

## Franklin County Human Services Plan Fiscal Year 2017-2018

**Submitted: June 2, 2017**

### **PART I: COUNTY PLANNING PROCESS**

*Describe the county planning and leadership team and the process utilized to develop the plan for the expenditure of human services funds by answering each question below.*

- 1. Please identify the critical stakeholder groups, including individuals and their families, consumer groups, providers of human services, and partners from other systems, involved in the county's human services system.*

Planning team members include human services providers and stakeholders as well as consumers and advocate family members. In addition, the team includes staff support from each of the departments included in the block grant. Appendix D includes a comprehensive list of the members of the planning team and their affiliations.

The leadership team is comprised of key fiscal and human service administration staff and includes: Human Services Administrator, Fiscal Specialist, Human Services Fiscal Director, MH/ID/EI Administrator, Drug & Alcohol Administrator, Health and Human Services Planning and Development Director, County Grants Director, and the County Administrator.

- 2. Please describe how these stakeholders were provided with an opportunity for participation in the planning process, including information on outreach and engagement efforts.*

We have a small but active Planning Team that deliberates on the larger Block Grant Plan, monitors implementation, and recommends adjustments throughout the year. In addition to participating in the Human Services Block Grant (HSBG) meetings, program consumers and their families are often asked for their input through surveys, evaluations, and informal feedback; this feedback informs the operation of Block Grant-funded programs. Block Grant hearings were advertised in the newspaper, the County website, and Facebook, to elicit stakeholder feedback.

- 3. Please list the advisory boards that were involved in the planning process.*

- The Franklin/Fulton Drug & Alcohol Drug Advisory Board holds eleven meetings per year, six in Franklin County and five in Fulton County. The voting members of the Advisory Board include the following sector representation: Criminal Justice; Business/Industry; Labor; Education; Medicine; Psycho-Social; Student; Elderly; Client and Community. They provide input into the Block Grant Plan, are informed of Block Grant impact and are made aware of any Drug/Alcohol requests for new funding, projects or service enhancements.
- The Franklin County Housing Task Force consists of about 25 people who meet bi-monthly on issues around housing and homelessness. Representatives from both

County shelters and the HAP program attend regularly, along with Housing Authority staff, staff from the domestic violence shelter, Salvation Army, an FQHC, two Boroughs, and several religious organizations. They also receive updates on Block Grant plans and funding requests. The Task Force now combines their meetings with those of the Program Coordinating Committee hosted by the County Housing Authority, a change which has engaged additional community members and offered opportunities for presentations on local housing resources.

- The Franklin/ Fulton County Mental Health/ Intellectual Disabilities/ Early Intervention Advisory Board meets bi-monthly, with 13 members, including one Commissioner from Fulton and one from Franklin. The committee requires representation from each county: four members from Fulton County; nine members from Franklin County. At least two representatives appointed to the Board are physicians (preferably, a psychiatrist and a pediatrician). Four participants are consumers or family members, of which half represent Intellectual Disabilities/ Early Intervention. Additional representation comes from the following areas of expertise: psychology, social work, nursing, education, religion, local health and welfare planning organizations, local hospitals, businesses and other interested community groups. The MH/ID/EI Administrator provides HSBG updates as applicable during the Board meetings. They have impact on decisions related to MH/ID/EI funding and decisions, which indirectly can impact the HSBG.

4. *Please describe how the county intends to use funds to provide services to its residents in the least restrictive setting appropriate to their needs. (The response must specifically address providing services in the least restrictive setting.)*

Franklin/Fulton Drug & Alcohol provides prevention, treatment and recovery services in the environment most appropriate for the individuals receiving the services. Prevention services are delivered to youth in either a school-based or after-school based environment appropriate to their age and the selected evidence-based program. Treatment services are delivered to individuals based on their substance use assessment's level of care recommendation. High levels of care (detox, short-term rehab and long-term rehab) include 24/7 monitoring and supervision as treatment services are delivered within the provider setting. Low levels of care (halfway housing, partial hospitalization, intensive outpatient, outpatient and early intervention) services are delivered in a community-based setting by the provider of their choice. Recovery support/housing services are delivered to individuals based on their recovery needs which vary from ancillary treatment needs to direct treatment care in a community-based setting. Individuals are assisted by the department in discovering what recovery supports and services are the best fit for their current stage of recovery. Services are delivered in the least restrictive manner appropriate for the individual.

Franklin/Fulton Mental Health / Intellectual Disabilities / Early Intervention follows the principle of least restrictive alternative when providing services. A full continuum of care from community based to inpatient hospitalization is provided. Tools such as the Strengths Intensity Scale (SIS) are utilized to match individual need with the least restrictive service. Multiple criteria such as disability, level of autonomy, individual's request, and potential harm to self or others are evaluated to assure least restrictive alternative is utilized through all levels of care.

5. *Please list any substantial programmatic and/or funding changes being made as a result of last year's outcomes.*

No substantial changes are planned; new programs may be added as part of the reallocation process in 2017-18.

## **PART II: PUBLIC HEARING NOTICE**

*Two (2) public hearings are required for counties participating in the Human Services Block Grant. One (1) public hearing is required for counties not participating in the Human Services Block Grant.*

1. *Proof of publication;*
  - a. *Please attach a copy of the actual newspaper advertisement for the public hearing (see below).*
  - b. *When was the ad published?*
  - c. *When was the second ad published (if applicable)?*

*Please attach proof of publication(s) for each public hearing.*

2. *Please submit a summary and/or sign-in sheet of each public hearing. (This is required whether or not there is public attendance at the hearing.)*

**NOTE:** *The public hearing notice for counties participating in a LCA should be made known to residents of all counties.*

Pursuant to the Sunshine Act, 65 Pa.C.S. 701-716, the County conducted two public hearings to receive input on the Human Services Plan detailed in this document. A draft of the Block Grant Plan was posted on the County's website on May 12, 2017 for public review and comments. Public hearings were held at 3:00 PM on May 22, 2017, as part of the Block Grant Planning Committee, and 9:30 AM on May 25, 2017, as part of the Board of County Commissioners meeting. Appendix B contains the proof of publication and summaries of the public hearings.

## **PART III: CROSS-COLLABORATION OF SERVICES** (Limit of 4 pages)

*For each of the following, please provide a description of how the county administers services collaboratively across categoricals and client populations. In addition, please explain how the county intends to leverage funds to link residents to existing opportunities and/or to generate new opportunities.*

*Employment:* The Franklin/Fulton ID Program participates in the Transition Council with OVR and the School Districts and providers to promote and support the Employment First Model. The Transition Council promotes employment as the first opportunity for students graduating from high school. The Transition Council has applied to be an Experience the Employment Connection Team to further promote the collaboration between these agencies to better support individuals with disabilities to obtain competitive integrated employment. Our Information And Referral specialist can refer individuals calling 2-1-1 to employment programs such as Career Link and United Way's Stepping Forward Works. The most promising movement in our employment collaboration has come from the newly formed Reentry Coalition, and we hope to see the benefit for all citizens regardless of their criminal justice involvement.

*Housing:* Our Housing Specialist works with our Information and Referral Coordinator and multiple housing providers to help ensure a good fit for individuals in need of housing. Transitional housing

options, master lease, rental assistance, and emergency housing supports are options available to individuals meeting a range of specific criteria, including income, mental health, ID, D&A involvement, family status, or criminal justice involvement. In 2017-18, we will be working with HUD to institute Coordinated Entry within our Regional Housing Advisory Board, which will impact the way we do intakes across multiple housing programs, with the hope that it will result in better collaboration, streamlining of services, and increased leveraging of funding sources.

#### **PART IV: HUMAN SERVICES NARRATIVE**

Created through a collaborative process utilizing local needs data and involving a cross-section of community stakeholders, the goal of this plan is to provide a comprehensive continuum of human services for residents in the least restrictive setting appropriate to their needs. Franklin County collaborates as a joinder with Fulton County in four of the funds included in the Block Grant. Both counties have longstanding Human Services Administrative models. Both counties are participating in the Block Grant and submit separate plans.

Franklin County's Human Services Block Grant Planning Committee has established as its mission: *To assist in identifying need-based program priorities for promoting the health, well-being, and self-sufficiency for all people in Franklin County by and through maximizing resources.* The services described in this plan are an outflow of this mission statement, and are measured against this guiding standard.

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#### **MENTAL HEALTH SERVICES**

*The discussions in this section should take into account supports and services funded (or to be funded) with all available funding sources, including state allocations, county funds, federal grants, HealthChoices, reinvestment funds, etc.*

##### **a) Program Highlights:**

*Highlight the achievements and other programmatic improvements that have enhanced the behavioral health service system in FY 16-17.*

The Franklin/ Fulton County Mental Health Program provides services to Franklin/ Fulton County adults with severe and persistent mental illness and children who have a mental health diagnosis or who are at risk of developing a mental illness.

Through contracted case management, our agency provides intake, assessment, and coordination of the following services: outpatient psychotherapy, psychiatric and psychological evaluation, medication monitoring, residential programs, vocational and social rehabilitation, short-term inpatient, partial hospitalization and 24- hour emergency services.

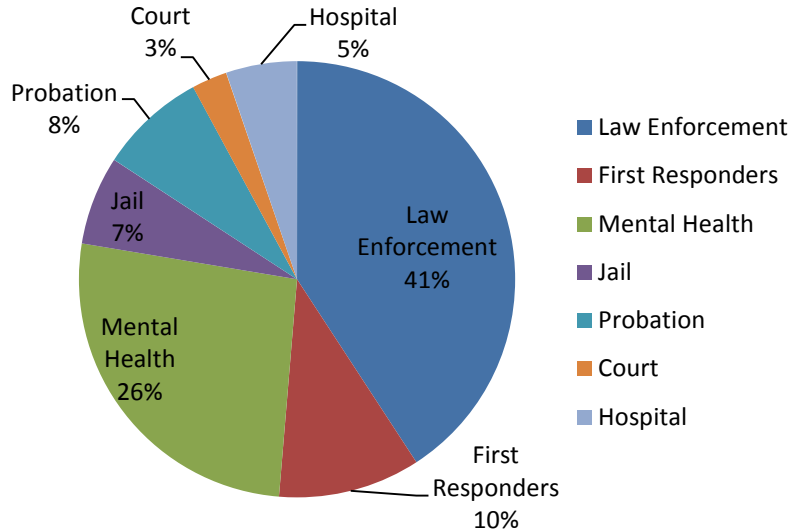
Due to the budget issues faced this fiscal year, we focused on maintaining and strengthening the current services already offered in our community. The following list describes program achievements and improvements:

**Crisis Intervention Team (CIT) –**

- On January 1, 2017, Franklin County was awarded a grant from the Pennsylvania Commission on Crime and Delinquency to pilot an innovative program to divert individuals with mental illness from the criminal justice system. The mental health co-responder program provides an integrated approach for individuals living with a mental illness, intellectual disability, Autism, and/or co-occurring disorder and coming into contact with law enforcement without rising to the level of police officer custody. The co-responder will be hired through a service provider and will be housed within the law enforcement departments. There are three municipal police departments targeted for this project and the co-responder will be assigned desk time at each. Greencastle, Waynesboro, and Washington Township, all in the southern part of Franklin County, have been identified by the District Attorney as benefiting from the additional support of a professional with MH background to assist them in their interventions with individuals with mental health issues.

The objectives of the co-responder program are to connect and integrate those individuals identified as being in crisis with community based and natural supports. This will involve the co-responder assisting with locating supports and helping the individual make appointments and transportation arrangements. The act of offering assistance fosters the individual's ability to independently remain connected and integrated in the future. The program is also designed to reduce the number of individuals (within the target population) getting involved in the justice system. When the police are dispatched for an incident where the behavior does not rise to the level of police officer custody, the co-responder will/can intervene and begin the screening and risk assessment to determine level of care.

- Our training program is in its fifth year and continuing to gain momentum. The team is now 76 strong with half of our members representing law enforcement and first responders. The remainder of the team represents crisis, jail officers/staff, probation/parole officers, hospital staff, mental health professionals and advocates.
- South Central Region CIT continues to follow the fidelity of the Memphis Model of CIT. During the 40 hours of training, we are fortunate to have a certified trainer for the Veterans module, 2 certified trainers for the de-escalation and 1 CIT Coordinator to be trained in August. We also offer evidence based training such as QPR (Question Persuade Refer) and Pat Madigan's *Hearing Voices* throughout the week.
- Outcomes:
  - To date we have held five (5) CIT trainings and have seventy six(76) members with half of our team being represented by law enforcement and first responders:



**Evidence Based Practices-**

- Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
  - To foster more trauma awareness in our communities, Franklin/Fulton County has five (5) providers certified to provide TF-CBT.
- Eye Movement Desensitization and Reprocessing Therapy
  - Our county was fortunate to be able to assist two local therapists, with managed care assisting five, to begin the training of becoming EMDR certified. This will increase our capacity for evidence-based therapies.
- Mental Health First Aid
  - There are four (4) trainers available to Franklin/Fulton County. They are certified to provide adult, youth, older adult and veteran Mental Health First Aid. Over the past six (6) years they have trained over 300 people within our community. During our mental health awareness conference in May, a class for Veterans and a class for older adults will be provided.

**b) Strengths and Needs:**

*Please identify the strengths and needs of the county/joiner service system specific to each of the following target populations served by the behavioral health system. When completing this assessment, consider any health disparities impacting each population. Additional information regarding health disparities is available at <https://www.samhsa.gov/health-disparities>.*

- **Older Adults (ages 60 and above)**
  - Strengths:
    - The Mental Health program has been presenting suicide prevention and mental health awareness within our senior centers and personal care homes.
    - The newly formed Franklin County Older Adult Advocacy Team consists of a partnership with advocates, Area Agency on Aging, mental health, crisis, and first responders. Their mission is to bridge the gap in aging and mental health services for individuals age 60 and over.
    - Currently, five (5) Area Agency on Aging staff have been trained to provide person-centered counseling. They are able to offer specific case management functions and needs assessments.

- Senior centers are moving towards functioning as senior center without walls. They are hosting functions attracting community to foster integration and intergenerational involvement.
  - Needs:
    - Specialized facilities for individuals living with dementia. Our crisis and ER's have seen an increase in patients and are having difficulty with locating facilities for care.
    - Front line staff working with our older adults need better education in working with individuals living with dementia.
    - More accessible transportation would be useful.
- **Adults (ages 18 and above)**
  - Strengths:
    - Physical and behavioral health providers have begun collaborating on health literacy and educating both our residents and our health system regarding the importance of addressing both issues for wellness.
    - Working towards increasing our supported employment opportunities for those in the workforce to turn into employment placements. We have had a significant increase this fiscal year. We credit this to the increased relationships our providers are fostering with employers in the community.

Employment				
	Fiscal Year 14-15	Fiscal year 15-16	*Fiscal year 16-17	% Change 15-16 to 16-17
AHEDD	21	18	30	+40%
OSI	21	21	22	+5%
<b>Total</b>	<b>42</b>	<b>39</b>	<b>52</b>	<b>+25%</b>

\*16-17 data through April

- Needs:
      - According to the 2015 Summit Health Community Health Needs Assessment (CHNA), Franklin County had a suicide death rate of 13.8 people/100,000 population. Individuals with a depressive disorder totaled 16% and 17% had an anxiety disorder. 52% reported depressive symptoms in the last 2 weeks.
      - Adults and families expressed a need for better communication with the doctor. According to the Mental Health Association of Franklin and Fulton Counties' Individual/Family Satisfaction Team January-March 2017 quarterly report, families report a barrier to services was having the doctors listen to them regarding symptoms.
- **Transition-age Youth (ages 18-26)- Counties are encouraged to include services and supports assisting this population with independent living/housing, employment, and post-secondary education/training.**
  - Strengths:
    - Mental Health Association is in contact with the OMHSAS to revise their Peer Support Services program description to also allow them to provide peer

support services to youth and young adults; most likely this will begin on or sometime after July 1, 2017.

