

## **Appendix B County Human Services Plan Template**

The County Human Services Plan (Plan) is to be submitted using the template outlined below. It is to be submitted in conjunction with Appendices A and C (C-1 or C-2, as applicable) to the Department of Human Services (DHS) as instructed in the Bulletin 2020-01.

### **PART I: COUNTY PLANNING PROCESS** (Limit of 3 pages)

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 participants 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 services administration staff and includes: the Human Services Administrator, Fiscal Specialist, Human Services Fiscal Manager, MH/IDD/EI Administrator, Drug & Alcohol Administrator, Human and Health Services Planning and Development Director, County Grants Management Director, Veterans Affairs Director, and the Director of the Area Agency on Aging.

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 participants 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 are advertised in the newspaper, on the County website, and the County's Facebook page to elicit stakeholder feedback.

3. Please list the advisory boards that participated in the planning process.
  - The Franklin/Fulton Drug & Alcohol Advisory Board holds recurring meetings throughout the fiscal year on a rotating basis between Franklin and 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. Sector representation is also evenly split among genders and county of residence. The Advisory Board provides input into the Block Grant plan, is informed of Block Grant impact, and is made aware of any Drug/Alcohol requests for funding, projects, or service enhancements.

- The Franklin County Local Housing Options Team consists of individuals who meet regularly on issues around housing and homelessness. Representatives from the Franklin County Housing Authority, both County emergency shelters, and the Homeless Assistance Program (HAP) attend regularly. In addition to these individuals, there are an array of representatives on the LHOT that also include Rapid Rehousing programs, Homeless Prevention programs, Permanent Supportive Housing programs, the Domestic Violence shelter, Veterans Housing Program, Legal Services, Connect to Home staff, the Self-Determination Housing Project of Pennsylvania, Inc. (SDHP), a Federally Qualified Health Center (FQHC), two Boroughs, several religious Organizations and Franklin County Grants Management. The group also receives updates on Block Grant plans and funding requests and provides input, as appropriate.
  - The Franklin/Fulton County Mental Health/Intellectual and Developmental Disabilities/Early Intervention Advisory Board meets bi-monthly, with 13 members, including one Commissioner from Fulton County and one from Franklin County. The committee requires representation from each county: four members from Fulton County and nine members from Franklin County. At least two representatives appointed to the Board are physicians (preferably, a psychiatrist and a pediatrician). Four individuals are program participants or family members, of which half represent Intellectual and Developmental 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/IDD/EI Administrator provides HSBG updates as applicable during the Board meetings. They have impact on decisions related to MH/IDD/EI funding, which indirectly can impact the Human Services Block Grant.
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 and Alcohol provides prevention/intervention, treatment, and recovery services in the environment most appropriate for the individual receiving the services. Prevention services are delivered to youth in either a school-based or afterschool based environment appropriate to their age and the selected evidence-based program. Intervention services are provided to individuals that meet program/service eligibility and occur through a variety of contracted service providers. Treatment services are delivered to individuals based on the state's use of the American Society of Addiction Medicine (ASAM) criteria and the appropriate level of care indicated as well as the utilization of risk assessments. High levels of care (withdrawal management, and residential)

include 24/7 monitoring and supervision as treatment services are delivered within the provider's 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 and Developmental Disabilities follows the principle of providing the least restrictive services and promotes the offering of individualized services which will best meet the participant's needs rather than putting an individual in a program that will not elicit best outcomes for that person. Assessed need for services and supports in the Intellectual and Developmental Disabilities Program is determined by a SIS (Supports Intensity Scale) which is mandated by the Office of Developmental Programs. People with IDD and their families are part of this process. Assessed need in the Intellectual and Developmental Disabilities program is determined using the SIS as directed by the Office of Developmental Programs.
5. Please describe any substantial programmatic and 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 2020-2021.

## **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 needed for non-block grant counties.

1. Proof of publication;
  - a. Please attach a copy of the actual newspaper advertisement(s) for the public hearing(s).
  - b. When was the ad published?
  - c. When was the second ad published (if applicable)?
  
2. Please submit a summary and/or sign-in sheet of each public hearing.

**NOTE:** The public hearing notice for counties participating in local collaborative arrangements (LCA) should be made known to residents of all counties. Please ensure that the notice is publicized in each county participating in the LCA.

See Appendix E

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

For each of the following, please explain how the county works collaboratively across the human services programs; how the county intends to leverage funds to link residents to existing opportunities and/or to generate new opportunities; and provide any updates to the county's collaborative efforts and any new efforts planned for the coming year.

Employment:

- The Franklin/ Fulton IDD Program participates in the Transition Council with the Office of Vocation Rehabilitation, 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. Franklin County's Information and Referral Specialist can refer individuals calling 2-1-1 to employment programs such as CareerLink and United Way's Stepping Forward Works program.
- The Franklin/ Fulton IDD Program also supports a TALS (Transition to Adult Life Success) program in the local high schools. This program is a collaboration between local school districts, providers and the Franklin/Fulton IDD Programs. The TALS program engages young adults with disabilities in discussions and activities pertaining to areas of self- determination and career exploration. The goal is to encourage and prepare students to find competitive integrated employment.
- The Mental Health and IDD programs support providers and encourage new opportunities from contracted entities for enhanced and expanded employment/training opportunities throughout Franklin County. Some examples of current providers include OSI (Occupational Services Inc.) and AHEDD (a specialized Human Resources organization). Individuals with mental illness and those with intellectual disabilities comprise the participants within these programs. Both of these programs are part of the "Employment First" initiative by the state and support Competitive Integrated Employment for people with disabilities.
- Franklin Together, Franklin County's Reentry Coalition, is actively pursuing local employers engaging in the employment of returning citizen's to the community after their incarceration. To date the Outreach Committee has identified and linked with 62 local employers who will hire returning citizens and work with them in the employment field. The Committee has reached out to Parole Officers, Drug Court staff and the Judge presiding over Drug Court to identify individuals in need of employment in this arena. The Outreach Committee has identified transportation as one of the barriers to successful employment in rural Franklin County and throughout the upcoming year the committee will continue to look for creative ideas to help overcome this barrier.

Housing:

- The Franklin County Local Housing Options Team (LHOT) consists of individuals who meet regularly on issues around housing and homelessness. Representatives from the Franklin County Housing Authority, both County emergency shelters, as well as, the Homeless Assistance Program (HAP) attend regularly. In addition to these individuals, there are an array of representatives on the LHOT that also include Rapid Rehousing programs, Homeless Prevention programs, Permanent Supportive Housing programs, the Domestic Violence shelter, Veterans Housing Program, Legal Services, Connect to Home staff, the Self-Determination Housing Project of Pennsylvania, Inc. (SDHP), a Federally Qualified Health Center (FQHC), two Boroughs, several religious Organizations and Franklin County Grants Management. The group also receives updates on Block Grant plans and funding requests.
- Our Case Management staff works through the Coordinated Entry Process with the assistance of multiple housing providers to help ensure a good match for individuals in need of housing. Through funds from the Homeless Assistance Program (HAP), Projects for Assistance in Transition from Homelessness (PATH), Housing and Urban Development (HUD), the Emergency Solutions Grant (ESG), the Pennsylvania Housing Finance Agency (PHFA), Emergency Solutions Grant – CARES (ESG-CV), Home 4 Good, the Pennsylvania Housing Affordability and Rehabilitation Enhancement Fund (PHARE), 8-1-1 Housing and the Pennsylvania Commission on Crime and Delinquency (PCCD), we provide an array of housing options, transitional housing, master lease, rental assistance, rapid rehousing, and emergency housing supports, all of which are available to individuals/families meeting a range of specific criteria. Criteria are based on the completion of a Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT) assessment. The VI-SPDAT examines factors of current vulnerability and future housing stability and assists to identify what supports and housing interventions will be most beneficial. In 2020 - 2021, we will continue to work through the Coordinated Entry process with the intent that this will result in continued collaboration, streamlining of services, and increased leveraging of funding resources.
- The IDD Program partners with the County Housing Program to support an Independent Living Apartment Program for people living in their own apartments who need less than 30 hours of support a week. Because the County subsidizes the rent with base funds, people are able to live in affordable and safer neighborhoods. There are currently 13 people in this program.

**PART IV: HUMAN SERVICES NARRATIVE**

**MENTAL HEALTH SERVICES**

The discussion 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, and other funding.

**a) Program Highlights:** (Limit of 6 pages)

Please highlight the achievements and other programmatic improvements that have enhanced the behavioral health service system in FY19-20.

- With the use of funds focusing on early intervention of mental health, mental health was able to purchase on-line training for staff of various local provider agencies with a primary focus on working with young residents. The cost of the on-line training unit was \$3,750. The staff were able to access and manage self-paced courses and webinars in their own training accounts with Achieve On Demand. There were over twenty (20) participants. The hope is to increase that in the coming year as we were able to extend this training opportunity. By having the ability to offer a training platform, the county is able to foster the growth and quality of the service system for the young individuals and their families in our community. Below is a list of a few courses available through Achieve On Demand.

<b>Self-Paced Courses</b>	<b>Webinars</b>
<b>ASQ-3</b>	<b>Being Present with Families</b>
<b>Basics of Home Visiting</b>	<b>Domestic Violence: Safety Planning</b>
<b>Building Engaging Relationships</b>	<b>Exploring Values &amp; Beliefs</b>
<b>Challenges: Substance Abuse</b>	<b>Home visiting Boundaries</b>
<b>Domestic Violence</b>	<b>Matching Resources</b>
<b>Infant mental health</b>	<b>Partnering for Change</b>
<b>Pregnancy</b>	<b>Motivational Interviewing</b>
<b>Supervising Home Visitors</b>	<b>Reflective Supervision</b>
<b>Trauma for Home Visitors</b>	<b>Impact of Domestic Violence</b>
<b>Trauma for Supervisors</b>	<b>Implementing Tools</b>

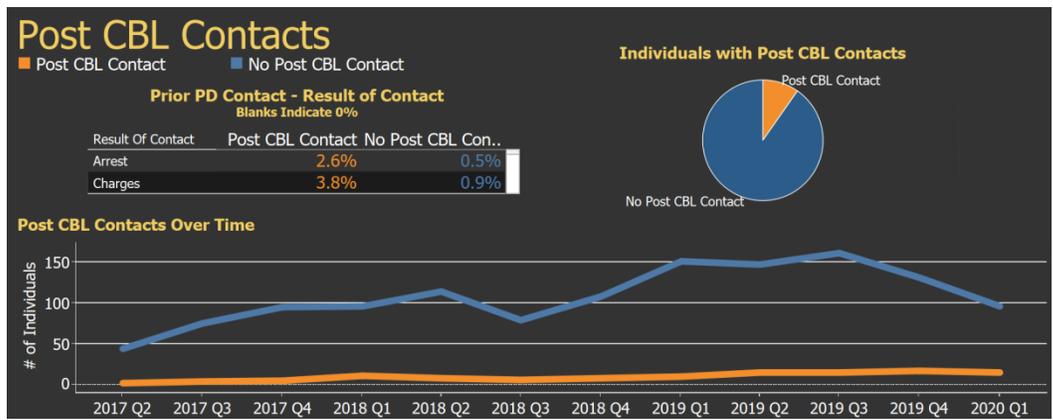
Table 1

- Franklin County was able to create a Forensic Specialized Community Residence (FSCR) with funds secured from The Office of Mental Health and Substance Abuse Services, (OMHSAS). This eight (8) bed facility will provide residential services to individuals with a serious mental illness and functional impairments along with any or all of the following; possible history of or current involvement with the judicial system, histories of institutionalization and ineffective use of other services. As of May 2020, all renovations have been completed within the facility, the occupancy permit has been secured and the application for state license has been submitted; however, due to the coronavirus restrictions all interviews for employment and occupancy were paused. It is expected to become operational this summer.

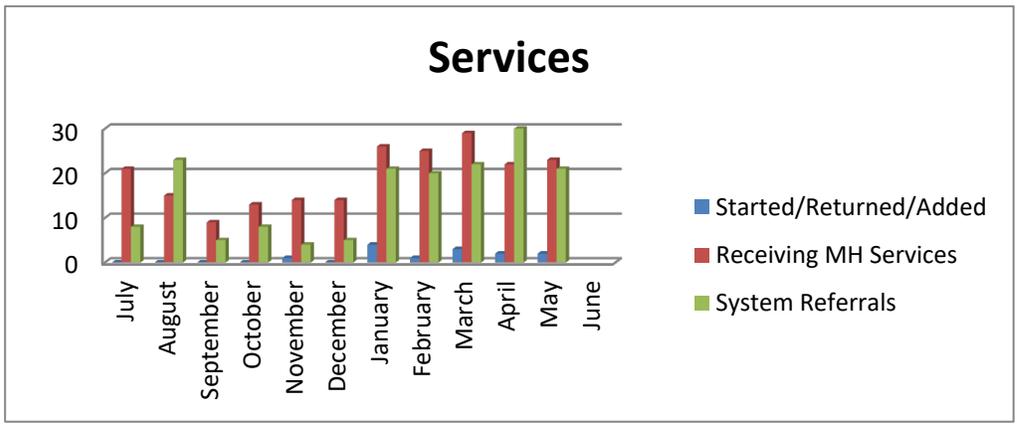
- Critical Time Intervention, (CTI), is an evidence-based practice that will create an adjunct to Mobile Crisis Intervention Services. Persons with unsuccessful, limited, or no engagement in behavioral health treatment will benefit from CTI as a diversion from forensic involvement or higher levels of care. The program may be utilized as a resource to the Crisis Intervention Team-Memphis Model that has been implemented by the County MH/IDD program. Referrals to the service will be initiated after a Mobile Crisis Intervention event has been delivered by Emergency Services, the Criminal Justice System, and Crisis. Through May, 95 individuals have been referred to CTI with 50% (48) engaging in the service. Of those involved with CTI, 82% (39) were connected to outpatient services at the completion of the 9 month program.
- In looking toward building resilience in the local community post COVID, MH purchased a license agreement for a Certified Clinical Trauma Professional Training course ([click here](#)). The total dollar amount for the training is \$2500 for Franklin County MH/IDD/EI to obtain the license. The course is available free to the counselors serving Franklin and Fulton Counties. The total video time for this course is 14 hours and 28 minutes. It is made up of multiple modules ranging in time from 6 minutes to almost 3.5 hours. It is completely self-paced so each person will be able to access it to fit their individual schedule. Anyone is encouraged to take the course; however, only those with a license will become certified. Initially, contracted providers were contacted by email to elicit interest in the course. They were then notified by email and at the mental health provider meeting of the opportunity to take the course. County employees were afforded the opportunity to participate via email. As of June, there are over forty (40) mental health and human services professionals signed up to complete the course. We are expecting others to complete the course throughout the year as well.
- Other COVID responses included the Medical Reserve Corp and Disaster Crisis Outreach and Referral Team (DCORT) responders addressing stress and anxiety in several nursing homes. There were virtual zoom meetings set up for first responders and other staff that continued to work on the front line during quarantine. Healthy Franklin County committees pushed out daily messaging to the community and made resources available on the web and in high traffic areas for community access.
- Healthy Franklin County (HFC) is composed of key community leaders from the education, healthcare, faith, business, nonprofits, local county government sectors and a peer run association for individuals with lived experience with mental illness. Mental health program staff participate and has provided resources and educational materials. The committee's goal is to create and support healthy behaviors and lifestyles through education, awareness, programs, and access to services. These key leaders continue to identify value in identifying and strengthening efforts to address health and health care needs from a collective perspective. Mental health, substance use, and prevention are priorities of this committee as a result of the community needs assessment completed in the summer of 2019. The task force assigned to this priority has been successful at

creating an interactive GPS (Global Positioning System) map of mental health providers. (<https://gis.franklincountypa.gov/MentalHealth/>). When you click on each point, a box will pop up that includes the name of the provider, a link to their website, their address, phone number and a basic description of their services. The goal for this year is to continue to grow the map and include substance use providers. The maps will change and be updated as the committee gathers feedback from the users. This committee has also participated in many awareness campaigns throughout the year to reduce the stigma of mental health.

