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 2023-01.

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, as appropriate, the critical stakeholder groups, including:
    a. Individuals and their families
    b. Consumer groups
    c. Providers of human services
    d. 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, 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 rotating between Franklin and Fulton County. The Advisory Board provides input into the Block Grant plan, is informed of the Block Grant impact, and is made aware of Drug/Alcohol requests for funding, projects, or service enhancements. The voting members of the Advisory Board includes 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 counties of

residence.

- A Way HOME (Housing and Opportunities Meant for Everyone) consists of individuals who meet regularly on issues around housing and homelessness. Representatives from the Franklin County Housing Authority, the County emergency shelters, and the Homeless Assistance Program (HAP) attend regularly. In addition to these individuals, there is an array of representatives that are a part of the A Way HOME group including 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. During the past year, several virtual meetings have been held to keep landlords up to date on housing programs and various items related to COVID 19 including moratoriums and funding programs. Landlords have become more actively involved with the A Way HOME group and it is the desire of the group to continue to offer opportunities and information that will keep our local landlords interested and involved.

- The Franklin/Fulton County Mental Health/Intellectual and Developmental Disabilities/Early Intervention (MH/IDD/EI) 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 a school-based or after-school-based environment suited to their age and the selected evidence-based program. Intervention services are provided to individuals that meet program/service eligibility and occur through various contracted service providers. Treatment services are delivered to individuals based on the state's use of the American Society of Addiction Medicine (ASAM) criteria, the appropriate level of care indicated, and the utilization of risk assessments. Services are delivered in the least restrictive manner appropriate for the individual. The highest levels of care (withdrawal management and residential) include 24/7 monitoring and supervision as treatment services are delivered within the provider setting. Less restrictive levels of care (halfway housing, partial hospitalization, intensive outpatient, outpatient, and early intervention) services are provided by the provider of their choice in a community-based setting. Recovery support/housing services are offered to individuals

based on their recovery needs, varying from ancillary treatment needs to direct treatment care in a community-based setting. The department assists individuals in discovering what recovery supports and services are the best fit for their current stage.

- 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 2023-2024.

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.

Public Hearings were advertised In the Public Opinion Newspaper and on the Franklin County website.

PART III: CROSS-COLLABORATION OF SERVICES

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. (Limit of 4 pages)

1. Employment:
   - Franklin/Fulton Transition Councils collaborate with the Office of Vocational Rehabilitation (OVR) in identifying individuals who will benefit from Pre-employment Transition Services, Paid Work Experiences and Job Shadowing within the school districts as well as students who need to connect with adult services. The Franklin/Fulton IDD Program participates in the Transition Council, which includes representative from OVR, School Districts and providers to promote and support the Employment First Model.

   - Franklin County's Information and Referral Specialist can refer individuals calling 211 to employment programs such as CareerLink and United Way's Stepping Forward Works program.

   - Franklin Together, Franklin County's Reentry Coalition, is actively pursuing local employers engaging in the employment of returning citizens to the community after their incarceration. 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.

2. Housing:
   - The Franklin County A Way HOME group consists of individuals who meet regularly on issues around housing and homelessness. Representatives from the Franklin County Housing Authority, the County emergency shelters, as well as, the Homeless Assistance Program (HAP) attend regularly. In addition to these individuals, there is an array of representatives from the A Way HOME group which includes 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 receives updates on Block Grant plans and funding requests. During the past year, we have continued to hold virtual meetings to keep landlords up to date on housing programs and various items related to COVID 19 including moratoriums and funding programs. Landlords have become more actively involved with the group and it is the desire of the group to continue to offer opportunities that will keep landlords interested and involved.

   - Franklin County's 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), Home 4 Good, The Pennsylvania Affordability and Rehabilitation Enhancement Fund

(PHARE), 8-1-1 Housing and the Emergency Rental Assistance Program (ERAP) 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 2023/2024 we will continue to work using the Coordinated Entry process with the intent that this will result in continued collaboration, streamlining of services, and increased leveraging of funding resources.

- The Intellectual and Developmental Disabilities 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 safer neighborhoods.

- Franklin County has been approved by the Eastern Pennsylvania CoC to apply for a new HUD family Permanent Supportive Housing Program. This application, if funded, will bring 4 units of family housing for chronically homeless families.

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 FY 22-23.

- Healthy Franklin County is a group of community leaders from the area of education, health, faith, business, non-profit, and local government sectors that functions as a community collaborative. Through the utilization of data, we can integrate practices and coordinate improvements that will provide collective impact, leading to positive change. Health is not just about disease or illness. We know that health depends on the mental, social and physical well-being of an individual. This year our group focused on mental health with a campaign slogan “Move for Mental Health”. Recognizing there is a large population in our community from young to old trying to manage anxiety and stress with not enough professional supports, the campaign focused on walking as a strategy to assist with mental wellness. We partnered with the Penn State Extension’s Everyone Walk Across Pennsylvania campaign and hosted our own incentives and outreach messaging. The Healthy Franklin County homepage received 1,266 visits since March 25, 2023, with 642 visits to the Move for Mental Health landing page. Of those who responded to the survey, 90% reported their mental health improved and 88% said their physical activity increased during the spring walking challenge. Our goal is to participate again this fall and increase our reach throughout the community. https://www.healthyfranklincounty.org/moveformentalhealth

- Franklin/Fulton County Mental Health secured grant dollars through the state to contract with a provider to conduct a review and assess our current crisis system. The goal is to create a system based on the Substance Abuse and Mental Health Services Administration (SAMHSA) best practice model of providing crisis. Keystone Rural Health Center Crisis Intervention is one of twelve (12) 988 call centers in PA. They have been providing this service for one (1) year, showing an increase in the utilization of the 988 system locally. Franklin and Fulton County is excited about the opportunity to restructure our crisis system to offer a continuum of care and support to those needing help within our communities.

- Tuscarora Managed Care Alliance (TMCA), the managed care provider, used reinvestment dollars to place community navigators in both Franklin and Fulton County. Community Navigators engaged with 116 Franklin County members and 119 Fulton County members since 2022; year to date, they have served 85 and 60 members, respectively. As of July 2023, the Navigators have provided $19,379 worth of community resources to members and have paid out $53,006 worth of contingency funds. Contingency funds are utilized when no other resources exist for an identified need or all other resources have been exhausted. Financial strain, housing instability/homelessness and utilities are the top Social Determinants of Health categories that have presented to Community Navigators as areas of need across both Franklin and Fulton counties.

- As action toward health literacy, resilience, and strengthening our provider system, the Franklin/Fulton Mental Health sponsored on-line certification training through PESI. The topics selected were based on provider requests to assist with increasing the knowledge and education in the areas that were most needed. Courses that were offered included Certified Dialectical Behavior Therapy Professional Training, Youth Mental Health Specialist Certification Training, Anxiety/Panic & Phobia Certification, and Essentials of Treating and Preventing Suicide.

- Keystone Behavioral Health provided 35,225 visits to 5,986 unique patients in 2022 and expects similar numbers for 2023 having provided 18,152 encounters as of the end of June. Keystone continues to provide Transcranial Magnetic Stimulation and prescribe Medication Assisted Treatment as well as Spravato. Keystone Behavioral Health is planning to move into a larger building in October 2023 and therefore, is recruiting additional providers for both psychiatry and therapy. Work has started on a new downtown location which will house a behavioral health urgent care, as well as other health related services. Completion of this project is expected for July 2025.

- TrueNorth Wellness Services had a long-standing dream come to fruition FY 22-23, as they completed a lengthy renovation process. This resulted in two (2) new apartments, bringing program capacity from 16 to 18 residents, and a larger community/group gathering area. Trauma-informed care continues to be the foundation of their services. As such, staff and residents participate in various trauma-informed training courses throughout the year. Residents, staff, and family members participated in the annual “Chili Cook-off” contest held during the Chambersburg Ice Fest which was another successful community event. There has been continued success in community collaboration through encouraging residents and staff to engage in their community by giving back, hosting community collaboration meetings/trainings such as Crisis Intervention Team (CIT), and ongoing communications with local police departments (police liaison). In addition, the ongoing support and collaboration between Franklin/Fulton County MH/IDD/EI services and TrueNorth Wellness services is recognized, respected, and valued. It takes a VILLAGE!!

- Supporting Individuals Transitioning To Employment Success (SITES): This program provides individuals with another “stepping stone” toward successful competitive employment within the community. The program provides individuals with more intensive guidance and support on targeted issues than is available through other programs. The SITES program provides a physical space that accommodates both individual and group activities. In addition, the maximum group size is six (6) individuals per one (1) staff person at any given time, with a maximum program enrollment of twelve (12) individuals. Limits to the program size allow for structured group activities to develop employment readiness skills, as well as more opportunity to receive individualized attention focused guidance in “soft skills” and coping strategies. SITES Program changes with current societal trends and technology incorporating laptop and cell phone usage and safety to the curriculum. Current trends and social media safety are discussed in open group sessions. SITES graduates are better prepared to enter a changing and competitive job market, work with all types of people, navigate their own community and its resources, and lead more independent lives. They are also prepared to maintain steady employment after program completion.

- Franklin County Health triennial health summit was held on October 20, 2022 at Wilson College. Key findings from WellSpan Health’s community health needs assessment were

presented which concluded that Franklin County residents' health issues are strongly associated with obesity and associated indicators such as poor eating, a lack of physical activities, and poor mental health. Healthy Franklin County also recognized residents and organizations who work to improve the health and well-being with the first-ever Community Health Champion award(s). There were three (3) categories of recipients honored for their service and commitment to improving community health, including lifelong service, which went to Sheldon "Shelly" Schwartz; young professional, which went to Sonja Payne; and organizational, which went to First Start Partnerships. Findings from the Community Health Needs Assessment (CHNA) and input from attendees helped inform the development of each task force's community health improvement plans (CHIP).

- Check & Connect is a model of ongoing, systematic intervention and support to promote students' engagement at school and with learning. Check & Connect is designed to work with students in 4th-9th grades who are referred by school personnel for one (1) or more of the following reasons: poor academic performance, poor attendance, negative school behavior, and/or lack of connectedness to school. Each student participating in Check & Connect is assigned an adult mentor. Check & Connect mentors seek to build long-term, sustained relationships with participating students that will connect them with their school and help them make academic progress. Students work with their assigned mentor for a period of two (2) years. Healthy Communities Partnership (HCP) has six (6) Check & Connect mentors in five (5) Franklin County school districts. There were 127 students that participated in Check & Connect in the 2022-2023 school year, with 93 students being new referrals.

- Healthy Communities Partnership (HCP) received grants and funding to continue offering an educational-running program, entitled Go Girls Go for upper elementary and middle school aged girls. Go Girls Go was designed to increase the health and wellness of girls while providing opportunities for pro-social bonding, increased self-esteem, enhanced mental health, and health education. The culmination of each season is a 5k walk/run hosted by Healthy Communities Partnership and is open to the community. During the 2022-2023 year, the Go Girls Go program was able to get back fully with five (5) schools participating in Fall 2022 and eight (8) schools participating in Spring 2023. There were 108 girls that participated in the Fall of 2022 while 178 joined in Spring 2023. The Spring 2023 season also saw 78 adult mentors assisting with the program, which was an all-time record of volunteer mentors. There were 213 participants in the Fall Go Girls Go 5K and the Spring race boasted a nice crowd of 273. Several of the schools are now providing Go Girls Go within their school community, with only technical support from HCP staff.

- A variety of programs are funded using Franklin/Fulton Drug and Alcohol monies, including various curricula lessons provided in classrooms and for community organizations. The following curricula were used in 2022-2023: Teen Intervene and Too Good for Drugs. Too Good for Drugs (TGFD) is an evidence-based curriculum developed by the Mendez Foundation. Each class receiving Too Good for Drugs has 10 lessons that are delivered in the classroom setting to students in grades five (5) through seven (7.) This year, over 956 students in seven (7) different schools received Too Good for Drugs instruction. Outcomes are measured for Too Good for Drugs participants using the evaluation tools included in the curriculum. The following outcomes were noted in 2022-2023:

Skill Measured	% Students Showing Improvement
Emotional Competency/Self-Efficacy	57%
Perceptions of Harmful Effects of Drugs	42%
Social/Resistance Skills	53%
Goal Setting and Decision-Making Skills	58%
Bonding with Prosocial Peers	52%
Attitudes Toward Drug Use	29%
Improved Knowledge	73%

b) Strengths and Needs by Populations: *(Limit of 8 pages #1-11 below)*

Please identify the strengths and needs of the county/joinder 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.