- Children’s Program Specialists as well as Adult Program Specialists are available to meet with youth and others to discuss needs and services.
- Needs:
  - There are no formalized transition services in the county, but CASSP can assist families with this as needed.
- **Children (under 18)- Counties are encouraged to include services like Student Assistance Program (SAP), Respite, and CASSP Coordinator Services and Supports, as well as the development of community alternatives and diversion efforts to residential treatment facility placements.**
  - Strengths:
    - Student Assistance Program (SAP)
      - Elementary SAP is being provided in several elementary schools in Franklin County with the goal of further expansion in Franklin County and initiating it in Fulton County schools
      - County human service agencies have begun a complex needs workgroup for early identification of children/adolescents in our community that may have complex needs and benefit from a better supported treatment/support team.
    - Children/Adolescent Service System Program (CASSP)
      - Continues to work with our adolescents to build capacity for more natural supports and remain in the community. Assists families in navigating the mental health service system and accessing services.
      - School-based mental health therapy services have continued to expand in area school districts and in addition delivery of service has improved. This service is monitored by a QI process including HealthChoices, MH, schools and providers.
    - Respite
      - Respite is available to Franklin and Fulton County children under the age of 18 on an hourly basis or an overnight stay. The number of children served is unduplicated; however, the hours represent all hours provided.

<b>Respite</b>	FY12-13	FY13-14	FY14-15	FY15-16	FY16-17
Children Served	15	12	16	4	8
Hours of Respite	519	637	636	288	344.5

- Needs:
  - Available community and inpatient services with specialty in complex issues. Crisis has seen an increased number of adolescents and has found barriers of finding inpatient placements and services for children/adolescents with complex needs to include dual diagnosis, sexualized behaviors and fire setting behaviors.
  - Respite services could be used more if the provider had more availability of beds and specialty for complex needs.



- Our area lost a very valuable resource and advocate service when the only educational advocate left. This is a very needed service and our closest educational advocate is in Pittsburgh.
- Provider staff turnover and lack of staff continue to be an issue that impacts treatment delivery. There is a meeting planned to review this issue and develop a response to assist in building capacity for enhanced treatment.

*Identify the strengths and needs of the county/joiner service system (including any health disparities) specific to each of the following special/underserved populations. If the county does not currently serve a particular population, please indicate and note any plans for developing services for that population.*

- **Individuals transitioning out of state hospitals**

- Strengths:
  - Franklin/Fulton County Mental Health continues to facilitate Community Support Plan meetings at the state hospital in order to assist in the transition of returning home and meeting the person's needs.
- Needs:
  - Many of our people currently at Danville State Hospital have complex needs which require nursing home level of care or structured residential programs (the latter has very limited capacity).

- **Co-occurring Mental Health/Substance Use Disorder**

- Strengths:
  - Training related to co-occurring disorder continues to be offered free to our providers to include continue education credits from the Pennsylvania State Board of Social Workers. We also offer an on-line training series that is available for all Franklin/Fulton County providers. It features training based on the Tip-42 to include motivational interviewing.
- Needs:
  - Health literacy of the community, recognizing that mental health and substance use disorder can be co-occurring and the treatment often includes addressing both.

- ***Justice-involved individuals-*** *Counties are encouraged to collaboratively work within the structure of County Criminal Justice Advisory Boards to implement enhanced services for justice-involved individuals to include diversionary services that prevent further involvement within the criminal justice system as well as reentry services to support successful community reintegration.*

- Strengths:
  - As of November 2016, Service Access Management has been providing forensic case management services for individuals currently incarcerated in the Franklin County Jail or recently released, as well as individuals who are within three months of maxing out their sentences at State Correctional Institutions. Individuals must express interest in returning to Franklin or Fulton

County and be agreeable to continuing with mental health services in the community.

- Also see information above regarding CIT and the Mental Health Co-Responder, which was initiated by a CJAB grant.
- The mental health program is very active on the Criminal Justice Advisory Board to include the Executive Committee and the Behavioral Health Committee.
- A mental health program specialist meets weekly with the Franklin County Jail to review individuals that are currently incarcerated with mental health issues.
- In May 2017, key behavioral health and criminal justice stakeholders in Franklin County met to update a sequential intercept mapping model, first created in 2009, to detail the intersection of local human services with the criminal justice system, identifying gaps and developing objectives to address unmet needs.
- Franklin County continues to be part of the national Stepping Up Initiative. We were one of 50 counties chosen to be part of the Stepping Up Initiative's National Summit in Washington DC in April 2016, an event that brought together jurisdictions of all sizes to learn from each other and from experts in the ongoing push to reduce the number of people with mental illnesses in local jails. We have seen new initiatives around MH and criminal justice-involved individuals develop as a result.
- MH/ID staff continue to be part of Franklin Together: The Franklin County Reentry Coalition as a vital voice regarding MH and criminality.
- Franklin County was chosen by SAMHSA to receive technical assistance in the form of train-the-trainers for their Trauma-Informed Criminal Justice program. By training 20 Franklin County staff as trainers, we will increase the number of departments we can reach with this program.
- Franklin County CJAB received a grant in January 2017 to provide Intensive Reentry Case Management for at least 10 women with complex MH, D&A, housing, and other needs. MH staff were an integral part of writing and now implementing the program, which has trauma as a central focus.
- Needs:
  - We hope to expand the MH Co-responder program to include the rest of the county, not just the southern portions. This will require additional staff. In addition, we would like to see a co-responder on each shift to ensure full coverage of any needs that might arise.

- **Veterans**

- Strengths:
  - In conjunction with the Copeland Center, Franklin County is offering a WRAP group session in June. The class is able to accommodate 16 Veterans. In addition a goal is that one of the Veterans will be interested in pursuing the opportunity to become a certified facilitator upon completion of the class.

- Veterans Affairs and mental health continue to work together to educate the primary health system, employers, and criminal justice system regarding resources and contacts available to the Veterans of Franklin County.
- Beginning in May, Veterans will be able to access a mental health counselor two days a month in the local Veterans Affairs office.
- Operation Save A Vet, Save A Pet program has made five (5) pairings and currently has four (4) dogs in class to become certified service dogs.
- Veterans Affairs is partnering with a group to begin offering hunting and fishing adventures to include Veterans with a disability, with a primary focus on mental health.
- Needs:
  - Reliable transportation to appointments and employment is needed. Currently it is a barrier due to having to cross state lines and not having handicapped vehicles available.
  - The closest VA clinic is 25 miles away and out of state. Again, being out of state poses a barrier to healthcare. The appointment times are limited due to the availability of transportation.
- **Lesbian/Gay/Bisexual/Transgender/Questioning/Intersex (LGBTQI) consumers**
  - Strengths:
    - Within this past year, an outpatient program has started group therapy for individuals identifying as LGBTQI.
    - Mental Health staff participated in the White House and the U.S. Department of Health and Human Services conference call with the LGBTQI community regarding the Affordable Care Act.
  - Needs:
    - Health literacy for physical and behavioral health care professionals. The LGBTQI community requires health care and having a professional with whom they feel safe and can discuss health related issues is important.
- **Racial/Ethnic/Linguistic minorities (including Limited English Proficiency)**
  - Strengths:
    - The County does have access to the language line that allows us to respond to any language.
    - Currently, we do have access to a small number of bilingual therapists in our community.
  - Needs:
    - The County continues to find it challenging to secure services of multiple bilingual professionals in our area.
- **Other (specify), if any (including Tribal groups, people living with HIV/AIDs or other chronic diseases/impairments, Traumatic Brain Injury)**
  - Strengths:

- HIV/AIDS Program – Keystone Health has been providing services in Franklin County for individuals living with HIV/AIDS since 1995. They offer a full range of services aimed at promoting healthy individuals and a healthy community.
- Needs:
  - Health literacy and supports for traumatic brain injury and other diseases would be helpful for our providers. It would also assist those living with the diseases to live healthier and happier lives.

**Is the county currently utilizing Cultural and Linguistic Competence (CLC) Training?**

Yes     No

If yes, please describe the CLC training being used. Plans to implement CLC training may also be included in the discussion. (Limit of 1 page)

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**c) Supportive Housing:**

The DHS' five- year housing strategy, [Supporting Pennsylvanians through Housing](#), is a comprehensive plan to connect Pennsylvanians to affordable, integrated and supportive housing. This comprehensive strategy aligns well with OMHSAS planning efforts, and OMHSAS is an integral partner in its implementation. Supportive housing is a successful, cost-effective combination of affordable housing with services that helps people live more stable, productive lives. Supportive housing works well for people who face the most complex challenges—individuals and families who have very low incomes and serious, persistent issues that may include substance use, mental illness, and HIV/AIDS; and may also be homeless, or at risk of homelessness.

**SUPPORTIVE HOUSING ACTIVITY** *Includes Community Hospital Integration Projects Program (CHIPPP), Reinvestment, County base funded or other projects that were planned, whether funded or not. **Include any program activity approved in FY 16-17 that is in the implementation process. Please use one row for each funding source and add rows as necessary.***

1. Capital Projects for Behavioral Health				<input checked="" type="checkbox"/> Check if available in the county and complete the section.				
Capital financing is used to create targeted permanent supportive housing units (apartments) for consumers, typically, for a 15-30 year period. Integrated housing takes into consideration individuals with disabilities being in units (apartments) where people from the general population also live (i.e. an apartment building or apartment complex).								
Project Name	*Funding Sources by Type (include grants, federal, state & local sources)	Total \$ Amount for FY 16-17 (only County MH/ID dedicated funds)	Projected \$ Amount for FY 17-18 (only County MH/ID dedicated funds)	Actual or Estimated Number Served in FY 16-17	Projected Number to be Served in FY 17-18	Number of Targeted BH Units	Term of Targeted BH Units (ex: 30 years)	Year Project first started
Housing Development Initiative	HealthChoices Reinvestment				15	15	20 years	
Housing Development Initiative	County	\$185,000	0	0	4-14	4	20 years	2017

<b>2. Bridge Rental Subsidy Program for Behavioral Health</b>	<input type="checkbox"/> Check if available in the county and complete the section.
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**Short term tenant based rental subsidies, intended to be a “bridge” to more permanent housing subsidy such as Housing Choice Vouchers.**

	*Funding Sources by Type (include grants, federal, state & local sources)	Total \$ Amount for FY 16-17	Projected \$ amount for FY 17-18	Actual or Estimated Number Served in FY 16-17	Projected Number to be Served in FY 17-18	Number of Bridge Subsidies in FY 16-17	Average Monthly Subsidy Amount in FY 16-17	Number of Individuals Transitioned to another Subsidy in FY 16-17	Year Project first started

<b>3. Master Leasing (ML) Program for Behavioral Health</b>	<input checked="" type="checkbox"/> Check if available in the county and complete the section.
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**Leasing units from private owners and then subleasing and subsidizing these units to consumers.**

	*Funding Source by Type (include grants, federal, state & local sources)	Total \$ Amount for FY 16-17	Projected \$ Amount for FY 17-18	Actual or Estimated Number Served in FY 16-17	Projected Number to be Served in FY 17 –18	Number of Owners/ Projects Currently Leasing	Number of Units Assisted with Master Leasing in FY 16-17	Average subsidy amount in FY 16-17	Year Project first started
HUD Master Lease PSH	Federal/HUD	\$178,435	\$178,435	21	20		21	\$538/month/participant	2006
	County Match	\$11,408	\$11,408						

<b>4. Housing Clearinghouse for Behavioral Health</b>	<input type="checkbox"/> Check if available in the county and complete the section.
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<b>An agency that coordinates and manages permanent supportive housing opportunities.</b>									
	*Funding Source by Type (include grants, federal, state & local sources)	Total \$ Amount for FY 16-17	Projected \$ Amount for FY 17-18	Actual or Estimated Number Served in FY 16-17	Projected Number to be Served in FY 17-18			Number of Staff FTEs in FY 16-17	Year Project first started

<b>5. Housing Support Services for Behavioral Health</b>	<input checked="" type="checkbox"/> Check if available in the county and complete the section.
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**HSS are used to assist consumers in transitions to supportive housing and/or services needed to assist individuals in sustaining their housing after move-in.**

	*Funding Sources by Type (include grants, federal, state & local sources)	Total \$ Amount for FY 16-17	Projected \$ Amount for FY 17-18	Actual or Estimated Number Served in FY 16-17	Projected Number to be Served in FY 17-18			Number of Staff FTEs in FY 16-17	Year Project first started
Franklin/Fulton PATH Program	Federal	\$49,485	\$54,558	26-30	25-35			32.25	2005
	State	\$16,495	\$18,186						

<b>6. Housing Contingency Funds for Behavioral Health</b>	<input checked="" type="checkbox"/> Check if available in the county and complete the section.
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**Flexible funds for one-time and emergency costs such as security deposits for apartment or utilities, utility hook-up fees, furnishings etc.**

	*Funding Sources by Type (include grants, federal, state & local sources)	Total \$ Amount for FY 16-17	Projected \$ Amount for FY 17-18	Actual or Estimated Number Served in FY 16-17	Projected Number to be Served in FY 17-18			Average Contingency Amount per person	Year Project first started
Franklin County Family Housing Grant	County HSBG	\$9,774		10-12	Uncertain if there will be funding			\$815/person	2016
Franklin County Housing Expansion	County	\$21,539.36	\$11,808	22-30	10-20			\$717/person	2006

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<b>7. Other: Identify the program for Behavioral Health</b>	<input checked="" type="checkbox"/> Check if available in the county and complete the section.
<p><b>Project Based Operating Assistance (PBOA</b> is a partnership program with Pennsylvania Housing Finance Agency in which the County provides operating or rental assistance to specific units then leased to eligible persons); <b>Fairweather Lodge (FWL</b> is an Evidenced Based Practice where individuals with serious mental illness choose to live together in the same home, work together and share responsibility for daily living and wellness); <b>CRR Conversion</b> (as described in the CRR Conversion Protocol ), <b>other</b>.</p>	



DHS Bulletin 2017-1  
County Human Services Plan Guidelines

	*Funding Sources by Type (include grants, federal, state & local sources)	Total \$ Amount for FY 16-17	Projected \$ Amount for FY 17-18	Actual or Estimated Number Served in FY 16-17	Projected Number to be Served in FY 17-18	# of Projects Projected in FY 17-18 (i.e. if PBOA; FWLs, CRR Conversions planned)	# of Projects projected in FY 17-18 (if other than PBOA, FWL, CRR Conversion)		Year Project first started
HUD 3 Leasing Assistance Program	Federal  County Match/In Kind	\$83,352  \$1,628	\$83,352  \$1,628	20	13-15	NA	NA		2008
Franklin County Housing Expansion	County	\$24,160	\$24,160	8	5-8	NA	NA		2006
Supportive Living Program	County	\$730,269	\$730,269	18	NA	NA	NA		2005
Specialized Community Residence	County	\$386,218	\$386,218	9	9	NA	NA		2005
Community Rehabilitative Residential	County	\$293,096	\$293,096	12	15	NA	NA		2003

**d) Recovery-Oriented Systems Transformation:**

*Based on the strengths and needs reported above in section (b), identify the top three to five priorities for recovery-oriented system transformation efforts the county plans to address in FY 17-18 at current funding levels. For **each** transformation priority, provide:*