- Crisis Intervention Team, (CIT), continues to be a priority for our community. It now has over 180 members throughout Franklin and Fulton Counties. Currently, in Franklin County there are two (2) co responders embedded inside four (4) local police departments. Since the inception of this program in May 2017, over 830 individuals all of whom had come into contact with law enforcement have been assisted. Of that number, 89% (739 persons) have had no further contact with law enforcement after engaging with the co responder, (table 2); 56% (465) of the individuals have been referred for services that range from human services, physical health, assistance, insurance, and an array of other services and/or supports (table 3).



CBL = Community Behavioral Liaison **Table 2**



**Table 3**

- Certified Recovery Specialist, (CRS), is a Peer-Based Recovery Support Service for persons striving to achieve long-term recovery from alcohol and/or substance use disorder and related problems. It is available before, during, after and in lieu

of formal treatment to help people engage into service, manage the recovery process, and work toward achieving a meaningful life in the community. Peer Based Recovery Support is a recognized means of enhancing the effectiveness of addiction treatment services - and promoting long-term recovery - by developing and mobilizing recovery supports and building bridges between treatment and natural resources. CRSs draw from their own substance use disorder experiences and specialized training to provide practical skill building services and supports. This program is becoming an in-plan service in the fall of 2020 after the reinvestment period. Thus far it has served a total of 92 individuals between four (4) community providers.

- **TARGET (Trauma Affect Regulation Guide to Education and Treatment)** is an educational and therapeutic intervention for the prevention and treatment of traumatic stress disorders. TARGET teaches a seven (7) step sequence of skills designed to enable individuals to understand and gain control of trauma related reactions triggered by current daily life stressors. TARGET does not require “exposure” therapy but can serve as a preparation for safe and therapeutic memory work. The TARGET model has been extensively studied with the forensic population. Currently there are sixteen (16) clinicians across outpatient mental health providers, school based mental health providers, and Franklin County Jail that are becoming certified in TARGET. Four (4) clinicians in the corrections system have become trained in T-Care to assist other clinicians and staff in recognizing their own stress responses and teach skills to manage these responses.
- It seems appropriate to end our strengths of this fiscal year with a thank you to our many human service providers that brought creativity to programming during the pandemic and the corresponding quarantine. Quickly turning to telehealth, outpatient providers were able to continue providing services to those that were quarantined or preferred non face-to-face contact. Our residential providers became creative in the ways they offered socialization to the residents. Some examples of their creative programming included: in home scavenger hunts with clues provided over the telephone, parking lots became marked with social distance spaces and there were dance parties, bubbles, and sidewalk chalk messages.

**b) Strengths and Needs:** (Limit of 8 pages)

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:
  - Franklin County Older Adult Advocacy Team (FCOAT) continues to meet monthly and collaboratively links older adults to services and identify service gaps. This also fosters cross systems training between the team members which assists in making appropriate support services available to the person in need. The team consists of Mental Health staff, Aging staff, the mobile psychiatric nurse, Ombudsman, Information and Referral and Human Services.
  - Mobile Psychiatric Nurse outreach continues to be available to the community to provide education, consultation and assessments. Some examples of access points include: the Senior Centers, Area Agency on Aging, personal care homes, CoResponders, and other referrals from mental health service providers.
  - Senior Reach program contacts individuals 60+ by phone once a week to check in and offer them some socialization. They are also able to refer the individuals to any supports or services that may be available to them as well.
- Needs:
  - The creation of an Aging Cross Systems case manager that could work collaboratively across systems in order to better serve our older adults. Additionally the person in this position would be able to support and guide individuals and families as they navigate the local system of care. This would include support for individuals and their families that are living at home with cognitive impairments and/or medical issues.
  - Franklin County Human Services has seen a recent increase in referrals for the over 60 population. The 2018-2019 Summit Health Community Health Needs Assessment reports that from 2010-2017 the largest growing segment of the population in Franklin County is 65 years of age and older. The report continues by indicating that Franklin County has a higher median age than the state or even the nation. About 22% of the county residents are under 18 and, an almost equal number are over 65. The population pyramid shows a slow growing population within our county. With this trend of an aging population, comes concerns such as: increased health care needs, special considerations for things such as adequate and affordable housing, transportation availability and the need for other supports. Likewise, there are implications on economic growth in

terms of workforce and employment capabilities.

(<http://healthyfranklincounty.org/> Berwood Yost presentation retrieved August 13, 2019)

- **Adults (ages 18 to 59)**

- Strengths:

- Franklin County has an active suicide prevention coalition. The strategic plan involves education and resources that are advertised in multiple venues. QPR, (Question, Persuade, Refer), is the evidence based training program the coalition offers throughout the county for free. Mental Health and the Mental Health Association (MHA) sponsors the training and provides the needed materials.

QPR		
	On line	In person
Quarter		
1	47	33
2	17	34
3	18	11
4	30	16

- The Suicide Prevention Coalition authors an annual, quarterly, and pandemic (monthly) suicide data report as well as an annual one page “What Does Suicide Look Like in Franklin County”. These documents are available for organizations and county government to be used as part of data driven decision making.
      - Critical Time Intervention (CTI) has been implemented for just a year now and the participants have had successful outcomes. CTI is a nine (9) month empirically based case management model. The target population for this service has been those encountering the criminal justice system or crisis intervention. CTI provides emotional and practical support during the critical time of transitions and strengthens the individual’s engagement to community service, family, and friends.

- Needs:

- MH is exploring the need of crisis beds or the use of respite for our adults to divert some inpatient hospitalizations.
      - The structure that residential services can offer that focus on individuals living with a dual diagnosis.

- **Transition-age Youth (ages 18-26)-** Counties are encouraged to include services and support assisting this population with independent living/housing, employment, and post-secondary education/training.

- Strengths:

- Franklin/Fulton County has two agencies (Mental Health Association and TrueNorth Wellness Services) that provide youth and young adult certified peer specialist services.

- Needs:
  - Supports and services for those in this transition age that do not have a serious mental illness diagnosis. In order for many individuals transitioning into adulthood and independence there is still a needed level of care that is not available.
- **Children (under age 18)-** Counties are encouraged to include services like Student Assistance Program (SAP), respite services, and Child and Adolescent Service System Program (CASSP) coordinator services and supports, as well as the development of community alternatives and diversion efforts to residential treatment facility placements.

- Strengths:
  - Child and Adolescent Service System Program (CASSP) consists of a coordinator that is knowledgeable of the child serving system in our community. The coordinator is available to assist families and treatment teams when referring to or accessing services.
  - Student Assistance Program (SAP) is a team approach designed to help mobilize resources to remove barriers to learning. SAP’s main goal is to assist in identifying barriers to learning such as: alcohol, tobacco, and mental health issues that interfere with the student’s success. (<https://www.education.pa.gov>) SAP teams are available in all secondary and most elementary schools in the county. The teams have about a 35% rate of referrals after screening. Again, we must remember that like everything else, COVID19 affected the SAP program. They did continue to engage students through zoom and by phone when possible.

	Screenings	Referrals
Franklin	202	586
Fulton	23	65

- SAP was able to provide several groups with the students that covered such topics as: Social skills, Gratitude, Generosity, Honesty, Manners, Attendance, Respect, Responsibility, Friendship, Mindfulness, Kindness, Self-Regulation, teamwork, managing emotions, stress, healthy relationships, as well as gender based groups such as Girls Circle and Boys Council.
- School based counseling services through managed care is available in all public school districts. This removes any transportation barrier that may have prohibited the access outside of school hours.
- Collaboration with school districts and local community services.
- Strengthening Families ages 10-14 is a scientifically tested curriculum that is designed to: help parents/caregivers learn nurturing skills that support their children, teaches parents/caregivers how to effectively discipline and guide their youth, gives youth a healthy future orientation and an increased appreciation of their parents/caregivers, and teaches youth skills for dealing with stress and peer pressure. This year 13 families completed the course and 5 were cut short due to COVID. Some of

the outcomes were as follows: 50% of parents reported the course improved their ability to set standards, 55% increased parental supportiveness while 49% of the youth reported improved coping skills and 59% improved peer pressure refusal skills. 69% of parents and 51% of youth reported improved family problem solving.

- Go Girls Go program is an after school program for young girls elementary and middle school age. While the program focuses on running there is an education component that addresses the young ladies' sense of self. With over 290 girls registered and 80 mentors, the program has seen growth in the last year. It has expanded to more school districts. The outcomes from the fall session were: 75% (218) of girls reported a change in habit or behavior as a result of being in the program (this includes changes in activity level, nutritional habits, or behaviors such as goal setting) and 69% (200) of girls' reported having a better image of their body as a result of the program.
- Needs:
  - There is an increasing need for children to have access to not only mental health services but also programming that will foster their growth and success. Examples of that programming are: residential services' social and emotional skill learning, partial hospitalization, and behavioral support.
  - School-based counseling services for students with commercial insurance. Due to credentialing, sometimes providers are not in service with some of the commercial insurances and that can be a barrier for students attempting to access services.

Please identify the strengths and needs of the county/joiner service system (including any health disparities) specific to each of the following special or 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 from state hospitals**

- Strengths:
  - Well-established, positive working relationship with the social services staff at the Danville State Hospital which allows for more efficient and successful discharge planning.
  - Franklin and Fulton Counties have active Community Support Programs, CSP. The monthly meeting consists of an education component as well as community news. The meetings continued by going virtual when the restrictions were put in place around social distancing due to COVID 19.
- Needs:
  - Additional appropriate residential placement options for the hard to serve who languish at the state hospital.

- **Individuals with co-occurring mental health/substance use disorder**
  - Strengths:
    - Certified Recovery Specialists are part of a Peer-Based Recovery Support Service for persons striving to achieve long-term recovery from alcohol and/or drug addiction and related problems. It is available before, during, after and in lieu of formal treatment to help people engage into service, manage the recovery process, and work toward achieving a meaningful life in the community. This program is becoming an in plan service in the fall of 2020 after the reinvestment period served 92 individuals over a span of four (4) community providers.
    - Franklin/Fulton County residents have access to two (2) dually diagnosed licensed outpatient providers.
    - Get Back Up program utilizes a Recovery Specialist that is available to assist and engage individuals struggling with substance use issues that have come into contact with law enforcement and the courts.
  - Needs:
    - The treatment of both (mental health and substance use) services versus just the focus on one.
  
- **Criminal justice-involved individuals-** Counties are encouraged to collaboratively work within the structure of County Criminal Justice Advisory Boards to implement enhanced services for individuals involved with the criminal justice system including diversionary services that prevent further involvement with the criminal justice system as well as reentry services to support successful community reintegration.
  - Strengths:
    - Franklin/Fulton Counties have strong and active CJAB committees. The committees are diverse in membership and foster collaboration among community services.
    - Franklin/Fulton County Sequential Intercept Model, (SIM), is revised yearly to ensure that all services are captured and service gaps are identified.
    - Franklin County has an active re-entry committee made up of mental health providers, drug & alcohol providers, faith based organizations, housing providers, individuals and their families with re-entry lived experience, employment specialists, probation and jail officers. Individuals involved in the criminal justice system, along with their families, are encouraged to be part of the coalition and guide the work through their lived experiences. Franklin Together is recognized on the state level as a leading coalition whose by-laws, strategic plan, and membership documents have been used as models for other coalitions to follow. Franklin Together Reentry

Simulation, an interactive learning experience, has been presented at numerous colleges and conferences where the response is overwhelmingly positive.

- Franklin Together has a number of initiatives that target the needs of returning individuals and works to reduce or remove obstacles in order to encourage successful reintegration into the community. We provide care packages with personal care items to those who have a need. Through a partnership with a local thrift store, clothing is gifted for anyone leaving the jail who has an immediate need. Basic items such as new undergarments are collected at coalition meetings and made available on an as needed basis. A peer support group is planned to start after COVID-19 restrictions are lifted.
- Franklin County's Case Assisted ReEntry (CARE) program provides access to mental health services for individuals under county supervision. CARE pays for doctor visits, therapy, and medications until a person has insurance coverage. CARE Plus is a program specifically for jail inmates who do not have home plans. CARE Plus pays for the first month's rent and security deposit for individuals who have a proven source of income in the community. In addition, CARE Plus can provide help with food, clothing and personal hygiene items.
- Needs:
  - While housing assistance has been developed as noted above with CARE Plus, affordable housing continues to be a barrier.
  - There is always a need for more local employment options.

- **Veterans**

- Strengths:
  - The Veteran's Administration counselor continues to come into the office twice a month to offer counseling sessions for Veterans.
  - Collaboration with community providers to ensure that Veterans are connected and are able to access any needed supports and services.
  - Continued development of programs through Franklin County Veterans Affairs to assist those who have a mental illness. Example of some of the programming: Save A Vet - Save A Pet, photography, and coming soon is an equestrian program.
- Needs:
  - Reliable transportation.
  - Veteran's Administration clinic closer to the area.
  - Awareness of Franklin County Veteran's Affairs versus the Veteran's Administration. When individuals hear the term VA they often think of Martinsburg, etc. and not the Franklin County VA. Oft

times individuals don't realize that they can access Veteran service and support locally.

