioner of the Department of Education	Executive Branch
Executive Director of the Office of Vocational Rehabilitation	Executive Branch
Director of Protection and Advocacy, Division of the Department of Public Advocacy	Executive Branch
Director of the Division of Family Resource and Youth Services Centers	Executive Branch
Director of the Division of Aging Services of the Cabinet for Health and Family Services	Executive Branch
Executive Director of the Criminal Justice Council	Executive Branch
Director of the Administrative Office of the Courts	Judicial Branch
Chief Executive Officer of the Kentucky Housing Corporation	Outside Stakeholder
Executive Director of the Office of Transportation Delivery of the Transportation Cabinet	Executive Branch
Commissioner of the Department for Public Health	Executive Branch
Three members of the House of Representatives	Legislative Branch
Three members of the Senate	Legislative Branch
Chairperson of a regional planning council	Outside Stakeholder-Appointed by Executive Branch
Consumer of mental health or substance abuse services	Outside Stakeholder-Appointed by Executive Branch
Adult family member of a consumer of mental health or substance abuse services	Outside Stakeholder-Appointed by Executive Branch

Source: Compiled by Program Review staff from KRS 210.502.

The 843 Commission's membership is heavily weighted toward executive branch agencies. Additional members represent consumers, legislators, and others involved in services and supports for the affected populations. The co-chairs of the commission are a member of the General Assembly and the cabinet secretary, as required by KRS 210.502(2).

The 144 Commission has similar representation and responsibilities for persons with mental retardation and other developmental disabilities. However, the 144 Commission is chaired by the cabinet secretary without a legislative co-chair. Table 2.2 shows the members of the 144 Commission and the stakeholders they represent.

**Table 2.2  
 Members of the 144 Commission and Their Representation**

<b>Statutorily Required Member</b>	<b>Stakeholder Representation</b>
Secretary of the Cabinet for Health and Family Services	Executive Branch
Commissioner of the Department for Mental Health and Mental Retardation Services	Executive Branch
Commissioner of the Department for Medicaid Services	Executive Branch
Executive Director of the Office of Vocational Rehabilitation	Executive Branch
Director of the University Affiliated Program at the Interdisciplinary Human Development Institute at the University of Kentucky	Executive Branch
Director of the Kentucky Council on Developmental Disabilities	Executive Branch
Two members of the House of Representatives	Legislative Branch
Two members of the Senate	Legislative Branch
Five family members	Outside Stakeholder-Appointed by Executive Branch
Three persons with mental retardation or other developmental disabilities	Outside Stakeholder-Appointed by Executive Branch
Two business leaders	Outside Stakeholder-Appointed by Executive Branch
Three direct service providers	Outside Stakeholder Appointed by Executive Branch
One representative of a statewide advocacy group	Outside Stakeholder Appointed by Executive Branch

Source: Compiled by Program Review staff from KRS 210.575.

State commissions' identification of needs is designed to show gaps in services and funding and how the gaps could be closed, regardless of current budgetary constraints.

The planning processes of the regional boards and the two commissions are designed to accomplish different purposes and operate independently of each other. The boards are required to participate in the annual plan and budget process to result in a contract with the department. The top-down approach is necessitated by the state budget process and the monetary constraints confronting the Commonwealth. On the other hand, the commissions' identification of funding needs does not result in a state budget obligation. Rather, the identification of needs is designed to show gaps in services and funding and to recommend how the gaps could be closed.

The 843 Commission addresses the needs of persons with mental illness, substance abuse problems, and dual diagnoses involving mental illness and substance abuse. The 144 Commission

addresses the needs of persons with mental retardation and other developmental disabilities, who also may have dual diagnoses, such as mental retardation and mental illness or mental retardation and substance abuse problems. Regional board staffs participate in all related planning activities. Other entities—such as schools, hospitals, the courts, local jails, and state correctional facilities—also are likely to have contact with all such persons. Combining the two commissions could facilitate the development of a state plan to address the needs of all persons in the Commonwealth.

### **Recommendation 2.1**

**If it is the intent of the General Assembly that the 843 Commission and the 144 Commission develop comprehensive plans for needed services and funding, then the General Assembly may wish to direct the commissions to present a plan to the governor and the Legislative Research Commission in sufficient time before each biennium so that the plan could be useful in the budgetary process. The plan should include specific population and service targets, funding needs, and measurable outcomes.**

### **Recommendation 2.2**

**The General Assembly may consider merging the 843 Commission and the 144 Commission to identify needs, prepare a plan for services and associated funding, and identify expected outcomes for individuals with mental illness, substance abuse disorders, mental retardation and other developmental disabilities, and dual diagnoses. The General Assembly may consider requiring the combined commission to have a legislator and the secretary of the Cabinet for Health and Family Services as co-chairs.**

If the commissions are merged, then recommendation 2.1 would apply to the combined commission.

### **Recommendation 2.3**

**Each regional board should develop a strategic plan that describes clearly set objectives, strategies and a timetable to implement them, and cost estimates. The board's plan should include expected outcomes and measurable indicators. The plans should be an integral part of statewide planning decisions.**

## Chapter 3

### Consumers and Services

This chapter describes characteristics of individuals who receive services from the centers and the types of services they receive. Because this report focuses on administrative rather than clinical functions, staff did not describe the great variety of individual clinical diagnoses. Instead, broad categories were analyzed.

#### Many People Receive Services From Community Centers

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People who receive services from community centers include those with mental illness, substance abuse problems, and mental retardation and other developmental disabilities.

People who receive services from community centers include those with mental illness, substance abuse problems, and mental retardation and other developmental disabilities. The prevalence of the need for services has been reported by numerous professionals and entities including the Surgeon General of the United States, the American Academy of Physicians, and the National Survey on Drug Use and Health.

In 1999, the Surgeon General of the United States reported, “Approximately 10 percent of children and adults receive mental health services from mental health specialists or general medical providers in a given year” (U.S. Department of Health. Substance. Center 19).

In 2000, the American Academy of Physicians reported, “Mental retardation in young children ... is present in 2 to 3 percent of the population, either as an isolated finding or as part of a syndrome or broader disorder.”

Program Review staff were unable to locate a national prevalence rate for substance abuse. According to the 2005 National Survey on Drug Use and Health, for persons aged 12 or older

- the rate of illicit drug use was 8.1 percent;
- the rate of alcohol use was 51.8 percent; and
- the rate of tobacco use was 29.4 percent (U.S. Department of Health. Substance. Office 13, 27, 37).

#### Sources of Information on Consumers and Services

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Information on consumers and services was obtained from the department and the centers.

Consumer information for this report was obtained from client data submitted by the regions to the department. The client data sets are the only source of reliable information on consumers.

Information on services for this report was obtained from regional cost reports submitted to the department. The cost reports are required to contain all services provided to all persons served by the centers. The department's data sets, on the other hand, are not required to include all services and thus were not used to aggregate total services. Program Review staff worked with the centers and the department to aggregate statistics on persons and services into broad groups based on a person's primary diagnosis and the type of service received: mental illness, substance abuse, mental retardation or other developmental disabilities, and other. The "other" category of consumers consists of a variety of persons, including but not limited to

- those receiving services for brain injury;
- those whose primary diagnosis was deferred, meaning that the person discontinued services before the clinician could determine a primary diagnosis; and
- those whose primary diagnosis could not be determined from the data because of information system problems.

The other category of services represents those that could not be distinctly classified as mental health, substance abuse, and mental retardation and other developmental disabilities. It can include brain injury services and services provided to groups of persons with various diagnoses, such as persons with mental illness and mental retardation who attend the same workshop.

Program Review staff selected state fiscal year 2001 as the base year for comparison. The reliability of consumer data submitted from the centers to the department for prior years was questionable because of problems with some centers' information systems. State fiscal year 2005 was used as the cut-off year for most comparisons because that was the latest fiscal year for which audited information was available.

### **The Numbers of Consumers and Services Are Increasing**

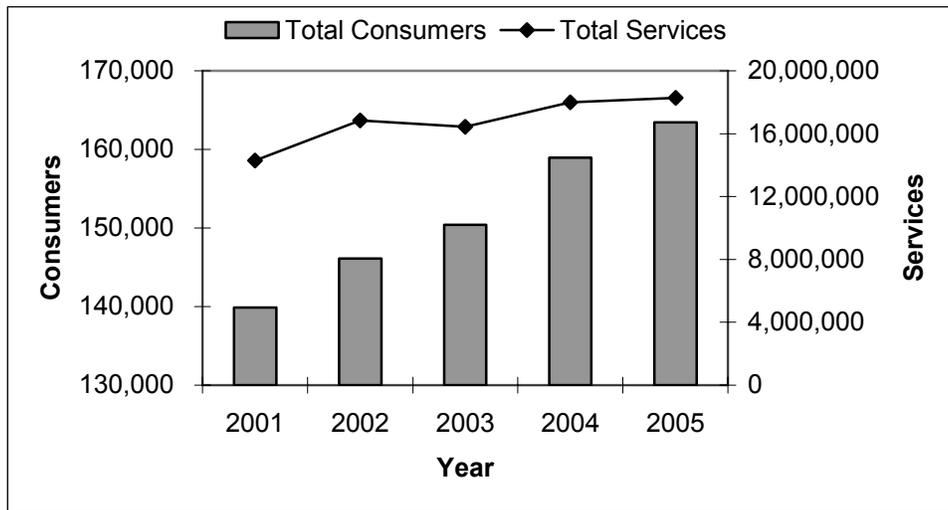
The number of people receiving services from the centers and the number of services they receive are increasing. Figure 3.A shows the increase in the number of individuals served and total services provided by the centers statewide from fiscal years 2001 to 2005.

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Over a five-year period, the number of consumers increased almost 17 percent and the number of services increased almost 28 percent.

In fiscal year 2005, the centers served 163,425 unique individuals statewide, a 16.8 percent increase from the 139,867 unique individuals served in fiscal year 2001. The services provided to these individuals increased by 27.8 percent over the same period, an increase from approximately 14 million services in 2001 to approximately 18 million services in 2005.

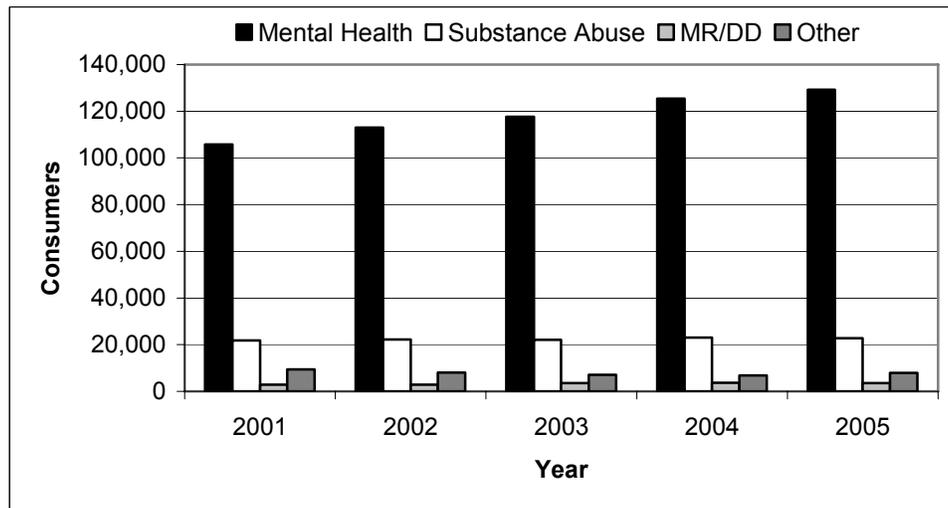
**Figure 3.A**  
**Consumers and Services**  
**Fiscal Years 2001 to 2005**



Source: Compiled by Program Review staff from information provided by the Department for Mental Health and Mental Retardation Services.

Figure 3.B shows the number of unique individuals by primary diagnosis from fiscal years 2001 through 2005.

**Figure 3.B**  
**Consumers by Primary Diagnosis**  
**Fiscal Years 2001 to 2005**



MR/DD is mental retardation and other developmental disabilities.  
 Source: Compiled by Program Review staff from information obtained from the Department for Mental Health and Mental Retardation Services.

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Most of the increase in the number of consumers is attributable to persons who received mental health services.

The number of persons receiving services increased from fiscal years 2001 through 2005 by more than 23,000 unique individuals. Persons with a mental health diagnosis accounted for the majority of this change, increasing by 22.2 percent. Individuals with a substance abuse diagnosis increased by 4.4 percent, and individuals with a diagnosis of mental retardation or other developmental disability increased by 22.7 percent. The number of individuals receiving a diagnosis of “other” declined by 15.8 percent. This decline most likely is related to improved information reporting capabilities rather than to an actual decline in consumers with other diagnoses.

Table 3.1 shows in detail the relative mix of consumers by primary diagnosis from fiscal years 2001 through 2005. The mix of consumer types remained relatively stable. On average, persons with a mental health diagnosis constituted 77.8 percent of the service population during this period. Persons with a primary diagnosis of substance abuse constituted 14.8 percent, and persons with a primary diagnosis of mental retardation or other developmental disabilities constituted 2.2 percent of the service population.

**Table 3.1**  
**Percentage of Statewide Consumers by Primary Diagnosis**  
**Fiscal Years 2001 to 2005**

	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
Mental Health	75.6	77.3	78.2	78.9	79.1
Substance Abuse	15.6	15.2	14.7	14.5	13.9
Mental Retardation and Other Developmental Disabilities	2.0	2.0	2.4	2.3	2.1
Other	6.8	5.5	4.7	4.3	4.9
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Compiled by Program Review staff from information obtained from the Department for Mental Health and Mental Retardation Services.

Table 3.2 provides regional details on population, consumers, and percentage served.<sup>1</sup> A lower percentage of state consumer population served does not necessarily mean that a region has better mental health or a lesser prevalence of substance abuse or mental retardation. The regional alternatives for care are also a factor. Persons with health insurance or more disposable income may choose to obtain services from private providers.

**Table 3.2**  
**Average of Population and Consumer Service Rates by Region**  
**Fiscal Years 2001 to 2005**

	<b>Region</b>	<b>Regional Population</b>	<b>% of State Population</b>	<b>% of State Consumer Population</b>	<b>Consumer Population</b>	<b>% of Regional Population Served</b>
1	Four Rivers	203,126	4.9%	5.1%	7,710	3.8%
2	Pennyroyal	204,508	5.0%	5.7%	8,620	4.2%
3	River Valley	209,022	5.1%	5.3%	7,992	3.8%
4	LifeSkills	261,874	6.4%	7.5%	11,314	4.3%
5	Communicare	250,165	6.1%	4.8%	7,375	2.9%
6	Seven Counties	888,196	21.6%	14.2%	21,646	2.4%
7	NorthKey	406,386	9.9%	4.6%	6,976	1.7%
8	Comprehend	55,964	1.4%	2.3%	3,531	6.3%
10	Pathways	214,824	5.2%	8.4%	12,818	6.0%
11	Mountain	159,077	3.9%	6.9%	10,377	6.5%
12	Kentucky River	119,544	2.9%	5.6%	8,578	7.2%
13	Cumberland River	240,653	5.8%	7.7%	11,680	4.9%
14	Adanta	197,171	4.8%	6.3%	9,448	4.8%
15	Bluegrass	706,978	17.2%	15.6%	23,687	3.3%
	State	4,117,488	100.0%	100.0%	151,752	3.7%

Source: Compiled by Program Review staff from information obtained from the Kentucky State Data Center and the Department for Mental Health and Mental Retardation Services.

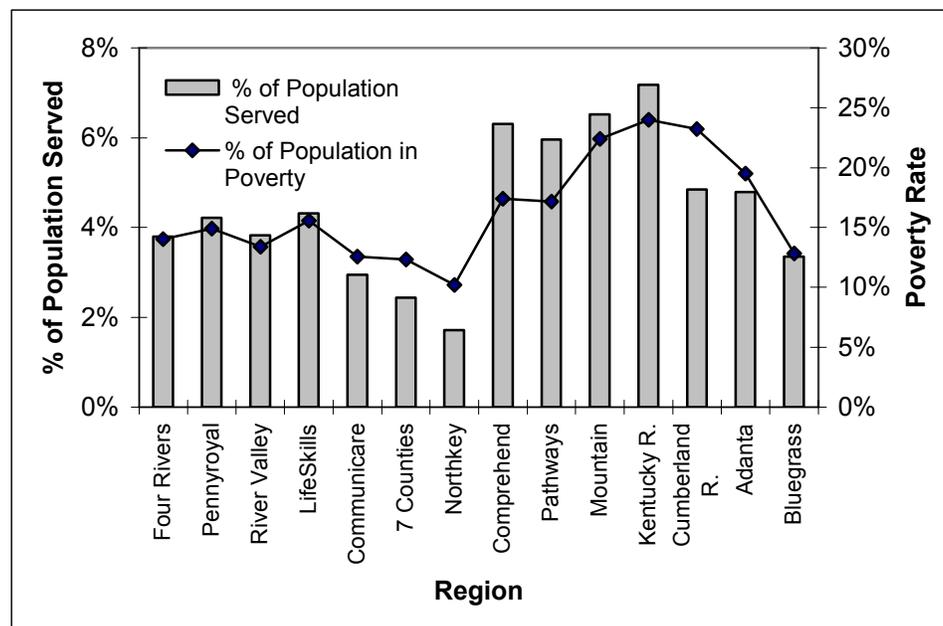
Table 3.2 shows that some regions, especially those in the eastern part of the state, comprise a greater percentage of the state consumer population than of the total state population. For example, the Kentucky River region in eastern Kentucky has 2.9 percent of the total state population, but its consumer population is 5.6 percent of the statewide consumer population.

<sup>1</sup> In this and other tables listing regions, there is no region 9. Regions Fiveco and Gateway merged to form Pathways (Region 10).

Regions with higher poverty rates serve a larger proportion of their populations than regions with lower poverty rates.

Figure 3.C compares service populations to poverty rates. The figures have been averaged for the period 2001 through 2005. In general, a higher regional poverty rate correlates to a larger percentage of the population accessing community services. For example, the Kentucky River region has the highest five-year poverty rate at 24 percent and likewise serves the largest percentage of its regional population at 7.2 percent. Conversely, NorthKey has the lowest poverty rate at 10.2 percent and serves the smallest percentage of its regional population at 1.7 percent.

**Figure 3.C**  
**Five-year Averages of Percentages of Population Served and Poverty Rates by Region**  
**Fiscal Years 2001 to 2005**



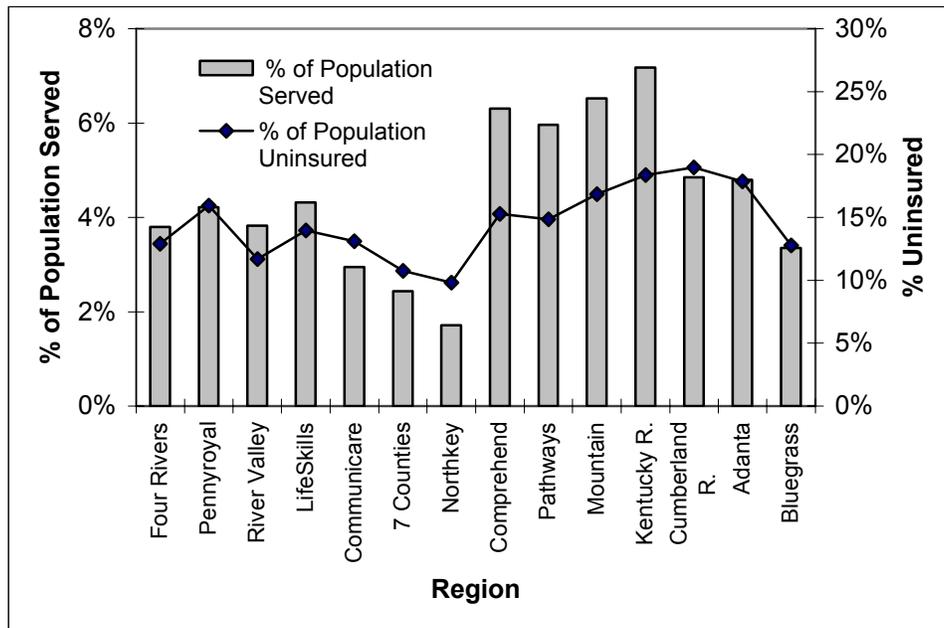
Source: Regional populations are from the University of Louisville's Kentucky State Data Center. Poverty rates are from the U.S. Department of Commerce's Census Bureau's *2003 Small Area Income and Poverty Estimates*. Consumer data were compiled by Program Review staff from information obtained from the Department for Mental Health and Mental Retardation Services.

Figure 3.D compares service populations to rates of uninsured individuals in each region. The figures for the service population have been averaged for the period 2001 through 2005. The figures for the uninsured rates are the U.S. Census Bureau's estimate for the year 2000.<sup>2</sup>

<sup>2</sup> The uninsured numbers are model-based estimates for the year 2000 from the U.S. Commerce Department's Census Bureau's *Small Area Health Insurance Estimates*. Information at the county level was available only for the year 2000 and was used by Program Review staff to aggregate county statistics into regions.

Relative comparisons can be made between regions with this data but are subject to significant margins of error. In general, the percentage of uninsured individuals in a given region is slightly lower than that of those at or below the poverty level. As with the poverty figures, a higher rate of uninsured individuals correlates to a larger percentage of the population accessing community services. For example, the Kentucky River region has the second-highest rate of uninsured persons at 18.4 percent and serves the largest percentage of its regional population at 7.2 percent. Conversely, NorthKey has the lowest uninsured rate at 9.8 percent and serves the smallest percentage of its regional population at 1.7 percent.

**Figure 3.D**  
**Five-year Averages of Percentages of Population Served and Uninsured Rates by Region**  
**Fiscal Years 2001 to 2005**



Source: Estimates of the uninsured population are from the U.S. Department of Commerce's Census Bureau's *2000 Small Area Health Insurance Estimates*. Consumer data were compiled by Program Review staff from information obtained from the Department for Mental Health and Mental Retardation Services.

Figure 3.E illustrates the regional variation in percentage of state population, percentage of the regional population served, and uninsured and poverty rates.

**Figure 3.E**  
**Percentages of Population, Population Served, Uninsured,**  
**and Below Poverty Level by Region**

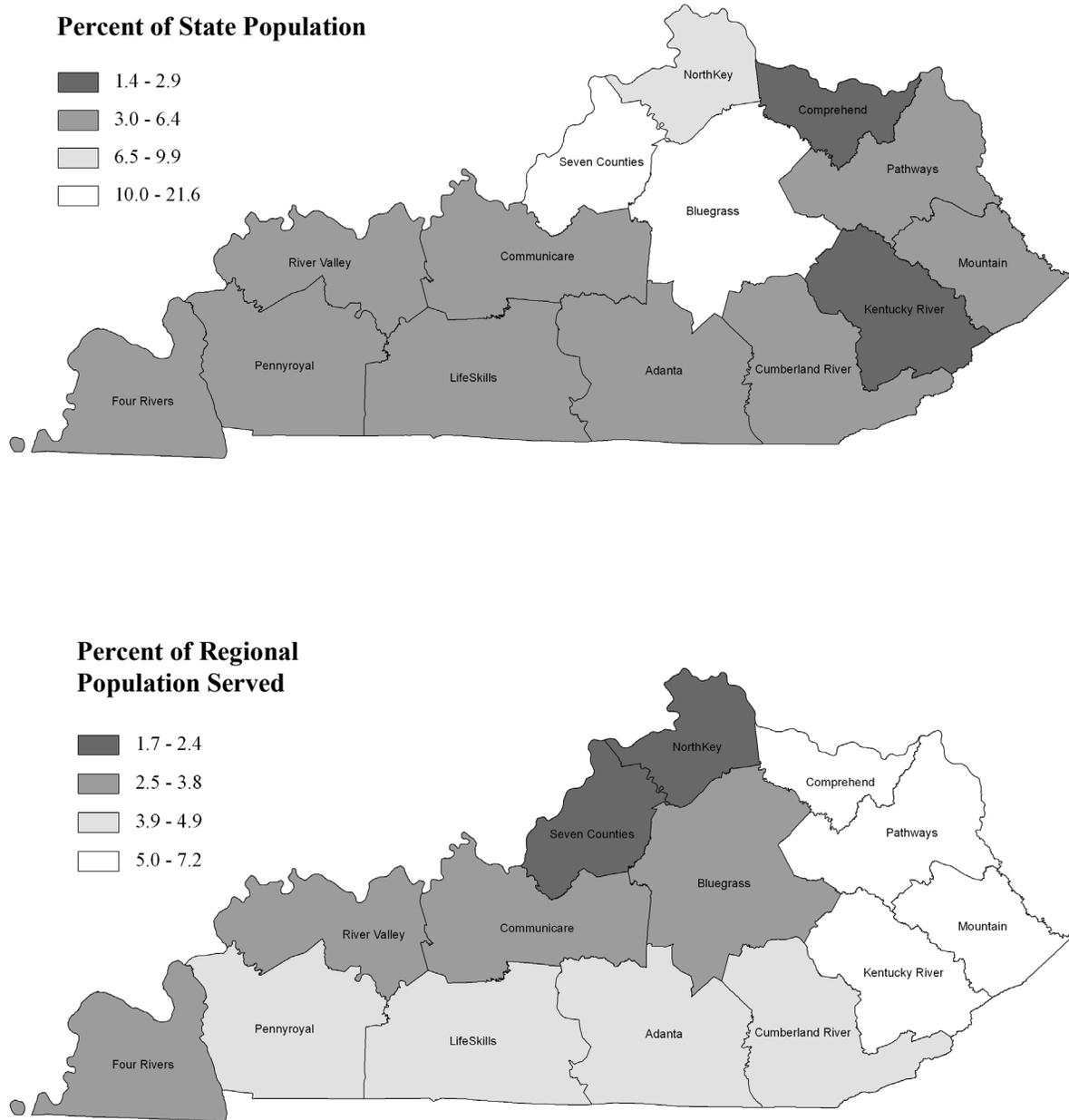
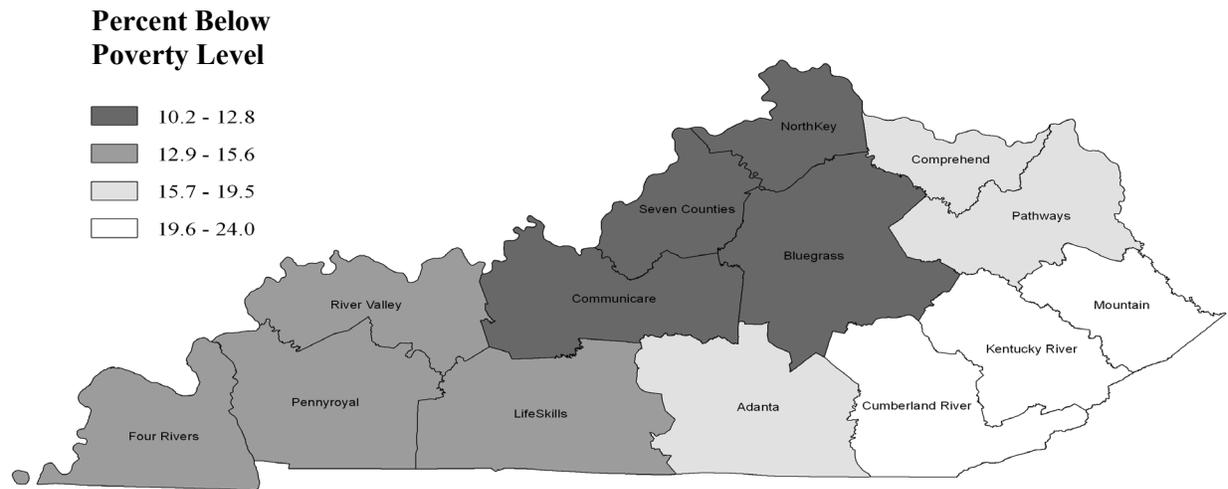
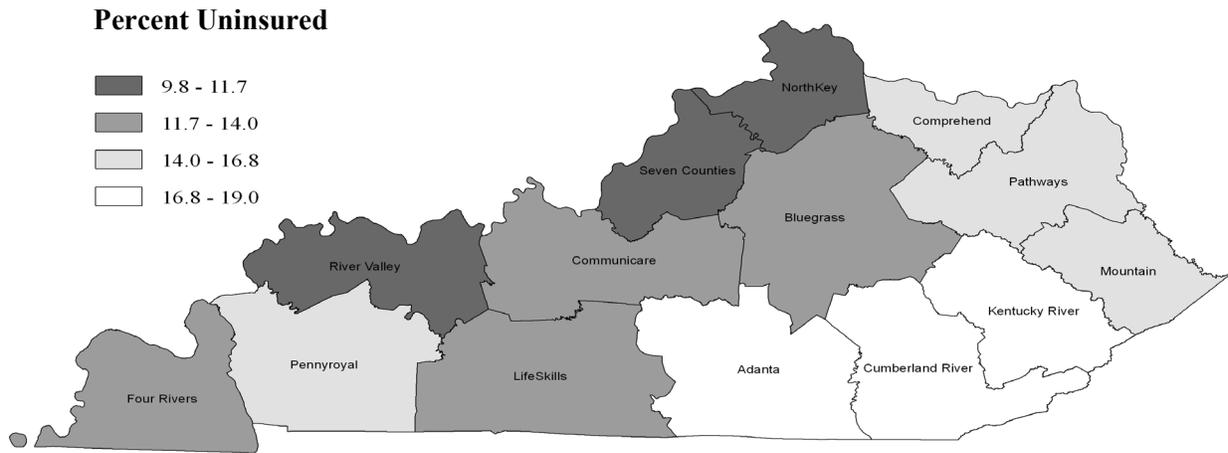


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**Figure 3.E Continued**



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The mix of consumer age groups has remained relatively stable.