- *A brief narrative description of the priority including action steps for the current fiscal year.*
- *A timeline to accomplish the transformation priorities including approximate dates for progress steps and priority completion.*
- *Information on the fiscal and other resources needed to implement the priorities (how much the county plans to utilize from state allocations, county funds, grants, HealthChoices, reinvestment funds, etc., and any non-financial resources).*
- *A plan/mechanism for tracking implementation of priorities.*

DRAFT

<b>Priority</b>	<b>Narrative</b>	<b>Action Steps</b>	<b>Timeline</b>	<b>Resources Needed</b>	<b>Tracking Mechanism</b>
1. Suicide Prevention	a. Develop a Zero Suicide Prevention philosophy statement and community education program emphasizing the value and importance of each individual	i. Identify key community influencers that share the Zero Suicide Prevention and can work on behalf of this effort.	December 2018	\$10,000 may be needed to support the education and awareness campaign.	This is monitored through the Suicide prevention task force and Healthy Franklin County. The coroner's office will be a source of data collection.
		ii. Schedule conversation with National Alliance for Suicide Prevention for technical assistance.	July 2017		
		iii. Create a community awareness/ education action plan for spreading this message into the community (QPR trainings, depression screenings)	December 2018		
2. Addressing health literacy in both our residents and our system	a. Increase the number of patients who are screened for depression within the primary care setting by December 2020.	i. Develop community consensus on a depression assessment instrument that can be used by all Primary Care Providers, Hospital Physicians, and Mental Health Professionals. The survey instrument should include questions related to screening for and managing patients with depression, and identifying resources needed to assist primary care providers.	December 2017	The dollar amount needed will be assessed as the committee is researching a program.	This is monitored through the MH task force and Healthy Franklin County.
		ii. Create an action plan for educating and gaining support on the use of the depression assessment tools, and compiling the assessment results at a centralized location for Primary Care Providers and Mental Health Providers.	March 2018		
		iii. Provide training and support for Primary Care Providers and Mental Health Professionals on the use of the assessment tools, documentation of assessment results, and making appropriate referrals for support for individuals experiencing depression.	January 2019		
		iv. Identify a lead organization for coordinating assessment tool training, collecting assessment results, and providing support and coaching for Primary Care Physicians and Mental Health Professionals in the assessment of patients for depression.	November 2018		
	b. Improve access and quality of care by designing a model by which behavioral health services are integrated with Primary Care offices.	i. Develop a model for integrating behavioral health services, training and resources into Primary Care offices to include education for special populations such as older adults and LGBTQI.	December 2018	Referral process	This is monitored through the MH task force and Healthy Franklin County.
		ii. Conduct a pilot program in which behavioral health therapists serve as a resource and provide support to one or more (maximum of 3) Summit Physician Services offices.			

<b>Priority</b>	<b>Narrative</b>	<b>Action Steps</b>	<b>Timeline</b>	<b>Resources Needed</b>	<b>Tracking Mechanism</b>
	c. Increase community awareness about depression and available resources within the community	i. The Mental Health Task Force will develop a community awareness and education action plan for informing the community about depression and other mental illnesses. ii. Continue and expand existing community campaigns that educate the public about effective ways to manage depression (i.e., physical activity, nutrition).	December 2020	\$5000 may be needed for educational and resource material identified to assist with community awareness campaign.	This is monitored through the MH task force and Health Franklin County.
3. Re-entry of individuals from our jail to our community.	As a result of Coalition Planning meetings and surveys, the Reentry Coalition has established the following priorities for the next steps of reentry planning:  a. EDUCATION	i. Create an awareness/education plan for the county, including plans for media.	ongoing	Stakeholders (faith organizations, jail, courts, human services, law enforcement, public)	Reentry Education Committee meetings
		ii. Educate employers about reentry and hiring individuals with criminal backgrounds.	ongoing	Stakeholders (faith organizations, jail, courts, human services, law enforcement, public, employers)	Reentry Education Committee meetings
	b. SUPPORT	i. Identify all existing community resources and update the Reentry Resource Guide available in print and digital formats.	ongoing	Stakeholders (jail, courts, human services, law enforcement)	Reentry Advisory Board reassess as needed
		ii. Identify inmate needs prior to release and craft individual release plan, providing the inmate with a resource directory and packet of materials. Offer guidance on how to connect with resources.	ongoing	Stakeholders (jail, courts, human services)	Case Review Task Force
		iii. Develop a reentry discharge planning team and/or follow up team to work with people before and after release.	Fall 2017	Stakeholders (faith organizations, jail, courts, human services, law enforcement, public)	Case Review Task Force
	c. INCREASE CAPACITY	i. Complete a housing inventory to ensure affordable housing is available to returning citizens and craft a comprehensive housing plan for reentry.	Fall 2017	Stakeholders (faith organizations, jail, courts, human services, law enforcement, public)	Housing Task Force
		ii. Commit to keeping formerly incarcerated people involved in Reentry Coalition meetings and include on committee work.	ongoing	Stakeholders (faith organizations, jail, courts, human services, law enforcement, public)	Coalition Advisory Board

<b>Priority</b>	<b>Narrative</b>	<b>Action Steps</b>	<b>Timeline</b>	<b>Resources Needed</b>	<b>Tracking Mechanism</b>
	d. ADVOCATE FOR CHANGE	i. Examine reentry processes and protocols, looking for opportunities to enhance or develop better processes and remove process barriers.	ongoing	Stakeholders (jail, courts, law enforcement, human services)	Intercept Task Force
4. Data collection to increase knowledge of quality of services in order to assist in making better decisions for service delivery.	a. Our local advocacy provider, Mental Health Association, has partnered with Penn State Mont Alto to begin the development of a data warehouse.	i. Training to authorized users	Summer 2016	Staff and computers needed	This is monitored by MH Task Force and Healthy Franklin County. Penn State Mont Alto is also monitoring.
		ii. Data entry to begin	October 2016	Data and data analyst	This is monitored by MH Task Force and Healthy Franklin County. Penn State Mont Alto is also monitoring.
		iii. Collaboration with county providers to educate and share the benefits to having a data warehouse for our community.	January 2017	Data and data analyst. Education and demonstration of the data.	This is monitored by MH Task Force and Healthy Franklin County. Penn State Mont Alto is also monitoring.
		iv. Actual use of the system	2018	Provider agency participation	This is monitored by MH Task Force and Healthy Franklin County. Penn State Mont Alto is also monitoring.
	b. County Human Services is working with our managed care organization to create a data warehouse to track human services data across systems.	i. Create process for data collection from each department	Winter 2017	County and HealthChoices have committed funds to pursue the project.	This is monitored through the County project planning.
		ii. Begin upload of data for county HS departments to compare and contrast for developing services	Spring 2018		

*\*On a quarterly basis, progress on each of the transformation priorities is reported to our Community Support Program.*

**e) Existing County Mental Health Services:**

Please indicate all currently available services and the funding source or sources utilized.

Services By Category	Currently Offered	Funding Source (Check all that apply)
Outpatient Mental Health	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> County <input checked="" type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Psychiatric Inpatient Hospitalization	<input checked="" type="checkbox"/>	<input type="checkbox"/> County <input checked="" type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Partial Hospitalization	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> County <input checked="" type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Family-Based Mental Health Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> County <input checked="" type="checkbox"/> HC <input type="checkbox"/> Reinvestment
ACT or CTT	<input type="checkbox"/>	<input type="checkbox"/> County <input type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Children's Evidence Based Practices	<input checked="" type="checkbox"/>	<input type="checkbox"/> County <input checked="" type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Crisis Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> County <input checked="" type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Emergency Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> County <input type="checkbox"/> HC <input checked="" type="checkbox"/> Reinvestment
Targeted Case Management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> County <input checked="" type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Administrative Management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> County <input type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Transitional and Community Integration Services	<input type="checkbox"/>	<input type="checkbox"/> County <input type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Community Employment/Employment Related Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> County <input type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Community Residential Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> County <input type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Psychiatric Rehabilitation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> County <input checked="" type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Children's Psychosocial Rehabilitation	<input type="checkbox"/>	<input type="checkbox"/> County <input type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Adult Developmental Training	<input type="checkbox"/>	<input type="checkbox"/> County <input type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Facility Based Vocational Rehabilitation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> County <input type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Social Rehabilitation Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> County <input type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Administrator's Office	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> County <input type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Housing Support Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> County <input type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Family Support Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> County <input type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Peer Support Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> County <input checked="" type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Consumer Driven Services	<input type="checkbox"/>	<input type="checkbox"/> County <input type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Community Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> County <input type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Mobile Mental Health Treatment	<input type="checkbox"/>	<input type="checkbox"/> County <input type="checkbox"/> HC <input type="checkbox"/> Reinvestment
BHRS for Children and Adolescents	<input checked="" type="checkbox"/>	<input type="checkbox"/> County <input checked="" type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Inpatient D&A (Detoxification and Rehabilitation)	<input checked="" type="checkbox"/>	<input type="checkbox"/> County <input checked="" type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Outpatient D&A Services	<input checked="" type="checkbox"/>	<input type="checkbox"/> County <input checked="" type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Methadone Maintenance	<input checked="" type="checkbox"/>	<input type="checkbox"/> County <input checked="" type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Clozapine Support Services	<input checked="" type="checkbox"/>	<input type="checkbox"/> County <input checked="" type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Additional Services (Specify – add rows as needed)	<input type="checkbox"/>	<input type="checkbox"/> County <input type="checkbox"/> HC <input type="checkbox"/> Reinvestment

\*HC= HealthChoices

**f) Evidence Based Practices Survey:**

Evidenced Based Practice	Is the service available in the County/ Joinder? (Y/N)	Current Number served in the County/ Joinder (Approx)	What fidelity measure is used?	Who measures fidelity? (agency, county, MCO, or state)	How often is fidelity measured?	Is SAMHSA EBP Toolkit used as an implementation guide? (Y/N)	Is staff specifically trained to implement the EBP? (Y/N)	Additional Information and Comments
Assertive Community Treatment	No							
Supportive Housing	Yes	18	Outcomes Rating Scale	Agency	6 months	No	Yes	
Supported Employment	No							Include # Employed
Integrated Treatment for Co-occurring Disorders (MH/SA)	Yes	135		Agency		No		Several agencies use different programs
Illness Management/ Recovery	Yes	18		Agency/County	Every session	No		Only included group numbers
Medication Management (MedTEAM)	No							
Therapeutic Foster Care	Yes							
Multisystemic Therapy								
Functional Family Therapy								
Family Psycho-Education	Yes	25	Strengthening Families Program 10-14	Agency	Every session	No	Yes	

\*Please include both county and Medicaid/HealthChoices funded services.

To access SAMHSA's EBP toolkits:

<http://store.samhsa.gov/list/series?name=Evidence-Based-Practices-KITs>

**g) Additional EBP, Recovery Oriented and Promising Practices Survey:**

Recovery Oriented and Promising Practices	Service Provided (Yes/No)	Current Number Served (Approximate)	Additional Information and Comments
Consumer Satisfaction Team	Yes	300	
Family Satisfaction Team	Yes	125	
Compeer	No	0	
Fairweather Lodge	Yes	8	
MA Funded Certified Peer Specialist	Yes	40	
Other Funded Certified Peer Specialist	Yes	39	
Dialectical Behavioral Therapy	Yes	20	2 providers offer group
Mobile Meds	No	0	
Wellness Recovery Action Plan (WRAP)	Yes	42	Groups & individual
High Fidelity Wrap Around	No	0	
Shared Decision Making	No	0	
Psychiatric Rehabilitation Services (including clubhouse)	Yes	84	
Self-Directed Care	No	0	
Supported Education	No	0	
Treatment of Depression in Older Adults	No	0	
Competitive/Integrated Employment Services**	Yes	174	Include # employed 52
Consumer Operated Services	Yes	350	Mental Health Association
Parent Child Interaction Therapy	Yes	17	Actual FY 16/17 as of April
Sanctuary	Yes	2	In our larger svstem
Trauma Focused Cognitive Behavioral Therapy	Yes	16	Actual FY 16/17 as of April
Eye Movement Desensitization And Reprocessing (EMDR)	Yes	15	
First Episode Psychosis Coordinated Specialty Care	No	0	
Other (Specify)Check & Connect	Yes	23	Middle school age

\*Please include both County and Medicaid/HealthChoices funded services.

\*\*Do not include numbers served counted in Supported Employment on Evidenced Based Practices Survey above [table (f)]



**Reference: Please see SAMHSA’s National Registry of Evidenced Based Practice and Programs for more information on some of the practices at the link provided below.**

<http://www.nrepp.samhsa.gov/AllPrograms.aspx>

**h) Certified Peer Specialist Employment Survey:**

“Certified Peer Specialist” (CPS) is defined as:

An individual who has completed a 10-day Certified Peer Specialist training course provided by either the Institute for Recovery and Community Integration or Recovery Innovations/Recovery Opportunities Center.

**Please include CPSs employed in any mental health service in your county/joinder including, but not limited to:**

- case management
- inpatient settings
- psychiatric rehabilitation centers
- intensive outpatient programs
- drop-in centers
- Medicaid-funded peer support programs
- consumer-run organizations
- residential settings
- ACT, PACT, or FACT teams

<b>Total Number of CPSs Employed</b>	<b>15</b>
<b>Number Full Time (30 hours or more)</b>	<b>2</b>
<b>Number Part Time (Under 30 hours)</b>	<b>13</b>

**INTELLECTUAL DISABILITY SERVICES**

*The Office of Developmental Programs (ODP), in partnership with the county programs, is committed to ensuring that individuals with an intellectual disability live rich and fulfilling lives in their community. It is important to also ensure that the families and other stakeholders have access to the information and support needed to help be positive members of the individuals’ teams.*

*This year, we are asking you to focus more in depth on the areas of the county plan that will help us achieve the goal of an Everyday Life for all individuals.*

*With that in mind, describe the continuum of services to enrolled individuals with an intellectual disability within the county. In a narrative format, please include the strategies that will be utilized for all individuals registered with the county, regardless of the funding stream. In completing the chart below, regarding estimated numbers of individuals, please include only those individuals for whom*

base or block grant funds have or will be expended. Appendix C should reflect only base or block grant funds except for the Administration category. Administrative expenditures should be included for both base/block grant and waiver administrative funds.

*\*Please note that under Person Directed Supports, individuals served means the individual used Vendor Fiscal/Employer Agent (VF/EA) or Agency with Choice (AWC) for at least one service during the fiscal year. The percentage of total individuals served represents all funding streams. The percentage might not add to 100 percent if individuals are receiving services in more than one category.*

The mission of Franklin/Fulton Mental Health/Intellectual Disabilities/ Early Intervention is to partner with the community to develop and assure the availability of quality MH/ID/EI services and supports for individuals and families. Through the use of a person-centered planning approach and the utilization of Prioritization of Urgency of Need for Services (PUNS), the ID program assists individuals in accessing services and supports within their community regardless of the funding stream. The PUNS gathers information from the person-centered planning approach to identify current and anticipated needs. This information allows Franklin/Fulton Mental Health/Intellectual Disabilities/Early Intervention to budget and plan for the continuum of services and to develop programs to meet the needs of the community. Programs support client engagement and provide access to services for employment, training, housing and family support as appropriate. As of April 30, 2017, there were 528 people registered in the Intellectual Disabilities program in Franklin County, of which 37 are participants in the life sharing program.