- **Lesbian/Gay/Bisexual/Transgender/Questioning/Intersex (LGBTQI)**

- Strengths:

- There is a bi-weekly support group in Chambersburg for people who are LGBTQ+. The average attendance is 14 participants. The support group assists with outreach to other support organizations as well.
- The Mental Health Association (MHA) provides supportive employment for people who are transitioning. Currently, 13.6% of their staff is transitioning and another 13.6% are pansexual.
- The Franklin County Coalition for Progress (FCCP), (a nonprofit) conducted a needs assessment/acceptance survey in 2018 and the results can be accessed from this link:  
[https://4e5c5dc7-a96b-4334-8cb1-98e6c1ce3daa.filesusr.com/ugd/2b3068\\_da0644cc5b6e41339333cd0c7314b525.pdf](https://4e5c5dc7-a96b-4334-8cb1-98e6c1ce3daa.filesusr.com/ugd/2b3068_da0644cc5b6e41339333cd0c7314b525.pdf)
- The FCCP coordinates [Pride Franklin County](#). The second annual Pride day was held August 4, 2019 with over 1,500 individuals in attendance. FCCP has been exploring other education and cultural awareness programming to support the LGBTQ community (we're working with a local photographer on a project - #pose4pride – which will display portraits of the LGBTQ community in various businesses in downtown Chambersburg). These programs help to increase visibility and support of the LGBTQ community.
- Shippensburg University, which is located in neighboring Cumberland county has a PRIDE Center <http://www.ship.edu/Pride/>.
- The Pennsylvania Department of Human Services (DHS) has released images that can be shared to raise awareness of the Trans Lifeline's Peer Support Hotline at 877-565-8860. You can find additional information on the Trans Lifeline's Peer Support Hotline on their website at <https://www.translifeline.org/>

- Needs:

- Additional support and awareness of LGBTQI.
- The county has no data on people in Fulton County who identify as LGBTQ. Mental Health Association of Franklin and Fulton Counties, hired a Prevention Specialist who will do more outreach in Fulton County. We hope to be able to have a support group there one day.

- **Racial/Ethnic/Linguistic Minorities (RELM) including individuals with Limited English Proficiency (LEP)**

- Strengths:

- A few of our mental health outpatient providers have been able to secure bilingual staff that are able to provide clinical services to individuals speaking Spanish.

- WellSpan medical facilities have access to a system that connects a live translation on a computer screen to assist during appointments.
- Franklin County has a Hispanic Center that is active and collaborates with human services.
- Needs:
  - Access to more bi lingual professional staff is a need in our community.
  - More providers with access to language lines or assistance with interpreters.
  - Educational material and resources easily accessible in other languages.
- **Other (specify), if any** (including tribal groups, people living with HIV/AIDS or other chronic diseases or impairments, acquired brain injury, fetal alcohol spectrum disorders)
  - Strengths:
    - Keystone Health Services provides free HIV/AIDS testing throughout the community. They provide mobile pop-up testing sites due to transportation being an issue throughout our community. They also provide free education to individuals or groups that request it.
  - Needs:
    - Services and support for individuals living with traumatic brain injury is needed in our community.
    - Education for professionals regarding traumatic brain injury has been difficult to locate.
    - Services and supports for individuals with fetal alcohol syndrome. There are services for substance use and educational material for prevention but nothing to support those individuals and families with the disease.

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

Yes     No

If yes, please describe the CLC training being used, including training content/topics covered, frequency with which training is offered, and vendor utilized (if applicable). If not, counties may include descriptions of plans to implement CLC training in FY 20-21. (Limit of 1 page)

**Does the county currently have any suicide prevention initiatives?**

Yes     No

If yes, please describe the initiatives. If not, counties may describe plans to implement future initiatives in the coming fiscal year. (Limit of 1 page)

**Franklin County Suicide Prevention Plan**

**Goal 4.2: Reduce the rates of suicide in Franklin County**

Objective 4.2.1: Expand the existing community-wide mental health initiatives to focus on supporting at-risk populations, reducing stigma, and increasing

Strategy	Activities	Lead/Responsible	Performance Measures	Status		
				Jul-Sep (Qtr 1)	Oct-Dec (Qtr 2)	Jan-Jun (Qtr 3 & 4)
<b>Strategy 4.2.1.1:</b> Increase local capacity to reduce suicide by providing evidence-based programming	Provide QPR training	Franklin County MH/IDD/EI & MHAFF	# of people trained # of trainings	10 – online 11-in person	6-online 11 in person	Propose to redesign to deliver virtual due to COVID
<b>Strategy 4.2.1.2:</b> Increase awareness of suicide prevention resources and interventions	Implement Suicide Prevention Month Campaign initiatives. <ul style="list-style-type: none"> <li>Distribute Talk About it Coasters</li> <li>The S Word Movie &amp; First Friday</li> <li>Proclamation &amp; Purple Ribbons/Lights</li> </ul> You're Worth It Window Clings	Suicide Prevention Coalition	# of events # of participants # of outreach	1 event/Community Film Night; 83 in attendance 993 coasters distributed 318 You're Worth It window clings distributed Leverage Recovery Month Purple Lights Campaign	556 You're Worth It Window Clings distributed	Propose redesign due to COVID
	Research and create Out of Darkness walk plan	Suicide Prevention Coalition	Plan created	Not started	Discussions	On hold due to COVID
<b>Strategy 4.2.1.3:</b> Work with schools to identify students with depression and connect families with appropriate services	Pilot a depression screening program in Chambersburg Area Senior High School.	HCP, CASD, Franklin County MH/IDD/EI	# of students screened # of referrals made to services # & % of screenings positive for depression	Not started	Pilot at CASD Career Magnet School; 31 students – 2 in crisis identified	Interrupted due to COVID

**PA Act 36 of 2018, The Employment First Act requires:**

State and county agencies and entities providing publicly funded education, training, employment and related services and long-term services and support for working-age Pennsylvanians with a disability that provide services and support to individuals with a disability to coordinate efforts and collaborate to ensure that State programs, policies, procedures and funding support competitive integrated employment for individuals with a disability who are eligible to work under Federal or State law.

When serving adults with severe mental illness (SMI) or children with severe emotional disturbance (SED), please describe how the county/joinder supports employment by providing the following:

1. Please outline the process the county/mental health case management system uses to identify and connect individuals with SMI to federal block-grant funded supported employment services.
  - a. Occupational Services Inc., (OSI), obtains referrals from Service Access Management, (SAM), Case Management for clients voicing an interest in obtaining/maintaining gainful integrated employment in the community. Typically the Supported Employment Services Manager of OSI receives a phone call or email to discuss possible referral. OSI offers Transitional Employment, Vocational Rehabilitation, Extended Employment Services and Supporting Individuals Transitioning to Employment Success (SITES).
  - b. AHEDD (a specialized Human Resources organization) receives referrals directly from case managers at Service Access and Management (SAM). Case managers assess an individual's interest in receiving supported employment services. AHEDD maintains regular contact with case management and conducts quarterly meetings, where progress is documented and discussed. AHEDD also maintains contact with the Mental Health Program Specialist, at MH/IDD/EI, regarding quarterly progress on numerous benchmarks.
  
2. What issues do individuals with SMI whom the county serves indicate they experience in connecting with the Office of Vocational Rehabilitation or CareerLink?
  - a. OSI (Occupational Services Inc.) has experienced difficulty logging in to the Office of Vocational Rehabilitation Website to assist an individual to apply for services. The system will boot you out and when you go to log back in, there is difficulty with the previous log-in information that you used. Clients report the Website to be hard to navigate.
  - b. Individuals report having difficulty connecting with counselors at the Office of Vocational Rehabilitation to complete the referral/application process. There is also a waiting list, which prohibits individuals from receiving services in a timely manner. Individuals report not wanting to open a case with the Office of Vocational Rehabilitation, due to the length of time it takes to receive services. AHEDD is not aware of any issues

connected with utilizing services through CareerLink. The CareerLink system seems to be user friendly and accessible to participants.

3. What activities does the county/mental health case management system perform to partner with school districts in support of pre-vocational activities identified on the Individualized Education Program (IEP) of students with SED or SMI?

- a. OSI (Occupational Services Inc.) has provided services to the **PETS** students at the Chambersburg Area Senior High School by obtaining work from Trickling Springs Creamery. OSI provided job coaching and observation of the students performing work and being paid minimum wage directly from the Company. OSI also attends and sets up tables at Transition Fairs and annual student day.
- b. AHEDD receives county funding to provide services to local school students with disabilities. This program is entitled, TALS (Transition to Adult Life Success). AHEDD currently partners with the following school districts: Chambersburg, Waynesboro, Greencastle, James Buchanan, and Fannett Metal.

4. Does the county have a mental health point of contact for employment services?

Yes     No

**c) Supportive Housing:**

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 the Office of Mental Health and Substance Abuse Services (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, or at risk of, experiencing homelessness.

**SUPPORTIVE HOUSING ACTIVITY** *includes Community Hospital Integration Projects Program (CHIPP), Reinvestment, County base-funded projects and others that were planned, whether funded or not. **Identify program activities approved in FY19-20 that are in the implementation process. Please use one row for each funding source and add rows as necessary. (However, do not report collected data (columns 3, 4 & 5) for the current year, FY19-20, until the submission of next year's planning documents.)***

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<b>1. Capital Projects for Behavioral Health</b>				<input type="checkbox"/> Check if available in the county and complete the section.					
<b>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).</b>									
Project Name	Funding Sources by Type (include grants, federal, state & local sources)	Total \$ Amount for FY18-19 (only County MH/ID dedicated funds)	Projected \$ Amount for FY20-21 (only County MH/ID dedicated funds)	Actual or Estimated Number Served in FY18-19	Projected Number to be Served in FY20-21	Number of Targeted BH Units	Term of Targeted BH Units (e.g., 30 years)		Year Project first started
<b>Notes:</b>									

<b>2. Bridge Rental Subsidy Program for Behavioral Health</b>				<input type="checkbox"/> Check if available in the county and complete the section.					
<b>Short-term tenant-based rental subsidies, intended to be a “bridge” to more permanent housing subsidy such as Housing Choice Vouchers.</b>									
	Funding Sources by Type (include grants, federal, state & local sources)	Total \$ Amount for FY18-19	Projected \$ Amount for FY20-21	Actual or Estimated Number Served in FY18-19	Projected Number to be Served in FY20-21	Number of Bridge Subsidies in FY18-19	Average Monthly Subsidy Amount in FY18-19	Number of Individuals Transitioned to another Subsidy in FY18-19	Year Project first started
<b>Notes:</b>									

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<b>3. Master Leasing (ML) Program for Behavioral Health</b>				<input type="checkbox"/> Check if available in the county and complete the section.					
<b>Leasing units from private owners and then subleasing and subsidizing these units to consumers.</b>									
	Funding Source by Type (include grants, federal, state & local sources)	Total \$ Amount for FY18-19	Projected \$ Amount for FY20-21	Actual or Estimated Number Served in FY18-19	Projected Number to be Served in FY20-21	Number of Owners/ Projects Currently Leasing	Number of Units Assisted with Master Leasing in FY18-19	Average Subsidy Amount in FY18-19	Year Project first started
				22	23	10 Landlords	27	\$550	2006
	Federal HUD	180,716	227,443						
	HTF Match	8,878	12,943						
In-Kind Match	In-Kind Match	15,725	18,726						
Notes:									

<b>4. Housing Clearinghouse for Behavioral Health</b>				<input type="checkbox"/> Check if available in the county and complete the section.					
<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 FY18-19	Projected \$ Amount for FY20-21	Actual or Estimated Number Served in FY18-19	Projected Number to be Served in FY20-21			Number of Staff FTEs in FY18-19	Year Project first started
Notes:									

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<b>5. Housing Support Services (HSS) for Behavioral Health</b>				<input type="checkbox"/> Check if available in the county and complete the section.					
<b>HSS are used to assist consumers in transitions to supportive housing or services needed to assist individuals in sustaining their housing after move-in.</b>									
	Funding Sources by Type (include grants, federal, state & local sources)	Total \$ Amount for FY18-19	Projected \$ Amount for FY20-21	Actual or Estimated Number Served in FY18-19	Projected Number to be Served in FY20-21			Number of Staff FTEs in FY18-19	Year Project first started
PATH				37	30-35			0.5	2005
	Federal	63,459	49,725						
	State HSBG	21,154	16,575						
	County Match	571	448						
Notes:									

<b>6. Housing Contingency Funds for Behavioral Health</b>				<input type="checkbox"/> Check if available in the county and complete the section.					
<b>Flexible funds for one-time and emergency costs such as security deposits for apartment or utilities, utility hook-up fees, furnishings, and other allowable costs.</b>									
	Funding Sources by Type (include grants, federal, state & local sources)	Total \$ Amount for FY18-19	Projected \$ Amount for FY20-21	Actual or Estimated Number Served in FY18-19	Projected Number to be Served in FY20-21			Average Contingency Amount per person	Year Project first started
Family Housing Grant				31	0			580.65	2016
	State HSBG	17,514	0						
	County Match	486	0						
Housing Expansion				6	0			471.50	2006
	State HSBG	2,594	0						
	County Match	72	0						
Notes:									

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7. Other: Identify the Program for Behavioral Health		<input 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 the 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>								
Project Name (include type of project such as PBOA, FWL, CRR Conversion, etc.)	Funding Sources by Type (include grants, federal, state & local sources)	Total \$ Amount for FY18-19	Projected \$ Amount for FY20-21	Actual or Estimated Number Served in FY18-19	Projected Number to be Served in FY20-21			Year Project first started
HUD PSH				5	10			2008
	Federal	31,279	86,568					
	In-Kind Match	7,951	21,642					
	Cash Match	1,076						
Housing Expansion				4	3			2006
	State HSBG	22,021	18,000					
	County Match	611						
SCR-KSS				9	8			2005
	State HSBG	383,618						
	Federal	14,113						

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	County Match	10,645						
SLP-TN				15	16			2005
	State HSBG	741,884						
	Federal	27,603						
	County Match	20,587						
CRR Full Care - NV				14	10			2003
	State HSBG	297,017						
	Federal	11,498						
	County Match	8,242						
Forensic SCR				0	8			2019
	State HSBG	72,002						
	County Match	1,998						
Notes:								

**d) Recovery-Oriented Systems Transformation:** (Limit of 5 pages)

1. Provide a brief summary of the progress made on the priorities listed in the FY 19-20 plan.

<b>Priority</b>	<b>Narrative</b>	<b>Action Steps</b>	<b>Timeline</b>	<b>Summary</b>
1. Suicide Prevention	a. Develop and implement a Zero Suicide Prevention initiative emphasizing the value and importance of each individual.	Create a scalable pilot program to promote a zero suicide philosophy	December 2018	Still researching – has proven difficult to implement
		Provide QPR, ASIST, and other suicide prevention evidence-based trainings.	continual	QPR trainings in person (94) and on line (112). We also hosted a train the trainer event. ASIST was not provided due to lack of trainers.
		Implement Suicide Prevention Month Campaign initiatives	September 2019	Commissioner’s proclamation, lights around trees on Main St., Window clings, magnets and coasters were distributed with the national suicide hotline. messaging promoting resources were distributed
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.	Done	This list has been completed.
		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	This was completed and action plan was implemented in 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	This continues as the tool identified was the PHQ.  This is still in progress.

