Pennsylvania

UNIFORM APPLICATION
FY 2022/2023 Community Mental Health Services Block Grant Plan

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 07/30/2021 12.17.05 PM)

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2022

End Year 2023

State DUNS Number

Number 796567790

Expiration Date

I. State Agency to be the Grantee for the Block Grant

Agency Name Department of Human Services

Organizational Unit Office of Mental Health and Substance Abuse Services

Mailing Address PO Box 2675

City Harrisburg

Zip Code 17105-2675

II. Contact Person for the Grantee of the Block Grant

First Name Kristen

Last Name Houser

Agency Name Office of Mental Health and Substance Abuse Services, Dept. of Human Services

Mailing Address PO Box 2675

City Harrisburg

Zip Code 17101

Telephone (717) 705-8167

Fax 717-772-2062

Email Address krhouser@pa.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

V. Date Submitted

Submission Date

Revision Date

VI. Contact Person Responsible for Application Submission

First Name Kayla

Last Name Sheffer

Telephone 717-705-8167

Fax 717-772-7964

Email Address kasheffer@pa.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2022

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Kristen Houser

Signature of CEO or Designee[1]: _____

Title: Deputy Secretary

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

American Rescue Plan of 2021 Funding Proposal
Community Mental Health Services Block Grant
Pennsylvania Office of Mental Health and Substance Abuse Services
Submitted 7/1/21

1. **Identify the needs and gaps of your state's mental health services continuum including prevention, intervention, access to crisis services, treatment, and recovery support services.**

   Both prior to and during the COVID-19 Public Health Emergency (PHE), the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) engaged in discussions with a broad array of stakeholders to identify mental health needs within Pennsylvania. The stakeholders include individuals with lived experience and their families, practitioners, provider agencies, counties, behavioral health managed care organizations, and partnering systems. Stakeholder engagement was conducted through a variety of mechanisms including virtual meetings, surveys, and the Mental Health Planning Council. Based on this broad feedback, four areas of need were identified by OMHSAS as priorities for the COVID-19 Supplemental Funding awarded to the state in the Consolidated Appropriations Act of 2021 (FY21 COVID-19 Supplemental Funding). These four areas include the Behavioral Health Crisis System, Technology Infrastructure for Telehealth, Residential Services to support community re-entry, and Children's Behavioral Health Services.

   OMHSAS created a $29.5M funding opportunity for County Mental Health Administrations using the Consolidated Appropriations Act of 2021 funding, along with additional annual Community Mental Health Services Block Grant (CMHSBG) funding. Counties Mental Health Administrations submitted 69 Letters of Interest (LOI) related to Mobile Crisis, Crisis Services, Residential Services, Student Assistance Programs, Telehealth Technology Infrastructure and Assisted Outpatient Treatment Start Up funding (AOT support with annual CMHSBG funding) for a total funding request of over $45M dollars. That majority of LOIs submitted (46/69) were for Mobile or Additional Crisis Services, totaling $39.7M. OMHSAS was able to conditionally accept 34 of the proposed Crisis Projects with $25M funding, leaving 12 projects or almost $15M unfunded, which highlights the additional need for funding in this area. In addition, 12 of the 48 County/Joinders did not submit any LOIs for the funding opportunity, 10 of which are largely rural counties where mental health crisis services are sparse.

   For 988 implementation, county mental health programs must ensure 24/7 telephone, mobile and stabilization and receiving crisis intervention services by July 2022. Currently, not all types of crisis intervention services are accessible in all 67 counties. For example, there are only 39 licensed telephone crisis intervention programs, 44 mobile crisis intervention programs, 5 medical mobile programs, 49 walk-in crisis intervention programs, and 15 crisis residential programs. The inconsistencies in Pennsylvania mental health crisis system have numerous potential consequences

including: contributing to health disparities in rural and underserved communities, difficulty coordinating care across county lines, overreliance on law enforcement in mental health crisis response, overreliance on hospital emergency rooms and inpatient facilities to serve individuals who could be treated in the community resulting in higher costs to Medicaid program, inappropriate incarceration of individuals with mental illness, and increased risk of suicide for individuals who are not able to access appropriate crisis services. Therefore, OMHSAS considers capacity building in the mental health crisis system our top priority for the mental health system.

2. **Identify the needs and gaps of your state's mental health services related to developing a comprehensive crisis continuum. Focus on access to your states services through crisis call centers with local knowledge of available services, availability of mobile crisis response teams and crisis receiving and stabilization services.**

   Mental health crisis intervention services are immediate, crisis-oriented services designed to ameliorate or resolve precipitating stress which are provided to children/youth and their families and adults who exhibit an acute problem of disturbed thought, behavior, mood or social relationships. The services provide rapid response to crisis situations, which threaten the well-being of the individual or others. In Pennsylvania, there are currently five types of licensed mental health crisis intervention services, including Telephone Crisis, Walk-In Crisis, Mobile Crisis, Medical Mobile, and Residential Crisis services. Pennsylvania has a decentralized system that uses federal, state, and county braided funding, and is implemented at the county level.

   County mental health programs are required to provide 24/7 telephone crisis intervention services and must also provide 24/7 emergency services. However, as discussed above, not all types of crisis intervention services are accessible in all 67 counties. There are some areas of the state that have local crisis call centers, some of which have limited hours. In addition, some of the calls divert to 911 or law enforcement instead of a trained mental health specialist. Rural providers struggle to provide consistent availability and delivery of services due to population sparsity and lack of resources. Fiscal sustainability of crisis stabilization services is also a challenge in lower population areas.

   Therefore, due to the county-based system, services are often delivered differently from county to county resulting in inconsistent practices and processes. These inconsistencies create challenges for individuals when accessing crisis intervention services across county borders and for mental health professionals when coordinating care for individuals who live in different counties. Additionally, the lack of service availability results in a heavy reliance on the hospital emergency department system to handle all levels of mental health crisis situations, which adds further stress to the mental health systems that are already strained by lack of fiscal and staffing resources which result in delays in access to appropriate services for individuals in crisis.

3. **Describe your state's spending plan proposal, including a budget that addresses the needs and gaps related to crisis and services continuum.**

OMHSAS will utilize the majority of these funds to build additional capacity in the mental health crisis system. The focus of these funds will be to assist counties in enhancing local crisis services and to meet the requirements for federal 988 implementation under the National Suicide Hotline Designation Act of 2020 and the Federal Communication Commission's rules adopted July 16, 2020. In order to oversee these efforts, a new OMHSAS 988 Administrator role will be created to oversee the implementation of 988 and ensure ongoing compliance statewide. This position will be initially funded through CMHSBG funding, because of the need to meet federal 988 guidance. Upon legislation passing at the state level, this position is anticipated to be sustained through the use of funding from Pennsylvania State 988 legislation that is currently in the review process.

OMHSAS will use the 10% First Episode Psychosis (FEP) set-aside funding to help continue the statewide expansion of FEP services, as currently only 22 of our 67 counties have specialty FEP services available. OMHSAS will be working with our 45 unserved counties during SFY21-22 to identify additional counties who are willing to develop FEP teams through American Rescue Plan Act of 2021 (ARPA) start-up funding.

Funding Area	Funding Amount
First Episode Psychosis Set Aside Funding	$4,684,262
Crisis System Developmental/988 Capacity Building	$41,983,353
988 Administrator Position	$175,000
Total	**$46,842,615**

4. **Describe how the state will advance the development of crisis and other needed prevention, intervention, treatment and recovery support services so that your state's system is responsive to the needs of your residents with SMI and SED. Refer to the Guidebook on crisis services.**

A comprehensive and integrated crisis network is the first line of defense in preventing tragedies of public and patient safety, civil rights, loss of lives, and in ensuring efficient use of resources. Pennsylvania will provide the majority of the ARPA funding to its county partners through a request for interest process to enhance crisis services. As a condition of receiving ARPA funds through OMHSAS, counties will be required to work within the framework of the SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practices Toolkit working toward ensuring that anyone, anywhere, anytime can receive appropriate mental health crisis services in Pennsylvania, with someone to talk to, someone to respond, and somewhere to go for a truly comprehensive crisis system.

In addition, Pennsylvania is working towards a 24-hour crisis call center network through several dedicated regional call centers which are part of the National Suicide Prevention Lifeline and will serve as the commonwealth's 9-8-8 call centers. These call centers will be equipped with a comprehensive database of local resources for callers in crisis. Crisis services will be supported through 9-8-8 funding as permitting under the National Suicide Hotline Designation Act of 2020 when state 988 legislation passes.

5. Explain how your state plans to collaborate with other departments or agencies to address crisis, treatment, and recovery support services.

The various behavioral health crisis services projects funded through the CMHSBG COVID-19 relief funding include a broad array of partners including individuals with lived experience and their families, statewide and local suicide prevention advocacy groups, practitioners and provider agencies with expertise in crisis services, county administrations, behavioral health managed care organizations, and partner state agencies. In addition, OMHSAS will work with partner systems that are involved in the mental health crisis system, such as the courts, to offer them training and technical assistance related to mental health crisis services.

6. Describe how the state plans to spend the ten percent set aside for first-episode psychosis/early SMI and, if applicable, the five percent set aside for crisis services.

Crisis 5% Set Aside

OMHSAS will be spending the majority of these funds on the Crisis system, over and above the mandatory 5% set aside. Specifics of the funding are provided in questions one through five.

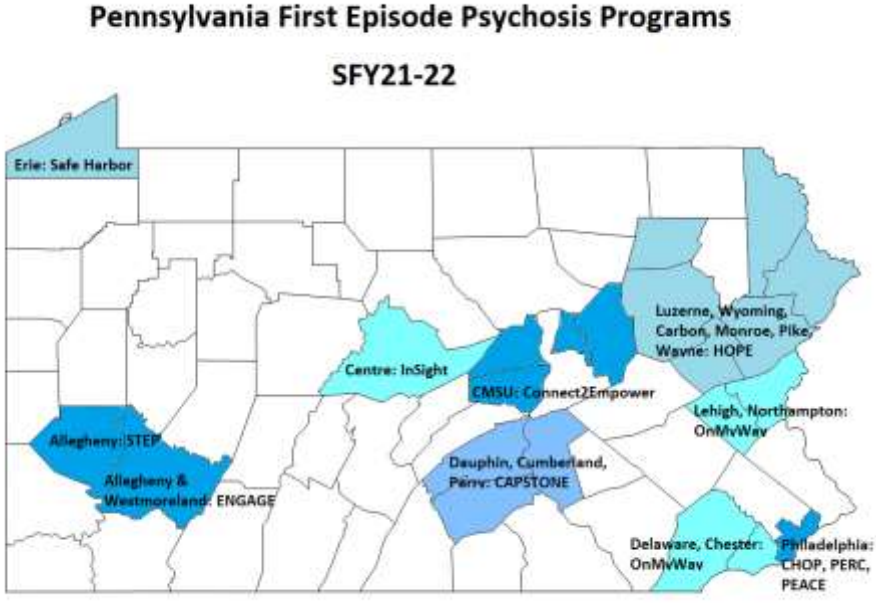
First Episode Psychosis 10% Set Aside

Pennsylvania will be supporting three additional First Episode Psychosis (FEP) Teams in SFY21-22, bringing the Commonwealth total to 17 FEP Teams serving 22 of the 67 Pennsylvania Counties. While Pennsylvania is proud to have FEP teams in each region of the state, as well as in a combination of rural, suburban, and urban counties, we are continuing to push to expand FEP services statewide. Of the 45 counties without an FEP Team, 7 are suburban and 38 are rural.

Utilizing the 10% set aside funding from the American Rescue Plan of 2021, OMHSAS will employ three strategies for increasing the FEP service area within the Commonwealth.

1. Actively engaging the 7 suburban counties without a current FEP Team to identify counties willing to develop FEP services with startup funding provided through these funds.

2. Supporting current FEP teams/counties in the development of cross county partnership to serve individuals from neighboring counties. This strategy has proved effective for our current Dauphin County FEP Team, which established an agreement with their neighboring Cumberland/Perry Mental Health Administration to serve residents of Cumberland/Perry Counties.
3. Working with rural counties, primarily in the largely uncovered areas of western and northern PA, OMHSAS would like to establish rural teams capable of serving multi-county service areas. While this strategy has been offered to counties prior to COVID-19, the extensive travel required for covering large service areas was seen as a significant barrier. Pennsylvania believes that due to the rapid expansion of telehealth service delivery that occurred during the COVID-19 Public Health Emergency, this strategy will now be more feasible.



7. Describe other state priorities or activities that the state plans to fund during the performance period using ARPA funds, with consideration given to disproportionately high rates of MH/SUD in certain communities and disparities in COVID-19 BH-related outcomes by race, ethnicity, and other factors.

OMHSAS has a number of ongoing priorities and activities that will continue during the ARPA performance period which are summarized below.

- Regulation Development: Developing and promulgating updated regulations for a number of behavioral health services including Crisis Services, Residential Treatment Facilities for Youth, and Psychiatric Rehabilitation Services.
- Telehealth: Preserving and expanding the ability to utilize telehealth for the delivery of behavioral health services.

- Trauma Informed Care: Promoting Trauma-Informed Care for both children and adults.
- Suicide Prevention: in addition to the suicide prevention impacts of 988 and the crisis system enhancements discussed above, OMHSAS is working on a number of suicide prevention efforts and will continue to do so over the coming years. These include work on the Garrett Lee Smith (GLS) Youth Suicide Prevention Grant that is working to improve continuity of care across youth-serving systems using the Zero Suicide framework, that National Strategy for Suicide Prevention Grant addressing suicide reduction for adults 25 and older in alignment with the GLS efforts, partnership with the Crisis Text Line to become a "keyword partner", and the Governor's Suicide Prevention Task Force which established a leadership team to develop and monitoring the statewide suicide prevention plan.
- System of Care: OMHSAS continues working towards building sustainable infrastructure and services to improve the mental health outcomes for children and youth through a multi-system involvement model. Currently 44 of Pennsylvania's 67 counties have developed or are developing the System of Care Approach. Pennsylvania recently submitted a grant for additional funding that would add four additional counties to the SOC approach.
- Diversity, Equity, and Inclusion: OMHSAS and the Pennsylvania Department of Human Services are actively working to ensure that Diversity, Equity, and Inclusion are woven into everything that we do, including, but not limited to regulations, grant making, outreach endeavors, recruitment and retention.
- Recovery and Resiliency System Orientation: Pennsylvania published our Call for Change document in 2005, which has been a foundational document driving system transformation from a medical model to a recovery and resiliency focused system. Over the past two years, OMHSAS has been partnering with the Mental Health Planning Council (MHPC) to complete a 15-year look-back at progress made since the original publication of the Call for Change. A look-back document is currently in the final review stages. Once complete, OMHSAS and the MHPC will be reconvening to develop a Call for Change 2.0 to continue to drive innovation in the behavioral health system towards recovery and resiliency.

8. **Describe how the state will use, or consider, health IT standards if using funds for health IT infrastructure or advancement. This includes a description of standards and, as applicable, conformance to Office of the National Coordinator certification criteria in health IT products used or that will be used to support behavioral health clinical priorities and interoperable data exchange. States must use standards identified by the Office of the National Coordinator for Health IT in 45 C.F.R. 170 where applicable and also should consider standards identified in the Interoperability Standards Advisory (https://www.healthit.gov/isa/), including but not limited to those standards described in the, the "Allows for the Exchange of State Prescription Drug Monitoring Program (PDMP) Data" section and the "Social Determinants of Health" section.**

   At this time, OMHSAS is not anticipating using any of the funds for Health IT infrastructure or advancement.

7/26/21 Response to SAMHSA Inquiry

OMHSAS does not intend to use any ARPA CMHSBG funding for the Student Assistance Program.

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2022

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Kristen Houser

Signature of CEO or Designee[1]: Kristen Houser

Title: OMHSAS Deputy Secretary

Date Signed: 7/27/21

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).
Standard Form LLL (click here)

Name

Kristen Houser

Title

Deputy Secretary

Organization

DHS- Office of Mental Health and Substance Abuse Services

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

No lobbying activities to disclose.

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).

Standard Form LLL (click here)

Name

Kristen Houser

Title

Deputy Secretary

Organization

DHS- Office of Mental Health and Substance Abuse Services

Signature:  Date: 7/27/21

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

pennsylvania
DEPARTMENT OF HUMAN SERVICES
OFFICE OF MENTAL HEALTH AND
SUBSTANCE ABUSE SERVICES

Community Mental Health Services Block Grant

FY22-23 Application

STRENGTHS AND NEEDS

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Pennsylvania System

Legislative Base

The mental health system in Pennsylvania is organized in conformance with the Mental Health/ Intellectual Disabilities (MH/ID) Act of 1966 and the Mental Health Procedures Act (MHPA) of 1976 as amended. Primary authority for the Commonwealth's public mental health program derives from these two acts, along with the Human Services Code (amended December 28, 2015). The location of the **Office of Mental Health and Substance Abuse Services** (OMHSAS) and the state hospitals within the Department of Human Services is established in the Pennsylvania Code. Three more recent statutes, namely, Act 80 of 2012, Act 55 of 2013, and Act 153 of 2016 modified the funding mechanism by affording greater flexibility to counties in managing their state allotted dollars.