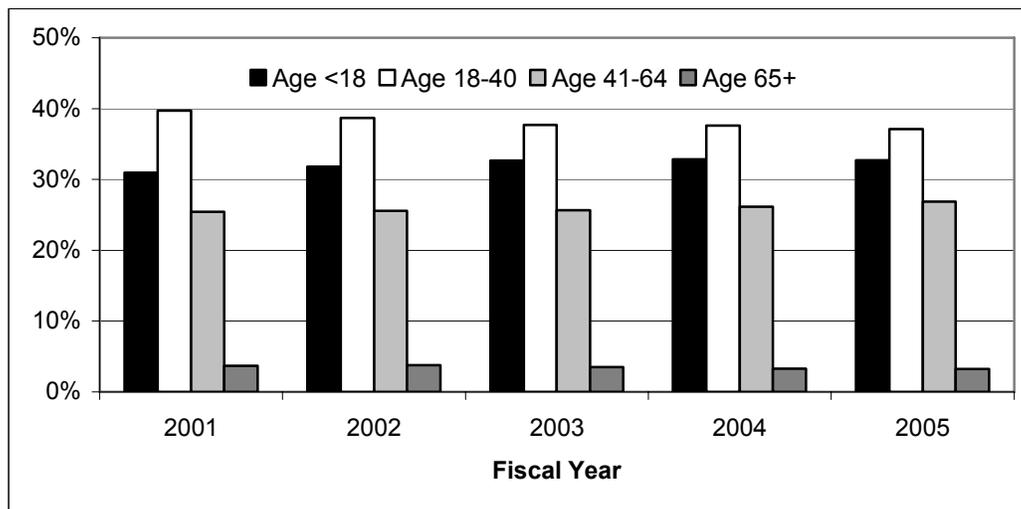
Figure 3.F shows the percentage of consumers by age group during the period 2001 to 2005. The mix of age groups remained relatively stable. As percentages of the total consumer population, there were small increases in consumers younger than 18 years and those between the ages of 41 and 64.

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Persons 40 years and younger were 70 percent of consumers.

Consumers between the ages of 18 and 40 years comprised the largest segment, on average representing 38.1 percent of the service population. Consumers younger than 18 years of age comprised 32.2 percent of the service population. Consumers between the ages of 41 and 64 years comprised 26 percent, and consumers older than 65 years comprised 3.5 percent of the service population. Appendix B provides more detail.

**Figure 3.F**  
**Percentage of Consumers by Age Group**  
**Fiscal Years 2001 to 2005**



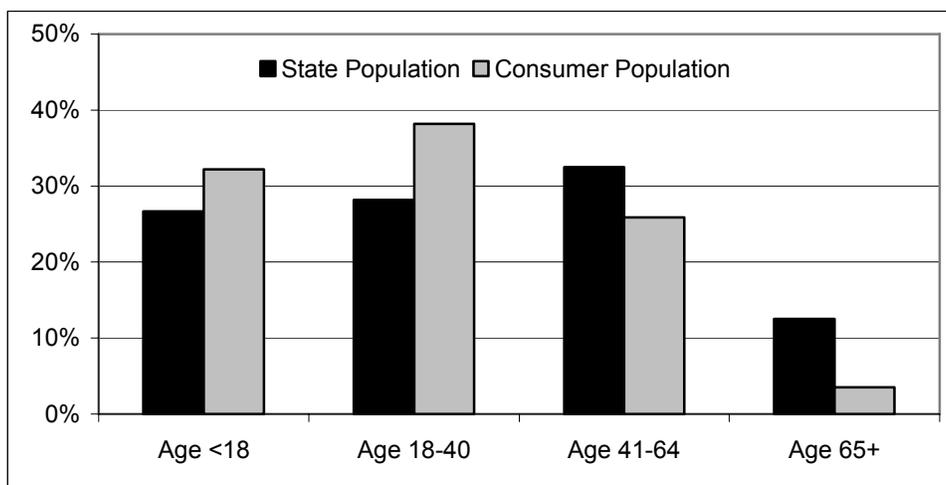
Source: Compiled by Program Review staff from information obtained from the Department for Mental Health and Mental Retardation Services.

Persons 40 years and younger are overrepresented in the consumer population by approximately 28 percent.

Figure 3.G displays the average mix of age groups for both consumers and the general state population from 2001 to 2005. Due to differences in data reporting, the first three age groups differ slightly but still offer useful comparisons.<sup>3</sup> On average, consumers younger than 18 years of age are overrepresented in the consumer population by approximately 20 percent. Consumers aged 18 to 40 years old are overrepresented by approximately 35 percent.

In contrast, older consumers are underrepresented relative to the general population. On average, consumers 41 to 64 years old are underrepresented by 20 percent and consumers older than 65 are underrepresented by 72 percent. A possible explanation for the low percentage of consumers over age 65 is that many of these people are homebound or live in facilities such as nursing homes rather than in the community. They may have no way to get to a community center. Another possible explanation is that the nursing homes do not contact the centers for residents' mental health needs. The nursing homes would be responsible for paying for the services, since the home's daily reimbursement rate is supposed to cover all forms of care for a person.

**Figure 3.G**  
**Percentages of Statewide Consumers and Population by Age Group**  
**Fiscal Years 2001 to 2005**



Source: Compiled by Program Review staff from information obtained from the Department for Mental Health and Mental Retardation Services and from *Annual Estimates of the Population by Sex and Age for Kentucky* (U.S. Department of Commerce. Census. Population).

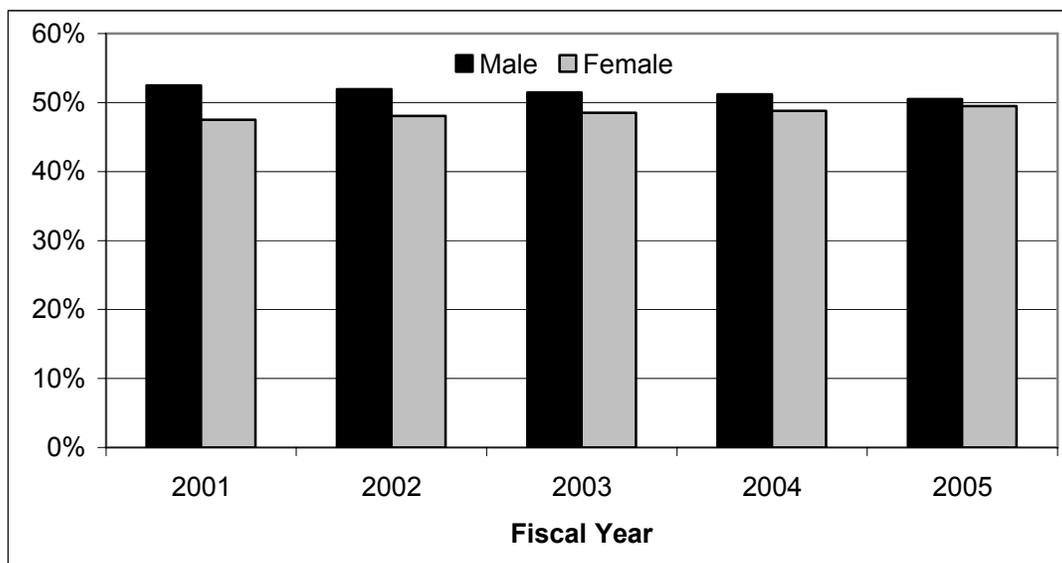
<sup>3</sup> The department and the Census Bureau compile information on different but similar age groups. The department uses the following groups: less than 18, 18 to 40, 41 to 64, and 65 and over. The Census Bureau uses less than 20, 20 to 39, 40 to 64, and 65 and over.

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Males and females were almost evenly represented.

Figure 3.H shows the percentage of consumers by gender during the period 2001 through 2005. As a percentage of the total consumer population, males declined by 2 percentage points and females increased by 2 percentage points. On average, male consumers comprised 51.5 percent of the service population and female consumers comprised 48.5 percent of the service population. In general, the trend during this time has been for the gender composition of the consumer population to converge to that of the general population. Still, on average, males make up slightly more of the consumer population than they do the general population. Appendix B provides more detail.

**Figure 3.H**  
**Percentage of Consumers by Gender**  
**Fiscal Years 2001 to 2005**



Source: Compiled by Program Review staff from information obtained from the Department for Mental Health and Mental Retardation Services.

Racial data for fiscal year 2003 was the earliest information available when this report was developed. On average, whites including Hispanics comprised 86.5 percent of consumers, and African Americans comprised 9.6 percent. Other racial groups comprised 1.9 percent of the total service population.

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On average, the white population including Hispanics is underrepresented by 4 percent in the consumer population. African Americans are overrepresented by approximately 30 percent.

As a percentage of total consumers, whites increased by 1.6 percentage points between 2003 and 2005. African Americans increased by 0.3 percentage points, while other racial groups declined by 0.3 percentage points.

On average, African Americans are overrepresented by approximately 30 percent in the consumer population. In contrast,

whites including Hispanics are underrepresented by roughly 4 percent in the consumer population. Appendix B provides regional details on consumers' race.

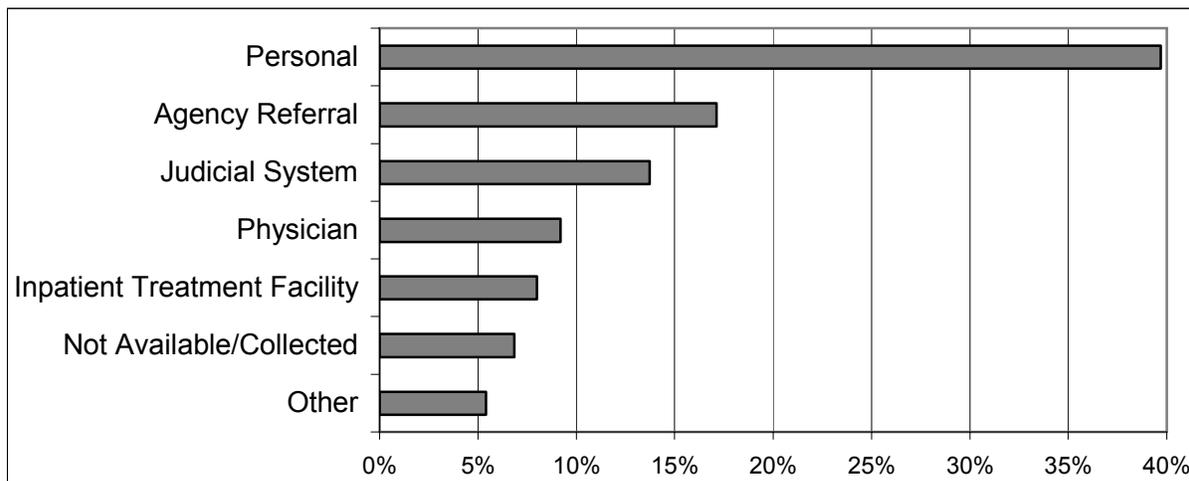
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Almost 40 percent of consumers were personal referrals, which are self-referrals.

Figure 3.I shows an average index of statewide consumer referral sources to community services from 2001 through 2005. On average, personal referrals, which are self-referrals, comprised 39.7 percent of consumers. This represented the largest referral group followed by agency referrals at 17.1 percent and judicial system referrals at 13.7 percent.

As a percentage of total consumers, personal referrals increased 6.1 percent between 2001 and 2005. Those referred by an agency increased 0.6 percent. Judicial system referrals declined 2.4 percent during the same period. Physician referrals and those referred through an inpatient treatment facility remained relatively stable during this period. Appendix B provides regional details on referral sources.

**Figure 3.I**  
**Average Percentage of Referrals by Source**  
**Fiscal Years 2001 to 2005**



Source: Compiled by Program Review staff from information obtained from the Department for Mental Health and Mental Retardation Services.

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On average, almost 84 percent of consumers reside in nonstaffed residences.

On average, consumers living in nonstaffed residences, which include their own homes, the homes of parents or guardians, and boarding homes, comprised 83.7 percent of the service population. This represented the largest consumer group. Those living in "other" residences comprised 11.2 percent of consumers. Other residences include foster care, alcohol or drug treatment facilities, and jail or prison. On average, consumers in licensed long-term

care facilities or with no fixed residence each comprised 1.8 percent of the service population.

As a percentage of total consumers, the relative mix of housing types remained stable between 2001 and 2005. A slight decline of 0.2 percent occurred in those consumers living in licensed long-term care facilities, relative to the total service population. An increase of 1.3 percent in those living in nonstaffed residences occurred during this period, relative to the total service population. Appendix B provides more detail.

## Chapter 4

### Services and Funding

This chapter discusses funding of the services provided by the centers. Services by program area (mental health, substance abuse, mental retardation and other developmental disabilities, and others) are discussed. Funding from different payers, levels of government, and other sources is examined.

#### Sources of Information on Services and Funding

Program Review staff worked with staff from the Department for Mental Health and Mental Retardation Services and the centers to define the services listed on regional cost reports as either mental health, substance abuse, mental retardation or other developmental disabilities, and other. Services classified as “other” could have been provided, for example, to persons with brain injury. Alternatively, these can be services provided to a combination of persons with mental health, substance abuse, and/or mental retardation diagnoses. For example, a sheltered workshop may employ consumers with various diagnoses. Funding information was obtained from the boards’ audited financial statements and other sources from the centers and the department.

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In fiscal years 2001 through 2005, the total number of services provided to consumers increased by more than 27 percent, from 14 million to 18 million.

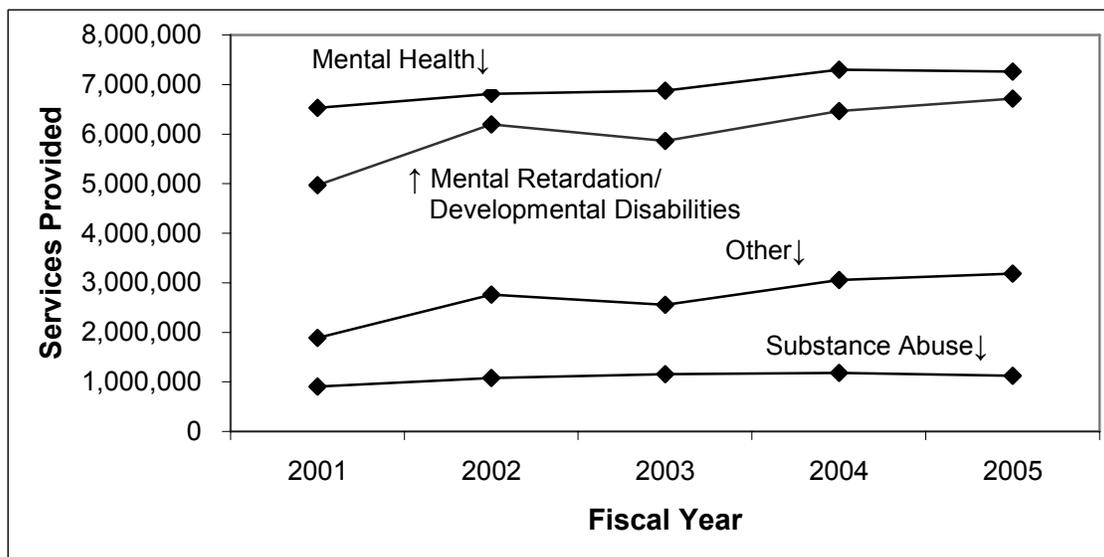
Figure 4.A shows the number of services provided by the centers in fiscal years 2001 through 2005. During this period, the total number of services provided to consumers changed from about 14 million to about 18 million, an increase of 27.8 percent. On average, mental health services constituted 41.6 percent, substance abuse services constituted 6.5 percent, and mental retardation and other developmental disabilities services constituted 36 percent of total services provided. Appendix C shows regional details of service units by program area.

Resources received by the centers for providing services to consumers can be characterized by type of payer:

- Department for Medicaid Services for the Supports for Community Living waiver program and other Medicaid-eligible services;
- Department for Mental Health and Mental Retardation Services for services paid for by the two major block grants and other state and federal sources for services not reimbursable by Medicaid and other sources; and

- Other payers, including self-pay consumers, private insurance, Medicare, local contributions, and grants from other sources.

**Figure 4.A**  
**Statewide Services by Type**  
**Fiscal Years 2001 to 2005**



Source: Compiled by Program Review staff from regional cost reports with assistance from the centers and the Department for Mental Health and Mental Retardation Services.

On average, Medicaid paid for 55 percent of services, the department paid for 34 percent, and other sources paid for 11 percent.

On average, Medicaid paid for 55 percent of services provided by the centers during fiscal years 2001 through 2005. The department paid for 34 percent of services from federal grants and state funds. Other sources paid for 11 percent. Table 4.1 shows the relative mix of services by payer in fiscal years 2001 through 2005. Medicaid payments for Supports for Community Living and other services are shown separately for informational purposes only.

**Table 4.1**  
**Statewide Services by Payer Source**  
**Fiscal Years 2001 to 2005**

	2001	2002	2003	2004	2005
Medicaid (Other)	29.6%	26.6%	27.5%	27.1%	27.1%
Medicaid (Supports for Community Living)	26.5%	27.4%	26.6%	27.6%	29.2%
Dept. for Mental Health & Mental Retardation Svcs.	29.6%	32.0%	35.6%	36.0%	35.3%
Other	14.3%	14.0%	10.4%	9.4%	8.4%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Compiled by Program Review staff from regional cost reports with assistance from the centers and the Department for Mental Health and Mental Retardation Services.

During this period, the number of services provided by centers increased by 27.8 percent. The increase in services was not evenly distributed among payer sources.

While services paid for by the department increased by more than 50 percent during this period, services with other payer sources declined by nearly 25 percent. This situation may point to an increasing number of consumers with no insurance and an increasing reliance on the safety net to pay for services. Appendix D provides regional details of services by payer source.

Another way to characterize funding is to analyze revenue from the different levels of government and other sources. For example, local revenues can be analyzed to indicate local governments' ability and willingness to participate in funding local services, as recommended in the 1966 *Pattern for Change* report (Commonwealth, Kentucky). Support can include local in-kind contributions, for example: donated space. In this type of analysis, revenue and support can be divided into six major sources:

1. federal government,
2. state government,
3. local taxes and/or appropriations,
4. other local support,
5. charges to patients, and
6. other miscellaneous.

Table 4.2 shows total revenue during fiscal years 2002 through 2005. State fiscal year 2001 is excluded because specific details were not available from all regions. The amounts in Table 4.2 are adjusted for inflation to reflect 2001 dollars.<sup>1</sup>

On average, from fiscal year 2002 through fiscal year 2005, 54 percent of revenue came from the federal government, and 32 percent came from state government sources. Charges to patients comprised approximately 7 percent of revenue during the same period.

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Adjusted for inflation, revenue from the federal government increased about 4 percent from fiscal year 2002 to fiscal year 2005, while revenue from the state decreased by about 0.5 percent.

Adjusted for inflation to reflect 2001 dollars, revenue from the federal government increased approximately 4 percent from fiscal year 2002 to fiscal year 2005, while revenue from the state decreased by approximately 0.5 percent. Other sources, including patient charges and local support increased, but relative to total revenues these increases were marginal.

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<sup>1</sup> Adjustments were made using the Consumer Price Index from the U.S. Department of Labor's Bureau of Labor Statistics. Medical inflation is typically higher than the Consumer Price Index.

**Table 4.2**  
**Revenue by Source, Adjusted for Inflation (in \$ million)**  
**Fiscal Years 2002 to 2005**

Revenue Source	2002	2003	2004	2005
Federal	\$178.1	\$180.1	\$180.3	\$185.3
State	104.6	106.9	106.3	104.2
Local Tax Match	2.5	2.6	2.7	2.8
Other Local Match	8.6	9.5	10.2	10.1
Charges to Patients	20.7	22.9	24.9	24.1
Other Revenue	9.4	10.6	11.1	13.3
Total (\$ million)	\$323.9	\$332.7	\$335.6	\$339.7

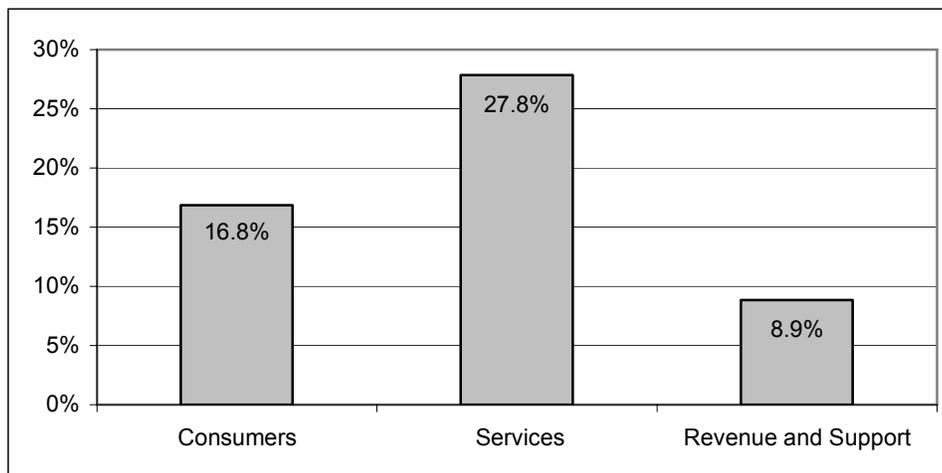
Fiscal year 2001 is excluded due to lack of detail on sources from certain regions.

Source: Compiled by Program Review staff from financial information from the regions' audited financial statements and additional information submitted by centers.

Over recent years, total revenue, adjusted for inflation, increased by 8.9 percent, while the number of consumers increased by 16.8 percent and the number of services increased by 27.8 percent.

Total revenue and support, adjusted for inflation to reflect 2001 dollars, has increased by 8.9 percent, from \$312 million in 2001 to \$339 million in 2005. Appendix E contains detailed revenue information for each region. The number of consumers increased by 16.8 percent, and the number of service units increased by 27.8 percent. Figure 4.B shows the relative difference between changes in consumers, services, and revenues from fiscal years 2001 through 2005. Regional details are provided in Appendix F.

**Figure 4.B**  
**Percentage Change in Consumers, Services, and Revenue**  
**Fiscal Years 2001 to 2005**



Note: Percentage change in revenue and support is based on inflation-adjusted dollars.

Source: Compiled by Program Review staff from financial information from the regions' audited financial statements, additional information submitted by centers, and consumer information obtained from the Department for Mental Health and Mental Retardation Services.

**Federal Revenue**

On average, Medicaid provides nearly 80 percent of federal funding.

Federal revenue to the centers comes from the Medicaid program, the Community Mental Health Services block grant, the Substance Abuse Prevention and Treatment block grant, and various grants from other federal agencies. On average, Medicaid provides nearly 80 percent of federal funding, with the community mental health services and substance abuse block grants providing another 12 percent. For details on the amounts provided by the Community Mental Health Services block grant and the Substance Abuse Prevention and Treatment block grants, see Appendix F. Table 4.3 depicts federal revenue by source for fiscal years 2002 and 2005, as well as the percent change during this time. Fiscal year 2001 is excluded due to lack of specific details from all regions.

**Table 4.3  
 Federal Revenue by Source, Adjusted for Inflation  
 Fiscal Years 2002 and 2005**

Federal Revenue Source	2002		2005		2002 to 2005
	Amount	% of Federal Revenue	Amount	% of Federal Revenue	% Change
Medicaid (not SCL)	\$109,011,166	61.2%	\$110,611,225	59.7%	1.5%
Medicaid (SCL)	\$32,850,553	18.4%	\$39,140,678	21.1%	19.1%
CMHS Block Grant	\$5,186,896	2.9%	\$4,943,102	2.7%	-4.7%
SAPT Block Grant	\$15,960,681	9.0%	\$16,232,486	8.8%	1.7%
Other	\$15,097,765	8.5%	\$14,410,294	7.8%	-4.6%
Total	\$178,107,061	100.0%	\$185,337,785	100.0%	4.1%

SCL-Supports for Community Living waiver, CMHS-Community Mental Health Services, SAPT-Substance Abuse Prevention and Treatment.

Source: Compiled by Program Review staff from financial information from the regions' audited financial statements and additional information submitted by the centers.

Adjusted for inflation to reflect 2001 dollars, federal revenue increased from approximately \$178 million in 2002 to roughly \$185 million in 2005. This change is an increase of 4 percent. Nearly all of this increase came from a 19.2 percent increase from Medicaid's Supports for Community Living waiver. Other Medicaid dollars and revenue from the Substance Abuse Prevention and Treatment block grant both increased by approximately 1.5 percent. In contrast, revenue from the Community Mental Health Services block grant declined, as did support from other federal sources.

## State Revenue

State revenue from the department represents 81 percent of centers' state revenue. Other state sources include the Department for Community Based Services.

State revenue from the department represents 81 percent of centers' state revenue. The remaining 19 percent comes from other agencies, such as the Department for Community Based Services. Table 4.4 shows state revenue from the department and other state sources for fiscal years 2002 and 2005. State fiscal year 2001 is excluded due to lack of specific details from all regions. The figures are adjusted for inflation to reflect 2001 dollars.

**Table 4.4**  
**State Revenue by Source, Adjusted for Inflation**  
**Fiscal Years 2002 and 2005**

State Revenue Source	2002		2005		2002 to 2005
	Amount	% of State Revenue	Amount	% of State Revenue	% Change
Dept. for Mental Health and Mental Retardation Services	\$85,581,808	81.8%	\$84,419,039	81.0%	-1.4%
Other State Revenue	\$19,007,789	18.2%	\$19,745,597	19.0%	3.9%
Total	\$104,589,597	100.0%	\$104,164,637	100.0%	-0.4%

Source: Compiled by Program Review staff from financial information from the regions' audited financial statements and additional information submitted by the centers.

Revenue from the department declined 1.4 percent from fiscal year 2002 to fiscal year 2005. Total state revenue declined approximately 0.4 percent over the same period.

## Community Care Support

The community care support grants are state general funds intended to support the safety net by funding services for consumers who have no other payer source.

The majority of state contract dollars are tied to specific services for specific consumer populations. For example, certain general fund allocations are dedicated to substance abuse, mental health, and mental retardation and other developmental disabilities services, and include specific allocations for services such as jail triage and crisis response. The community care support grants made to each region from the state general fund are flexible dollars intended to support the safety net by funding services for consumers who have no other payer source.

The community care support dollars are allocated by the department to the regions based on a formula in 908 KAR 2:050. The allocation formula has four parts:

1. Per capita funds—15 percent is allocated on a per capita basis.
2. Discretionary funds—10 percent is allocated at the discretion of the cabinet secretary.

3. Cost-related fee-for-service funds—60 percent is allocated based on service units reported in each region’s annual plan and budget.
4. Incentive funds—15 percent is allocated based on the local tax match and other local match of each region. These funds are weighted based on the per capita wealth of the region. Local tax match may be a mental health and mental retardation tax and/or a direct appropriation by a county fiscal court or city legislative body. Other local match includes in-kind contributions, cash donations, sale of workshop products, interest income, rental income, and certain funds derived from affiliates.