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		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	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	No action to report. Still working towards this goal.
	with Primary Care offices.	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.	December 2019	2 doctor's offices have implemented a behavioral health therapist into their practices.
	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.	December 2020	May recognized with commissioner proclamation. Many of our other activities were interrupted due to COVID. An interactive mental health provider GPS map was created that is accessible from several websites. Mental health Monday was created. Small positive messaging is posted on social media.
		ii. Continue and expand existing community campaigns that educate the public about effective ways to manage depression (i.e., physical activity, nutrition).		
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	Re-entry simulation is available Interactive web site
		ii. Educate employers about reentry and hiring individuals with criminal backgrounds.	ongoing	PA Careerlink continues to educate our local employers. United Way continues to host certified classes for forklift drivers and welders
	b. SUPPORT	i. Identify all existing community resources and update the Reentry Resource Guide available in print and digital formats.	Done	

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		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	Resources are available by print or on line
		iii. Develop a reentry discharge planning team and/or follow up team to work with people before and after release.	Done	Development of CARE program. Care packages upon reentry Clothing vouchers Case studies workgroup
	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 2018	Re-entry committee members are active in the LHOT (local housing option team) coalition
		ii. Commit to keeping formerly incarcerated people involved in Reentry Coalition meetings and include on committee work.	ongoing	The outreach committee meets at the re-entry center for ease of access to members participating. Re-entry story is a standing agenda item on the coalition meeting
	d. ADVOCATE FOR CHANGE	i. Examine reentry processes and protocols, looking for opportunities to enhance or develop better processes and remove process barriers.	ongoing	The committee has developed a re-entry simulation program that has been provided throughout the community as well as in other communities by request.
	4. Data collection to increase knowledge of quality of services in order to assist in making better decisions for service delivery.	County Human Services are working with our managed care organization to create a data warehouse to track human services data across systems.	i. Begin upload of data for county HS departments to compare and contrast for developing services	Spring 2018
		ii. Data scrubbing to ensure that the data is accurate and all paths are uploading correctly.	Spring 2018	Human Services Data Warehouse (HSDW) has implemented interactive dashboards for the following departments: Drug and Alcohol, Mental Health, Intellectual Disabilities, Administration, and reinvestment programs. Other departments that are scheduled to be added include CYS, Veterans, Aging, Early Intervention, Housing (HMIS), Information and Referral, and Department of Emergency Services. As of 6/30/2020 there will be 27 individuals with access to the Data Warehouse and information from this is being used in presentations for the HSBG Committee, to other counties, and for support in interdepartmental meetings.
		iii. Creating dashboards and report to begin analysis.	Fall 2019	
		iv. Begin data driven decision making	Winter 2019	

2. Based on the strengths and needs reported in section (b), please identify the top three to five priorities for recovery-oriented system transformation efforts the county plans to address in FY 20-21 at current funding levels. For **each** transformation priority, please provide:

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

**1. (Identify Priority)**

<b>Priority</b>	<b>Narrative</b>	<b>Action Steps</b>	<b>Timeline</b>	<b>Resources Needed</b>	<b>Tracking Mechanism</b>
1. Suicide Prevention ( <input checked="" type="checkbox"/> Continuing from prior year <input type="checkbox"/> New Priority)	a. Develop and implement a Suicide Prevention initiative emphasizing the value and importance of each individual.	Provide QPR training to the community free. Training available in person or online.	continual	\$12,000 may be needed to support train the trainer event for ASIST and some materials for the campaign initiatives	This is monitored through the Suicide prevention task force and Healthy Franklin County. The coroner's office will be a source of data collection.
		Train the Trainer event for ASIST	June 2021		
		Implement Suicide Prevention Month Campaign initiatives	September 2020		
2. Addressing health literacy and resilience in our community ( <input checked="" type="checkbox"/> Continuing from prior year <input type="checkbox"/> New Priority)	a. Increase provider awareness of trauma informed care.	i. MH will purchase license agreement with PESI, for training, "Treatment Certification Workshop: EMDR, CBT and Somatic Based Interventions to Move Clients from Surviving to Thriving" for contracted providers to complete and licensed providers will be certified trauma professionals	November 2020	\$2,000	This is monitored through the Franklin/Fulton County MH/IDD/EI, MH task force and Healthy Franklin County.
		ii. CIT will sponsor several refresher training courses to CIT officers "How Being Trauma Informed Improves Your Criminal Justice Response" and De-escalation Techniques	June 30		

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		iii. Provide training and support for local community to include: business, neighbors, providers etc.	continual	\$500	
	b. 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.	September 2020		This is monitored through the MH task force and Health Franklin County.
		ii. Continue and expand existing community campaigns that educate the public about effective ways to manage depression (i.e., physical activity, nutrition).	January 2021	\$1,500	This is monitored through Chambersburg Cares, the MH task force and Health Franklin County.
		iii. 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, TBI, fetal alcohol syndrome, and LGBTQI.	June 2021	\$5,500	This is monitored through Franklin/Fulton MH/IDD/EI, TMCA, the MH task force and Health Franklin County.
3. Housing placements and supportive services needed for individuals with intense behaviors  ( <input type="checkbox"/> Continuing from prior year <input checked="" type="checkbox"/> New Priority)	a. Identify models of housing programs available	i. Identify scenarios and case studies of behaviors that have been prohibited to successful placement of residential options.	December 2020	Funds needed will be determined during action steps.	This is monitored through Franklin/Fulton MH/IDD/EI
		ii. Create workgroup to develop residential/housing model for those needs.	April 2021	Funds needed will be determined during action steps.	This is monitored through Franklin/Fulton MH/IDD/EI
	b. Identify models of supportive services that support individuals experiencing an immediate crisis need	i. Create a workgroup to include families that would be able to utilize respite to research and create a model of respite for our community.	December 2020	\$8,000 (ball park guess)	This is monitored through Franklin/Fulton MH/ID/EI and Human Services Block Grant Committee

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		ii. Research the models in which crisis beds can be provided and create plan for implementation.	April 2021	\$10,000 (ball park guess)	This is monitored through Franklin/Fulton MH/IDD/EI and TMCA
4. Continue growth of CIT program  ( <input type="checkbox"/> Continuing from prior year <input checked="" type="checkbox"/> New Priority)	a. Training for Franklin/Fulton first responders	i. Continue to host 40 Memphis model based CIT training at least every April. Depending on COVID a make-up training may be held Sept 2020 due to cancelation of April 2020	Sept 2020 April 2021	\$3,000	This is monitored by Franklin/Fulton MH/IDD/EI and CJAB's First Contact Committee
		ii. Host CIT refresher trainings. Topics to include: trauma and de-escalation.	March 2021 May 2021	\$450	This is monitored by Franklin/Fulton MH/IDD/EI and CJAB's First Contact Committee
		iii. Expansion of co responder program to include 3 <sup>rd</sup> co responder with a focus of the 60+ population. This co responder would take the lead on inmates who are ready for release also.	June 2021	\$75,000	This is monitored by Franklin/Fulton MH/IDD/EI and CJAB's First Contact Committee

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

Please indicate all currently available services and the funding source(s) 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 checked="" 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 - Adult	<input checked="" type="checkbox"/>	<input type="checkbox"/> County <input checked="" type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Partial Hospitalization - Child/Youth	<input checked="" type="checkbox"/>	<input 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
Assertive Community Treatment (ACT) or Community Treatment Team (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
Telephone Crisis Services		
Walk-in Crisis Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> County <input checked="" type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Mobile Crisis Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> County <input checked="" type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Crisis Residential Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> County <input checked="" type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Crisis In-Home Support Services	<input type="checkbox"/>	<input type="checkbox"/> County <input type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Emergency Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> County <input type="checkbox"/> HC <input 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 checked="" type="checkbox"/>	<input checked="" 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 Rehabilitation Services	<input checked="" type="checkbox"/>	<input type="checkbox"/> County <input checked="" type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Psychiatric Rehabilitation	<input type="checkbox"/>	<input type="checkbox"/> County <input 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 checked="" type="checkbox"/>	<input checked="" type="checkbox"/> County <input type="checkbox"/> HC <input checked="" type="checkbox"/> Reinvestment
Community Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> County <input type="checkbox"/> HC <input checked="" type="checkbox"/> Reinvestment
Mobile Mental Health Treatment	<input type="checkbox"/>	<input type="checkbox"/> County <input type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Behavioral Health Rehabilitation Services for Children and Adolescents	<input checked="" type="checkbox"/>	<input type="checkbox"/> County <input checked="" type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Inpatient Drug & Alcohol (Detoxification and Rehabilitation)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> County <input checked="" type="checkbox"/> HC <input type="checkbox"/> Reinvestment
Outpatient Drug & Alcohol Services	<input checked="" type="checkbox"/>	<input checked="" 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 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

Note: HC= HealthChoices

**f) Evidence-Based Practices (EBP) 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	N	N/A	N/A	N/A	N/A	N/A	N/A	County would like to have service
Supportive Housing	Y	41	N/A	Agency/ County	annually	N	Y	
Supported Employment	Y	124	N/A	Agency/ County	annually	N	Y	Include # Employed
Integrated Treatment for Co-occurring Disorders (Mental Health/SUD)	Y	N/A	CodeCat	Agency/ County/ HC	annually	N	Y	
Illness Management/ Recovery	N	N/A	N/A	N/A	N/A	N/A	N/A	
Medication Management (MedTEAM)	N	N/A	N/A	N/A	N/A	N/A	N/A	
Therapeutic Foster Care	Y	N/A	N/A	Agency/ State	annually	N/A	N/A	Provided by C&Y Services
Multisystemic Therapy	N	N/A	N/A	N/A	N/A	N/A	N/A	
Functional Family Therapy	N	N/A	N/A	N/A	N/A	N/A	N/A	
Family Psycho-Education	N	N/A	N/A	N/A	N/A	N/A	N/A	Information not tracked

\*Please include both county and HealthChoices funded services.

To access SAMHSA’s EBP toolkits visit:

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

g) <u>Additional EBP, Recovery-Oriented and Promising Practices Survey</u> *:Recovery-Oriented and Promising Practices	Service Provided (Yes/No)	Current Number Served (Approximate )	Additional Information and Comments
Consumer/Family Satisfaction Team	Yes	477	101 (County) 376 (MC)
Compeer	No	N/A	
Fairweather Lodge	Yes	10	Not County or MC funded
MA Funded Certified Peer Specialist (CPS)- Total**	Yes	125	111 in age group 27-64
CPS Services for Transition Age Youth (TAY)	Yes	1	Age 17-26
CPS Services for Older Adults (OAs)	Yes	13	Age 65+
Other Funded CPS- Total**	Yes	42	
CPS Services for TAY	Yes	9	2 youth/7 young adults
CPS Services for OAs	Yes	24	
Dialectical Behavioral Therapy	Yes	N/A	Providers offer, but not tracked MC or Co. tracked MC or county
Mobile Medication	No	N/A	
Wellness Recovery Action Plan (WRAP)	Yes		
High Fidelity Wrap Around	No	N/A	
Shared Decision Making	No	N/A	
Psychiatric Rehabilitation Services (including clubhouse)	No	N/A	
Self-Directed Care	No	N/A	
Supported Education	No	N/A	
Treatment of Depression in OAs	No	N/A	
Consumer-Operated Services	Yes	60	CRS/Peer Operated Rec Center Approval
Parent Child Interaction Therapy	Yes	5	1 provider (Laurel Life)
Sanctuary	No	N/A	
Trauma-Focused Cognitive Behavioral Therapy	Yes	48	5 providers
Eye Movement Desensitization and Reprocessing (EMDR)	Yes	N/A	Providers offer EMDR, not tracked by MC/Co.

First Episode Psychosis Coordinated Specialty Care	No	N/A	
Other (Specify) TARGET	Yes	51	16 clinicians: OP, OP-SB, & Jail setting
Other (Specify) Critical Time Intervention (CTI)	Yes	59	1 provider: PCS out of 59 referrals, 30 open/active
Other (Specify) Juvenile Sex Offender Program	Yes	24	Providers: FBR & PCS
Other (Specify) Recovery Housing	Yes	89	1 provider – 2 Recovery Houses – 1 M/1F
Other (Specify) MH Co-Responders	Yes	38	2 MH Professionals embedded in 4 Police Depts.

\*Please include both county and HealthChoices funded services.

\*\*Include CPS services provided to all age groups in total, including those in the age break outs for TAY and OAs.

**Reference: Please see SAMHSA’s National Registry of Evidenced-Based Practices and Programs for more information on some of the practices.**

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

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

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

An individual with lived mental health recovery experience who has been trained by a Pennsylvania Certification Board (PCB) approved training entity and is certified by the PCB.

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

- case management
- inpatient settings
- psychiatric rehabilitation centers
- intensive outpatient programs
- drop-in centers
- HealthChoices peer support programs
- consumer-run organizations
- residential settings
- ACT or Forensic ACT teams

<b>Total Number of CPSs Employed</b>	<b>5</b>
<b>Number Full Time (30 hours or more)</b>	<b>2</b>
<b>Number Part Time (Under 30 hours)</b>	<b>3</b>

**i) Involuntary Mental Health Treatment**

1. During CY2019, did the County/Joinder offer Assisted Outpatient Treatment (AOT) Services under PA Act 106 of 2018?
  - No, chose to opt-out for all of CY2019

- Yes, AOT services were provided from \_\_\_\_\_ to \_\_\_\_\_ after a request was made to rescind the opt-out statement
- Yes, AOT services were available for all of CY2019

2. If the County/Joinder chose to provide AOT, list all outpatient services that were provided in the County/Joinder for all or a portion of CY2019 (check all that apply):

- Community psychiatric supportive treatment
- ACT
- Medications
- Individual or group therapy
- Peer support services
- Financial services
- Housing or supervised living arrangements
- Alcohol or substance abuse treatment when the treatment is for a co-occurring condition for a person with a primary diagnosis of mental illness
- Other, please specify: \_\_\_\_\_

3. If the County/Joinder chose to opt-out of providing AOT services for all or a portion of CY2019:

- How many written petitions for AOT services were received during the opt-out period? 0
- How many individuals did the county identify who would have met the criteria for AOT under Section 301(c) of the Mental Health Procedures Act (MHPA) (50 P.S. § 7301(c))? \_\_\_\_\_

	AOT	IOT
Number of individuals subject to involuntary treatment in CY2019	N/A	73 unduplicated
Inpatient hospitalizations following an involuntary outpatient treatment for CY2019		1 (interpreted as a 306 hearing)
Number of AOT modification hearings in CY2019	0	
Number of 180-day extended orders in CY2019	N/A	109 (duplicated total; interpreted as 305 commitment orders)
Total administrative costs (including but not limited to court fees, costs associated with law enforcement, staffing, etc.) for providing involuntary services in CY2019	N/A	\$28,838.00*

**\*includes the following expenses: all emergency delegates; hearing testimony by psychiatrist at WellSpan Behavioral Health and Keystone Behavioral Health; and, all Mental Health Review Officer expenses**

## **INTELLECTUAL DISABILITY SERVICES**

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

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

With that in mind, please describe the continuum of services to registered individuals with an intellectual disability and autism 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 individuals for whom Base or HSBG funds have been or will be expended. Appendix C should reflect only Base or HSBG funds except for the Administration category. Administrative expenditures should be included for both base and HSBG and waiver administrative funds.