1. Older Adults (ages 60 and above)

- Strengths:
  - Franklin County has psychiatrists whose specialize in gerontology.
  - Franklin County Older Adults Advocacy Team (FCOAAT) continues to have monthly meetings and work together to collaborate services for the older adult population. The team has representatives from Mental Health, Aging, Criminal Justice, Community Outreach, Housing, and others as needed.
  - The Mental Health Association provides Senior Reach. Seniors receive at least a weekly phone call from a trained call specialist. This has proven to be a powerful tool in reducing stress and preventing loneliness and depression.
  - The availability of having a Mobile Psychiatric Nurse who can meet with seniors where they are, conduct a physical and mental health assessment and make recommendations for potential services and supports.
  - 23% of the referrals the Co-responders receive from the police are for individuals over the age of 60. The issues that seem to be dominant are dementia, confusion, hoarding, and financial issues. The Co-responders maintain relationships in the community to refer to for support and services.
- Needs:
  - More support is needed for those with dementia living in the community. It appears that individuals are staying home longer and need in-home support.
  - There is a lack of service and support that is able to manage some of the older adults' physical, medical, and behavioral needs.
  - Some of our older adult population is struggling with being able to afford home ownership with the taxes and are losing their homes, resulting in homelessness.

2. **Adults (ages 18 to 59)**

   - Strengths:
     - The Community Navigator program, through HealthChoices, partners with individuals and community based organizations to improve their resiliency and self-
     - determination. This program provides linkages to behavioral health services, while also addressing any needs regarding an individual's social determinants of health. These are factors that impact an individual's daily life, that are typically unable to be addressed by our behavioral health providers.
     - The availability of having a Mobile Psychiatric Nurse who can meet with individuals where they are and conduct a physical and mental health assessment and make recommendations for potential services and supports, discuss diet and nutrition, medication, etc.
   - Needs:
     - Due to a number of reasons, our community is struggling with waiting lists for outpatient counseling. There is a lack of credentialed counselors for commercial insurances. That has proven to be a hardship.
     - There continues to be a need for mobile crisis response. County staff has discussed the potential to look into crisis respite beds for adults to divert them from inpatient hospitalization; however, funding is an ongoing issue. Keystone Behavioral Health, the Franklin County crisis provider, is able to provide limited mobile response due to not having adequate staff nor the funding to increase staffing. In addition to insufficient staffing, this provider was approved as one (1) of the twelve 988 call centers, which makes additional funding for the crisis system even more crucial. TrueNorth Wellness Services, a Fulton County crisis provider, focused on discharge and follow up after being seen. They were able to increase the use of community services to divert from inpatient stays; however, more community services are needed. We are hopeful for some resolution to this issue with the crisis consultation assessment expected this fall.

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

   - Strengths:
     - Franklin/Fulton County has two (2) agencies (Mental Health Association and TrueNorth Wellness Services) that provide youth and young adult Certified Peer Specialist services.

   - Needs:
     - Due to a number of reasons, our community is struggling with waiting lists for outpatient counseling. There is a lack of credentialed counselors for commercial insurances. That has proven to be a hardship.
     - 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 a need for supports in learning to live independently and how to care for a home that is not available.
- Housing supports and services are a need for those in the transition age population in our community.

4. **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, System of Care (SOC) as well as the development of community alternatives and diversion efforts to residential treatment facility placements.

- Strengths:
  - Kidz Therapy Zone offers a three (3) hour respite program for children twice a month. The evening session has a theme and the activities and snacks are all included. This program offers a small amount of time for caregivers to rejuvenate or run errands.

22-23 Fiscal Year – Respite Services		
	Total Participants	New Children Served
Chambersburg	179	39
Waynesboro	35	5
*New children served refers to a child that has not received respite services with this fiscal year		

  - A Threat Assessment and Management Team has been formed in Franklin County. The District Attorney's office is spearheading the team under the direction of the FBI. This team has representation from all local school districts, Mental Health, Crisis, Emergency Services Department, local municipality police, and state police. The team meets monthly to review any situations and offer education surrounding collaboration and safety. This team is a supplement to the existing school threat assessment teams.
  - Youth and Young Adult Peer Support Services availability for individuals ages 14-17 provided by certified and trained peer specialists.
  - Healthy Communities Partnership receives funds from Franklin/Fulton Mental Health/Intellectual & Developmental Disabilities/Early Intervention and Franklin/Fulton Drug & Alcohol Program to provide the Student Assistance Program (SAP) liaison services in schools throughout Franklin and Fulton Counties. HCP SAP Liaisons serve 16 total teams in secondary schools in the two (2) counties. Most teams meet weekly to discuss referrals and students of concern. This year, many of these meetings resumed as in-person meetings. During the 2022-23 school year, the SAP teams throughout the two (2) counties received 660 referrals, showing a 4% increase from the previous year, which itself was an all-time high. This year, we were able to secure 326 parental permissions to further work with students, demonstrating a 7% increase in the number of parents providing permission for us to work with their students from the previous year.
  - HCP provides elementary (ESAP) services in all districts in Franklin and Fulton counties. Some school teams met virtually while others held in-person meetings. Two (2) school districts do not participate in ESAP services at all. The meetings were sporadic again this year; however, referrals increased dramatically. A total of

225 referrals were received in 2022-2023. This is about a 13% increase from the previous year, which was itself a large increase from 2020-2021. Other components of ESAP include small group interventions and classroom lessons. Group topics include: Changing Families, Attendance, and Too Good for Violence, Kindergarten, Girls Circle, Boys Council, and Social Skills, and were based on school need. HCP also offered classroom lessons to some schools. These lessons covered topics such as social skills, respect, self-confidence, responsibility, gratitude, optimism, kindness, perseverance, fairness, and loyalty. A group called “Newcomers Group” was held for the first time at an elementary school and included students who primarily speak Spanish. The group was led by a fully bilingual staff liaison and the students were able to communicate together using their primary language. Combined HCP staff offered over 290 groups and lessons to elementary students. This represents a 107% increase in the number of lessons and groups overall.

- School-based counseling services through managed care are available in most public schools in both Franklin and Fulton counties.
- Child and Adolescent Service System Program (CASSP) services are available to all children who are experiencing behavioral/mental health concerns. CASSP is able to get families and providers around the table to determine the best services and supports for the child in need.
- Healthy Community Partnership SAP liaisons and Mental Health Association team members completed certification in Why Try program. The Why Try Program is an evidence-based social and emotional learning (SEL) program. Why Try is a curriculum that provides hands-on strategies and resources to help motivate the unmotivated student, support students with trauma, improve engagement, and increase academic success. This program teaches life skills and resilience to youth in a way they can understand and remember. When occurring in the school setting, Why Try groups are facilitated by trained HCP staff members. In the 2022-2023 school year, six (6) staff members facilitated ten Why Try groups across four (4) school districts in Franklin County and served 54 students. Students are typically referred by school administrators and guidance counselors. Outcomes for Why Try are measured using The Why Try Measure R which is a pre/post-test designed to measure youth’s knowledge of the Why Try curriculum, decision-making skills, locus of control, resistance to peer pressure, positive self-concept, self-control, and access to support systems. The desired outcomes of the Why Try Program are to improve academic performance and behavior. Research has consistently linked increased internal locus of control with greater academic success and positive behavior. Of the students whom completed a pre and post Why Try Measure R, 64% showed improvement in their scores, with the average improvement being 31%.

- Needs:
  - This past year continued to see an increase in referrals for school aged children needing mental health counseling. Due to a number of reasons, our community is struggling with waiting lists for outpatient counseling. There is a lack of credentialed counselors for commercial insurances. That has proven to be a hardship. Our SAP team completed certification in evidence based programming that is specific to group work to assist.

- The local school districts have begun a conversation discussing the need for a partial hospitalization. This will be explored in the coming year.

Please identify the strengths and needs of the county/joinder 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.

5. Individuals transitioning from state hospitals

- Strengths:
  - Service Access & Management (SAM) has an assigned case manager that functions as the Danville State Hospital liaison. The liaison does a great job in monitoring the status of individuals at the state hospital and connecting individuals to services in the community when they are ready for discharge. The social workers at the state hospital are also very easy to work with and make sure that the person has completed their Medicaid application, etc. prior to discharge.
  - Community based services that are available include outpatient, peer specialist, and housing supports to mention a few.
  - Franklin and Fulton counties have active Community Support Programs (CSP). The monthly meeting consists of an educational component as well as community news. It is offered as a hybrid meeting so folks are able to attend virtually or in person.
- Needs:
  - Securing available, appropriate housing can sometimes contribute to extended inpatient stays at the state hospital. Generally speaking, the liaison is able to secure the necessary appointments in a timely manner. Establishing and maintaining contact with family while the person is at the state hospital can sometimes be challenging for the social workers.
  - Our county lost access to an extended acute care setting several years ago and has not had success securing a contract with any providers to regain access for our community residents. This level of care would prove helpful as a step down from the state hospital and from a diversionary perspective. Our communities have seen some of our individuals living with serious mental illness (SMI) have frequent contact with law enforcement due to concerned citizens calling the police for well checks.

6. Individuals with co-occurring mental health/substance use disorder

- Strengths:
  - The Mental Health Co-Responders and the Certified Recovery Specialists (CRS) have begun meeting on a monthly basis. This increases the resources and support available to the community members throughout both counties.
  - Franklin County has a Good Wolf Treatment Court.
  - Franklin/Fulton County residents have access to two (2) dual-licensed (DHS/DDAP) substance use disorder outpatient providers.

- Needs:
  - Outpatient therapies for individuals living with a co-occurring disorder have proven difficult. Local dual-licensed SUD outpatient providers have experienced difficulties hiring/retaining properly credentialed staff to conduct services to individuals with co-occurring disorders. These difficulties have instituted waitlists for medication management and mental health therapies for individuals with co-occurring disorders.
  - A clear understanding/education on the proper way to treat co-occurring disorders. There have been many situations where a psychiatrist will note that the substance use needs to be addressed prior to their mental health and vice versus. This can often delay the supports and services that an individual needs and/or prevent an individual from receiving immediate services

7. **Criminal justice-involved individuals-** Counties are encouraged to collaboratively work within the structure of County Criminal Justice Advisory Boards (CJABs) 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:
     - The Courts have committed to creating a protocol/process where the District Attorney, Public Defender and judges are alerted to individuals with an Autism Spectrum Disorder (ASD), or similar situation, in which certain aspects of court may be difficult for them due to sensory issues, attention issues, etc. They would like to develop a protocol for things such as assessments or checklists that can be completed prior to court hearings that will give the court staff some insight into what to expect from individuals once they are in the courtroom. This will allow court staff to be aware of and sensitive to their needs and better prepare for those court hearings.
     - Franklin County has an active Re-Entry Committee, Franklin Together, 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, and 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 continues to host re-entry simulations locally as well as for other counties when requested.
     - Franklin County has expanded to have three (3) co-responders embedded with four (4) of the municipality police departments. The program has been operational for five (5) years and has served over 1,900 persons resulting in 9,940 contacts. Of that, 90% of the individuals have not had re-contact with the police after engaging with the co-responder.

- Mental Health is able to provide evaluations in the jail by use of telehealth.
- Weekly Mental Health meetings are held with the Franklin County Jail, which includes jail personnel, Prime Care Mental Health staff, Franklin County Adult Probation and Franklin/Fulton MH/IDD/EI, to discuss the current status and needs of inmates in a collaborative manner.
- The Criminal Justice Advisory Board (CJAB) remains active and has a progressive strategic plan. 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.
- Forensic Blended Case Management (BCM) is available and works with individuals involved with probation and preparing to be released from jail, assisting individuals accessing services and supports to foster their success upon re-entry to the community.
- Mental Health and the Public Defender's office have met to discuss a process for better communication and collaboration in an effort to divert individuals with a mental health diagnosis from the criminal justice system.