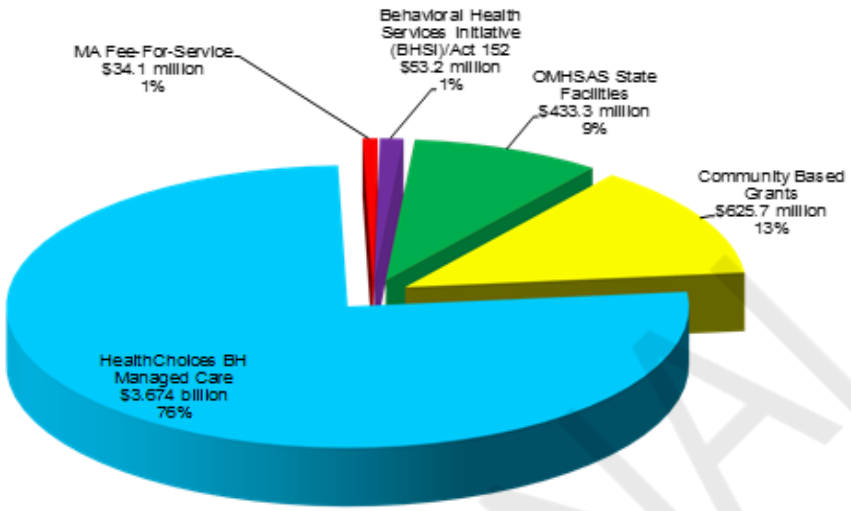
Role of State Government

State government has the statutory responsibility to oversee the provision of community mental health services in the Commonwealth and has direct operational responsibility for the state mental hospitals. Responsibility for operation of the state mental hospitals and oversight of the public mental health system is vested in OMHSAS, which is a program office within the Department of Human Services (DHS). DHS is a multi-program human services agency headed by a cabinet level secretary. DHS was formerly known as the Department of Public Welfare; it was renamed as DHS in September 2014 to be more reflective of the wide array of services provided by the Department. In addition to OMHSAS, the various program offices under DHS include:

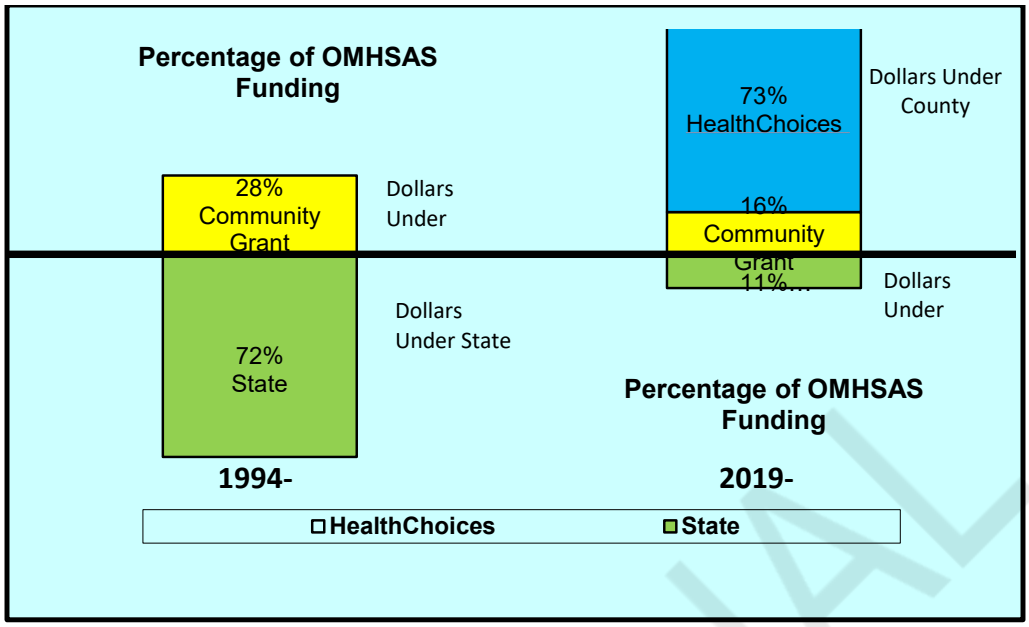
- Office of Developmental Programs (ODP)
- Office of Children, Youth, and Families (OCYF)
- Office of Child Development and Early Learning (OCDEL)
- Office of Long Term Living (OLTL)
- Office of Income Maintenance (OIM)
- Office of Medical Assistance Programs (OMAP)

Through OMHSAS, the state develops programs and policy, licenses many service components, allocates funds for services, and develops guidelines for county service planning. OMHSAS administers behavioral health Medicaid, community mental health funds, Behavioral Health Services Initiative (BHSI) funds for both mental health and substance abuse services for individuals no longer eligible for Medical Assistance, and Act 152 funds to provide non-hospital residential substance abuse services. OMHSAS is also responsible for the administration of the state hospitals. Pennsylvania prides itself in its innovative efforts to support a robust mental

health service system. As illustrated below, the estimated FY 2021/22 budget for behavioral health services is $6.186 billion in state and federal dollars.



Over the last two and a half decades, as shown in the chart below, there has been significant movement of funding from the direct control of the state government to county administrations, allowing increased flexibility at the local levels to manage resources to address the service needs of their communities. In addition to overseeing the mental health services funded with the appropriated state funds, the vast majority of the counties also serve as the primary contractors for the Behavioral Health Medicaid Managed Care Program known as Behavioral Health HealthChoices.



Services for Children

The Bureau of Children's Behavioral Health Services (Children's Bureau) within OMHSAS helps ensure focused attention on the behavioral health needs of children and adolescents. Children's Bureau provides leadership in the planning, program development, and implementation of a comprehensive statewide behavioral health services plan for children and adolescents with serious emotional disturbance (SED). The Bureau collaborates with state, county, and local agencies in the development of programs to support the best provision of care to children and families. The Bureau oversees an array of children's behavioral health services that are comprehensive and community-based, and that express the importance and continuous application of the Child and Adolescent Service System Program (CASSP) principles.

OMHSAS has an Intergovernmental Agreement with The University of Pittsburgh to operate the Pennsylvania Youth and Family Training Institute. The Youth and Family Training Institute is a major component of the effort to transform Pennsylvania's Children's Behavioral Health System. The vision of the transformed system is one which will engage and empower child and family teams as the primary determinants of service. The Institute is responsible for extending the practice of the nationally recognized High Fidelity Wraparound model across the Commonwealth. It provides and coordinates training, coaching, credentialing, evaluation and technical assistance to engage and empower youth and their families in the treatment and recovery process.

There are currently 17 counties involved in the High Fidelity Wraparound system, which include the 14 System of Care counties, as well as, Allegheny, Bucks, and Northampton counties. Over 2,200 youth and their families have been served since the initiation of High Fidelity Wraparound in 2008. Youth and Family Training Institute, in collaboration with the System of Care also provides training for the newly developing Family Peer Support Specialist role in Pennsylvania, with more than 150 family members/supervisors trained to date.

Other Partner State Agencies

Programs in other state agencies, which have a relationship with the mental health system include the Department of Drug and Alcohol Programs, Departments of Aging, Department of Corrections, Department of Education, Department of Health, Department of Insurance, and Department of State as well as the Office of Vocational Rehabilitation within the Department of Labor and Industry. Many of these partners have staff representatives appointed to the Mental Health Planning Council, in addition to partnership on other state efforts. OMHSAS utilizes the counsel and recommendations of the Mental Health Planning Council in the planning, provision, and development of behavioral health and substance abuse services in the state.

State Hospitals

OMHSAS directly operates six state mental health hospitals and one long-term nursing facility. The six hospitals are general purpose psychiatric hospitals for adults. The long-term nursing facility, South Mountain Restoration Center, provides licensed skilled nursing and intermediate long-term care services to elderly individuals with special needs whose needs cannot be met by other community nursing facilities. Children and adolescents are not served in state hospitals with the rare exception in the forensic units when individuals under the age of 18 are being charged as an adult. Each state mental hospital has a nine-member citizen advisory board of trustees, the members of which are appointed by the Governor and confirmed by the State Senate.

For the past three decades, Pennsylvania has been on the leading edge of developing local partnerships and community-based service options that promote recovery for people living with mental illness. The State continues to fund community services and support those living with mental illness through closures and funding of Community Hospital Integration Participation Program (CHIPP) slots. CHIPP slots support the development of needed community infrastructure and residential services.

In keeping with the OMHSAS commitment to reducing reliance on institutional care and improving access to home and community-based services for Pennsylvanians living with mental illness, Norristown State Hospital's civil section was closed in 2019.

Impact of COVID-19 on State Hospitals

In order to reduce exposure and spread of COVID-19, admissions and discharges were paused for short periods of time during the COVID-19 Public Health Emergency (PHE) in 2020. In order to mitigate spread and comply with CDC guidelines, quarantine units were developed for those who tested positive and for new admissions.

Expanded video capabilities were implemented in order to maintain visitation with family and friends while in-person visitation was paused. Video resources were grown through purchasing iPads for use and expanding internet and WIFI capabilities throughout the facilities. These resources have proven successful and will remain in place to give residents expanded access to

visitation past the PHE. These expanded resources have also proven helpful for remote court appearances, as well as virtual treatment sessions for social work, psychology and other therapies.

In-house COVID testing was also implemented to control COVID-19 spread. Testing capabilities will remain, and there are plans to use in-house testing for other contagious diseases, such as the flu and RSV. Vaccinations were provided to individuals in treatment and staff member in the first wave of vaccinations in Pennsylvania. Learning from the COVID-19 pandemic, the state hospitals in Pennsylvania now have policies in place to mitigate further spread of viruses in the future.

Role of Counties

The Mental Health and Intellectual Disability (MH/ID) Act of 1966 requires county governments to provide community mental health services, including short-term inpatient treatment, outpatient services, partial hospitalization services, emergency services, aftercare services for individuals released from state and county facilities, specialized rehabilitation training, vocational rehabilitation and intake services. Services may be operated directly by the county or contracted out to provider agencies, with many counties utilizing a combination of both. The 67 counties in the state are grouped into 48 single-county or multi-county MH/ID Program Offices that operate under the direction of the County MH/ID Administrators. The county commissioners hire and supervise the MH/ID County Administrator, who has a board of 13 individuals to provide advice and consultation in the operation of the program. All County Administrators also function as the directors of the county Intellectual Disability programs and, in 35 counties, as the Drug and Alcohol (D&A) Program Administrators.

OMHSAS allocates funds to the county governments for the provision of community mental health services. County MH/ID and D&A Programs are uniquely positioned to coordinate behavioral health services with other county human services programs. This control and authority over necessary ancillary services such as housing, family courts, and welfare programs are pivotal to a working infrastructure that is capable of providing a seamless system of care. Counties also take leadership roles in their communities by promoting activities aimed at increasing awareness of mental illness among community human service agencies, professional personnel, and the general public

Funding and Other Resources for Counties

The general state revenue funds, county funds, Medicaid dollars, Mental Health Block Grant, Substance Abuse Block Grant, Social Services Block Grant, Projects Assisting the Transition from Homelessness (PATH) grant, and other federal grants comprise much of the funding pool that County MH/ID programs use to provide services to individuals in need of services. Some other resources available to the counties and providers include OMHSAS funded/sponsored technical assistance (TA) and training on a variety of areas. Some examples are Peer Specialist training, Case Management training, training and TA provided to PATH providers, TA in the

development and advancement of evidence-based practices such as the Heads Up First Episode Psychosis technical assistance center at the University of Pennsylvania, Assertive Community Treatment training, the Youth and Family Training Institute, and TA for the development of housing options in the counties. Additionally, OMHSAS is currently developing an Electronic Learning Management System that will central existing state trainings and expand training opportunities available to both counties and their provider agencies, as well as other interested stakeholders.

County Human Services Planning Process

In 2012, as part of DHS's continuing efforts to streamline the planning and reporting requirements for county human services programs, the County Mental Health Planning process and the Integrated Children's Services Planning process were replaced with a County Human Services planning process. The Human Services Planning guidance issued by the Department asked that the counties in their leadership role, with input from their stakeholders, identify local needs, develop goals, create strategies, and identify and track outcomes that support the implementation of quality, cost effective and efficient services. Each county had to create a county planning team that also included representatives of other aspects of the human services system and individuals who receive services and their families. Many counties utilized their existing groups developed through System of Care, Integrated Children's Services, Community Support Programs or other multi system initiatives to assist with the planning process.

The new planning process, while consolidated to present a holistic view of the human services system, also included specific planning requirements for different service areas, namely, Mental Health, Drug and Alcohol Services under DHS's jurisdiction, Intellectual Disabilities, and Homeless Assistance Programs. For the mental health portion of the plan, the counties are required to identify the strengths and needs of various populations and describe the recovery-oriented systems transformation efforts the county plans to initiate in the current year to address concerns and needs. The counties are expected to review data and various indicators to determine local needs and develop a plan to meet those needs. The plans also need to contain strategies to be implemented including specific activities to monitor and improve outcomes.

HealthChoices: Pennsylvania's Medicaid Managed Care Program

Implementation of behavioral health Medicaid managed care in HealthChoices, Pennsylvania's managed care system, began with the Southeast zone in 1997 and was completed in July 2007, when the final set of counties moved into HealthChoices. In the Pennsylvania managed care model, behavioral health services are "carved out" from the management of the physical health services. The success of the HealthChoices Behavioral Health (HC-BH) managed care program was built on partnering with county governments. County governments were given the right of first opportunity to bid on managing the HC-BH risk-based contracts for their respective areas. HC-BH unifies service development and financial resources at the local level, closest to the people served. Individuals receiving Medicaid are automatically enrolled in the BH program in

the county of their residence. A risk-based contract allows flexibility to make decisions that meet the unique needs of the county and, if savings are created, the county must reinvest the money in approved programs and supports that meet the needs of people served. The HC-BH model has achieved its mission and fostered counties' success in controlling the growth of Medicaid spending while increasing access and improving quality. As of March 2021, there were 3,084,957 individuals covered by the Pennsylvania Behavioral Health HealthChoices program, a 17% enrollment increase over March 2020 (2,629,179 enrolled). Each of Pennsylvania's 67 counties was impacted by increased enrollment, with individual county increased enrollment ranging from 10.9% in Cameron County to 23.9% in Dauphin County.

Community HealthChoices

Community HealthChoices (CHC) is Pennsylvania's mandatory managed care program for dually eligible (Medicaid and Medicare) individuals and individuals with physical disabilities—serving more people in communities, giving them the opportunity to work, and experience an overall better quality of life. CHC is available in all counties within Pennsylvania. CHC uses managed care organizations (CHC-MCOs) to coordinate physical health and long-term services and supports (LTSS) for participants. CHC is working to: (1) enhance access to and improve coordination of medical care; and (2) create a person-driven, long term support system in which people have choice, control and access to a full array of quality services that provide independence, health and quality of life. OMHSAS has partnered with the DHS Office of Long Term Living to ensure that behavioral health care needs will be met for all individuals enrolled in CHC. Behavioral Health will continue to be offered through the existing network of behavioral health managed care organizations (BH-MCOs). CHC-MCOs and BH-MCOs will work together to ensure that all participants receive the coordinated services they need. Implementation of Phase 1 of CHC was completed in January 2018 in 14 counties in the southwest part of the state. Phase 2 of the implementation covered the counties in the southeast. With the implementation of Phase 3 in January 2020, all 67 counties of the state have CHC.

New Initiatives

- OMHSAS is currently in the process of revising the Psychiatric Rehabilitation Services (PRS) regulations to allow for individuals ages 14 through 17 to receive PRS. Additionally, the eligibility diagnoses are expanding, and wellness is being added as a domain that can be worked on in PRS.
- OMHSAS is working to establish Family Peer Services for youth and adults as a viable service within the next three years.
- OMHSAS is working to expand the Peer Run Crisis Residential (PRCR) program to other counties within the state in the next three years. The first PRCR program in Pennsylvania, The Path Home, in the Columbia/Snyder/Montour/Union County Joinder, was provided initial startup funding in SFY18-19 through CMHSBG and has demonstrated successful services filling a much needed gap in a primarily rural area of the state. Based on this success, OMHSAS will be funding a second PRCR using

CMHSBG COVID-19 Relief Funding from the Consolidated Appropriations Act of 2021. This program will be located in the Allegheny County, the second largest urban area in Pennsylvania with the City of Pittsburgh.

- Using CMHSBG Early Serious Mental Illness (EMSI) set aside funds, OMHSAS established five additional First Episode Psychosis (FEP) Programs in SFY20-21 and will be establishing three new FEP programs in SFY21-22. As of SFY21-22, Pennsylvania will have 17 total FEP Programs serving 22 Counties which are geographically distributed in each region of the state and represent a mix of rural, suburban, and urban areas.
- During the COVID-19 PHE, OMHSAS rapidly expanded the allowability of telehealth services within the behavioral health system to ensure continuity of care during stay-at-home orders and for individuals requiring quarantine, issuing a memorandum *Telehealth Guidelines Related to COVID-19* within 11 days of the initial Pennsylvania Governor's Emergency Disaster Declaration (initial issue date 3/15/20, update re-issued 5/5/20). OMHSAS is now actively working to make the expansion of telehealth service delivery sustainable past the PHE in order to preserve the increased access to services that have resulted.

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

[The system/services discussed under this criterion apply to both adults as well as children (unless specified in the sub-heading as adult only) Services specific to children are discussed under criterion 3]

Community Support Program

Pennsylvania is guided by the Community Support Program (CSP) principles for the development and delivery of mental health services for adults. Pennsylvania's public mental health system is shaped by a strong influence of individuals with lived experience, family members, and advocacy groups, who provide valuable input into the development of programs and policies that shape changes in the public mental health system throughout the Commonwealth. The CSP philosophy embraces the notion that services should be provided in such a way as to maintain the dignity of the individual and respect the individual's desires, choices, strengths and treatment needs.

Call for Change

In July 2004, the OMHSAS Adult Advisory Committee (now a part of the Mental Health Planning Council) called for a workgroup to guide the recovery transformation efforts in

Pennsylvania. In November 2004, the workgroup held its first meeting and a steering committee was formed to move forward with recommendations. In 2005 *A Call for Change* was published and has since that time been a foundational document for the Pennsylvania mental health system.

A Call for Change offers a basic framework for transformation, including indicators of a recovery-oriented system. In addition, it discusses some of the implications of these changes and recommends some approaches for using the indicators to initiate changes in local, county, and statewide systems. It is to be considered a "living-breathing" document and not a "set in stone" plan.

In September 2018, the Mental Health Planning Council requested that OMHSAS revisit *A Call for Change* and provide the council with a status report on the progress made since its publication. Although this project has faced delays due to the COVID-19 PHE, following extensive stakeholder input from across the system and across the state, OMHSAS provided the MHPC with a 15 year look back at the behavioral health system, *A Call for Change: 15 Years of Progress in HealthChoices Behavioral Health,* in June 2021. This document, which looks back on the gains made in the system since 2005, will serve as a foundation for *Advancing the Call for Change Phase 2*, which will develop a future oriented document setting new priorities for continuing to advance the recovery and resiliency based system over the next five years.

Available Services: Mental Health and Rehabilitation Services

Medical Assistance for Workers with Disabilities *(Adult only)*

Pennsylvania's Medical Assistance for Workers with Disabilities (MAWD) Program is a medical insurance program that supports individuals with disabilities to obtain employment, earn more money and still maintain their Medicaid coverage. Through MAWD availability, individuals with disabilities desiring to return to work can do so without fear of losing their medical benefits. A key and continued goal in the MAWD program is a steady increase in the number of individuals with disabilities returning to competitive employment in the community workforce.

Assertive Community Treatment *(Adult only)*

Over the past several years, OMHSAS has strongly promoted the expansion of fidelity-based Assertive Community Treatment (ACT) programs in the state. Pennsylvania currently has 43 licensed ACT teams, and 1-3 new teams are in development. OMHSAS surveys the ACT teams annually to gather a graphical snapshot of key performance indicators including employment and inpatient hospitalizations. Point in time data collected in February of 2020, shows that Pennsylvania's rate of Competitive Integrated Employment (CIE) for individuals served by ACT teams is 11% for both full-time and part-time employment. Seventy-one percent of those who were hospitalized in the year before they were enrolled in ACT were not hospitalized again in 2019 while enrolled in ACT. In 2019, 2,294 psychiatric ER visits made by ACT team clients

resulted in 1,482 psychiatric inpatient hospitalizations, meaning that 35% of the time the individuals were able to be supported without the need for hospitalization.

The Tool for Measurement of ACT (TMACT) is a fidelity review required annually by Pennsylvania's ACT bulletin which helps guide quality improvement by providing reliable quantitative indicators of performance of ACT teams. During the COVID-19 PHE in 2020, OMHSAS allowed the use of video or phone calls in lieu of in-person contact to attempt to complete the TMACT requirement. Additionally, OMHSAS permitted the use of telehealth in ACT during the PHE including use of audio-video or telephone communication when working with clients in order to ensure continuity of services which are particularly critical for the high acuity individuals served by the ACT program.

First Episode Psychosis

OMHSAS approved funding for 3 new First Episode Psychosis programs in 2021. The new sites included expansions of 2 existing sites into new counties, and one site at the Children's Hospital of Philadelphia. Pennsylvania now has a total of 17 FEP programs throughout the state.

One difficulty that remains true for FEP in Pennsylvania is the expansion of FEP into rural counties. OMHSAS is prioritizing the COVID ARPA funding to specifically target rural counties for new FEP programs.

In addition, OMHSAS provides funding through the CMHSBG to the Pennsylvania Early Intervention Center at the University of Pennsylvania (PEIC) to help support statewide access to FEP services. Over the past two years, PEIC has rebranded and is now known as Headsup. Headsup has created a comprehensive website. In 2020, Headsup helped develop a train-the-trainer for the statewide annual training to expand the number of certified trainers in Pennsylvania. Due to COVID 19, both the train-the-trainer for the annual training and the annual training had to be held virtually. Along with providing virtual trainings throughout the COVID 19 PHE, Headsup also performed their fidelity reviews and data collections entirely virtually.