*\*Please note that under Person-Directed Supports (PDS), 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 & Developmental Disabilities/ Early Intervention is to partner with the community to develop and assure the availability of quality MH/IDD/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 IDD 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 IDD program 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 May 31, 2020, there were 540 individuals registered in the IDD program in Franklin County. These individuals are from all funding streams. The breakdown is shown in the chart below:

<b>Diagnosis</b>	<b>Number of individuals</b>	<b>Percentage</b>
Autism Only	21	4
Intellectual Disability with Secondary Diagnosis of Autism	164	30
Intellectual Disability Only	355	66

### Individuals Served

	<i>Estimated Number of Individuals served in FY 19-20</i>	<i>Percent of total Number of Individuals Served</i>	<i>Projected Number of Individuals to be Served in FY 20-21</i>	<i>Percent of total Number of Individuals Served</i>
Supported Employment	25	4.5	25	4.5
Pre-Vocational	0	0	0	0
Community participation	6	1.2	6	1.2
Base-Funded Supports Coordination	65	12	65	12
Residential (6400)/unlicensed	0	0	0	0
Lifesharing (6500)/unlicensed	0	0	0	0
PDS/AWC	0	0	0	0
PDS/VF	0	0	0	0
Family Driven Family Support Services	29	5.3	31	5.6

**Supported Employment:** “Employment First” is the policy of all commonwealth executive branch agencies under the jurisdiction of the governor. ODP is strongly committed to competitive integrated employment for all.

- Please describe the services that are currently available in the county such as discovery, customized employment, and other services.
- Please identify changes in the 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 the county is a participant.

Employment First is a policy that promotes competitive integrated employment. Franklin/ Fulton IDD Program is supporting this policy in a variety of ways.

The “Transition to Adult Life Success” (TALS) program engages young adults with disabilities in discussions and activities pertaining to areas of self-determination and career exploration. The TALS 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 were 28 students in the TALS program in Franklin County. The TALS program has a goal of placing ten (10)

individuals into a competitive job. As of December 2019, the TALS program has placed six (6) students in competitive employment.

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 disabilities in a competitive job. Of the 25 people receiving base funded Supported Employment, all 25 have competitive integrated employment jobs.

Providers continue to work on becoming trained in the discovery process. They also continue to have staff become certified by the Association of Community Rehabilitation Educators (ACRE) and Certified Employment Support Professional (CESP).

Small Group Employment services consist of supporting participants in transitioning to competitive integrated employment through work that occurs in a location other than a facility subject to 55 Pa. Code Chapter 2380 or Chapter 2390 regulations. The goal of Small Group Employment is competitive integrated employment. Participants participating in this service must have a competitive integrated employment outcome included in their service plan and it must be documented in the service plan how and when the provision of this service is expected to lead to competitive integrated employment. Work that participants perform during the provision of Small Group Employment services must be paid at least minimum wage and the compensation must be similar to compensation earned by workers without disabilities performing the same work. Small Group Employment service options include mobile workforce, work station in industry, affirmative industry and enclave. While there are no base funded individuals participating in Small Group Employment, there are eight (8) individuals receiving Small Group Employment Services.

Discovery is a targeted service for a participant who wishes to pursue competitive integrated employment but, due to the impact of their disability, their skills, preferences and/or potential contributions cannot be best captured through traditional, standardized means, such as functional task assessments, situational assessments and/or traditional normative assessments which compare the participant to others or arbitrary standards of performance and/ or behavior. Discovery involves a comprehensive analysis of the participant in relation to the following:

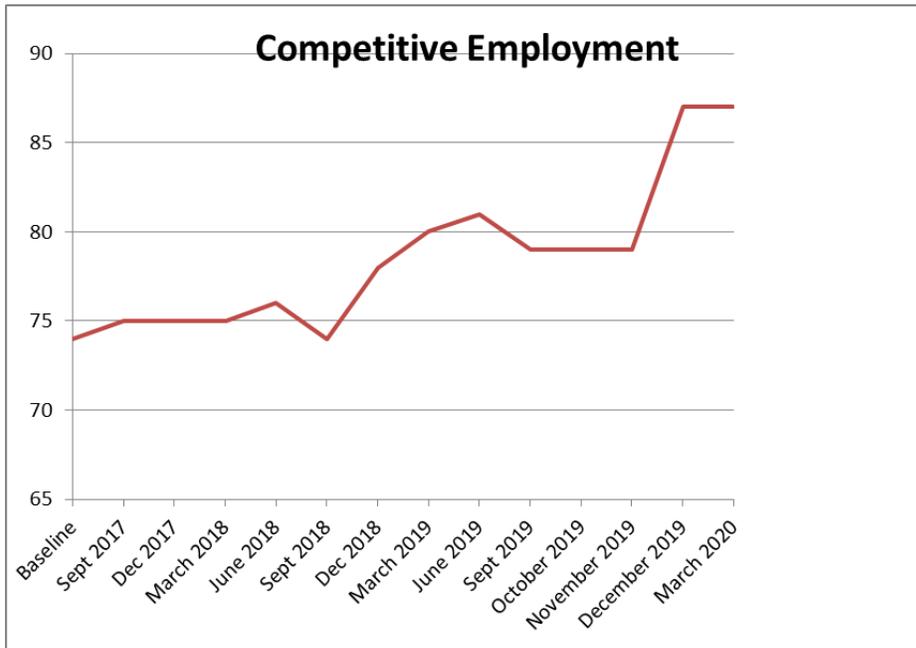
- Strongest interests toward one or more specific aspects of the labor market and
- Skills, strengths and other contributions likely to be valuable to employers or valuable to the community if offered through self-employment and
- Conditions necessary for successful employment or self-employment

All Employment providers use Discovery as part of their employment process. One of our providers has a staff person credentialed to provide Discovery as a

discrete service. At this time no one in Franklin County uses Discovery as discrete services.

Community Participation Support is defined as “providing opportunities and support for community inclusion and building interest in and developing skills and potential for competitive integrated employment”. Services should result in active, valued participation in a broad range of integrated activities that build on the participants’ interests, preferences, gifts and strengths while reflecting his or her desired outcomes related to employment, community involvement and membership. Community Participation Support is intended to flexibly wrap around or otherwise support community life secondary to employment, as a primary goal. This service involves participation in integrated community settings, in activities that involve persons without disabilities who are not paid or unpaid caregivers. This service is expected to result in the participant developing and sustaining a range of valued social roles and relationships, building natural supports, increasing independence, increasing potential for employment, and experiencing meaningful community participation and inclusion.” The Franklin/ Fulton IDD program will continue to support providers in providing Community Participation Support. There are currently six (6) individuals who utilize base dollars to fund Community Participation Support within a pre-vocational setting. All six of these individuals have experienced difficulty working due to COVID-19, though some are able to work remotely. All six individuals will hopefully regain full employment when the COVID-19 pandemic is over.

The IDD program is concentrating on Competitive Integrated Employment which includes Supported Employment and Small Group Employment for our Quality Management Goal (See Appendix E). The outcome for the Quality Management Plan is “*people who choose to work are employed in the community.*” There were 87 individuals who were employed in Competitive Integrated Employment before the COVID-10 pandemic. The Franklin/ Fulton County IDD program have not been able to have an accurate count of those employed. As with the rest of the state, some individuals have been laid off, furloughed, the business has closed temporarily and some are still working in an essential business. The program will assess who is still working once the pandemic crisis is over and it can be determined who has returned to work. The following graph shows how employment has increased over the past 3 years of the QM plan. This outcome will continue into the next QM plan year also.



Franklin/ Fulton County IDD Program collaborates with OVR in identifying people who will benefit from Pre-employment Transition Services, Paid Work Experiences and Job Shadowing within the school districts. The Franklin/ Fulton IDD Program participates in the Transition Council which includes representatives from OVR, School Districts and providers to promote and support the Employment First Model. OVR and the IDD Program facilitate the STAR (Student Transition to Adult Review) meetings for students and their parents to focus on their plan for transitioning from high school. Discussion centers on student's interests, goals and present levels in relation to employment and independent living and support needed. This also provides an opportunity to register with the IDD program and OVR if the person has not already done so. Franklin/ Fulton County IDD Program also attends the transition fairs at the high school to provide information to students and families, as well as, funding and assisting in the organization of a County Transition Fair for students at a local college. The fair was cancelled this year due to COVID -19, but will resume for 2020-2021.

### Supports Coordination:

- Please describe how the county will assist the support coordination organization (SCO) to engage individuals and families to explore the communities of practice/supporting families model using the life course tools to link individuals to resources available in the community.
- Please describe how the county will assist coordinators to effectively engage and plan for individuals on the waiting list.
- Please describe the collaborative efforts the county will utilize to assist SCOs with promoting self-direction.

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 and individuals who do not qualify for MA. These services are only paid for individuals who have had a denial of Medical Assistance Coverage. There are 51 people who have base funded Support Coordination either because they are not eligible for MA or they lost their MA for part of the year. There are ten (10) people (9 Franklin; 1 Fulton) who have the OBRA Waiver and have base funded Supports coordination. There are 4 people who reside in an ICF/ID or State Center and receive base funded Support Coordination. Currently, no one is interested in leaving the State Center system from Franklin County, so transition services are not needed at this time. See Community for All Section form more information. The IDD program has MA denials for the people who are receiving base services over \$8,000.

The IDD Program collaborates with the Supports Coordination Organization (SCO) by holding monthly meetings with Support Coordination Supervisors. During these meetings, individuals who are deemed high profile or have an 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, Levels of Care, incident management, provider risk assessments, IM4Q and other items are part of the standing agenda discussed at this monthly meeting.

The SCO is also represented on the Transition Council and is encouraged to participate in State Employment Leadership Network (SELN) training to promote community integrated employment.

The IDD Program and the SCO collaborate and participate in training with the Office of Vocational Rehabilitation on implementation of Workforce Innovation and Opportunity Act (WIOA). The IDD program developed and uses an OVR referral process to streamline, track and facilitate in accessing OVR services. OVR has implemented an Order of Closure and now has a waiting list. While the IDD program is still working closely with OVR during the closure, all individuals interested in competitive integrated employment are authorized to receive supportive employment if needed.

Franklin/ Fulton County is part of one of the Regional Collaboratives for the Community of Practice. Franklin/ Fulton has combined their stakeholder group with York/ Adams Counties in the past year. The SCO is part of the Stakeholder group for the Regional Collaborative. The State Community of Practice has established the following goals: Family Engagement, Employment, Front Door and Supports Coordination. Supports Coordinators use the life course principles and activities to help individuals and families plan for the future. The Supports Coordination Organization supports the initiatives of the Community of Practice. See more information about Regional Collaborative in Administrative Funding.

### **Lifesharing and Supported Living:**

- Please describe how the county will support the growth of Lifesharing and Supported Living as an option.

- Please describe the barriers to the growth of Lifesharing and Supported Living in the county.
- Please describe the actions the county found to be successful in expanding Lifesharing and Supported Living in the county despite the barriers.
- Please explain how ODP can be of assistance to the county in expanding and growing Lifesharing and Supported Living as an option in the 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’s outcome “*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 & Developmental 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 is “adult foster care.” We will continue to help 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 the home of a relative and receiving 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 information). The funding that supports 36 of these individuals in their life-sharing homes is waiver funding. The remaining person is private pay for his life-sharing home. The Intellectual and Developmental Disability Program’s Quality Management outcome is “people live where they choose.” The QM objective is to increase the number of new and unique people in life-sharing in Franklin/ Fulton Counties by 10% (n=4) by June 30, 2020. There are currently five (5) new people who have moved into life-sharing homes this QM plan. While the AE will continue to promote life-sharing and measure data, the QM plan will not include a life-sharing outcome due to the success of the life-sharing program.

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 (Community Rehabilitation Residential) facilities and Children's Foster Care to life-sharing when they age out of the children's system.

In July 2018, ODP expanded their waiver offerings by adding the Community Living Waiver (CLW); this waiver has a funding cap of \$70,000 dollars. This is enough funding to support an individual that has a low SIS Needs Group in a Life Sharing Home as long as that individual is either working or not attending a traditional day program. Franklin/Fulton has two individuals in Life Sharing funded by CLW.

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

- Please describe how the county will use funding, whether it is HSBG or Base funding, to increase the capacity of the county's community providers to more fully support individuals with multiple needs, especially medical needs.
- Please 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 and promote the life course/supporting families paradigm.
- Please 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 enable individuals and families to access community resources, as well as formalized services and supports through ODP.

The IDD program collaborates with the following agencies to increase the support for individuals with multiple needs. The IDD program staff attends Child and Adolescent Service System Program (CASSP) meetings to discuss the support needed for individuals to be supported in their community and school. The IDD staff also has a working relationship with Home Health Aid providers to support individuals with medical needs in their home and community. Lastly, the Managed Care Organization Specialized Needs Unit is available for individuals under the age of 18 who meet their criteria.

The IDD program collaborates with the school districts by offering informational sessions to both parents and teachers. The IDD staff attends IEPs when requested to help problem-solve and/or to provide intake information. The IDD program has also worked with school districts and the PA Family Network to provide information to families and hold workshops after Back to School Nights on different subjects. The Administrative Entity (AE) also is a member of the Transition Council and attends the Transition Fairs at all High Schools county-wide. The IDD program partners with Children and Youth (C&Y) through CASSP. There are also individual cases where C&Y and the IDD program are involved and the collaboration between the two agencies has resulted in the best outcome for the child while protecting the

individual's rights. The IDD program collaborates with the Franklin County Office of Aging through participation in the Aging/IDD meetings as well as reviewing PASSAR packets. With the implementation of Community Health Choices, contact with Area Agency on Aging is imperative to determine whether people are receiving the appropriate support.

The Mental Health and Intellectual & Developmental Disabilities program has a long history of communication and collaboration. IDD 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 Occupational Services, Inc. (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. Franklin County IDD staff presented WRAP® for People with Developmental Distinctions at the Dual Diagnosis Conference and at the Everyday Lives Conference in 2019-2020.

The IDD program presents the module on Intellectual & Developmental Disabilities in the Crisis Intervention Team (CIT) Curriculum. This curriculum helps police officers, Mental Health professionals and First Responders respond to someone with a disability in the course of their professions. The last CIT training was cancelled due to COVID. The IDD section has been revised to better suit the audience of police officers and first responders for 2020-2021.