- Needs:
  - The Courts and the community are working towards a stronger collaboration in an attempt to reduce recidivism in the criminal justice system. Developing processes and better communication are among the goals.
  - Local employment options.
  - Affordable housing poses a barrier for individuals trying to re-establish themselves in the community.
  - Franklin County continues to explore the Stepping Up initiative and implementing strategies within the jail, courts and Mental Health to identify gaps and needs to reduce recidivism.

8. **Veterans**-counties are encouraged to collaboratively work with the Veterans' Administration and the PA Department of Military and Veterans' Affairs (DMVA) and county directors of Veterans' Affairs (found at the following list):
https://www.dmva.pa.gov/Veterans/HowToGetAssistance/Documents/MA-VA%20400%20County%20Directors.pdf

- Strengths:
  - Franklin County Veteran Connection is a recently formed committee focused on supporting the local veterans in Franklin County. Membership is made up of our faith, business, local government and other community members and members meet monthly to educate and promote resources. The goal is to insure a proper welcome home and assist with transition to civilian life.
  - Franklin County Veteran Affairs office maintains a relationship with the community human service providers that fosters warm hand-offs for veterans needing services and supports.

        - Franklin County Military Share provides fresh, nutritious food once a month, free of charge, to Franklin County families with at least one member who has served, or is currently serving, in the armed forces. The program is made possible thanks to a partnership with the Central Pennsylvania Food Bank and the Franklin County Human Services Block Grant.
    - Needs:
        - Easier access to the mental health support and services through the VA.
        - Locally, a larger choice of counselors that are knowledgeable and competent in the military culture.

9. Lesbian/Gay/Bisexual/Transgender/Questioning/Intersex (LGBTQI)

- Strengths:
    - Mental Health Association hosts a support group called THRIVE. This group is set to meet on the 1st and 3rd Sunday of the month. It continues to grow and be a support needed in our community.
    - The welcoming project has continued. Our community currently has 141 allies to date. Allies are defined as a business, health care provider, faith community, or organization that has taken the pledge to commit to having a workplace and community that is diverse and welcoming for everyone
- Needs:
    - Education and resources are needed for our community.

10. 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 is able to provide clinical services to individuals speaking Spanish.
    - WellSpan and Keystone medical facilities have access to a system that connects a live translator on a computer screen to assist during appointments.
    - Franklin County does have a Hispanic Center that is active and collaborates with Human Services.
- Needs:
    - Access to more bilingual professional staff is a need in our community. We have recognized that there are several dialects of Spanish in our community.
    - More providers with access to the language line or assistance with interpretation to the different dialects spoken here in our community.

11. Other populations, not identified in #1-10 above (if any, specify) (including tribal groups, people living with HIV/AIDS or other chronic diseases or impairments, acquired brain injury (ABI), fetal alcohol spectrum disorders (FASD), or any other groups not listed)

- Strengths:

- Brain Injury Association of Pennsylvania hosted a presentation during our forty-hour training week of Crisis Intervention Team (CIT).
- Franklin County has a strong Community Connections Housing Access Center that works directly with those who are homeless, at risk of homelessness, or seeking housing stability services.

- Needs:
  - Support for individuals and families affected by traumatic injury living in our community.
  - Homelessness has increased in our community and there is a need for affordable housing options.

c) <u>Recovery-Oriented Systems Transformation (ROST):</u> *(Limit of 5 pages)*

Priority	***Narrative***	***Action Steps***	***Timeline***	***Progress made***
1. Crisis Intervention Service system (☒ Continuing from prior year ☐ New Priority)	a. Department of Human Services are updating the state regulations regarding crisis intervention services and preparing for the initiation of the 988#	Upon the release (projected fall 2021) of the updated crisis regulations, the county		Received a program planning grant for the state and will be using a consultant as of August 2023 to do an assessment of the crisis system in both Franklin and Fulton counties. Crisis regulations are still pending; expected Winter 2024.
		Assist with startup and implementation of 988		
2. Addressing health literacy and resilience in our community (☒ Continuing from prior year ☐ New Priority)	a. Provide training opportunities for the providers in order to strengthen our system	i. MH will purchase license agreement with PESI, for training and consider other trainings as they become available	continual	County offered training Essentials of Treating & Preventing Suicide, Anxiety, Panic & Phobia Certification Training, Youth Mental Health Specialist Certification Training, Certified Dialectical Behavior Therapy Professional Training. i. Mental Health First Aid, QPR and verbal de-escalation skills were a few offered to the community.
		ii. Provide training and support for local community to include: business, neighbors, providers etc.	continual	
		iii.		
	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.		Utilizing emails, billboards, and a webpage to promote wellness education and activities. Planning an expansion for posters and handouts.
		ii. Continue and expand existing community campaigns that educate the public about effective ways to manage depression (i.e., physical activity, nutrition).		Partnered with Penn State Extension to promote Everyone Walk Across Pennsylvania for our Move for Mental Health.

		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.		MH task force is working with the education library for WellSpan to increase the education offered to the doctors.
3. Housing placements and supportive services needed for individuals with intense behaviors (☒ Continuing from prior year ☐ New Priority)	a. Identify models of housing programs available	i. Gather information on different housing options and explore the working structure.		Chose an LTSR to focus on the forensic population.
		ii. Create workgroup to develop residential/housing model for those needs.		In August, meeting with Cumberland/Perry County as they will be our partners in a forensic 16 bed LTSR.
	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.		Postponed until the crisis system assessment is complete.
		ii. Research the models in which crisis beds can be provided and create plan for implementation.		Postponed until the crisis system assessment is complete.

ii. Coming Year List:

- Based on Section b **Strengths and Needs by Populations,** please identify the top three (3) to five (5) ROST priorities the county plans to address in FY 23-24 at current funding levels.
- For each coming year (FY 23-24) ROST priority, please provide:

a. A brief narrative description of the priority including action steps for the current fiscal year.
b. A timeline to accomplish the ROST priority including approximate dates for progress steps and priority completion in the upcoming fiscal year.
   - Timelines which list only a fiscal or calendar year for completion are not acceptable and will be returned for revision.
c. 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.
d. A plan mechanism for tracking implementation of the priorities.
   - Example: spreadsheet/table listing who, when and outputs/outcomes

Priority	***Narrative***	***Action Steps***	***Timeline***	***Resources Needed***	***Tracking Mechanism***
1. Crisis Intervention Service system (☒ Continuing	a. Mental Health secured grant funding for a crisis system assessment and for	Data analysis, focus groups, stakeholder meetings	June 2024	This will be determined as plan is created.	This is monitored through Franklin/Fulton County MH/IDD/EI, TMCA, MHA, DHS,

from prior year ☐ New Priority)	implementation toward the SAMHSA best practice model				RI
2. Addressing health literacy and resilience in our community (☒ Continuing from prior year ☐ New Priority)	a. Provide training opportunities for the providers in order to strengthen our system	i. MH will purchase license agreement with PESI, for training and consider other trainings as they become available	continual	$3,000 $500	This is monitored through the Franklin/Fulton County MH/IDD/EI.
		ii. Provide training and support for local community to include: business, neighbors, providers etc.	continual		
		iii.			
	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.		$6,500	This is monitored through the MH task force and Healthy Franklin County.
		ii. Continue and expand existing community campaigns that educate the public about effective ways to manage depression (i.e., physical activity, nutrition).		$1,500	This is monitored through Chambersburg Cares, the MH task force and Healthy 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.		$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	a. Housing need for our mental health forensic population	i. Working with Cumberland/Perry County to create a partnership for a 16 bed LTSR	Dec 2025	The needed funds will be determined during action steps.	This is monitored through Franklin/Fulton MH/IDD/EI, Cumberland/Perry MH/ID and DHS.
		ii.			

(☒ Continuing from prior year ☐ New Priority)	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.	Feb 2024	Approximately $8,000	This is monitored through Franklin/Fulton MH/ID/EI and Human Services Block Grant Committee.
		ii. Research the models in which crisis beds can be provided and create plan for implementation.	Feb 2024	Approximately $10,000	This is monitored through Franklin/Fulton MH/IDD/EI and TMCA.

d) <u>Strengths and Needs by Service Type:</u> *(#1-7 below)*

1. Describe telehealth services in your county *(limit of 1 page)*:

a. How is telehealth being used to increase access to services?

- PerformCare data showed an increase in mental health outpatient (MHOP) psychiatric evaluation access in 2022, returning to previous levels seen in 2020. A major barrier to higher MHOP psychiatric access is the national shortage of child and adult psychiatry. The added flexibility that is available through telehealth has allowed providers to expand their psychiatric coverage while improving access for new patients.
- All of our MHOP and substance use outpatient (SUOP) providers offer telehealth options, and see it as a convenience for patients rather than it necessarily increasing their access. Whether provided in person or through telehealth, a therapist is still needed to provide the service. There continues to be a shortage of sufficient therapists, and many do work from home, but rather in an office setting.

b. Is the county implementing innovative practices to increase access to telehealth for individuals in the community*? (For example, providing technology or designated spaces for telehealth appointments)*

- The County is open to entertaining any ideas that providers may have in order to increase access to services for our community.

2. Is the county seeking to have service providers embed trauma informed care initiatives (TIC) into services provided?

☐ Yes ☒ No

If yes, please describe how this is occurring. If no, indicate any plans to embed TIC in FY 23-24. (Limit of 1 page)

- The Behavioral Health subcommittee of CJAB has created a Trauma-Informed Care page on the Franklin County website. Located on this page are definitions of trauma and links to access resources and information.
- Franklin/Fulton County has ten (10) trained facilitators for “How Being Trauma-Informed Improves Criminal Justice System Responses” with access to three (3) out of county

trainers as well. This training is offered as a CIT re-fresher course for our first responders. The plan will be to expand the invitation to include other providers and community members.

- Franklin/Fulton County MH has been sponsoring PESI on-line courses for our contracted providers. Trauma Treatment with EMDR, CBT and Somatic-Based Intervention: A Certified Clinical Trauma Professional Training Course, Anxiety, Panic, and Phobia Certification Training: Interventions for All Types of Worry, and the New Era of Anxiety: Helping Clients Navigate Stress, Fear, Loss & Grief during Turbulent Times are just a few of the courses that were available for the providers. The plan is to continue to offer these courses to our providers.

3. 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 no, counties may include descriptions of plans to implement CLC trainings in FY 23-24. *(Limit of 1 page)*

4. Are there any Diversity, Equity, and Inclusion (DEI) efforts that the county has completed to address health inequities?

☒ Yes ☐ No

If yes, please describe the DEI efforts undertaken. If no, indicate any plans to implement DEI efforts in FY 23-24. *(Limit of 1 page)*

The health disparities task force works to increase access to comprehensive high quality care to populations that experience health disparities. Below is a summary of completed activities:

- Educated task force members and professionals working in the social care coordination space about WellSpan Health's plan to implement FindHelp, a closed-loop referral tool, to improve navigation of resources and to better track outcomes.
- Developed a bi-monthly community health professional development networking program to improve the skills and knowledge of those who help at-risk populations access care and connect to community resources. There were two (2) events which were held on March 28th (39 attended) and May 23rd (33 attended).
- Tuscarora Managed Care Alliance (TMCA) contracted with local community-based organizations (CBOs) to provide community navigation services to help individuals with social determinants of health issues access resources. There were 124 individuals served, and 75 referrals were made.
- TMCA conducted a survey of CBOs to assess services and gaps provided to immigrant and newcomer communities in Franklin County. There were 56 individuals who completed the survey representing 44 unique organizations.