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Adjusted for inflation, the community care support funds have declined nearly 7 percent since fiscal year 2001. An additional \$1.9 million would be needed in fiscal year 2006 to equal the 2001 allocation.

Adjusted for inflation to reflect 2001 dollars, the community care support funds have declined nearly 7 percent from fiscal year 2001 to fiscal year 2006. Table 4.5 shows the total allocation of community care support dollars by region for fiscal years 2001 and 2006. Included for each year is the percentage of total allocation for that region and the total change from 2001 to 2006. See Appendix H for details on the allocation of community care support funds.

In nominal dollars, the fiscal year 2006 allocation was \$25.55 million, which includes an additional \$2 million to shore up the safety net of the community care support funds. However, adjusted for inflation, the funds declined \$1.67 million from 2001 to 2006. To equal the fiscal year 2001 allocation, the 2006 allocation would need to be \$27.45 million in nominal dollars, which is \$1.9 million more than the actual 2006 allocation.

**Table 4.5**  
**Community Care Support Allocations by Region**  
**Adjusted for Inflation**  
**Fiscal Years 2001 and 2006**

Region	2001		2006		2001 to 2006
	Dollars	% of Total Allocation	Dollars	% of Total Allocation	% Change
1 Four Rivers	\$1,137,139	4.7%	\$1,030,923	4.6%	-9.3%
2 Pennyroyal	\$1,139,091	4.7%	\$1,024,361	4.6%	-10.1%
3 River Valley	\$1,141,330	4.7%	\$1,035,324	4.6%	-9.3%
4 LifeSkills	\$1,506,801	6.3%	\$1,385,288	6.2%	-8.1%
5 Communicare	\$1,445,403	6.0%	\$1,339,129	6.0%	-7.4%
6 Seven Counties	\$5,030,762	20.9%	\$4,794,722	21.4%	-4.7%
7 NorthKey	\$1,858,637	7.7%	\$1,921,066	8.6%	3.4%
8 Comprehend	\$470,441	2.0%	\$418,494	1.9%	-11.0%
10 Pathways	\$1,476,235	6.1%	\$1,377,521	6.1%	-6.7%
11 Mountain	\$1,542,018	6.4%	\$1,351,278	6.0%	-12.4%
12 Kentucky River	\$1,302,726	5.4%	\$1,126,252	5.0%	-13.5%
13 Cumberland River	\$1,503,188	6.2%	\$1,360,730	6.1%	-9.5%
14 Adanta	\$955,806	4.0%	\$915,555	4.1%	-4.2%
15 Bluegrass	\$3,573,823	14.8%	\$3,332,875	14.9%	-6.7%
State	\$24,083,400	100.0%	\$22,413,518	100.0%	-6.9%

Source: Compiled by Program Review staff from information obtained from the Department for Mental Health and Mental Retardation Services.

### Potential Revenue Is Decreased by Charity Allowances

The charity allowance is the amount an indigent person is not required to pay.

The centers are required by statute to provide services regardless of a person's ability to pay. The charity allowance is the amount an indigent person is not required to pay and is determined on an income-related sliding fee schedule unique to each region.

Program Review staff used the charity allowance as an estimate of the amount of community care support funds that would be needed to maintain the safety net. However, the reliability of the estimate is uncertain because of different interpretations of what should be measured and variations in accounting systems among regions.

Program Review staff obtained from each center its total charity allowance for fiscal years 2001 through 2005. Staff used the charity allowance as an estimate of the amount of community care support funds that would be needed to maintain the safety net. However, the reliability of the estimate is uncertain because of different interpretations of what should be measured and variations in accounting systems among the centers. Some centers reported the net difference between expenses and revenues received from their contracts with the department. Some reported the difference between the usual charge for a service and the amount collected from the consumer based on the sliding fee scale. Some included amounts that should have been classified as bad debts because the full amount of revenue was expected to be received but was not.

Table 4.6 shows the average charity allowance estimates for fiscal year 2001 to fiscal year 2005 for each region and compares the estimates to the community care support allocation for state fiscal year 2006. The difference between the two is noted in dollars and as a percentage of the 2006 allocation. The regions vary in dollars and percentages, in part because of differences in reporting the charity allowance.

**Table 4.6**  
**Charity Care Estimates and Community Care Support Funds by Region**  
**(Nominal Dollars)**

<b>Region</b>	<b>Estimated Avg. Annual Charity Allowance 2001 to 2005</b>	<b>Community Care Support Allocation 2006</b>	<b>Difference in Dollars</b>	<b>Difference as % of 2006 Allocation</b>
1 Four Rivers	\$2,856,616	\$1,175,137	\$(1,681,479)	-143.1%
2 Pennyroyal	\$406,697	\$1,167,657	\$760,960	65.2%
3 River Valley	\$450,419	\$1,180,153	\$729,734	61.8%
4 LifeSkills	\$2,157,080	\$1,579,073	\$(578,007)	-36.6%
5 Communicare	\$1,665,741	\$1,526,457	\$(139,284)	-9.1%
6 Seven Counties	\$2,739,140	\$5,465,446	\$2,726,306	49.9%
7 NorthKey	\$2,229,577	\$2,189,800	\$(39,777)	-1.8%
8 Comprehend	\$586,338	\$477,036	\$(109,302)	-22.9%
10 Pathways	\$1,129,352	\$1,570,220	\$440,868	28.1%
11 Mountain	\$493,311	\$1,540,306	\$1,046,995	68.0%
12 Kentucky River	\$395,041	\$1,283,801	\$888,760	69.2%
13 Cumberland River	\$2,017,870	\$1,551,080	\$(466,790)	-30.1%
14 Adanta	\$4,829,952	\$1,043,630	\$(3,786,322)	-362.8%
15 Bluegrass	\$6,889,215	\$3,799,104	\$(3,090,111)	-81.3%
State	\$28,846,348	\$25,548,900	\$(3,297,448)	-12.9%

Source: Compiled by Program Review staff from information obtained from the centers.

The 2006 community care support allocation is \$3 million less than the five-year average charity allowance. However, this should not be interpreted to mean that an additional \$3 million in community care support funding is needed.

The statewide community care support allocation for fiscal year 2006 is \$3 million less than the five-year average charity allowance. Stated differently, the community care support allocation is 12.9 percent less than needed to cover financially the reported charity allowance.

However, the information in Table 4.6 should not be interpreted to mean that an additional \$3 million in community care support funding is needed. The variations among regions emphasize the different ways that charity allowances are defined and reported. The differences may be caused, in part, by the definitions used by the boards in preparing their annual cost reports, which are required by the department. Certain costs—including charity allowances, courtesy allowances, and bad debts—are not allowed

to be paid with federal funds and are deducted from total costs on the cost report. The cost report instructions defines these terms:

- “Charity allowances” are reductions in charges made by the provider of services because of the person’s indigence or medical indigence.
- “Courtesy allowances” are reductions in charges for services as approved by the policies of the governing board.
- “Bad debts” are amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services (Commonwealth. Cabinet. *Community*. 208.01).

For the annual cost report, it would not be necessary for a center’s accounting system to be able to distinguish between charity allowances, courtesy allowances, and bad debts since the total of the three must be reported. However, the three terms infer different intent. A charity allowance is required by statute to ensure that indigent people are not denied care. A courtesy allowance is a business decision to collect less than the normal charge for a service, for example, to a corporate employer for which the center provides an employee assistance program. A bad debt is a charge that was expected to be collected but was not. Neither bad debts nor courtesy allowances are directly related to the statutory requirement to provide care to indigent persons.

The department and the centers need to know how much charity care is being provided, and a standardized method of calculating and reporting charity care is necessary for developing a reasonable budget estimate.

#### **Recommendation 4.1**

**The Department for Mental Health and Mental Retardation Services should develop a standardized method to calculate charity allowances. The department should require the boards to use that method and report annually, in conjunction with their annual financial statement audit, a separate schedule of charity allowances. The boards’ independent auditors should be required to certify that the charity allowances are reported in accordance with the department’s instructions.**

### Financial Results Vary Among the Regions

Figures 4.C and 4.D illustrate the total percentage change in net assets and the average annual operating margin for each region from fiscal year 2001 to fiscal year 2005. These indicators illustrate the financial health, operational efficiency, and profitability of the regions and the statewide system.

Net assets of the regions, defined as total assets less total liabilities, increased 40 percent, on average, from 2001 to 2005. The Pennyroyal region's net assets declined slightly, while net assets of the LifeSkills region increased 105 percent. This variation typifies the wide range of financial strength among the regions. The aggregate rate of increase in net assets declined from 11.5 percent between 2001 and 2002 to 7.6 percent between 2004 and 2005.

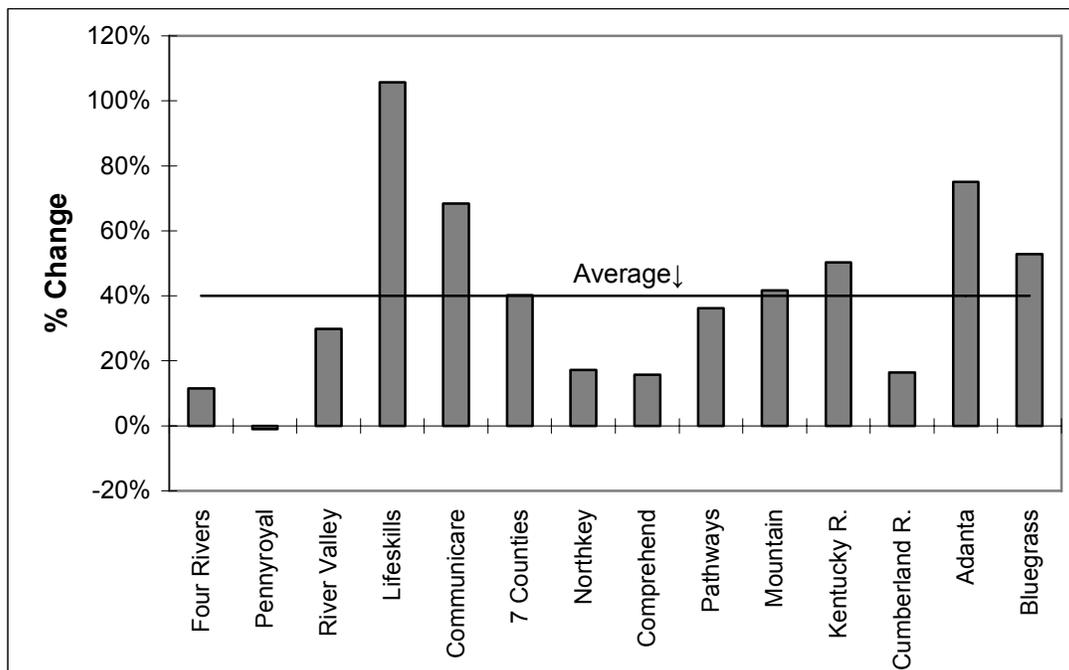
Similar variations are seen between regions in operating margins, defined as the difference between total revenues and operating expenses divided by total revenues. The statewide average during the period 2001 to 2005 was 2.5 percent. Average margins ranged from more than 6 percent in the Adanta region to 0.2 percent in the Four Rivers region. The average operating margin declined during this period from 2.9 percent to 2.6 percent.

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Staff analysis of financial results shows great variation among regions. The system statewide appears to be capable of providing current services to current populations, but the ability to expand services or serve larger populations is questionable, particularly in some regions.

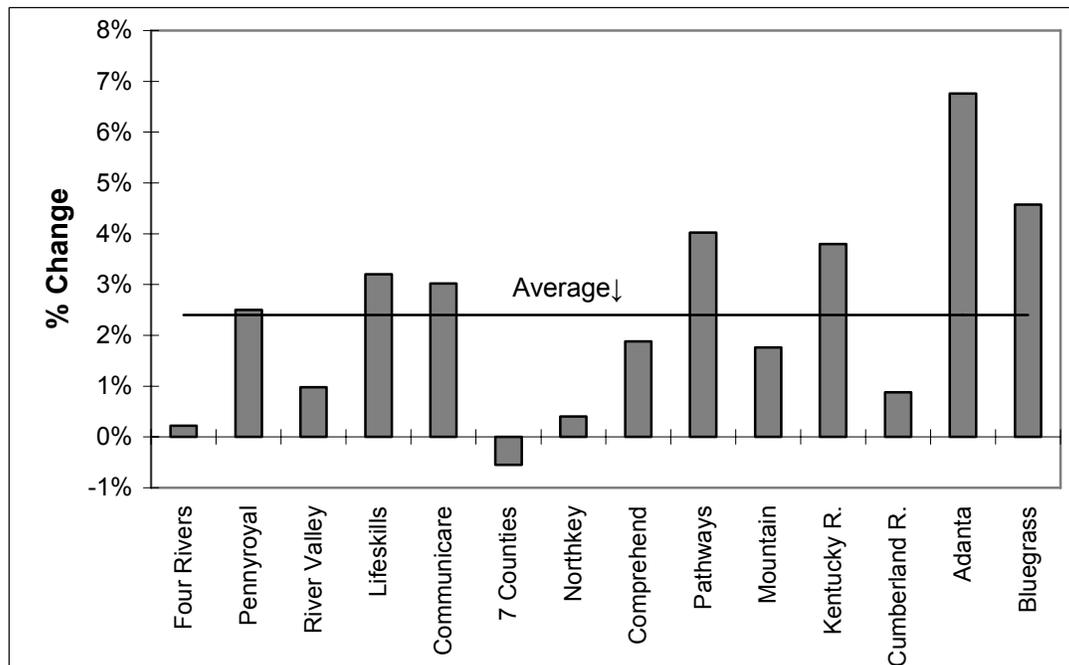
The decline in the rate of increase in net assets and the decline in average operating margin may reflect pressure from increasing expenses not matched by new revenue. There is great variability among the regions. In general, the system statewide appears to be stable in terms of providing current services to current populations. The system's capacity to expand services or serve larger populations remains in question. Appendix I provides detail on common financial measures for all regions from fiscal year 2001 to 2005.

**Figure 4.C**  
**Total Percentage Change in Net Assets by Region (Nominal Dollars)**  
**Fiscal Years 2001 to 2005**



Source: Compiled by Program Review staff from regional audited financial statements.

**Figure 4.D**  
**Five-year Average of Operating Margin by Region (Nominal Dollars)**  
**Fiscal Years 2001 to 2005**



Source: Compiled by Program Review staff from regional audited financial statements.

## Chapter 5

### Consumer Outcomes and Other Performance Measures

Chapter 2 discussed the roles of consumer groups required by state and federal law to be involved in planning for services. This chapter provides an overview of additional groups that assist in planning for services and improving consumer outcomes. The chapter also provides information on a pilot project to decrease psychiatric hospital admissions, as well as consumer outcome measures and state performance indicators.

#### Consumer Groups Advocate for Improved Outcomes

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Consumer groups advocate for improved outcomes. Their members and programs vary.

Many groups advocate for improved outcomes for people who receive services from the centers. This chapter highlights three such groups: NAMI Kentucky (National Alliance for the Mentally Ill), the Kentucky Consumer Advocate Network, and the Arc of Kentucky (Association for Retarded Citizens).

NAMI Kentucky is a self-help organization. Its members and staff include persons with severe mental illness and their families and friends. Its goals and programs include educating the public about the prevalence of mental illness, alternative treatments, and the need for community facilities and services. Following are examples of its programs:

- The Family-to-Family program for family caregivers of individuals with severe mental illness teaches the clinical treatment of certain illnesses and the knowledge and skills that family members need to cope more effectively.
- The Facilitator Skills Support Group training is designed to enable facilitators to run positive and productive local support groups for persons with mental illness and their families and friends.
- The Crisis Intervention Team training program for police officers provides instruction on the signs and symptoms of mental illness and the ways officers can help individuals. NAMI Kentucky reports that more than 95 percent of persons with mental illness encountering police officers who have completed the training are diverted to treatment rather than being taken to jail.

- The In Our Own Voice program is a presentation by consumers that creates awareness about recovery from mental illness. One of its purposes is to reduce the stigma of mental illness by changing people's attitudes about it. In addition, the program provides an opportunity for consumers to gain income, self-confidence, and self-esteem.

The Kentucky Consumer Advocate Network is a nonprofit organization of mental health consumers that promotes the rights, concerns, and issues of persons with mental illness. Following are examples of its programs:

- The Building Recovery of Individual Dreams and Goals through Education and Support program is commonly known by its acronym, BRIDGES. BRIDGES Education is a consumer-taught program that provides detailed information on certain mental illnesses and ways of coping with the challenges of living with a mental illness. BRIDGES Support trains consumers to facilitate ongoing peer-to-peer support groups. It uses consumers' expertise and abilities to help each other. In BRIDGES Best Practice, stipends are provided to consumers who lead classes in their home areas of the state.
- Under contract with the state, the network coordinates independent consultative peer reviews of the 14 regional boards. The reviews are conducted by teams of consumers, family members, and providers. The teams' reports are intended to be used by all stakeholders to effect and enhance improvements in the system of health care.
- The Wellness Recovery Action Plan is presented in workshops that teach consumers how to identify, monitor, modify, and eliminate the symptoms of their mental illnesses.

The Arc of Kentucky addresses the needs of persons with mental retardation and other developmental disabilities. Its Advocates in Action program is a self-determination leadership training program designed to train individuals with disabilities, family members, and professionals working with people with disabilities. The goal is to enable participants to become advocates who can effectively influence public policy.

### **A New Project Seeks To Decrease the Rate of Psychiatric Hospital Admissions**

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The cabinet has introduced a new project to reduce the number of state hospital admissions by enhancing services in the community.

In fiscal year 2007, the cabinet introduced a new project to target the rising rate of adults being hospitalized in state psychiatric facilities. The project is called Direct Intervention: Vital Early

Responsive Treatment System. It is commonly known by its acronym, DIVERTS. The project, initiated in western Kentucky, seeks to enhance community-based services to include early intervention options to reduce the number of admissions to Western State Hospital. The project partners are the cabinet, the department, NAMI Kentucky, Western State Hospital, and the Four Rivers, Pennyroyal, River Valley, and LifeSkills boards.

Admissions to Western State Hospital have been increasing, and the cabinet noted that it appeared that a new unit would have to be built if the trend was not reversed. Rather than build a new unit at a cost of \$2 million, the cabinet decided to partner with the hospital and the boards to increase community services and avert hospital admissions when appropriate.

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The project proposes to use telecommunications technology to connect the community and the psychiatric hospital staff.

A foundation of the project is the use of telecommunications technology to provide mental health services. Referred to as telemental health, the system would establish Internet connections between the hospital and the four partner regions. Using this system, a “virtual treatment team” would be created between the community and the inpatient psychiatric facility staff. This approach is expected to be particularly helpful in rural areas. Since the project is just beginning, no significant results are yet available.

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The project should help alleviate local resource problems, including shortages of clinical staff and consumer transportation.

The DIVERTS project should help alleviate some of the resource shortages the centers identified to Program Review staff. All 14 regions cited difficulties in recruiting and retaining psychiatrists. Twelve regions noted shortages in nursing staff, and nine noted problems hiring social workers. The centers reported that a common problem is the physical location of program services in rural areas. In addition, all regions reported that their salary scales are below those in the private market. Accessing clinical staff through telemental health may help the regions cope with staff shortages.

Consumer transportation is another resource shortage reported by all regions. Some areas of the state have no bus or taxi service, and the consumers have no vehicles of their own or family members who can bring them to services. The transportation problem frequently causes consumers to miss appointments, increasing costs for the centers and breaking the continuity of care for the consumer.

## Assessing Consumer Outcomes Is Difficult

Consumers seek various outcomes of treatment. Some of the outcomes identified in the professional literature include reduced symptoms, increased independence, employment, housing stability, consumer satisfaction, reduced hospitalizations, reduced criminal justice involvement, and reduced suicides.

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Assessing consumer outcomes is difficult, in part because of a lack of consensus on the performance to be measured and how it should be measured.

A 2006 report from the National Academy of Sciences' Institute of Medicine states that the infrastructure necessary to support quality improvement of mental health and/or substance-use health care is insufficient for several reasons:

- Clinical assessment and treatment practices have not been standardized and classified for inclusion in the administrative databases widely used to analyze variations in care and other quality-related issues in general health care.
- Initiatives to disseminate advances in evidence-based care often fail to use effective strategies and available resources.
- The development of performance measures for mental and/or substance-use health care has not received sufficient attention in the private sector, and efforts in the public sector have not achieved consensus.
- The understanding and use of modern quality improvement methods are not implemented in the day-to-day practice of those delivering mental health and/or substance-use health care services (141).

Authors of the report suggest that the methods for treating mental and substance-use illnesses vary due to poor dissemination of research on the effectiveness of specific methods. This variation in methodology creates a barrier to the consistent and reliable evaluation of treatment outcomes. Several types of treatments are used by different clinicians or organizations to treat the same symptoms, which creates the need for multiple evaluation tools. Some of the measures target a specific illness such as depression or schizophrenia, whereas others provide a more generalized evaluation of overall mental health. Lack of consensus on which measures should be used is an additional barrier to the evaluation of outcomes.

### National Outcome Measures

The federal Substance Abuse and Mental Health Services Administration lists several potential outcomes:

- abstinence from drug or alcohol use,
- decreased mental illness symptomatology (symptoms),

- increased or retained employment or returned to or stayed in school,
- decreased criminal justice involvement,
- increased stability in housing,
- increased social supports or social connectedness,
- increased access to services,
- increased retention in substance abuse treatment,
- reduced utilization of psychiatric inpatient beds,
- clients' perceptions of care,
- cost effectiveness, and
- use of evidence-based practices (U.S. Department of Health. Substance. "Substance").

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Kentucky provides data for most of the mental health outcomes and some of the substance abuse outcomes identified by the federal Substance Abuse and Mental Health Services Administration.

The outcomes are consistent with those reported in the literature. However, several of the outcomes are not being evaluated because a measurement tool has not been created or agreed upon. Kentucky currently provides data for most of the mental health outcomes. The data are collected in two surveys:

- Mental Health Statistics Improvement Program (for adults with severe mental illness); and
- Mental Health Statistics Improvement Program Youth Services Survey for Families (for children with serious emotional disturbance).

Consumer outcomes in Kentucky were similar to the average outcomes of other reporting states. The outcomes for persons with mental illness are shown in Table 5.1.

**Table 5.1**  
**National Mental Health Outcome Measures**

<b>Outcome:</b> Increased/retained employment						
<b>Measure:</b> Rate of adult consumers competitively employed						
	<b>2003</b>	<b>2004</b>				
All Reporting States	21.9%	21.3%				
Kentucky	21.8%	20.9%				
<b>Outcome:</b> Stability in housing						
<b>Measure:</b> Percentage of consumers by living situation						
	<b>Private Residence</b>		<b>Jail/Correctional Facility</b>		<b>Homeless or Shelter</b>	
	<b>2003</b>	<b>2004</b>	<b>2003</b>	<b>2004</b>	<b>2003</b>	<b>2004</b>
All Reporting States	77.3%	75.0%	2.9%	2.6%	3.7%	2.9%
Kentucky	87.2%	88.0%	0.8%	0.8%	1.4%	1.6%
<b>Outcome:</b> Increased access to services						
<b>Measure:</b> Rate of utilization of services per 1,000 population						
	<b>2003</b>	<b>2004</b>				
All Reporting States	18.6%	19.3%				
Kentucky	27.2%	30.9%				
<b>Outcome:</b> Reduced utilization of psychiatric inpatient beds						
<b>Measure:</b> Percentage of patients with readmissions to state psychiatric hospitals						
	<b>Within 30 Days</b>		<b>Within 180 Days</b>			
	<b>2003</b>	<b>2004</b>	<b>2003</b>	<b>2004</b>		
All Reporting States	8.5%	9.1%	18.9%	20.3%		
Kentucky	8.3%	8.1%	27.9%	27.2%		
<b>Outcome:</b> Clients' perceptions of care						
<b>Measure:</b> Percentage of consumers reporting positive outcomes from care						
	<b>Adult Consumers</b>		<b>Families of Child/Adolescent Consumers</b>			
	2003	2004	2003	2004		
All Reporting States	72.2%	70.9%	60.0%	64.7%		
Kentucky	No report	No report	No report	No report		

Source: Compiled by Program Review staff from U.S. Dept. Substance. "Substance."

Kentucky does not report as much information on substance abuse outcomes. The reasons are that some of the national measures are not yet required, and Kentucky has traditionally reported alternative information from the Kentucky Substance Abuse Treatment Outcome Study. The department and the centers are determining how to report the national outcome measures for substance abuse. The outcomes reported by the department for persons with substance abuse problems are shown in Table 5.2.

**Table 5.2  
 National Substance Abuse Outcome Measures**

<b>Outcome:</b> Increased access to services						
<b>Measure:</b> Percent needing but not receiving treatment for alcohol abuse in the past year by age group						
	Ages 12 to 17		Ages 18 to 25		Ages 26 or Older	
	2003	2004	2003	2004	2003	2004
All Reporting States	5.6%	5.7%	16.9%	16.7%	5.7%	5.8%
Kentucky	5.2%	5.4%	14.2%	13.7%	4.6%	5.1%
<b>Outcome:</b> Increased access to services						
<b>Measure:</b> Percent needing but not receiving treatment for illicit drug abuse in the past year by age group						
	Ages 12 to 17		Ages 18 to 25		Ages 26 or Older	
	2003	2004	2003	2004	2003	2004
All Reporting States	5.0%	4.9%	7.5%	7.5%	1.5%	1.5%
Kentucky	5.0%	4.6%	7.0%	7.7%	1.5%	1.8%

Source: Compiled by Program Review staff from U.S. Dept. Substance. "Substance."

**State Outcome Measures**

Additional outcome requirements are included in the contracts between the department and the boards.

The contracts between the department and the boards require the centers to collect consumer outcome data using multiple tools. Two are the Mental Health Statistics Improvement Program and the Mental Health Statistics Improvement Program Youth Services Survey for Families. Other tools listed in an appendix to the contract include the

- Brief Psychiatric Rating Scale,
- Multnomah Community Ability Scales,
- Kentucky Substance Abuse Treatment Outcome Study,
- Kids Now Plus,
- Opiate Replacement Treatment Programs,
- National Core Indicators Pre-Survey Form,
- IMPACT Outcomes System, and
- Early Childhood Mental Health Outcomes System.

## Best Practices Are Being Implemented in Kentucky

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The department has collected and reported information on centers' best practices.

The best-practices movement is based on the premise that the needs and choices of consumers must be matched with services that will result in the desired outcomes. In 2005, Department for Mental Health and Mental Retardation Services staff visited each region to obtain information about best practices planned, adopted, and/or sustained in specific program areas. The department reported the findings in 2006 in *Best Practice Implementation in Kentucky's Public Mental Health & Mental Retardation System* (Commonwealth. Cabinet. Department for Mental Health). The emerging themes from that report are described below.

### Organizational Structure

**Formation of Medical Services Units.** Typically headed by the medical director, these units focus on improving the quality of medical services in areas such as medication prescription and administration, diagnosing, and alignment with recognized practice standards.

**Integration of Services Across Population Groups.** This “breaking down of silos” is being attempted by cross-training staff, assigning staff such as case managers to serve individuals from multiple population groups, providing services such as supported employment to multiple populations, and organizing supervisory structures around service clusters.

### Community Collaboration

**Increased Focus on Collaboration.** A concentrated focus on collaboration with other community service organizations that serve a mutual clientele is a strategy to increase access to a broader array of needed services. All centers have formal or informal agreements with jails, schools, and local Department for Community Based Services offices. Outreach to these sister organizations is accomplished in unique ways, such as hosting one-hour brown bag informational sessions; lunches for partner groups such as police; or regularly scheduled meetings focused on training, case review, or planning.

### Training

**Training Coordinators.** The majority of centers have employed or are planning to hire a full-time training coordinator, primarily housed within the human resources department.

**Localized Training.** In response to increased travel costs, loss of billable time, and an interest in controlling content to better meet needs, trainings and professional development activities are increasingly being offered by the centers or in their respective regions. Limited funds are available for critical training offered outside the region.

**Advanced Technology.** Training is being delivered in a variety of formats using advanced technology, such as the development of computer training labs, Web-based or CD-ROM-based instruction, teleconferencing, and E-learning.