The IDD program continues to collaborate with Mental Health, CASSP, Tuscarora Managed Care Alliance and Perform Care to support people who have a dual diagnosis.

### **Emergency Supports:**

- Please describe how individuals in an emergency situation will be supported in the community (regardless of availability of county funding or waiver capacity).
- Please provide details on the county's emergency response plan including:
  - Does the county reserve any base or HSBG funds to meet emergency needs?
  - What is the county's emergency plan in the event an individual needs emergency services, residential or otherwise, whether within or outside of normal working hours?
  - Does the county provide mobile crisis services?
  - If the county does provide mobile crisis services, have the staff been trained to work with individuals who have an ID and/or autism diagnosis?
  - Do staff who work as part of the mobile crisis team have a background in ID and/or autism?

- Is training available for staff who are part of the mobile crisis team?
- If the county does not have a mobile crisis team, what is the county's plan to create one within the county's infrastructure?
- Please submit the county 24-hour emergency crisis plan as required under the Mental Health and Intellectual Disabilities Act of 1966.

If waiver capacity is unavailable in an emergency situation, 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, to allow their parents to maintain their employment status. The Franklin County IDD Department will increase the availability for combinations of Family Aide, Day Programs, transportation, adaptive equipment, home modifications and respite care so that individuals may continue to live at home instead of residential programs, which are more costly. Franklin County reserves 28 days for Emergency Respite care in base funds.

The IDD Independent Apartment Program has 13 people living in their own apartments with less than 30 hours of support per week. Base funds are used to subsidize the rent. This program is the least restrictive housing option for individuals who wish to live independently.

The AE has a Risk Management Committee that meets quarterly to discuss incident management, to review restrictive procedures, discuss risk mitigation and any items that may lend to a future emergency. Under the direction of ODP, the County is implementing Provider Risk Assessments as a proactive means to determine if a provider has risk in their operations.

Franklin County responds to emergencies outside of normal work hours in Procedure Statement IDD505 Risk Mitigation. In this procedure statement, all Program Specialists are listed, as well as the MH/IDD/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. Initial incidents are reviewed daily to assure 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 business hours. These services may become Emergency Life Sharing or 43 DHS Bulletin County Human Services Plan Guidelines Emergency Residential while the person is in respite. This provides for the safety of the person and finds a long-term solution.

The MH/IDD Department's mission of essential functions is 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 and Developmental Disabilities Program utilizes the current contract with Keystone Behavioral Health for Crisis Services. The Crisis Department is operated 24 hours per day, 7 days per week, 365 days per year. One aspect of this contracted service is Mobile Crisis and 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 & Developmental 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 Support Coordinator or the AE if the person is not registered with the IDD program. The Co-Responder program is also a way to divert people with disabilities from being incarcerated and seek the community resources help that they need. Please see the Mental Health Section for details.

The Franklin/Fulton IDD Program supports CSG's Mobile MH/IDD Behavioral Intervention Services to expand the Mobile Crisis service in Franklin/Fulton County. The service would be a "time limited service designed to evaluate the current situation, develop treatment strategies, provide direct interventions with the individual, deliver consultation, provide resources and develop skills so that existing supports can continue to implement the treatment strategies developed by the team" for individuals who have a dual diagnosis and are struggling to have an "everyday life." The program has served three (3) individuals this past year.

The County 24-hour Emergency Response Plan, as required under the Mental Health and Intellectual Disabilities Act of 1966, is on file and 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 trainers.

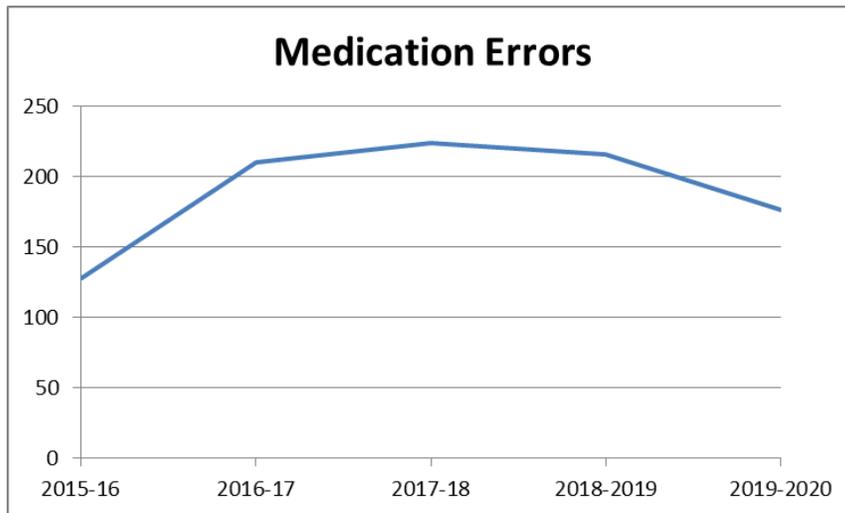
- Please describe the county's interaction with PA Family Network to utilize the network trainers with individuals, families, providers, and county staff.
- Please describe other strategies the county will utilize at the local level to provide discovery and navigation services (information, education, skill building) and connecting and networking services (peer support) for individuals and families.
- Please describe the kinds of support the county needs from ODP to accomplish the above.

- Please describe how the county will engage with the HealthCare Quality Units (HCQUs) to improve the quality of life for individuals in the county's program.
- Please describe how the county will use the data generated by the HCQU as part of the Quality Management Plan process.
- Please describe how the county will engage the local Independent Monitoring for Quality (IM4Q) Program to improve the quality of life for individuals and families.
- Please 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, and other reasons.
- Please describe how ODP can assist the county's support efforts of local providers.
- Please describe what risk management approaches the county will utilize to ensure a high quality of life for individuals and families.
- Please describe how the county will interact with individuals, families, providers, advocates and the community at large in relation to risk management activities.
- Please describe how ODP can assist the county in interacting with stakeholders in relation to risk management activities.
- Please describe how the county will utilize the county housing coordinator for people with autism and intellectual disabilities.
- Please describe how the county will engage providers of service in the development of an Emergency Preparedness Plan.

Franklin/Fulton IDD 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. The 2017-2020 Quality Management Plan has an outcome that families receive support to help make an Everyday Life possible. The objective for this outcome for 2017-2020 is to reach 20 families in collaboration with the PA Family Network to disseminate the Communities of Practice Life Course Planning Tool in small groups or 1:1 sessions by June 30, 2020. Due to the COVID-19 pandemic, all in-person training has been cancelled. The PA Family Network will continue to provide weekly Family Forums using a Zoom platform. The PA Family Advisor on the Regional Collaborative continues to support families via internet/ phone during this time. The Regional Collaborative will concentrate on the four (4) areas that ODP has initiated. They are Employment, Family Engagement, Front Door and Support Coordination. York/ Adams and Franklin/ Fulton have merged into one Regional Collaboration. Franklin/ Fulton is concentrating on collaborating with other Human Services Departments to create a user friendly guide for Franklin County residents to use to find community resources. Franklin/ Fulton is naming this as the "Front Porch" project.

The IDD program uses the vast experience of the HCQU. Monthly training by the HCQU is 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 participates on both the Risk Management Committee and the Quality Improvement Council. Medication Errors is one of the outcomes and objectives in the Quality Management 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 "people are healthy, and

the Franklin/Fulton Intellectual and Developmental Disabilities Program will use the objective of reducing the number of medication errors by 10% by June 30, 2020". The baseline data is 216 medication errors from July 2018 - April 2019. As of April 30, 2020, there are 176 medication errors this 2019-2020 QM year, demonstrating an increase in the number of medication errors. As a result of this increase, the action plan for 2020-2021 QM Plan has been revised and will be evaluated for progress.

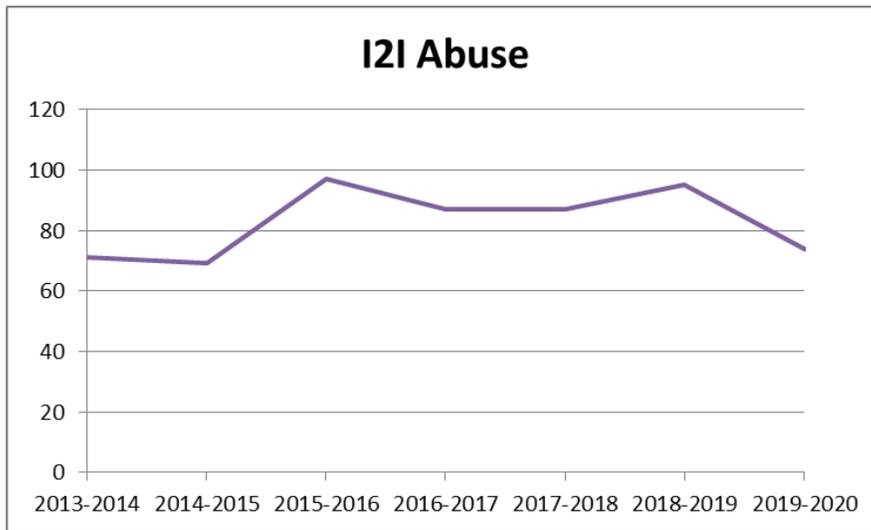


As with the HCQU, a representative for the IM4Q local program sits on the QI Council. The QI Council also reviews Employment and Life Sharing IM4Q data to determine satisfaction with services. Both outcomes are included in the QM Plan. The greatest barrier to reviewing IM4Q data is that the reports are not current. As a result, there is a lag in developing QM outcomes and objectives. When a new QM plan is developed, IM4Q data is reviewed for Franklin/Fulton County to determine if and where the IDD program is falling behind the state average or if there is a recurring issue for consideration.

The IDD program supports local providers by encouraging them to develop a relationship with the HCQU for training needed for their staff to support individuals with higher levels of need. The HCQU can also do biographical timelines, Consumer Data Collection (CDCs), medication/pharmacy reviews and provide training. CDCs were being scheduled for all residential homes on a routine basis. Providers have been utilizing the Health Risk Screening Tool to improve the quality of life for individuals. The AE continues to support providers in developing relationships with the local hospital. As previously mentioned, the MH/IDD Coordination meetings help to support providers.

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 95 incidents of I-2-I abuse for 2018-2019. As of April 30, 2020, there were 74 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 IDD Program partners with the County Housing Program to support an Independent Living Apartment Program for people living in their own apartments who need less than 30 hours of support a week. The County subsidizes the rent with base funds and therefore, individuals are able to live in affordable and safe neighborhoods. There are currently 13 people in this program. The County engages providers of service by ensuring that all ISPs have backup/emergency plans included. All providers updated their Emergency Preparedness Plans during the COVID-19 pandemic. Providers will continue to update their Emergency Plans as needed. Through the IM4Q considerations, Franklin/ Fulton Counties made emergency folders with the local information from the Department of Emergency Services and Ready.gov. These are available to all families upon request or when a consideration from IM4Q is indicated.

### Participant Directed Services (PDS):

- Please describe how the county will promote PDS (AWC, VF/EA) including challenges and solutions.
- Please describe how the county will support the provision of training to SCO's, individuals and families on self-direction.
- Are there ways that ODP can assist the county in promoting or increasing self-direction?

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) if they wish to self-direct their services. Franklin County has thirteen (13) families using AWC supports. All of their supports and services are paid with waiver funding, including

the administration fee. The County coordinates training for families through the Arc of Franklin/ Fulton Counties (the AWC provider) and the HCQU.

The major challenges for AWC continue to be 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, as well as families' lack of knowledge of the IDD system and the service definition changes. Additionally, families become frustrated with the amount of documentation and training required. ODP assistance could be used to find creative ways to address these issues and to provide training to families regarding AWC.

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

- Please describe how the county will enable individuals in congregate settings to return to the community.

Franklin County has 14 individuals in congregate settings. Three (3) individuals reside at State Centers and all have been given the choice to move into the community. All three (3) individuals have stated that they are happy where they currently reside and have no desire to move. One person resides in a private ICF/ID and continues to choose that placement. The remaining ten (10) individuals (9 Franklin; 1 Fulton) reside in nursing homes. All but one of these individuals are age-appropriate and/ or have a nursing home level of care required, making the nursing home an appropriate placement. The one exception is a woman who is too young to be in the nursing home, but repeatedly refuses appropriate residential options that are offered to her, though she does have a long-term level of care that was determined by ODP. The Supports Coordinator will continue to offer and encourage her to look at residential options that are appropriate.

## **HOMELESS ASSISTANCE PROGRAM SERVICES**

Please describe the continuum of services to individuals and families within the county who are experiencing homelessness or facing eviction. 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.

### **Bridge Housing Services:**

- Please describe the bridge housing services offered. Include achievements and improvements in services to families at risk or experiencing homelessness, as well as unmet needs and gaps.
- How does the county evaluate the efficacy of bridge housing services? Please provide a brief summary of bridge housing services results.
- Please describe any proposed changes to bridge housing services for FY 20-21.
- If bridge housing services are not offered, please provide an explanation of why services are not offered.

Due to limited funding, 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 at risk or experiencing homelessness, as well as unmet needs and gaps.
- How does the county evaluate the efficacy of case management services?  
Please provide a brief summary of case management services results.
- Please describe any proposed changes to case management services for FY 20-21.
- 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 Housing Assistance Program (HAP) Case Management and the South Central Community Action Program (SCCAP) Family and Asset Development Services. A service plan will be established 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 Family Development Specialist 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.
- Assistance in developing a future story and SMART goals designed to lead to long term stability
- Assessing service needs and eligibility and discussion with the individual of available and acceptable service options.
- Referring individuals 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 Family Development Specialist will refer the individual to appropriate agencies/resources as needed for services such as linkages to income

supports, parenting skills, life skills, budgeting, hygiene, food, 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 Family Development Specialist will assure that individuals who are eligible have accessed Emergency Shelter Assistance (ESA) through the Title IV-A program at the CAO so long as the ESA program exists. The SCCAP HAP Family Development Specialist will discuss with the individual any service needs and options and any goals the family has identified.

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, the HAP Family Development Specialist will complete a payment agreement between the individual, landlord and SCCAP and will work with the client to complete a goal plan specific for the individual needs of the family and appropriate referrals will be made.

Some notable successes for Case Management have 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.

Another notable success is the creation of a housing landlord survey that is shared with families that can meet the needs of high barrier families (those who have had an eviction in the past or may have a non-violent criminal history).

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 and Homeless Prevention 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 or ESG Homeless Prevention 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. Followed by ongoing services through Case Management or Support Circles. The addition of these services along with the coordination of internal and external supports provides a much better continuum of care for families experiencing the trauma of homelessness or near homelessness.

Of notable success are two additional partnerships. HAP is currently working with individuals referred through the Veterans program and the Franklin Together

Reentry 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.

In assessing the barriers to services 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 six 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 members complete 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.