**Individuals Served**

	<i>Estimated Individuals served in FY 16-17</i>	<i>Percent of total Individuals Served</i>	<i>Projected Individuals to be served in FY 17-18</i>	<i>Percent of total Individuals Served</i>
Supported Employment	22	4	23	4
Pre-Vocational	5	1	5	1
Adult Training Facility	0	0	0	0
Base Funded Supports Coordination	76	14	63	12
Residential (6400)/unlicensed	0	0	0	0
Life sharing (6500)/unlicensed	0	0	0	0
PDS/AWC	34	6	34	6
PDS/VF	0	0	0	0
Family Driven Family Support Services	18	4	50	8

**Supported Employment:** *“Employment First” is the policy of all commonwealth executive branch agencies under the jurisdiction of the governor. Therefore, ODP is strongly committed to Community Integrated Employment for all.*

- *Please describe the services that are currently available in your county such as discovery, customized employment, etc.*
- *Identify changes in your county practices that are proposed for the current year that will support growth in this area and ways that ODP may assist the county in establishing employment growth activities.*
- *Please add specifics regarding the Employment Pilot if your county is a participant.*

Employment First is a concept promoting community integrated employment. Franklin/ Fulton ID program is supporting this concept in a variety of ways.

The "Transition to Adult Life Success" program engages young adults with disabilities in discussions and activities pertaining to areas of self-determination and career exploration. The "Transition to Adult Life Success" program activities include presentations on employability, community resources, and post-secondary opportunities. One-to-one services include connecting with employers, job shadowing, community-based work assessments, and work incentive counseling. There are currently 44 students in the TALS program in Franklin County. The TALS program has a goal of placing 10 individuals into a competitive job. As of March 2017, 5 individuals had been placed into a competitive job.

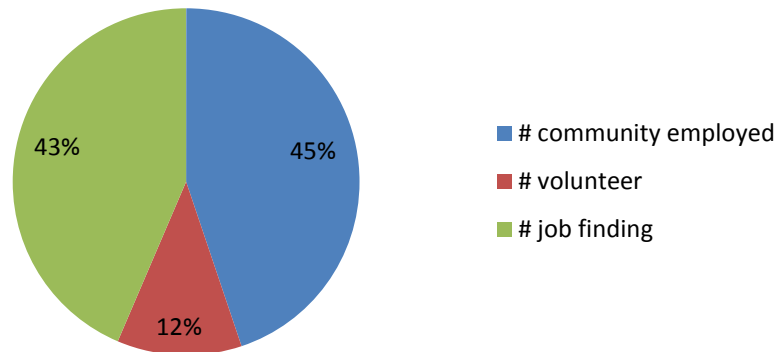
Supported Employment Services include direct and indirect services provided in a variety of community employment work sites with co-workers who do not have disabilities. Supported Employment Services provide work opportunities and support individuals in competitive jobs of their choice. Supported Employment Services enable individuals to receive paid employment at minimum wage or higher from their employer. Providers of Supported Employment Supports have outcomes of “placing individuals with intellectual disabilities in a competitive job.” Of the 22 people receiving base funded supported employment, 20 have competitive jobs.

Transitional Work Services support individuals transitioning to integrated, competitive employment through work that occurs at a location other than a facility subject to 55 Pa. Code Chapter 2380 or Chapter 2390 regulations. Transitional work service options include mobile work force, work station in industry, affirmative industry, and enclave. Franklin/ Fulton County currently serves all individuals using Transitional Work Services in the Waiver. There are currently 57 individuals in the Transitional Work Program. All these individuals are waiver funded. With the waiver renewals, this service will change to “small group employment.” Individuals must be paid at least minimum wage. Therefore, people who are currently enrolled in transitional work will switch to pre-vocational services completing the same pre-employment functions until the small group employment service is created by providers.

The ID department is concentrating on Community Employment which includes supported employment and transitional work for the Quality Management Goal and logic model (see Appendix E). The outcome for the Quality Management Plan/ logic model is *“people who choose to work are employed in the community.”* As of April 1, 2017, there were 101 Franklin County residents in community employment. Franklin County’s QM/logic model objective is to increase by 5% the number of people who want to work to achieve community employment by June 30, 2017. The percentage of individuals working in the community is currently 45% (108/241). This is a decrease in the percentage of people who are community employed. The Intellectual Disability Program’s QM plan will be measuring the number of new people in Competitive Integrated Employment as defined by the

Department of Labor in the upcoming 2017-2019 QM year. This also aligns with the Office of Developmental Program's Quality initiative as set by the ISAC.

## Employment



The Franklin County ID Program started supporting a new program which began in June 2016. The Pathways Program is a time-limited program that teaches independent living skills and/or employment skills. The outcome of this program is for individuals to complete this curriculum in a 2 year period and live independently in their own apartment and/or have competitive employment at the end of the 2 years. There are currently 10 people enrolled in the first year of this program. The program is almost at capacity and has pending referrals for recent graduates.

During the summer of 2017, the ID Program will also fund a summer youth work program through Occupational Services, Inc. to provide paid work experience opportunities to 16 students who have learning disabilities or intellectual disabilities. The program will target students in Franklin County school districts who do not have the opportunity for extended school year, transition activities or paid work during the summer months. This will be the last year for this program as OVR is operating a Pre-employment Transition Service (PETS). Franklin County ID Program will encourage students to attend this program as appropriate. The Franklin/Fulton ID Program participates in the Transition Council with OVR, the School Districts, and providers to promote and support the Employment First Model.

### **Supports Coordination:**

- *Describe how the county will assist the supports coordination organization to engage individuals and families in a conversation to explore natural support available to anyone in the community.*
- *Describe how the county will assist supports coordinators to effectively plan for individuals on the waiting list.*
- *Describe how the county will assist the supports coordination organizations to develop ISPs that maximize community integration and Community Integrated Employment.*

Base Funded Supports Coordination includes home and community based case management for individuals in nursing facilities, MA eligible individuals who are admitted for psychiatric hospitalization and in community residential settings. These services are only paid for individuals who have had a

denial of Medical Assistance Coverage. There are 47 people who have base funded Supports Coordination. There are 9 people who have the OBRA Waiver and have base funded Supports Coordination. There are 6 people who reside in an ICF/ID or State Center and receive base funded Supports Coordination. Currently no one is leaving a State Hospital system from Franklin or Fulton Counties, so transition services are not needed at this time. The program has MA denials for people who are receiving base services over \$8000.

The ID Program collaborates with the Supports Coordination Organization (SCO) by holding monthly meetings with Supports Coordination Supervisors. During these meetings, individuals who are deemed high profile or have Emergency PUNS are discussed regarding natural supports and what supports are necessary for that person. Any individual can be added to this list. At these meetings, PUNS, ISPs, Physicals, Levels of Care and other items are part of the standing agenda discussed monthly. The SCO is also represented on the Transitional Council and is encouraged to participate in SELN trainings to promote community integrated employment. The ID Program collaborates and participates in training with the Office of Vocational Rehabilitation on implementation of WIOA. The ID Program developed an OVR referral process to streamline, track, and facilitate in accessing OVR services.

***Lifesharing Options:***

- *Describe how the county will support the growth of Lifesharing as an option.*
- *What are the barriers to the growth of Lifesharing in your county?*
- *What have you found to be successful in expanding Lifesharing in your county despite the barriers?*
- *How can ODP be of assistance to you in expanding and growing Lifesharing as an option in your county?*

According to 55 Pa. Code Chapter 6500: "Family Living Homes are somewhat different than other licensed homes as these settings provide for life sharing arrangements. Individuals live in a host life sharing home and are encouraged to become contributing members of the host life sharing unit. The host life sharing arrangement is chosen by the individual, his or her family and team and with the life sharing host and Family Living Provider Agency in accordance with the individual's needs. Licensed Family Living Homes are limited to homes in which one or two individuals with an intellectual disability who are not family members or relatives of the life sharing host reside." Satisfaction surveys have shown that people in life sharing living arrangements are more satisfied with their life. This, along with the QM plan/ Logic Model that people choose where they wish to live, has driven the objective for Life Sharing, "to increase the number of people in life sharing."

The Franklin/Fulton County Intellectual Disabilities Program will support the growth of life sharing in the following ways:

- The Administrative Entity (AE) and SCO will continue to work on providing information to individuals and families on the values and benefits of Life Sharing and correcting the "stigma" that it is "adult foster care. We will continue helping families understand that Life Sharing is a supportive, sharing and mentoring environment that enhances the natural supports of the family.
- The AE has encouraged local Life Sharing providers to develop new licensed homes to be used for periodic and emergency respite situations that can be available when needed. This has helped to expedite emergency respite placements which, in turn, has developed into a

new life sharing connection.

- The AE will work with providers with the expansion of the Life Sharing service definition to include individuals living in their own home or a home of a relative and receive agency-managed life sharing services.

Life sharing is the first residential option offered to any person who needs a residential placement. This is documented in the Individual Support Plan. Currently, there are 37 people living in life sharing homes in Franklin County (Franklin/ Fulton QM/ logic model information). All 37 people have waiver funding to support the services they need in the life sharing home. The Intellectual Disability Program's Quality Management/ logic model outcome is "*people live where they choose.*" The QM objective is to increase the number of people in life sharing in Franklin/ Fulton Counties by 10% (n=44) by June 30, 2019.

Some of the barriers to growth in life sharing in Franklin/ Fulton County are the lack of families interested in life sharing. Another barrier is the complex needs of individuals that may be interested in life sharing. The final barrier is that caregivers that are life sharers are aging. As they age, their own needs increase and they cannot continue to provide the care required. While there are barriers to life sharing in Franklin/ Fulton Counties, there are also successes. Many of the people in life sharing have lived in their life sharing homes for 20+ years. One provider of life sharing actively recruits life sharing families successfully. Finally, Franklin/Fulton has been successful in moving people from CRR and Children Foster Care to life sharing when they age out of the children's system.

#### **Cross Systems Communications and Training:**

- *Describe how the county will use funding, whether it is block grant or base, to increase the capacity of your community providers to more fully support individuals with multiple needs.*
- *Describe how the county will support effective communication and collaboration with local school districts in order to engage individuals and families at an early age.*
- *Describe how the county will communicate and collaborate with local children and youth agencies, the Area Agency on Aging and the mental health system to ensure individuals and families are provided with the information they need to access needed community resources as well as formalized services and supports through ODP.*

The ID program collaborates with the following agencies to increase the support for individuals with multiple needs. The ID program staff attends Child and Adolescent Service System Program (CASSP) meetings to discuss the supports needed for individuals to be supported in their community and school. The ID staff also has a working relationship with Home Health Aid Providers to support individuals in the home and community. Lastly, the Managed Care Organization Specialized Needs Unit is available for individuals who meet their criteria.

The ID program also collaborates with the school districts by offering information sessions to both parents and teachers. The ID staff has attended IEPs when requested to help problem solve and/or to provide intake information. The Administrative Entity (AE) also is a member of the transition council and attends the Transition Fairs at all High Schools county-wide.

The ID program partners with Children and Youth through CASSP. There are also individual cases where C & Y and the ID Program are involved where communication between the two agencies resulted in the best outcome for the child while protecting the individual's rights.

The ID program collaborates with Franklin County Office of Aging through participation in the Aging/ ID Meetings as well as reviewing PASSAR packets. The ID staff also attends the Building Bridges Conference.

The Mental Health and Intellectual Disabilities program has a long history of communication and collaboration. ID collaborated with the Copeland Center for Wellness and Recovery and Mental Health to pilot WRAP® for People with Developmental Distinctions, which supports people with both a mental illness and Developmental Disability. WRAP® is a recovery oriented evidence-based model that is accepted internationally. Franklin/ Fulton County and Philadelphia are the pilot areas. The first group was held at OSI in 2013. The County is also on the committee that wrote the WRAP® for People with Developmental Distinctions curriculum in collaboration with The Copeland Center, OMHSAS, NASDDDS and ODP. This curriculum is the next step for WRAP® for People with Developmental Distinction to become evidenced-based. The County has supported WRAP® efforts to explain this new program at conferences and trainings. WRAP® groups were held throughout the year. (See Mental Health Section.)

The ID program also presents the module on Intellectual Disabilities in the Crisis Intervention Team Curriculum. This curriculum helps police officers, MH professionals and first responders respond to someone with a disability in the course of their professions.

The ID program continues to collaborate with Tuscarora Managed Care Alliance and PerformCare to develop policy and procedures for people who have a dual diagnosis.

The Quality Management Plan/ Logic Model also includes an outcome to “*collaborate and implement promising practices to assist people in achieving outcomes.*” The objective for the 2015-2017 QM Plan/ logic model was to identify individuals who have a dual diagnosis and/or a Behavior Support Plan, then develop a toolkit for them to assist in recovery and achieve their outcomes. In 2015, the baseline data was gathered and the toolkit started. The toolkit was developed and is available for use for those teams that would like to use it. This outcome was met and will be discontinued in the next QM plan.

**Emergency Supports:**

- *Describe how individuals in an emergency situation will be supported in the community (regardless of availability of county funding or waiver capacity).*
- *Provide details on your county’s emergency response plan including:*
  - *Does your county reserve any base or block grant funds to meet emergency needs?*
  - *What is your county’s emergency plan in the event an individual needs emergency services, residential or otherwise, whether within or outside of normal working hours?*
  - *Does your county provide mobile crisis?*
  - *If your county does provide mobile crisis, have the staff been trained to work with individuals who have an ID and/or Autism diagnosis?*
  - *What is the composition of your mobile crisis team?*
  - *Do staff who work as part of the mobile crisis team have a background in ID and/or Autism?*
  - *Is there training available for staff who are part of the mobile crisis team?*
  - *If your county does not have a mobile crisis team, what is your plan to create one within your county’s infrastructure?*

- *Please submit the county 24-hour Emergency Response Plan as required under the Mental Health and Intellectual Disabilities Act of 1966.*

If waiver capacity is unavailable, individuals will be supported out of funds in the Block Grant. Base money will be provided to graduates for day programs and transportation to maintain their residence at home, so their parents can maintain their employment status. The ID Independent Apartment Program has 11 people living in their own apartments with less than 30 hours of support per week. Base funds are used to subsidize the rent. The Franklin County ID department will increase the availability for combinations of Family Aide, Day Programs, Transportation, Adaptive Equipment, Home modifications and Respite so that individuals can continue to live at home instead of residential programs which are more costly.

The AE has a Risk Management Committee that meets quarterly to discuss incident management and any items that may arise to become a future emergency.

Franklin County responds to emergencies outside of normal work hours in Procedure Statement ID-2014-505 Incident Management. In this procedure statement, all Program Specialists are listed as well as the MH/ID/EI Administrator with their cell phone numbers. These contacts can be used after hours for any emergency. All providers have been trained in the policy. The Incident Management Program Specialist checks the HCSIS database on a daily basis to assure that all the incidents provide for the health and safety of the individuals served. This includes weekends and holidays. Franklin County reserves base respite funds to authorize respite services as needed in an emergency and works with providers and the Supports Coordination Organization to set up these services, whether during normal business hours or after. These services may become Emergency Life sharing or Emergency Residential while the person is in respite. This provides for the safety of the person and finds a long term solution.

The MH/ID Department's mission-essential functions are those critical processes the department must maintain, during the response and recovery phases of an emergency, to continue to serve its constituents. The department's mission-essential functions must be able to be executed within 12 hours of a major emergency and be sustainable for up to 30 days during the recovery phase of the emergency.

The Intellectual Disabilities Program utilizes the current contract with Keystone Behavioral Health for Crisis Services. The Crisis Department is operated 24 hrs. per day, 7 days per week for 365 days. One aspect of this contracted service is Mobile Crisis. Mobile Crisis is available in Franklin County. Any of the Crisis workers can provide mobile crisis. Some of the crisis workers do have a background in working with individuals with Autism and/or Intellectual Disabilities. They do have some trained staff; training is available for any staff as requested. As with the other Crisis Services Offered, when an individual with an Intellectual Disability or Autism utilizes crisis services, the crisis staff will notify either the Supports Coordinator or the AE if the person is not registered with the ID program. A program is being piloted in Franklin



County to utilize a co-responder for individuals with MH or ID. Please see Mental Health Section for details.