5. Does the county currently have any suicide prevention initiatives which addresses all age groups?

☒ Yes ☐ No

If yes, please describe the initiatives. If no, counties may describe plans to implement future initiatives in the coming fiscal year. *(Limit of 1 page)*

Goal 1: Educate, train, and provide resources directed toward youth to help reduce the number of suicide deaths and suicidal ideation.	Objective 1.1: Provide suicide prevention training for the local middle/high schools for staff, students, and parents. Objective 1.2: Identify teen/youth-specific informational material that can be handed out during youth events. Objective 1.3: Identify and attend events that are specifically marketed for youth and their families to hand out information. Objective 1.4: Identify and be trained in youth-specific suicide prevention trainings so they may be offered to the community.	The coalition will hold a minimum of 3 QPR training sessions a year to the local middle/high schools. The coalition will attend at least 2 events a year that are specifically targeted toward youth and their families to hand out information. The coalition will be trained in and be able to offer youth-specific suicide prevention training.
Goal 2: Educate, train, and provide resources to help reduce the number of suicide deaths in the 18-35 age category.	Objective 2.1: Provide suicide prevention training for the local colleges' students and staff. Objective 2.2: Work with local universities to distribute resources and information regarding suicide. Objective 2.3: Provide suicide prevention training to different businesses that employ 18–35-year-olds.	The coalition will conduct at least 3 suicide prevention training sessions for the local colleges each year. The coalition will work with local university staff to distribute resources twice a year. The coalition will provide at least 4 suicide prevention training sessions a year to local businesses.
Goal 3: Reduce access to lethal means	Objective 2.1: Collaborate with the DA and police on drug take back programs. Objective 2.2: Partner with local gun stores to provide safety locks and offer information on limiting access to lethal means.	The coalition will establish collaboration with the DA/police for drug take-back programs within two years. The coalition will create a flyer that includes suicide prevention resources that can be provided to local gun shops.

6. Individuals with Serious Mental Illness (SMI): Employment Support Services

The Employment First Act (Act 36 of 2018) requires county agencies to provide services to support competitive integrated employment for individuals with disabilities who are eligible to work

under federal or state law. For further information on the Employment First Act, see Employment-First-Act-three-year-plan.pdf (pa.gov)

a. Please provide the following information for your County MH Office Employment Specialist single point of contact (SPOC).
- Name: Jim Gilbert
- Email address: jgilbert@franklincountypa.gov
- Phone number: (717) 264-5387

b. Please indicate if the county **Mental Health office** follows the SAMHSA Supported Employment Evidence Based Practice (EBP) Toolkit:

☐ Yes ☒ No

Please complete the following table for all supported employment services provided to **only** individuals with a diagnosis of Serious Mental Illness.

Previous Year: FY 22-23 County Supported Employment Data for **ONLY** Individuals with Serious Mental Illness		
• Please complete all rows and columns below • If data is available, but no individuals were served in a category, list as **zero (0)** • Only if no data available for a category, list as **N/A** *Include additional information for each population served in the **Notes** section. (For example, 50% of the Asian population served speaks English as a Second Language, or number served for ages 14-21 includes juvenile justice population).*		
Data Categories	**County MH Office Response**	**Notes**
i. Total Number Served	133	
ii. # served ages 14 up to 21	36	
iii. # served ages 21 up to 65	97	
iv. # of male individuals served	74	
v. # of female individuals served	59	
vi. # of non-binary individuals served	1	
vii. # of Non-Hispanic White served	11	
viii. # of Hispanic and Latino served	6	
ix. # of Black or African American served	11	
x. # of Asian served	0	
xi. # of Native Americans and Alaska Natives served	0	
xii. # of Native Hawaiians and Pacific Islanders served	0	
xiii. # of multiracial (two or more races) individuals served	3	
xiv. # of individuals served who have more than one disability	39	
xv. # of individuals served working part-time (30 hrs. or less per wk.)	27	
xvi. # of individuals served working full-time (over 30 hrs. per wk.)	5	
xvii. # of individuals served with lowest hourly wage (i.e.: minimum wage)	4	$10/hour = lowest hourly wage
xviii. # of individuals served with highest hourly wage	2	$22/hour = highest hourly wage
xix. # of individuals served who are receiving employer offered benefits (i.e., insurance, retirement, paid leave)	1	

7. Supportive Housing:

a. Please provide the following information for the County MH Office Housing Specialist/point of contact (SPOC).

Name: Jennifer Hutchinson
Email address: jchutchinson@franklincountypa.gov
Phone number: (717) 264-5387

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 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.

b. **Supportive Housing Activity** *to include:*
- *Community Hospital Integration Projects Program funding (CHIPP)*
- *Reinvestment*
- *County Base funded*
- *Other funded and unfunded, planned housing projects*

i. Please identify the following for all housing projects operationalized in SFY 22-23 and 23-24 in each of the tables below**:**
- Project Name
- Year of Implementation
- Funding Source(s)

ii. Next, enter amounts expended for the previous state fiscal year (SFY 22-23), as well as projected amounts for SFY 23-24. If this data isn't available because it's a new program implemented in SFY 23-24, do not enter any collected data.

- Please note: Data from projects initiated and reported in the chart for SFY 23-24 will be collected in next year's planning documents.

1. Capital Projects for Behavioral Health	Check box ☐ if available in the county and complete the section.

Capital financing is used to create targeted permanent supportive housing units (apartments) for consumers, typically, for a 15–30-year period. Integrated housing takes into consideration individuals with disabilities being in units (apartments) where people from the general population also live (i.e., an apartment building or apartment complex).

1. Project Name	2. Year of Implementation	3. Funding Sources by Type (Including grants, federal, state & local sources)	4. Total Amount for SFY 22-23 (only County MH/ID dedicated funds)	5. Projected Amount for SFY 23-24 (only County MH/ID dedicated funds)	6. Actual or Estimated Number Served in SFY 22-23	7. Projected Number to be Served in SFY 23-24	8. Number of Targeted BH United		9. Term of Targeted BH Units (e.g., 30 years)
Totals									
Notes:									

2. Bridge Rental Subsidy Program for Behavioral Health	Check box ☐ if available in the county and complete the section.

Short-term tenant-based rental subsidies, intended to be a "bridge" to more permanent housing subsidy such as Housing Choice Vouchers.

1. Project Name	2. Year of Implementation	3. Funding Sources by Type (include grants, federal, state & local sources)	4. Total $ Amount for SFY 22-23	5. Projected $ Amount for SFY 23-24	6. Actual or Estimated Number Served in SFY 22-23	7. Projected Number to be Served in SFY 23-24	8. Number of Bridge Subsidies in SFY	9. Average Monthly Subsidy Amount in SFY 22-23	10. Number of Individuals Transitioned to another Subsidy in SFY 22-23
Totals									
Notes:									

3. Master Leasing (ML) Program for Behavioral Health	Check box ☐ if available in the county and complete the section.

Leasing units from private owners and then subleasing and subsidizing these units to consumers.

1. Project Name	2. Year of Implementation	3. Funding Source by Type (include grants, federal, state & local sources)	4. *Total* $ Amount for SFY 22-23	5. Projected $ Amount for SFY 23-24	6. Actual or Estimated Number Served in SFY 22-23	7. Projected Number to be Served in SFY 23-24	8. Number of Owners/ Projects Currently Leasing	9. Number of Units Assisted with Master Leasing in SFY 22-23	10. Average Subsidy Amount in SFY 22-23
Totals									
Notes:									

4. Housing Clearinghouse for Behavioral Health				Check box ☐ if available in the county and complete the section.					
An agency that coordinates and manages permanent supportive housing opportunities.									
1. Project Name	2. Year of Implementation	3. Funding Source by Type (include grants, federal, state & local sources)	4. *Total* $ Amount for SFY 22-23	5. Projected $ Amount for SFY 23-24	6. Actual or Estimated Number Served in SFY 22-23			7. Projected Number to be Served in SFY 23-24	8. Number of Staff FTEs in SFY 22-23
Totals									
Notes:									

5. Housing Support Services (HSS) for Behavioral Health				Check box ☐ if available in the county and complete the section.					
HSS are used to assist consumers in transitions to supportive housing or services needed to assist individuals in sustaining their housing after move-in.									
1. Project Name	2. Year of Implementation	3. Funding Sources by Type (include grants, federal, state & local sources)	4. *Total* $ Amount for SFY 22-23	5. Projected $ Amount for SFY 23-24	6. Actual or Estimated Number Served in SFY 22-23			7. Projected Number to be Served in SFY 23-24	8. Number of Staff FTEs in SFY 22-23
PATH	2005	Federal	71,906	54,558	35			40	1
		State	14,202	18,186					
Totals			86,108	72,744	35			40	1
Notes:									

6. Housing Contingency Funds for Behavioral Health				Check box ☐ if available in the county and complete the section.					
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.									
1. Project Name	2. Year of Implementation	3. Funding Sources by Type (include grants, federal, state & local sources)	4. *Total* $ Amount for SFY 22-23	5. Projected $ Amount for SFY 23-24	6. Actual or Estimated Number Served in SFY 22-23			7. Projected Number to be Served in SFY 23-24	8. Average Contingency Amount per person
Totals									
Notes:									

7. Other: Identify the Program for Behavioral Health				Check box ☐ if available in the county and complete the section.				
Project Based Operating Assistance (PBOA) 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; **Fairweather Lodge (FWL)** 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; **CRR Conversion** (as described in the CRR Conversion Protocol), **other.**								
1. Project Name (include type of project such as PBOA, FWL, CRR Conversion, etc.)	2. Year of Implementation	3. Funding Sources by Type (include grants, federal, state & local sources)	4. *Total* $ Amount for SFY 22-23	5. Projected $ Amount for SFY 23-24	6. Actual or Estimated Number Served in SFY 22-23			7. Projected Number to be Served in SFY 23-24
Keystone Service Systems FSCR-RFP	2019	State HSBG	0		8			0
	(RF 2022)	Federal	0					
		Match	0					
Keystone Service Systems SCR	2005	State Federal Match	458,970 0 12,600	461,930 0 11,160	8			8
New Visions CRR Full Circle (2003)	2003	State Federal Match	388,865 0 8,400	394,737 0 7,440	8			8
True North Wellness SLP	2005	State Federal Match	732,228 0 16,800	720,020 5,100 14,880	18			18

Housing Expansion	2005	State Match	32,192 0	10,200 0	4			3
Totals			1,650,055	1,625,467	46			37
Notes:	*There is one agency in Franklin County which operates a lodge; however, it does not meet the criteria of being a Fairweather Lodge. Historically, there has only been one CRR. Since this continues to be considered an important level of residential placement in our continuum of care, there are no plans to enter into a CRR Conversion Protocol. * The Forensic Specialized Community Residence did not become operational. The provider gave a 60-day notice to terminate the contract as a result of their inability to secure adequate staff to open the program.							

e) <u>Certified Peer Specialist Employment Survey:</u>

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.

<u>In the table below</u>, please include CPSs employed in <u>any</u> 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

County MH Office CPS Single Point of Contact (SPOC)	Name: Jim Gilbert Email: jgilbert@franklincountypa.gov Phone number: (717) 264-5387
Total Number of CPSs Employed	**19**
Average number of individuals served (ex: 15 persons per peer, per week)	**66**
Number of CPS working full-time (30 hours or more)	**4**
Number of CPS working part-time (under 30 hours)	**13**
Hourly Wage (low and high), *seek data from providers as needed*	**$14 - $21.60**
Benefits, such as health insurance, leave days, etc. (Yes or No), *seek data from providers as needed*	**Full time: Yes & No** **PT – no benefits but receive personal time & no (providers differ)**
Number of New Peers Trained in CY 2022	**7**