During the COVID 19 Pandemic we have been able to coordinate services with clients while maintaining safety for the client and their families. We have been able to perform most of the eligibility via the phone and sending documents via text or email. We anticipate managing the program in a similar manner as long as needed to keep HAP clients and their families safe.

Individuals will be informed in writing by SCCAP, 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 during their initial appointment. The appeal plan is explained at the first appointment and a copy is signed by the individual.

### **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 provide a brief summary of rental assistance services results.
- Please describe any proposed changes to rental assistance services for FY 20-21.

- If rental assistance services are not offered, please provide an explanation of why services are not offered.

HAP's Rental Assistance program is used 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 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 six months prior to applying for assistance. Rental Assistance is only provided to Franklin County applicants who can demonstrate that they will be able to become self-sustaining after help is provided. 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 and can show that with assistance they can be stable in the future.
- Persons fleeing domestic violence.
- Individuals who have fallen on hard times who need rental assistance and can show that with assistance they can be stable in the future.

To receive financial assistance, the individual or family must be below 200% of the Federal Poverty Income Guidelines. Referrals to other agencies can provide needed services and will be made available to those who do not meet the income or residency 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).

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 Family Development Specialist/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 provided. Written agreements must be confirmed by the HAP Family Development Specialist before funds can be released.

Franklin County staff members complete 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 Homeless Prevention and 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 and ESG Homeless Prevention 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. 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 at risk or experiencing homelessness, as well as unmet needs and gaps.
- How does the county evaluate the efficacy of emergency shelter services? Please provide a brief summary of emergency shelter services results.
- Please describe any proposed changes to emergency shelter services for FY 20-21.
- 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 in downtown Chambersburg, at 223 South Main Street. The Shelter provides nine bedrooms with the capacity to house up to 18 individuals at one time. During the COVID 19 pandemic, SCCAP has kept its shelter capacity to a level that allows for individuals to quarantine in place. We have worked with the local health system for a process on testing and quarantining, should it be needed, in order to keep everyone safe. Two of the rooms at the shelter are family rooms and seven others are designed for single adults or couples. The Franklin County Shelter for the Homeless is the safety net for the residents who may find themselves without a place to live. The Franklin County Shelter uses a Housing First Model and staff work diligently to get individuals into housing quickly and then work to help them stabilize and move forward. Our goal 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 during and after their stay. We also coordinate with other agencies within the County to direct residents to the available resources that will help them achieve their established goals and long term success.

In order to receive services, the Franklin County Shelter for the Homeless, an individual/family must be legally homeless. Families either come to the shelter, where we work with the coordinated entry system to get them registered and evaluated for service, or we receive a referral from the coordinated entry system and a family or individual comes to the shelter referred through 211. Immediately we perform a housing barriers assessment to identify what will prevent the family or individual from getting housed quickly and then begin the work of finding safe, affordable, appropriate housing and stabilizing the family. Our work with the family continues after the family is housed so we can provide the best opportunity for long term success. Homeless Assistance Program funds are needed to support the daily operational costs of the Franklin County Shelter for the Homeless and the extensive case management needed to help families and individuals, many of whom are chronically homeless or have extensive housing barriers, obtain and maintain long term housing.

Another addition to the Homeless Services Toolkit for SCCAP is Homeless Prevention and Rapid Rehousing through HUD and ESG funding. SCCAP's emergency shelter had attempted fragmented one time 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. 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 and Homeless Prevention 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. We believe these supports will help families stabilize and maintain long-term, safe, affordable housing!

Franklin County staff members complete 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.

### **Innovative Supportive Housing Services:**

- Please describe the other housing support 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 support services? Please provide a brief summary of other housing support services results.
- Please describe any proposed changes to other housing support services for FY 20-21.
- If other housing supports services are not offered, please provide an explanation of why services are not offered.

Franklin County has not used Housing Assistance Program (HAP) funding for other housing support services. Independent living and forensic apartments are available

through other funding sources.

**Homeless Management Information Systems:**

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

Franklin County has actively participated in the Homeless Management Information System (HMIS) and has taken a lead role by providing an access center as a secondary option to the 211 system, for those who are seeking housing services. This process allows for individuals and families to be triaged, prescreened and assessed through HMIS so that appropriate services can assist in making individuals achieve permanent housing successfully.

In addition, this system works as a starting point to connect individuals and families with the Emergency Solutions Grant, HUD Permanent Supportive Housing Programs, PATH and one Shelter Plus Care Program. Individuals and families are connected by use of referrals and/or the housing prioritization queue tools that are a part of HMIS. The goal is to have individuals entered into HMIS immediately following enrollment in the housing programs. Multiple County employees are familiar with entering data into HMIS as well as running reports.

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

This section should describe the entire substance use service system available to all county residents regardless of funding sources.

Please provide the following information:

**1. Waiting List Information:**

Services	# of Individuals*	Wait Time (days)**
Withdrawal Management	53	1-2 days
Medically-Managed Intensive Inpatient Services	0	2-4 weeks
Opioid Treatment Services (OTS)	27	Intake-1 day 1 <sup>st</sup> Tx Session-2-4 days
Clinically-Managed, High-Intensity Residential Services	61	1-7 days
Partial Hospitalization Program (PHP) Services	0	Individuals typically step down from Residential to PHP versus directly admitted to PHP from the community
Outpatient Services	194	Intake – 1 day 1 <sup>st</sup> Tx Session – 2-3 days
Other (specify)	49	7-14 days

\*Average weekly number of individuals

\*\*Average weekly wait time

\*Reported numbers are representative of the number of SCA funded and or case managed individuals that experienced a wait time and the average wait time for the specific level of care from the time of the request/need to the time of admission in FY19/20 year to date (7/1/19-3/31/20)

- **Withdrawal Management Services:** In FY19/20, average wait time for a detox bed in or out of the county was 1-2 days from the time of the request and regardless of the current environment of the individual. The primary substances for detox placement were opioids (prescription and illicit) and alcohol.
- **Medically-Managed Intensive Inpatient Services:** In FY19/20 to date, FFDA has not provided funding/case management services to any individuals in need of complex medically managed/high intensity residential services.
- **Opioid Treatment Services:** In FY19/20, 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 (4) Buprenorphine prescribing providers within the county. There are a total of three (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 MAT to be able to engage in a community-based delivered process. FFDA continues to partner with a mobile Vivitrol provider, Positive Recovery Solutions (PRS) to assist in reducing this barrier for individuals that have started Vivitrol as their chosen MAT. In FY19/20, PRS provided mobile Vivitrol services in two locations, one time per month. In FY19/20, FFDA also provided funding for Buprenorphine, which allowed FFDA to provide three primary forms of MAT for individuals with opioid use disorder.

- Clinically-Managed, High-Intensity Residential Services: In FY 19/20, the average wait for a residential bed was one-seven (1-7) days from the time of the request across all provider networks (in/out of Franklin County). There were a total of 61 individuals that received this level of care. Wait times were dependent on bed accessibility, priority population requests, unplanned discharges and time day that the request was made from FFDA.
- Partial Hospitalization Services: In FY19/20, 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), nor did FFDA fund/case manage any individuals in need of this level of care.
- Outpatient Services: In FY19/20, there was no significant wait to access this Intensive Outpatient Program (IOP) or Outpatient Program levels 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 a same day intake 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.
- Recovery Housing: In FY 19/20, FFDA contracted with two PARR certified recovery houses (one male home and one female home). Wait time for this service is dependent on bed availability. Typical wait period is 7-14 days.

Opioid Treatment Services: In FY19/20, 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 (4) Buprenorphine prescribing providers within the county. There are a total of three (3) prescribing physicians of oral naltrexone (Vivitrol) in the county with limited physician time.

2. **Overdose Survivors' Data:** Please describe the SCA plan for offering overdose survivors direct referral to treatment 24/7 in the county. Please indicate if a specific model is used and provide the following data for the State Fiscal Year 2018-2019.

# of Overdose Survivors	# Referred to Treatment	Referral method(s)	# Refused Treatment
25	unknown	Recovery Liaison, Leave Behind Kits	unknown

\*Reported information is data from the Commonwealth of PA Overdose Information Network (ODIN) Naloxone Usage by County. This survivor data is based upon law enforcement naloxone usage data inputted into ODIN for 7/1/19-5/31/20.

FFDA contracts with a provider to offer Recovery Liaison services throughout Franklin County through PCCD funding. These funds provide a Recovery Liaison who is on call for any law enforcement to provide Warm Handoff services to overdose survivors and other clients with substance use concerns to help the individuals access treatment. The Recovery Liaison works with the referred individual to identify barriers to success and assists in linking individuals to services. The liaison position provides warm handoff services for a variety of clients (not just overdose survivors) and focuses on emergent care by connecting clients to treatment, however data tracking does not include separate tracking specifically for overdose survivors. Overall Warm Handoff data is reported below, and this tracking is currently being reviewed to see if data collection could be enhanced to track overdose survivors in FY20/21. Law enforcement agencies have access to Recovery Liaison services for overdose survivors and EMS/BMS/ALS also have access to Leave Behind Kits for survivors. Leave Behind Kits include the following: Pouch with OSAL branding and contact information of SCA, non-latex gloves, mouth shields, Need Help Now hotline card, Naloxone, and Naloxone instruction pamphlet.

3. **Levels of Care (LOC):** Please provide the following information for the county’s contracted providers.

<b>LOC American Society of Addiction Medicine (ASAM) Criteria</b>	<b># of Providers</b>	<b># of Providers Located In-County</b>	<b># of Co-Occurring/Enhanced Programs</b>
4 WM	1	0	1
4	1	0	1
3.7 WM	20	1	0
3.7	18	1	8
3.5	29	1	13
3.1	6	0	0
2.5	3	0	1
2.1	5	4	2
1	6	4	2

4. **Treatment Services Needed in County:** Please provide a brief overview of the services needed in the county to afford access to appropriate clinical treatment services. Include any expansion or enhancement plans for existing providers and any use of HealthChoices reinvestment funds to develop new services.

Tuscarora Managed Care Alliance (TMCA) oversees Franklin/Fulton County’s Behavioral Health HealthChoices Program. Reinvestment Plans that benefit Franklin County residents include two approved and currently implemented programs for Recovery Bridge Housing Subsidy and Certified Recovery Support Specialists. The Recovery Bridge Housing plan focuses on providing a rent subsidy for individuals who are Medicaid eligible/members to receive financial assistance for recovery housing rent. The recovery house must be PARR certified or an Oxford House Model in order to receive a contract from TMCA for this plan. TMCA’s Certified Recovery Specialist plan provides the opportunity for

the in-network local outpatient drug/alcohol providers to employ a certified recovery specialist to provide peer support to individuals transitioning from a high level of care (detox/inpatient) to a lower, local level of care such as IOP or OP services. FFDA partners with TMCA on this endeavor by providing funds to PA Counseling to operate Lighthouse Recovery to community-based recovery support services, including case management. The primary goal is to provide individuals with needed, yet voluntary peer support while in turn reducing the rate of readmission into a higher level of care. A current need in Franklin County is the lack of drug/alcohol free pro-social activities for individuals who struggle with substance use disorders and their families/natural supports.

TMCA also has invested in and has been approved to secure a peer operated Recovery Center to serve Adults (18 years and older) with a substance use disorder, either active or in recovery. The recovery center will also be a resource and support for individuals impacted by substance use of a loved one.

TMCA has invested reinvestment dollars into TARGET (Trauma Affect Regulation Education and Training), an evidenced based treatment modality to address individuals that have experienced trauma. This Evidence Based treatment modality has been implemented in our Substance Abuse Outpatient Provider network and at Franklin County Jail by treatment specialists working with individuals experiencing substance use issues.

Another community-based treatment need is funding/financial assistance for individuals that are under/un-insured to obtain assistance with medication-assisted treatment. FFDA will continue to meet this need in FY20/21 by providing funding to provide financial assistance to those that meet the funding and clinical eligibility criteria.

5. **Access to and Use of Narcan in County:** Please describe the entities that have access to Narcan, any training or education done by the SCA and coordination with other agencies to provide Narcan.

Intranasal 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. FFDA 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 intranasal naloxone upon completion of the OSAL training. Training occurs monthly in various geographic areas within Franklin County for easy accessibility. FFDA provides funding to contract with Healthy Communities Partnership (HCP) to deliver the majority of the community-based training. The SCA completes OSAL training for professionals as well as County of Franklin employees. 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 intranasal naloxone. In FY17/18, FFDA began serving as the Centralized

Coordinating Entity (CCE) through PCCD and has continued this role throughout 2019-2020. The CCE’s role is to provide free intranasal naloxone to agencies/organizations that serve as first responders in the county. Current partners include agencies within the following categories: EMS/BLS/ALS, Fire & Rescue, Treatment Providers, Prevention Providers, Recovery Houses, Wilson College, Penn State Mont Alto, Mental Health Association, Children & Youth Services, Juvenile Probation Office, Adult Probation Office, Hotels/Motels, Public School Districts (Nurses), South Central Community Action Council and the Private K-12 School Sector. FFDA has expanded to offer Leave Behind Kits for EMS/BLS/ALS units that wish to participate. Leave Behind Kits include the following: Pouch with OSAL branding and contact information of SCA, non-latex gloves, mouth shields, Need Help Now hotline card, Naloxone, and Naloxone instruction pamphlet.

6. **County Warm Handoff Process:** Please provide a brief overview of the current warm handoff protocols established by the county including challenges with the warm handoff process implementation.

**Warm Handoff Data:**

# of Individuals Contacted	120
# of Individuals who Entered Treatment	77
# of individuals who have Completed Treatment	unknown

\*Reported numbers are representative of the number of clients served with Warm Hand Off services through the contracted Recovery Liaison FY19/20 year to date (7/1/19-3/31/20)

Franklin County’s Warm Hand Off process is the primary model to address overdose survivors’ linkages to treatment. It is implemented in two out of the two hospital emergency room departments (Chambersburg Hospital and Waynesboro Hospital) in the county. In both hospitals, the crisis department can do an intake and referral for clients after they are medically cleared by medical staff.

Additionally, FFDA contracts with a provider to offer Recovery Liaison services throughout Franklin County through PCCD funding. These funds provide a Recovery Liaison who is on call for law enforcement and is called out to work with clients with substance use concerns to help the individuals access treatment. The liaison position focuses on emergent care and connects clients to treatment; however tracking of completion of treatment does not occur under the current system. This will be reviewed to see if data collection could be enhanced in future years.

FFDA will be entertaining ways to extend the warm hand off process to EMS/first responders through the county’s Overdose Task Force in FY20/21.