Partial Hospitalization

Partial Hospitalization is a non-residential treatment service licensed by OMHSAS for persons with mental illness who require less than 24-hour continuous care but require more intensive and comprehensive services than are offered in outpatient treatment. Partial hospitalization services may be:

- A day service designed for persons able to return to their home in the evening
- An evening service designed for persons working and/or in residential care
- A weekend program

While partial hospitalization programs did shift to offering services through telehealth delivery early in the COVID-19 PHE in 2020, both anecdotal reports from stakeholder and results from a large scale OMHSAS Telehealth Survey of individuals and families raised concerns the effectiveness of partial hospitalization services when delivered through telehealth. OMHSAS is

currently engaging with our Telehealth Steering Committee to evaluate specific services and develop best practice recommendations. Partial Hospitalization has been identified as a priority service for the steering committee to review. In addition, OMHSAS will be conducting the Telehealth Individual and Family Survey again in August 2021 and will be closely examining survey results for this service to see if providers were able to become more effective as the PHE continued or if there are still as significant of concerns about ongoing use of telehealth in the context of partial hospitalization programs.

Outpatient Services

Outpatient services are treatment services provided to individuals living in the community. The services, which are directed by the client's treatment plan, are provided to the individual and/or the family. Outpatient services are intended to prevent the need for a more intensive level of care and also act as a follow-up to inpatient services. The services include:

- Psychiatric, psychological, or psycho-social therapy
- Supportive counseling for the client's family, friends and other interested community persons
- Individual or group therapy
- Treatment plan development, review and reevaluation of a client's progress
- Psychiatric services, including evaluation, medication clinic visit, and medical treatment required as part of the treatment of the psychiatric service
- Psychological testing and assessment

Mental Health Crisis Intervention Services

OMHSAS recognizes the critical role of a responsive crisis system in reducing the intensity and duration of the individual's distress and utilizing least restrictive options while ensuring safety. Mental Health Crisis Intervention Services (MHCI) are defined as immediate, crisis-oriented services designed to ameliorate or resolve precipitating stress that are provided to adults or children and adolescents and their families who exhibit an acute problem of disturbed thought, behavior, mood or social relationships. These services provide rapid response to crisis situations which threaten the well-being of the individual or others.

MHCI services include intervention, assessment, counseling, screening, and disposition. Telephone crisis services must be available 24 hours a day, seven days a week to screen incoming calls and provide appropriate counseling, consultation and referral. Additionally, HealthChoices, the mandatory Medicaid managed care behavioral health program, requires access to mobile crisis intervention services as part of the program access standards for members. Within Pennsylvania's mental health service system, telephone, walk-in, mobile, and residential crisis services are provided to all individuals who need the service regardless of funding resources or established connections to the behavioral health service delivery system.

As part of the review of the existing crisis intervention system and the continued transformation of the entire mental health system to a recovery-oriented system, OMHSAS has engaged a stakeholder workgroup to provide recommendations for improving the system. Understanding that any crisis situation has the potential to traumatize the individual who may be subjected to forcible removal from their home, being taken into police custody, transported to a hospital in a police car or ambulance, involuntarily evaluated in an emergency department of a local hospital, and civilly committed to a psychiatric facility against their will, the need for the delivery of effective crisis intervention services in the community is an essential part of the mental health service system.

Based upon the recommendations of the workgroup, OMHSAS is developing a series of training products that will be available to all county crisis service system and their community partners to ensure that standardized training is provided. The first product developed was a regional training on the Mental Health Procedures Act (MHPA) to address the interpretation and application of voluntary and involuntary treatment. The training included information on crisis diversion services as options to inpatient treatment when appropriate and information from an individual and peer perspective on the delivery of crisis intervention services.

OMHSAS, in collaboration with stakeholders and Temple University, developed and distributed an emergency and crisis intervention services training manual to all county mental health administrators. The 220-page manual included an overview of legislation, procedures, principles and practices for the delivery of crisis intervention services. The training manual consisted of six sections addressing laws and regulations, implementation of the Mental Health Procedures Act (MHPA), crisis intervention overview, skill building, special populations, and collaboration with law enforcement and physicians. Each section includes a test to determine knowledge, a variety of scenarios to apply skills and knowledge and links to additional national research material to enhance the written information provided in the manual. The manual will be reviewed and updated annually.

The evaluation and evolution of OMHSAS's crisis services seeks to provide a seamless integration with the forthcoming 988 national crisis hotline and related crisis services. OMHSAS has been working to ensure the availability of crisis services to meet increased demand following 988 implementation and meet national standards. These efforts seek to ensure that every Pennsylvanian has access to someone to talk to, someone to respond, and somewhere to go when facing a mental health crisis and that law enforcement and emergency departments are utilized only when necessary. Toward this end, OMHSAS has obtained a planning grant from Vibrant Health to assist Pennsylvania's thirteen National Suicide Prevention Lifeline call centers prepare for increased call volume. In addition, a signification portion of the CMHSBG COVID-19 relief funds from both the Consolidated Appropriations Act of 2021 and the American Rescue Plan of 2021 will be utilized to assist counties in expanding their crisis service system in preparation for 988 implementations.

Rehabilitation Service

Pennsylvania Psychiatric Rehabilitation Services (PRS) operate under Chapter 5230. Psychiatric Rehabilitation Services regulations promulgated in 2013. PRS has expanded from 22 licensed providers in 2005, to 115licensed providers with 33 satellite locations as of July 2021. Pennsylvania has the largest chapter of the Psychiatric Rehabilitation Association (PRA) in the country, the Pennsylvania Association of Psychiatric Rehabilitation Services (PAPRS). The Commonwealth also has the largest number of Certified Psychiatric Rehabilitation Practitioners (CPRP) of any state in the nation.

Twenty of Pennsylvania's licensed PRS providers follow the Clubhouse Model. Pennsylvania's clubhouses are members of the Pennsylvania Clubhouse Coalition (PCC). PCC membership is contingent upon a clubhouse attaining or moving toward Clubhouse International certification and fidelity to the clubhouse principles.

Pennsylvania is currently working to update the psychiatric rehabilitation regulations to allow for individuals ages 14 through 17 to receive PRS. Additionally, the eligibility diagnoses are expanding, and wellness is being added as a domain that can be worked on in PRS.

OMHSAS permitted the use of telehealth in PRS during the public health emergency including use of video or phone communication when working with clients.

Employment Services

OMHSAS endorses the following employment resources for individuals with SMI:

- SAMHSA's Supported Employment Toolkit
- Peer Support Services
- Fairweather Lodge
- Psychiatric Rehabilitation Services to include Clubhouse model
- Assertive Community Treatment
- First Episode Psychosis
- Supported Education

OMHSAS supports the belief that every person with a serious mental illness (SMI) is capable of working competitively in the community provided the right job and work environment is available. The goal of employment supports for those with SMI is to develop resources that help individuals find and keep jobs that capitalize on individual strengths and skills while accommodating needs with support services as necessary. OMHSAS promotes Supported Employment and although more limited, Supported Education, for individuals with SMI which focuses on community integrated employment.

OMHSAS is emphasizing training and certification to increase the number of Certified Peer Specialists (CPS), including additional sub-specializations for young adults, family, Veterans, forensic, and older adults. As OMHSAS builds the capacity of peer services across PA, and intended outcome is to increase the employment rate of CPS and grow this work force.

OMHSAS is anticipating increasing collaboration with the Office of Vocational Rehabilitation through the development of Memorandums of Understanding for the purpose of gaining data to identify areas of need in service capacity and innovation.

Housing Services

The DHS Five-Year Affordable Housing Strategy, most recently updated in 2017-18, is a comprehensive plan to connect Pennsylvanians to affordable, integrated and supportive housing through a partnership effort between DHS, Pennsylvania Housing Finance Agency (PHFA) and Pennsylvania Department of Community and Economic Development (DCED).

The 2017-18 update includes strategies, goals and action steps through 2020 to address challenges face by these populations. These strategies include:

1. Connect people to housing
2. Strengthen services and supports that address housing needs
3. Expand funding opportunities for housing
4. Measure and communicate progress

Some of the action steps announced in the 2017-2018 update that have been met or have made significant progress in furthering housing strategies for populations, including people with serious mental illness and/or co-occurring serious mental illness and substance use disorder, include the following:

- Expand the 811 program service area to respond to individual needs for housing by increasing the number of 811 apartments from 100 to 250. As of June 18, 2019, 54 Rental Assistance Contracts have been signed with 336 units have been created, which exceeds the goal. A total of 266 consumers have moved into 811 PRA units successfully using 811 PRA funding (117) or HCV (149). 79 of the 117 consumers who moved in using the 811 PRA funding are individuals with serious mental illness.
- Deploy 300 units of public housing or Housing Choice Vouchers that Public Housing Authority partners committed in support of the 811 programs. As of June 18, 2019, 361 Housing Choice Vouchers have been leveraged.
- Determine the benefit of Permanent Supportive Housing (PSH) by comparing Medicaid costs before and after housing is secured; partner with the University of Pittsburgh, DCED, and the Homeless Continuum of Care. This study is complete and the findings suggest that entry in PSH appears to address some health needs for this population (i.e. reduced acute care utilization including emergency department, inpatient and residential utilization including residential treatment for substance use disorder and increase in community mental health services) and the potential for Pennsylvania Medicaid program to realize long-term savings when Medicaid enrollees who are experiencing homelessness receive permanent supportive housing.

Since 2016, the number of regional housing coordinators has expanded to eleven and a “team approach” has been implemented, providing a team of 3 to 4 regional housing coordinators (RHCs) per each of the three regions, along with a dedicated manager to better coordinate and

direct their efforts regionally and statewide. Some of the impacts of the RHCs and manager include:

- RHCs provide technical assistance to social service and other professional staff statewide with the goals of ensuring adequate housing is available to meet the needs of people with disabilities and older adults
- The RHCs attend local housing meetings with service providers and other agencies in their service area to identify the needs of the service area
- RHCs facilitate the Prepared Renter Education Program (PREP) Train the Trainer Program and have been doing so for 10 years. This program provides information on everything a prospective tenant needs to know such as how to apply for housing, how to be a successful tenant, addiction protection tools, how to apply for benefits including SSI and SSDI to name a few.
- The RHCs can assist in helping social service professionals' work with property owners and property managers/landlords to understand the needs of consumers with disabilities
- The RHCs provide technical assistance on providing reasonable accommodation, Fair Housing issues with landlords, and solving difficult housing issues
- The RHCs are on various boards, Local Housing Option Teams and are always at the table with latest information from Housing and Urban Development (HUD), Pennsylvania Housing Finance Agency (PHFA) etc.
- The RHCs work directly with the Local Lead Agencies and provide waitlist management and direct support to the Local Referral Network on the roll-out of the 811 program.

OMHSAS continues to implement a successful Permanent Supportive Housing (PSH) Strategy utilizing local, state and federal resources to expand affordable, supportive housing and residential programs for adults with SMI. This commitment is based on the principle that where people live matters; it is essential to recovery. It is also a practical commitment and addresses a key Social Determinant of Health (SDoH). PSH, an evidence-based practice, enables each consumer to make informed choices about their own housing and to retain more of their income than if residing in congregate facilities or their own residence without rental support. Based on repeated cost comparisons, it enables counties to reduce costs associated with legacy housing programs including Community Residential Rehabilitation (CRR) and Long Term Structured Residences (LTSRs), acute and institutional care. The OMHSAS Initiative was critical to the state's ability to make two competitive applications for 811 PRA resources and is essential for OMHSAS and Counties to meet their Olmstead integration obligation.

To further support the integration of individuals with SMI/SUD with the general population, OMHSAS provided additional guidance to counties when making any commitment of reinvestment for capital development on the percentage of units in a building/project that could be targeted to individuals with SMI/SUD. This guidance is included in the document titled *Utilizing HealthChoices Reinvestment Funds to Create Permanent Supportive Housing, Revised October 4, 2018*.

PSH is typically created by utilizing and combining funding sources to assure housing is affordable, sustainable and meets a person's individual housing needs and choices. OMHSAS provided Counties an opportunity to invest in seven interconnected housing strategies:

- **Capital** or equity investment in development projects
- **Project-based operating assistance (PBOA)** in tax credit developments in collaboration with the Pennsylvania Housing Finance Agency (PHFA)
- **Short term bridge rental assistance**
- **Master leasing** for consumers with criminal or poor tenancy histories
- **Housing clearinghouse** to manage outreach and referral to PSH options
- **Housing support services**
- **Contingency** funds such as security deposit or payment of back rent.

OMHSAS provides some technical assistance and training for this program through individual conference calls specific to individual county reinvestment plans, quarterly OMHSAS Housing calls, and Annual OMHSAS Regional Housing meetings.

A significant benefit of the PSH program is the operating principle that no one should pay more than 30% of their income in rent. According to the December 2017 edition of *Priced Out: The Housing Crisis for People with Disabilities,* by the Technical Assistance Collaborative and the Consortium for Citizens with Disabilities Housing Task Force, there were 231,047 people who received SSI in Pennsylvania, and the SSI payment of $755 was equal to just 19.0% of the area median income statewide. The average cost of a one-bedroom market rate rental in Pennsylvania was 103% of an individual's monthly SSI check. In five local housing market areas, the percentage of monthly SSI to rent a 1-bedroom apartment was above 100% with Philadelphia (and including Wilmington and Camden) being at 133%. 75% of renter households who meet income eligibility for rental assistance don't receive it. The Pennsylvania Housing and Affordability and Rehabilitation Enhancement (PHARE) Act 105 of 2010 was established to provide certain allocated state or federal funds to be used to assist with the creation, rehabilitation and support of affordable housing throughout the Commonwealth.

The goals of the OMHSAS PSH Initiative are unchanged from the start of the initiative:

1. to create affordable supportive housing for people with disabilities, specifically OMHSAS/DHS target populations
2. to use HealthChoices Reinvestment, CHIPPS or base funding to access and leverage mainstream housing resources and create partnerships with state and local housing and community development entities.

Low Income Housing Tax Credits (LIHTC) and HOME funds continue to be extremely important to housing development. County MH/ID programs are becoming more comfortable working with private landlords and property managers to build confidence and thereby gain access to housing for consumers who would have been denied in the past, as well as working to sustain consumers in their housing.

The chart below shows the total dollars committed to the seven categories (as well as an "other" category) from the inception of the initiative through June 2019:

Total Reinvestment Housing Commitment	
Bridge	$53,023,803
Master Leasing	$15,662,442
Capital	$30,728,368
PBOA	$9,021,258
Clearinghouse	$10,865,590
Housing Support	$27,981,637
Contingency	$19,101,099
Other- Fairweather Lodge ($481,034) and Recovery Houses ($2,093,825)	$2,574,859
Total	**$166,642,056**

During the COVID-19 PHE, there was a tremendous spike in unemployment with the temporary and permanent closure of many businesses, raising concerns that individuals and families would be unable to pay rent, which was addressed at the federal level and by many local jurisdictions by enacting moratoriums on evictions. In different areas, motels were repurposed to function as shelters to house the homeless and ensure social distancing. Some motels and hotels were used to help infected individuals to isolate themselves. DHS activated the Commonwealth's Sheltering Taskforce made up of local, county and state agencies and other partners to work on the issues of sheltering individuals around the state. This included DCED planning the issuance of Emergency Solutions Grants to facilitate rapid rehousing efforts. Federal funding was important spring through fall of 2020, as it continues to be important at this time while Pennsylvania has begun to reduce the restrictions due to the pandemic. The funds have helped people retain housing and landlords to receive financial relief. Grants have been distributed to the counties through PHFA and other agencies with the counties directly, including:

- Act 24 Coronavirus Relief Funds (CRF)
- CARES Act funding provided $10M to counties to fund the Homeless Assistance Programs
- Consolidated Appropriations Act of 2021 provided Pennsylvania with approximately $569 mil to administer assistance to renters, landlords and utility providers affected by COVID 19

Fairweather Lodge (Adult only)

Fairweather lodges are small groups of four to eight people who share a house and own a small business or work in the community. The lodges that have businesses select the business amongst the group and then develop and implement a business plan. Lodge businesses include lawn care, custodial or laundry services, printing, furniture building, shoe repair, catering, and other

services. Lodge members assume specific positions of responsibility within the household and the business.

Pennsylvania currently has 41 Fairweather lodges including 3 which are veteran-specific. Pennsylvania recognizes the importance of continued and consistent participation in national outcome reporting by all Pennsylvania lodges. Pennsylvania has a statewide coalition of Fairweather lodge coordinators. The Fairweather lodge program coordinators hold regional meetings to further the growth of the lodge principles and practices among the Pennsylvania lodges.

Our progress with the development of housing options continues to recognize that many individuals who have a disability, including individuals who have a serious and persistent mental illness, can live successfully in the community if they have appropriate supports and services. We are continuing our progress to develop a viable integration plan for Pennsylvanians with mental illness and the need to have community alternatives in place for those who reside in the state hospitals or experience homelessness, as well as, individuals with criminal justice histories, veterans, and others who live in congregate settings. We have been successful in advancing our endeavor and will continue to pursue opportunities to further Permanent Supportive Housing across Pennsylvania.

Fairweather Lodges (FWL) foster mental well-being, independence and community connection for four to eight people with serious mental illness in a shared living arrangement known as a lodge. These individuals, also known as lodge members, agree to live collectively in a lodge/house and either collaboratively own a small business or work in competitive integrated employment the local community. Lodge businesses include lawn care, custodial or laundry services, printing, furniture building, shoe repair, catering, and other services. Lodge members assume specific positions of responsibility within the household and the business. Pennsylvania currently has over 40 Fairweather lodges including 2 which are Veteran-focused. Pennsylvania recognizes the importance of continued and consistent participation in national outcome reporting by all Pennsylvania lodges. Pennsylvania has a statewide coalition of Fairweather lodge coordinators. The Fairweather lodge program coordinators hold regional meetings to further the growth of the lodge principles and practices among the Pennsylvania lodges.

Case Management Services

In Pennsylvania mental health case management services are categorized as Administrative Case Management (ACM) and Targeted Case Management (TCM). TCM includes Intensive Case Management (ICM), Resource Coordination (RC) and Blended Case Management (BCM).

ACM refers to those activities and administrative functions undertaken to ensure intake of clients into the county mental health system so that they can access available resources and specialized services. The activities include, but are not limited to:

- Processing intake into the Base Service Unit

- Verifying disability
- Determining liability
- Authorizing services
- Maintaining records and case files

TCM is provided in the Commonwealth of Pennsylvania to adults with serious mental illness (SMI) and to children with a serious emotional disturbance (SED), who are eligible for Medical Assistance under the State Plan. Clients who meet the medical necessity criteria for TCM but who are not eligible for Medicaid and do not have other means to pay could be eligible for TCM services paid for with state funds. TCM services are administered either directly by the County MH/ID administrations or by the providers contracted by the County MH/ID administrations. TCM services are available throughout the state.