**Cross-training.** Staff are being cross-trained in mental health, substance abuse, and mental retardation.

**Orientation.** Human resources provides an agency orientation for new staff, ranging from one to five days. The remainder of the orientation is typically carried out by the program supervisor through a variety of methods such as mentoring, shadowing, and additional classroom training.

## **Workforce**

**Planning for Retirement Window.** Planning is occurring related to the anticipated exodus of long-term staff at the next retirement window.

**Public-sector Training.** Graduates at both the bachelor's and master's levels are being trained in a private-practice model rather than a public-sector model. This training fails to adequately prepare them to work effectively in a community mental health and mental retardation center. Thus, the centers are serving as the major training ground for graduates through internships, practica, and on-the-job training.

**Recruitment of Qualified Staff.** Critical staff shortages exist for psychiatrists, specifically child psychiatrists. Centers are investing a great deal of time and money to fill vacant positions. Staff recruitment is typically done by hiring interns or practicum students. One center has developed a comprehensive, structured interview tool and rating criteria that are used in the hiring process to assess core competencies.

**Assessing Staff Readiness.** A few centers have assessed clinician readiness to adopt evidence-based practices using an instrument developed by Gregory Aarons of the Child and Adolescent Services Research Center in California. Results are being used to specify training and supervision needs.

**Staff Evaluations.** Position descriptions are developed based on required competencies. Performance evaluations are linked to these competencies.

**Credentialing.** Credentialing committees or professional service organizations are established to assure that staff have and maintain proper credentials, primarily for billing purposes. There are problems, however, with certification board regulations as to initial and ongoing training requirements for obtaining and maintaining licensure.

### **University Linkages**

**Influence on Curricula.** There is very little services research being conducted in the public sector. While center staff teach in university settings, there is little formal input into the design of university curricula such as training in evidence-based practices. Some management staff participate on higher education advisory committees.

**Lindsey Wilson College.** Lindsey Wilson College has developed unique bachelor's and master's programs in at least seven regions. This is the result of a formal partnership between each center and the college.

### **Quality Assurance**

**Accreditation.** The value of accreditation appears to be waning among centers. While a handful maintain full accreditation by the Joint Commission on Accreditation of Healthcare Organizations, others have dropped their accreditation because of associated costs, the fact that accreditation is not required by the department and other funders, and it does not result in "deemed status." Deemed status means that the center is deemed in compliance with all relevant requirements and would not have to undergo additional oversight visits by the department.

**Oversight Structures.** Most centers have established formal quality assurance committees that are linked to the required Program Planning and Evaluation Committee of the board. Chart

reviews, data analyses, and reviews of performance indicators are common activities. These committees typically are positioned to promote the introduction of new practices or procedures in the agency.

**Treatment Protocols.** Many centers have developed diagnosis-specific treatment protocols or guidelines. One center has developed cluster-specific treatment protocols based on symptoms.

### **Adoption of Evidence-based Practices**

**Clinician Level.** The majority of clinicians are allowed to adopt practices and approaches that fit the clientele served. Some centers are attempting to raise competency of clinicians by developing Master Clinician programs, rolling out specific practices, or creating clinician training modules. A focus for supervisors is teaching clinicians to choose evidence-based practices within the context of the individual consumer.

**Program Level.** There has been some adoption of the Substance Abuse and Mental Health Services Administration tool kits and other system-oriented evidence-based practices, but very few are being implemented with fidelity. The practices that are being adopted are those that require less funding and are most easily merged with existing practices. There is a strong belief that evidence-based practices must be adapted to meet local needs, particularly in rural areas, and that strict adherence to the model or approach as it was implemented in the research setting is less important.

**Agency Level.** Most centers believe they have been implementing best practices for many years but have not been acknowledged as such.

**Incentives.** One center restricts the use of elective clinical training funds to evidence-based practice topics.

**Most Commonly Used Practices.** The report listed the most commonly used best practices in the areas of mental retardation, mental health, and substance abuse. In mental retardation, the practices were person-centered planning, supported employment, cross-training in mental health and mental retardation, consumer-directed options, and supported living. In mental health, the practices were brief solution-focused therapy, cognitive behavior therapy, dialectical behavior therapy, motivational interviewing, illness management and recovery, parent-child interaction therapy,

and wraparound. In substance abuse, the practices were integrated treatment for co-occurring disorders, motivational interviewing, brief solution-focused therapy, cognitive behavior therapy, recovery dynamics, drug courts, and the Seven Challenges program for adolescents and young adults who are abusing or dependent on substances.

### **Performance-based Contracting**

**Incentives.** The majority of staff interviewed perceive the department's performance-based contracting process as a disincentive as opposed to an incentive. They uniformly understand the rationale for performance-based contracting; however, rewarding positive performance through incentive funding or other methods is preferred.

**Best Practice Training Requirement.** While the response to this performance-based contract item has been primarily positive, some centers have chosen to develop their own training materials, and others are using the slides developed by the department with some adaptations.

### **Technology**

**Electronic Medical Records.** A few centers are forging ahead with the development of an electronic medical records system. The majority reported that they were awaiting funding and uniform standards from the department.

**Hardware.** The majority of centers have well-developed technology plans that call for equipping all clinical staff with either desktop or laptop computers. Most are well along in securing the necessary hardware but are faced with challenges in connectivity, securing resources to hire staff to provide technology support, and upgrading obsolete hardware.

**Telehealth.** Most centers have access to videoconferencing equipment that would allow the delivery of behavioral health services through a telehealth network. There appears to be a consensus that this system is underutilized, the rules for payment are not well understood, and the department needs to take the lead in learning to better use this technology and to work with Medicaid to develop clear guidance about the delivery of behavioral health services through this modality.

## Consumer and Family Involvement

**Advocacy Organizations.** The majority of centers have at least one National Alliance for the Mentally Ill chapter operating in their regions. Where one is not present, the development of a chapter is under way. While the majority also have active Association for Retarded Citizens groups operating, these are less well developed than the NAMI chapters in some regions.

**Best Practices.** NAMI's Family-to-Family program is the primary best practice to which center clinicians refer families. NAMI also promotes the establishment of crisis intervention teams in local communities. While there is very little evidence of active consumer-run organizations operating in the regions, there is some level of peer support services. The evolution of the Supports for Community Living waiver to a consumer-directed option model is the major policy change initiative on the horizon.

**Level of Involvement.** Involvement in the development of treatment plans, completion of consumer satisfaction surveys, participation in consumer and family focus groups, attendance at consumer conferences, and membership on regional planning councils are the primary ways in which families and consumers are involved with the centers. One center has established an ombudsman office.

### Best Practices Requirements Are Included in Contracts

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Best practices requirements are incorporated in the contracts between the department and the boards. The practices are tied to incentive funding provisions.

Best practices have been incorporated in the contracts between the department and the boards. The contracts include incentive funding provisions that require centers to demonstrate the use of certain practices to earn a portion of state general funds. Table 5.3 summarizes the provisions in the fiscal year 2007 contracts.

**Table 5.3**  
**Incentive Funding Provisions Included in Department's Contracts With Regional Boards**

<b>Incentive Amount</b>	<b>Required Practice</b>
1% of total state general funds	All board members and employees must receive a best-practices orientation to help ensure that all activities of the organization contribute to a best-practices culture that will result in positive consumer outcomes.
3% of total state general funds	The board will incorporate outcome information in quality improvement initiatives by identifying up to three individual-, program-, or system-level outcomes and by measuring performance on those outcomes. Performance measures will be used to initiate changes in service delivery to improve quality or continue measuring quality.
0.5% of state general funds allocated for crisis stabilization services	To improve access to the crisis stabilization programs and/or units, the board must evaluate the fiscal year 2006 plan to improve access to the programs/units for adults and children with co-occurring (mental health, mental retardation, acquired brain injury, and/or substance abuse) diagnoses who present with a psychiatric crisis. The evaluation must include a quantitative analysis of the progress of this plan, timelines for continued improvement, and a revised or updated plan for fiscal year 2007.
1.5% of state general funds allocated for crisis stabilization services	The board must conduct thorough assessments of adults and children admitted to and discharged from crisis stabilization programs or units, including completion of the Brief Psychiatric Rating Scale. The resulting data can direct quality improvement efforts.
1% of total state general funds	To identify consumers who have a mental health diagnosis within the substance abuse treatment centers, all consumers with a completed psychosocial evaluation will be administered an identified screening tool.
2% of total state general funds	The board will expand the number of persons with severe mental illness and mental retardation or other developmental disabilities who are employed or working toward employment. The goal is to increase the number of such persons in proportion to the increase in employment in the general population of the region.
1% of total state general funds	The board will resolve correctable recurring errors in data submitted to the department on consumers, services, and staff.

Source: Developed by Program Review staff from information obtained from the Department for Mental Health and Mental Retardation Services.

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## **Appendix A**

### **Overview of Planning**

This appendix provides information on statutory and other planning authorities for persons with mental illness, mental retardation and other developmental disabilities, substance abuse, and dual diagnoses. It covers committees, councils, and commissions involved in needs assessment, planning, and/or coordination of services. It outlines federal and state initiatives that impact state and regional planning efforts and describes efforts of the regional boards and the issues they encounter in planning for services.

#### **Statutory Planning Entities**

The regional mental health and mental retardation boards and other entities are directly involved in regional and statewide needs assessment, planning, monitoring, evaluation, and coordination of services.

#### **Regional Mental Health and Mental Retardation Boards**

The statutory planning authority for community mental health and mental retardation services is provided in part by KRS 210.400. The statute directs each board to review and evaluate mental health and mental retardation services, be responsible for the development and approval of an annual plan and budget, and oversee the management of the community mental health and mental retardation programs in conformity with the adopted annual plan and budget.

Under 908 KAR 2:030, the board's Program Planning and Evaluation Committee is responsible for the efficacy of the existing programs; the identification of regional needs in terms of mental health, mental retardation, alcoholism, and drug abuse; and education and treatment.

#### **Regional Planning Councils**

KRS 210.506 requires the boards to institute regional planning councils to conduct needs assessment and strategic planning. A member of the regional board is required to chair the council. The duties of the regional council include but are not limited to

- assessing regional needs of individuals with mental illness, alcohol and other drug abuse disorders, and dual diagnoses;
- studying the regional treatment delivery system and identifying specific barriers to accessing services;
- assessing the capacity of and gaps in the existing system, including the adequacy of a safety net system and the adequacy and availability of the regional professional work force;
- assessing the coordination and collaboration of efforts between public and private facilities and entities;

- developing a regional strategy to increase community-based services and supports;
- identifying funding needs and reporting to the 843 Commission on the use of flexible safety net funding appropriated by the General Assembly;
- evaluating the access of children and youth to mental health and substance abuse services and preventive programs in the region;
- collecting and evaluating data on individuals with mental illness, alcohol and other drug abuse disorders, and dual diagnoses who experience repeated hospital admissions; involvement with law enforcement, courts, and the judicial system; and repeated referrals from hospitals to community-based services; and
- making recommendations to the 843 Commission by July 1 of each odd-numbered year. These recommendations may be incorporated into the regional annual plans required by KRS 210.400.

### **The Kentucky Commission on Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnoses and the Regional Mental Health Planning Councils (843 Commission)**

The Kentucky Commission on Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnoses is commonly known as the 843 Commission. KRS 210.502 establishes the commission and specifies that the secretary of the Cabinet for Health and Family Services and one member of the General Assembly appointed to the commission shall serve as co-chairs. KRS 210.504 defines the commission's duties, which include but are not limited to

- assessing the needs statewide of individuals with mental illness, alcohol and other drug abuse disorders, and dual diagnoses;
- assessing the capabilities of the existing statewide treatment delivery system, including gaps in services and the adequacy of a safety net system;
- identifying funding needs and related fiscal impact;
- developing a comprehensive state plan that provides a template for decision making for program development and funding;
- developing a two-year work plan that specifies goals and strategies relating to services and supports, as well as efforts to reduce the stigma associated with mental illness and substance abuse disorders; and
- reviewing the plan and submitting annual updates no later than October 1 to the governor and the Legislative Research Commission.

During fiscal year 2001, a great deal of needs assessment and planning was conducted. The regional planning councils performed needs assessments and reported recommendations to the commission. Reports were reviewed by two sets of workgroups adopting different perspectives. The first set of workgroups looked at the reports from the perspective of needs of different categories of consumers (adults, children, and the aging population). The second set approached the reports from an issue perspective. Issues included quality assurance and consumer satisfaction and the relationship between criminal justice and behavioral health issues. Based on the reports of the regional planning councils and the workgroups, the commission issued its first report.

The commission's report has been updated annually, pointing out progress, issues, and priority recommendations to be considered by the executive and legislative branches in the future. Common issues and priorities in the 2005 update include the

- lack of flexible funding for the regional boards;
- need for cost-of-living adjustments for the regional boards;
- lack of suitable housing options and housing supports for consumers;
- need for increased community-based services, proactive case management, and wraparound services to address all the needs of a person, including food, housing, and physical health care;
- need for medical and nonmedical detoxification services for individuals with substance abuse disorders;
- need for an accessible continuum of care for children and youth with substance abuse diagnoses (therapeutic foster care and residential treatment facilities);
- need for transportation for consumers to access services and supports;
- shortage of trained professionals in different areas; and
- need for more collaboration with the criminal justice system for a more appropriate and effective response to the needs of individuals with mental health and substance abuse problems (Commonwealth Commission on Services and Support for Individuals with Mental Illness).

### **The Kentucky Commission on Services and Supports for Individuals with Mental Retardation and Other Developmental Disabilities (144 Commission)**

The Kentucky Commission on Services and Supports for Individuals with Mental Retardation and Other Developmental Disabilities is commonly known as the 144 Commission. The commission includes a wide range of stakeholders and was established based on legislative findings that the system of services to individuals with mental retardation and other developmental disabilities suffered from a lack of program coordination, funding, controls on quality of care, and review and evaluation.

KRS 210.575 establishes the commission and names the secretary of the Cabinet for Health and Family Services as its chair. KRS 201.577 outlines its purposes and goals, which include but are not limited to

- developing a statewide strategy to increase access to community-based services and supports, including funding needs and related fiscal impact;
- developing a comprehensive 10-year plan for placement of qualified persons in integrated settings;
- recommending an effective quality assurance and consumer satisfaction monitoring program; and
- developing recommendations for implementing a self-determination model of funding services and supports.

The commission is required to review its plan annually and submit annual updates no later than October 1 to the governor and to the Legislative Research Commission.

*Kentucky's Plan: From Dreams to Reality for Quality and Choice for All Individuals with Mental Retardation and Other Developmental Disabilities* was submitted to the governor

and the General Assembly in 2001. The plan covered the areas of prevention; promoting choice, quality, and access to services; and system financing.

The commission has met at least biennially and has annually updated its report. Identified needs include day and community habitation, supported community living, transportation, employment, respite services, recreation and behavior supports, and transition services from birth through the life span. The fiscal year 2005 report indicated that the system served 2,726 in the Supports for Community Living program and 970 in licensed beds for intermediate care facilities for persons with mental retardation and other developmental disabilities (Commonwealth Commission on Services and Support for Individuals with Mental Retardation).

### **The 843 Commission and 144 Commission Joint Ad Hoc Committee on Planning for Transition from Childhood to Adulthood**

KRS 210.580 directs the 843 Commission and 144 Commission to establish a joint ad hoc committee that focuses on issues specific to children transitioning from childhood to adulthood. It also requires the joint committee to develop recommendations for the implementation of specific plans of action to meet the needs of children who reach age 21 and still need services and support.

### **Interagency Transition Core Team**

Before the ad hoc committee members were nominated, the commissions learned that an interagency transition core team funded by a U.S. Department of Education grant was addressing similar issues. In June 2005, the team came before the 843 Commission to inform members of its mission, goals, accomplishments, and areas in need of improvement. The team focuses on children with disabilities aged 14 to 21. The goal of the team is to collaborate with all agencies that provide services to children in this age range to help them transition from the children's service system to the adult services system and to life. Services include vocational training, housing, and counseling.

### **Kentucky Interagency Transition Council for Persons with Disabilities**

Established in 1989, the council includes representatives from 15 state agencies. Its work is supported by an agreement among the agencies. Its mission is to design, deliver, and improve statewide transitional services for persons ages 14 to 21 with disabilities through school into community living, recreation, continuing education, and employment.

### **State Interagency Council for Services to Children with an Emotional Disability**

The state interagency council was established in 1990 by KRS 200.505 to oversee coordinated policy development, comprehensive planning, and collaborative budgeting for services to children with emotional disturbance. Its planning activity is carried out at regional and local councils and consists of developing services and treatment plans for children.

The state interagency council has broad representation, including the commissioners of the departments of Education, Mental Health and Mental Retardation Services, Public Health, Community Based Services, and Medicaid Services. Other council members represent the Department of Juvenile Justice, the Division of Family Resource and Youth Services Centers, and the Division of Juvenile Services of the Administrative Office of the Courts. The council is statutorily required to include a parent of a child with an emotional disability and an alternate member.

The state council's duties consist mainly of directing the regional councils to coordinate services and identify factors contributing to a lack of coordination; assessing the effectiveness of the regional councils; reviewing services and treatment plans for children referred by regional councils; promoting services to prevent the emotional disability of a child; developing services for children; and considering issues and making recommendations annually to the governor and the Legislative Research Commission regarding the provision of services to children with emotional disabilities.

### **Regional Interagency Councils for Services to Children with an Emotional Disability**

Regional interagency councils are created in KRS 200.509. The regional councils are formed in each area development district, except those districts that contain a county with a population greater than 100,000 may form up to three regional councils. Councils are chaired either by the Department for Community Based Services' regional service administrator or by a program specialist designated by the district supervisor. Other members include the children's services coordinator from each regional community mental health center or a designee; a court-designated worker chosen by the chief regional district judge in the region; one specialist in special education chosen by the school district superintendents in the area; one parent of a child with an emotional disability and an alternate; a representative of other local public or private agencies that provide services to children with an emotional disability; and representatives from the Department of Juvenile Justice and local health departments.

The regional councils' functions include but are not limited to

- reviewing case histories of children referred to them;
- coordinating the development of interagency service plans for children with emotional disabilities in the least restrictive alternative mode of treatment;
- identifying the time frames necessary and the parties responsible for the timely development of interagency service plans;
- verifying that services identified in the plans are developed, accessed, and delivered in a coordinated and timely manner;
- initiating and adopting interagency agreements for providing services to children with emotional disabilities;
- advising the state interagency council about service delivery;
- referring to the state council children for whom the regional councils cannot provide adequate services; and
- promoting services to prevent the emotional disability of a child.

## **The Kentucky Commission on Autism Spectrum Disorders**

The Kentucky Commission on Autism Spectrum Disorders was established in 2005 and is covered in KRS 194A.622. The commission was directed to assess the needs of the population with autism spectrum disorders and identify appropriate funding sources; to develop a plan for the identification of individuals with such disorders and create a statewide registry; to develop a comprehensive training plan to respond to training needs; to analyze standards for provider training and qualifications; to identify best practices for standards for services; to assess the need for education and treatment for children with these disorders; and to set a timeline for implementing and monitoring the plan's recommendations.

The commission developed its plan and submitted it to the Governor and the Legislative Research Commission in October 1, 2006. The plan includes 15 recommendations, most of which require legislative action.

## **Kentucky Mental Health Services Planning Council**

Federal law requires every state receiving Community Mental Health Services block grant funds to engage in a planning process for mental health services. The Kentucky Mental Health Services Planning Council was established by executive order. Its members include consumers, family members, consumer organizations, providers, and state agencies. Members other than state employees or providers are required to represent more than 50 percent of the council's members.

The council's role in the planning process consists of reviewing plans for allocation of mental health services statewide, submitting recommendations to the state for modification, monitoring and reviewing services, evaluating at least annually the allocation and adequacy of mental health services within the state, and playing a role in improving mental health services within the state.

In the last five years, the council has focused its efforts on

- the 843 Commission's ongoing activities;
- the regional block grant review process;
- activities designed to align the status of the state's current mental health system with the goals of the federal New Freedom Commission's recommendations;
- implementation of evidence-based practices by the regional boards;
- implementation of the Olmstead Supreme Court decision at the state level; and
- the suicide prevention initiative.

## **Federal Planning Initiatives and Their Impact at the State Level**

Federal initiatives have provided states with guidelines and have helped them shape and refocus their policies on serving persons with mental illness, substance abuse problems, and mental retardation and other developmental disabilities. The common goal of all the initiatives is to ensure that all Americans with disabilities can have access to services they

need in the most integrated setting, can make choices of a treatment tailored to their needs, and can have the opportunity to learn skills and participate in the community.

The 1999 Report of the Surgeon General states that a range of efficient treatments is available for most mental disorders and that individuals should have the option to choose a particular approach to suit their needs and preferences. The report recommends a continuum in building the science base; overcoming stigma; improving public awareness of effective treatment; ensuring the supply of mental health services and providers; ensuring delivery of state-of-the-art treatments; tailoring treatment to age, gender, race, and culture; facilitating entry into treatment; and reducing financial barriers to treatment (U.S. Department of Health. Substance. Center).

The 1999 *Olmstead v. L.C.* Supreme Court decision requires states to administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities. It interpreted Title II of the Americans with Disabilities Act, which gives civil rights and protections to individuals with disabilities and guarantees equal opportunity for them in public accommodations, employment, transportation, state and local government services, and telecommunications.

In April 2000, the state *Olmstead* Executive Commission was established in the Cabinet for Health and Family Services. The commission produced a plan and made recommendations to the cabinet secretary in 2001. In December 2002, the cabinet released a plan that outlines goals and strategies, makes recommendations, and identifies potential challenges. In fiscal year 2005, the focus was on consumer oversight and satisfaction, access to housing options, and workforce development.

The President's New Freedom Initiative supports the states' efforts to ensure that all Americans have the opportunity to learn and develop skills, engage in productive work, choose where they live, and participate in community life. To implement the first goal of the initiative to ensure that Americans understand that mental health is essential to overall health, the Commonwealth has produced a suicide prevention plan, facilitated collaboration between jails and mental health programs through jail staff training and screening for mental health needs, and promoted the use of medication algorithms to ensure adequate medical support to persons with mental illness.

### **Statewide Planning Initiatives**

Some state planning initiatives are based on federal initiatives. Others are not.

#### **Healthy Kentuckians 2010**

Based on the national Healthy People 2010 initiative, the Department for Public Health produced the *Healthy Kentuckians 2010* report in 2000. The report set goals for a healthy life for Kentuckians and the elimination of health disparities. The document has served as a basis for program planning, prevention initiatives, grant preparation, and policy

formulation. Some goals and objectives have since been revised, including the areas of mental health and substance abuse.

Mental health objectives that could be applied to the regional boards include but are not limited to

- increasing to 30 percent the number of children with serious emotional disturbance who receive mental health services or coordinated interagency services;
- increasing to 30 percent the number of adults with serious mental illness who receive services from the regional boards or their contractors;
- increasing by 5 percent the number of adults with serious mental illness who are employed; and
- increasing to 75 percent the number of staff who have received cultural competency training (Commonwealth. Cabinet. Dept. for Public Health. *Healthy Kentuckians 2010*).

A progress report issued in 2006 showed that targets were achieved for the first two goals and that progress had been made in other areas. Of the 51 objectives and sub-objectives related to substance abuse, 6 had been realized and 11 showed progress. For the remainder, there was no progress or the progress could not be tracked (Commonwealth. Cabinet. Dept. for Public Health. *Healthy Kentuckians 2010 Mid-Decade Review*).

### **Department for Mental Health and Mental Retardation Services' Strategic Plan**

KRS 48.810 directs each cabinet to submit a four-year strategic plan. As a part of the cabinet's strategic planning, each department should develop its individual plan describing its goals and objectives. The department is in the second year of implementing its strategic plan. The plan outlines the following objectives:

- Consumer access to services and inclusion in the community;
- Implementing evidence-based practices;
- Promoting best practices, including resiliency, recovery, and inclusion in the community;
- Promoting quality outcomes through best practices and data-driven decisions;
- Enhancing capacity to update relevant technology for programs and increasing the use of technology in workforce development; and
- Reinforcing responsible fiscal and programmatic oversight and accountability and increasing provider monitoring.

### **843 Commission Mapping Project**

The department received a technical assistance grant from the Substance Abuse and Mental Health Services Administration to implement a systems mapping project in Kentucky. The project aims to address the emergency response for persons seeking voluntary admission to psychiatric hospitals. It will help provide timely assessment, stabilization, and transportation for these persons and will foster collaborative efforts among hospitals, mental health centers, law enforcement, and emergency medical services. The ultimate goal is to guarantee needed services to persons in crisis.

On September 13, 2006, the 843 Commission held a retreat for commission members and other stakeholders. A project facilitator identified and discussed existing and potential gaps, barriers, and problem areas. Another retreat was scheduled for December 13 to develop a template for project implementation at the local level.

### **Community Mental Health Services Block Grant**

The federal Community Mental Health Services block grant requires states to submit plans to the federal government describing how the funds will be used in a statewide initiative to support and improve comprehensive community-based mental health services and supports.

In 1998, the block grant planning requirements were revised to promote longer-range strategic planning and allow states the flexibility to adjust their plans due to changing priorities and conditions. However, Kentucky still uses a one-year plan.

To initiate the regional planning process, the department requires the boards to submit

- a comprehensive regional plan for services to priority populations;
- a detailed spending plan;
- performance targets; and
- data related to performance indicators and clinical outcomes.

The department uses the information to develop a plan that describes the state service system; identifies and analyzes the system's strengths, challenges, needs, and priorities; and outlines performance goals and actions to achieve those goals. The state plan is submitted to the Mental Health Services Planning Council for formal review before its submission to the federal government. The fiscal year 2006 block grant application includes the following major objectives for adults and children.

#### **Adults with Severe Mental Illness**

- Develop, implement, and monitor behavioral health via a jail telephonic triage system;
- Develop memoranda of agreement between state-operated and state-contracted hospitals and regional boards;
- Provide crisis stabilization services to persons with co-occurring disorders;
- Implement the next phase of the adult outcome initiative;
- Continue the discharge initiative by using wraparound funding; and
- Promote best practices in service delivery.

#### **Children with Serious Emotional Disturbance**

- Promote family involvement in the child's system of care;
- Establish interagency collaboration;
- Establish a statewide system for measuring client satisfaction;
- Partner with regional boards to promote best practices and share information among stakeholders; and

- Develop a partnership with the Kentucky Center for Instructional Discipline to provide statewide training and technical assistance to regional board staff and local education authorities in implementing initiatives that would help address mental health needs in schools.

### **Substance Abuse Prevention and Treatment Block Grant**

This block grant funds substance abuse prevention and treatment services, allowing states to design solutions to specific local problems. Covered services include outreach, detoxification, outpatient counseling, residential rehabilitation, hospital-based care (but not inpatient hospital services), vocational counseling, case management, central intake, and program administration. The grant also provides funding for primary prevention activities.

The requirements of the block grant are summarized as follows:

- States must spend at least 20 percent for individuals who do not require treatment for substance abuse. Programs should provide individuals with education and counseling on substance abuse and activities to reduce risk of such abuse.
- Programs should target special populations, including pregnant and postpartum women and their children.
- The application for the grant must include a state plan for substance abuse prevention and treatment services.

As a part of the plan, the state should include narratives on how the grant money was used and how the state intends to use it for the next fiscal year. The department is also required to respond to 17 federal goals, objectives, and activities, noting the last year's accomplishments and the next fiscal year's related target objectives

## **Regional Board Planning Initiatives**

### **Annual Plan and Budget**

Planning for regional budget purposes revolves around the available funds that are determined by the Cabinet for Health and Family Services. KRS 210.400 requires each regional board to develop an annual plan and budget. Most regional staff stated that the planning and budget document has a twofold purpose. It is used as a spending plan and as a budget framework for the regional boards. Yet, boards' staff explained that planning conducted through this process does not respond to regional needs.

Boards' staff reported that, as a part of their annual plan and budget, they always submitted an annual expansion request for review and approval by the department. Staff added that this document was always approved with little or no associated funding support.

## Appendix B

### Summary of Consumer Demographics

Tables were compiled by Program Review Staff based on data sets provided by the Department for Mental Health and Mental Retardation Services.