The County 24-hour Emergency Response Plan, as required under the Mental Health and Intellectual Disabilities Act of 1966, is on file, but will be provided if requested due to the personal phone numbers published in it.

**Administrative Funding:** *ODP has engaged the PA Family Network to provide support and training in the community. The PA Family Network will be providing individuals who are person centered thinking trainers.*

- *Describe how the county will utilize the trainers with individuals, families, providers, and county staff.*
- *Describe other strategies you will utilize at the local level to provide discovery and navigation (information, education, skill building) and connecting and networking (peer support) for individuals and families.*
- *What kinds of support do you need from ODP to accomplish the above?*
- *Describe how the county will engage with the Health Care Quality Units (HCQU) to improve the quality of life for the individuals in your community.*
- *Describe how the county will use the data generated by the HCQU as part of the Quality Management Plan process.*
- *Describe how the county will engage the local Independent Monitoring for Quality (IM4Q) Program to improve the quality of life for individuals in your program.*
- *Describe how the county will use the data generated by the IM4Q process as part of your Quality Management Plan.*
- *Are there ways that ODP can partner with you to utilize data more fully?*
- *Describe how the county will support local providers to increase their competency and capacity to support individuals who present with higher levels of need related to: aging, physical health, behavioral health, communication, etc.*
- *How can ODP assist the county's support efforts of local providers?*
- *Describe what Risk Management approaches your county will utilize to ensure a high-quality of life for individuals.*
- *Describe how the county will interact with individuals, families, providers, advocates and the community at large in relation to risk management activities.*
- *How can ODP assist the county in interacting with stakeholders in relation to risk management activities?*
- *Describe how you will utilize the county housing coordinator for people with an intellectual disability.*
- *Describe how the county will engage providers of service in the development of an Emergency Preparedness Plan.*

Franklin/ Fulton ID program is a Regional Collaborative for the Community of Practice. As part of the Community of Practice, the PA Family Network is part of our Stakeholder Group. In collaboration with the PA Family Network, the Franklin/ Fulton County Collaborative will host events and parent seminars to present the Life Course Planning Tools. The Stakeholder group is meeting on a monthly basis and has hosted two different kinds of events. The PA Family Network and ID

Program attended the Early Childhood Learning Expo and had five families express interest in more information. They also collaborated to provide a family session to a family support group. The ID program will continue to collaborate with the PA Family Network and the Stakeholder Group to provide more family sessions. The Stakeholder group also wants to reach providers of Human Services to work with individuals who are not registered with the county. As a result, Nancy Richey and the PA Family Network will be presenting at the Human Service Training Days in October as the Keynote on the Community of Practice and a break out session on the tools.

The ID program uses the vast experience of the HCQU. Monthly trainings by the HCQU are held in Franklin County. They also provide individualized training that is requested by providers and families. The AE attends the Positive Practices Committee Meetings as well as Regional HCQU meetings. The HCQU is represented at our provider meetings and sits on both the Risk Management Committee and the QI Council. As a result of this collaboration, a Medication Error Task Force has been convened in Franklin/Fulton Counties. This is an outcome and objective in both the Logic model and QM Plan. The HCQU provides training to individuals, provider homes, staff or individuals depending on the trends found while analyzing the data. This supports the outcome *to assure the health and safety of individuals receiving services, Franklin/ Fulton Intellectual Disabilities Program will use the objective of reducing the number of medication errors by 10% by June 30, 2017*. The baseline data is 270 medication errors from July 2013- April 2015. As of March 31, 2017, there are 291 medication errors this 2015-2017 QM year. This is not a decrease and this outcome will continue with the Medication Error Task Force taking the lead. The Med Error Task Force has nurses from all residential providers on the committee as well as HCQU nurses. They evaluate the Medication Administration processes at each provider and brainstorm ways together to solve the problems that they have with medication errors. The Task Force has not been in existence long enough to note if these changes are effective.

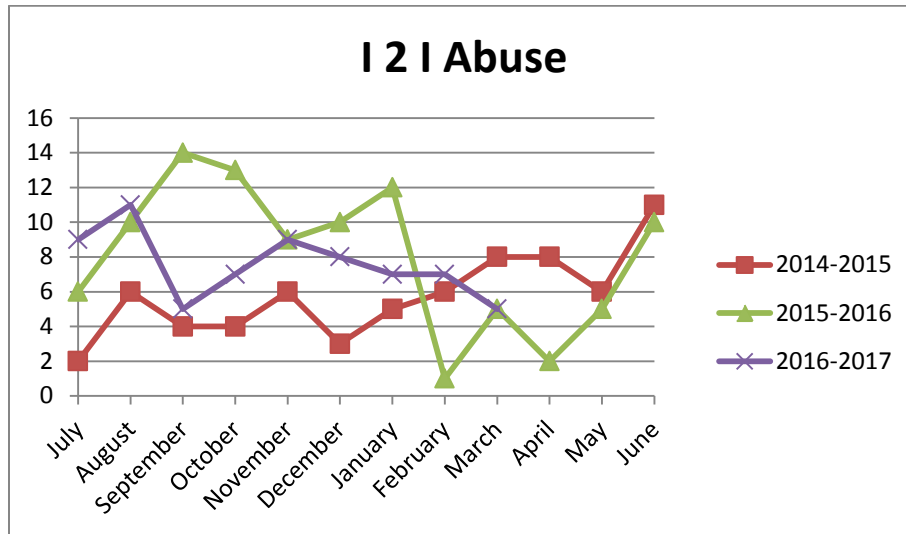
As with the HCQU, a representative for the IM4Q local program sits on the QI Council. As a result of the IM4Q data, the local program realized that people did not know what to do in an Emergency even though they had a backup plan in their ISP. So, the QI Council recommended that a one page "What to do in an Emergency" form be developed. This has turned into a folder with different Emergency Preparedness information in it. This folder is given to individuals when reviewing what to do in an emergency or at ISPs when questions are raised. The QI Council also reviews Employment and Life sharing IM4Q data to determine satisfaction with services. Both of these Outcomes are included in the QM Plan and Logic Model. The biggest barrier to reviewing IM4Q data is that the reports are not current. As a result, there is a lag in developing QM outcomes and objectives.

The ID program supports local providers by encouraging them to develop a relationship with the HCQU for trainings needed for their staff to support individuals with higher levels of need. The HCQU can also do biographical timelines, CDCs, medication/pharmacy reviews and provide training. The AE continues to support providers in developing relationships with the local hospital. As previously mentioned, the MH/ID Coordination Meetings help to support providers also.

Franklin/ Fulton County ID Program has collaborated with the HCQU to provide training to individuals. These trainings are held monthly and are on various topics such as Summer Safety, Hygiene, How To Make A Friend, etc.

The Risk Management Committee holds quarterly meetings to assess incidents to establish a higher quality of life for individuals. The Risk Management Committee realized that Individual to Individual (I-2-I) abuse was an issue that needed addressed. The logic model and QM Plan both address the I-2-I

abuse issue. The outcome, “*People are abuse free,*” is measured by the objective of reducing the number of I-2-I abuse incidents by 5%. The number of incidents of I-2-I abuse will be measured through quarterly analysis of the HCSIS Incident Data and the target trends to prevent future incidents will be analyzed by the Risk Management Team. The baseline data is 115 incidents of I-2-I abuse for 2013-2015. As of March 31, 2017, there were 165 incidents of I-2-I abuse. The Risk Management Committee has found several trends over this year as evidenced by the peaks in the graph and worked to resolve these situations. Several of the trends were resolved by making residential moves as the target and victim were always the same. Some of the trends required Behavior Support Plans to be modified or training for the individual or direct support staff. The Risk Management Committee will continue to monitor the data for trends.



The ID Program partners with the County Housing Program to provide an Independent Living Apartment Program. The people living in these apartments need less than 30 hours of support a week and the county helps subsidize the rent with base funds. There are currently 11 people in this program.

The County engages providers of service by ensuring that all ISPs have emergency plans included. As stated in the IM4Q paragraph, the county has developed Emergency Preparedness Folders for people who request them. A total of 13 folders were given out to individuals and their families over the last year. Folders will continue to be updated and given to individuals and their families.

**Participant Directed Services (PDS):**

- Describe how your county will promote PDS services.
- Describe the barriers and challenges to increasing the use of Agency with Choice.
- Describe the barriers and challenges to increasing the use of VF/EA.
- Describe how the county will support the provision of training to individuals and families.
- Are there ways that ODP can assist you in promoting/increasing PDS services?

Franklin/ Fulton Counties have no individuals or families using VF/EA. When the VF/EA is explained to families, they choose Agency with Choice (AWC) instead. Franklin County has 34 families using AWC supports. All of their supports and services are paid with waiver funding. The county coordinates trainings for families through the Arc of Franklin/ Fulton Counties (the AWC provider) and the HCQU.

The major challenge for AWC is that families have trouble finding staff especially in the rural areas of the county. This is due to the low wage, lack of transportation and/ or locations far from any services, to name a few. Another challenge is that families have a lack of knowledge of the ID system and the service definitions. And finally, families get frustrated at the amount of documentation required of them. ODP assistance could be used to find creative ways to address these issues and to provider trainings to families.

**Community for All:** *ODP has provided you with the data regarding the number of individuals receiving services in congregate settings.*

- *Describe how the county will enable these individuals to return to the community.*

Franklin County has 13 individuals in congregate settings. Two of these individuals are in Private ICF/ID. Both of the individuals have medical needs too complex to be supported by current providers in the local community. Two of the people at State Centers could leave and go to a Nursing Home but are happy where they currently reside. The remaining person at a State Center is offered community placement annually and chooses to stay at the State Center. One person in the nursing home expresses the wish to return to the community and is too young for the nursing home. She repeatedly refuses placements that are offered for various reasons. The remaining seven individuals reside in nursing homes. This is a generic support for them due to their need for a nursing home level of care.

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## **HOMELESS ASSISTANCE SERVICES**

*Describe the continuum of services to individuals and families within the county who are experiencing homelessness or facing eviction by answering each question below. An individual or family is facing eviction if they have received either written or verbal notification from the landlord that they will lose their housing unless some type of payment is received. Include achievements and improvements in services to families experiencing or at risk for homelessness, as well as unmet needs and gaps.*

### **Bridge Housing:**

- *Please describe the Bridge Housing services offered. Include achievements and improvements in services to families experiencing or at risk for homelessness, as well as unmet needs and gaps.*
- *How does the county evaluate the efficacy of Bridge Housing services?*
- *Please describe any proposed changes to Bridge Housing services for FY 17-18.*
- *If Bridge Housing services are not offered, please provide an explanation of why services are not offered.*

Due to limited funds, Franklin County has not expanded into bridge housing support.

### **Case Management:**

- *Please describe the Case Management services offered. Include achievements and improvements in services to families experiencing or at risk for homelessness, as well as unmet needs and gaps.*

- *How does the county evaluate the efficacy of Case Management services?*
- *Please describe any proposed changes to Case Management services for FY 17-18.*
- *If Case Management services are not offered, please provide an explanation of why services are not offered.*

Every Rental Assistance applicant will be part of HAP Case Management. A service plan will be established with and signed by each applicant that will include referrals to address factors that led to the housing crisis in addition to other factors that may have contributed to the problem. Specifically, case management will be available through referrals with regard to budgeting, parenting, hygiene, sanitary housekeeping, accessing resources, and life skills with a goal of working towards self-sufficiency. Individuals that consistently do not participate in the service plan may transition out of the program and become ineligible for the program for a period of up to two years. In this event the efforts will be made to refer the individual to other programs for alternative shelter assistance.

The SCCAP HAP Program Coordinator will be responsible for completing all intakes and assessments for Franklin County Homeless Assistance Program. This process will include assessment of other needs, especially those that brought the family to a housing crisis.

Case management services/activities offered by SCCAP, as defined by the HAP Guidelines, may include but are not limited to the following:

- Intake and assessments (service plan) for individuals who are in need of supportive services and who need assistance in accessing the service system.
- Assessing service needs and eligibility and discussion with the individual of available and acceptable service options.
- Referring individual to appropriate agencies for needed services.
- Providing referrals to direct services such as budgeting, life skill training, job preparation, etc.
- Providing advocacy, when needed, to ensure the satisfactory delivery of requested services.
- Protecting the individual's confidentiality.

The SCCAP HAP Program Coordinator will refer the individual to appropriate agencies/resources as needed for services such as linkages to income supports, parenting skills, life skills, budgeting, hygiene, feeding, making appointments, priority setting, maintaining records, literacy training, adult basic education, etc. The case manager will establish linkages with the Housing Authority and other local housing programs for low-income housing and the County Assistance Office. Specifically, the HAP Program Coordinator will assure that individuals who are eligible have accessed Emergency Shelter Assistance through the Title IV-A program at the CAO so long as the ESA program exists. The SCCAP HAP case manager will discuss with the individual any service needs and options.

Confidentiality of the individual will be protected, and all reasonable efforts will be made to coordinate service delivery and to avoid duplication of services. Therefore, Releases of Information will be required so that all other agencies offering housing services can be contacted to cross reference whether the family is receiving services elsewhere and to ensure coordination of services.

After the individual has been approved, we will complete a payment agreement between the individual, landlord and us. We will then complete a goal plan specific for the individual needs.

Individuals will be informed in writing by SCCAP, Inc. of the right to appeal if service is denied to them as set forth per the HAP guidelines. The following will be provided in writing to any individual who is denied or terminated from service:

- the action being taken;
- the reason for the action;
- the effective date of the action and
- the availability of an appeal process at the County and State level.

Written appeal may be made to the County of Franklin. The individual will be informed in writing of the result of the appeal. Further appeals will follow the guidelines as set forth by HAP which states that after exhausting the first level of appeal at the County, an individual may appeal to DHS to the Office of Hearings and Appeals.

All individuals will be informed of the appeal process at the point when they sign their service plan. The appeal plan will be spelled out on a least one document which the individual will sign.

Some notable successes for Case Management has been the intentional referral to Support Circles for all HAP clients. That has allowed both families from the shelter and families applying for rental assistance to be enrolled in a long-term program that will support the family on their journey out of poverty. While not a requirement, we have seen several families take advantage of this opportunity and they are receiving ongoing appropriate support.

As we have evaluated the results of this program and the recidivism of families returning for help, we are also opening our case management opportunities to families after they receive help and promoting that as an ongoing opportunity so families can come back to talk through options before they are in another crisis.

Another addition to this component for SCCAP is Rapid Rehousing through HUD and ESG funding. This allows us the opportunity to identify the appropriate program for the individual. SCCAP can now work with families before they become homeless through HAP dollars, if they are currently homeless through our Emergency Shelter to get them off the streets and then through HAP or Rapid Rehousing to help them get into safe affordable housing and then on an ongoing basis through Case Management or Support Circles. We feel the addition of these services along with the coordination of internal and external supports provides a much better continuum of care for families.

Of notable success are two additional partnerships created this year. HAP is currently working with individuals referred through the Veterans program and the Franklin Together Re-entry Coalition. Both of those county collaborative groups have a host of supports which assist the individual in having a better opportunity of long term success.

SCCAP has also added, in coordination with Franklin County Government, a Recovery Specialist who can assist us in working with individuals dealing with alcohol or drug addiction. While SCCAP has many of the social supports for families, we have not traditionally had supports directed specifically at addictions.

Unmet needs for this program include a longer term money management program. SCCAP does not currently administer a Money Management Program. In assessing current programs in the community, we have a few organizations that offer financial services but most of those are geared toward individuals not in crisis. The ones offered for low income families are only budgeting sessions

(one time – teach you to budget class) and we do that in our Case Management with all HAP clients. What we have seen be successful in the past were programs that met weekly for 6 – 12 weeks and helped individuals reassess their values and perceptions of money – planning for a way to stabilize their situation and then seeing what could happen if that was accomplished. There was a program like this in the past that had significant success but funding for the program was lost. We continue to look for ways to create or identify a resource similar to this.