Authorized under Section 1915(g) of the Social Security Act, Case Management services are services that will assist individuals with mental illness eligible under the State Plan in gaining access to needed medical, social, educational and other services. OMHSAS continues to introduce innovative case management practices to facilitate recovery for adults and resiliency for children. This is consistent with the guiding principle to provide services that are responsive to an individual's unique strengths and needs. The following are the categories of Targeted Case Management services provided in Pennsylvania:

- Intensive Case Management: ICM provides assistance to persons with SMI or SED in a variety of ways and is intended to assist the client to achieve specific outcomes such as independent living, vocational/educational participation, adequate social supports and reduced hospitalization. Intensive Case Managers coordinate efforts to gain access to needed resources such as medical, social, educational and other resources through natural supports, generic community resources and specialized mental health treatment, rehabilitation and support services.
- Resource Coordination: RC is targeted to individuals with SMI or SED who do not need the intensity and frequency of contacts provided through ICM, but who do need assistance in accessing, coordinating and monitoring resources and services. RC services assess an individual's strengths/needs and assist the person to access resources and services in order to achieve stability in the community.
- Blended Case Management: In the BCM model, an individual is able to keep the same "blended case manager" despite a change in level of service need, from ICM to RC level or from RC to ICM level. This model does not change the Case Management services being delivered, but rather *how* these services are delivered. It was theorized that by permitting the blended case manager to adjust service intensity based on client need, there would be improved continuity of care for the individual receiving services. In essence, the blended case manager would provide *either* ICM or RC level of service, essentially eliminating the distinction between RC and ICM.

There are other types of case management services that do not distinctly identify with the Case Management system previously described and are therefore not captured as Case Management by existing data collection systems. These services are provided by community treatment teams, primary therapists, peers, friends, families, natural supports and other human services systems.

OMHSAS believes Case Management is a core service, and much emphasis is placed on training case managers. The training institute Western Psychiatric Institute and Clinic provides a mandated state-approved core Case Management training to all new case managers. Additionally, biennial "refresher" training is required for all current case managers as of 2012. During SFY21-22, OMHSAS will be launching an electronic learning management system, MyOMHSAS, which will also offer e-learning training for case managers.

Available Services: Substance Use Disorder/Co-Occurring

With the passage of Act 50 of 2010, the Commonwealth of Pennsylvania established the Department of Drug and Alcohol Programs (DDAP) with the statutory authority for administering all substance use services. DDAP was funded and implemented in Fiscal Year 2012/13 state budget. DDAP maintains responsibility for the development of the State Plan, and for the control, prevention, intervention, treatment, rehabilitation, research, education, and training aspects of substance use issues. DDAP is responsible for the allocation of the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) in combination with state appropriations to the Single County Authorities (SCAs). The SCA system provides the administrative oversight to local substance use programs that are required to provide prevention, intervention, and treatment services. The SCA system contracts with the local licensed treatment providers for the availability of a full continuum of care for individuals who qualify for substance use services within their geographical region. The continuum of substance use services includes outpatient, intensive outpatient, partial, non-hospital detoxification, non-hospital residential, halfway house, medically managed detoxification, and medically managed residential treatment.

Within DHS, OMHSAS is responsible for the oversight of two state funding streams to support substance use services. Additionally, OMHSAS oversees the statewide mandated Medicaid behavioral health managed care program (mental health and substance use services) known as HealthChoices, as well as, the Medicaid fee-for-service funds for mental health and substance use services.

For HealthChoices members, the continuum of care provides an array of treatment interventions as well as additional ancillary services to support a recovery environment. Clinical services are determined based upon the comprehensive assessment process and the application of standardized placement criteria, the American Society of Addiction Medicine Criteria (ASAM), Third Edition, 2013, for all individuals seeking substance use treatment services.

Within HealthChoices, substance use service expansion opportunities are provided through reinvestment dollars (unexpended capitation money). Counties, in partnership with their stakeholders and managed care organizations, identify service gaps in their continuum of care and community recovery support resources and develop plans for the use of reinvestment funds to support additional services. All the plans are reviewed by OMHSAS for various factors before granting approvals.

Co-occurring for individuals with both a substance use disorder (SUD) and Mental Health disorder services continue to be supported the DHS OMHSAS by recognizing the need for providers to have competencies in co-occurring disorders. A bulletin outlining the core competency criteria for any licensed treatment program to be certified as a co-occurring competent program continues to be utilized as a minimum standard for the delivery of these services. With the transition to the use of the ASAM criteria for placement, the bulletin is in the process of being revised for consistency with ASAM criteria. This is a joint initiative between OMHSAS and DDAP.

There is a Co-Occurring Disorders Professional certification for clinicians offered by the Pennsylvania Certification Board (PCB) which became the model for the International Certification and Reciprocity Consortium in 2007. Professionals continue to meet the criteria and test for this credential. The counties and BH-MCOs have partnered to increase access to co-occurring services and supports across the state.

Available Services: Medical and Dental Services

Medical Provisions

As of March 2021, over 3.2 million individuals were enrolled in the Pennsylvania Medicaid Program. Now more people in the commonwealth have access to critical health care services including preventative care than ever before. The services covered under Pennsylvania's Medicaid program for adults include:

- **Various ambulatory services** that include: Primary Care Provider; Physician Services and Medical and Surgical Services provided by a Dentist; Certified Registered Nurse Practitioner; Federally Qualified Health Center/Rural Health Clinic; Independent Clinic; Outpatient Hospital Clinic; Podiatrist Services; Chiropractor Services; Optometrist Services; Hospice Care; Radiology; Dental Care Services; Outpatient Hospital Short Procedure Unit (SPU); Outpatient Ambulatory Surgical Center (ASC); Non-Emergency Medical Transportation; Family Planning Clinic, Services and Supplies; Renal Dialysis

- **Emergency Services** that include: Emergency Room; Ambulance

- **Hospitalization** that include: Inpatient Acute; Inpatient Rehab; Inpatient Psychiatric; Inpatient Drug & Alcohol

- **Maternity and Newborn Services** that include: Physician Certified Nurse Midwives, Birth Centers

- **Mental Health and Substance Abuse (Behavioral Health)** Services include: Psychiatric Inpatient, Drug & Alcohol Inpatient, Outpatient Psychiatric Clinic; Mobile Mental Health Treatment; Outpatient Drug and Alcohol Treatment; Methadone Maintenance; Clozapine; Psychiatric Partial Hospitalization; Peer Support; Crisis Intervention; Targeted Case Management; Family Based Mental Health Services for Children and Adolescents; Residential Treatment Services for Children, as well as all medically necessary Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) behavioral health services for children under 21. Additionally, various cost-effective in-lieu-of state plan services are also available, including, but not limited to Assertive Community Treatment, Drug & Alcohol Non-Hospital Residential, Psychiatric Rehabilitation, Certified Drug& Alcohol Recovery Specialists, First Episode Psychosis programs, etc.

- **Prescription Drugs**, including all drugs used in opioid use disorder treatment

- **Rehabilitation and Habilitation Services and Devices** that include: Skilled Nursing Facility; Home Health Care including Nursing, Aide and Therapy services; ICF/IID and ICF/ORC; Durable Medical Equipment; Prosthetics and Orthotics; Eyeglass Lenses; Eyeglass Frames; Contact Lenses; Medical Supplies; Therapy (Physical, Occupational, Speech)- Rehabilitative; Therapy (Physical, Occupational, Speech)-Habilitative

- **Laboratory Services**

- **Preventative/Wellness Services and Chronic Care** such as Tobacco Cessation, etc**.**

- **Dental Services** that include diagnostic, preventive, restorative, and surgical dental procedures, prosthodontics and sedation. The availability of dental benefits that a Medical Assistance (MA) recipient is eligible for has been standardized under the HealthChoices Expansion. MA provides coverage for the following dental services:
  - All medically necessary dental services for children under age 21
  - Adults (individuals 21 years of age or older) are eligible for diagnostic, preventive, restorative, and surgical dental procedures, prosthodontics and sedation.

- Key Limitations: Dentures 1 per lifetime; Exams/prophylaxis 1 per 180 days; Crowns and adjunctive services, Periodontics and Endodontics only via approved benefit limit exception

Pennsylvania also has a 100% state-funded medical assistance program known as General Assistance (GA-MA). Individuals who do not qualify for federally funded Medicaid due to non-financial reasons may receive Medical Assistance under this program if they meet the eligibility requirements for GA-MA (example: qualified aliens with a five-year bar to receive federally funded Medicaid).

Available Services: Integrated Services

Pennsylvania ended its participation in the CCBHC Demonstration effective June 30, 2019. This was due to the uncertainty of continued funding at the federal level at that time and because the data did not overwhelmingly support continuing or ending the demonstration. In an effort to implement a sustainable coordinated care model, Pennsylvania developed the Integrated Community Wellness Centers (ICWCs), which was implemented January 1, 2020. The Department of Human Services (DHS) defines Integrated Community Wellness Centers (ICWC) as a service delivery model that requires coordinated, comprehensive and quality care. Additional requirements include the provision of nine (9) core services:

1. Crisis Mental Health Services, including 24- hour mobile crisis team, emergency crisis intervention, and crisis stabilization
2. Targeted case management
3. Outpatient mental health and substance use services
4. Patient-centered treatment planning, including risk assessment and crisis planning
5. Screening, assessment, and diagnosis, including risk assessment
6. Psychiatric rehabilitation services
7. Peer support and counselor services and family support
8. Intensive, community-based mental health care for veterans and members of the military
9. Outpatient clinic primary care screening and monitoring of key health indicators and health risk

The ICWC populations being served are adults with serious mental illness, children with serious emotional disturbance, and those with long term and serious substance use disorders, as well as others with mental illness and substance use disorders. Data will be analyzed to evaluate the outcomes of the ICWC and will also be compared to the outcomes of the 2 year CCBHC Demonstration.

Support Services

Suicide Prevention

In 2019, Governor Tom Wolf announced the formation of a statewide Suicide Prevention Task Force created to develop a new, comprehensive statewide suicide prevention plan. The Task

Force included representatives from the Departments of Aging, Human Services, Drug and Alcohol Programs, Health, Military and Veterans Affairs, Education, Corrections, Transportation, PA State Police and the PA Commission on Crime and Delinquency, as well as members of the General Assembly. From August through December 2019, the Task Force hosted a series of 10 listening sessions attended by over 800 stakeholders throughout the Commonwealth, who provided feedback and recommendations that were incorporated into the goals and objectives of the statewide plan. The 2020-2024 Pennsylvania Suicide Prevention Plan, released in September 2020, is aligned with the 2012 National Action Alliance for Suicide Prevention's National Strategy but reflects Pennsylvania's areas of priority. Since then the Task Force continues to meet quarterly under the guidance of a cross-agency leadership team, working to map out current suicide prevention initiatives and strategies for implementation and monitoring of the plan's goals and objectives.

Pennsylvania's statewide suicide prevention organization, Prevent Suicide PA, has been a partner in the ongoing efforts of the Governor's Suicide Prevention Task Force. Training, screening, and awareness initiatives have been ongoing but were impacted by the COVID-19 pandemic. In May 2021, Prevent Suicide PA held their fourth annual Statewide Suicide Prevention Conference virtually. Plenary sessions were provided by Dr. Thomas Joiner and representatives from the Pennsylvania Suicide Prevention Task Force, and a range of breakout sessions covered topics such as the alignment of equity and suicide prevention practices in schools, the integration of trauma-informed approaches into suicide prevention efforts, and suicide prevention initiatives and outcomes within Pennsylvania's correctional system. Prevent Suicide PA has continued to oversee an annual suicide prevention PSA contest for high school students. In lieu of the large-scale suicide awareness nights previously hosted with sports teams around the Commonwealth, Prevent Suicide PA hosted virtual recognition celebrations to honor the high school winners of this contest in 2020 and 2021. The PSA posters, video, and audio clips are publicly available and widely promoted throughout the Commonwealth.

Since the formation of the Governor's Task Force, Pennsylvania's suicide prevention efforts have been largely focused on infrastructure development and the identification and engagement of key partners to support the newly released statewide plan. Pennsylvania has received multiple grants, described in further detail below, to support ongoing expansion of statewide suicide prevention efforts.

Since 2008, OMHSAS has received four Garrett Lee Smith (GLS) grants from SAMHSA, to implement suicide prevention and early intervention strategies for youth between the ages of 10 and 24. The first two grants (2008-2014) targeted primary care settings, while the third grant (2014-2019) focused on training, screening and awareness efforts in schools and colleges, as well as Pennsylvania's Student Assistance Program (SAP) infrastructure. The core goal of the current grant (2019-2024) involves use of the Zero Suicide framework to improve continuity of care across youth-serving systems, for youth at risk of suicide and their families. Additionally, the project builds upon prior GLS grants through continued development and dissemination of

suicide prevention resources statewide, including through the Suicide Prevention Online Learning Center (https://pspalearning.com/) and Higher Education Suicide Prevention Coalition (https://hespc.org/).

988 Implementation

The evaluation and evolution of OMHSAS's crisis services seeks to provide a seamless integration with the forthcoming 988 national crisis hotline and related crisis services. OMHSAS has been working to ensure the availability of crisis services to meet increased demand following 988 implementation and meet national standards. These efforts seek to ensure that every Pennsylvanian can have someone to talk to, someone to respond, and somewhere to go when facing a mental health crisis and that law enforcement and emergency departments are utilized only when necessary. OMHSAS has obtained a planning grant from Vibrant Health to assist Pennsylvania's thirteen National Suicide Prevention Lifeline call centers prepare for increased call volume. Additionally, OMHSAS will be using much of the COVID-19 Relief Funding through CMHSBG, from both the Consolidated Appropriations Act of 2021 and the American Rescue Plan Act of 2021, in order to support counties in enhancing their crisis system in advance of the 988 transition.

Compeer

Compeer is an award-winning, non-profit organization that recruits adult volunteers and matches them in supportive friendship with individuals with serious mental illness. Compeer volunteers provide one-to-one support, friendship and mentor relationships during an individual's recovery process. Compeer services are evidenced-based and considered adjunct to traditional mental health services. The Compeer program has received the Presidential Recognition Award by the U.S. Department of Health and Human Service, the first Eleanor Roosevelt Community Service Award, the Presidential Volunteer Action Award, four Points of Light awards, and recognition from the American Psychiatric Association.

Pennsylvania's coalition of Compeer affiliates launched a CompeerCORPS veteran's program in 2013-2014, based on the Vet2Vet model developed by Compeer, Inc. This program focuses on the unique mental health needs of veterans transitioning back to civilian life.
In SFY20-21, the Pennsylvania Compeer Coalition received a $24,625 state grant from OMHSAS. The primary purpose of this grant continues to be for the Compeer programs of Pennsylvania to be strengthened through outreach, collaboration, and continued expansion of services to veterans and youth and young adults. OMHSAS continues to work with and monitor the Pennsylvania Compeer Coalition's growth and sustainability. Each year the Compeer program continues to be successful in expansion and growth programmatically and financially, therefore requiring less support and funding from OMHSAS.

Family Support Services

In fall 2017 Pennsylvania utilized funding from PA Care Partnership Pennsylvania's State System of Care Cooperative Agreement, Philadelphia System of Care Cooperative Agreement and Pennsylvania's Certified Community Behavioral Health Clinic funds to purchase the

Family-Run Executive Director Leadership Association (FREDLA) Parent Peer Support Practice Model curriculum. FREDLA developed and owns the curriculum and provided an initial training for what Pennsylvania refers to as Family Peer Support Specialists (FPSS). Trainers and FPSSs are required to have lived experience in navigating the child and young adult serving systems. An FPSS Supervisor training was held during October/November 2017. A Train-the-Trainer was held in 2018. FREDLA also provides coaching of FPSS trainers and issues a certificate to provide training. FPSSs will provide peer support to families whose children are between the ages of 0 to 26 with Serious Emotional Disturbances (SED), Serious Mental Illness (SMI) or MH/SUD Co-Occurring Disorders (COD). FREDLA provided a year of technical assistance to the trainers and to Pennsylvania as the training of FPSS spread across the state developing the beginnings of this new peer workforce. Pennsylvania hopes to be able to expand the curriculum to include FPSS to families across the lifespan so families in the adult system understand their role of support, resilience and recovery for their family members. Since the inception of FPSS in Pennsylvania, over 200 family peers have been trained.

In order to ensure that the implementation of FPSS reflects the needs of families and other stakeholders, OMHSAS utilized a stakeholder advisory group including individuals and family members to develop and distribute the application for the Subject Matter Experts (SME) that are required by the PCB to develop the formal certification.

Family peer support builds effective engagement and can facilitate more positive outcomes for a family. This face-to-face intensive work is usually provided in the family's home and community based upon the family's schedule and preference. Sessions and length of service can vary based on the needs of the family, programmatic guidelines and funding requirements. FPSSs can be employed in positions across the spectrum of service intensity levels, from trainers and community education, to individual family support and care coordination, to functioning member of a treatment team in a residential or inpatient setting. It is important that FPSSs receive training on the core competencies and skill sets of FPSS. The current FPSS model that Pennsylvania is utilizing offers this essential training, as well as training in effective supervision of the FPSS workforce and coaching for trainers of the FREDLA Practice Model.

The framework for training the essential functions of the FPSS workforce:

- Connect—Presenting self as a peer and establishing role with family
- Discover—Understanding family level of need, strengths, and goals
- Support—Support of family across systems, including developing and implementing a support plan with tasks and building collaborative relationships
- Empower—Empowering families and informing systems, around family perspective, family voice and choice, and family-driven services
- Prepare—Transitioning from formal support, including the development of an ongoing plan for support and acknowledging skills learned
- Take Care— Establishing a work-life balance, recognizing triggers, understanding FPSS role and setting limits, using supervision effectively

The establishment of FPSS is a priority of the he MHPC Children's Committee under the overall MHPC Priority of expanding Peer Led Services. The committee sees these system and natural resource navigator and support roles as consistent with the historical design of the community mental health systems, the expansion of the System of Care model and the evolving system of integrated and coordinated care and treatment through the empowering of parents and caregivers to advocate for their child/youth with emotional, developmental, behavioral, substance use, or mental health concerns. With the introduction of the FREDLA curriculum and the building of the FPSS workforce the Children's Committee of the MHPC sees this initial priority as having been achieved of establishing FPSS services within Pennsylvania. In 2021, the Children's Committee has broadened the priority to include expanding FPSS across the lifespan, establishing a FPSS credential with Pennsylvania Certification Board, and creating a sustainable funding mechanism for FPSS within the Pennsylvania behavioral health system. OMHSAS supports the MHPC recommendation for expanding FPSS and has established a new CMHSBG priority related to FPSS in this application.

Family engagement is a core component of the Coordinated Specialty Care (CSC) model used for First Episode Psychosis (FEP) programming. Program sites have varied types of family engagement in place, but they typically include a combination of treatment planning, family therapy, and multi-family groups. Pennsylvania's FEP Programs have found Certified Peer Specialists (CPS) to be an excellent resource for engaging program participants. In 2020, Pennsylvania made CPS a required service element for CMHSBG funded FEP programs. The FEP Programs are looking at the possibility of utilizing the newly developed FPSS service in the future as the workforce development for this service continues to similarly help with engaging family members and supporting them through the program. Currently, one FEP program site offers FPSS, with more sites considering adding the service in the future.

Peer Support Services

Pennsylvania's peer support specialist (PSS) initiative has continued to grow and develop. In 2019, Pennsylvania took the steps necessary to place credentialing of CPS under the Pennsylvania Certification Board (PCB) and issued revised standards for PSS that reflect this change and oversight. As of September 1, 2019, in order to provide Medicaid-billable PSS, a CPS must complete a PCB-approved CPS training, attain CPS certification through the PCB within one year of hire as a CPS, and maintain certification as a CPS through the PCB. As of May 2021, approximately 7,105 individuals have met the 75-hour training requirement to become Certified Peer Specialists (CPS) and X individuals have been trained as supervisors of CPS. Pennsylvania currently has one of the largest cadre of CPS of all states. Of the 1,321 CPSs trained in the last two years, 72 percent were employed either full-time or part-time at the time of certification. As of June 2021, there are 2,341 CPSs in Pennsylvania with active CPS certification and X licensed peer support service agencies. In addition to licensed peer support services agencies, CPSs work throughout the Pennsylvania Behavioral Health System in ACT Teams, FEP Teams, State Hospitals, Inpatient Hospitals, and Crisis Services.