**Table B.1  
 Consumer Age Groups by Region  
 Fiscal Years 2001 and 2005**

Region	Age	2001		2005		2001-2005
		Number	% of Total	Number	% of Total	% Change
<b>Four Rivers</b>	<18	1,963	25.8	2,230	29.9	13.6
	18-40	3,391	44.6	3,065	41.0	-9.6
	41-64	2,035	26.8	2,011	26.9	-1.2
	65+	210	2.8	160	2.1	-23.8
	Unknown	0	-	1	0.0	n/a
	Total	7,599	100.0	7,467	100.0	
<b>Pennyroyal</b>	<18	2,228	26.8	2,815	27.0	26.3
	18-40	3,576	43.0	4,276	41.0	19.6
	41-64	1,982	23.8	2,963	28.4	49.5
	65+	529	6.4	383	3.7	-27.6
	Unknown	0	-	0	-	n/a
	Total	8,315	100.0	10,437	100.0	
<b>River Valley</b>	<18	2,412	32.8	2,826	32.3	17.2
	18-40	3,047	41.5	3,367	38.5	10.5
	41-64	1,657	22.6	2,333	26.7	40.8
	65+	230	3.1	221	2.5	-3.9
	Unknown	0	-	0	-	n/a
	Total	7,346	100.0	8,747	100.0	
<b>LifeSkills</b>	<18	3,231	29.3	3,595	31.2	11.3
	18-40	4,454	40.3	4,258	37.0	-4.4
	41-64	2,949	26.7	3,319	28.8	12.5
	65+	354	3.2	349	3.0	-1.4
	Unknown	53	0.5	2	0.0	-96.2
	Total	11,041	100.0	11,523	100.0	

Region	Age	2001		2005		2001-2005
		Number	% of Total	Number	% of Total	% Change
<b>Communicare</b>	<18	1,833	28.9	2,405	29.3	31.2
	18-40	2,640	41.7	3,269	39.8	23.8
	41-64	1,621	25.6	2,074	25.2	27.9
	65+	242	3.8	466	5.7	92.6
	Unknown	0	-	5	0.1	n/a
	Total	6,336	100.0	8,219	100.0	
<b>Seven Counties</b>						
<b>Seven Counties</b>	<18	8,403	39.6	12,264	44.2	45.9
	18-40	6,800	32.1	8,393	30.3	23.4
	41-64	4,732	22.3	5,916	21.3	25.0
	65+	1,278	6.0	1,159	4.2	-9.3
	Unknown	1	0.0	4	0.0	300.0
	Total	21,214	100.0	27,736	100.0	
<b>NorthKey</b>						
<b>NorthKey</b>	<18	2,006	33.2	2,593	31.4	29.3
	18-40	2,358	39.0	3,180	38.6	34.9
	41-64	1,460	24.2	2,260	27.4	54.8
	65+	220	3.6	206	2.5	-6.4
	Unknown	0	-	9	0.1	n/a
	Total	6,044	100.0	8,248	100.0	
<b>Comprehend</b>						
<b>Comprehend</b>	<18	1,146	34.1	1,209	32.2	5.5
	18-40	1,353	40.3	1,504	40.1	11.2
	41-64	746	22.2	929	24.8	24.5
	65+	112	3.3	109	2.9	-2.7
	Unknown	0	-	1	0.0	n/a
	Total	3,357	100.0	3,752	100.0	
<b>Pathways</b>						
<b>Pathways</b>	<18	2,942	28.1	3,954	28.1	34.4
	18-40	4,581	43.7	5,881	41.7	28.4
	41-64	2,579	24.6	3,703	26.3	43.6
	65+	380	3.6	457	3.2	20.3
	Unknown	2	0.0	94	0.7	4,600.0
	Total	10,484	100.0	14,089	100.0	
<b>Mountain</b>						
<b>Mountain</b>	<18	2,501	22.3	2,589	23.0	3.5
	18-40	4,532	40.5	4,099	36.5	-9.6
	41-64	3,652	32.6	4,237	37.7	16.0
	65+	311	2.8	318	2.8	2.3
	Unknown	204	1.8	1	0.0	-99.5
	Total	11,200	100.0	11,244	100.0	

Region	Age	2001		2005		2001-2005
		Number	% of Total	Number	% of Total	% Change
<b>Kentucky River</b>	<18	1,895	25.5	2,603	24.7	37.4
	18-40	3,265	43.9	4,421	42.0	35.4
	41-64	2,138	28.8	3,169	30.1	48.2
	65+	137	1.8	266	2.5	94.2
	Unknown	1	0.0	72	0.7	7,100.0
	Total	7,436	100.0	10,531	100.0	
<b>Cumberland River</b>	<18	2,603	27.8	4,014	29.6	54.2
	18-40	3,713	39.7	5,179	38.2	39.5
	41-64	2,775	29.7	3,975	29.3	43.2
	65+	257	2.7	385	2.8	49.8
	Unknown	0	-	2	0.0	n/a
	Total	9,348	100.0	13,555	100.0	
<b>Adanta</b>	<18	3,400	34.5	3,192	39.3	-6.1
	18-40	3,587	36.4	2,490	30.7	-30.6
	41-64	2,559	25.9	2,113	26.0	-17.4
	65+	319	3.2	317	3.9	-0.6
	Unknown	1	0.0	0	-	-100.0
	Total	9,866	100.0	8,112	100.0	
<b>Bluegrass</b>	<18	7,477	33.0	8,846	35.6	18.3
	18-40	9,208	40.6	9,138	36.7	-0.8
	41-64	5,286	23.3	6,250	25.1	18.2
	65+	693	3.1	637	2.6	-8.1
	Unknown	8	0.0	6	0.0	-25.0
	Total	22,672	100.0	24,877	100.0	
<b>State</b>	<18	44,040	31.0	55,135	32.7	25.2
	18-40	56,505	39.7	62,520	37.1	10.6
	41-64	36,171	25.4	45,252	26.8	25.1
	65+	5,272	3.7	5,433	3.2	3.1
	Unknown	270	0.2	197	0.1	-27.0
	Total	142,258	100.0	168,537	100.0	

**Table B.2**  
**Consumer Gender by Region**  
**Fiscal Years 2001 and 2005**

Region	Gender	2001		2005		2001-2005
		Number	% of Total	Number	% of Total	% Change
<b>Four Rivers</b>	Male	4,309	56.7	3,996	53.6	-7.3
	Female	3,290	43.3	3,465	46.4	5.3
	Total	7,599	100.0	7,461	100.0	
<b>Pennyroyal</b>	Male	4,483	53.9	5,358	51.3	19.5
	Female	3,832	46.1	5,079	48.7	32.5
	Total	8,315	100.0	10,437	100.0	
<b>River Valley</b>	Male	3,745	51.0	3,884	44.4	3.7
	Female	3,601	49.0	4,863	55.6	35.0
	Total	7,346	100.0	8,747	100.0	
<b>LifeSkills</b>	Male	5,906	53.5	5,713	49.6	-3.3
	Female	5,135	46.5	5,811	50.4	13.2
	Total	11,041	100.0	11,524	100.0	
<b>Communicare</b>	Male	3,254	51.3	3,852	47.2	18.4
	Female	3,083	48.7	4,306	52.8	39.7
	Total	6,337	100.0	8,158	100.0	
<b>Seven Counties</b>	Male	10,752	50.7	14,595	52.6	35.7
	Female	10,444	49.3	13,134	47.4	25.8
	Total	21,196	100.0	27,729	100.0	
<b>NorthKey</b>	Male	3,069	50.8	4,007	48.6	30.6
	Female	2,975	49.2	4,232	51.4	42.3
	Total	6,044	100.0	8,239	100.0	
<b>Comprehend</b>	Male	1,847	55.0	1,998	53.3	8.2
	Female	1,510	45.0	1,753	46.7	16.1
	Total	3,357	100.0	3,751	100.0	
<b>Pathways</b>	Male	5,795	55.3	6,944	50.3	19.8
	Female	4,687	44.7	6,867	49.7	46.5
	Total	10,482	100.0	13,811	100.0	
<b>Mountain</b>	Male	5,858	53.3	5,869	52.2	0.2
	Female	5,138	46.7	5,374	47.8	4.6
	Total	10,996	100.0	11,243	100.0	

Region	Gender	2001		2005		2001-2005
		Number	% of Total	Number	% of Total	% Change
<b>Kentucky River</b>	Male	3,946	53.1	5,239	51.2	32.8
	Female	3,489	46.9	4,992	48.8	43.1
	Total	7,435	100.0	10,231	100.0	
<b>Cumberland River</b>	Male	5,049	54.0	7,339	54.2	45.4
	Female	4,299	46.0	6,213	45.8	44.5
	Total	9,348	100.0	13,552	100.0	
<b>Adanta</b>	Male	5,159	52.3	3,971	49.0	-23.0
	Female	4,707	47.7	4,141	51.0	-12.0
	Total	9,866	100.0	8,112	100.0	
<b>Bluegrass</b>	Male	11,345	50.1	11,996	48.3	5.7
	Female	11,319	49.9	12,853	51.7	13.6
	Total	22,664	100.0	24,849	100.0	
<b>State</b>	Male	74,517	52.5	84,761	50.5	13.7
	Female	67,509	47.5	83,083	49.5	23.1
	Total	142,026	100.0	167,844	100.0	

**Table B.3**  
**Consumer Racial Demographics by Region**  
**Fiscal Years 2003 and 2005**

Region	Race	2003		2005		2003-2005
		Number	% of Total	Number	% of Total	% Change
<b>Four Rivers</b>	White	6,758	86.8	6,480	86.8	-4.1
	African American	932	12.0	921	12.3	-1.2
	Other	91	1.2	63	0.8	-30.8
	Unknown/Not Collected	1	0.0	3	0.0	200.0
	Total	7,782	100.0	7,467	100.0	
<b>Pennyroyal</b>	White	7,705	86.7	8,681	83.2	12.7
	African American	1,066	12.0	1,560	14.9	46.3
	Other	121	1.4	196	1.9	62.0
	Unknown/Not Collected	0	0.0	0	0.0	n/a
	Total	8,892	100.0	10,437	100.0	
<b>River Valley</b>	White	7,468	89.9	7,855	89.8	5.2
	African American	617	7.4	572	6.5	-7.3
	Other	224	2.7	295	3.4	31.7
	Unknown/Not Collected	0	0.0	25	0.3	n/a
	Total	8,309	100.0	8,747	100.0	
<b>LifeSkills</b>	White	10,151	89.4	10,077	87.4	-0.7
	African American	943	8.3	897	7.8	-4.9
	Other	162	1.4	177	1.5	9.3
	Unknown/Not Collected	93	0.8	373	3.2	301.1
	Total	11,349	100.0	11,524	100.0	
<b>Communicare</b>	White	6,213	86.5	7,246	88.2	16.6
	African American	526	7.3	658	8.0	25.1
	Other	214	3.0	241	2.9	12.6
	Unknown/Not Collected	232	3.2	74	0.9	-68.1
	Total	7,185	100.0	8,219	100.0	
<b>Seven Counties</b>	White	13,867	55.3	18,809	67.8	35.6
	African American	6,554	26.1	7,427	26.8	13.3
	Other	668	2.7	1,079	3.9	61.5
	Unknown/Not Collected	3,988	15.9	421	1.5	-89.4
	Total	25,077	100.0	27,736	100.0	
<b>NorthKey</b>	White	6,346	91.3	7,399	89.7	16.6
	African American	490	7.0	643	7.8	31.2
	Other	117	1.7	191	2.3	63.2
	Unknown/Not Collected	0	0.0	15	0.2	n/a
	Total	6,953	100.0	8,248	100.0	

Region	Race	2003		2005		2003-2005
		Number	% of Total	Number	% of Total	% Change
<b>Comprehend</b>	White	3,376	94.5	3,595	95.8	6.5
	African American	137	3.8	119	3.2	-13.1
	Other	60	1.7	37	1.0	-38.3
	Unknown/Not Collected	0	0.0	1	0.0	n/a
	Total	3,573	100.0	3,752	100.0	
<b>Pathways</b>	White	11,972	94.8	13,414	95.2	12.0
	African American	168	1.3	179	1.3	6.5
	Other	489	3.9	158	1.1	-67.7
	Unknown/Not Collected	0	0.0	338	2.4	n/a
	Total	12,629	100.0	14,089	100.0	
<b>Mountain</b>	White	10,747	99.3	11,144	99.1	3.7
	African American	48	0.4	43	0.4	-10.4
	Other	27	0.2	25	0.2	-7.4
	Unknown/Not Collected	0	0.0	32	0.3	n/a
	Total	10,822	100.0	11,244	100.0	
<b>Kentucky River</b>	White	7,755	98.9	9,759	92.7	25.8
	African American	48	0.6	52	0.5	8.3
	Other	13	0.2	33	0.3	153.8
	Unknown/Not Collected	22	0.3	686	6.5	3,018.2
	Total	7,838	100.0	10,530	100.0	
<b>Cumberland River</b>	White	11,726	98.5	13,344	98.4	13.8
	African American	154	1.3	163	1.2	5.8
	Other	20	0.2	32	0.2	60.0
	Unknown/Not Collected	0	0.0	16	0.1	n/a
	Total	11,900	100.0	13,555	100.0	
<b>Adanta</b>	White	9,210	95.5	7,716	95.1	-16.2
	African American	301	3.1	264	3.3	-12.3
	Other	130	1.3	132	1.6	1.5
	Unknown/Not Collected	0	0.0	0	0.0	n/a
	Total	9,641	100.0	8,112	100.0	
<b>Bluegrass</b>	White	19,678	84.8	21,648	87.0	10.0
	African American	2,704	11.6	3,064	12.3	13.3
	Other	828	3.6	161	0.6	-80.6
	Unknown/Not Collected	4	0.0	4	0.0	0.0
	Total	23,214	100.0	24,877	100.0	

		2003		2005		2003-2005
Region	Race	Number	% of Total	Number	% of Total	% Change
State	White	132,972	85.7	147,167	87.3	10.7
	African American	14,688	9.5	16,562	9.8	12.8
	Other	3,164	2.0	2,820	1.7	-10.9
	Unknown/Not Collected	4,340	2.8	1,988	1.2	-54.2
	Total	155,164	100.0	168,537	100.0	

Note: Only data to 2003 were available. "Other" includes Asian, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and other classifications. These were combined due to the low numbers attributed.

**Table B.4**  
**Consumer Referral Sources by Region**  
**Fiscal Years 2001 and 2005**

Region	Type of Referral	2001		2005		2001-2005
		Number	% of Total	Number	% of Total	% Change
<b>Four Rivers</b>	Agency Referral	879	11.6	908	12.2	3.3
	Inpatient Treatment Facility	642	8.4	794	10.6	23.7
	Judicial System	1,878	24.7	1,352	18.1	-28.0
	Not Available/Collected	886	11.7	16	0.2	-98.2
	Personal	2,578	33.9	3,300	44.2	28.0
	Physician	602	7.9	870	11.7	44.5
	Other	134	1.8	227	3.0	69.4
	Total	7,599	100.0	7,467	100.0	
<b>Pennyroyal</b>	Agency Referral	928	11.2	931	8.9	0.3
	Inpatient Treatment Facility	523	6.3	672	6.4	28.5
	Judicial System	1,710	20.6	2,426	23.2	41.9
	Not Available/Collected	0	0.0	0	0.0	n/a
	Personal	3,510	42.2	5,435	52.1	54.8
	Physician	809	9.7	973	9.3	20.3
	Other	835	10.0	0	0.0	-100.0
	Total	8,315	100.0	10,437	100.0	
<b>River Valley</b>	Agency Referral	1,266	17.2	1,032	11.8	-18.5
	Inpatient Treatment Facility	501	6.8	654	7.5	30.5
	Judicial System	1,081	14.7	511	5.8	-52.7
	Not Available/Collected	126	1.7	145	1.7	15.1
	Personal	2,542	34.6	5,174	59.2	103.5
	Physician	417	5.7	669	7.6	60.4
	Other	1,413	19.2	562	6.4	-60.2
	Total	7,346	100.0	8,747	100.0	
<b>LifeSkills</b>	Agency Referral	1,596	14.5	2,026	17.6	26.9
	Inpatient Treatment Facility	568	5.1	833	7.2	46.7
	Judicial System	2,164	19.6	1,844	16.0	-14.8
	Not Available/Collected	1,693	15.3	624	5.4	-63.1
	Personal	3,392	30.7	4,400	38.2	29.7
	Physician	1,157	10.5	1,458	12.7	26.0
	Other	471	4.3	339	2.9	-28.0
	Total	11,041	100.0	11,524	100.0	

Region	Type of Referral	2001		2005		2001-2005
		Number	% of Total	Number	% of Total	% Change
<b>Communicare</b>	Agency Referral	759	12.0	1,899	23.1	150.2
	Inpatient Treatment Facility	411	6.5	989	12.0	140.6
	Judicial System	1,058	16.7	1,068	13.0	0.9
	Not Available/Collected	222	3.5	112	1.4	-49.5
	Personal	2,775	43.8	2,689	32.7	-3.1
	Physician	697	11.0	1,090	13.3	56.4
	Other	415	6.5	372	4.5	-10.4
	Total	6,337	100.0	8,219	100.0	
<b>Seven Counties</b>	Agency Referral	5,047	23.8	7,400	26.7	46.6
	Inpatient Treatment Facility	2,511	11.8	3,557	12.8	41.7
	Judicial System	1,776	8.4	3,062	11.0	72.4
	Not Available/Collected	419	2.0	15	0.1	-96.4
	Personal	6,591	31.1	9,921	35.8	50.5
	Physician	825	3.9	1,867	6.7	126.3
	Other	4,044	19.1	1,914	6.9	-52.7
	Total	21,213	100.0	27,736	100.0	
<b>NorthKey</b>	Agency Referral	1,285	21.3	1,918	23.3	49.3
	Inpatient Treatment Facility	739	12.2	956	11.6	29.4
	Judicial System	763	12.6	1,130	13.7	48.1
	Not Available/Collected	84	1.4	17	0.2	-79.8
	Personal	2,033	33.6	3,091	37.5	52.0
	Physician	676	11.2	829	10.1	22.6
	Other	464	7.7	307	3.7	-33.8
	Total	6,044	100.0	8,248	100.0	
<b>Comprehend</b>	Agency Referral	725	21.6	750	20.0	3.4
	Inpatient Treatment Facility	187	5.6	223	5.9	19.3
	Judicial System	768	22.9	784	20.9	2.1
	Not Available/Collected	13	0.4	1	0.0	-92.3
	Personal	1,244	37.1	1,383	36.9	11.2
	Physician	360	10.7	533	14.2	48.1
	Other	60	1.8	78	2.1	30.0
	Total	3,357	100.0	3,752	100.0	
<b>Pathways</b>	Agency Referral	2,915	27.8	2,995	21.3	2.7
	Inpatient Treatment Facility	718	6.8	897	6.4	24.9
	Judicial System	2,195	20.9	2,163	15.4	-1.5
	Not Available/Collected	227	2.2	135	1.0	-40.5
	Personal	3,496	33.4	6,293	44.7	80.0
	Physician	853	8.1	1,204	8.5	41.1
	Other	78	0.7	402	2.9	415.4
	Total	10,482	100.0	14,089	100.0	

Region	Type of Referral	2001		2005		2001-2005
		Number	% of Total	Number	% of Total	% Change
<b>Mountain</b>	Agency Referral	1,023	9.1	1,114	9.9	8.9
	Inpatient Treatment Facility	968	8.6	893	7.9	-7.7
	Judicial System	1,193	10.7	1,099	9.8	-7.9
	Not Available/Collected	266	2.4	3	0.0	-98.9
	Personal	5,400	48.2	7,710	68.6	42.8
	Physician	1,763	15.7	148	1.3	-91.6
	Other	584	5.2	277	2.5	-52.6
	Total	11,197	100.0	11,244	100.0	
<b>Kentucky River</b>	Agency Referral	920	12.4	1,280	12.2	39.1
	Inpatient Treatment Facility	546	7.3	485	4.6	-11.2
	Judicial System	919	12.4	887	8.4	-3.5
	Not Available/Collected	338	4.5	1,292	12.3	282.2
	Personal	3,141	42.2	4,587	43.6	46.0
	Physician	1,181	15.9	1,534	14.6	29.9
	Other	390	5.2	465	4.4	19.2
	Total	7,435	100.0	10,530	100.0	
<b>Cumberland River</b>	Agency Referral	1,569	16.8	1,630	12.0	3.9
	Inpatient Treatment Facility	671	7.2	477	3.5	-28.9
	Judicial System	1,476	15.8	1,727	12.7	17.0
	Not Available/Collected	140	1.5	31	0.2	-77.9
	Personal	3,735	40.0	4,722	34.8	26.4
	Physician	1,057	11.3	1,060	7.8	0.3
	Other	700	7.5	3,908	28.8	458.3
	Total	9,348	100.0	13,555	100.0	
<b>Adanta</b>	Agency Referral	1,898	19.2	1,769	21.8	-6.8
	Inpatient Treatment Facility	526	5.3	314	3.9	-40.3
	Judicial System	1,552	15.7	995	12.3	-35.9
	Not Available/Collected	715	7.2	1	0.0	-99.9
	Personal	3,995	40.5	3,829	47.2	-4.2
	Physician	1,144	11.6	886	10.9	-22.6
	Other	36	0.4	318	3.9	783.3
	Total	9,866	100.0	8,112	100.0	
<b>Bluegrass</b>	Agency Referral	3,918	17.3	4,625	18.6	18.0
	Inpatient Treatment Facility	2,392	10.6	2,446	9.8	2.3
	Judicial System	2,973	13.1	2,390	9.6	-19.6
	Not Available/Collected	143	0.6	329	1.3	130.1
	Personal	9,254	40.8	11,353	45.6	22.7
	Physician	2,255	9.9	3,012	12.1	33.6
	Other	1,732	7.6	722	2.9	-58.3
	Total	22,667	100.0	24,877	100.0	

Region	Type of Referral	2001		2005		2001-2005
		Number	% of Total	Number	% of Total	% Change
State	Agency Referral	24,728	17.4	30,277	18.0	22.4
	Inpatient Treatment Facility	11,903	8.4	14,190	8.4	19.2
	Judicial System	21,506	15.1	21,438	12.7	-0.3
	Not Available/Collected	5,272	3.7	2,721	1.6	-48.4
	Personal	53,686	37.7	73,887	43.8	37.6
	Physician	13,796	9.7	16,133	9.6	16.9
	Other	11,356	8.0	9,891	5.9	-12.9
	Total	142,247	100.0	168,537	100.0	

**Table B.5**  
**Consumer Living Arrangements by Region**  
**Fiscal Years 2001 and 2005**

Region	Living Arrangement	2001		2005		2001-2005
		Number	% of Total	Number	% of Total	% Change
<b>Four Rivers</b>	No Fixed Residence	80	1.1	108	1.4	35.0
	Staffed Residence	77	1.0	72	1.0	-6.5
	Nonstaffed Residence	6,312	83.1	6,452	86.4	2.2
	Licensed Long-term Care	62	0.8	73	1.0	17.7
	Other	1,068	14.1	762	10.2	-28.7
	Total	7,599	100.0	7,467	100.0	
<b>Pennyroyal</b>	No Fixed Residence	21	0.3	43	0.4	104.8
	Staffed Residence	8	0.1	38	0.4	375.0
	Nonstaffed Residence	8,043	96.7	9,877	94.6	22.8
	Licensed Long-term Care	130	1.6	221	2.1	70.0
	Other	113	1.4	258	2.5	128.3
	Total	8,315	100.0	10,437	100.0	
<b>River Valley</b>	No Fixed Residence	224	3.0	197	2.3	-12.1
	Staffed Residence	90	1.2	122	1.4	35.6
	Nonstaffed Residence	5,825	79.3	7,453	85.2	27.9
	Licensed Long-term Care	289	3.9	231	2.6	-20.1
	Other	918	12.5	744	8.5	-19.0
	Total	7,346	100.0	8,747	100.0	
<b>LifeSkills</b>	No Fixed Residence	60	0.5	136	1.2	126.7
	Staffed Residence	94	0.9	123	1.1	30.9
	Nonstaffed Residence	9,517	86.2	10,070	87.4	5.8
	Licensed Long-term Care	216	2.0	257	2.2	19.0
	Other	1,154	10.5	938	8.1	-18.7
	Total	11,041	100.0	11,524	100.0	
<b>Communicare</b>	No Fixed Residence	82	1.3	45	0.5	-45.1
	Staffed Residence	134	2.1	118	1.4	-11.9
	Nonstaffed Residence	5,260	83.0	6,707	81.6	27.5
	Licensed Long-term Care	138	2.2	329	4.0	138.4
	Other	723	11.4	1,020	12.4	41.1
	Total	6,337	100.0	8,219	100.0	
<b>Seven Counties</b>	No Fixed Residence	876	4.1	976	3.5	11.4
	Staffed Residence	538	2.5	674	2.4	25.3
	Nonstaffed Residence	14,821	69.9	19,615	70.7	32.3
	Licensed Long-term Care	557	2.6	354	1.3	-36.4
	Other	4,421	20.8	6,117	22.1	38.4
	Total	21,213	100.0	27,736	100.0	

Region	Living Arrangement	2001		2005		2001-2005
		Number	% of Total	Number	% of Total	% Change
<b>NorthKey</b>	No Fixed Residence	205	3.4	285	3.5	39.0
	Staffed Residence	156	2.6	172	2.1	10.3
	Nonstaffed Residence	4,954	82.0	6,566	79.6	32.5
	Licensed Long-term Care	263	4.4	261	3.2	-0.8
	Other	466	7.7	964	11.7	106.9
	Total	6,044	100.0	8,248	100.0	
<b>Comprehend</b>	No Fixed Residence	31	0.9	31	0.8	0.0
	Staffed Residence	17	0.5	26	0.7	52.9
	Nonstaffed Residence	3,125	93.1	3,416	91.0	9.3
	Licensed Long-term Care	87	2.6	56	1.5	-35.6
	Other	97	2.9	223	5.9	129.9
	Total	3,357	100.0	3,752	100.0	
<b>Pathways</b>	No Fixed Residence	78	0.7	139	1.0	78.2
	Staffed Residence	161	1.5	194	1.4	20.5
	Nonstaffed Residence	8,551	81.6	12,541	89.0	46.7
	Licensed Long-term Care	0	0.0	134	1.0	n/a
	Other	1,692	16.1	1,081	7.7	-36.1
	Total	10,482	100.0	14,089	100.0	
<b>Mountain</b>	No Fixed Residence	73	0.7	113	1.0	54.8
	Staffed Residence	36	0.3	46	0.4	27.8
	Nonstaffed Residence	9,113	81.4	10,314	91.7	13.2
	Licensed Long-term Care	218	1.9	155	1.4	-28.9
	Other	1,757	15.7	616	5.5	-64.9
	Total	11,197	100.0	11,244	100.0	
<b>Kentucky River</b>	No Fixed Residence	45	0.6	57	0.5	26.7
	Staffed Residence	41	0.6	46	0.4	12.2
	Nonstaffed Residence	6,681	89.9	9,005	85.5	34.8
	Licensed Long-term Care	82	1.1	177	1.7	115.9
	Other	586	7.9	1,245	11.8	112.5
	Total	7,435	100.0	10,530	100.0	
<b>Cumberland River</b>	No Fixed Residence	55	0.6	69	0.5	25.5
	Staffed Residence	83	0.9	127	0.9	53.0
	Nonstaffed Residence	8,209	87.8	11,236	82.9	36.9
	Licensed Long-term Care	160	1.7	192	1.4	20.0
	Other	841	9.0	1,931	14.2	129.6
	Total	9,348	100.0	13,555	100.0	

Region	Living Arrangement	2001		2005		2001-2005
		Number	% of Total	Number	% of Total	% Change
<b>Adanta</b>	No Fixed Residence	69	0.7	42	0.5	-39.1
	Staffed Residence	132	1.3	138	1.7	4.5
	Nonstaffed Residence	8,291	84.0	7,429	91.6	-10.4
	Licensed LTC	130	1.3	195	2.4	50.0
	Other	1,244	12.6	308	3.8	-75.2
	Total	9,866	100.0	8,112	100.0	
<b>Bluegrass</b>						
<b>Bluegrass</b>	No Fixed Residence	781	3.4	791	3.2	1.3
	Staffed Residence	354	1.6	508	2.0	43.5
	Nonstaffed Residence	19,351	85.4	21,394	86.0	10.6
	Licensed LTC	471	2.1	367	1.5	-22.1
	Other	1,710	7.5	1,817	7.3	6.3
	Total	22,667	100.0	24,877	100.0	
<b>State</b>						
<b>State</b>	No Fixed Residence	2,680	1.9	3,032	1.8	13.1
	Staffed Residence	1,921	1.4	2,404	1.4	25.1
	Nonstaffed Residence	118,053	83.0	142,075	84.3	20.3
	Licensed LTC	2,803	2.0	3,002	1.8	7.1
	Other	16,790	11.8	18,024	10.7	7.3
	Total	142,247	100.0	168,537	100.0	



## Appendix C

### Total Service Units by Major Program Area Fiscal Years 2001 and 2005

Tables were compiled by Program Review staff from Schedule D of regional cost reports.