The most common reasons we are unable to help individuals is due to individuals being over the income limit or not being a resident of Franklin County for 6 months. We also receive many calls about people wanting us to help before they have an eviction notice. Individuals are reaching out to receive help to prevent an eviction notice. If we are not able to help, there are not many other organizations in the community that are able to provide support. Many organizations have the same regulations; at times local churches can assist and we make those referrals as appropriate.

Franklin County staff completes an annual onsite monitoring visit to evaluate case management services to ensure that all program requirements are being met. This process includes an evaluation of fiscal and program requirements along with individual file chart reviews.

**Rental Assistance:**

- *Please describe the Rental Assistance services offered. Include achievements and improvements in services to families experiencing or at risk for homelessness, as well as unmet needs and gaps*
- *How does the county evaluate the efficacy of Rental Assistance services?*
- *Please describe any proposed changes to Rental Assistance services for FY 17-18.*
- *If Rental Assistance services are not offered, please provide an explanation of why services are not offered.*

HAP's Rental Assistance program is for rent and security deposits for eligible low-income applicants who are homeless or near homeless as defined below:

Individuals or families are homeless if they:

- Are residing in a group shelter; domestic violence shelter; hotel or motel paid for with public or charitable funds; a mental health; drug, or alcohol facility; jail; or hospital with no place to reside; or living in a home, but due to domestic violence; needs a safe place to reside;
- Have received a verification that they are facing foster care placement of their children solely because of lack of adequate housing, or need housing to allow reunification with children who are in foster care placement;
- Are living in a “doubled-up” arrangement for six months or less on a temporary basis;
- Are living in a condemned building;
- Are living in housing in which the physical plant presents life and /or health threatening conditions; e.g. having dangerous structural defects or lacking plumbing, heat, or utilities; or
- Are living on the streets, in cars, doorways, etc.

Individuals and families are **near homeless** if they;

- Are facing eviction (having received either written or verbal notification from the landlord that they will lose their housing unless some type of payment is received. Verbal notification must be followed up with written documentation). Actual Eviction notice is required in the file.

Individuals served by the HAP program must have been a resident of Franklin County for 6 months prior to applying for assistance.

Priority for Rental Assistance will be given to Franklin County applicants who can demonstrate that they will be able to become self-sufficient within three (3) months with regard to housing. Applicants are to engage with case management services and individuals will be required to sign a service plan showing areas of responsibility between the case manager and the individual.

Individuals served by the HAP Rental Assistance Program will fall into one or more of the following categories:

- Franklin County families with children who are homeless or near homeless.
- Persons fleeing domestic violence.
- Individuals who have fallen on hard times who need temporary assistance to get back on their feet.

To receive financial assistance, the individual or family must be at or below 150% poverty. Referrals to other agencies that can provide needed services will be made available to those who do not meet the income guidelines as appropriate. Income requirements will be waived for persons fleeing domestic violence and for those who are experiencing a housing crisis due to a disaster such as fire or flood (upon State approval by the State HAP Manager as stated in the guidelines).

In cases where extenuating circumstances have been identified and a county based eligibility requirement is less than the States' HAP guidelines (e.g. income eligibility of 150% of FPIG is a county guideline and is less than the HAP guideline of up to 200% of FPIG, or the 6 month county residency requirement which is a county determined regulation) the HAP Program Coordinator may request a waiver from SCCAP's Executive Director or their designee to allow services to be provided to an otherwise eligible family or individual. The Executive Director or their designee may approve services, but under no circumstances can services be provided that violate the State Eligibility Criteria for the HAP Program. In instances where a waiver was granted, a note must be added to the file with the reason for the waiver and who approved the waiver.

The amount of Rental Assistance allocated will be determined by the facts of the case and the creation of a service plan for each household addressing the conditions which precipitated the housing crisis and addressing the acquisition of permanent housing including the schedule for disbursement of rental assistance funds. The service plan is signed and placed within the individual's file. The service plan will address other services needed and referrals made. In all cases the goal for the family will be to acquire stability and permanent, affordable housing. The household must demonstrate through the service plan and their actions that they have the ability to become self-sufficient and a commitment to work toward that goal. All service plans will include an agreement to cooperate with the HAP Program Coordinator/Case Manager. Individuals that consistently do not



participate in the service plan may be transitioned out of the program and ineligible for assistance for up to two years.

Applicants will be expected to contribute financially towards the housing plan as determined by their individual service plan. The individual or family must have anticipated income sufficient to pay the rent in the future. Whenever possible and practical, payment plans will be established whereby the applicant retains part of the responsibility for current or back rent or utility payments.

The maximum assistance available in a 24-month period is \$1,500 for families with children, and \$1,000 for adult only households. In most instances, households will not receive the maximum amount of assistance, but only the amount determined appropriate as stated in their service plan. Assistance given by Emergency Shelter Assistance (ESA) or Emergency Food and Shelter Program (EFSP) will be included in the maximum allowed per household, as per DHS.

Applicants will be required to exhaust all other resources available through the County Assistance Office (CAO) or other local resources before being considered for HAP Rental Assistance. This includes but is not limited to Emergency Shelter Assistance (ESA), Low Income Home Energy Assistance Program (LIHEAP), fuel assistance, utility assistance, etc. Applicants who may be eligible for Title IV-A Emergency Shelter Assistance must apply at the County Assistance Office, and receive a determination from the CAO before HAP can be considered. Families with a child under 21 whose income is below 80% of poverty will be referred for ESA before Rental Assistance is utilized. This requirement will end if the ESA program is discontinued.

Individuals or families must have an agreement with the landlord to rent to them before financial assistance will be given. Written agreements must be confirmed by the HAP Case Manager before funds can be released.

Special services may be available in extreme hardship cases to provide services and/or items necessary to obtain or retain permanent housing or to achieve self-sufficiency. Applicants who receive Housing Vouchers/Section 8 or who live in subsidized housing will receive the same consideration as all other applicants. Circumstances that led to a housing crisis will be considered as will the applicant's ability to pay future rent.

Franklin County staff completes an annual onsite monitoring visit to evaluate case management services to ensure that all program requirements are being met. This process includes an evaluation of fiscal and program requirements along with individual file chart reviews.

Another addition to this component for SCCAP is Rapid Rehousing through HUD and ESG funding. SCCAP's emergency shelter had attempted rental assistance in the past with limited success. With the implementation of the longer term supports of Rapid Rehousing, we have found we are better able to help families find and maintain housing. While a relatively new program, this addition is strengthening our continuity for families. This allows us the opportunity to identify the appropriate program for the individual. SCCAP can now work with families before they become homeless through HAP dollars, if they are currently homeless through our Emergency Shelter to get them off the streets, and then through HAP or Rapid Rehousing to help them get into safe affordable housing and then on an ongoing basis through Case Management or Support Circles. We feel the addition of these services along with the coordination of internal and external supports provides a much better continuum of care for families.

SCCAP has also added, in coordination with Franklin County Government, a Recovery Specialist who can assist us in working with individuals dealing with alcohol or drug addiction. While SCCAP has many of the social supports for families, we have not traditionally had supports directed specifically at addictions. We believe these supports will help families stabilize and maintain long-term, safe, affordable housing!

**Emergency Shelter:**

- *Please describe the Emergency Shelter services offered. Include achievements and improvements in services to families experiencing or at risk for homelessness, as well as unmet needs and gaps*
- *How does the county evaluate the efficacy of Emergency Shelter services?*
- *Please describe any proposed changes to Emergency Shelter services for FY 17-18.*
- *If Emergency Shelter services are not offered, please provide an explanation of why services are not offered.*

Emergency Shelter is provided to families who are currently homeless. Basic needs (shelter and food) are provided in conjunction with intensive case management and effective referrals.

This program is evaluated on a number of factors:

- Did the individual increase their income?
- Did the individual obtain needed supportive services (mental health, job training, physical health needs, etc.)?
- Did the individual achieve safe affordable housing?

The Franklin County Shelter for the Homeless is located centrally at 223 South Main Street in Chambersburg, PA. The Shelter provides 10 bedrooms, two of which are family rooms, with the capacity to house up to 18 individuals at one time. The Franklin County Shelter for the Homeless is the last safety net for the residents who may find themselves without a place to live. One of its major goals is to move homeless residents back into permanent housing and toward self-sufficiency. In order to accomplish this, the Shelter staff provides case management activities, setting goals with the residents to be accomplished during and after their stay, and cooperates with other agencies within the County to direct residents to the available resources that will help them achieve their established goals. Individuals also participate in a basic life skills program.

In order to become an individual at the Franklin County Shelter for the Homeless, an individual/family must be legally homeless. If legally homeless, the potential individual completes an Application for Assistance and Assessment package, which includes a self-declaration of homelessness. Upon completion of an intake, the individual/family works with the staff to identify his/her/their particular causes for homelessness. Once the causes have been identified, the individual/family, in coordination with the staff, develops a plan of action including specific goals to be achieved during their stay at the Shelter. Long term goals that lead to the attainment of stable housing are also set. The caseworker assesses the individual's work history, medical history, and educational background. This information becomes a permanent part of the individual's file. The staff identifies the individual's family needs such as nutritional education, parenting classes, and drug/alcohol treatment services. Using this information, staff, under supervision from the Program Coordinator, acquire the necessary information or services to address that particular individual/family's needs.

Homeless Assistance Program funds are needed to support the daily operational costs of the Franklin County Shelter for the Homeless as it tries to adapt to the steady increase in homeless needs and

extensive supportive services. The shelter staff is finding that an increasing number of homeless individuals need more than 30 days of emergency shelter due to the lack of employment opportunities.

Franklin County staff completes an annual onsite monitoring visit to evaluate case management services to ensure that all program requirements are being met. This process includes an evaluation of fiscal and program requirements along with individual file chart reviews.

**Other Housing Supports:**

- *Please describe the Other Housing Supports services offered. Include achievements and improvements in services to families experiencing or at risk for homelessness, as well as unmet needs and gaps*
- *How does the county evaluate the efficacy of Other Housing Supports services?*
- *Please describe any proposed changes to Other Housing Supports services for FY 2017-2018.*
- *If Other Housing Supports services are not offered, please provide an explanation of why services are not offered.*

Franklin County has not used HAP funding for other housing support services. Independent living and forensic apartments are available through other funding sources.

**Homeless Management Information Systems:**

- *Describe the current status of the county's Homeless Management Information System (HMIS) implementation. Does the Homeless Assistance provider enter data into HMIS?*

Franklin County has actively participated in HMIS. The Emergency Solutions Grant, HUD Permanent Supportive Housing Programs, PATH and one Shelter Plus Care Program through Franklin County are currently entering data into the PA-HMIS. Intake forms are organized to capture the information that needs to be entered into the PA-HMIS system. The goal is to have individuals entered in to PA-HMIS immediately following enrollment in the housing programs. Multiple staff members are familiar with entering data into the system as well as running reports.

**SUBSTANCE USE DISORDER SERVICES** (Limit of 10 pages for entire section)

*This section should describe the entire substance use disorder service system available to all county residents that is provided through all funding sources, including state allocations, county funds, federal grants, HealthChoices, reinvestment funds, etc.*

Franklin/Fulton Drug & Alcohol (FFDA) ensures that all Franklin County residents are able to access and receive any drug/alcohol related service needed at any point in time of its request and/or need. FFDA ensures that the full continuum of substance use services (Prevention, Intervention, Treatment and Recovery) are available and easy to access and utilizes a comprehensive strategic planning process to assess, develop, enhance and expand any additional services that are needed. FFDA provides funding for all levels of care for substance use treatment. These levels include detoxification, rehabilitation, Medication Assisted Treatment (MAT), halfway housing, partial hospitalization, intensive outpatient, outpatient, and early intervention services for Franklin and Fulton county

residents. FFDA also provides case management services and oversight of medication assisted treatment.

1. Waiting list information (time frames, number of individuals, etc.) for:

- Detoxification services: In FY16/17, average wait for a detox bed in or out of county was 2-3 days from the time of the request and regardless of current environment of the individual. The majority of primary substances for detox placement were opioids (prescription and illicit) and alcohol.
- Non-hospital rehabilitation services: In FY 16/17, average wait for a short-term rehab bed was 0-1 days from the time of the request across all provider networks (in/out of Franklin County); however, average wait for a long-term rehab bed was 2-3 weeks from the time of the request, across all provider networks (in/out of Franklin County). There were a total of 6 individuals that received a long-term rehab bed within 1-2 days due to someone at the provider facility leaving against medical advice.
- Medication Assisted treatment: In FY16/17, FFDA contracted with one methadone provider (closest in geographical proximity) as there aren't any methadone providers within Franklin County. There are a total of four Buprenorphine prescribing physicians (4 provider systems) within the county, one of whom just obtained the waiver and is limited to 30 patients. This physician provides women's OB/GYN services and has allocated patients slots for pregnant women and women of childbearing age, as this is a priority population, but also an increasing population in need of MAT services within the county. There are a total of 3 prescribing physicians of oral naltrexone (Vivitrol) in the county with limited physician time. Same day/same week access hasn't been obtainable. This is extremely important for individuals stepping down from a high level of care/secure environment (rehab, incarceration, psychiatric placement, etc.) where they received Vivitrol to be able to engage in a community-based delivered process. FFDA has partnered with a mobile Vivitrol provider to assist in reducing this barrier.
- Halfway House Services: In FY16/17, there was no indication of any wait to access this level of care (whether entry was a step-down from a higher level of care or direct entry).
- Partial Hospitalization: In FY16/17, there was no indication of any wait to access this level of care (whether entry was a step-down from a higher level of care or direct entry).
- Outpatient: In FY16/17, there was no indication of any wait to access this level of care (whether entry was a step-down from a higher level of care or direct entry). One outpatient treatment provider that operates two (2) sites in the county offers same day intakes which has allowed individuals to get into outpatient services more quickly, but also allowed individuals waiting for a detox or inpatient bed to engage in treatment services until the bed became available.

2. Barriers to accessing any level of care.

An estimated 3,100 Franklin County residents will receive substance use assessments in FY 2017-2018. Level of care assessments are completed by contracted outpatient providers or FFDA Case Management staff. An estimated 289 adults/adolescents are projected to be funded for treatment services through the drug and alcohol program in Fiscal Year 2017-2018. Treatment services are inclusive of detoxification, short and long-term inpatient, halfway house, partial hospitalization, intensive outpatient and outpatient services. The primary barrier to accessing treatment services revolves around the need for detoxification and long-term inpatient treatment beds when the placement is needed. Current wait times to secure placement in these two levels of care produces barriers to getting individuals engaged in treatment when it's needed and when they're ready. This occurs state-wide with the capacity needs of detox and inpatient beds available. Treatment services occurring within the community, on an outpatient basis, do not encounter access issues as individuals are able to enter into these levels of care within 7 days of the request, with an average of 2-3 days of the request.

3. Narcan resources available in the county.

Intra-nasal naloxone is available to both professionals as well as the general community in Franklin County without a prescription due to the current standing order status in which the medication has been made available. Franklin/Fulton Drug & Alcohol provides overdose response/naloxone administration training, known as "Operation Save A Life" (OSAL) to anyone that wishes to attend, free of charge. Individuals that are residents of Franklin County are eligible to receive a free dose of intra-nasal naloxone upon completion of the OSAL training. Trainings occur monthly in various geographic areas within Franklin County for easy accessibility. Residents that wish to purchase the medication can do so at any Franklin County pharmacy, as 100% of them are carrying/dispensing the medication. Naloxone is also available and used by county first responders. Each of the six (6) law enforcement agencies in Franklin County are also carrying/administering intra-naloxone.