Pennsylvania has undertaken multiple peer support initiatives. Pennsylvania has developed a one-day, five-hour documentation training course for CPS to enhance their Medicaid

documentation skills. In addition, Pennsylvania's Department of Corrections instituted the 75-hour, 10-day CPS training program within its facilities and has trained over 600 CPS in each state correctional facility including 10 percent of whom are serving life sentences. Upon release from prison, CPS in good standing receive a letter of recommendation from the Department of Corrections and peers have gone on to obtain employment as CPS in the community. Specialized areas of continuing education for CPS in Pennsylvania include a 3-day training on Peer Support Within the Criminal Justice System, 2-day Veteran Peer Support, 3-day Peers Working in Crisis Services and 2-day Supporting Youth and Young Adult Training.

In December 2016, OMHSAS issued OMHSAS-16-12 Peer Support Services- Revised. This updated policy allows individuals 14 to 17 years of age to receive PSS if they meet the admission criteria. To support this expansion, a 2-day continuing education training was developed for CPS supporting youth, and a specialized training was developed for supervisors of CPS working with youth.

A 75-hour CPS training was piloted in December 2017 for qualified individuals who are deaf and use American Sign Language, in an effort to increase behavioral health services for the deaf population. OMHSAS worked closely with the Office of Vocational Rehabilitation on this initiative.

In August 2018, OMHSAS released a request for applications (RFA) for the development of Peer Run Crisis Residential (PRCR) programs in state FY 2018-2019. One county/joinder was selected to develop a PRCR program in their region and began offering services on October 15, 2019 with a three-bed capacity. The PRCR is designed to support the principles of recovery and recognize the importance of trained CPSs to assist individuals experiencing a MH crisis to determine strategies to stabilize the current situation. The PRCR has been licensed as a modified crisis residential program, and PRCR service is MA-billable. Pennsylvania continues to work with the county/joinder towards fiscal and programmatic sustainability of the PRCR pilot in FY20-21, with a goal of expanding this service to other counties in the next three years.

Cultural and Linguistic Competence in Mental Health Services

OMHSAS has identified Cultural and Linguistic Competence (CLC) as an important priority for both OMHSAS staff and the state mental health system. In 2018, the OMHSAS CLC workgroup identified a need to obtain improved data regarding the status of CLC services across the state as an important step in planning system improvements. OMHSAS has taken several steps in improving data collection since that time, including enhancing CLC Reporting from the Counties as a part of the Human Services Planning Process. In addition, the collection of demographic information on OMHSAS surveys and programmatic reports for CMHSBG funded projects has been updated to include options for reporting non-binary gender, transgender identity, and sexual orientation data.

In addition to broad CLC efforts, OMHSAS has also provided focused training efforts for the LGBTQIA+ community through continued partnership with the Gender and Sexuality Development Clinic at the Children's Hospital of Philadelphia (CHOP) and Keystone Pride

Resources Institute (KPRI). Starting is SFY18-19, OMHSAS partnered with CHOP to offer training to providers within the Behavioral Health System to better serve individuals who are transgender or non-binary. In SFY20-21, both an introductory training and advanced training were offered. Session continue to fill consistently with waitlists, demonstrating an ongoing need for and interest in this training. Based on this, OMHSAS is planning to continue the partnership with CHOP in SFY21-22.

KPRI was organized in 2008 with the mission to protect LGBTQIA+ individuals receiving behavioral health services from discrimination and mistreatment; to ensure that OMHSAS and contracted providers provide culturally affirmative environments of care for LGBTQI individuals; and to ensure clinically competent behavioral health care for LGBTQI individuals. OMHSAS provides funding to KPRI to support three trainings offered throughout Pennsylvania; a 2.5-hour web-based training ("LGBTQI Welcoming and Affirming Practice"); a one-day classroom training ("Creating Welcoming and Affirming Services for Persons who are LGBTQI"); and a three-day clinical classroom training ("Principles and Practice for Clinicians Working with LGBTQI individuals"). In addition, KPRI and the Pennsylvania Peer Support Coalition partnered to develop a continuing education training for Certified Peer Specialists that seek additional competency when working with individuals that identify as LGBTQI. KPRI also offers a Speaker's Bureau, which offers specialized presentations for educators, hospital staff, community groups, and professional organizations interested in creating more affirming environments.

OMHSAS has two bulletins addressing the needs of the LGBTQIA+ community in the behavioral health system, OMHSAS-11-01 *Non-Discrimination Toward Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex People* and OMHSAS-11-02 *Guidelines to Ensure Affirmative Environments and Clinically Appropriate Services for Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex Consumer and their Family Members*. OMHSAS is currently working on the development of a single combined guidance bulletin that will enhance our ability to ensure non-discrimination for the LGBTQIA+ community and to enhance our ability to offer culturally competent services in the behavioral health system.
OMHSAS, along with the full Department of Human Services, has been actively focused on Diversity, Equity, and Inclusion (DEI) during SFY20-21. At the direction of former DHS Secretary Teresa Miller, DHS Executive Staff were engaged to enhance DEI work in each program office, convened a DHS Racial Equity Steering Committee, and increased training for commonwealth employees. In addition to the Departmental work, the Pennsylvania Mental Health Planning Council (MHPC) has been actively working on DEI efforts as well, which has included developing discussion guidelines for the council and holding ongoing DEI conversations on a monthly basis open to all council members as well as smaller group discussions for interested members.

Forensic Services

Criminal Justice Mental Health Advisory Committee (MHJAC), a collaborative effort between OMHSAS and the Pennsylvania Commission on Crime and Delinquency (PCCD), advocates the

"Sequential Intercept Model" as a best practice for mental health consumers in the criminal justice system. This model delineates five points of interception:

1. Law Enforcement and Emergency Services
2. Initial Detention and Initial Hearings
3. Jail, Courts, Forensic Evaluations, and Forensic Commitments
4. Reentry from Jails, State Prisons, and Forensic Hospitalization
5. Community Corrections and Community Support.

Each point of contact provides an opportunity to divert mental health consumers from funneling further into the criminal justice system.

MHJAC formally recognizes Stepping UP Pennsylvania as a committee priority and has deemed it appropriate for the Council of State Governments (CSG) to provide technical assistance to counties for the advancement of the Stepping Up Initiative. Funding is provided through MHJAC to support a multi-pronged approach to support counties' Stepping Up related work including, but not limited to, the implementation of a cohort approach to technical assistance, the identification and use of best-practices, and the creation of a central information bank on the intersection of serious mental illness and criminal justice. To date 35 of 67 Pennsylvania counties have signed a Stepping Up Resolution. Pennsylvania has 5 counties recognized by Stepping Up as Innovator Counties: Berks, Montgomery, Dauphin, Cumberland, and Philadelphia, more than any other state. To be recognized as an innovator county a three-step approach to data collection must be implemented:

1. Establish a shared definition of SMI for your Stepping Up efforts that is used throughout local criminal justice and behavioral health systems
2. Use a validated mental health screening tool on every person booked into the jail and refer people who screen positive for symptoms of SMI to a follow-up clinical assessment by a licensed mental health professional
3. Record clinical assessment results and regularly report on this population.

U.S. Department of Justice's Bureau of Justice Assistance selected Pennsylvania to work with the Council of State Governments Justice Center (CSG) on a pilot project to identify and advance statewide strategies to help counties meet their Stepping Up goals. At the completion of the policy scan, CSG Justice Center recommended that the state focus on three priority areas that are most directly responsive to local needs, opportunities, and scale of impact on the target population. The priorities include:

- Improving local capacity to collect data and share information
- Increasing local diversion as early as possible
- Increasing local availability of and connections to housing.

The MHJAC subcommittee reviewed the full report and prioritized the recommendations that met the following criteria: medium to high scale of impact, low resource need, and short-term plausibility. Focusing on these recommendations will allow the state to make significant progress even while facing substantial budget constraints.

OMHSAS standard of practice is to complete court ordered competency evaluations for individuals who are incarcerated at a PA county prison. OMHSAS provides outpatient competency evaluation services as an alternative to inpatient services so individuals who are incarcerated can receive services in a timely manner. As of June 2020, 1,897 competency evaluations have been completed on an outpatient basis through this program.

OMHSAS Staff represent the mental health system at an interagency coordinating committee for the forensic population. The Pennsylvania Forensic Interagency Task Force (FITF) is a group of committed professionals, family members, and consumers who have met for over twenty years at varying times to address issues related to the care of persons with serious mental illness who are involved in the criminal justice system. Past initiatives have had effective outcomes for this population in both community mental health services and in state and county correctional institutions.

Mobile Mental Health

Mobile Mental Health Treatment (MMHT) is an array of services for individuals who have encountered barriers to, or have been unsuccessful in, receiving services in an outpatient clinic. MMHT has been a Medicaid state plan service since 2006. The purpose of MMHT is to enhance the array of services by providing treatment traditionally offered in an outpatient clinic in the least restrictive setting possible to reduce the need for more intensive levels of service. MMHT encompasses evaluation and treatment, including individual, group and family therapy, as well as medication visits, in an individual's residence or other appropriate community-based settings.

Adult Developmental Training *(Adult only)*

Adult Developmental Training (ADT) programs are community-based programs designed to facilitate the acquisition of prevocational skills, enhance activities of daily living, and improve independent living skills. As a prerequisite for work-oriented programming, ADT programs concentrate on improving cognitive development, communication development, physical development, and working skills development. Adult development training programs are provided in facilities licensed under Adult Day Centers regulations.

Other Activities Leading to Reduction of Hospitalization

Pennsylvania has two approaches for impacting the rate of hospitalization: 1) the development of new services designed specifically to meet the needs of persons with serious mental illness or serious emotional disturbance; and 2) the allocation of state mental hospital financial resources through the Community Hospital Integration Program Project and other funding sources.

Community/Hospital Integration Projects Program

The Community/Hospital Integration Projects Program (CHIPP) is a state initiative, in partnership with local county mental health programs, that enables the discharge of people served in Pennsylvania state hospitals who have extended lengths of stay or complex service needs, to less restrictive community-based programs and supports. CHIPP was designed to develop the needed resources for successful community placement of individuals that include: Case Management services, residential services and rehabilitation/treatment services. CHIPP was created to build local community capacity for diversionary services to prevent unnecessary future hospitalizations. CHIPP is dependent on the involvement of the consumer and family in the design, implementation, and monitoring of individual Community Support Plans. CHIPP was built upon Community Support Program principles that require consumers, family members and persons in recovery be involved in the decision-making process.

History of CHIPPs

- Approximately 4 people can be served in the community with the funds needed to support 1 person in a state hospital.
- Started in fiscal year 1991/92 with an initial funding of $6.5 million.
- As of the end of July 26, 2021, hospital mental health census for the six state hospitals was a total of 1,497 individuals.
    - 961 Civil (9% reduction from 2019 census reported in prior CMHSBG application)
    - 107 Long Term Care
    - 373 Forensic
    - 56 Act 21 Sexual Responsibility and Treatment Program
- More than 87% of the state mental health budget is now spent on community- based services.
- Through CHIPP-funded opportunities, 3551 people have been discharged since inception
- The CHIPP/SIPP funding for SFY18-19 is $284 million.

Details regarding how CHIPPs initiative works:

- County submits a proposal to the state for CHIPP discharges as part of annual plan
- Assessments are completed with people identified for likely CHIPP discharge
- County submits CHIPP budget to state for approval
- County works with local area provider agencies to begin the discharge process and identify best match of consumers
- State hospital civil beds are closed as people are discharged
- State transfers state hospital funds to the county budget to support those discharged
- CHIPP funding is annualized

- Process takes approximately 12 months to complete and traditionally has included the allocation of 6 months startup funding.

AOT

Assisted Outpatient Treatment (AOT) was signed into law on October 24, 2018 as Act 106 of 2018 (P.L.690, No.106). AOT took effect on April 22, 2019, and amended the Mental Health Procedures Act (MHPA) to add AOT as an alternative for involuntary outpatient treatment under Sections 303, 304 and 305. The addition of AOT does not eliminate or modify existing voluntary or involuntary mental health treatment procedures. AOT is an outpatient treatment ordered by the court for a person who is determined to be severely mentally ill. AOT is provided in a community setting and is not an inpatient treatment. AOT services are unique to each individual and are based on an AOT Plan designed in collaboration with the person. AOT is "treatment" under the MHPA that includes care and other services that supplement treatment (of mental illness) and aid or promote such recovery which may include substance use disorder (SUD) treatment or support service recommendations.

During 2019, OMHSAS offered two webinars regarding AOT. In March, a webinar which focused on the overall provisions as required by AOT was offered to county administrators. Later in November of that year, a webinar which focused on the implementation of AOT was also offered to county administrators. In addition, OMHSAS Bulletin-19-04 (Guidelines for Implementing Assisted Outpatient Treatment) was released in November as well.

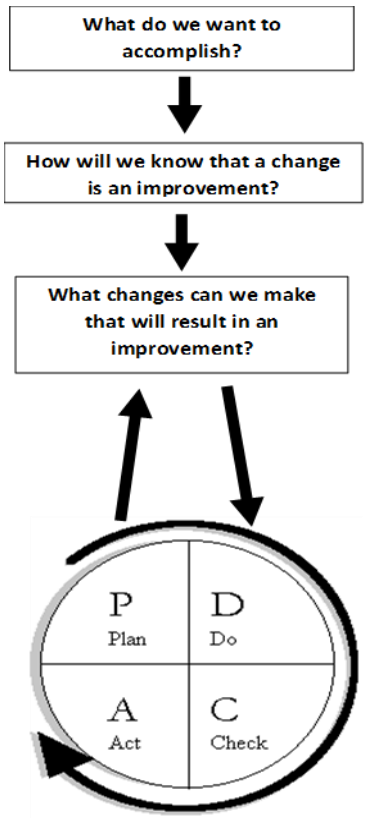
AOT services are offered in almost all 50 states. In Pennsylvania, each county/joinder must decide whether or not to provide AOT annually; counties electing to opt-out of providing AOT must submit the MH-791 form on or before December 31 of each year. To date, no counties/joinders have opted to provide AOT services since its implementation. However, OMHSAS is working with a few counties/joinders on startup pilot projects to implement AOT over the next two years using COVID-19 relief funds. If implemented successfully, AOT may assist with connecting and engaging with treatment and support services that will help those who qualify move forward in their recovery process. AOT may also help to decrease hospitalization, decrease incarceration, decrease stress on crisis and emergency services with fewer police calls for behavioral health reasons, and perhaps improve quality of life for individuals in need of mental health treatment. Counties/joinders have been hesitant to implement AOT as there will need to be extensive training for everyone who will be involved in the process, including, police, district magistrates, judges, district attorneys, public defenders, behavioral health providers, hospital staff, and county personnel. In addition, there have been concerns about the strain it may cause the county/joinder mental health system, both in a fiscal and workload capacity. With the use of COVID-19 relief funds, this may quell the training, fiscal, and workload concerns of counties/joinders and pave the way for AOT service delivery to begin in Pennsylvania.

Medicaid Targets Specific to Children's Services

Based on the expenditure data from the past fiscal year, it is estimated that $1,253,604,523 of HealthChoices (Pennsylvania's Medicaid Managed Care Program) funding will be spent on inpatient, residential, and community-based services for children in FY 2017/18. These numbers do not include services funded fully with state, local, or grant (federal or other) dollars. The following chart shows the breakdown of Medicaid funding for various children's behavioral health services:

Service Name	HC Expenditures
Inpatient Psychiatric	$170,396,506
Outpatient Psychiatric	$202,575,615
Behavioral Health Rehab Services	$479,759,032
RTF - Accredited	$120,634,877
RTF - Non-Accredited	$36,589,454
Ancillary Support	$478,969
Other	$35,495,971
Community Support	$170,608,012
Crisis	*$4,238,540*
Family Based	*$121,982,679*
Targeted Case Management	*$43,813,828*
Peer Support Services	*$562,592*
Other Community Support	*$10,373*
Substance Abuse Services	$37,066,088
Total	**$1,253,604,523**

Criterion 2: Mental Health System Data Epidemiology



Quality Management

OMHSAS Continuous Quality Improvement (CQI) Model is based on the Institute of Healthcare Improvement (IHI) CQI Model. This refinement emphasizes process and outcomes, the suitability for quick wins and application to new improvement cycles and the identification of best practices. The Department of Human Services have added two additional Medicaid Managed Care Programs (MMCs) and have been working between offices to streamline and consolidate federal quality processes and efforts.

The 2020 Medical Assistance Quality Strategy for Pennsylvania is complete and has been submitted to the Centers for Medicare and Medicaid Services (CMS) for approval. OMHSAS along with the other DHS Program Offices outlined a blueprint for ensuring each of Pennsylvania's managed care programs to align with the healthcare coordination and integration priorities identified in *CMS Quality Strategy 2016* and priorities as outlined by SAMHSA's *Strategic Plan FY 2019-FY 2023.*

Performance Measurement Reporting

The External Quality Review validated performance measurements and the HealthChoices Behavioral Health (HC BH) average results for the review years 2017-2019 calendar years (CYs) are as follows:

Statewide averages (%)

Performance Measures	2017	2018	2019
Follow up after Hospitalization for Mental Illness-7 days (HEDIS®) (QI-1)[1] ages 6 and above	39.1	35.5	35.9
Follow up after Hospitalization for Mental Illness-30 days (HEDIS®) (QI-2)[2] ages 6 and above	60.6	56.0	55.8

[1] QI-1 = Quality Indicator 1
[2] Both QI-1 & QI-2 are Adult and CHIPRA CMS Core Measures

PA Specific Follow up after Hospitalization for Mental Illness-7 days (PA Specific Measure) [3] (QI-A) ages 6 and above	52.2	53.1	52.9
PA Specific Follow up after Hospitalization for Mental Illness-30 days (PA Specific Measure) [4] (QI-B) ages 6 and above	69.6	69.6	69.5
Readmission within 30 Days of an Inpatient Psychiatric Discharge (REA)	13.4	13.7	13.5

Since 2013, OMHSAS has expected a root cause analysis (RCA) and a corresponding action plan (CAP) if there was a year to year lack of improvement in the behavioral health managed care organizations (BH-MCO) QI-1, QI-2, QI-A and QI-B and REA rates. In CYs 2014-2015, the decision was made to set yearly incremental improvement goals for the BH-MCOs and the Primary Contractors. OMHSAS also focused the RCA and CAP requirements to the QI-1 and QI-2 measure results. These two measures have national benchmarks and are drivers to improve all follow up measures after hospitalization for mental illness.

In 2017, DHS started the Managed Long-Term Services and Supports (MLTSS) program of Community Health Choices (CHC). Participants enrolled in CHC access behavioral health services through the HealthChoices BH-MCO that serves each county. OMHSAS decided to use the wider population age range of 6 and older to set yearly BH-MCO and Primary Contractor goals in measures QI-1 and QI-2. This decision will allow the results of these measures to track the access of those newly enrolled in MLTSS for 7 and 30 days to MH treatment following discharge from a psychiatric inpatient hospitalization.