f) 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	☒	☒ County ☒ HC ☐ Reinvestment
Psychiatric Inpatient Hospitalization	☒	☐ County ☒ HC ☐ Reinvestment
Partial Hospitalization - Adult	☒	☐ County ☒ HC ☐ Reinvestment
Partial Hospitalization - Child/Youth	☒	☐ County ☒ HC ☐ Reinvestment
Family-Based Mental Health Services	☒	☐ County ☒ HC ☐ Reinvestment
Assertive Community Treatment (ACT) or Community Treatment Team (CTT)	☐	☐ County ☐ HC ☐ Reinvestment
Children's Evidence-Based Practices	☒	☐ County ☒ HC ☐ Reinvestment
Crisis Services	☐	☐ County ☐ HC ☐ Reinvestment
Telephone Crisis Services		
Walk-in Crisis Services	☒	☒ County ☒ HC ☐ Reinvestment
Mobile Crisis Services	☒	☒ County ☒ HC ☐ Reinvestment
Crisis Residential Services	☐	☐ County ☐ HC ☐ Reinvestment
Crisis In-Home Support Services	☐	☐ County ☐ HC ☐ Reinvestment
Emergency Services	☒	☒ County ☐ HC ☐ Reinvestment
Targeted Case Management	☒	☒ County ☒ HC ☐ Reinvestment
Administrative Management	☒	☒ County ☐ HC ☐ Reinvestment
Transitional and Community Integration Services	☐	☐ County ☐ HC ☐ Reinvestment
Community Employment/Employment-Related Services	☒	☒ County ☐ HC ☐ Reinvestment
Community Residential Rehabilitation Services	☒	☒ County ☐ HC ☐ Reinvestment
Psychiatric Rehabilitation	☐	☐ County ☐ HC ☐ Reinvestment
Children's Psychosocial Rehabilitation	☐	☐ County ☐ HC ☐ Reinvestment
Adult Developmental Training	☒	☒ County ☐ HC ☐ Reinvestment
Facility-Based Vocational Rehabilitation	☒	☒ County ☐ HC ☐ Reinvestment
Social Rehabilitation Services	☒	☒ County ☐ HC ☐ Reinvestment
Administrator's Office	☒	☒ County ☐ HC ☐ Reinvestment
Housing Support Services	☒	☒ County ☒ HC ☒ Reinvestment
Family Support Services	☒	☒ County ☐ HC ☐ Reinvestment
Peer Support Services	☒	☒ County ☒ HC ☐ Reinvestment
Consumer-Driven Services	☒	☒ County ☒ HC ☐ Reinvestment
Community Services	☒	☒ County ☐ HC ☐ Reinvestment
Mobile Mental Health Treatment	☒	☐ County ☒ HC ☐ Reinvestment
Behavioral Health Rehabilitation Services for Children and Adolescents	☒	☐ County ☒ HC ☐ Reinvestment
Inpatient Drug & Alcohol (Detoxification and Rehabilitation)	☐	☐ County ☐ HC ☐ Reinvestment
Outpatient Drug & Alcohol Services	☒	☒ County ☒ HC ☐ Reinvestment
Methadone Maintenance	☒	☒ County ☒ HC ☐ Reinvestment
Clozapine Support Services	☐	☐ County ☐ HC ☐ Reinvestment
Additional Services (Specify – add rows as needed)	☐	☐ County ☐ HC ☐ Reinvestment

Note: HC= HealthChoice

g) Evidence-Based Practices (EBP) Survey

Please include both county and HealthChoices funded services.

(Below: if answering Yes (Y) to **#1. Service available,** please answer questions #2-7)

Evidenced-Based Practice	1. Is the service available in the County/ Joinder? (Y/N)	2. Current number served in the County/ Joinder (Approx.)	3. What fidelity measure is used?	4. Who measures fidelity? (agency, county, MCO, or state)	5. How often is fidelity measured?	6. Is SAMHSA EBP Toolkit used as an implementation guide? (Y/N)	7. Is staff specifically trained to implement the EBP? (Y/N)	8. Additional Information and Comments
Assertive Community Treatment	No	N/A	N/A	N/A	N/A	N/A	N/A	County would like to have service
Supportive Housing	Yes	30	N/A	Agency/ County		No	N/A	
Supported Employment	Yes	40	N/A	Agency/ County	Annually	No	N/A	Include # Employed
Integrated Treatment for Co-occurring Disorders (Mental Health/SUD)	Yes	N/A	CodeCat	Agency/ County/HC	Annually	No	Yes	
Illness Management/ Recovery	No	N/A	N/A	N/A	N/A	N/A	N/A	
Medication Management (MedTEAM)	No	N/A	N/A	N/A	N/A	N/A	N/A	
Therapeutic Foster Care	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Provided by C&Y Services
Multisystemic Therapy	Yes		TAM/SAM	Agency	Monthly	No	Yes	
Functional Family Therapy	No	N/A	N/A	N/A	N/A	N/A	N/A	
Family Psycho-Education	Yes		N/A	N/A	N/A	N/A	N/A	Information not tracked

SAMHSA's EBP toolkits: https://store.samhsa.gov/product/Supported-Education-Evidence-Based-Practices-EBP-KIT/SMA11-4654

h) Additional EBP, Recovery-Oriented and Promising Practices Survey:

- 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.

(Below: if answering yes to **#1. service provided**, please answer questions #2 and 3)

Recovery-Oriented and Promising Practices	1. Service Provided (Yes/No)	2. Current Number Served (Approximate)	3. Additional Information and Comments
Consumer/Family Satisfaction Team	Yes		
Compeer	No	0	
Fairweather Lodge	Yes		No County involvement
MA Funded Certified Peer Specialist (CPS)- Total**	Yes		
CPS Services for Transition Age Youth (TAY)	Yes		
CPS Services for Older Adults (OAs)	Yes		
Other Funded CPS- Total**	Yes		
CPS Services for TAY	Yes		
CPS Services for OAs	Yes		
Dialectical Behavioral Therapy	Yes		
Mobile Medication	No	0	
Wellness Recovery Action Plan (WRAP)	Yes		
High Fidelity Wrap Around	No	0	
Shared Decision Making	No	0	
Psychiatric Rehabilitation Services (including clubhouse)	No	0	
Self-Directed Care	No	0	
Supported Education	No	0	
Treatment of Depression in OAs	No	0	
Consumer-Operated Services	Yes		MHA
Parent Child Interaction Therapy	Yes		1 provider
Sanctuary	No	0	
Trauma-Focused Cognitive Behavioral Therapy	Yes		5 providers
Eye Movement Desensitization and Reprocessing (EMDR)	Yes		
First Episode Psychosis Coordinated Specialty Care	No	0	
Other (Specify)			

Reference: Please see SAMHSA's National Registry of Evidenced-Based Practices and Programs for more information on some of the practices**:** Resource Center | SAMHSA

i) Involuntary Mental Health Treatment

1. During CY 2022, did the County/Joinder offer *Assisted Outpatient Treatment (AOT)* Services under PA Act 106 of 2018?
   - ☒ No, chose to opt-out for all of CY 2022
   - ☐ 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 CY 2022

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 CY 2022 (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 CY 2022:
   a. Provide the number of written petitions for AOT services received during the opt-out period. ___0_____
   b. Provide the number of individuals the county identified who would have met the criteria for AOT under Section 301(c) of the Mental Health Procedures Act (MHPA) (50 P.S. § 7301(c)). __68_____

4. Please complete the following chart as follows:
   a. Rows I through IV fill in the number
      i. **AOT services column**:
         1) Available in your county, BUT if no one has been served in the year, enter 0.
         2) Not available in your county, enter N/A.
      ii. **Involuntary Outpatient Treatment (IOT) services column:** if no one has been served in the last year, enter 0.
   b. Row V fill in the administrative costs of AOT and IOT

	AOT	IOT
I. Number of individuals subject to involuntary treatment in CY 2022	0	53
II. Number of involuntary inpatient hospitalizations following an IOT or AOT for CY 2022	0	2
III. Number of AOT modification hearings in CY 2022	0	
IV. Number of 180-day extended orders in CY 2022	0	30

V. Total administrative costs (including but not limited to court fees, costs associated with law enforcement, staffing, etc.) for providing involuntary services in CY 2022	N/A	$20.815

j) Consolidated Community Reporting Initiative Data reporting

DHS requires the County/Joinder to submit a separate record, or "pseudo claim," each time an individual has an encounter with a provider. An encounter is a service provided to an individual. This would include, but not be limited to, a professional contact between an individual and a provider and will result in more than one encounter if more than one service is rendered. For services provided by County/Joinder contractors and subcontractors, it is the responsibility of the County/Joinder to take appropriate action to provide the DHS with accurate and complete encounter data. DHS' point of contact for encounter data will be the County/Joinder and no other subcontractors or providers. It is the responsibility of the County/Joinder to take appropriate action to provide DHS with accurate and complete data for payments made by County/Joinder to its subcontractors or providers. DHS will evaluate the validity through edits and audits in PROMISe, timeliness, and completeness through routine monitoring reports based on submitted encounter data.

File	Description	Data Format/Transfer Mode	Due Date	Reporting Document
837 Health Care Claim: Professional Encounters v5010	Data submitted for each time an individual has an encounter with a provider. Format/data based on HIPAA compliant 837P format	ASCII files via SFTP	Due within 90 days of the county/joinder accepting payment responsibility; or within 180 calendar days of the encounter	HIPAA implementation guide and addenda. PROMIS*e*™ Companion Guides

❖ Have all available claims paid by the county/joinder during CY 2022 been reported to the state as an encounter? ☐Yes ☒ No

k) Provide a brief narrative as to the services that would be expanded or new programs that would be implemented with increased base funding?

- Our Counties would look into expanding mobile crisis so it would be available throughout the community when needed, as well as, building a Crisis Stabilization Unit.
- We would like the opportunity to start an Assertive Community Treatment (ACT) team to serve individuals in the community. We have a need for a psychiatric rehabilitation center as well as expansion of services that are provided in our social rehabilitation program.
- Supportive and affordable housing are something that could increase the success of individuals living in the community. Housing such as a Community Residential Rehabilitation (CRR), Long-Term Structured Residence and Specialized Community Residences are needed.
- An increase in base funding would also allow counties to increase wages for front line staff in residential programs and other provider agencies. Many agencies are struggling with staffing with one of the reasons for staff leaving being wages.

l) Categorical State Funding-FY 22-23 [ONLY to be completed by counties not participating in the Human Services Block Grant (i.e. Non-Block Grant)]

State Categorical Funding				
Please complete the following chart below for all funding received. Funding expended can be estimated for fourth quarter expenditures of FY 22-23. If yes, complete the question below the chart that pertains to the specific line of funding. If no funding received for a line, please indicate with n/a. These numbers will be compared to the county Income and Expenditure Reports when received to ensure accuracy.				
Program	**Funding Received Yes or No**	**Funding Received FY 22-23**	**Funding Expended FY 22-23**	**Balance of funds**
Respite Services				
Consumer Drop-in Center				
Direct Service Worker R&R				
Philadelphia State Hospital Closure				
Forensic Support Team				
Eastern State School & Hospital				
Mayview Children's Unit Closing				
Student Assistance Program				

1. **If your county currently receives state funds for Respite services, describe the services rendered with these funds, including an estimate of the number of individuals served.**

2. **If your county currently receives state funds for Consumer Drop-in Centers, describe the services rendered with these funds, including an estimate of the number of individuals served.**

3. **If your county currently receives state funds for Direct Care Worker Recruitment & Retention, describe the services rendered with these funds, including an estimate of the number of individuals served.**

4. **If your county currently receives state funds for the closure of Philadelphia State Hospital, describe the services rendered with these funds, including an estimate of the number of individuals served.**

5. **If your county currently receives state funds to support the Forensic Support Team, describe the services rendered with these funds, including an estimate of the number of individuals served.**

6. **If your county currently receives state funds to support the closure of the Eastern State School & Hospital, describe the services rendered with these funds, including an estimate of the number of individuals served.**

7. **If your county currently receives state funds to support the closure of the Mayview Children's Unit, describe the services rendered with these funds, including an estimate of the number of individuals served.**

8. **If your county currently receives state funds to for the Student Assistance Program, describe the services rendered with these funds, including an estimate**

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 for FY 22-23:

1. **Waiting List Information:**

Services	# of Individuals*	Wait Time (days)**
Withdrawal Management	1	1-2 days
Medically-Managed Intensive Inpatient Services	2	1-2 weeks
Opioid Treatment Services (OTS)	2	1-2 days
Clinically-Managed, High-Intensity Residential Services	2	1-2 days
Partial Hospitalization Program (PHP) Services	1	1-7 days
Outpatient Services	6	2-3 days
Other (specify)	1	7-14 days

*Average weekly number of individuals

**Average weekly wait time per person

- Withdrawal Management (WM) Services: In FY22/23, the average wait time for WM services in or out of the county was 1-2 days from the time of the request, regardless of the individual's current environment. The primary substances for WM placement were opioids (prescribed and illicit) and alcohol.
- Medically-Managed Intensive Inpatient Services: In FY22/23, FFDA has funded treatment for two medically managed/high-intensity residential services.
- Opioid Treatment Services: In FY22/23, FFDA contracted with one methadone provider (closest in geographical proximity) as there aren't any methadone providers within Franklin

County. There are five (4) Buprenorphine prescribing providers within the county, and only one contracts with the county SCA. There are four (4) prescribing practices of oral naltrexone (Vivitrol) in the county with limited physician time – our SCA contracts with two of those. 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 (residential SUD, incarceration, psychiatric placement, etc.) where they received MAT 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 FY22/23, PRS provided mobile Vivitrol services in one location per month. In FY22/23, 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 22/23, the average wait for a residential bed was one-two (1-2) days from the time of the request across all provider networks (in/out of Franklin County). Wait times depended on bed accessibility, priority population requests, unplanned discharges, and time of day (evening) for the request from FFDA.
- Partial Hospitalization Services: In FY22/23, the average wait for Partial Hospitalization Services was one-two (1-2) days from the time of the request across all provider networks (in/out of Franklin County).
- Outpatient Services: In FY22/23, there was no significant wait to access this Intensive Outpatient Program (IOP) or Outpatient Program levels of care (whether the entry was a step-down from a higher level of care or direct entry).
- Recovery Housing: In FY 22/23, FFDA contracted with three PARR-certified recovery houses (one male home and two female homes). Wait time for this service is dependent on availability. The typical wait period is 7-14 days.