4. Resources developed to address the opioid epidemic such as warm hand-off protocols, use of CRS, 24/7 Case management services, use of toll free hotline, coordination with local emergency departments, police, EMS, etc.

Franklin County's warm hand off process is implemented in two out of the two hospital emergency room departments (Chambersburg Hospital and Waynesboro Hospital) in the county; however, each set of protocols as well as resources look different due to the lack of financial resources to support the process. FFDA is able to supply one full-time case management specialist to the Chambersburg Hospital to complete assessments, make appropriate level of care treatment placements and provide case management services to individuals entering through the Chambersburg ER onsite. Waynesboro Hospital utilizes FFDA to make referrals for a case manager or recovery support specialist (both current FFDA employees) to come onsite to provide assessments, placements and case management services. FFDA works collaboratively with both hospital systems to leverage resources and to

also offer these services to any individual that presents as needing substance use disorder treatment; however, overdose survivors are a prioritized population within this process. Franklin County will be entertaining ways to extend the warm hand off process to EMS/first responders through the county's Overdose Task Force as a strategic plan goal.

FFDA employs a full-time Recovery Support Specialist (RSS) to enhance current community recovery supports, implement new recovery supports and provide recovery support case management services to individuals who are FFDA funded for substance use treatment. FFDA's RSS also works closely with in and out of county recovery houses, treatment providers, managed care, medical professionals, behavioral health providers and family members/support systems for individuals engaging in treatment and recovery. The RSS conducts educational presentations for the community (schools, faith-based community, human service providers, forensics system, etc.), assists with community recovery-oriented events and represents recovery on multiple task forces/coalitions/work groups within the county. FFDA is in and will continue with its partnership with the Franklin County District Attorney's Office to provide outreach to those administered naloxone by local law enforcement officers. The RSS serves as the outreach worker for these individuals.

5. Treatment Services expansion including the development of any new services or resources to meet local needs.

The Early Intervention level of care has been created by the Department of Drug & Alcohol Programs and is used within Franklin County for individuals meeting its criteria. This level of care is not a covered service through Medicaid as a diagnostic code for it doesn't exist within the DSM-V; therefore it's a covered service for FFDA in regards to funding individuals in need of Early Intervention. In the past year, this level of care is most present in DUI-related assessments, whether the primary substance leading to the DUI is alcohol or another substance.

Franklin County will be expanding the availability of oral naltrexone (Vivitrol) on a mobile basis. FFDA anticipates contracting with Positive Recovery Solutions (PRS) to deliver this mobile service for anyone that needs it; however, FFDA will provide funding for this service for any resident that is Medicaid ineligible/denied as well.

Franklin County treatment providers (outpatient and inpatient) will all be trained in Moral Reconciliation Therapy (MRT) with the intention of incorporating MRT into their service delivery model for criminal-justice involved patients, which accounts for over 50% of their patient population.

6. Any emerging substance use trends that will impact the ability of the county to provide substance use services.

The implementation of the Commonwealth's Prescription Monitoring Program may create higher demand for treatment services within Franklin/Fulton County. With the reduction of access to prescription opioids, it's anticipated for counties to see a rise in heroin use, heroin

related overdoses and heroin related overdose fatalities. With the current high level treatment bed capacity issues across the Commonwealth, it's anticipated that detox and inpatient beds will quickly fill up and remain consistently utilized.

*This overview should not include the DHS-issued guidelines for the use of Act 152 or BHSI funds. The focus should be a comprehensive overview of the substance use services and supports provided by the SCA and any challenges to providing services.*

## **Target Populations**

Please identify the county resources to meet the service needs for the following populations:

- **Adults (including older adults, transition age youth, ages 18 and above)**

- **Older Adults (ages 60 and above)**

If indicated, older adults are eligible for all levels of care for substance use treatment. These levels include detoxification, short and long term rehabilitation, halfway house, partial hospitalization, intensive outpatient, outpatient, and early intervention outpatient services for Franklin and Fulton county residents. FFDA also provides case management services and oversight of medication assisted treatment. Older adults covered by Medicare qualify for county funding due to the lack of Medicare providers within a 50 mile radius of Franklin and Fulton Counties.

- **Adults (ages 18 and above)**

If indicated, adults ages 18 to 55 are eligible for all levels of care for substance use treatment. These levels include detoxification, short and long terms rehabilitation, halfway house, partial hospitalization, intensive outpatient, outpatient, and early intervention outpatient services for Franklin and Fulton county residents. FFDA also provides case management services and oversight of medication assisted treatment. It is anticipated that many of our priority populations, including Pregnant Injection Drug Users, Pregnant Substance Users, Injection Substance Users, Overdose Survivors and Veterans will fall into this age demographic.

- **Transition Age Youth (ages 18 to 26)**

If indicated, transition-age youth are eligible for all levels of care for substance use treatment. These levels include detoxification, short and long term rehabilitation, halfway house, partial hospitalization, intensive outpatient, outpatient, and early intervention outpatient services for Franklin and Fulton county residents. FFDA also provides case management services and oversight of medication assisted treatment. It is anticipated that some of our priority populations, including Pregnant Injection Drug Users, Pregnant Substance Users, Injection Substance Users and Overdose Survivors will fall into this age demographic.

- **Adolescents (under 18)**

- If indicated, adolescents are eligible for all levels of care for substance use treatment. These levels include detoxification, short and long term rehabilitation, halfway house, partial hospitalization, intensive outpatient, outpatient, and early intervention outpatient services for Franklin and Fulton county residents. FFDA also

provides case management services and oversight of medication assisted treatment. Additionally, FFDA also contracts with providers of prevention and intervention programs focusing on the adolescent population.

- **Individuals with Co-Occurring Psychiatric and Substance Use Disorders**
  - If indicated, individuals with co-occurring disorders are eligible for all levels of care for substance use treatment. These levels include detoxification, short and long term rehabilitation, halfway house, partial hospitalization, intensive outpatient, outpatient, and early intervention outpatient services for Franklin and Fulton county residents. FFDA also provides case management services and oversight of medication assisted treatment. It is anticipated that all of our priority populations, will fall into this demographic. Individuals are encouraged to engage with a co-occurring provider, regardless the level of care to ensure that both the mental health and the substance use needs are being addressed simultaneously with the same provider.
  
- **Women with Children**
  - If indicated, women with children in need of substance use services are eligible for all levels of care for treatment. These levels include detoxification, short and long term rehabilitation, halfway house, partial hospitalization, intensive outpatient, outpatient, and early intervention outpatient services for Franklin and Fulton county residents. FFDA also provides case management services and oversight of medication assisted treatment. The county contracts with multiple providers with women with children specific services. There will be a targeted focus placed on mothers of chemically dependent newborns entering the NICU due to their chemical dependency at birth. Services will focus on treatment as well as in-home support for non-treatment, ancillary services.
  
- **Overdose survivors**
  - If indicated, overdose survivors are eligible for all levels of care for substance use treatment. These levels include detoxification, short and long term rehabilitation, halfway house, partial hospitalization, intensive outpatient, outpatient, and early intervention outpatient services for Franklin and Fulton county residents. FFDA also provides case management services and oversight of medication assisted treatment. Additionally, FFDA also contracts with providers of prevention and intervention programs focusing on the adolescent population. Overdose survivors present throughout the majority of community-based systems in Franklin County (acute care, primary care, forensics, education, employment, treatment/recovery, etc.).
  
- **County's identified priority populations:**
  - Franklin/Fulton Drug & Alcohol prioritizes the following populations in the priority order listed below:
    - Pregnant Injection Substance Users
    - Pregnant Substance Users
    - Injection Substance Users
    - Overdose Survivors
    - Veterans



- If indicated, these priority populations are eligible for all levels of care for substance use treatment. These levels include detoxification, short and long term rehabilitation, halfway house, partial hospitalization, intensive outpatient, outpatient, and early intervention outpatient services for Franklin and Fulton county residents. These specific individuals receive priority on any service delivered through FFDA's continuum of substance use services (screening, assessment, funding, treatment placement/aftercare and case management).

## Recovery–Oriented Services

In FY16/17, Franklin County has engaged in many efforts to incorporate recovery-oriented services across its multiple service delivery systems, such as community coalitions, task forces, work groups, strategic planning initiatives, forensic system, medical systems, behavioral health systems, consumer driven advocacy groups, faith-based community, education and employment sectors. The following entities currently/will be employing recovery support specialists:

- Franklin/Fulton Drug & Alcohol
- South Central Community Action Programs
- Summit Health's Primary Care
- Treatment Providers (Pyramid, Pennsylvania Counseling Services, Dohi Center for Well-being and Roxbury)

Franklin County now has a PARR certified recovery house for men, Noah's House, which can house up to 15 men at any given time. More recovery houses are needed within the county as the county currently doesn't have any halfway houses. Women specific recovery houses are a need that is being explored by multiple entities, as secure/safe housing conducive to recovery is a necessity.

*Describe the current recovery support services including CRS services available in the county including any proposed recovery support services being developed to enhance the existing system. Do not include information on independently affiliated 12 step programs (AA,NA,etc).*

FFDA employs a full-time Recovery Support Specialist (RSS) to enhance current community recovery supports, implement new recovery supports and provide recovery support case management services to individuals who are FFDA funded for substance use treatment. FFDA's RSS also works closely with in and out of county recovery houses, treatment providers, managed care, medical professionals, behavioral health providers and family members/support systems for individuals engaging in treatment and recovery. The RSS conducts educational presentations for the community (schools, faith-based community, human service providers, forensics system, etc.), assists with community recovery-oriented events and represents recovery on multiple task forces/coalitions/work groups within the county. FFDA is in and will continue with its partnership with the Franklin County District Attorney's Office to provide outreach to those administered naloxone by local law enforcement officers. The RSS serves as the outreach worker for these individuals. The RSS will be exploring expansion efforts within the community in FY17/18 to include: certified recovery housing (specifically for women), increase number of traditional 12-step programs in each

municipality, implementation of SMART Recovery and reduction of stigma/increase in community awareness.

The South Central Community Action Programs (SCCAP) now employs a full-time Certified Recovery Specialist to assist individuals in need of substance use support services with opportunities for peer support and guidance. SCCAP interfaces with high risk individuals who often also struggle with substance use disorder or are living with someone that struggles with substance use disorder. The SCCAP CRS will serve as a peer support mechanism for individuals in need of treatment, recovery and community resources and will assist the individuals with engagement and maintenance within these services.

Tuscarora Managed Care Alliance (TMCA) in partnership with FFDA has developed two (2) substance use recovery service plans in which were approved for implementation:

**Supportive Housing Bridge Subsidy:**

The target population is MA eligible adults 18 and older who have successfully completed treatment in a rehabilitation program for substance abuse or persons at risk of requiring intensive treatment in a rehabilitation program. Subsidies are provided in one of two ways. The first is to provide rental subsidies to individuals who need a short term subsidy until they can obtain employment. These subsidies would cover the cost of up to three months of room and board costs for MA recipients accessing recovery house services. The second is to provide a shallow subsidy of up to \$200/month for up to six months to rapidly rehouse individuals who can likely return to work but who require a shallow rental subsidy for a short period of time in order to obtain and maintain housing.

Goals: The primary goals are to (1) to reduce the number of non-hospital drug and alcohol rehabilitation readmissions to below 10% during the first full 12 months of treatment, and (2) to increase the members' ability to be employed and/or participate in volunteer activities.

**Drug and Alcohol Certified Recovery Specialist Services:**

The target population consists of Medical Assistance eligible adults, 18 years and over, who have been diagnosed with a substance use disorders (SUD); participants may also have co-occurring mental health disorders (COD). The program focuses primarily on individuals who have had a high re-entry rate into substance abuse rehabilitation centers and assistance for persons transitioning to the community from inpatient treatment. CRS will be employed by Substance Abuse Outpatient clinics and the care they deliver will be integrated with the OP services. Core functions of the CRS include:

- Recovery Capital Needs Assessment – to assess the sum of the personal, social, family and community resources that the individual may draw on to begin and sustain recovery;
- Stage appropriate recovery education/coaching – to build or enhance self-management skills;
- Assistance with identifying and mobilizing needed resources, including mental health and addiction recovery supports, substance free social and recreational activities, and community resources to ensure that basic needs are met;
- Assertive linkages to assist with treatment and navigating other service systems;

- Recovery check-ups, advocacy, leadership development and empowerment.  
The outcomes expected include:
  - Increase in outpatient follow-up within 7 days of discharge from 24-hour LOC;
  - Increase in continuity of outpatient treatment;
  - Decrease in readmissions to detox and rehab;
  - In addition CRS service providers will be given access to the DLA-20 functional assessment tool. This tool will assess for functional deficits to drive treatment and on reassessment improvement in daily living areas will be noted.

## **HUMAN SERVICES AND SUPPORTS/ HUMAN SERVICES DEVELOPMENT FUND**

*For each of these categories (Adult Services, Aging Services, Children and Youth Services, Generic Services and Specialized Services), please use the fields and dropdowns to describe how the county intends to utilize HSDF funds on allowable expenditures (please refer to the HSDF Instructions and Requirements for more detail).*

**Adult Services:** No services are funded through the block grant

**Aging Services:** No services are funded through the block grant

**Children and Youth Services:** No services are funded through the block grant

### **Generic Services:**

*Program Name:* Information and Referral

*Description of Services:* I&R provides a service that links individuals and the community through a variety of communication channels, including in person presentations to local agencies to help educate the community of the various services throughout the County. The I&R department is also the contact point for PA 211 coordination.

*Service Category:* Information & Referral - The direct provision of information about social and other human services, to all persons requesting it, before intake procedures are initiated. The term also includes referrals to other community resources and follow-up.

Please indicate which client populations will be served (must select at least **two**):

Adult  Aging  CYS  SUD  MH  ID  HAP

**Specialized Services:** No services are funded through the block grant

### **Interagency Coordination:**

*If the county utilizes funds for Interagency Coordination, describe how the funding will be utilized by the county for planning and management activities designed to improve the effectiveness of categorical county human services. The narrative should explain both:*

- *how the funds will be spent (e.g. salaries, paying for needs assessments, etc.).*
- *how the activities will impact and improve the human services delivery system.*

Beginning this year, the Franklin County Human Services Training Days will be a 1 day event, held in October and April of each year, as a format to provide up-to-date training for those who serve in the human services profession.

The participants who attend, are from a wide array of human services agencies, faith-based organization, not-for-profits, and medical programs and range from case managers, to support staff, to directors and administrators. Our goal is to provide them with quality professional training that will enhance their skills, increase their professional development, and ensure that they are aware of the current trends in their profession. From the information they receive, agencies and staff can use the new tools as a way to take their existing and new programs and strengthen the delivery of the service.

The event is held at the Rhodes Grove Conference Center, which is located in Chambersburg, Pennsylvania. The site is chosen because of the unique ability to provide space for 200 – 250 individuals to attend. All training is provided at no cost to those who are a part of the human services community.

The Franklin County Human Services Training Days format provides the opportunity for individuals to learn from several different areas in the field of human services. The event is kicked off by having a Keynote Speaker, who will present for an hour. Afterwards individuals will attend one of the five 1 ½ hour sessions/presentations that are occurring. A total of 15 session/presentations are held over the course of the one day.

Individuals are given the opportunity to register for the specific classes that they feel they will benefit most from. From this, we can expect approximately 20-50 participants for each session, unless there is a request for a limit due to the nature of the presentation. These sessions will cover areas of topics that relate to Veterans/Military, the Aging Community, Mental Health, Early Intervention, Intellectual Disabilities, Services to Children, as well as ways to take care of ourselves as the human service professionals.