Major program areas were defined as mental health (MH), substance abuse (SA), mental retardation and developmental disabilities (MR/DD), and other. "Other" represents services generally serving all or some mix of the other three program areas.

Region	Program Area	2001		2005		2001-2005
		Number	% of Total	Number	% of Total	% Change
<b>Four Rivers</b>	MH	149,813	28.1	156,434	29.8	4.4
	SA	84,990	15.9	30,001	5.7	-64.7
	MR/DD	254,292	47.6	231,816	44.2	-8.8
	Other	44,739	8.4	105,986	20.2	136.9
	Total	533,834	100.0	524,237	100.0	-1.8
<b>Pennyroyal</b>	MH	204,464	32.4	200,517	33.2	-1.9
	SA	79,158	12.5	118,858	19.7	50.2
	MR/DD	217,606	34.4	109,555	18.1	-49.7
	Other	130,640	20.7	175,410	29.0	34.3
	Total	631,868	100.0	604,340	100.0	-4.4
<b>River Valley</b>	MH	421,518	48.6	576,197	53.6	36.7
	SA	27,970	3.2	22,111	2.1	-20.9
	MR/DD	349,450	40.3	390,729	36.4	11.8
	Other	68,705	7.9	85,322	7.9	24.2
	Total	867,643	100.0	1,074,359	100.0	23.8
<b>LifeSkills</b>	MH	442,554	37.6	500,636	28.1	13.1
	SA	30,132	2.6	27,081	1.5	-10.1
	MR/DD	596,484	50.6	942,973	52.9	58.1
	Other	109,275	9.3	310,499	17.4	184.1
	Total	1,178,445	100.0	1,781,189	100.0	51.1
<b>Communicare</b>	MH	172,935	15.9	265,374	12.8	53.5
	SA	31,934	2.9	187,163	9.0	486.1
	MR/DD	880,323	80.7	1,592,655	76.6	80.9
	Other	5,166	0.5	35,298	1.7	583.3
	Total	1,090,358	100.0	2,080,490	100.0	90.8

Region	Program Area	2001		2005		2001-2005
		Number	% of Total	Number	% of Total	% Change
<b>Seven Counties</b>	MH	1,263,206	61.7	1,348,753	60.0	6.8
	SA	203,580	9.9	231,354	10.3	13.6
	MR/DD	488,447	23.9	587,777	26.1	20.3
	Other	92,649	4.5	81,303	3.6	-12.2
	Total	2,047,882	100.0	2,249,187	100.0	9.8
<b>NorthKey</b>	MH	222,440	44.1	292,622	27.3	31.6
	SA	40,474	8.0	52,159	4.9	28.9
	MR/DD	80,761	16.0	234,100	21.8	189.9
	Other	161,137	31.9	494,218	46.1	206.7
	Total	504,812	100.0	1,073,099	100.0	112.6
<b>Comprehend</b>	MH	153,317	28.6	192,636	29.4	25.6
	SA	43,407	8.1	41,932	6.4	-3.4
	MR/DD	274,618	51.3	245,304	37.4	-10.7
	Other	63,991	12.0	175,806	26.8	174.7
	Total	535,333	100.0	655,678	100.0	22.5
<b>Pathways</b>	MH	576,383	35.3	513,901	38.1	-10.8
	SA	110,961	6.8	90,596	6.7	-18.4
	MR/DD	303,794	18.6	408,358	30.3	34.4
	Other	640,284	39.2	336,821	25.0	-47.4
	Total	1,631,422	100.0	1,349,676	100.0	-17.3
<b>Mountain</b>	MH	371,652	57.9	354,730	49.7	-4.6
	SA	18,260	2.8	28,870	4.0	58.1
	MR/DD	169,995	26.5	271,260	38.0	59.6
	Other	82,208	12.8	58,899	8.3	-28.4
	Total	642,115	100.0	713,759	100.0	11.2
<b>Kentucky River</b>	MH	314,726	52.3	355,254	45.3	12.9
	SA	25,302	4.2	59,058	7.5	133.4
	MR/DD	212,852	35.4	215,047	27.4	1.0
	Other	49,180	8.2	155,597	19.8	216.4
	Total	602,060	100.0	784,956	100.0	30.4
<b>Cumberland River</b>	MH	538,957	45.6	773,645	40.6	43.5
	SA	15,862	1.3	26,972	1.4	70.0
	MR/DD	521,016	44.1	691,912	36.3	32.8
	Other	106,724	9.0	413,588	21.7	287.5
	Total	1,182,559	100.0	1,906,117	100.0	61.2

Region	Program Area	2001		2005		2001-2005
		Number	% of Total	Number	% of Total	% Change
<b>Adanta</b>	MH	600,782	50.7	557,157	39.4	-7.3
	SA	88,103	7.4	90,377	6.4	2.6
	MR/DD	345,208	29.2	403,541	28.5	16.9
	Other	150,016	12.7	363,232	25.7	142.1
	Total	1,184,109	100.0	1,414,307	100.0	19.4
<b>Bluegrass</b>	MH	1,099,899	66.0	1,170,696	56.6	6.4
	SA	107,759	6.5	114,955	5.6	6.7
	MR/DD	275,155	16.5	392,903	19.0	42.8
	Other	184,647	11.1	391,572	18.9	112.1
	Total	1,667,460	100.0	2,070,126	100.0	24.1
<b>State</b>	MH	6,532,646	45.7	7,258,552	39.7	11.1
	SA	907,892	6.3	1,121,487	6.1	23.5
	MR/DD	4,970,001	34.8	6,717,930	36.7	35.2
	Other	1,889,361	13.2	3,183,551	17.4	68.5
	Total	14,299,900	100.0	18,281,520	100.0	27.8



## Appendix D

### Summary of Total Service Units by Payer Source Fiscal Years 2001 and 2005

Tables were compiled by Program Review staff from Schedule D of regional cost reports.

Payers were defined as Medicaid (Other): Medicaid, other than Supports for Community Living; Medicaid (SCL): Medicaid, through the Supports for Community Living waiver; DMHMRS: Department for Mental Health and Mental Retardation Services through its contracts with the centers; and Other: self-pay clients, private insurance, and miscellaneous third-party payers.

Region	Source	2001		2005		2001-2005
		Number	% of Total	Number	% of Total	% Change
<b>Four Rivers</b>	Medicaid (Other)	67,391	12.6	76,521	14.6	13.5
	Medicaid (SCL)	235,258	44.1	221,604	42.3	-5.8
	DMHMRS	168,381	31.5	188,789	36.0	12.1
	Other	62,804	11.8	37,323	7.1	-40.6
	Total	533,834	100.0	524,237	100.0	-1.8
<b>Pennyroyal</b>	Medicaid (Other)	95,325	15.1	106,083	17.6	11.3
	Medicaid (SCL)	206,254	32.6	87,493	14.5	-57.6
	DMHMRS	192,142	30.4	262,395	43.4	36.6
	Other	138,147	21.9	148,369	24.6	7.4
	Total	631,868	100.0	604,340	100.0	-4.4
<b>River Valley</b>	Medicaid (Other)	265,333	30.6	256,648	23.9	-3.3
	Medicaid (SCL)	317,375	36.6	360,422	33.5	13.6
	DMHMRS	200,810	23.1	274,905	25.6	36.9
	Other	84,125	9.7	182,384	17.0	116.8
	Total	867,643	100.0	1,074,359	100.0	23.8
<b>LifeSkills</b>	Medicaid (Other)	282,578	24.0	291,210	16.3	3.1
	Medicaid (SCL)	572,242	48.6	836,600	47.0	46.2
	DMHMRS	242,552	20.6	588,576	33.0	142.7
	Other	81,073	6.9	64,803	3.6	-20.1
	Total	1,178,445	100.0	1,781,189	100.0	51.1
<b>Communicare</b>	Medicaid (Other)	93,882	8.6	157,126	7.6	67.4
	Medicaid (SCL)	237,661	21.8	704,841	33.9	196.6
	DMHMRS	681,807	62.5	995,744	47.9	46.0
	Other	77,008	7.1	222,779	10.7	189.3
	Total	1,090,358	100.0	2,080,490	100.0	90.8

Region	Source	2001		2005		2001-2005
		Number	% of Total	Number	% of Total	% Change
<b>Seven Counties</b>	Medicaid (Other)	883,816	43.2	1,075,412	47.8	21.7
	Medicaid (SCL)	374,740	18.3	491,385	21.8	31.1
	DMHMRS	511,277	25.0	410,284	18.2	-19.8
	Other	278,049	13.6	272,106	12.1	-2.1
	Total	2,047,882	100.0	2,249,187	100.0	9.8
<b>NorthKey</b>	Medicaid (Other)	128,341	25.4	171,321	16.0	33.5
	Medicaid (SCL)	65,907	13.1	209,349	19.5	217.6
	DMHMRS	278,255	55.1	654,828	61.0	135.3
	Other	32,309	6.4	37,601	3.5	16.4
	Total	504,812	100.0	1,073,099	100.0	112.6
<b>Comprehend</b>	Medicaid (Other)	101,019	18.9	110,574	16.9	9.5
	Medicaid (SCL)	267,771	50.0	241,775	36.9	-9.7
	DMHMRS	132,683	24.8	268,753	41.0	102.6
	Other	33,860	6.3	34,576	5.3	2.1
	Total	535,333	100.0	655,678	100.0	22.5
<b>Pathways</b>	Medicaid (Other)	244,700	15.0	348,716	25.8	42.5
	Medicaid (SCL)	200,129	12.3	375,722	27.8	87.7
	DMHMRS	318,147	19.5	542,458	40.2	70.5
	Other	868,446	53.2	82,780	6.1	-90.5
	Total	1,631,422	100.0	1,349,676	100.0	-17.3
<b>Mountain</b>	Medicaid (Other)	267,674	41.7	245,815	34.4	-8.2
	Medicaid (SCL)	139,319	21.7	225,218	31.6	61.7
	DMHMRS	209,762	32.7	206,250	28.9	-1.7
	Other	25,360	3.9	36,476	5.1	43.8
	Total	642,115	100.0	713,759	100.0	11.2
<b>Kentucky River</b>	Medicaid (Other)	235,083	39.0	281,889	35.9	19.9
	Medicaid (SCL)	183,580	30.5	192,225	24.5	4.7
	DMHMRS	151,505	25.2	268,064	34.2	76.9
	Other	31,892	5.3	42,778	5.4	34.1
	Total	602,060	100.0	784,956	100.0	30.4
<b>Cumberland River</b>	Medicaid (Other)	340,937	28.8	537,462	28.2	57.6
	Medicaid (SCL)	503,617	42.6	691,370	36.3	37.3
	DMHMRS	279,326	23.6	583,965	30.6	109.1
	Other	58,679	5.0	93,320	4.9	59.0
	Total	1,182,559	100.0	1,906,117	100.0	61.2

Region	Source	2001		2005		2001-2005
		Number	% of Total	Number	% of Total	% Change
<b>Adanta</b>	Medicaid (Other)	484,574	40.9	475,559	33.6	-1.9
	Medicaid (SCL)	281,258	23.8	348,018	24.6	23.7
	DMHMRS	284,230	24.0	500,831	35.4	76.2
	Other	134,047	11.3	89,899	6.4	-32.9
	Total	1,184,109	100.0	1,414,307	100.0	19.4
<b>Bluegrass</b>	Medicaid (Other)	742,064	44.5	817,485	39.5	10.2
	Medicaid (SCL)	204,564	12.3	343,817	16.6	68.1
	DMHMRS	587,612	35.2	713,140	34.4	21.4
	Other	133,220	8.0	195,684	9.5	46.9
	Total	1,667,460	100.0	2,070,126	100.0	24.1
<b>State</b>	Medicaid (Other)	4,232,717	29.6	4,951,821	27.1	17.0
	Medicaid (SCL)	3,789,675	26.5	5,329,839	29.2	40.6
	DMHMRS	4,238,489	29.6	6,458,982	35.3	52.4
	Other	2,039,019	14.3	1,540,878	8.4	-24.4
	Total	14,299,900	100.0	18,281,520	100.0	27.8



## Appendix E

### Summary of Revenues by Source Fiscal Years 2001 to 2005

Tables were compiled by Program Review staff from financial information self-reported by regions and from audited financial statements.

Tables have been adjusted for inflation to reflect 2001 dollars. Adjustments were made using the Consumer Price Index from the U.S. Department of Labor's Bureau of Labor Statistics.

In these tables, there is no region 9. Regions Fiveco and Gateway merged to form Pathways (Region 10).

**Table E.1  
 Total Revenues by Region  
 Adjusted for Inflation (2001 Dollars)  
 Fiscal Years 2001 to 2005**

Region		2001	2002	2003	2004	2005
1	Four Rivers	\$8,850,511	\$9,720,887	\$11,400,786	\$12,328,909	\$12,973,819
2	Pennyroyal	\$13,863,205	\$12,816,980	\$13,930,231	\$14,391,229	\$15,837,916
3	River Valley	\$27,803,438	\$26,404,667	\$28,264,722	\$29,312,439	\$30,617,230
4	LifeSkills	\$20,021,015	\$21,568,540	\$21,339,775	\$22,124,533	\$21,919,419
5	Communicare	\$14,976,907	\$16,176,363	\$17,649,530	\$18,372,782	\$18,612,433
6	Seven Counties	\$62,014,535	\$64,781,724	\$63,610,058	\$61,517,680	\$61,298,006
7	NorthKey	\$18,395,871	\$19,391,410	\$20,303,573	\$20,774,438	\$21,638,804
8	Comprehend	\$5,665,976	\$6,073,626	\$6,211,992	\$6,666,512	\$6,416,926
10	Pathways	\$19,245,071	\$20,839,314	\$20,762,835	\$21,175,194	\$20,728,352
11	Mountain	\$15,725,100	\$15,668,098	\$16,062,172	\$15,376,021	\$14,991,613
12	Kentucky River	\$18,065,298	\$18,208,666	\$18,586,737	\$19,395,377	\$20,434,881
13	Cumberland River	\$17,769,550	\$19,445,670	\$20,207,879	\$19,743,746	\$19,829,577
14	Adanta	\$22,332,409	\$22,764,003	\$22,576,108	\$21,945,724	\$20,992,558
15	Bluegrass	\$47,368,179	\$50,065,840	\$51,838,367	\$52,436,435	\$53,447,141
	<b>Total</b>	<b>\$312,097,065</b>	<b>\$323,925,788</b>	<b>\$332,744,764</b>	<b>\$335,561,019</b>	<b>\$339,738,674</b>

**Table E.2**  
**Federal Revenues by Region**  
**Adjusted for Inflation (2001 Dollars)**  
**Fiscal Years 2001 to 2005**

Region		2001	2002	2003	2004	2005
1	Four Rivers	\$4,128,723	\$5,072,200	\$4,615,813	\$4,627,650	\$4,638,811
2	Pennyroyal	n/a	\$5,262,461	\$4,990,398	\$4,987,433	\$5,470,557
3	River Valley	\$19,730,814	\$17,550,598	\$17,802,980	\$16,623,889	\$16,267,245
4	LifeSkills	\$10,829,152	\$12,428,983	\$12,807,950	\$13,631,999	\$13,824,767
5	Communicare	\$7,449,452	\$8,140,662	\$8,885,713	\$9,190,450	\$10,466,202
6	Seven Counties	\$36,363,335	\$40,175,822	\$38,986,607	\$37,964,742	\$38,611,870
7	NorthKey	\$9,751,072	\$10,334,796	\$10,500,582	\$11,358,258	\$12,506,042
8	Comprehend	\$3,223,243	\$3,632,782	\$3,572,141	\$3,370,278	\$3,317,519
10	Pathways	\$9,402,673	\$11,095,307	\$11,673,984	\$12,218,667	\$13,263,134
11	Mountain	\$8,733,680	\$8,995,409	\$9,281,275	\$8,911,988	\$8,506,520
12	Kentucky River	\$8,569,002	\$8,473,101	\$8,912,659	\$9,280,525	\$10,207,259
13	Cumberland River	\$11,150,162	\$12,320,267	\$12,952,444	\$12,976,833	\$12,668,744
14	Adanta	\$10,849,109	\$11,911,953	\$11,755,321	\$10,967,431	\$11,212,633
15	Bluegrass	\$20,344,212	\$22,712,719	\$23,408,648	\$24,176,624	\$24,376,482
	Total	\$160,524,629	\$178,107,061	\$180,146,515	\$180,286,764	\$185,337,785

**Table E.3**  
**State Revenues by Region**  
**Adjusted for Inflation (2001 Dollars)**  
**Fiscal Years 2001 to 2005**

Region		2001	2002	2003	2004	2005
1	Four Rivers	\$3,414,992	\$3,043,701	\$3,622,478	\$3,689,501	\$3,502,527
2	Pennyroyal	n/a	\$5,422,280	\$5,820,781	\$6,440,388	\$6,713,044
3	River Valley	\$4,087,413	\$4,047,932	\$3,956,505	\$5,005,540	\$7,034,222
4	LifeSkills	\$6,963,037	\$7,015,772	\$6,450,040	\$6,344,200	\$5,550,172
5	Communicare	\$5,150,270	\$5,994,703	\$6,391,681	\$6,231,152	\$5,689,603
6	Seven Counties	\$20,685,311	\$19,382,672	\$19,989,908	\$18,204,709	\$17,517,312
7	NorthKey	\$6,739,613	\$6,832,020	\$7,417,229	\$7,534,806	\$7,196,400
8	Comprehend	\$1,841,574	\$2,037,145	\$2,042,285	\$2,382,421	\$2,266,606
10	Pathways	\$7,167,668	\$7,234,588	\$6,802,633	\$6,773,621	\$5,898,858
11	Mountain	\$5,243,272	\$4,779,135	\$4,846,066	\$4,696,942	\$4,412,402
12	Kentucky River	\$8,255,011	\$8,404,897	\$8,383,503	\$8,565,720	\$8,291,692
13	Cumberland River	\$4,767,940	\$5,277,833	\$5,640,056	\$5,023,491	\$5,037,974
14	Adanta	\$9,721,366	\$9,415,942	\$9,561,881	\$9,670,063	\$8,501,001
15	Bluegrass	\$16,724,266	\$15,700,978	\$16,006,044	\$15,767,621	\$16,552,825
	Total	\$100,761,733	\$104,589,597	\$106,931,092	\$106,330,176	\$104,164,637

**Table E.4  
 Local Tax Match by Region  
 Adjusted for Inflation (2001 Dollars)  
 Fiscal Years 2001 to 2005**

Region		2001	2002	2003	2004	2005
1	Four Rivers	\$259,869	\$301,373	\$300,868	\$406,334	\$462,359
2	Pennyroyal	n/a	\$0	\$0	\$0	\$8,786
3	River Valley	\$11,300	\$8,212	\$8,042	\$7,788	\$7,596
4	LifeSkills	\$243,507	\$260,127	\$254,747	\$246,700	\$240,601
5	Communicare	\$0	\$0	\$0	\$0	\$0
6	Seven Counties	\$774,067	\$832,739	\$916,781	\$1,007,219	\$940,751
7	NorthKey	\$748,318	\$788,345	\$860,960	\$801,238	\$873,514
8	Comprehend	\$0	\$0	\$0	\$0	\$0
10	Pathways	\$0	\$0	\$0	\$0	\$0
11	Mountain	\$0	\$0	\$0	\$0	\$0
12	Kentucky River	\$12,000	\$11,873	\$11,628	\$11,260	\$10,982
13	Cumberland River	\$14,639	\$17,983	\$1,232	\$16,567	\$19,173
14	Adanta	\$17,600	\$17,414	\$17,054	\$16,515	\$16,107
15	Bluegrass	\$278,150	\$260,426	\$240,370	\$221,574	\$203,716
	Total	\$2,359,450	\$2,498,494	\$2,611,681	\$2,735,194	\$2,783,584

**Table E.5  
 Other Local Match by Region  
 Adjusted for Inflation (2001 Dollars)  
 Fiscal Years 2001 to 2005**

Region		2001	2002	2003	2004	2005
1	Four Rivers	\$390,592	\$428,025	\$2,044,484	\$2,622,054	\$2,771,986
2	Pennyroyal	n/a	\$820,732	\$1,399,057	\$1,636,480	\$1,236,571
3	River Valley	\$1,030,412	\$964,770	\$784,985	\$788,369	\$770,174
4	LifeSkills	\$73,200	\$115,635	\$154,830	\$130,545	\$129,602
5	Communicare	\$1,373,318	\$1,269,470	\$1,153,765	\$1,132,668	\$1,198,673
6	Seven Counties	\$1,156,647	\$1,024,111	\$542,720	\$404,499	\$341,645
7	NorthKey	\$205,003	\$202,662	\$185,858	\$169,535	\$180,907
8	Comprehend	\$446,772	\$324,978	\$243,913	\$482,214	\$433,665
10	Pathways	\$179,252	\$168,118	\$235,621	\$156,892	\$202,250
11	Mountain	\$1,105,608	\$1,116,684	\$1,122,113	\$999,818	\$1,023,018
12	Kentucky River	\$536,918	\$776,465	\$354,665	\$379,801	\$459,196
13	Cumberland River	\$324,398	\$282,684	\$198,619	\$181,437	\$218,576
14	Adanta	\$449,587	\$229,292	\$234,151	\$255,050	\$246,507
15	Bluegrass	\$926,549	\$900,983	\$870,498	\$856,278	\$863,413
	Total	\$8,198,256	\$8,624,606	\$9,525,279	\$10,195,641	\$10,076,183

**Table E.6**  
**Charges to Patients by Region**  
**Adjusted for Inflation (2001 Dollars)**  
**Fiscal Years 2001 to 2005**

Region		2001	2002	2003	2004	2005
1	Four Rivers	\$505,980	\$742,246	\$579,204	\$719,344	\$628,449
2	Pennyroyal	n/a	\$1,108,489	\$1,503,749	\$1,163,397	\$2,098,239
3	River Valley	\$2,681,689	\$3,779,355	\$5,623,185	\$6,662,601	\$6,293,997
4	LifeSkills	\$632,580	\$859,412	\$824,893	\$824,543	\$897,071
5	Communicare	\$819,866	\$544,105	\$850,790	\$1,496,566	\$860,787
6	Seven Counties	\$1,581,946	\$2,499,622	\$1,505,622	\$1,507,618	\$1,396,434
7	NorthKey	\$549,510	\$740,146	\$783,707	\$722,368	\$587,284
8	Comprehend	\$154,387	\$78,722	\$353,652	\$336,597	\$357,676
10	Pathways	\$2,163,519	\$2,124,576	\$1,922,013	\$1,867,982	\$1,176,389
11	Mountain	\$492,726	\$637,202	\$628,149	\$515,925	\$858,559
12	Kentucky River	\$681,715	\$502,729	\$496,568	\$800,659	\$769,476
13	Cumberland River	\$1,126,269	\$1,138,980	\$1,014,967	\$1,044,640	\$1,167,915
14	Adanta	\$762,094	\$710,221	\$544,027	\$626,546	\$631,938
15	Bluegrass	\$4,707,315	\$5,259,374	\$6,295,208	\$6,658,352	\$6,394,517
	Total	\$16,859,596	\$20,725,178	\$22,925,735	\$24,947,136	\$24,118,730

**Table E.7**  
**Other Revenues by Region**  
**Adjusted for Inflation (2001 Dollars)**  
**Fiscal Years 2001 to 2005**

Region		2001	2002	2003	2004	2005
1	Four Rivers	\$150,355	\$133,342	\$237,940	\$264,027	\$969,687
2	Pennyroyal	n/a	\$203,018	\$216,245	\$163,530	\$310,720
3	River Valley	\$261,810	\$53,799	\$89,024	\$224,252	\$243,995
4	LifeSkills	\$1,279,539	\$888,612	\$847,315	\$946,546	\$1,277,206
5	Communicare	\$184,001	\$227,424	\$367,581	\$321,946	\$397,169
6	Seven Counties	\$1,453,229	\$866,757	\$1,668,420	\$2,428,893	\$2,489,994
7	NorthKey	\$402,355	\$493,441	\$555,235	\$188,233	\$294,656
8	Comprehend	\$0	\$0	\$0	\$95,002	\$41,461
10	Pathways	\$331,959	\$216,726	\$128,583	\$158,033	\$187,721
11	Mountain	\$149,814	\$139,669	\$184,569	\$251,348	\$191,114
12	Kentucky River	\$10,652	\$39,600	\$427,715	\$357,412	\$696,276
13	Cumberland River	\$386,142	\$407,923	\$400,562	\$500,778	\$717,195
14	Adanta	\$532,653	\$479,181	\$463,673	\$410,120	\$384,372
15	Bluegrass	\$4,387,687	\$5,231,359	\$5,017,598	\$4,755,987	\$5,056,188
	Total	\$9,530,196	\$9,380,852	\$10,604,462	\$11,066,108	\$13,257,755

## Appendix F

### Total Consumers, Service Units, and Revenues Fiscal Years 2001 and 2005

Tables were compiled by Program Review staff from Department for Mental Health and Mental Retardation Services data sets, regional cost reports, financial information self-reported by regions, and audited financial statements.

Tables have been adjusted for inflation to reflect 2001 dollars. Adjustments were made using the Consumer Price Index from the U.S. Department of Labor's Bureau of Labor Statistics.

		2001		2005		2001-2005
Region		Number	% of Total	Number	% of Total	% Change
<b>Four Rivers</b>	Total Consumers	7,576	5.4%	7,494	4.6%	-1.1%
	Total Services	533,834	3.7%	524,237	2.9%	-1.8%
	Total Revenue	\$8,850,511	2.8%	\$12,973,819	3.8%	46.6%
<b>Pennyroyal</b>	Total Consumers	8,295	5.9%	9,223	5.6%	11.2%
	Total Services	631,868	4.4%	604,340	3.3%	-4.4%
	Total Revenue	\$13,863,205	4.5%	\$15,837,916	4.7%	14.2%
<b>River Valley</b>	Total Consumers	7,361	5.3%	8,663	5.3%	17.7%
	Total Services	867,643	6.1%	1,074,359	5.9%	23.8%
	Total Revenue	\$27,803,438	8.9%	\$30,617,230	9.1%	10.1%
<b>LifeSkills</b>	Total Consumers	11,042	7.9%	11,539	7.1%	4.5%
	Total Services	1,178,445	8.2%	1,781,189	9.7%	51.1%
	Total Revenue	\$20,021,015	6.4%	\$21,919,419	6.5%	9.5%
<b>Communicare</b>	Total Consumers	6,344	4.5%	8,235	5.0%	29.8%
	Total Services	1,090,358	7.6%	2,080,490	11.4%	90.8%
	Total Revenue	\$14,976,907	4.8%	\$18,612,433	5.5%	24.3%
<b>Seven Counties</b>	Total Consumers	18,727	13.4%	24,286	14.9%	29.7%
	Total Services	2,047,882	14.3%	2,249,187	12.3%	9.8%
	Total Revenue	\$62,014,535	19.9%	\$61,298,006	18.0%	-1.2%
<b>NorthKey</b>	Total Consumers	6,018	4.3%	8,266	5.1%	37.4%
	Total Services	504,812	3.5%	1,073,099	5.9%	112.6%
	Total Revenue	\$18,395,871	5.9%	\$21,638,804	6.4%	17.6%
<b>Comprehend</b>	Total Consumers	3,226	2.3%	3,777	2.3%	17.1%
	Total Services	535,333	3.7%	655,678	3.6%	22.5%
	Total Revenue	\$5,665,976	1.8%	\$6,416,926	1.9%	13.3%

		2001		2005		2001-2005
Region		Number	% of Total	Number	% of Total	% Change
<b>Pathways</b>	Total Consumers	10,755	7.7%	14,329	8.8%	33.2%
	Total Services	1,631,422	11.4%	1,349,676	7.4%	-17.3%
	Total Revenue	\$19,245,071	6.2%	\$20,728,352	6.1%	7.7%
<b>Mountain</b>	Total Consumers	11,230	8.0%	10,357	6.3%	-7.8%
	Total Services	642,115	4.5%	713,759	3.9%	11.2%
	Total Revenue	\$15,725,100	5.1%	\$14,991,613	4.4%	-4.7%
<b>Kentucky River</b>	Total Consumers	7,422	5.3%	10,486	6.4%	41.3%
	Total Services	602,060	4.2%	784,956	4.3%	30.4%
	Total Revenue	\$18,065,298	5.8%	\$20,434,881	6.0%	13.1%
<b>Cumberland River</b>	Total Consumers	9,280	6.6%	13,562	8.3%	46.1%
	Total Services	1,182,559	8.3%	1,906,117	10.4%	61.2%
	Total Revenue	\$17,769,550	5.7%	\$19,829,577	5.9%	11.6%
<b>Adanta</b>	Total Consumers	9,836	7.0%	8,113	5.0%	-17.5%
	Total Services	1,184,109	8.3%	1,414,307	7.7%	19.4%
	Total Revenue	\$22,332,409	7.2%	\$20,992,558	6.2%	-6.0%
<b>Bluegrass</b>	Total Consumers	22,755	16.3%	25,095	15.4%	10.3%
	Total Services	1,667,460	11.7%	2,070,126	11.3%	24.1%
	Total Revenue	\$47,368,179	15.2%	\$53,447,141	15.8%	12.8%
<b>State</b>	Total Consumers	139,867	-	163,425	-	16.8%
	Total Services	14,299,900	-	18,281,520	-	27.8%
	Total Revenue	\$312,097,065	-	\$339,738,674	-	8.9%

## Appendix G

### Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant, Fiscal Years 2001 and 2005

Tables were compiled by Program Review staff from Department for Mental Health and Mental Retardation Services block grant figures provided by Ron Southworth.