In CY 2016, OMHSAS and Office of Medical Assistance Programs (OMAP) created a pay for performance (P4P) expectation for both the Physical Health Managed Care Organizations (PH-MCOs) and the BH-MCOs to improve this measure. The improvement in the Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET) was between the 50th and 75th percentiles for the national benchmark for initiation into AOD treatment and greater than or equal to the 75th percentile national benchmark for retention in treatment (engagement).[5]

[3] The measure specification for the PA Specific Follow-up after Hospitalization for Mental Illness within Seven and Thirty Days include PA services that are supplemental and recovery-oriented, in addition to the services covered by the HEDIS® specification for Follow-up After Hospitalization for Mental Illness within Seven and Thirty Days After Discharge

[4] Ibid.

[5] The improvement in this measure as compared to the previous year (CY 2016) resulted in a payout of $1,368,954 to the BHHC Primary Contractors in CY 2018.

Performance Improvement Project (PIP)

In 2019, OMHSAS identified a new Performance Improvement Project. The topic is, "Successful Prevention, Early Detection, Treatment and Recovery (SPEDTAR) for Substance Use Disorders". The PIP will be extended from 2021through 2023, including the final report to be submitted in 2024. The aim of the project is to, "Significantly slow (and eventually stop) the growth of SUD prevalence among HC members while improving outcomes for those individuals with SUD, and also addressing racial and ethnic health disparities through a systematic and person-centered approach."

OMHSAS selected three common (for all MCOs) clinical objectives and one non-clinical population health objective:

1. Increase access to appropriate screening, referral, and treatment for members with an Opioid and/or other SUD;

2. Improve retention in treatment for members with an Opioid and/or other SUD diagnosis;

3. Increase concurrent use of Drug & Alcohol counseling in conjunction with Pharmacotherapy (Medication-Assisted Treatment); and

4. Develop a population-based prevention strategy with a minimum of at least two activities across the MCO/HC BH Contracting networks.

Additionally, OMHSAS identified the following core PMs for the SPEDTAR PIP:

1. Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)

2. Substance Use Disorder-Related Avoidable Readmissions (SAR)

3. Mental Health-Related Avoidable Readmissions (MHR)

4. Medication-Assisted Treatment for Opioid Use Disorder (MAT-OUD) counseling.

5. Medication-Assisted Treatment for Alcohol Use Disorder (MAT-AUD)

Data Strategy

To align the data strategy with quality activities, OMHSAS has embarked on the Consolidated Community Reporting Initiative to build a statewide infrastructure necessary to report consumer level service utilization and outcome information on persons receiving County base-funded mental health services.

OMHSAS uses the External Quality Review Organization (EQRO) vendor to provide this multi-year HealthChoices (HC) encounter data validation process. Quality encounter data serves

multiple purposes, such as determining capitation rates, the identification of utilization trends, patterns of care and potential waste for the HC BH managed care program.

Other QM Activities

The following is a discussion of some of the other QM activities utilized by OMHSAS:

- **Performance Measures Monitoring (other uses) –** The Department of Human Services / OMHSAS monitors performance by measuring the various processes. This function provides current information to the BH-MCO, HC Contracts and to OMHSAS to identify areas of compliance, needed improvement or to initiate corrective action plans.

- **Behavioral Health Consumer/ Beneficiary Focus Groups – Consumer/Family Satisfaction Surveys** - The local surveys are conducted quarterly with a small subset of questions asked of all consumers and family members across the HC Contracts. This survey is used locally to assess satisfaction with plan, providers, identify service needs, access issues, and areas for improvement or new services. The statewide questions are reported quarterly to OMHSAS and used as an on-going source of information about the satisfaction of adult and children HC members.

- **Mental Health Statistics Improvement Program (MHSIP)** - annual adult consumer and family member perception of care surveys are conducted to assess a variety of individual and system domains. The nationally-recognized domains and the surveyed population (in parentheses) are identified below:

    - Access to Care (Adult Consumer, Family Member of Child or Adolescent Consumer)
    - Cultural Sensitivity of Staff (Family)
    - Functioning (Adult, Family)
    - General Satisfaction (Adult, Family)
    - Outcomes of Care (Adult, Family)
    - Participation in Treatment Planning (Adult, Family)
    - Quality and Appropriateness (Adult)
    - Social Connectedness (Adult, Family)

    The surveys also address the following consumer-level outcomes of care:
    - Arrests, pre and post mental health services (Adult, Child)
    - School Attendance (Child)

    Additionally, beginning in 2011, the adult survey includes eight (8) questions from the Centers for Disease and Prevention's Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS questions address the linkage between adult consumer mental health and comorbid physical health concerns.

- **External Quality Review -** The EQR-related activities are included in an annual detailed technical report are reviewed to determine MCO compliance with the following:
    - structure and operations standards established by the State,
    - validation of performance improvement projects,
    - validation of the BH-MCO performance measure submissions.

  In addition, OMHSAS will implement voluntary EQR Protocols with BH-MCOs to meet Pennsylvania's data strategic goals & initiatives. These include the validating BH encounter data by comparing the BH-MCO performance measure submissions to the encounters submitted to OMHSAS.

- **Data analysis (non-claims) - Behavioral Health Denials of Referral Requests** – OMHSAS conducts annual reviews of quarterly data submitted by the BH-MCOs. The results of the review are summarized and used to assess compliance in the Program Evaluation Performance Summary (PEPS) for each HCBH Primary Contractor /BH-MCO.

- **Behavioral Health Complaints and Grievances Data** – OMHSAS conducts annual Reviews of quarterly data submitted by the BH-MCOs. The results of the review are summarized and subsequently used to assess compliance in the Program Evaluation Performance Summary (PEPS) for each HCBH Primary Contractor/BH-MCO. The results may also be used to track and trend complaints and grievances to identify systematic deficiencies.

- **Provider Self Report Data - Survey of Providers** – An annual survey is performed to garner provider insight about the management and interaction with the Behavioral Health Manage Care Organizations. Analysis of the results leads to identification of barriers to quality operation and opportunities to improve provider related processes. This is reported through the Program Evaluation Performance Summary (PEPS) process described below.

Program Evaluation Performance Summary (PEPS) – The Program Evaluation Performance Summary database is used to track the annual and triennial review of compliance with programmatic standards. Reviews are conducted using the federal & state standards and findings are applied to maintain the expected standard for a state Medicaid Managed Care program. PEPS reviews findings identify non-compliance and partial compliance and can result in a Corrective Action Plan (CAP), which is followed until resolution. OMHSAS has implemented a PEPS web-based application to streamline the collection of monitoring data; to increase the efficiency of data entry and retrieval to meet program monitoring needs.

Criterion 3: Children's Services

Child and Adolescent Service System Program

Pennsylvania is guided by the Child and Adolescent Service System Program (CASSP) principles for the development and delivery of services to children and adolescents with serious emotional disorders, and their families. The CASSP principles require that services provided be child-centered, family-focused, community-based, multi-system, culturally competent, and least restrictive/intensive. County Mental Health programs are expected to have a person identified as a CASSP or children's behavioral health coordinator who serves as the contact person for children with multi-system needs. This comprehensive and effective system of care recognizes that children and adolescents with severe emotional disorders and behavioral health needs often require services from more than one child-serving system.

Pennsylvania System of Care Partnership

Pennsylvania has been awarded several grants from SAMHSA to develop Systems of Care to serve youth ages 8-18 that have serious mental health needs, and their families. These youth are often involved with child welfare or juvenile justice, and are in, or at risk of, out-of-home placement. Pennsylvania is part of the national movement to utilize organized, multi-level and multi-disciplinary systems, in partnership with youth and families, to more effectively serve multi-system youth with serious behavioral health challenges and their families.

The System of Care Partnership builds on and enhances cross-systems efforts that have been underway for several years to integrate and more effectively provide services to youth. Each participating county will utilize High Fidelity Wraparound (HFW), or another validated cross system planning model, as the engagement and care planning process for youth involved in multiple systems. The Youth and Family Training Institute, a division of the University of Pittsburgh and Western Psychiatric Institute and Clinic of UPMC, will train, support, monitor, and evaluate the HFW teams in each county, and will provide training and support for other cross system planning models.

Intensive Behavioral Health Services

Intensive Behavioral Health Services (IBHS) are individualized, based on the specific needs of the child, youth or young adult, and built around the strengths of the individual and their family. IBHS are available through Pennsylvania's expanded Medical Assistance Program for children up to age 21 and include services such as mobile therapy, behavior consultation, behavioral health technician, applied behavior analysis (ABA) services, a variety of evidence-based therapies and group services. Children, youth and young adults must have a behavioral health diagnosis and a written order from a licensed practitioner which establishes why IBHS is medically necessary. Interagency teams are utilized throughout the treatment process and expected to include the child, youth or young adult and their family. With the introduction of more expansive IBHS services BHRS services have been phased out in Pennsylvania.

Multisystemic Therapy

Multisystemic Therapy (MST) is an intensive family and community-based treatment program that works with youth who are at-risk for out of home placements. It is a time-limited therapeutic program that typically provides services for four to six months. MST's distinctive characteristics include 24-hour availability of staff and delivery of services in the home, school, and community. The program focuses on making improvements in the psychosocial functioning of the youth and family. Family interventions are aimed at promoting parental capacities to monitor the adolescent's behaviors and to provide effective discipline. MST peer interventions focus on removing youth from their deviant group of peers and encouraging pro-social peer relationships.

As of July 1, 2021, there are 42 MST providers serving over 54 counties in Pennsylvania. All of these programs are enrolled in Medical Assistance. The target population is adolescents who exhibit severe or chronic acting out behaviors, many of whom have been involved with Juvenile Probation due to delinquent activities.

Family-Based Mental Health Services

Pennsylvania's model of intensive in-home services is called Family-Based Mental Health Services (FBMHS). Family-Based services are team-delivered, rapid response, time-limited, holistic treatment and support, that provide clinical intervention for families including skill-building, crisis management, linkages to community services and family support services. The guiding principle is that children thrive in their own homes and communities. Families are partners and resources in treatment planning and delivery. FBMHS teams are available 24 hours a day, seven days a week. They also ensure coordination of services among all child-serving agencies. Children must have a serious emotional disturbance and be determined at risk for out of home placement, and at least one adult member of the child's family must agree to participate in the service.

The OMHSAS Children's Bureau has been collaborating with the three approved FBMHS trainers to strengthen the role of the clinical supervisor in the model which will in turn strengthen the clinical service delivery to families. The process involves intensifying the role of the supervisor within the training program; requiring all staff to pass certification requirements and modifying the exam process to reflect the certification requirements.

Evidence Based Practices

The OMHSAS Children's Bureau continues to meet with Pennsylvania Commission on Crime and Delinquency (PCCD), Office of Children Youth and Families (OCYF), and the Center for Evidence Based Practices to coordinate roles related to funding, data collection, and technical assistance to providers. The Bureau also works to utilize appropriate resources to identify further Evidence Based Practices (EBP) and promising practices. These meetings have been instrumental in supporting the implementation of EBPs in Pennsylvania and have resulted in the

development of a new data system to better monitor the outcomes of EBPs in the Commonwealth. In addition to coordination with state partners for EBPs OMHSAS also conducts annual site visits to ensure providers are meeting Medical Assistance standards, as well as maintaining fidelity to the national models.

Functional Family Therapy

Functional Family Therapy (FFT) is an outcome-driven, evidence-based intervention program that treats at-risk adolescents and their families. The program includes children and adolescents from 11 to 18 years of age. It focuses on targeting risk and protective factors in the family system that can be changed, and then systematically working to make the necessary modifications. The treatment interventions address known causes of delinquency that are related to peer and family dynamics along with school and community factors.

As of July 1, 2021, there are 8 FFT providers serving 8 counties in the Commonwealth that have been approved by OMHSAS for Medical Assistance funding. The Children's Bureau, in conjunction with the OMHSAS Field Offices, has conducted site reviews of FFT providers. The reviews are based on an extensive survey tool that assesses compliance with a variety of FFT practices along with state regulations and policies.

Respite Services

Respite care is defined as temporary short-term care that helps a family take a break from the daily routine and stress associated with caring for a child with serious emotional and/or behavioral disorders. Respite care can be provided to families on either a planned or unplanned basis and can take place in the family's home or in a variety of out of home settings. Respite care is used to help prevent family disruptions, allow families the time they need to renew their energy. It also enables them to continue caring for their children at home and prevent out-of-home placement of a child with serious emotional disturbances and behavioral difficulties. Many County MH/ID Programs in Pennsylvania provide some respite services for families whose children receive behavioral health services. OMHSAS wants to continue to support counties in their efforts to better meet the respite needs of families.

School Based Behavioral Health

The Children's Bureau is working in conjunction with the Department of Education to ensure that schools are supportive environments that maximize learning, and promote healthy social, emotional, and behavioral development. School Based Behavioral Health (SBBH) brings together schools, county mental health programs, and community resources to develop a continuum of services that enable children to have their educational and mental health needs met within their school districts. The Children's Bureau is moving forward in several areas of the state to support school-based mental health initiatives.

Pennsylvania began implementing School-Wide Positive Behavioral Interventions and Supports (SWPBIS) through a small pilot project 8 years ago. As of 2019-2020 school year, 2701 schools in Pennsylvania are in some stage of the implementation process. In addition, the Commonwealth has been supporting the growth of program-wide PBIS in the Early Childhood learning settings.

Outpatient Psychiatric Clinic Services

Outpatient mental health services are delivered in a community treatment setting under medical supervision. Services include examination, diagnosis, and treatment for children and adolescents with serious emotional disturbance. Outpatient services are delivered on a planned and regularly-scheduled basis. Satellite outpatient clinics may provide services to children in schools, detention centers, or childcare facilities.

Partial Hospitalization Services

Partial hospitalization is a nonresidential form of treatment in a freestanding or school-based program providing 3-6 hours per day of structured treatment and support services to enable children to return to, or remain at, home, in school and in their community. Activities include therapeutic recreation, individual, family and group therapies, and social skill development. Persons receiving this level of care require more intensive and comprehensive services than are offered in outpatient clinic programs, but do not require a 24-hour level of care. Children attending partial programs must have a moderate to severe mental or emotional disorder.

Residential Treatment Facilities

Residential treatment facilities (RTF) provide 24-hour care where children and adolescents receive intensive and structured comprehensive behavioral health services. The RTF works actively with the family and other agencies to create brief, intense treatment that will result in the child's successful return home or to a less restrictive community living setting. The child/adolescent must have an SED, be Medical Assistance eligible, and have the medical necessity for that level of care.

Psychiatric Inpatient Hospitalization

Psychiatric inpatient hospitalization is the most intensive and restrictive treatment setting for treating children and adolescents. This highly structured environment provides acute treatment interventions, diagnostic evaluations, stabilization and treatment planning so that the child can be quickly stabilized and appropriately discharged to less restrictive services. The child/adolescent must have a serious emotional disturbance or mental illness.

Crisis Intervention and Emergency Services

These services are designed to provide a rapid response to crisis situations that threaten the well-being of children, adolescents, and their families. Crisis services include intervention, assessment, counseling, screening, and disposition.

Commonwealth Student Assistance Program

The Commonwealth Student Assistance Program (SAP) is a state mandated multidisciplinary school-based program for students from Kindergarten through grade 12. It is a systematic process designed to assist school personnel in identifying students who are experiencing behavioral and/or academic difficulties, which pose a barrier to learning and academic success. The primary goal of SAP is to help students overcome barriers to learning. SAP teams use concrete, observable behaviors to identify student's barriers to learning. SAP team members do not diagnose or treat; however, they may refer a student for a MH or D&A screening or assessment to identify appropriate school and community-based recommendations, including treatment. SAP Liaisons from county MH and D&A agencies are contracted by the schools to perform the screening and assessments and refer to treatment as necessary. Parents and guardians are vital members of the team, and must give written permission for their child's SAP involvement.

OMHSAS, the Department of Education and the Department of Drug and Alcohol Programs collaboratively oversee the Student Assistance Program through the PA Network of Student Assistance Programs (PNSAS), and representatives from each agency make up the SAP Interagency Committee. The Interagency Committee meets regularly to discuss and problem-solve issues as they arise. In addition, there are 10 regional coordinator positions, 5 of which are funded by OMHSAS (PDE funds the remaining 5 through a contract with the IUs.) The Regional Coordinators are responsible for the oversight of county SAP operations, as well as of the Pennsylvania Approved SAP Training Providers (PASTPs), the statewide training network responsible for training school SAP teams. The Regional Coordinators are the most direct source of information and SAP coordination at the county level. \

81,511 students statewide were referred to school SAP core teams during FY 19/20. Through the Joint Quarterly Reporting System (JQRS) maintained by OMHSAS, SAP liaison agencies reported that 29,135 screenings or assessments were conducted, including 14,920 suicide screens or assessments. Of those students referred for assessment, 70.6% were identified with a mental

health concern, 12.7% were identified with a drug or alcohol concern, and 16.7% were identified with a co-occurring concern.

Services Provided Under Individuals with Disabilities Education Act

The Individuals with Disabilities Education Act (IDEA), first signed into law in 1975, established that all children with disabilities have a right to a free, appropriate public education. It offers funding and policy assistance to states in providing appropriate support services (e.g. counseling, transportation) to students with special needs. In light of significant amendments to the Act in 1997 (known as IDEA 97), Pennsylvania developed a Memorandum of Understanding (MOU) between the Departments of Education, Public Welfare (now Human Services), Health, and Labor and Industry that defines the way those departments must work together to ensure appropriate educational services for children with disabilities. The reauthorization of IDEA in 2004 along with the No Child Left Behind provisions, have strengthened the partnerships created by the MOU.

Criterion 4: Targeted Services to Rural and Homeless Populations and Older Adults

The system/services discussed under this criterion apply to both adults and children/adolescents where the services are age appropriate for children/adolescents.

Homeless Outreach and Services

Pennsylvania's approach to providing services to persons who are homeless or at risk of becoming homeless is to expand and improve the community programs in each locality, especially those critical support services such as housing, crisis outreach, and benefit acquisition. Pennsylvania has also focused specific attention on the homeless population by developing specialized outreach and supportive and housing services, and through the utilization of state and federal funds. Every county mental health program has identified a housing specialist who receive technical assistance from OMHSAS.

Homelessness continues to be an issue in many communities across the Commonwealth, including most rural counties. On any given day, over 15,000 Pennsylvanians are known to be homeless, including over 8,000 individuals in the more rural regions. Individuals who are homeless include individuals living on the streets, doubled up with family or friends, or in shelters. The homeless count includes both children and adults.

DCED administers Emergency Solutions Grant (ESG) funds that support homeless services and facilities across Pennsylvania. Priority is given to the non-entitlement municipalities of the state; all areas may apply for funding. In 2018 DCED funded 28 counties with awards totaling $5,276,043. Projects included:

- 44 Rapid Rehousing
- 24 Homeless Prevention
- 14 Emergency Shelter
- 11 Street Outreach Activities

Additional services and facilities are funded directly by the direct entitlement jurisdictions with their own ESG funding.

In addition to the federal funding, the Commonwealth has a number of programs through DHS to address the needs of individuals experiencing homelessness. The ones most often leveraged with ESG funding in Pennsylvania Transition to HOME program, Housing Assistance Program (HAP), and SOAR.

Projects for Assistance in Transition from Homelessness

OMHSAS contracts with 24 County MH/ID program offices to provide PATH services. These 24 county MH/ID offices, which encompass 36 of the state's 67 counties. Many of the MH/ID program offices that receive PATH funds then sub-contract with local community sources to provide PATH services. While most of the PATH programs provide services to all PATH eligible adults ages 18 and over, some focus on transition-age youth and forensic populations that meet the PATH eligibility criteria.