Listed below are some of the Warm Hand Off process challenges and barriers for Franklin County:

1. The Warm Hand Off process in Franklin County is currently a partnership with a contracted agency providing a Recovery Liaison who is on call for law enforcement needs surrounding substance use. The local townships and jurisdictions call the Recovery Liaison to assist in helping clients to access treatment and resources as an emergent care resource. This liaison helps refer clients to treatment and can set up services. One challenge with this process is that some law enforcement jurisdictions do not call the liaison and that EMS doesn't notify the liaison of an overdose if the client refuses transport. Work will continue in 2020-2021 to increase partnerships to increase utilization of the Recovery Liaison and Warm Handoff process.
2. Additionally, referrals can be accepted from the hospital Emergency Room departments for assessments and case management. The Crisis department at the Chambersburg and Waynesboro Emergency rooms can do referrals for substance use treatment services after the clients are medically cleared, however the clients often leave before completing their crisis intake.

### **HUMAN SERVICES AND SUPPORTS/ HUMAN SERVICES DEVELOPMENT FUND (HSDF)**

Please use the fields and dropdowns to describe how the county intends to utilize HSDF funds on allowable expenditures for the following categories. (Please refer to the HSDF Instructions and Requirements for more detail.)

***Dropdown menu may be viewed by clicking on "Please choose an item." Under each service category.***

Copy and paste the template for each service offered under each categorical, ensuring each service aligns with the service category when utilizing Adult, Aging, Children and Youth, or Generic Services.

**Adult Services:** Please provide the following:

Program Name:

Description of Services:

Service Category: Please choose an item.

No services are funded through the block grant.

**Aging Services:** Please provide the following:

Program Name:

Description of Services:

Service Category: Please choose an item.

No services are funded through the block grant.

**Children and Youth Services:** Please provide the following:

Program Name:

Description of Services:

Service Category: Please choose an item.

No services are funded through the block grant.

**Generic Services:** Please provide the following:

Program Name: Information and Referral Coordination

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 Franklin County. The I&R department is also the contact point for PA 211 coordination. In addition, I&R serve as the local Connect to Home Coordinated Entry Systems Access Center as a secondary option to the 211 system for those who are seeking housing services. This process allows individuals to be triaged, prescreened, and assessed through HMIS so that appropriate services can assist in helping the individual achieve permanent housing successfully.

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:** Please provide the following: (Limit 1 paragraph per service description)

Program Name:

Description of Services:

No services are funded through the block grant.

**Interagency Coordination:** (Limit of 1 page)

If the county utilizes funds for Interagency Coordination, please 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, and other allowable costs).
- how the activities will impact and improve the human services delivery system.

Franklin County Human Services Training Days is 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 organizations, not-for-profit, 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 four 1.25 hour sessions/presentations that are occurring. A total of 12 sessions/presentations are held over the course of the one day. These sessions depending on the topics, are also established as a Continuing Education Credits for those in the social work field. 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.

If funding becomes available, the expenses associated with this event will be for the facility's fees, trainers and supplies.

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.

**Other HSDF Expenditures – Non-Block Grant Counties Only**

If the county plans to utilize HSDF funds for Mental Health, Intellectual Disabilities, Homeless Assistance, or Substance Use Disorder services, please provide a brief description of the use and complete the chart below.

Only HSDF-allowable cost centers are included in the dropdowns.

Category	Allowable Cost Center Utilized
Mental Health	
Intellectual Disabilities	
Homeless Assistance	
Substance Use Disorder	

***Note: Please refer to Planned Expenditures directions at the top of Appendix C-2 for reporting instructions (applicable to non-block grant counties only).***

## **Eligible Human Services Cost Centers**

### **Mental Health**

For further detail refer to Cost Centers for County Based Mental Health Services Bulletin (OMHSAS-12-02), effective July 1, 2012.

### **Administrative Management**

Activities and administrative functions undertaken by staff in order to ensure intake into the county mental health system and the appropriate and timely use of available resources and specialized services to best address the needs of individuals seeking assistance.

### **Administrator's Office**

Activities and services provided by the Administrator's Office of the County Mental Health (MH) Program.

### **Adult Development Training (ADT)**

Community-based programs designed to facilitate the acquisition of prevocational, behavioral activities of daily living, and independent living skills.

### **Assertive Community Treatment (ACT) Teams and Community Treatment Teams (CTT)**

ACT is a SAMHSA-recognized Evidence Based Practice (EBP) delivered to individuals with Serious Mental Illness (SMI) who meet multiple specific eligibility criteria such as psychiatric hospitalizations, co-occurring mental health and substance use disorders, being at risk for or having a history of criminal justice involvement, and at risk for or having a history of experiencing homelessness. CTT services merge clinical, rehabilitation and support staff expertise within one delivery team.

### **Children's Evidence Based Practices**

Practices for children and adolescents that by virtue of strong scientific proof are known to produce favorable outcomes. A hallmark of these practices is that there is sufficient evidence that supports their effectiveness.

### **Children's Psychosocial Rehabilitation Services**

Activities designed to assist a child or adolescent (e.g., a person aged birth through 17, or through age 21 if enrolled in a special education service) to develop stability and improve capacity to function in family, school and community settings. Services may be delivered to the child or adolescent in the home, school, community or a residential care setting.

### **Community Employment and Employment-Related Services**

Employment in a community setting or employment-related programs, which may combine vocational evaluation, vocational training and employment in a non-specialized setting such as a business or industry.

### **Community Residential Services**

Care, treatment, rehabilitation, habilitation, and social and personal development services provided to persons in a community-based residential program which is a DHS-licensed or approved community residential agency or home.

**Community Services**

Programs and activities made available to community human service agencies, professional personnel, and the general public concerning the mental health service delivery system and mental health disorders, in order to increase general awareness or knowledge of the same.

**Consumer-Driven Services**

Services that do not meet the licensure requirements for psychiatric rehabilitation programs, but which are consumer-driven and extend beyond social rehabilitation services.

**Emergency Services**

Emergency-related activities and administrative functions undertaken to proceed after a petition for voluntary or involuntary commitment has been completed, including any involvement by staff of the County Administrator's Office in this process.

**Facility-Based Vocational Rehabilitation Services**

Programs designed to provide paid development and vocational training within a community-based, specialized facility using work as the primary modality.

**Family-Based Mental Health Services**

Comprehensive services designed to assist families in caring for their children or adolescents with emotional disturbances at home.

**Family Support Services**

Services designed to enable persons with SMI, children and adolescents with or at risk of Serious Emotional Disturbance (SED), and their families, to be maintained at home with minimal disruption to the family unit.

**Housing Support Services**

Services provided to mental health consumers which enable the recipient to access and retain permanent, decent, affordable housing, acceptable to them.

**Mental Health Crisis Intervention Services**

Crisis-oriented services designed to ameliorate or resolve precipitating stress, which are provided to adults or children and adolescents and their families who exhibit an acute problem of disturbed thought, behavior, mood or social relationships.

**Other Services**

Activities or miscellaneous programs which could not be appropriately included in any of the cited cost centers.

**Outpatient** Treatment-oriented services provided to a consumer who is not admitted to a hospital, institution, or community mental health facility for twenty-four hour a day service.

**Partial Hospitalization**

Non-residential treatment services licensed by the Office of Mental Health & Substance Abuse Services (OMHSAS) for persons with moderate to severe mental illness and children and adolescents with SED who require less than twenty-four hour continuous care but require more intensive and comprehensive services than are offered in outpatient treatment.

**Peer Support Services**

Refers specifically to the Peer Support Services which meet the qualifications for peer support services as set forth in the Peer Support Services Bulletin (OMHSAS 08-07-09), effective November 1, 2006.

**Psychiatric Inpatient Hospitalization**

Treatment or services provided an individual in need of twenty-four hours of continuous psychiatric hospitalization.

**Psychiatric Rehabilitation**

Services that assist persons with long-term psychiatric disabilities in developing, enhancing, and/or retaining: psychiatric stability, social competencies, personal and emotional adjustment and/or independent living competencies so that they may experience more success and satisfaction in the environment of their choice, and can function as independently as possible.

**Social Rehabilitation Services**

Programs or activities designed to teach or improve self-care, personal behavior and social adjustment for adults with mental illness.

**Targeted Case Management**

Services that provide assistance to persons with SMI and children diagnosed with or at risk of SED in gaining access to needed medical, social, educational, and other services through natural supports, generic community resources and specialized mental health treatment, rehabilitation and support services.

**Transitional and Community Integration Services**

Services that are provided to individuals who are residing in a facility or institution as well as individuals who are incarcerated, diversion programs for consumers at risk of incarceration or institutionalization, adult outreach services, and homeless outreach services.

**Intellectual Disabilities**

**Administrator's Office**

Activities and services provided by the Administrator's Office of the County Program. The Administrator's Office cost center includes the services provided relative to the Administrative Entity Agreement, Health Care Quality Units (HCQU) and Independent Monitoring for Quality (IM4Q).

**Case Management**

Coordinated activities to determine with the individual what services are needed and to coordinate their timely provision by the provider and other resources.

### **Community Residential Services**

Residential habilitation programs in community settings for individuals with intellectual disabilities or autism.

### **Community-Based Services**

Community-based services are provided to individuals with intellectual disabilities or autism who need assistance in the acquisition, retention, or improvement of skills related to living and working in the community and to prevent institutionalization.

### **Other**

Activities or miscellaneous programs which could not be appropriately included in any of the cited cost centers.

### **Homeless Assistance Program**

#### **Bridge Housing**

Transitional services that allow individuals who are in temporary housing to move to supportive long-term living arrangements while preparing to live independently.

#### **Case Management**

Case management is designed to provide a series of coordinated activities to determine, with each individual, what services are needed to prevent the recurrence of experiencing homelessness and to coordinate timely provision of services by the administering agency and community resources.

#### **Rental Assistance**

Payments for rent, mortgage arrearage for home and trailer owners, rental costs for trailers and trailer lots, security deposits, and utilities to prevent and/or end homelessness or possible eviction by maintaining individuals and families in their own residences.

#### **Emergency Shelter**

Refuge and care services to persons who are in immediate need and are experiencing homelessness; e.g., have no permanent legal residence of their own.

#### **Innovative Supportive Housing Services**

Other supportive housing services outside the scope of existing Homeless Assistance Program components for individuals and families who are experiencing homelessness or facing eviction. 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.

### **Substance Use Disorder**

#### **Care/Case Management**

A collaborative process, targeted to individuals diagnosed with substance use disorders or co-occurring psychiatric disorders, which assesses, plans, implements, coordinates,

monitors, and evaluates the options and services to meet an individual's health needs to promote self-sufficiency and recovery.

### **Inpatient Non-Hospital**

#### **Inpatient Non-Hospital Treatment and Rehabilitation**

A licensed residential facility that provides 24-hour professionally directed evaluation, care, and treatment for individuals with substance use disorder in acute distress, whose addiction symptomatology is demonstrated by moderate impairment of social, occupation, or school functioning. Rehabilitation is a key treatment goal.

#### **Inpatient Non-Hospital Detoxification**

A licensed residential facility that provides a 24-hour professionally directed evaluation and detoxification of an individual with a substance use disorder.

#### **Inpatient Non-Hospital Halfway House**

A licensed community-based residential treatment and rehabilitation facility that provides services for individuals to increase self-sufficiency through counseling, employment and other services. This is a live in/work out environment.

### **Inpatient Hospital**

#### **Inpatient Hospital Detoxification**

A licensed inpatient health care facility that provides 24-hour medically directed evaluation and detoxification of individuals diagnosed with substance use disorders in an acute care setting.

#### **Inpatient Hospital Treatment and Rehabilitation**

A licensed inpatient health care facility that provides 24-hour medically directed evaluation, care and treatment for individuals with substance use disorder with co-existing biomedical, psychiatric and/or behavioral conditions which require immediate and consistent medical care.

### **Outpatient/Intensive Outpatient**

#### **Outpatient**

A licensed organized, non-residential treatment service providing psychotherapy and substance use/disorder education. Services are usually provided in regularly scheduled treatment sessions for a maximum of five hours per week.

#### **Intensive Outpatient**

An organized non-residential treatment service providing structured psychotherapy and stability through increased periods of staff intervention. Services are provided in regularly scheduled sessions at least three days per week for at least five hours (but less than ten).

#### **Partial Hospitalization**

Services designed for those individuals who would benefit from more intensive services than are offered in outpatient treatment programs, but do not require 24-hour inpatient

care. Treatment consists of the provision of psychiatric, psychological and other types of therapies on a planned and regularly scheduled basis at least three days per week with a minimum of ten hours per week.

### **Prevention**

The use of social, economic, legal, medical or psychological measures aimed at minimizing the use of potentially addictive substances, lowering the dependence risk in susceptible individuals, or minimizing other adverse consequences of psychoactive substance use.

### **Medication Assisted Therapy (MAT)**

Any treatment for addiction that includes a medication approved by the U.S. Food and Drug Administration for opioid addiction detoxification or maintenance treatment. This may include methadone, buprenorphine, naltrexone, or vivitrol.

### **Recovery Support Services**

Services designed and delivered by individuals who have experience with substance-related disorders and recovery to help others initiate, stabilize, and sustain recovery from substance use disorder. These services are forms of social support not clinical interventions. This does not include traditional 12 step programs.

### **Recovery Specialist**

An individual in recovery from a substance-related disorder that assists individuals in gaining access to needed community resources to support their recovery on a peer-to-peer basis.

### **Recovery Centers**

A location where a full range of Recovery Support Services are available and delivered on a peer to peer basis.

### **Recovery Housing**

A democratically run, self-sustaining and drug-free group home for individuals in recovery from substance related disorders.

## **Human Services Development Fund**

### **Administration**

Activities and services provided by the Administrator's Office of the Human Services Department.

### **Interagency Coordination**

Planning and management activities designed to improve the effectiveness of county human services.

### **Adult Services**

Services for adults (persons who are at least 18 years of age and under the age of 60, or persons under 18 years of age who are the head of an independent household) include: adult day care, adult placement, chore, counseling, employment, home delivered meals, homemaker, housing, information and referral, life skills education,

protective, service planning/case management, transportation, or other services approved by DHS.

### **Aging**

Services for older adults (persons who are 60 years of age or older) include: adult day service, assessments, attendant care, care management, congregate meals, counseling, employment, home delivered meals, home support, information and referral, overnight shelter, personal assistance service, personal care, protective services, socialization/recreation/education/health promotion, transportation (passenger), volunteer services or other services approved by DHS.

### **Children and Youth**

Services for individuals under the age of 18 years, under the age of 21 years who committed an act of delinquency before reaching the age of 18 years, or under the age of 21 years who was adjudicated dependent before reaching the age of 18 years, and requests retention in the court's jurisdiction until treatment is complete. Services to these individuals and their families include: adoption services, counseling/intervention, day care, day treatment, emergency placement services, foster family services (except room & board), homemaker, information and referral, life skills education, protective services and service planning.

### **Generic Services**

Services for individuals that meet the needs of two or more populations include: adult day care, adult placement, centralized information and referral, chore, counseling, employment, homemaker, life skills education, service planning/case management, and transportation services.

### **Specialized Services**

New services or a combination of services designed to meet the unique needs of a specific population that are difficult to meet within the current categorical programs.