Tables G.2 and G.4 have been adjusted for inflation to reflect 2001 dollars. Adjustments were made using the Consumer Price Index from the U.S. Department of Labor's Bureau of Labor Statistics.

In these tables, there is no region 9. Regions Fiveco and Gateway merged to form Pathways (Region 10).

**Table G.1**  
**Community Mental Health Services Block Grant Expenditures by Region**  
**Nominal Dollars**  
**Fiscal Years 2001 and 2005**

Region		2001		2005		2001-2005
		Number	% of Total	Number	% of Total	% Change
1	Four Rivers	\$150,343	2.9%	\$165,979	3.1%	10.4%
2	Pennyroyal	\$282,016	5.5%	\$214,048	4.0%	-24.1%
3	River Valley	\$236,721	4.6%	\$283,114	5.4%	19.6%
4	LifeSkills	\$309,768	6.0%	\$456,051	8.6%	47.2%
5	Communicare	\$160,405	3.1%	\$242,829	4.6%	51.4%
6	Seven Counties	\$1,490,781	28.9%	\$1,317,878	24.9%	-11.6%
7	NorthKey	\$279,414	5.4%	\$449,205	8.5%	60.8%
8	Comprehend	\$133,966	2.6%	\$64,694	1.2%	-51.7%
10	Pathways	\$437,532	8.5%	\$317,734	6.0%	-27.4%
11	Mountain	\$242,709	4.7%	\$252,093	4.8%	3.9%
12	Kentucky River	\$126,541	2.5%	\$173,662	3.3%	37.2%
13	Cumberland River	\$397,437	7.7%	\$349,365	6.6%	-12.1%
14	Adanta	\$182,060	3.5%	\$194,497	3.7%	6.8%
15	Bluegrass	\$726,718	14.1%	\$804,302	15.2%	10.7%
	Total	\$5,156,410	100.0%	\$5,285,451	100.0%	2.5%

**Table G.2**  
**Community Mental Health Services Block Grant Expenditures by Region**  
**Adjusted for Inflation (2001 Dollars)**  
**Fiscal Years 2001 and 2005**

Region		2001		2005		2001-2005
		Number	% of Total	Number	% of Total	% Change
1	Four Rivers	\$150,343	2.9%	\$151,898	3.1%	1.0%
2	Pennyroyal	\$282,016	5.5%	\$195,890	4.0%	-30.5%
3	River Valley	\$236,721	4.6%	\$259,097	5.4%	9.5%
4	LifeSkills	\$309,768	6.0%	\$417,363	8.6%	34.7%
5	Communicare	\$160,405	3.1%	\$222,229	4.6%	38.5%
6	Seven Counties	\$1,490,781	28.9%	\$1,206,078	24.9%	-19.1%
7	NorthKey	\$279,414	5.4%	\$411,097	8.5%	47.1%
8	Comprehend	\$133,966	2.6%	\$59,206	1.2%	-55.8%
10	Pathways	\$437,532	8.5%	\$290,780	6.0%	-33.5%
11	Mountain	\$242,709	4.7%	\$230,707	4.8%	-4.9%
12	Kentucky River	\$126,541	2.5%	\$158,930	3.3%	25.6%
13	Cumberland River	\$397,437	7.7%	\$319,727	6.6%	-19.6%
14	Adanta	\$182,060	3.5%	\$177,997	3.7%	-2.2%
15	Bluegrass	\$726,718	14.1%	\$736,071	15.2%	1.3%
	Total	\$5,156,410	100.0%	\$4,837,070	100.0%	-6.2%

**Table G.3**  
**Substance Abuse Prevention and Treatment Block Grant Expenditures by Region**  
**Nominal Dollars**  
**Fiscal Years 2001 and 2005**

Region		2001		2005		2001-2005
		Number	% of Total	Number	% of Total	% Change
1	Four Rivers	578,875	3.5%	\$743,559	4.1%	28.4%
2	Pennyroyal	785,841	4.8%	\$780,292	4.3%	-0.7%
3	River Valley	700,022	4.3%	\$694,865	3.8%	-0.7%
4	LifeSkills	1,026,184	6.3%	\$1,103,188	6.1%	7.5%
5	Communicare	\$789,025	4.8%	\$901,373	5.0%	14.2%
6	Seven Counties	\$4,626,346	28.3%	\$5,297,450	29.2%	14.5%
7	NorthKey	\$1,181,833	7.2%	\$1,385,147	7.6%	17.2%
8	Comprehend	\$296,273	1.8%	\$241,240	1.3%	-18.6%
10	Pathways	\$978,938	6.0%	\$1,101,479	6.1%	12.5%
11	Mountain	\$642,032	3.9%	\$725,628	4.0%	13.0%
12	Kentucky River	\$592,296	3.6%	\$876,262	4.8%	47.9%
13	Cumberland River	\$1,039,387	6.3%	\$1,018,970	5.6%	-2.0%
14	Adanta	\$700,552	4.3%	\$618,189	3.4%	-11.8%
15	Bluegrass	\$2,437,515	14.9%	\$2,663,686	14.7%	9.3%
	Total	\$16,375,119	100.0%	\$18,151,327	100.0%	10.8%

**Table G.4**  
**Substance Abuse Prevention and Treatment Block Grant Expenditures by Region**  
**Adjusted for Inflation (2001 Dollars)**  
**Fiscal Years 2001 and 2005**

Region		2001		2005		2001-2005
		Number	% of Total	Number	% of Total	% Change
1	Four Rivers	\$578,875	3.5%	\$680,480	4.1%	17.6%
2	Pennyroyal	\$785,841	4.8%	\$714,097	4.3%	-9.1%
3	River Valley	\$700,022	4.3%	\$635,917	3.8%	-9.2%
4	LifeSkills	\$1,026,184	6.3%	\$1,009,601	6.1%	-1.6%
5	Communicare	\$789,025	4.8%	\$824,907	5.0%	4.5%
6	Seven Counties	\$4,626,346	28.3%	\$4,848,050	29.2%	4.8%
7	NorthKey	\$1,181,833	7.2%	\$1,267,641	7.6%	7.3%
8	Comprehend	\$296,273	1.8%	\$220,775	1.3%	-25.5%
10	Pathways	\$978,938	6.0%	\$1,008,037	6.1%	3.0%
11	Mountain	\$642,032	3.9%	\$664,071	4.0%	3.4%
12	Kentucky River	\$592,296	3.6%	\$801,926	4.8%	35.4%
13	Cumberland River	\$1,039,387	6.3%	\$932,527	5.6%	-10.3%
14	Adanta	\$700,552	4.3%	\$565,746	3.4%	-19.2%
15	Bluegrass	\$2,437,515	14.9%	\$2,437,717	14.7%	0.0%
	Total	\$16,375,119	100.0%	\$16,611,492	100.0%	1.4%



## Appendix H

### Summary of Community Care Support Fund Fiscal Years 2001 to 2006

Tables were compiled by Program Review staff from Department for Mental Health and Mental Retardation Services Community Care Support Fund figures provided by Patrick Mooney.

Tables H.3, H.4, H.6, H.8, H.10, H.12, and H.14 have been adjusted for inflation to reflect 2001 dollars. Adjustments were made using the Consumer Price Index from the U.S. Department of Labor's Bureau of Labor Statistics.

In these tables, there is no region 9. Regions Fiveco and Gateway merged to form Pathways (Region 10).

#### Summary of Community Care Support Fund, Total Allocation

**Table H.1**  
**Total Allocation by Region (Nominal Dollars)**  
**Fiscal Years 2001 to 2006**

Region		2001	2002	2003	2004	2005	2006
1	Four Rivers	\$1,137,139	\$1,103,727	\$1,101,075	\$1,106,104	\$1,097,486	\$1,175,137
2	Pennyroyal	\$1,139,091	\$1,104,332	\$1,097,413	\$1,102,903	\$1,093,125	\$1,167,657
3	River Valley	\$1,141,330	\$1,107,861	\$1,100,946	\$1,107,998	\$1,100,180	\$1,180,153
4	LifeSkills	\$1,506,801	\$1,466,364	\$1,472,578	\$1,484,144	\$1,477,457	\$1,579,073
5	Communicare	\$1,445,403	\$1,427,945	\$1,422,746	\$1,436,627	\$1,428,910	\$1,526,457
6	Seven Counties	\$5,030,762	\$4,894,908	\$4,905,722	\$4,943,530	\$4,921,706	\$5,465,446
7	NorthKey	\$1,858,637	\$1,811,842	\$1,816,132	\$1,838,621	\$1,829,438	\$2,189,800
8	Comprehend	\$470,441	\$456,808	\$455,619	\$458,107	\$456,010	\$477,036
10	Pathways	\$1,476,235	\$1,460,192	\$1,487,021	\$1,387,968	\$1,477,064	\$1,570,220
11	Mountain	\$1,542,018	\$1,498,242	\$1,484,227	\$1,487,624	\$1,480,304	\$1,540,306
12	Kentucky River	\$1,302,726	\$1,306,173	\$1,293,489	\$1,282,063	\$1,244,664	\$1,283,801
13	Cumberland River	\$1,503,188	\$1,462,083	\$1,457,905	\$1,467,303	\$1,458,895	\$1,551,080
14	Adanta	\$955,806	\$966,989	\$953,101	\$910,988	\$966,426	\$1,043,630
15	Bluegrass	\$3,573,823	\$3,481,434	\$3,500,926	\$3,534,920	\$3,517,235	\$3,799,104
	<b>Total</b>	<b>\$24,083,400</b>	<b>\$23,548,900</b>	<b>\$23,548,900</b>	<b>\$23,548,900</b>	<b>\$23,548,900</b>	<b>\$25,548,900</b>

**Table H.2**  
**Percent Change in Total Allocation by Region (Nominal Dollars)**  
**Fiscal Years 2001 to 2006**

Region		2001 to 2002	2002 to 2003	2003 to 2004	2004 to 2005	2005 to 2006	% Change, 2001-2006
1	Four Rivers	-2.94%	-0.24%	0.46%	-0.78%	7.08%	3.34%
2	Pennyroyal	-3.05%	-0.63%	0.50%	-0.89%	6.82%	2.51%
3	River Valley	-2.93%	-0.62%	0.64%	-0.71%	7.27%	3.40%
4	LifeSkills	-2.68%	0.42%	0.79%	-0.45%	6.88%	4.80%
5	Communicare	-1.21%	-0.36%	0.98%	-0.54%	6.83%	5.61%
6	Seven Counties	-2.70%	0.22%	0.77%	-0.44%	11.05%	8.64%
7	NorthKey	-2.52%	0.24%	1.24%	-0.50%	19.70%	17.82%
8	Comprehend	-2.90%	-0.26%	0.55%	-0.46%	4.61%	1.40%
10	Pathways	-1.09%	1.84%	-6.66%	6.42%	6.31%	6.37%
11	Mountain	-2.84%	-0.94%	0.23%	-0.49%	4.05%	-0.11%
12	Kentucky River	0.26%	-0.97%	-0.88%	-2.92%	3.14%	-1.45%
13	Cumberland River	-2.73%	-0.29%	0.64%	-0.57%	6.32%	3.19%
14	Adanta	1.17%	-1.44%	-4.42%	6.09%	7.99%	9.19%
15	Bluegrass	-2.59%	0.56%	0.97%	-0.50%	8.01%	6.30%
	Total	-2.22%	0.00%	0.00%	0.00%	8.49%	6.09%

**Table H.3**  
**Total Allocation by Region (Adjusted to 2001 Dollars)**  
**Fiscal Years 2001 to 2006**

Region		2001	2002	2003	2004	2005	2006
1	Four Rivers	\$1,137,139	\$1,092,070	\$1,066,910	\$1,037,884	\$1,004,383	\$1,030,923
2	Pennyroyal	\$1,139,091	\$1,092,669	\$1,063,362	\$1,034,880	\$1,000,392	\$1,024,361
3	River Valley	\$1,141,330	\$1,096,161	\$1,066,785	\$1,039,661	\$1,006,848	\$1,035,324
4	LifeSkills	\$1,506,801	\$1,450,877	\$1,426,886	\$1,392,608	\$1,352,120	\$1,385,288
5	Communicare	\$1,445,403	\$1,412,864	\$1,378,600	\$1,348,022	\$1,307,691	\$1,339,129
6	Seven Counties	\$5,030,762	\$4,843,212	\$4,753,505	\$4,638,633	\$4,504,182	\$4,794,722
7	NorthKey	\$1,858,637	\$1,792,707	\$1,759,780	\$1,725,222	\$1,674,241	\$1,921,066
8	Comprehend	\$470,441	\$451,984	\$441,482	\$429,853	\$417,325	\$418,494
10	Pathways	\$1,476,235	\$1,444,771	\$1,440,881	\$1,302,364	\$1,351,760	\$1,377,521
11	Mountain	\$1,542,018	\$1,482,419	\$1,438,174	\$1,395,873	\$1,354,725	\$1,351,278
12	Kentucky River	\$1,302,726	\$1,292,378	\$1,253,354	\$1,202,990	\$1,139,075	\$1,126,252
13	Cumberland River	\$1,503,188	\$1,446,642	\$1,412,669	\$1,376,806	\$1,335,132	\$1,360,730
14	Adanta	\$955,806	\$956,776	\$923,528	\$854,802	\$884,441	\$915,555
15	Bluegrass	\$3,573,823	\$3,444,666	\$3,392,298	\$3,316,900	\$3,218,857	\$3,332,875
	Total	\$24,083,400	\$23,300,194	\$22,818,215	\$22,096,497	\$21,551,171	\$22,413,518

**Table H.4**  
**Percent Change in Total Allocation by Region (Adjusted to 2001 Dollars)**  
**Fiscal Years 2001 to 2006**

Region		2001 to 2002	2002 to 2003	2003 to 2004	2004 to 2005	2005 to 2006	% Change, 2001-2006
1	Four Rivers	-3.96%	-2.30%	-2.72%	-3.23%	2.64%	-9.34%
2	Pennyroyal	-4.08%	-2.68%	-2.68%	-3.33%	2.40%	-10.07%
3	River Valley	-3.96%	-2.68%	-2.54%	-3.16%	2.83%	-9.29%
4	LifeSkills	-3.71%	-1.65%	-2.40%	-2.91%	2.45%	-8.06%
5	Communicare	-2.25%	-2.43%	-2.22%	-2.99%	2.40%	-7.35%
6	Seven Counties	-3.73%	-1.85%	-2.42%	-2.90%	6.45%	-4.69%
7	NorthKey	-3.55%	-1.84%	-1.96%	-2.96%	14.74%	3.36%
8	Comprehend	-3.92%	-2.32%	-2.63%	-2.91%	0.28%	-11.04%
10	Pathways	-2.13%	-0.27%	-9.61%	3.79%	1.91%	-6.69%
11	Mountain	-3.87%	-2.98%	-2.94%	-2.95%	-0.25%	-12.37%
12	Kentucky River	-0.79%	-3.02%	-4.02%	-5.31%	-1.13%	-13.55%
13	Cumberland River	-3.76%	-2.35%	-2.54%	-3.03%	1.92%	-9.48%
14	Adanta	0.10%	-3.48%	-7.44%	3.47%	3.52%	-4.21%
15	Bluegrass	-3.61%	-1.52%	-2.22%	-2.96%	3.54%	-6.74%
	Total	-3.25%	-2.07%	-3.16%	-2.47%	4.00%	-6.93%

**Summary of Community Care Support Fund by Allocation Method**

**Table H.5**  
**Total Community Care Support Fund by Allocation Method (Nominal Dollars)**  
**Fiscal Years 2001 and 2006**

Allocation Method	2001		2006		2001-2006
	Dollars	% of Allocation	Dollars	% of Allocation	% Change
Per Capita	\$3,612,510	15.0%	\$5,132,335	20.1%	42.1%
Discretionary	\$2,408,340	10.0%	\$2,354,890	9.2%	-2.2%
Fee-for-Service	\$14,450,040	60.0%	\$14,129,340	55.3%	-2.2%
Incentive	\$3,612,510	15.0%	\$3,532,335	13.8%	-2.2%
Total	\$24,083,400	100.0%	\$25,548,900	100.0%	6.1%

**Table H.6**  
**Total Community Care Support Fund by Allocation Method**  
**(Adjusted to 2001 Dollars)**  
**Fiscal Years 2001 and 2006**

Allocation Method	2001		2006		2001-2006
	Dollars	% of Allocation	Dollars	% of Allocation	% Change
Per Capita	\$3,612,510	15.0%	\$4,502,491	20.1%	24.6%
Discretionary	\$2,408,340	10.0%	\$2,065,896	9.2%	-14.2%
Fee-for-Service	\$14,450,040	60.0%	\$12,395,376	55.3%	-14.2%
Incentive	\$3,612,510	15.0%	\$3,098,844	13.8%	-14.2%
Total	\$24,083,400	100.0%	\$22,413,518	100.0%	-6.9%

**Summary of Community Care Support Fund, Per Capita Allocation**

**Table H.7  
 Per Capita Allocation by Region (Nominal Dollars)  
 Fiscal Years 2001 and 2006**

Region		2001		2006		2001-2006
		Dollars	% of Allocation	Dollars	% of Allocation	% Change
1	Four Rivers	\$183,655	5.1%	\$253,184	4.9%	37.9%
2	Pennyroyal	\$188,670	5.2%	\$253,426	4.9%	34.3%
3	River Valley	\$189,455	5.2%	\$260,418	5.1%	37.5%
4	LifeSkills	\$224,085	6.2%	\$325,810	6.3%	45.4%
5	Communicare	\$218,758	6.1%	\$311,776	6.1%	42.5%
6	Seven Counties	\$768,508	21.3%	\$1,107,955	21.6%	44.2%
7	NorthKey	\$344,029	9.5%	\$505,759	9.9%	47.0%
8	Comprehend	\$50,207	1.4%	\$69,545	1.4%	38.5%
10	Pathways	\$191,346	5.3%	\$267,622	5.2%	39.9%
11	Mountain	\$151,825	4.2%	\$198,508	3.9%	30.7%
12	Kentucky River	\$114,971	3.2%	\$149,060	2.9%	29.7%
13	Cumberland River	\$215,019	6.0%	\$300,488	5.9%	39.7%
14	Adanta	\$173,701	4.8%	\$246,032	4.8%	41.6%
15	Bluegrass	\$598,281	16.6%	\$882,752	17.2%	47.5%
	Total	\$3,612,510	100.0%	\$5,132,335	100.0%	42.1%

**Table H.8  
 Per Capita Allocation by Region (Adjusted to 2001 Dollars)  
 Fiscal Years 2001 and 2006**

Region		2001		2006		2001-2006
		Dollars	% of Allocation	Dollars	% of Allocation	% Change
1	Four Rivers	\$183,655	5.1%	\$222,113	4.9%	20.9%
2	Pennyroyal	\$188,670	5.2%	\$222,325	4.9%	17.8%
3	River Valley	\$189,455	5.2%	\$228,459	5.1%	20.6%
4	LifeSkills	\$224,085	6.2%	\$285,826	6.3%	27.6%
5	Communicare	\$218,758	6.1%	\$273,515	6.1%	25.0%
6	Seven Counties	\$768,508	21.3%	\$971,986	21.6%	26.5%
7	NorthKey	\$344,029	9.5%	\$443,692	9.9%	29.0%
8	Comprehend	\$50,207	1.4%	\$61,010	1.4%	21.5%
10	Pathways	\$191,346	5.3%	\$234,779	5.2%	22.7%
11	Mountain	\$151,825	4.2%	\$174,147	3.9%	14.7%
12	Kentucky River	\$114,971	3.2%	\$130,767	2.9%	13.7%
13	Cumberland River	\$215,019	6.0%	\$263,612	5.9%	22.6%
14	Adanta	\$173,701	4.8%	\$215,839	4.8%	24.3%
15	Bluegrass	\$598,281	16.6%	\$774,420	17.2%	29.4%
	Total	\$3,612,510	100.0%	\$4,502,491	100.0%	24.6%

**Summary of Community Care Support Fund, Discretionary Allocation**

**Table H.9**  
**Discretionary Allocation by Region (Nominal Dollars)**  
**Fiscal Years 2001 and 2006**

Region		2001		2006		2001-2006
		Dollars	% of Allocation	Dollars	% of Allocation	% Change
1	Four Rivers	\$49,393	2.1%	\$48,024	2.0%	-2.8%
2	Pennyroyal	\$11,956	0.5%	\$11,625	0.5%	-2.8%
3	River Valley	\$12,007	0.5%	\$11,674	0.5%	-2.8%
4	LifeSkills	\$83,276	3.5%	\$80,968	3.4%	-2.8%
5	Communicare	\$142,814	5.9%	\$138,855	5.9%	-2.8%
6	Seven Counties	\$322,822	13.4%	\$313,874	13.3%	-2.8%
7	NorthKey	\$4,313	0.2%	\$4,193	0.2%	-2.8%
8	Comprehend	\$160,395	6.7%	\$155,949	6.6%	-2.8%
10	Pathways	\$346,465	14.4%	\$336,862	14.3%	-2.8%
11	Mountain	\$299,571	12.4%	\$291,267	12.4%	-2.8%
12	Kentucky River	\$611,482	25.4%	\$607,006	25.8%	-0.7%
13	Cumberland River	\$151,623	6.3%	\$148,252	6.3%	-2.2%
14	Adanta	\$77,497	3.2%	\$75,349	3.2%	-2.8%
15	Bluegrass	\$134,726	5.6%	\$130,992	5.6%	-2.8%
	Total	\$2,408,340	100.0%	\$2,354,890	100.0%	-2.2%

**Table H.10**  
**Discretionary Allocation by Region (Adjusted to 2001 Dollars)**  
**Fiscal Years 2001 and 2006**

Region		2001		2006		2001-2006
		Dollars	% of Allocation	Dollars	% of Allocation	% Change
1	Four Rivers	\$49,393	2.1%	\$42,130	2.0%	-14.7%
2	Pennyroyal	\$11,956	0.5%	\$10,198	0.5%	-14.7%
3	River Valley	\$12,007	0.5%	\$10,241	0.5%	-14.7%
4	LifeSkills	\$83,276	3.5%	\$71,032	3.4%	-14.7%
5	Communicare	\$142,814	5.9%	\$121,815	5.9%	-14.7%
6	Seven Counties	\$322,822	13.4%	\$275,355	13.3%	-14.7%
7	NorthKey	\$4,313	0.2%	\$3,678	0.2%	-14.7%
8	Comprehend	\$160,395	6.7%	\$136,811	6.6%	-14.7%
10	Pathways	\$346,465	14.4%	\$295,522	14.3%	-14.7%
11	Mountain	\$299,571	12.4%	\$255,522	12.4%	-14.7%
12	Kentucky River	\$611,482	25.4%	\$532,514	25.8%	-12.9%
13	Cumberland River	\$151,623	6.3%	\$130,058	6.3%	-14.2%
14	Adanta	\$77,497	3.2%	\$66,102	3.2%	-14.7%
15	Bluegrass	\$134,726	5.6%	\$114,917	5.6%	-14.7%
	Total	\$2,408,340	100.0%	\$2,065,896	100.0%	-14.2%

**Summary of Community Care Support Fund, Fee-for-Service Allocation**

**Table H.11  
 Fee-for-Service Allocation by Region (Nominal Dollars)  
 Fiscal Years 2001 and 2006**

Region		2001		2006		2001-2006
		Dollars	% of Allocation	Dollars	% of Allocation	% Change
1	Four Rivers	\$712,952	4.9%	\$697,129	4.9%	-2.2%
2	Pennyroyal	\$742,107	5.1%	\$725,637	5.1%	-2.2%
3	River Valley	\$742,693	5.1%	\$726,210	5.1%	-2.2%
4	LifeSkills	\$966,224	6.7%	\$944,780	6.7%	-2.2%
5	Communicare	\$877,588	6.1%	\$858,111	6.1%	-2.2%
6	Seven Counties	\$3,139,608	21.7%	\$3,069,928	21.7%	-2.2%
7	NorthKey	\$1,152,247	8.0%	\$1,126,674	8.0%	-2.2%
8	Comprehend	\$207,586	1.4%	\$202,979	1.4%	-2.2%
10	Pathways	\$796,532	5.5%	\$778,854	5.5%	-2.2%
11	Mountain	\$932,610	6.5%	\$911,912	6.5%	-2.2%
12	Kentucky River	\$486,034	3.4%	\$475,247	3.4%	-2.2%
13	Cumberland River	\$912,765	6.3%	\$892,507	6.3%	-2.2%
14	Adanta	\$562,937	3.9%	\$550,443	3.9%	-2.2%
15	Bluegrass	\$2,218,157	15.4%	\$2,168,929	15.4%	-2.2%
	Total	\$14,450,040	100.0%	\$14,129,340	100.0%	-2.2%

**Table H.12  
 Fee-for-Service Allocation by Region (Adjusted to 2001 Dollars)  
 Fiscal Years 2001 and 2006**

Region		2001		2006		2001-2006
		Dollars	% of Allocation	Dollars	% of Allocation	% Change
1	Four Rivers	\$712,952	4.9%	\$611,577	4.9%	-14.2%
2	Pennyroyal	\$742,107	5.1%	\$636,586	5.1%	-14.2%
3	River Valley	\$742,693	5.1%	\$637,089	5.1%	-14.2%
4	LifeSkills	\$966,224	6.7%	\$828,836	6.7%	-14.2%
5	Communicare	\$877,588	6.1%	\$752,803	6.1%	-14.2%
6	Seven Counties	\$3,139,608	21.7%	\$2,693,184	21.7%	-14.2%
7	NorthKey	\$1,152,247	8.0%	\$988,408	8.0%	-14.2%
8	Comprehend	\$207,586	1.4%	\$178,069	1.4%	-14.2%
10	Pathways	\$796,532	5.5%	\$683,272	5.5%	-14.2%
11	Mountain	\$932,610	6.5%	\$800,001	6.5%	-14.2%
12	Kentucky River	\$486,034	3.4%	\$416,924	3.4%	-14.2%
13	Cumberland River	\$912,765	6.3%	\$782,978	6.3%	-14.2%
14	Adanta	\$562,937	3.9%	\$482,892	3.9%	-14.2%
15	Bluegrass	\$2,218,157	15.4%	\$1,902,756	15.4%	-14.2%
	Total	\$14,450,040	100.0%	\$12,395,376	100.0%	-14.2%

**Summary of Community Care Support Fund, Incentive Allocation****Table H.13  
Incentive Allocation by Region (Nominal Dollars)  
Fiscal Years 2001 and 2006**

Region		2001		2006		2001-2006
		Dollars	% of Allocation	Dollars	% of Allocation	% Change
1	Four Rivers	\$191,139	5.3%	\$176,800	5.0%	-7.5%
2	Pennyroyal	\$196,358	5.4%	\$176,969	5.0%	-9.9%
3	River Valley	\$197,175	5.5%	\$181,851	5.1%	-7.8%
4	LifeSkills	\$233,216	6.5%	\$227,515	6.4%	-2.4%
5	Communicare	\$206,243	5.7%	\$217,715	6.2%	5.6%
6	Seven Counties	\$799,824	22.1%	\$773,689	21.9%	-3.3%
7	NorthKey	\$358,048	9.9%	\$353,174	10.0%	-1.4%
8	Comprehend	\$52,253	1.4%	\$48,563	1.4%	-7.1%
10	Pathways	\$141,892	3.9%	\$186,882	5.3%	31.7%
11	Mountain	\$158,012	4.4%	\$138,619	3.9%	-12.3%
12	Kentucky River	\$90,239	2.5%	\$52,488	1.5%	-41.8%
13	Cumberland River	\$223,781	6.2%	\$209,833	5.9%	-6.2%
14	Adanta	\$141,671	3.9%	\$171,806	4.9%	21.3%
15	Bluegrass	\$622,659	17.2%	\$616,431	17.5%	-1.0%
	Total	\$3,612,510	100.0%	\$3,532,335	100.0%	-2.2%

**Table H.14  
Incentive Allocation by Region (Adjusted to 2001 Dollars)  
Fiscal Years 2001 and 2006**

Region		2001		2006		2001-2006
		Dollars	% of Allocation	Dollars	% of Allocation	% Change
1	Four Rivers	\$191,139	5.3%	\$155,103	5.0%	-18.9%
2	Pennyroyal	\$196,358	5.4%	\$155,251	5.0%	-20.9%
3	River Valley	\$197,175	5.5%	\$159,534	5.1%	-19.1%
4	LifeSkills	\$233,216	6.5%	\$199,594	6.4%	-14.4%
5	Communicare	\$206,243	5.7%	\$190,997	6.2%	-7.4%
6	Seven Counties	\$799,824	22.1%	\$678,741	21.9%	-15.1%
7	NorthKey	\$358,048	9.9%	\$309,832	10.0%	-13.5%
8	Comprehend	\$52,253	1.4%	\$42,603	1.4%	-18.5%
10	Pathways	\$141,892	3.9%	\$163,948	5.3%	15.5%
11	Mountain	\$158,012	4.4%	\$121,608	3.9%	-23.0%
12	Kentucky River	\$90,239	2.5%	\$46,047	1.5%	-49.0%
13	Cumberland River	\$223,781	6.2%	\$184,082	5.9%	-17.7%
14	Adanta	\$141,671	3.9%	\$150,722	4.9%	6.4%
15	Bluegrass	\$622,659	17.2%	\$540,782	17.5%	-13.1%
	Total	\$3,612,510	100.0%	\$3,098,844	100.0%	-14.2%

## Appendix I

### Summary of Financial Indicators by Region Fiscal Years 2001 and 2005

Tables were compiled by Program Review staff from regional boards' audited financial statements.