Pennsylvania has a two-tiered oversight mechanism, one at the county MH/ID level through PATH Coordinators and another at the state level through the State PATH Coordinator (SPC). The SPC oversees all activities related to the PATH program and monitors county MH/ID programs who receive PATH funds as well as the local programs with whom they sub-contract. The county PATH coordinators work very closely with the contracted agencies to develop and implement new programs and provide oversight to the existing programs.

The counties and contracted providers have developed innovative PATH programs to best serve the needs of the SMI homeless population in their geographical areas. Some recent programs have adopted evidence-based practices such as Critical Time Intervention (CTI), a time-limited evidence-based practice that mobilizes support for society's most vulnerable individuals during periods of transition. It facilitates community integration and continuity of care by ensuring that a person has enduring ties to their community and support systems during these critical periods. In general, the services provided for PATH-eligible individuals include: outreach, screening and diagnostic treatment, habilitation/rehabilitation, community mental health services, alcohol and/or drug treatment, staff training, case management, supportive and supervisory services in residential settings, referrals for primary health, job training, educational services and allowable housing services.

PA Housing Advisory Committee

The PA Affordable Housing Act of Dec 18, 1992 P.L. 1376, No. 172 emphasized the writing and yearly updates of The Commonwealth's Statewide Comprehensive Housing Affordability Strategy (CHAS) as established by the Cranston-Gonzalez National Affordable Housing Act (Public Law 101-625, 42 U.S.C. § 12701 et seq.), also known as the National Affordable Housing Act of 1990 (NAHA). As a result, the PA Housing Advisory Committee (PHAC) was established, with the primary mission of preparing and maintaining The Consolidated Plan for the Commonwealth of Pennsylvania (Consolidated Plan). Legislation dictates composition of the PHAC.

Homelessness Program Coordination Committee/Interagency Council

The Homelessness Program Coordination Committee (HPCC) is a statewide committee comprised of the public agencies, housing and service providers, and stakeholders of the homeless community, which serves as the working body to support the Pennsylvania Housing Advisory Committee. The HPCC will be able to identify those statewide policies for assisting homeless people, recommend the resources to eradicate homelessness conditions, and propose action steps to the PHAC so the Commonwealth may effectively assist the homeless population in gaining stability and limit its effect on the lives of homeless individuals and families.

Consolidated Plan

The Consolidated Plan for Housing and Community Development (Consolidated Plan) details the efforts of the Commonwealth in addressing the housing, community, homeless and economic development needs of its constituents, with specific focus on extremely low-, low-, and moderate-income persons and communities. The Consolidated Plan is intended to outline the goals, strategies and resources to be utilized in addressing those needs as well as related information on performance in realizing these goals. This Consolidated Plan is developed for a five-year period encompassing Fiscal Years of 2019 through 2023. Each year, the Commonwealth is required to submit an Annual Action Plan based on the goals of the Consolidated Plan as part of its application process to the U.S. Department of Housing and Urban Development (HUD). This document also includes the Commonwealth's Action Plan for Federal Fiscal Year (FFY) 2019 and the program year that began on January 1, 2019.

The Consolidated Plan covers the needs of the residents that are not directly funded with HUD funding and is submitted to HUD on a five-year cycle. In Pennsylvania, the Department of Community and Economic Development (DCED) is responsible for the Consolidated Plan and OMHSAS is provides input and support into the development.

The Commonwealth's overarching direction for its Consolidated Plan is outlined in the mission of DCED. The mission is applicable to the Commonwealth's efforts to provide housing, homelessness and community and economic development assistance through both federal and state resources.

> "The Department of Community and Economic Development's mission is to encourage the shared prosperity of all Pennsylvanians by supporting good stewardship and sustainable development initiatives across our commonwealth. With a keen eye toward diversity and inclusiveness, we act as advisors and advocates, providing strategic technical assistance, training, and financial resources to help our communities and industries flourish."

In order to fulfill this mission for housing, homeless and community and economic development programs, the Consolidated Plan establishes six goals:

1. Affordable Housing
2. Community Stabilization

3. Public Facility and Infrastructure
4. Public Services
5. Economic Development
6. Community Planning and Capacity Building

In pursuing these goals, the Commonwealth has also established priorities for the use of its resources. Those priorities emphasize targeting of activities, leveraging other resources and public investments, and promoting community changing impact. The Action Plan for FFY 2019 continues allocating the state's resources toward these priorities and achieving the goals set forth in the Consolidated Plan.

To achieve the Consolidated Plan's goals, DCED relies on interaction of the following entities: PA Housing Finance Agency (PHFA), Regional Housing Advisory Boards (RHABs), PA Housing Advisory Committee (PHAC), PA's 16 Continuums of Care (CoCs), Housing Alliance of PA, PA Emergency Management Agency, and The Governor's Office of Broadband Initiatives. The latest work is in draft form as the 2019-2023 Consolidated Plan and 2019 Annual Action Plan (dated June 14, 2019).

PA Coordinated Entry

The CoC Homelessness Steering Committee was restructured in 2019 with the implementation of local level CoC meetings as the new governing method. Included are the 14 county-based CoCs and 2 regional CoC's, which are collectively known as "Balance of State." The Balance of State covers 53 of Pennsylvania's 67 counties. Each CoC Board has quarterly meetings that are open to stakeholders and the public. Coordinating entry ensures prioritization of housing and services for families and individuals based on vulnerability and severity of need. The individuals with the most need are considered for housing opportunities first.

Local Housing Option Teams (LHOT)

There are currently 44 LHOTs operating in 54 counties. County team membership includes representatives from the County Office of Mental Health, Public Housing Authority and other public and private agencies. The groups meet regularly to plan for increased availability of accessible, affordable housing opportunities for people with mental illness. The major purpose of LHOT is to bring together the key stakeholders in the community to identify the housing needs of people with disabilities and to take action to meet those needs.

State Plan to End Homelessness

The PA General Assembly recognized the need to complete a comprehensive analysis of Pennsylvania's homelessness problem and developed a set of recommendations that would move the Commonwealth toward permanently reducing and eliminating homelessness. In March 2014, House Resolution 550 of 2014 directed the Joint State Government Commission to establish a bipartisan legislative task force and an advisory committee to conduct a study on the occurrence, effects and trends of homelessness in Pennsylvania and to report its findings and recommendations to the House of Representatives. The *Joint State Commission Report on*

Homelessness in PA – Causes Impacts and Solutions, A Task Force and Advisory Committee Report (HR 550) was released in April, 2016.

Pennsylvania's *"Agenda for Ending Homelessness in Pennsylvania"* is based upon three state-driven strategies that correlate with the HR 550. These strategies outline steps that will occur at both the state and local levels, including:

- Improve coordination between state agencies and promote targeting of resources consistent with the state vision and guiding principles. A central part of the Agenda is to assess the effectiveness of the current state and local housing and human service delivery systems, and to ensure that they support the above vision and guiding principles.

- Foster and support local efforts to end homelessness. Given the size and diversity of the Commonwealth, the health of the local network of homeless housing and service providers is a critical factor in successfully implementing the Agenda for Ending Homelessness in Pennsylvania. Since every region of the state is different, the Plan must be designed to support local participation, while accommodating regional differences. Training and technical assistance are needed to build local capacity, especially in areas of the state where resources are limited.

- Promote recovery-oriented housing and services for homeless individuals with serious mental illness, substance abuse and/or co-occurring disorders. PA OMHSAS has embraced the recovery model for the provision of housing and services to individuals served through the mental health system, including homeless individuals and families. The goals and objectives for preventing and ending chronic and episodic homelessness reflect the state's commitment to the recovery model for all people with serious mental illness.

Point-In-Time Count

CoCs by REGION	Number of Homeless with SMI - 2021
1. Southeast PA	
Philadelphia County	1,222
Delaware County	4
Montgomery County	62
Bucks County	83
Chester County	36
Total Southeast PA	**1,407**

2. Eastern PA	
Eastern PA CoC (Adams, Bedford, Blair, Bradford, Cambria, Carbon, Centre, Clinton, Columbia, Cumberland, Franklin, Fulton, Huntingdon, Juniata, Lebanon, Lehigh, Lycoming, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Pike, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Tioga, Union, Wayne, and Wyoming Counties) **Note:** County-level data provided on the next page	171
Berks County	118
Dauphin County	69
Lackawanna County	65
Lancaster County	39
Luzerne County	12
York County	33
Total Eastern PA	**507**
3. Western PA	
Western PA CoC (Armstrong, Butler, Cameron, Clarion, Clearfield, Crawford, Elk, Fayette, Forest, Greene, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Venango Warren, Washington, and Westmoreland Counties) **Note:** County-level data provided on the next page	121
Allegheny County	373
Beaver County	35
Erie County	134
Total Western PA	**663**

PA TOTAL HOMELESS WITH SERIOUS MENTAL ILLNESS (SMI)	**2,577**

***Note:** It is not feasible to compare 2020 PIT Count data to 2021 PIT Count data related to persons experiencing homelessness with serious mental illness, as 10 out of 16 CoCs did not collect information on SMI during the 2021 PIT Count due to the COVID-19 flexibilities from HUD outlined above.

Philadelphia County, Allegheny County, and the Eastern PA CoC are the three CoCs with the largest populations of people experiencing homelessness who have a serious mental illness. EP

Pennsylvania is working to increase access to permanent housing resources for individuals with serious mental illness using several methods including:

- Prioritizing Rapid Rehousing and Permanent Supportive Housing
- Prioritizing individuals with the highest-level service needs and longest time homeless
- Utilizing Coordinated Entry to assess individuals and match with appropriate housing services

While PIT Count data is a valuable source of information on the homeless population in Pennsylvania, OMHSAS recognizes the following limitations:

1. This data is collected on a single day and does not reflect the total number of homeless individuals over the course of a year.
2. The data is based on a specific definition of homeless from HUD – those living in emergency shelters, transitional housing for the homeless, safe havens for homeless individuals and in places not intended for human habitation (unsheltered). This may result in an undercount of individuals who experience homelessness under broader definitions, such as youth/young adults who "couch surf" or individuals/families residing in hotels.
3. The PIT Count often utilizes self-report or informal report by shelter staff for designating SMI. Some areas are working to address this limitation, such as the Allegheny County CoC, which utilizes HMIS data with mental health assessments rather than self-report/staff report.
4. The 2021 PIT Count is dissimilar from previous PIT Counts, as 10 out of 16 CoCs did not collect SMI information for unsheltered persons. As such, it is not feasible to analyze changes in population from 2020 to 2021. Because of this, CoCs will most likely need to compare 2020 PIT data to 2022 PIT data once available, in order to draw conclusions about changes in the number of persons with SMI.

It is anticipated that the count of the number of individuals who are experiencing homelessness who have serious mental illness will continue to decline as a result of several HUD policy priorities to increase access:

- HUD has encouraged CoCs to eliminate or reduce the amount of Transitional Housing in favor of creating more permanent housing resources, both Rapid Rehousing and Permanent Supportive Housing. As a result, fewer individuals with Serious Mental Illness are living in Transitional Housing. In addition, many CoCs have reduced or eliminated Safe Haven capacity over the past several years, resulting in fewer individuals with Serious Mental Illness living in Safe Havens.

- Most CoCs have adopted HUD's prioritization standards under Notice CPD 16-11 to prioritize those individuals with the most severe service needs and the longest length of time homeless for Permanent Supportive Housing, facilitating entrance into PSH by individuals with Serious Mental Illness.

- As of January 2018, all CoCs have implemented Coordinated Entry through which each household is assessed for vulnerability and length of time homeless, in order to offer housing to those most in need of assistance in order to end this homelessness. As this requirement is still relatively new, CoCs are still assessing its impact and working to right-size their systems based on the needs in their community.

Homeless Management Information System

DCED has established a Homeless Management Information System, known as PA HMIS, for the 54 counties included in the two rural regions of Pennsylvania. In addition, nine of the ten urban, or proprietary, counties/joinders have established their own HMIS system. The remaining proprietary county uses PA HMIS.

Pennsylvania continues to work toward generating a count of homeless with serious mental illness using the Homeless Management Information System (HMIS) in each CoC; however, the current level of participation is still not adequate for an accurate count. With the implementation of Coordinated Entry throughout the CoC, more information will be collected in HMIS on households being served. This information provides an opportunity to more thoroughly determine the flow of people through the system, identify gaps, and needs and assess the effectiveness of programs and strategies. This information can be used to set the priorities of various grants to assure that the best use of the funds.

Domestic violence programs are not covered by the HMIS, so there will remain a need for a manual point in time count of a portion of homeless programs in each CoC. One of the major changes in the HMIS standards that were introduced with the implementation of the Homeless Prevention and Rapid Re-housing Program (HPRP) was a designation of people who are not homeless but received homeless prevention services. This will enable the HMIS to also report on people with mental illness who are at risk of homelessness and therefore PATH eligible. PA HMIS has accommodated this pre-enrollment population; proprietary HMIS have either already augmented their system or have a plan in place to do so.

SSI/SSDI Outreach, Access and Recovery

PA continues to have a strong SSI/SSDI Outreach, Access and Recovery program. With the growth of SOAR in PA, the State SOAR Team Lead has restructured the SOAR steering

committee to implement the Fundamentals format and include other updates. As of June 2021, twenty (20) of the 24 PATH MH/ID counties and 1 non-PATH county have received SOAR training and several others are exploring potential for training. The State PATH Contact will continue to work with all PATH counties to have at least one SOAR trained staff within each PATH program across the state by the end of FY 21/22.

The SOAR Program in Pennsylvania has been nationally recognized for several years including:

- Ranked #1 in quality in 2018
- 100-day statewide average for benefit decision (national average of 96 days)
- 68-day average for benefit decision in Philadelphia SOAR program.
- Over 3000 decisions
- Over 2000 approvals
- Top 10 approval rates nationally

In December 2020, the SOAR TA Center released the 2020 National SAMHSA SOAR Outcomes Issue Brief, which highlighted PA as follows:

> *Despite the COVID-19 pandemic, SOAR in the state remained strong. A new SOAR initiative in Delaware County had one of their first claims approved during COVID. Allegheny County not only retained all positions despite the economic downturn of the pandemic, but was able to have practitioners work remotely, with staff acclimating quickly. Montgomery County also was able to work remotely to continue processing SOAR-assisted applications, in addition to adding new SOAR staff.*

Three SOAR programs continued to gain momentum in FY 20-21. The first is a revitalization of SOAR in Lehigh/Northampton Counties led by a member of Magellan Behavioral Health of PA. The second is Delaware County's CoC SOAR initiative, made possible by a Homes4Good grant from the PA Housing Finance Agency. Bucks County is the third major expansion in PA in FY 20-21. The Bucks Co lead secured permission and hired a SOAR Specialist to expand and organize SOAR use in the Bucks County area. PHARE funding and Home4Good grants were used for the project, with the staff being hired by Bucks County Housing Group.

Made possible with funding from Community Mental Health Services Block Grant (CMHSBG), eighteen SSI/SSDI Outreach, Access and Recover (SOAR) leaders participated in the 2019 Statewide SOAR Leader's Summit held May 15-16, in Boalsburg, PA. The summit pivoted around in-person sharing of the expansive knowledge and experience bases of 24 counties, the Social Security Administration (SSA), the SOAR TA Center, and the PA SOAR State Lead with the goal of proliferating best practices in SOAR as well as synchronizing local lead efforts to assist the SOAR State Lead. Programs were represented from across the state and country. Requests for funding to expand the Summit to include Bureau of Disability Determination representatives in the future. Quarterly SOAR conference calls will also be implemented to ensure statewide cohesion of SOAR process.

Also funded by CMHSBG in 2019 was creation of a SOAR database. The database will feature essential SOAR provider information such as location, scope of SOAR practice, organization

name, and contact information to efficiently match those in need with proper SOAR resources. Similar information on PATH providers would be included as well to heighten the effectiveness of the data to be queried, as well as for more efficient distribution of materials and procedural updates. This project has been initiated but is temporarily on hold due to the COVID-19 needs in the state.

A regional SOAR training team is being formed to expand PA's SOAR initiative. This tier of leadership will allow for more-timely scheduling of Fundamentals, regionalized communications and a stronger overall SOAR presence in PA. As of July 2021, there are three western trainers, a central trainer, one southeastern trainer, and one northeastern trainer. Other locations will be filled as space is available in Leadership Academy slots.

Services in Rural Areas

Pennsylvania has a large number of residents living in rural areas, which are consistently distributed across the state. According to the *Center for Rural Pennsylvania*, a legislative agency of the Pennsylvania General Assembly, Pennsylvania has 48 rural counties and 19 urban counties. In 2018, nearly 3.4 million people, or about 26 percent of the state's 12.8 million residents, lived in Pennsylvania's 48 rural counties. From 2000 to 2018, rural Pennsylvania's population became more racially diverse. In 2000, there were about 168,114 residents, or 5 percent of the total population, who were non-white and/or Hispanic, whereas, in 2018, 311,606 rural residents, or 9 percent of the total population, were non-white and/or Hispanic. On average, rural Pennsylvania residents are older than urban Pennsylvania residents. In 2018, 19 percent of the rural population was 65 years old or older compared to 17 percent of the urban population. It is projected that, by 2040, Pennsylvania rural counties will have a total population of 3.61 million people, a 4 percent increase from 2010.

At the school district level, 238 of the state's 501 public school districts are rural. In the 2017-2018 academic year, an estimated 406,450 students were enrolled in Pennsylvania's 235 rural school districts. From 2010 to 2018, the number of rural students decreased 10 percent. From 2010 to 2018, there was a 1 percent decline in enrollment. Enrollment projections by the Pennsylvania Department of Education show enrollment continuing to decline for the next 10 years. From the 2019-20 to the 2028-29 academic years, rural school districts are projected to decline 7 percent.

Several counties have shortages of psychiatrists, psychologists, and social workers, as well as physical health providers including dentists and specialist physicians. Pennsylvania is, as much of the country, experiencing a shortage of both general healthcare professionals and mental health care professionals. The Health Professional Shortage Areas (HPSAs) for both general and mental health in Pennsylvania significantly impact the rural areas of the state (Pennsylvania State Health Assessment 2021 Update). Rural counties frequently utilize satellite clinics, mobile teams, or other specialized services designed for that population. Services are generally more decentralized, and outreach is more evident since transportation and distance are obstacles. OMHSAS has worked collaboratively with the Office of Medical Assistance Programs (OMAP), Medical Assistance Transportation Program (MATP) providers, and consumer advocate organizations to review and assess Medical Assistance Transportation Program services,

standards, and county practices, in order to improve statewide access to transportation. In many areas, mobile behavioral health services are being offered to assist individuals who may not have access to transportation. In addition, the rapid expansion of telehealth services during the COVID-19 PHE offered additional options for individuals in rural areas to access services. However, OMHSAS is mindful of the limitations of broadband access in some areas of the state, particularly in the most rural areas of Pennsylvania. In order to ensure ongoing access post-PHE, OMHSAS would like to see ongoing support from partner agencies and the federal government in order to continue expanding internet access. In the interim, OMHSAS also is advocating for the continued allowability for telephone-only service delivery when lack of internet/devices would prevent an individual from receiving the behavioral health care they need.

Managed Care provides many opportunities for rural counties. Under managed care, there are required services and access standards. In rural areas services must be available within 60 minutes of travel time. In addition, emergency services must be available in one hour, urgent services in 24 hours, and routine services in 7 days. Rural counties, in order to come into compliance with managed care standards are required to increase both the number and array of service providers.