2. **Overdose Survivors' Data**: Please describe below the SCA plan for offering overdose survivors direct referral to treatment for FY 22-23.

# of Overdose Survivors	# Referred to Treatment	Referral method(s)	# Refused Treatment
86	Unknown/Data not collected	Recovery Liaison, ER Crisis Workers	Unknown/Data Not Collected

Franklin County has the grant to fund a provider to offer Recovery Liaison services throughout Franklin County through various funding sources. These funds provide a Recovery Liaison on call for any law enforcement to provide Warm Handoff services to overdose survivors and other clients with substance use concerns to help the individual 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 various clients (not just overdose survivors) and focuses on emergent care by connecting clients to treatment; however, data tracking does not include separate searches specifically for overdose survivors. Overall Warm Handoff data is reported above, and this tracking is currently being reviewed to see if data collection could be enhanced to track overdose survivors in FY22/23 more effectively. Law enforcement agencies have access to Recovery Liaison services for overdose survivors, and EMS/BMS/ALS also has 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.

LOC American Society of Addiction Medicine (ASAM) Criteria	# of Providers	# of Providers Located In-County	# of Co-Occurring/Enhanced Programs
4 WM	2	**0**	0
4	2	0	2
3.7 WM	20	1	0
3.7	2	0	2
3.5	31	1	15
3.1	5	0	0
2.5	2	0	2
2.1	5	4	2
1	5	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.

    a. Provide a brief overview of the services needed in the county to afford access to appropriate clinical treatment services:

    Community-based treatment need is funding/financial assistance for individuals that are under/uninsured to obtain assistance with medication-assisted treatment. FFDA will continue to meet this need in FY23/24 by providing funding to provide financial assistance to those that meet the funding and clinical eligibility criteria.

    b. Provide an overview of any expansion or enhancement plans for existing providers:

    County SCA is working with Health Choices Program to identify a Post Overdose Response Public Health Intervention to decrease substance use-related overdoses, improve engagement and retention of individuals with substance use into treatment and recovery programs, and improve harm reduction strategies related to substance use. County SCA is reviewing MOUD/MAUD access in Franklin County to ensure all community members have flexible treatment options to obtain FDA medications to fit their life demands. Medications have proven to dramatically reduce opioid overdose mortality and decrease cravings for individuals with AUD. Low barrier/threshold MOUD/MAUD options allow for quick initiation and continued maintenance and have proven to increase treatment engagement over thirty days to six months compared to non-MOUD/MAUD. County SCA continues enhancing services and opportunities for incarcerated individuals with SUD/Co-Occurring disorders. Recently began offering recovery support group services within the jail setting to assist returning community members in identifying social

determinants needs allowing for recovery support and case management staff to assist with care coordination and public assistance applications, housing, employment, and food/clothing insecurities.

c. Provide an overview of 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 three approved and currently implemented programs for Recovery Bridge Housing Subsidy, Certified Recovery Support Specialists, and Recovery Capital Mini-Grants. 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 DDAP Licensed 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 (withdrawal management/residential) 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, Pyramid HealthCare, and Gaudenzia. The primary goal is to provide individuals with needed yet voluntary peer support while, in turn, reducing the rate of readmission to 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. OHMSAS recently approved the TMCA Recovery Capital Mini-Grants reinvestment plan. The Recovery Capital Mini-Grants will be used, in part, for an effort to support pro-social events. The success of this initiative could lead to the establishment of a group to eventually operate and sustain a community-based recovery organization.

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 professionals and the general community in Franklin County without a prescription due to the current standing order status in which the medication has been made public.

FFDA provides overdose response/naloxone administration training, known as "Operation Save A Life" (OSAL), to anyone that wishes to attend, free of charge. Residents of Franklin County are eligible to receive a free dose of intra-nasal naloxone upon completion of the OSAL training.

Training often occurs and was offered virtually/in-person this past fiscal year to continue offering the training during the impacts of COVID-19. FFDA provides funding to contract with Healthy Communities Partnership (HCP) and Fulton County Family Partnership (FCFP) to deliver most community-based trainings.

The SCA completes OSAL training for professionals and 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 is also carrying/administering intra-nasal naloxone.

In FY17/18, FFDA began serving as the Centralized Coordinating Entity (CCE) through PCCD and has continued this role throughout 2020-2021. The CCE's position is to provide free intra-nasal naloxone to agencies/organizations that serve as first responders in the county, and these definitions were broadened dramatically in 2020.

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, Shippensburg University, 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 implementing warm handoff process.

    a. **Warm Handoff Data:**

# of Individuals Contacted	**83**
# of Individuals who Entered Treatment	62
# of individuals who have Completed Treatment	Unknown/Data Not Collected

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

Additionally, the county contracts with a provider to offer Recovery Liaison services throughout Franklin County through various funding sources. 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 individual's 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 is studying enhancing the Warm Handoff Process throughout the community by examining several models currently utilized in Pennsylvania that conform to specific funding limitations on using such allocations.

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

1. The Warm Handoff process in Franklin County is currently a partner 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 such as emergent care resources. 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 2023-2024 to increase partnerships and consistent utilization of the Recovery Liaison and Warm Handoff process.

2. Additionally, referrals can be accepted from the emergency room departments for assessments and case management. The Crisis department at the Chambersburg and Waynesboro Emergency rooms can refer to substance use treatment services after the clients are medically cleared; however, the clients often leave before completing their crisis intake.

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.*

Individuals Served

	Estimated Number of Individuals served in FY 22-23	*Percent of total Number of Individuals Served*	*Projected Number of Individuals to be Served in FY 23-24*	*Percent of total Number of Individuals Served*
Supported Employment	22	12	27	16
Pre-Vocational	0	0	0	0

Community participation	5	3	5	3
Base-Funded Supports Coordination	63	34	69	39
Residential (6400)/unlicensed	0	0	0	0
Lifesharing (6500)/unlicensed	0	0	0	0
PDS/AWC	20	11	20	11
PDS/VF	1	1	2	1
Family Driven Family Support Services	75	40	52	30

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 concept promoting competitive integrated employment. Franklin/Fulton IDD program is supporting this concept in a variety of ways. Due to the COVID pandemic, individuals with disabilities were either laid off, quit their jobs, were furloughed or were terminated just like those without disabilities. As the pandemic continued, individuals with disabilities again, like those without disabilities, continued to work, found new jobs or decided not to return to work. With the end of the State of Emergency regarding the pandemic, Franklin/ Fulton IDD program has brought their numbers for individuals employed in Competitive Integrated Employment back to the pre-pandemic rate.

The "Transition to Adult Life Success" program engages young adults with disabilities in discussions and activities pertaining to areas of self-determination and career exploration. The "Transition to Adult Life Success" program activities include presentations on employability, community resources and post-secondary opportunities. One-to-one services include connecting with employers, job shadowing, community-based work assessments, and work incentive counseling. There were 23 students in the TALS program in Franklin County in Fiscal Year 2022-2023. The TALS program has a goal of placing eight (8) individuals into a competitive job. Seven (7) individuals had been placed into a competitive job in 2022-2023.

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 Services have outcomes of “placing individuals with intellectual disabilities in a competitive job.” Of the 22 people receiving base funded supported employment, all 21 have competitive jobs.

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 Services is competitive integrated employment. Participants receiving 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 work force, 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 utilizing Small Group Employment Services via waiver funding.

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 other or arbitrary standard of performance and/ or behavior. Discovery involves a comprehensive analysis of the participant in relation to the following:

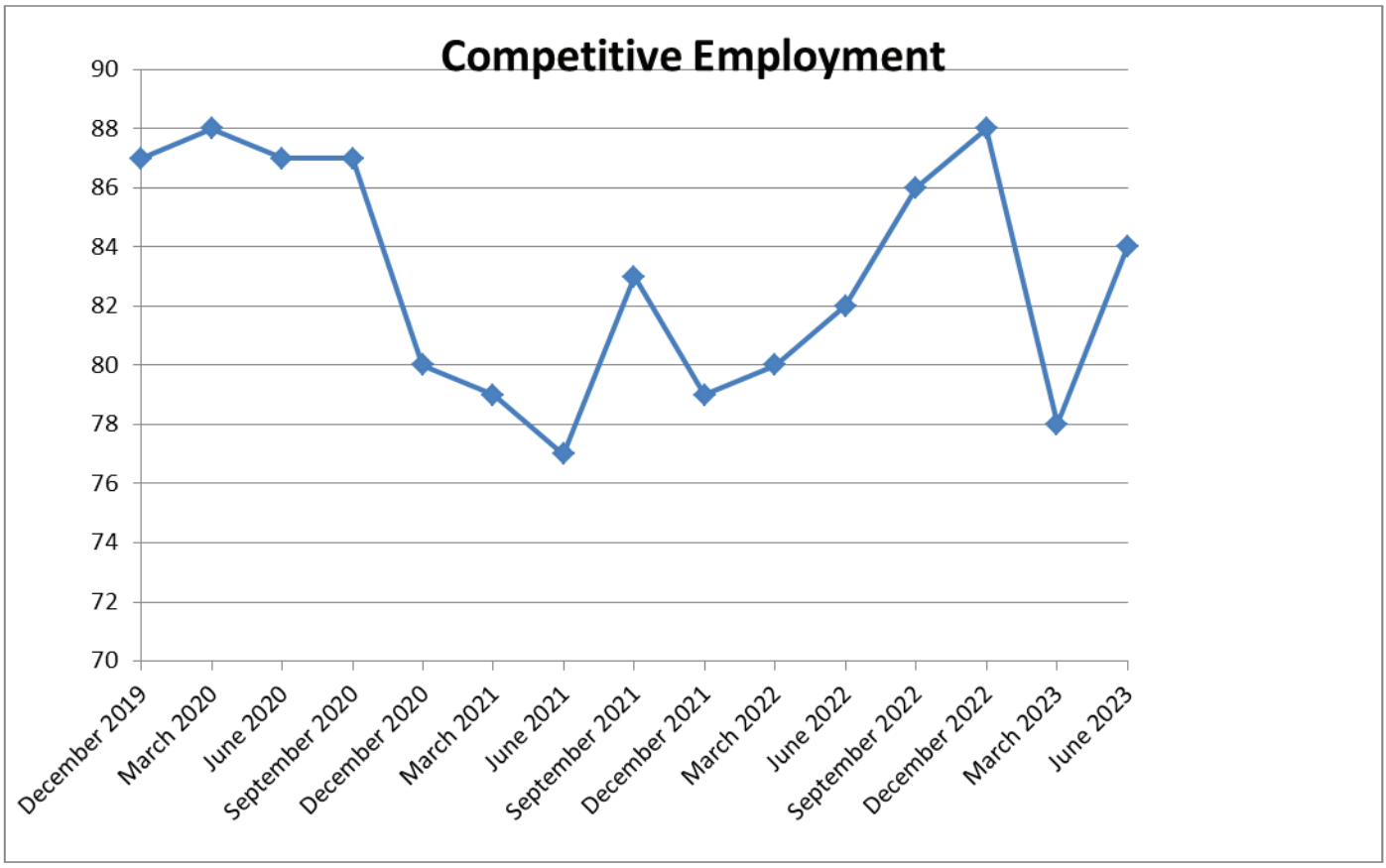
- Strongest interests toward one or more specific aspects of the labor market;
- Skills, strengths and other contributions likely to be valuable to employers or valuable to the community if offered through self-employment; and
- Conditions necessary for successful employment or self-employment.