Franklin County Intro to Human Services is a second training event that provides individuals the ability to become educated directly on the specific services that the Franklin County Human Services Administration departments offer to the residents of Franklin County.

The event is open to the first 40 who register to attend. There is no cost associated with this training. Individuals are given an overview of each of the departments and how their services are able to benefit those in the Franklin County community. The session is held twice a year. The participants are from a wide array of human service agencies, faith-based organization, not-for-profits, and medical programs and range from case managers, to support staff, to directors and administrators who will be in attendance.

Appendix A  
Fiscal Year 2017-2018

**COUNTY HUMAN SERVICES PLAN**  
**ASSURANCE OF COMPLIANCE**

**COUNTY OF:** \_\_\_\_\_

- A. The County assures that services will be managed and delivered in accordance with the County Human Services Plan submitted herewith.
- B. The County assures, in compliance with Act 80, that the County Human Services Plan submitted herewith has been developed based upon the County officials' determination of County need, formulated after an opportunity for public comment in the County.
- C. The County and/or its providers assures that it will maintain the eligibility records and other records necessary to support the expenditure reports submitted to the Department of Human Services.
- D. The County hereby expressly, and as a condition precedent to the receipt of state and federal funds, assures that in compliance with Title VI of the Civil Rights Act of 1964; Section 504 of the Federal Rehabilitation Act of 1973; the Age Discrimination Act of 1975; and the Pennsylvania Human Relations Act of 1955, as amended; and 16 PA Code, Chapter 49 (Contract Compliance regulations):
  - 1. The County does not and will not discriminate against any person because of race, color, religious creed, ancestry, origin, age, sex, gender identity, sexual orientation, or disability in providing services or employment, or in its relationship with other providers; or in providing access to services and employment for individuals with disabilities.
  - 2. The County will comply with all regulations promulgated to enforce the statutory provisions against discrimination.

**COUNTY COMMISSIONERS/COUNTY EXECUTIVE**

<i>Signatures</i>	<i>Please Print</i>
_____	Date: _____
_____	Date: _____
_____	Date: _____

Appendix B: Minutes/ Proof of Publication

DRAFT

**APPENDIX C-1 : BLOCK GRANT COUNTIES  
HUMAN SERVICES PROPOSED BUDGET AND INDIVIDUALS TO BE SERVED**

County: Franklin	1. ESTIMATED INDIVIDUALS SERVED	2. HSBG ALLOCATION (STATE & FEDERAL)	3. HSBG PLANNED EXPENDITURES (STATE & FEDERAL)	4. NON-BLOCK GRANT EXPENDITURES	5. COUNTY MATCH	6. OTHER PLANNED EXPENDITURES
<b>MENTAL HEALTH SERVICES</b>						
ACT and CTT	-		\$ -	\$ -	\$ -	\$ -
Administrative Management	389		\$ 261,508	\$ -	\$ 7,059	\$ -
Administrator's Office			\$ 612,648	\$ -	\$ 3,420	\$ -
Adult Developmental Training	-		\$ -	\$ -	\$ -	\$ -
Children's Evidence-Based Practices	-		\$ -	\$ -	\$ -	\$ -
Children's Psychosocial Rehabilitation	-		\$ -	\$ -	\$ -	\$ -
Community Employment	143		\$ 271,081	\$ -	\$ 7,319	\$ -
Community Residential Services	45		\$ 1,518,503	\$ -	\$ 38,674	\$ -
Community Services	1,537		\$ 533,608	\$ -	\$ 14,407	\$ -
Consumer-Driven Services	-		\$ -	\$ -	\$ -	\$ -
Emergency Services	123		\$ 40,980	\$ -	\$ 1,106	\$ -
Facility Based Vocational Rehabilitation	31		\$ 75,799	\$ -	\$ 2,047	\$ -
Family Based Mental Health Services	2		\$ 27,686	\$ -	\$ 748	\$ -
Family Support Services	10		\$ 6,020	\$ -	\$ 163	\$ -
Housing Support Services	55		\$ 53,208	\$ 54,558	\$ 1,437	\$ -
Mental Health Crisis Intervention	3,145		\$ 304,289	\$ -	\$ 8,216	\$ -
Other	-		\$ -	\$ -	\$ -	\$ -
Outpatient	168		\$ 23,953	\$ -	\$ 647	\$ -
Partial Hospitalization	-		\$ -	\$ -	\$ -	\$ -
Peer Support Services	26		\$ 55,109	\$ -	\$ 1,488	\$ -
Psychiatric Inpatient Hospitalization	1		\$ 49,114	\$ -	\$ 1,326	\$ -
Psychiatric Rehabilitation	56		\$ 76,909	\$ -	\$ 2,077	\$ -
Social Rehabilitation Services	125		\$ 252,807	\$ -	\$ 6,826	\$ -
Targeted Case Management	213		\$ 285,720	\$ -	\$ 7,714	\$ -
Transitional and Community Integration	-		\$ -	\$ -	\$ -	\$ -
<b>TOTAL MENTAL HEALTH SERVICES</b>	<b>6,069</b>	<b>\$ 4,448,942</b>	<b>\$ 4,448,942</b>	<b>\$ 54,558</b>	<b>\$ 104,674</b>	<b>\$ -</b>

**INTELLECTUAL DISABILITIES SERVICES**

Administrator's Office			\$ 562,342	\$ -	\$ 3,129	\$ -
Case Management	63		\$ 58,973	\$ -	\$ 1,592	\$ -
Community-Based Services	156		\$ 286,376	\$ -	\$ 38,317	\$ -
Community Residential Services	11		\$ 67,495	\$ -	\$ 1,822	\$ -
Other	-		\$ -	\$ -	\$ -	\$ 2,275
<b>TOTAL INTELLECTUAL DISABILITIES SERVICES</b>	<b>230</b>	<b>\$ 975,186</b>	<b>\$ 975,186</b>	<b>\$ -</b>	<b>\$ 44,860</b>	<b>\$ 2,275</b>

**APPENDIX C-1 : BLOCK GRANT COUNTIES  
HUMAN SERVICES PROPOSED BUDGET AND INDIVIDUALS TO BE SERVED**

County: Franklin	1. ESTIMATED INDIVIDUALS SERVED	2. HSBG ALLOCATION (STATE & FEDERAL)	3. HSBG PLANNED EXPENDITURES (STATE & FEDERAL)	4. NON-BLOCK GRANT EXPENDITURES	5. COUNTY MATCH	6. OTHER PLANNED EXPENDITURES
<b>HOMELESS ASSISTANCE SERVICES</b>						
Bridge Housing	-		\$ -		\$ -	\$ -
Case Management	290		\$ 50,860		\$ -	\$ -
Rental Assistance	290		\$ 42,000		\$ -	\$ -
Emergency Shelter	21		\$ 15,000		\$ -	\$ -
Other Housing Supports	-		\$ -		\$ -	\$ -
Administration			\$ 5,798		\$ -	\$ -
<b>TOTAL HOMELESS ASSISTANCE SERVICES</b>	<b>601</b>	<b>\$ 113,658</b>	<b>\$ 113,658</b>		<b>\$ -</b>	<b>\$ -</b>
<b>SUBSTANCE USE DISORDER SERVICES</b>						
Case/Care Management	-		\$ -	\$ -	\$ -	\$ -
Inpatient Hospital	-		\$ -	\$ -	\$ -	\$ -
Inpatient Non-Hospital	31		\$ 86,047	\$ -	\$ -	\$ -
Medication Assisted Therapy	12		\$ 15,600	\$ -	\$ -	\$ -
Other Intervention	77,830		\$ 29,751	\$ -	\$ -	\$ -
Outpatient/Intensive Outpatient	48		\$ 25,400	\$ -	\$ -	\$ -
Partial Hospitalization	-		\$ -	\$ -	\$ -	\$ -
Prevention	265		\$ 26,000	\$ -	\$ -	\$ -
Recovery Support Services	264		\$ 62,400	\$ -	\$ -	\$ -
Administration			\$ 45,328	\$ -	\$ -	\$ -
<b>TOTAL SUBSTANCE USE DISORDER SERVICES</b>	<b>78,450</b>	<b>\$ 290,526</b>	<b>\$ 290,526</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>HUMAN SERVICES DEVELOPMENT FUND</b>						
Adult Services	-		\$ -		\$ -	\$ -
Aging Services	-		\$ -		\$ -	\$ -
Children and Youth Services	-		\$ -		\$ -	\$ -
Generic Services	3,233		\$ 71,353		\$ -	\$ -
Specialized Services	-		\$ -		\$ -	\$ -
Interagency Coordination			\$ -		\$ -	\$ -
Administration			\$ 24,615		\$ -	\$ -
<b>TOTAL HUMAN SERVICES DEVELOPMENT FUND</b>	<b>3,233</b>	<b>\$ 95,968</b>	<b>\$ 95,968</b>		<b>\$ -</b>	<b>\$ -</b>
<b>GRAND TOTAL</b>	<b>88,583</b>	<b>\$ 5,924,280</b>	<b>\$ 5,924,280</b>	<b>\$ 54,558</b>	<b>\$ 149,534</b>	<b>\$ 2,275</b>



**Appendix D**  
**Block Grant Planning Committee**

**Committee Members:**

- Megan Shreve (HAP Provider)
- Sheldon Schwartz (Mental Health/Intellectual Disabilities Community Rep)
- Kim Wertz (MH Advocate)
- Anne Larew (ID Advocate)
- Karen Johnston (Prevention Provider)
- Ann Spottswood (Summit Health)
- Amy Hicks (United Way)

**Staff Members:**

- Carrie Gray\* (County Administrator)
- Stacy Rowe\* (Fiscal)
- Christy Briggs\* (Fiscal)
- Sharyn Overcash (Human Services)
- Jennifer Wenzel (Mental Health Housing Specialist)
- Steve Nevada\* (Mental Health/Intellectual Disabilities/Early Intervention Director, Interim Human Services Administrator, and Assistant County Administrator)
- Lori Young (Intellectual Disabilities)
- Shalom Black\* (Grants Director)
- Doug Amsley (Children and Youth Services Director)
- Traci Kline (Aging Director)
- Justin Slep (Veterans Affairs Director)
- April Rouzer (Drug and Alcohol Director)

*\*denotes Leadership Team Members*

Appendix E: 2017-2019 Quality Management Plan

<b>Administrative Entity Name:</b> Franklin/Fulton Intellectual Disabilities Program			<b>Year:</b> 2017-2019
<b>Focus Area:</b> Promote Health , Wellness and Safety			
<b>Goal</b>	<b>Outcome</b>	<b>Target Objective</b>	<b>Performance Measures/Data Source(s)/ Frequency/Responsible Person</b>
People are safe and secure in their homes and communities.	People are safe and restraint free.	Due to the low number of restraints, Franklin/ Fulton County Risk Management Team monitors the number of restraint incidents and takes action immediately as warranted.  Baseline: FY 2015-2017= 2 restraints	<b>Performance Measure:</b> # of Restraint Incidents  <b>Data Sources:</b> EIM Incident Data  <b>Frequency:</b> Quarterly  <b>Responsible Party:</b> F/F Incident Manager F/F Risk Management Team

**Administrative Entity Name:** Franklin/Fulton Intellectual Disabilities Program **Year:** 2017-2019

**Focus Area:** Expand Options for Community Living

<b>Goal</b>	<b>Outcome</b>	<b>Target Objective</b>	<b>Performance Measures/Data Source(s)/ Frequency/Responsible Person</b>
<p>Lifesharing is the first option that individuals have and they also have the support they need to live where they choose in the community.</p>	<p>People live where they choose.</p>	<p>Increase the number of new and unique people in Lifesharing by 10% (n=4) by June 30, 2019.</p> <p>Baseline: 40 people in Lifesharing in FY 2015-2017</p>	<p><b>Performance Measure:</b>            # of new and unique individuals enrolled in Lifesharing settings</p> <p><b>Data Sources:</b>            Franklin/Fulton ID Lifesharing Tracking Form/            Service Authorizations in HCSIS</p> <p><b>Frequency:</b>            Monthly</p> <p><b>Responsible Party:</b>            F/F ID Lifesharing Point Person</p>

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**Administrative Entity Name:** Franklin/Fulton Intellectual Disabilities Program **Year:** 2017-2019

**Focus Area:** Increase Employment

<b>Goal</b>	<b>Outcome</b>	<b>Target Objective</b>	<b>Performance Measures/Data Source(s)/ Frequency/Responsible Person</b>
Individuals work in the community.	People who choose to work are employed in the community.	Increase the number of new hires in Competitive Integrated Employment by 10% ( n=5).  Baseline: On February 28, 2017, 45 people were employed in Competitive Integrated Employment.	<p><b>Performance Measure:</b>            Number of new and unique individuals hired in competitive integrated employment</p> <p><b>Data Sources:</b>            AE spreadsheet, ISPs, Provider data</p> <p><b>Frequency:</b>            Quarterly</p> <p><b>Responsible Party:</b>            F/F ID Employment Point Person</p>

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**Administrative Entity Name:** Franklin/Fulton Intellectual Disabilities Program **Year:** 2017-2019

**Focus Area:** Promote Health, Wellness and Safety

Goal	Outcome	Target Objective	Performance Measures/Data Source(s)/ Frequency/Responsible Person
<p>People are supported to achieve and maintain optimal medical health.</p>	<p>People are healthy.</p>	<p>Reduce the number of medication errors by 10% by June 30, 2019 (n&lt;260).</p> <p>Baseline FY 2015-2017 = 291 medication errors as of March 31, 2017.</p>	<p><b>Performance Measure:</b> The number of medication errors.</p> <p><b>Data Sources:</b> EIM/ Incident counts report</p> <p><b>Frequency:</b> Quarterly</p> <p><b>Responsible Party:</b> Risk Management Committee Incident Management Point Person Medication Task Force</p>

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**Administrative Entity Name:** Franklin/Fulton Intellectual Disabilities Program **Year:** 2017-2019

**Focus Area:** Promote Health, Wellness and Safety

<b>Goal</b>	<b>Outcome</b>	<b>Target Objective</b>	<b>Performance Measures/Data Source(s)/ Frequency/Responsible Person</b>
<p>People are safe in their homes and their community.</p>	<p>People are abuse free.</p>	<p>Reduce the # of I-2-I abuse incidents by 5% by June 30, 2019 (n&lt;149).</p> <p>Baseline: Fiscal Year 2015-2017            I-2-I abuse = 157 as of March 31, 2017.</p>	<p><b>Performance Measure:</b>            # of incidents of I-2-I abuse</p> <p><b>Data Sources:</b>            EIM Incident Data</p> <p><b>Frequency:</b>            Quarterly</p> <p><b>Responsible Party:</b>            F/F Incident Manager            F/F Risk management Team</p>

**Administrative Entity Name:** Franklin/Fulton Intellectual Disabilities Program **Year:** 2017-2019

**Focus Area:** Support Families Throughout the Lifespan

<b>Goal</b>	<b>Outcome</b>	<b>Target Objective</b>	<b>Performance Measures/Data Source(s)/ Frequency/Responsible Person</b>
Develop a Regional Collaborative and support the work of the PA Family network to support families.	Families receive support to help make an Everyday Life possible.	Reach 20 families in collaboration with the Family Network to disseminate the Communities of Practice Lifecourse Planning Tools in small group sessions by June 30, 2019.  Baseline: none	<p><b>Performance Measure:</b>            Number of families who participate in Family Network Lifecourse Planning sessions</p> <p><b>Data Sources:</b>            Family Network Sign in Sheets</p> <p><b>Frequency:</b>            Monthly</p> <p><b>Responsible Party:</b>            QM Point Person            Regional Collaborative point person            PAFamily Network</p>

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