In these tables, there is no region 9. Regions Fiveco and Gateway merged to form Pathways (Region 10).

**Table I.1**  
**Net Assets by Region (Nominal Dollars)**  
**Fiscal Years 2001 and 2005**

Region		2001		2005		2001-2005
		Dollars	% of Allocation	Dollars	% of Allocation	% Change
1	Four Rivers	\$3,075,375	3.3%	\$3,429,939	2.6%	11.5%
2	Pennyroyal	\$6,871,828	7.3%	\$6,800,780	5.1%	-1.0%
3	River Valley	\$4,128,925	4.4%	\$5,361,878	4.0%	29.9%
4	LifeSkills	\$2,921,374	3.1%	\$6,008,058	4.5%	105.7%
5	Communicare	\$3,891,888	4.1%	\$6,554,258	4.9%	68.4%
6	Seven Counties	\$12,083,254	12.8%	\$16,937,282	12.7%	40.2%
7	NorthKey	\$8,133,454	8.6%	\$9,530,742	7.2%	17.2%
8	Comprehend	\$3,134,598	3.3%	\$3,629,188	2.7%	15.8%
10	Pathways	\$7,161,604	7.6%	\$9,754,661	7.3%	36.2%
11	Mountain	\$3,919,673	4.1%	\$5,555,227	4.2%	41.7%
12	Kentucky River	\$5,644,363	6.0%	\$8,480,895	6.4%	50.3%
13	Cumberland River	\$4,531,158	4.8%	\$5,276,056	4.0%	16.4%
14	Adanta	\$7,498,355	7.9%	\$13,130,100	9.9%	75.1%
15	Bluegrass	\$21,456,022	22.7%	\$32,803,065	24.6%	52.9%
	<b>Total</b>	<b>\$94,451,871</b>	<b>100.0%</b>	<b>\$133,252,129</b>	<b>100.0%</b>	<b>41.1%</b>

**Table I.2**  
**Operating Income by Region (Nominal Dollars)**  
**Fiscal Years 2001 to 2005**

Region		2001	2002	2003	2004	2005
1	Four Rivers	\$(115,811)	\$(390,347)	\$(1,270,737)	\$849,165	\$1,166,483
2	Pennyroyal	\$1,548,121	\$335,817	\$(141,731)	\$(719,148)	\$454,013
3	River Valley	\$160,700	\$242,429	\$423,757	\$567,238	\$89,529
4	LifeSkills	\$406,079	\$556,732	\$784,399	\$759,377	\$986,176
5	Communicare	\$507,769	\$500,310	\$(13,816)	\$549,670	\$542,478
6	Seven Counties	\$70,293	\$141,915	\$262,620	\$3,040,334	\$720,489
7	Northern Kentucky	\$(186,240)	\$188,386	\$343,071	\$352,368	\$(299,037)
8	Comprehend	\$141,914	\$169,390	\$41,163	\$181,103	\$60,709
10	Pathways	\$1,285,637	\$1,205,708	\$1,065,778	\$644,530	\$(291,463)
11	Mountain	\$(68,526)	\$460,815	\$650,030	\$64,098	\$635,911
12	Kentucky River	\$722,250	\$638,114	\$925,743	\$582,958	\$689,406
13	Cumberland River	\$145,637	\$93,664	\$191,887	\$105,906	\$353,441
14	Adanta	\$1,599,795	\$1,736,716	\$1,676,383	\$1,409,210	\$809,436
15	Bluegrass	\$1,117,088	\$3,036,110	\$1,862,055	\$2,621,698	\$3,063,228
	Total	\$7,517,537	\$9,043,301	\$6,731,904	\$10,249,339	\$7,171,641

Note: Operating income is defined as Total Revenue and Support minus Expenses. For some regions the above figures include nonoperating income.

**Table I.3**  
**Operating Margin by Region (Nominal Dollars)**  
**Fiscal Years 2001 to 2005**

Region		2001	2002	2003	2004	2005	Average, 2001-2005
1	Four Rivers	-1.3%	-3.8%	-9.7%	6.9%	9.0%	0.2%
2	Pennyroyal	12.6%	2.7%	-1.0%	-4.5%	2.7%	2.5%
3	River Valley	0.6%	0.9%	1.5%	1.6%	0.3%	1.0%
4	LifeSkills	2.1%	2.6%	3.7%	3.3%	4.3%	3.2%
5	Communicare	3.5%	3.2%	2.8%	2.9%	2.7%	3.0%
6	Seven Counties	0.1%	0.2%	0.4%	4.9%	1.1%	1.3%
7	Northern Kentucky	-1.0%	1.0%	1.7%	1.6%	-1.3%	0.4%
8	Comprehend	2.5%	2.8%	0.6%	2.6%	0.9%	1.9%
10	Pathways	7.2%	6.1%	5.2%	2.9%	-1.3%	4.0%
11	Mountain	-0.4%	2.8%	2.0%	0.4%	4.0%	1.8%
12	Kentucky River	4.2%	3.6%	5.1%	2.9%	3.2%	3.8%
13	Cumberland River	0.8%	0.5%	0.9%	0.5%	1.7%	0.9%
14	Adanta	7.7%	8.2%	7.8%	6.4%	3.7%	6.8%
15	Bluegrass	2.4%	6.4%	3.6%	4.9%	5.5%	4.6%
	State Average	2.9%	2.7%	1.8%	2.7%	2.6%	2.5%

Note: Operating Margin is defined as Total Revenue and Support divided by Expenses minus 1. It is a measure of profitability and shows the percentage of revenue and support relative to expenses.

**Table I.4**  
**Liability (Debt to Equity) Ratio by Region (Nominal Dollars)**  
**Fiscal Years 2001 to 2005**

Region		2001	2002	2003	2004	2005	Average, 2001-2005
1	Four Rivers	0.231	0.264	0.417	0.6	0.612	0.425
2	Pennyroyal	0.217	0.259	0.213	0.218	0.212	0.224
3	River Valley	0.745	0.734	0.725	0.714	0.695	0.723
4	LifeSkills	0.554	0.541	0.514	0.487	0.405	0.500
5	Communicare	0.428	0.438	0.45	0.387	0.364	0.413
6	Seven Counties	0.464	0.43	0.427	0.372	0.372	0.413
7	NorthKey	0.34	0.335	0.305	0.288	0.301	0.314
8	Comprehend	0.316	0.308	0.302	0.305	0.291	0.304
10	Pathways	0.433	0.401	0.359	0.407	0.397	0.399
11	Mountain	0.446	0.442	0.399	0.429	0.391	0.421
12	Kentucky River	0.439	0.371	0.26	0.297	0.339	0.341
13	Cumberland River	0.432	0.373	0.424	0.407	0.414	0.410
14	Adanta	0.291	0.217	0.191	0.202	0.173	0.215
15	Bluegrass	0.417	0.38	0.37	0.331	0.322	0.364
	State Average	0.411	0.392	0.383	0.389	0.378	0.390

Note: Liability ratio is defined as Total Liabilities divided by Total Assets. It is an asset composition ratio and shows the percentage of total liabilities relative to total assets.

**Table I.5**  
**Cash to Asset Ratio by Region (Nominal Dollars)**  
**Fiscal Years 2001 to 2005**

Region		2001	2002	2003	2004	2005	Average, 2001-2005
1	Four Rivers	0.063	0.037	0.084	0.18	0.36	0.145
2	Pennyroyal	0.406	0.356	0.272	0.201	0.126	0.272
3	River Valley	0.112	0.197	0.187	0.279	0.217	0.198
4	LifeSkills	0.097	0.223	0.247	0.323	0.341	0.246
5	Communicare	0.107	0.229	0.173	0.291	0.164	0.193
6	Seven Counties	0.034	0.122	0.26	0.16	0.115	0.138
7	NorthKey	0.152	0.174	0.191	0.418	0.361	0.259
8	Comprehend	0.239	0.242	0.16	0.245	0.193	0.216
10	Pathways	0.425	0.372	0.339	0.198	0.255	0.318
11	Mountain	0.086	0.167	0.119	0.138	0.154	0.133
12	Kentucky River	0.294	0.232	0.214	0.213	0.084	0.207
13	Cumberland River	0.382	0.341	0.328	0.318	0.224	0.319
14	Adanta	0.372	0.43	0.424	0.514	0.518	0.452
15	Bluegrass	0.292	0.199	0.214	0.291	0.239	0.247
	State Average	0.219	0.237	0.229	0.269	0.239	0.239

Note: Cash to Asset ratio is defined as Cash and Cash Equivalents divided by Total Assets. It is an asset composition ratio and shows the degree to which an organization's assets are liquid.

**Table I.6**  
**Unrestricted Net Assets Ratio by Region (Nominal Dollars)**  
**Fiscal Years 2001 to 2005**

Region		2001	2002	2003	2004	2005	Average, 2001-2005
1	Four Rivers	0.274	0.22	0.062	0.073	-0.007	0.124
2	Pennyroyal	0.558	0.571	0.487	0.395	0.404	0.483
3	River Valley	0.149	0.165	0.167	0.171	0.161	0.163
4	LifeSkills	0.149	0.164	0.201	0.22	0.262	0.199
5	Communicare	0.259	0.275	0.274	0.315	0.305	0.286
6	Seven Counties	0.195	0.19	0.196	0.257	0.256	0.219
7	NorthKey	0.439	0.434	0.43	0.425	0.398	0.425
8	Comprehend	0.546	0.534	0.507	0.505	0.5	0.518
10	Pathways	0.399	0.418	0.46	0.457	0.425	0.432
11	Mountain	0.239	0.27	0.277	0.286	0.345	0.283
12	Kentucky River	0.275	0.304	0.347	0.344	0.351	0.324
13	Cumberland River	0.257	0.236	0.233	0.235	0.248	0.242
14	Adanta	0.362	0.434	0.505	0.561	0.593	0.491
15	Bluegrass	0.464	0.524	0.534	0.563	0.593	0.536
	State Average	0.326	0.339	0.334	0.343	0.345	0.338

Note: Unrestricted Net Asset ratio is defined as Unrestricted Net Assets divided by Annual Expenses. It is a liquidity ratio and shows the percentage of unrestricted net assets relative to annual expenses.

**Table I.7**  
**Current Ratio by Region (Nominal Dollars)**  
**Fiscal Years 2001 to 2005**

Region		2001	2002	2003	2004	2005	Average, 2001-2005
1	Four Rivers	2.716	2.343	1.02	1.066	3.295	2.088
2	Pennyroyal	3.084	2.611	3.052	2.671	2.847	2.853
3	River Valley	1.385	1.554	1.535	1.641	1.719	1.567
4	LifeSkills	0.888	1.148	1.409	1.664	2.092	1.440
5	Communicare	1.676	2.105	1.953	2.755	2.174	2.133
6	Seven Counties	2.076	2.142	2.206	2.728	2.591	2.349
7	NorthKey	2.646	2.51	2.668	2.787	2.513	2.625
8	Comprehend	3.876	3.487	3.52	3.423	3.52	3.565
10	Pathways	2.663	2.592	2.951	3.973	3.863	3.208
11	Mountain	2.525	2.944	3.212	2.655	3.09	2.885
12	Kentucky River	1.984	2.086	2.576	2.143	2.018	2.161
13	Cumberland River	n/a	n/a	n/a	n/a	n/a	n/a
14	Adanta	n/a	n/a	n/a	n/a	n/a	n/a
15	Bluegrass	1.385	1.19	1.186	1.477	1.481	1.344
	State Average	2.242	2.226	2.274	2.415	2.600	2.352

Note: Current ratio is defined as Current Assets divided by Current Liabilities. It is a liquidity ratio and shows the percentage of current assets relative to current liabilities.

**Table I.8**  
**Working Capital Ratio by Region (Nominal Dollars)**  
**Fiscal Years 2001 to 2005**

Region		2001	2002	2003	2004	2005	Average, 2001-2005
1	Four Rivers	0.311	0.284	0.007	0.017	0.3	0.184
2	Pennyroyal	0.437	0.339	0.345	0.29	0.324	0.347
3	River Valley	0.08	0.125	0.152	0.18	0.192	0.146
4	LifeSkills	-0.051	0.061	0.166	0.259	0.343	0.156
5	Communicare	0.132	0.199	0.192	0.309	0.204	0.207
6	Seven Counties	0.338	0.326	0.361	0.467	0.455	0.389
7	NorthKey	0.352	0.347	0.36	0.388	0.376	0.365
8	Comprehend	0.245	0.257	0.254	0.267	0.263	0.257
10	Pathways	0.335	0.31	0.335	0.38	0.386	0.349
11	Mountain	0.327	0.383	0.389	0.311	0.372	0.356
12	Kentucky River	0.262	0.264	0.309	0.267	0.217	0.264
13	Cumberland River	n/a	n/a	n/a	n/a	n/a	n/a
14	Adanta	n/a	n/a	n/a	n/a	n/a	n/a
15	Bluegrass	0.131	0.058	0.056	0.125	0.124	0.099
	State Average	0.242	0.246	0.244	0.272	0.296	0.260

Note: Working Capital ratio is defined as Current Assets minus Current Liabilities divided by Total Assets. It is a liquidity ratio and shows the percentage of assets that are available to use over the course of a year.

**Table I.9**  
**Cash Interval by Region (Nominal Dollars)**  
**Fiscal Years 2001 to 2005**

Region		2001	2002	2003	2004	2005	Average, 2001-2005
1	Four Rivers	11	5	6	30	89	28
2	Pennyroyal	106	100	61	37	23	65
3	River Valley	24	45	41	61	42	43
4	LifeSkills	12	29	37	50	55	37
5	Communicare	18	48	32	55	31	37
6	Seven Counties	5	15	33	24	17	19
7	NorthKey	37	42	43	91	75	58
8	Comprehend	70	73	47	67	51	62
10	Pathways	109	95	89	56	66	83
11	Mountain	14	32	26	26	33	26
12	Kentucky River	62	48	42	43	18	43
13	Cumberland River	63	47	48	46	35	48
14	Adanta	69	87	97	132	135	104
15	Bluegrass	85	61	66	89	76	75
	State Average	49	52	48	58	53	52

Note: Cash Interval is defined as Cash and Cash Equivalents divided by (Annual Operating Expense divided by 365). It is a liquidity indicator and shows how many days one can operate with just cash on hand.



## Appendix J

### Response From the Kentucky Department for Mental Health and Mental Retardation Services



ERNIE FLETCHER  
GOVERNOR

#### Cabinet For Health and Family Services

MARK D. BIRDWHISTELL  
SECRETARY

DEPARTMENT FOR MENTAL HEALTH  
AND MENTAL RETARDATION SERVICES  
100 FAIR OAKS LANE 4E-B  
FRANKFORT, KENTUCKY 40621-0001  
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[HTTP://CHFS.KY.GOV/](http://CHFS.KY.GOV/)

December 14, 2006

Program Review and Investigations Committee  
Legislative Research Commission  
Frankfort, Kentucky

Ladies and Gentlemen:

Thank you for the opportunity to respond to the recommendations contained within the report “**Kentucky’s Community Mental Health System Is Expanding and Would Benefit From Better Planning and Reporting.**”

The Department considers **Recommendations 2.1 and 2.2** as matters for the General Assembly to consider, and as such, we provide no response to these recommendations.

**Recommendation 2.3** recommends action on behalf of the Boards such that each board should develop a strategic plan. Each plan would include expected outcomes and measurable indicators and would become an integral part of statewide planning decisions.

We are in agreement with this recommendation and feel that it is highly complementary of ongoing and evolving efforts by our Department and the Regional Boards to further refine and improve the integration between strategic planning efforts and each Board’s Plan & Budget activities. An example of this movement has been the Department’s recent emphasis on performance-based contracting that emphasizes the attainment of a variety of goals, objectives and desired outcomes. Another example is the collaborative emphasis by the Department and the Regional Boards to further refine the utility and reliability of the Department’s overall data set. These ongoing efforts over the past couple of years have now afforded us a high degree of confidence that we are in fact comparing

“apples with apples.” This greatly enhanced confidence level will lead to increased utilization of our data in both regional and statewide planning decisions. We gladly offer our assistance to the Boards in any way that we might facilitate the implementation of the plans.

**Recommendation 4.1** requires action by the Department in developing a standardized method to calculate charity allowances, including these calculations as part of the required audit and establishing standardized reporting. “Charity Care” has been widely discussed over the last few years, particularly as the Boards are increasingly being called upon to serve more people and provide more services without commensurate funding. We concur with the report that differing interpretations of charity allowances and different accounting and reporting mechanisms prevent us from comparing this consistently across all regions. The Department has committed to working with KARP and the Boards in developing standardized reporting and verification methods.

We appreciate the work of Cindy Upton, Perry Papka and Rkia Rhrif during this review. They were knowledgeable, cordial, and patient, and we enjoyed working with them. We found the report to be thorough and informative.

Sincerely,



John M. Burt, Ed.D.  
Commissioner

cc: William D. Hacker, MD, Undersecretary for Health

## Appendix K

### Response From the Kentucky Association of Regional Programs

#### PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

Thursday, December 14, 2006  
10:00 a.m.  
Room 169 Capitol Annex

Kentucky's Community Mental Health System is Expanding and Would Benefit from Better Planning and Reporting

#### Introduction

- Steve Shannon, Executive Director of KARP.
- KARP is the association of the fourteen (14) Community Mental Health and Mental Retardation Centers in Kentucky. The CMHCs constitute the statewide network, referred to as the public safety net, for individuals needing mental health, mental retardation and substance abuse services and supports. We also see ourselves, and encourage you to as well, as the behavioral health public utility, a necessary service. As the report clearly shows, the CMHCs contribute significantly to healthy people and strong communities.

#### Thank You's

Senator Harris and Representative Thompson and committee members on behalf of the fourteen (14) CMHCs, 312 Board members, 9,356 employees and most importantly the 163,425 individuals (approximately 1 out of every 25 or 4% of Kentuckians) served and supported by the 14 CMHCs, we thank you for the opportunity to be here today and more importantly we thank you and your staff for this exceptional report. Your staff made the effort and took the time to become extremely knowledgeable about the CMHCs; asking for documentation, attending board and commission meetings, meeting with consumers, advocates and stakeholders and visiting all fourteen (14) CMHCs. As you all know, the best

way to learn about an issue is to go to the people who live it every day. Again, thank you for requesting this study, the fine work of your staff and your time today.

### Response to Recommendations

Reiterate four (4) recommendations

- 1) *GA may wish to direct the 843 and 144 commissions to present a plan to the Governor and LRC in sufficient time before each biennium so that the plan could be useful in the budgetary process.* [Recommendation 2.1]
  - a. Karp concurs with this recommendation; we believe the work of these two vital commissions should contribute directly to the budgetary process.
- 2) *GA may consider merging the 843 and 144 Commission and the GA may consider requiring the combined commission to have a legislator and the secretary of CHFS as co-chairs.* [Recommendation 2.2]
  - a. It should be noted the two commissions operate quite differently. The Regional Planning Councils which are instrumental to the success of HB 843 do not exist in the HB 144 Commission process. The Regional Planning Councils make the HB 843 process a 'bottom-up' planning process; and, therefore, HB 843 recommendations are clearly based upon the needs of local communities.
  - b. Karp acknowledges merging the two commissions may facilitate planning. However, the process of merging needs to be conducted in a planful and prudent manner.
  - c. The merging process needs to be well planned to ensure the different constituencies of the two commissions are adequately represented. This may cause the size of the merged commission to become too large to be effective.
  - d. The HB 843 Commission has always had a legislator co-chair. This enhances the effectiveness of that commission which ensures good coordination between the Legislative Branch and the Executive Branch.

3) *Each regional board should develop a strategic plan that describes clearly set objectives, strategies to implement them and a timetable, and cost estimates. The board's plan should include expected outcomes and measurable indicators. The plans should be an integral part of statewide planning decisions.* [Recommendation 2.3]

- a. Karp and the fourteen (14) CMHCs concur with this recommendation. It should be noted that the 14 CMHCs do take their statutory planning authority very seriously. They are committed to providing services which are responsive to the needs of their respective communities.
- b. The annual plan and budget process required by MHMR ensures that strategic planning occurs.
- c. The significance of this recommendation lies not in the development of a strategic plan including the submission of cost estimates which is the current practice but lies in the last sentence of the recommendation.

**The plans should be an integral part of statewide planning decisions.**

- d. It has been the experience of the 14 CMHCs that the annual plan and budget process has **not** been an integral part of statewide planning decisions for a number of years. This statement is not intended to be critical of any Administration or of the General Assembly, but reflects the budgetary climate within which the Commonwealth has operated in the recent past.
- e. The current annual plan and budget process can be summarized as (page 13 of the report)
  - i. MHMR tells each CMHC how much money they will receive
  - ii. Each CMHC limits its plan based on that dollar amount
  - iii. MHMR approves each annual plan and budget
- f. It is recommended that the process be changed to the following:
  - i. MHMR requests the plan and budget from each CMHC
  - ii. Each CMHC submits plan and budget independent of available funding amount

- iii. MHMR accepts the annual plans and budgets
  - iv. Annual plan and budget may need to be amended due to budgetary constraints.
  - v. The proposed process would make identification of needs and planning to meet those needs the priority versus planning within a predetermined budgetary amount.
  - g. It is recommended that the strategic plans be submitted for inclusion in the biennium budget planning process. This would result in the expected outcomes, measurable indicators and cost estimates to be included in the biennium budget preparation process. As we all know, budget preparation is a key component of good planning.
  - h. The 14 CMHCs understand as well as anyone the realities of the budget process; however, we believe realistic strategic planning needs to be completed; and if necessary, amended to reflect the budget and not the inverse. The identification of needs and the strategic planning process should not be constrained by the availability of funding.
  - i. The 14 CMHCs agree to implement recommendation 2.3.
- 4) The Department for MHMR Services should develop a standardized method to calculate charity allowances. The department should require the boards to use that method and report annually, in conjunction with their annual financial statement audit, a separate schedule of charity allowances. The boards' independent auditors should be required to certify that the charity allowances are reported in accordance with the department's instructions.

[Recommendation 4.1]

- a. We concur with this recommendation and offer to assist the Department in developing a standardized method to calculate charity allowances.

### General Comments

There are two issues relating to the statewide behavioral health network that need to be reinforced.

The first one is Community Mental Health Centers are established in statute, KRS 210.370 to 485. Since the CMHCs are established in statute they are not a typical not-for-profit organization. They are charged with specific duties by the General Assembly, thus creating a different relationship with the Commonwealth.

In statute, the Commonwealth of KY charges the CMHCs to serve individuals in every county across the entire span of mental illness, mental retardation and substance abuse diagnoses and across the entire life span regardless of the individuals' ability to pay. As the report references, all of the 14 regions provide Charity Care over and above the Community Care Support Funds, which are the general fund allocation to the CMHCs.

Data submitted in the report indicate that the CMHCs over the past five years have served 17% more people and provided 28% more services, while total revenue adjusted for inflation increased by only 9%. **For the past five fiscal years as documented in the report and the years preceding that, the CMHCs have been doing more with less.** In addition, since the rate of growth in services provided exceeds the rate of growth of persons served, the persons served are requiring more services and supports. Therefore, it can be concluded that the persons served are more severe and in need of greater services to remain in the community.

The second issue which must be stressed is whether or not the 14 CMHCs can sustain the growth in persons served and units of services provided. It is our contention that during the last five fiscal years management techniques to control costs have been implemented by the CMHCs. These include efficiency goals for clinicians, maximizing the amount of time clinicians spend doing therapy, and maximum caseload sizes for case managers. These have all been implemented without sacrificing the quality of care. However, since there has not been an across-the-board increase to compensate for the increasing cost of doing business the system of care and the network of services across the Commonwealth are at risk. It should be noted that there has not been an

increase in Community Care Support Funds for 12 years and Medicaid rates have remained frozen at 2001 levels. In addition, Table 4.5 on page 36 indicates that Community Care Support Allocations, which are the general fund allocations to the CMHCs, have actually decreased by 7% when adjusted for inflation from FY '01 to FY '05. Clearly, the cost of doing business has increased during this period.

Continuation funding, which has been the pattern for the past several years, is coupled with an unfunded mandate the financial stress on the CMHCs increases exponentially. The unfunded mandate is the significant increase in the employer contribution to the KY Employee Retirement System for which the CMHCs received no additional funding. The increase in FY '07 will cost the CMHCs approximately \$ 4 million and in FY '08 will be \$ 7 million.

Therefore, we believe the conclusion in the report 'the system's capacity to expand services or serve larger populations remains in question' is an overly optimistic statement. We believe that continued growth in people served, "continuation budgets" (which are really a deficit budget with no cost of living increase) and increases in KERS will make it very challenging to sustain services in all 120 counties in FY '08, and through the next biennium.

We are eager to fulfill the charge established 40-plus years ago in KRS 210, to continue to serve well those Kentuckians dealing with mental illness, mental retardation and substance abuse. However, we know that the **business** of providing quality behavioral health care is daily becoming more challenging and that our ability to continue to meet the increasing demand for services is seriously in jeopardy. We are confident that this report can be used by the KY General Assembly to ensure the outcome that we all desire – that every Kentuckian will have access to the behavioral health services that they need when they need them.