All employment providers use Discovery as part of their supported employment process. At this time, no one in Franklin County uses Discovery as a discrete service. Information on certification for this process continues to be shared with providers.

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 participant's 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. A total of five (5) individuals utilized base dollars to pay for Community Participation Support during FY 22/23.

The IDD department is concentrating on Competitive Integrated Employment, which includes supported employment and small group employment for the 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-19 pandemic. As with the rest of the state, some individuals were laid off or furloughed, or the business may have closed or the individual may have chosen to leave their job, while other individuals continued to work in essential businesses throughout the pandemic. The following graph shows how employment has increased or decreased the last five (5) years and the effect of the pandemic. There are 84 individuals currently employed in Competitive Integrated Employment. While this is a fluid number, it is comparable to the 87 who were employed pre-pandemic. Franklin/ Fulton IDD Employment Providers will continue to support people to continue to work or to find new jobs.



Franklin/Fulton Transition Councils collaborate with the Office of Vocational Rehabilitation (OVR) in identifying individuals 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 representative from OVR, school districts and providers to promote and support the Employment First Model. OVR and the Franklin/Fulton 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 and adult supports/services. Discussion centers are focused on students' interests, goals and present levels in relation to employment and independent living and supports needed. This also provides an opportunity to register with the IDD Program and OVR if the person has not already done so. The Franklin/Fulton County Transition Councils created virtual transition sites during the pandemic to provide useful resource documents, presentations, etc. that school districts and families can access at any time. As the councils rebuild and educate new members, the goal is to resume in-person Transition Fairs. In the interim, the virtual platforms continue to be updated with resources.

The IDD Program and the SCO collaborate and participate in trainings with OVR 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 for Franklin County individuals.

Supports Coordination:

- Please describe how the county will assist the supports 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 supports 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 included home and community case management for individuals in nursing facilities, Medical Assistance (MA) eligible individuals who are admitted for hospitalization, individuals residing in Intermediary Care Facilities, and individuals who do not qualify for MA. These services are only paid for individuals who have a denial of MA coverage. There are 54 people who have base funded Supports Coordination either because they are not eligible for MA or lost their MA for part of the year. There are six (6) individuals who have the OBRA waiver and have base funded Supports Coordination, and two (2) people (one passed away in 2022-2023) who reside in an ICF/ID or state center and receive base funded Supports Coordination. Currently, Franklin/Fulton is working on transitioning one (1) individual out of the private ICF/ID that will be closing by December 31, 2023. See Community for All section for more information. The IDD program has MA denials for individuals who are receiving base services over $8,000.

The IDD Program collaborates with the Supports Coordination Organization (SCO) by holding monthly meetings with the SC 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 the list. During these monthly meetings, PUNS, ISPs, Levels of Care, incident management, provider risk assessments, IM4Q and other items are part of the standing agenda.

The SCO is also represented on the Transition Councils and is encouraged to participate in State Employment Leadership Network (SELN) trainings, Community of Practice employment calls, and Secondary Transition Conferences, to promote community integrated employment. Franklin/ Fulton County is part of one (1) of the Regional Collaboratives for the Community of Practice. Franklin/ Fulton has combined their stakeholder group with York/ Adams Counties and has become the South Central Regional Collaborative. The Franklin/ Fulton part of the Regional Collaborative is working on creating a one-page profile of the AE this year to be discussed at intake so when an individual is referred to the SCO, he/she is already aware of the Lifecourse Tools. 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. Support Coordinators use the life course principles and activities to help individuals and families plan for the future. The SCO supports the initiatives of the Community of Practice. See more information about Regional Collaboratives in Administrative Funding.

In addition to the Transition Council and Regional Collaborative, the SCO also sends representatives for the Risk Management Committee and the Quality Improvement Council.

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 6100 regulations: “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 (1) or two (2) individuals with an intellectual disability, who are not family members or relatives of the life-sharing host, reside.” Satisfaction surveys have shown that individuals in life-sharing living arrangements are more satisfied with their life.

The Franklin/Fulton County IDD 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, have developed into new life-sharing connections.
- 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 33 people living in Life-Sharing homes in Franklin County (Franklin/Fulton QM information). The funding that supports 32 of these individuals in their life-sharing homes is waiver funding. The remaining person is private pay for his life-sharing home.

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. Life-Sharing providers have the final say in who they will support and individuals with complex needs are harder to find an appropriate long term match. 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. Finally, Franklin/Fulton has been successful in moving individuals

from CRR (Community Rehabilitation Residential) facilities and Children's Foster Care to Life-Sharing care 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 capacity of $85,000 dollars. This is enough funding to support an individual that has a low Supports Intensity Scale Needs Group in a Life-Sharing home as long as that individual is either working or not attending a traditional day program.

During the COVID pandemic, the IDD Program checked in with Life-Sharing Providers, as well as other residential providers to determine whether they had enough personal protective equipment (PPE), number of COVID cases and to check on the health and safety of individuals in their program. The meetings started out weekly and are still being held, but have changed to every 3-4 weeks. These virtual meetings have helped the AE and the provider stay in contact to discuss other issues, as well as COVID, and will continue even though the pandemic has ended.

The IDD program presents the module on Intellectual & Developmental Disabilities at 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 profession. The IDD section was revised to better suit the audience of police officers and first responders for 2020-2021.The training was presented twice in 2021-2022 and is planned to be held twice again in 2022-2023. Many of the local first responder agencies or police departments have most of their staff trained in CIT.

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

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 multisystem needs, and complex 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 supports needed for individuals to be supported in their community and school. The IDD staff also has a working relationship with Home Health Aide 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 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. STAR meetings (Student Transition to Adult Review) meetings facilitated by the OVR Supervisor and

IDD Program Specialist discuss and plan for services/supports after graduation. 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. During COVID, these sessions were not held, or were held virtually, due to the restrictions of ODP, Franklin County and school districts. 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 (2) agencies has resulted in the best outcome for the child while protecting the individual's rights.

The Mental Health and IDD 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 individuals 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. WRAP® Sessions are available upon request from providers or by contacting peer agencies who also have WRAP® facilitators.

The IDD program presents the module on Intellectual & Developmental Disabilities at 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 IDD section has been revised to better suit the audience of police officers and first responders for 2020-2021.The training is planned to be held twice in 2023-2024. Many of the local first responder agencies or police departments have most of their staff trained in CIT.

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

Franklin/ Fulton County has had a recent increase in individuals being discharged from the jail/prison system. While some of the individuals are registered with the AE, others are not known to the IDD system. This delays the provision of services and supports as many do not have the documentation necessary to determine eligibility. Franklin County has also organized a Complex System Triage Team workgroup to discuss certain cases that may cross different departments, and to develop policies and procedures to make it easier to support individuals in need.

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 using funds from the Block Grant. Base money can be provided for day programs and transportation to maintain an individual's residence at home and/ or 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 in residential programs, which are more costly. Franklin County reserves 28 days for Emergency Respite care using base funds.

The IDD Independent Apartment Program has 11 individuals 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. The AE reviewed two (2) residential providers for whom Franklin/Fulton is the assigned AE and also provided information to other assigned AEs about their providers in 2022-23. In 2023-24, Franklin/Fulton plan to add another unlicensed provider of services to the list to review with the provider risk assessment.

Franklin County responds to emergencies outside of normal work hours as stated in Procedure Statement IDD505: Risk Mitigation. In this procedure statement, 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, Adult Protective Services, and the Supports Coordination Organization to set up these services, whether during normal business hours or after business hours. These services may include Life-Sharing or 6400 residential care. This provides for the safety of the person and offers 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 IDD Program utilizes the current contract with Keystone Behavioral Health for Crisis Services. The Crisis Department is operated 24 hours per day, seven (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 are able to provide mobile crisis services. Some of the Crisis workers do have a background in working with individuals with autism and/or intellectual disabilities and training is available for any staff as requested. As with the other crisis services offered, when an individual with an intellectual disability or autism utilizes crisis services, the crisis staff will notify either the Supports Coordinator or the AE if the person is not registered with the IDD program. The Co-Responder program is also a way to divert individuals with disabilities from being incarcerated and to seek the community resources help that they need. Please see 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 two (2) 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.

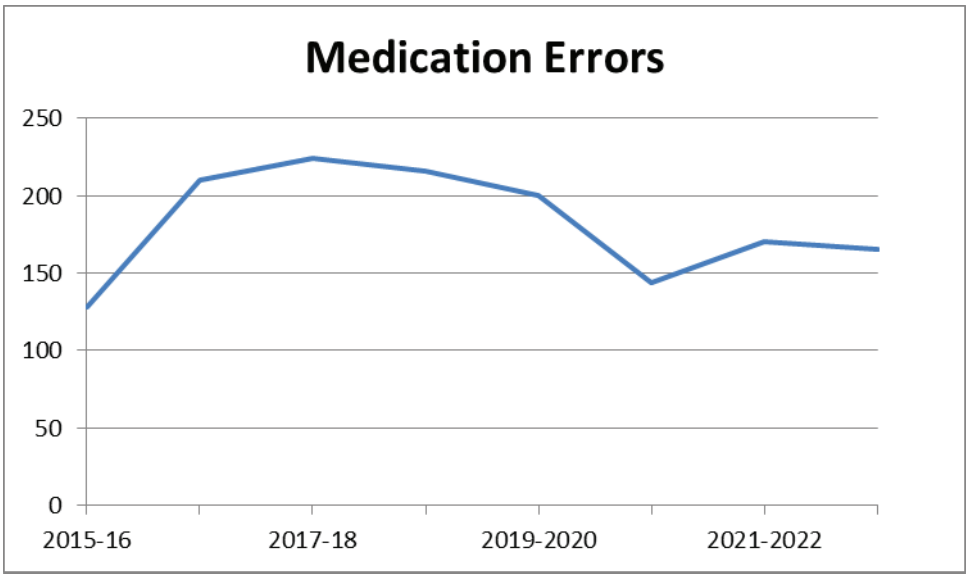
- Please describe the county's interaction with PA Family Network to utilize the network trainers with individuals, families, providers, and county staff.
- Please describe other strategies the county will utilize at the local level to provide discovery and navigation services (information, education, 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 Health Care 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.

The IDD Program has hired a Community Mobile Nurse. The Community Mobile Nurse is primarily stationed in one (1) home, but will visit IDD individuals who reside in Franklin/Fulton counties when a referral is made to the Administrative Entity through the Support Coordination Organization or when an Incident Report is entered into the IDD state system suggesting a nurse make a Health and Safety visit to that individual. This position was established to aid in providing individuals living with family members with added nursing support when needed. The Community Mobile Nurse has served 22 individuals/ families in 2021-2022.

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. Due to the COVID-19 pandemic, all in-person trainings had 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 took another job within the organization, but resumed as co-lead effective July 1, 2023. The Regional Collaborative will concentrate on the four (4) areas that ODP has initiated to include Employment, Family Engagement, Front Door, and Supports Coordination. York/ Adams and Franklin/ Fulton have merged into one Regional Collaboration and are now called the South Central Regional Collaborative. Franklin/ Fulton is the process of taking the resource guide and mapping it through the GIS department, making it searchable and printable. This will generate an electronic application to be used by Human Services professionals, individuals and families. The next step is creating more Maps, as the Behavioral Health and Food Resources have been completed. The Information and Referral Coordinator was the lead for this project; the position is currently open and filled, the project plans resume.

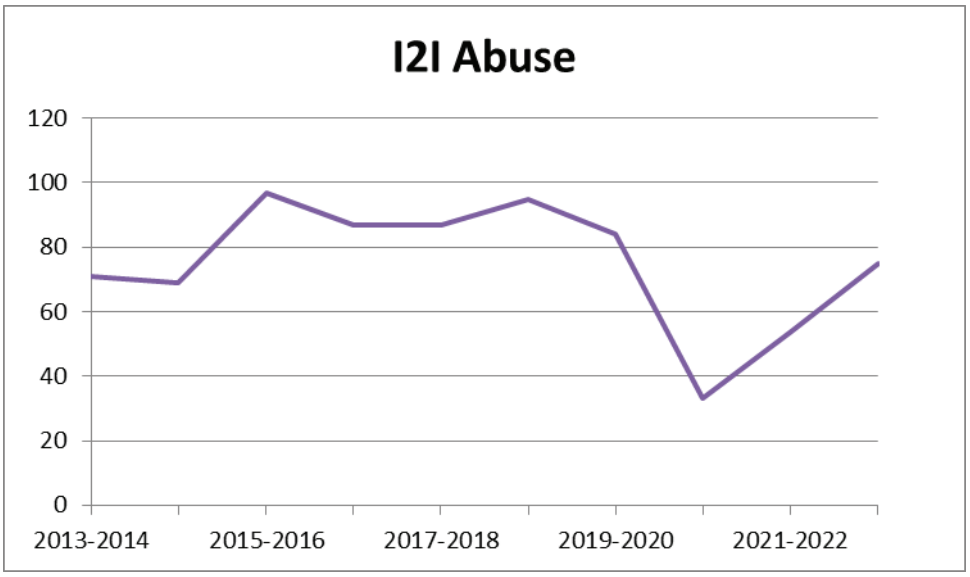
The IDD program uses the vast experience of the HCQU. Trainings by the HCQU are held virtually, which allows individuals to participate in any scheduled training regardless of the county you live in. They also provide individualized training as requested by providers and families. The AE attends the 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 (1) 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 Franklin/Fulton IDD Program will use the objective of reducing the number of medication errors by 10% by June 30, 2024”. The baseline data is 165 medication errors from July 2022 to June 2023. This outcome will remain in the 2023-2027 Quality Management plan.



As with the HCQU, a representative for the IM4Q local program sits on the Quality Insurance (QI) Council. The QI Council also reviews Employment IM4Q data to determine satisfaction with services. The QI Council also looks for trends in IM4Q data where satisfaction of services is below the state average. 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 the 2023- 2027 QM plan was developed, IM4Q data was 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 trainings 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 QM Plan addresses 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 75 incidents of I-2-I abuse for 2022-2032. This is an increase from the previous year. The Risk Management Committee will continue to monitor the data for trends and act accordingly.



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 safer neighborhoods. There are currently 11 individuals in this program.

The AE created two (2) new outcomes for the 2023- 2027 QM plan. The first is to comply with the Information and Sharing Advisory Committee (ISAC) recommendation to improve racial equity. Franklin/ Fulton AE's outcome is to have equal availability to supports and funding regardless of race. The Target Objective is to gather data on racial diversity in both counties as a whole and compare with racial diversity in the IDD program(s). The second outcome is that families need connections with other families and support services. The target objective ties in with our Front Porch program and is to create a family mailing list to distribute events, trainings and community resources. Both of these new outcomes will be reevaluated at the end of 2023- 2024 by the QM Specialist to determine if they need revised or changed as a result of the Plan, Do, Check, Act Cycle.

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. Franklin/ Fulton AE continues to follow up with providers monthly. These meetings were scheduled as a result of the pandemic, but will continue as they are beneficial for both the AE and the providers. Through the IM4Q considerations, Franklin/ Fulton Counties made emergency folders with the local information from the Department of Emergency Services and Ready.gov. Due to the local Department of Emergency Services discontinuing the notification forms that were formerly used, the AE, Crisis Intervention Team and Regional Collaborative are looking into other avenues to let local first responders know there is a person with a disability living in a home. This project is ongoing and will continue to be explored and implemented.

Franklin/ Fulton IDD Program received American Rescue Plan Act (ARPA) funding from the Office of Developmental Programs. These dedicated funds were used to fund a new Program Specialist Position and for Respite and Family Drive Support Services (FDSS). The new Program Specialist started in June 2022 and that position will be funded in 2023-2024 with ARPA funds.

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 SCOs, 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 two (2) individuals and their families using VF/EA and both are new to this model. Both families are using a Support Broker to help assist with self-directing their services. The Supports Coordinator checks in with the families regularly since this is new to everyone in Franklin and Fulton Counties. When the VF/EA is explained to families, they usually choose Agency with Choice (AWC) if they wish to self-direct their services. Franklin County has 20 families using AWC supports. All of the supports and services are paid with ODP waiver funding for both the VF/EA and AWC. 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 having a lack of knowledge of the IDD system and the service definition changes, and the COVID- 19 pandemic. 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. However, due to the COVID pandemic, more families considered using AWC services as documented by the increase in families willing to self-direct their services.

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 nine (9) individuals in congregate settings. One (1) individual resides at State Centers and has been given the choice to move into the community. This individual has stated that he is happy where he currently lives and has no desire to move. One (1) person resides in a private ICF/ID and will be transitioning back to a 6400 community home by December 2023. The remaining seven (7) individuals reside in nursing homes. All but one (1) 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 (1) 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.

It should be noted that the Franklin/ Fulton Administrative Entity is working on eligibility for two (2) individuals who are medically complex to move from a congregate care facility to a community home. Both of these individuals will be aging out of the EPSDT in the next few years. Barriers to these moves include getting proper evaluations to meet the eligibility determination and families that do not want their

loved one to move out of the facility. The AE will continue to work with the pediatric facilities to place people in community homes.

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 23-24.
- If bridge housing services are not offered, please provide an explanation of why services are not offered.

The County does not provide bridge housing services due to the limited availability of funds.

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 23-24.
- If case management services are not offered, please provide an explanation of why services are not offered.

Every Rental Assistance applicant receives case management and service navigation services through South Central Community Action Programs (SCCAP). 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, 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 efforts will be made to refer the individual to other external partner programs for alternative shelter assistance.

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

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

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

The Family Services 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 Family Services 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 Family Services 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 Family Services Specialist will complete a payment agreement between the individual, landlord and SCCAP and will then 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 through HUD and ESG funding.

This allows us the opportunity to identify the appropriate program for the individual. SCCAP can now work with families before they become homeless through HAP dollars, if they are currently homeless through our Emergency Shelter to get them off the streets and then through HAP or Rapid Rehousing to help them get into safe affordable housing and then on an ongoing basis through Case Management or Support Circles. 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 Re-entry Coalition. Both of those County collaborative groups have a host of supports which assist the individual in having a better opportunity of long term success.

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 the 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.

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.

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 OHS 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 23-24.

- 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 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 OHS.

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 62 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 and ERAP rental and utility assistance. 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 provide 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 23-24.
- 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 supports services offered. Include achievements and improvements in services to families experiencing or at risk for homelessness, as well as unmet needs and gaps.
- How does the county evaluate the efficacy of other housing supports services? Please provide a brief summary of other housing supports services results.
- Please describe any proposed changes to other housing supports services for FY 23-24.
- If other housing supports services are not offered, please provide an explanation of why services are not offered.

Due to unavailability of funds, innovative supportive housing services are not provided through HAP. Independent living and forensic housing is 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 211system, 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.

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.

Aging Services: Please provide the following:
Program Name:
Description of Services:
Service Category: Please choose an item.

Children and Youth Services: Please provide the following:
Program Name:
Description of Services:
Service Category: Please choose an item.

Generic Services: Please provide the following:
Program Name: Information & Referral (I&R)
Description of Services: Information and Referral 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 on the services available throughout the County. Information and Referral is also the contact point for PA 211 coordination.
Service Category: Please choose an item.
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:

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.

The County provides professional development events each year which provides information on services available in the County, and up-to-date training that addresses challenges that are faced by those who serve in a human services profession. The goal is to provide quality professional training that will raise awareness on availability of services, enhance skills, increase professional development, and provide awareness of current trends in their profession. Attendees can then use these tools to strengthen delivery service.

The events are held off-site to accommodate maximum attendance. Funds are expended on the venue, guest speakers, and training tools. The training is provided at no cost to participants.

Other HSDF Expenditures – <u>Non-Block Grant Counties Only</u>

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).

Appendix D
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 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 reoccurrence 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).

Warm Handoff
Direct referral of overdose survivors from the Emergency Department to a drug treatment provider.

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, and 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.

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

County: Franklin	1. ESTIMATED INDIVIDUALS SERVED	2. HSBG ALLOCATION (STATE & FEDERAL)	3. HSBG PLANNED EXPENDITURES (STATE & FEDERAL)	4. NON-BLOCK GRANT EXPENDITURES	5. COUNTY MATCH	6. OTHER PLANNED EXPENDITURES
MENTAL HEALTH SERVICES						
ACT and CTT						
Administrative Management	325		$ 257,000		$ 5,000	
Administrator's Office			$ 535,000		$ 13,000	
Adult Developmental Training						
Children's Evidence-Based Practices						
Children's Psychosocial Rehabilitation						
Community Employment	140		$ 293,350		$ 7,000	
Community Residential Services	37		$ 1,975,000		$ 47,000	
Community Services	1,905		$ 800,000		$ 25,000	
Consumer-Driven Services						
Emergency Services	360		$ 50,000		$ 1,000	
Facility Based Vocational Rehabilitation	20		$ 95,000		$ 2,000	
Family Based Mental Health Services	6		$ 33,000			
Family Support Services	45		$ 43,450			
Housing Support Services	95		$ 81,650	$ 49,725	$ 3,000	
Mental Health Crisis Intervention	3,000		$ 365,833		$ 4,958	
Other						
Outpatient	8		$ 4,000			
Partial Hospitalization						
Peer Support Services	35		$ 41,000			
Psychiatric Inpatient Hospitalization						
Psychiatric Rehabilitation						
Social Rehabilitation Services	134		$ 395,000		$ 8,000	
Targeted Case Management	200		$ 120,000		$ 5,000	
Transitional and Community Integration						
TOTAL MENTAL HEALTH SERVICES	6,310	$ 5,089,283	$ 5,089,283	$ 49,725	$ 120,958	$ -

INTELLECTUAL DISABILITIES SERVICES						
Administrator's Office			$ 200,000	$ 78,134	$ 7,863	
Case Management	69		$ 70,000		$ 2,147	
Community-Based Services	75		$ 418,634	$ 38,061	$ 33,060	
Community Residential Services	11		$ 70,575		$ 1,930	
Other						
TOTAL INTELLECTUAL DISABILITIES SERVICES	155	$ 759,209	$ 759,209	$ 116,195	$ 45,000	$ -

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

County: Franklin	1. ESTIMATED INDIVIDUALS SERVED	2. HSBG ALLOCATION (STATE & FEDERAL)	3. HSBG PLANNED EXPENDITURES (STATE & FEDERAL)	4. NON-BLOCK GRANT EXPENDITURES	5. COUNTY MATCH	6. OTHER PLANNED EXPENDITURES
HOMELESS ASSISTANCE SERVICES						
Bridge Housing						
Case Management	100		$ 27,658			
Rental Assistance	225		$ 52,000			
Emergency Shelter	30		$ 32,000			
Innovative Supportive Housing Services						
Administration			$ 2,000			
TOTAL HOMELESS ASSISTANCE SERVICES	355	$ 113,658	$ 113,658		$ -	$ -
SUBSTANCE USE DISORDER SERVICES						
Case/Care Management						
Inpatient Hospital	30		$ 110,000			
Inpatient Non-Hospital						
Medication Assisted Therapy	11		$ 20,000			
Other Intervention	7		$ 10,000			
Outpatient/Intensive Outpatient	65		$ 94,425			
Partial Hospitalization						
Prevention	250		$ 15,000			
Recovery Support Services	52		$ 50,000			
Administration			$ 52,800			
TOTAL SUBSTANCE USE DISORDER SERVICES	415	$ 352,225	$ 352,225	$ -	$ -	$ -
HUMAN SERVICES DEVELOPMENT FUND						
Adult Services						
Aging Services						
Children and Youth Services						
Generic Services	425		$ 80,371			
Specialized Services						
Interagency Coordination			$ 6,000			
Administration			$ 9,597			
TOTAL HUMAN SERVICES DEVELOPMENT FUND	425	$ 95,968	$ 95,968		$ -	$ -
GRAND TOTAL	7,660	$ 6,410,343	$ 6,410,343	$ 165,920	$ 165,958	$ -