Telehealth

Prior to the COVID-19 PHE, OMHSAS was in the process of expanding the allowability of telehealth within the Pennsylvania Behavioral Health Medicaid System. On February 20, 2020, *OMHSAS-20-02 Guidelines for the Use of Telehealth Technology in the Delivery of Behavioral Health Services*, which expanded both the allowable practitioner types and service types that could be offered through telehealth, for the first time in Pennsylvania allowed telehealth in community settings in some services, and simplified the provider process for participating in the telehealth program.

However, on March 6, 2020 Governor Tom Wolf issued the initial Proclamation of Disaster Emergency due to the novel coronavirus COVID-19 in Pennsylvania. On March 15, 2020 OMHSAS issued a memorandum *Telehealth Guidelines Related to COVID-19*, which temporarily expanded telehealth services significantly to ensure the continuity of critical behavioral health services during stay-at-home and quarantine conditions. OMHSAS processed over 2,300 provider attestations in March 2020 alone, with over 3,000 completed by the end of CY2020, as the behavioral health system in Pennsylvania rapidly transformed temporarily to the majority of services being offered through telehealth. This memorandum was reissued on May 5, 2020 with additional guidance added for two specific children's services, Behavioral Health Rehabilitation Services and Intensive Behavioral Health Services, along with *OMHSAS-20-03 Instructions and Guidelines for the Delivery of BHRS and IBHS Through Telehealth*.

OMHSAS conducted telehealth surveys of individuals/families and direct behavioral health service practitioners early in the COVID-19 PHE. Just under 10,000 people responded, providing critical feedback to the state that has been foundational for long-term telehealth planning. Key findings included:

- 96% of individuals/families reported receiving telehealth services at home
- 55% of individuals/families state that they needed to cancel or reschedule appointments less often when using telehealth
- 75% of respondents want to continue using telehealth for at least some of their services after COVID-19
- Individuals and families reported that telehealth reduced the following treatment barriers: Travel time (66%), Transportation issues (58%), Scheduling Issues (40%), Conflicts with Employment (36%), and Child/Family Caregiving Demands (30%)
- Individuals and families reported that lack of/limited internet and lack of/limited access to internet capable devices were the two most common barriers to receiving services through telehealth
- 54% of behavioral health practitioners reported using little or no telehealth service delivery prior to COVID-19
- 56% of behavioral health practitioners anticipate using telehealth to deliver a considerable amount of services (over 50%) following COVID-19.
- 83% of behavioral health practitioners found that increased flexibility in telehealth rules improved access to services considerably or significantly.
- 57% of behavioral health practitioners felt they could provider effective services using telephone-only (without video)

Full survey results are available in the OMSHAS report, *Telehealth Service Delivery for the Pennsylvania Behavioral Health System: Stakeholder Survey Input During COVID-19*. OMHSAS is currently in the final stages of planning for the 2021 Telehealth Surveys for Individuals/Families and Behavioral Health Practitioners, expected to be released in August 2021. These surveys will gather updated stakeholder perspectives based on a longer period of time (SFY20-21).

OMHSAS has also convened a Telehealth Steering Committee, which is providing critical advice to the state on the future of telehealth following COVID-19. The steering committee initially convened in Summer 2020 and in partnership with Mercer (contracted by OMHSAS for technical assistance), produced an initial recommendations in the OMHSAS 2020 *Behavioral Health Telehealth* report. The Telehealth Steering Committee has reconvened in Summer 2021 and currently is working on recommendations in three key areas: Service Delivery, Quality Monitoring, and Workforce Development.

On June 10, 2021 the Pennsylvania Legislature enacted a concurrent resolution, House Resolution 106 of 2021, immediately ending the COVID-19 Disaster Emergency Declaration for Pennsylvania. In addition, House Bill 854 of 2021 was enacted, allowing agencies under the Governor's jurisdiction to extend flexibilities related to the Governor's Emergency Disaster Declaration through September 30, 2021. OMHSAS is actively working on finalizing a new telehealth policy bulletin that will allow many of the flexibilities introduced during the COVID-19 PHE to remain in place.

Services for Older Adults

Persons aged 65 years and older represent the fastest growing age group in the United States. According to NIH, estimates of behavioral health disorders for ages 50 and up account for 14% percent of the total population. However, according to the National Council on Aging, older persons are less likely to seek treatment from behavioral health professionals for many reasons such as lack of knowledge about the effects of behavioral health treatment; inadequate insurance coverage; a shortage of geriatric mental health providers; denial of problems; the stigmatizing impact of admitting to a behavioral health problem and access barriers such as transportation. Unfortunately, older adults with behavioral health disorders who do not receive treatment increase their risk of hospitalization, reduced physical functioning, and earlier death. In addition to the general population of older adults who have never received services, many current recipients of behavioral health services are aging and in need of more specialized services for older adults.

OMHSAS supports the use of the Certified Older Adult Peer Specialists (COAPS) program, which is a much-needed service to older adults with behavioral health diagnoses. The COAPS program addresses older adults' mental health and wellness issues.

COAPS program is in line with SAMHSA's strategic initiative goals:

- **Promote** health and recovery-oriented service systems for individuals with or in recovery from mental and substance use disorders.
- **Ensure** that permanent housing and supportive services are available for individuals with or in recovery from mental and substance use disorders.
- **Increase** gainful employment and educational opportunities for individuals with or in recovery from mental and substance use disorders.
  Promote peer support and the social inclusion of individuals with or in recovery from mental and substance use disorders in the community.

Although the COAPS program was not able to offer training during the COVID-19 PHE, there are currently plans underway to revitalize the program.

Criterion 5: Management Systems

Additional Information about Criterion 5 is available in Environmental Factors Section 9.

Intended Use of Block Grant Funds

As instructed by SAMHSA, OMHSAS based the CMHSBG FY22-23 application on the FY2021 President's Budget which would bring Pennsylvania's allocation to $23,597,645 annually.

SFY21-22 CMHSBG Pennsylvania Budget			
	Annual Funds	**CAA Funds**	**ARPA Funds**
County Funding- Non Categorical	$18,543,438		
County Funding- Categorical Allocations (Housing and Infant/Early Childhood Mental Health Training Funds)	$480,000		
Special Projects		$19,071,498	$175,000
Crisis Funding*	$1,179,882	$5,335,970	$41,983,353
First Episode Psychosis*	$2,359,765	$2,711,941	$4,684,262
OMHSAS Administrative Costs	$979,000		
FY22-23 CMHSBG Budget	**$23,542,085**	**$27,119,409**	**$46,842,615**

*These funds were made available to all County Mental Health Administrations through competitive applications. In state FY 21-22, 17 of counties/joinders receive FEP funding. CAA and APRA funds have not yet been distributed to counties.

OMHSAS encourages counties to utilize CMHSBG towards the SAMHSA identified purposes. We also strongly encouraged the counties to use the CMHSBG dollars to support the priorities identified in the state MHBG Plan. Most of the county allocations will be allocated as non-categorical, which technically allows the counties to expend the Block Grant funds in any of the allowable service areas listed below.

CMHSBG Allowable Cost Centers	
Administrator's Office	Family-Based MH Services
Community Services	Administrative Management
Targeted Case Management	Housing Support Services
Outpatient	ACT and CTT
Partial Hospitalization	Psychiatric Rehabilitation Services
MH Crisis Intervention Services	Children's Psychosocial Rehabilitation
Adult Developmental Training	Children's EBPs
Community Employment Services	Peer Support Services
Facility Based Vocational Rehabilitation	Consumer Driven Services
Social Rehabilitation Services	Other Services*
Family Support Services	

Source: OMHSAS Bulletin *Cost Centers for County Based Mental Health Services OMHSAS-12-02*
*Requires OMHSAS approval

FY20-21CMHSBG County Allocations					
County	**Total County Non-Categorical Allocation**	**County Categorical Allocation (Training Funds)**	**First Episode Psychosis**	**Special Projects**	**Total Allocation**
Allegheny	$1,529,185	$10,000	$403,194	$5,250	**$1,947,629**
Armstrong/Indiana	$197,276	$10,000	$0	$0	**$207,276**
Beaver	$213,174	$10,000	$0	$0	**$223,174**
Bedford/Somerset	$177,304	$10,000	$0	$0	**$187,304**
Berks	$514,303	$10,000	$0	$0	**$524,303**
Blair	$158,861	$10,000	$0	$0	**$168,861**
Bradford/Sullivan	$93,542	$10,000	$0	$0	**$103,542**
Bucks	$781,561	$10,000	$0	$0	**$791,561**
Butler	$229,828	$10,000	$0	$0	**$239,828**
Cambria	$637,157	$10,000	$0	$0	**$647,157**
Cameron/Elk	$52,880	$10,000	$0	$0	**$62,880**
Carbon/Monroe/Pike	$365,575	$10,000	$360,000	$0	**$735,575**
Centre	$192,488	$10,000	$172,980	$0	**$375,468**
Chester	$623,608	$10,000	$180,000	$0	**$813,608**
Clarion	$78,680	$10,000	$0	$0	**$88,680**
Clearfield/Jefferson	$413,119	$10,000	$0	$0	**$423,119**
Columbia/Montour/Snyder/Union	$212,764	$10,000	$240,000	$175,000	**$637,764**
Crawford	$110,956	$10,000	$0	$0	**$120,956**
Cumberland/Perry	$493,008	$10,000	$0	$0	**$503,008**
Dauphin	$335,125	$10,000	$163,542	$0	**$508,667**
Delaware	$698,724	$10,000	$150,000	$0	**$858,724**
Erie	$350,708	$10,000	$199,107	$0	**$559,815**
Fayette	$207,600	$10,000	$0	$0	**$217,600**
Forest/Warren	$61,914	$10,000	$0	$0	**$71,914**
Franklin/Fulton	$205,579	$10,000	$0	$0	**$215,579**
Greene	$129,264	$10,000	$0	$0	**$139,264**
Huntingdon/Mifflin/Juniata	$146,539	$10,000	$0	$0	**$156,539**
Lackawanna/Susquehanna	$706,949	$10,000	$0	$0	**$716,949**
Lancaster	$649,306	$10,000	$0	$0	**$659,306**
Lawrence	$599,482	$10,000	$0	$0	**$609,482**
Lebanon	$166,960	$10,000	$0	$0	**$176,960**
Lehigh	$436,871	$10,000	$180,000	$0	**$626,871**
Luzerne/Wyoming	$436,493	$10,000	$210,000	$0	**$656,493**
Lycoming/Clinton	$194,186	$10,000	$0	$0	**$204,186**

McKean	$59,235	$10,000	$0	$0	**$69,235**
Mercer	$145,797	$10,000	$0	$0	**$155,797**
Montgomery	$999,843	$10,000	$0	$1,000,000	**$2,009,843**
Northampton	$372,169	$10,000	$200,000	$0	**$582,169**
Northumberland	$118,160	$10,000	$0	$0	**$128,160**
Philadelphia	$2,234,351	$10,000	$609,999	$0	**$2,854,350**
Potter	$56,099	$10,000	$0	$0	**$66,099**
Schuylkill	$185,361	$10,000	$0	$0	**$195,361**
Tioga	$52,476	$10,000	$0	$0	**$62,476**
Venango	$90,406	$10,000	$0	$0	**$100,406**
Washington	$568,466	$10,000	$0	$0	**$578,466**
Wayne	$133,171	$10,000	$0	$0	**$143,171**
Westmoreland	$456,461	$10,000	$180,000	$0	**$646,461**
York/Adams	$670,474	$10,000	$0	$0	**$680,474**
Statewide Total	**$18,543,438**	**$480,000**	**$3,248,822**	**$1,180,250**	**$23,452,510**

*CAA and ARPA funds have not yet been fully distributed

The counties account for their block grant spending as part of the annual Income and Expenditure financial reporting. OMHSAS reviews this report to ensure that block grant expenditures are being made consistent with the federal and state intent of the funds.

In addition to the mandatory set asides and county specific funding, OMSAS also funds numerous special projects through CMHSBG funding. Current Special projects include:

- Case Management Training
- Peer Run Crisis Respites
- Electronic Learning Management System Development
- Support and Referral Warmline
- SAP support
- Technology Infrastructure development for Telehealth
- Non-Mobile Crisis Projects
- FEP Technical Assistance Center

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system of care as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system of care.
States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, SUD prevention, and SUD treatment goals at the state level.

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Footnotes:

UNMET NEEDS AND CRITICAL GAPS

The Office of Mental Health and Substance Abuse Services (OMHSAS) utilizes data from a number of sources in order to set priorities for the Community Mental Health Services Block Grant (CMHSBG) including:

- County Level Data from the County Human Services Plans
- OMHSAS Data
- Stakeholder Feedback from the Public Meetings
- Call for Change
- Consultation with Subject Matter Experts for each priority area

County Human Services Plans

In their annual County Mental Health Plans, which are included in the County Human Services Plans, counties are asked to identify their top recovery-oriented systems transformation priorities to address the unmet needs identified as a part of the planning process. The counties also identified the fiscal and other resources needed to implement those priorities. Housing has been the top priority for many years, however, in the FY20-21 County Plans, community education and outreach was the top priority. Evidence based practices was the second highest ranked priority with Forensic, and housing closely behind.

Other important priorities which were received mention at a lesser frequency included Crisis Services, Inpatient/Residential Services, Suicide Prevention, Cultural and Linguistic Competence, Data Infrastructure, Integrated Physical Health Services, Education and employment services, Peer support, trauma informed care, and Psychiatry access.

Mental Health Planning Council/Public Feedback

In December 2020, OMHSAS requested the MHPC select representative members from each of the subcommittees to convene a CMHSBG Application Workgroup. The MHPC met throughout March, April, and May of 2021 to review the current CMHSBG priorities and make recommendations on the priorities for the current application. OMHSAS and the MHPC worked together to take a close look at the priorities and create goals and outcomes that are realistic and will show progress in the Pennsylvania System of Mental Health. OMHSAS staff from CMHSBG, Quality Monitoring and Data, Children's Bureau, and other subject matter experts routinely attended MHPC workgroup meetings in order to support the council with requested data and program information. The final recommendations of the MHPC CMHSBG Application Workgroup were presented to the larger MHPC council at the May 18, 2021 Quarterly Meeting. MHPC Quarterly Meetings are open to the public and both appointed members and public attendees were given the opportunity to provide feedback. Meeting Outcomes for each committee are attached to this application. OMHSAS was able to accept seven of the nine priority areas recommended by the council. Both of the recommendation that were not included in the application, Youth and Family Involvement and Diversity, Equity and Inclusion, are recognized as important areas for the mental health system, but were not able to be included due to limitations on available data. OMHSAS will continue to work to support both of these efforts

and explore options for improving data in the next two years for possible formal inclusion as priorities in the next application.

OMHSAS provided appointed MHPC members a preliminary draft of the full application document in July 2021 and met with the council for Q&A and additional comments on July 29, 2021. MHPC members are also encouraged to submit additional comments through the public comment period.

Call for Change

OMHSAS initially developed the *Call for Change: Toward a Recovery-Oriented Mental Health Service System for Adults (Call for Change)* document in 2005 in partnership with a wide array of stakeholders, including representation from the MHPC. The *Call for Change* addressed the following domains towards creating a recovery oriented mental health system:

1. Validated Personhood
2. Person Centered Decision-Making and Choice
3. Connection—Community Integration and Social Relationships
4. Basic Life Resources
5. Self-Care, Wellness, and Finding Meaning
6. Rights and Informed Consent
7. Peer Support/Self-Help
8. Participation, Voice, Governance, and Advocacy
9. Treatment Services
10. Worker Availability, Attitude and Competency
11. Addressing Coercive Practices
12. Outcome Evaluation and Accountability

This was followed in 2010 with a *Call for Change: Transformation of the Children's Behavioral Health System in Pennsylvania (Children's Call for Change)* developed in partnership with the Children's Behavioral Health Taskforce, made up of over 400 stakeholders. The *Children's Call for Change* focuses on the following goals:

1. Develop the capacity for the system to be youth and family driven.
2. Ensure ready access to a cost-effective array of quality services including assessment, treatment and support services that help to sustain and nurture family and community ties. Quality services are comprehensive, integrated, and provided in the least restrictive environment as defined by the needs of the youth.
3. Establish the infrastructure (financing, policies, training, etc.) to implement a system of comprehensive, integrated, cost-effective array of services.
4. Develop a public health approach to social and emotional wellness for children, youth and families.
5. Develop increased capacity for service systems to meet the needs of transition age youth and young adults through cross systems collaborative relationships and initiatives.

Each of the priorities in the FFY22-23 CMHSBG application is works to continue making progress in the domains identified during the Call for Change process. Supportive Housing works to ensure individuals have access to basic life resources, now referred to as Social Determinants of Health. Having calls to the Suicide Prevention Lifeline answered in state works to ensure both children with SED and adults with SMI are appropriately connected within their own communities. Family Peer Support Services, Peer Run Crisis Respite Services, and employing more peers to work in Mobile Crisis Teams will continue to grow the impact that peer support services have had on pushing the behavioral health system to be recovery oriented and value the wisdom and knowledge gained from lived experience of SMI/SED. Family Peer Support Services also help to ensure that child serving system is youth and family driven. Working to ensure mental health professionals can respond in the community to mental health crisis situations through Mobile Crisis Teams, reducing the need for police responses and emergency room boarding, makes progress to reducing coercion in the mental health system and works to ensure that individuals are able to receive the care they need in the least restrictive environment. Both First Episode Psychosis (FEP) Programs and Service Access for Older Adults work to ensure that across the lifespan, individuals have access to the treatment services that they need in order to pursue their recovery. FEP programs also, along with Student Assistance programs, are important services within the Pennsylvania mental health system in ensuring access to cost-effective, quality services for youth and children in the least restrictive environment.

OMHSAS and the MHPC are currently partnering to update the Call for Change, after recently completing a 15 year look back of progress made since the initial publication. We will continue to work to ensure that CMHSBG priorities in the future align to the recovery and resiliency efforts and continue to work towards Pennsylvanians with SMI/SED have access to quality services that empower them to leave full and fulfilling lives within their communities of choice.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Supportive Housing

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Enhance the available data on supported housing services for individuals with SMI and children with SED as a step towards ensuring adequate supportive housing services across Pennsylvania.

Strategies to attain the goal:

Work with county partners to review current data collection techniques and compile best practices statewide. Research other state's methods of collecting and analyzing data. Develop a plan to implement enhanced supportive housing data collection.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Supportive housing data set

Baseline Measurement: n/a

First-year target/outcome measurement: CMHSBG staff conducts county subrecipient monitoring visits with 24 counties/joinders

Second-year target/outcome measurement: CMHSBG staff conducts county subrecipient monitoring visits with remaining 24 counties/joinders

Data Source:

County subrecipient monitoring visits

Description of Data:

CMHSBG staff will track completion of subrecipient monitoring and document findings related to supportive housing.

Data issues/caveats that affect outcome measures:

No baseline data available as this is a new process which is planned for Fall 2021 implementation.

Indicator #: 2

Indicator: Plan for enhanced supportive housing data collection

Baseline Measurement: County human service plans, CCRI data, county income and expenditure reports

First-year target/outcome measurement: Compile list of recommendations based on initial 24 county/joinder visits

Second-year target/outcome measurement: Finalize recommendations with remaining 24 county/joinder visits and other available data sources.

Data Source:

CMHSBG staff subrecipient monitoring report, county human service plans, CCRI data, county income and expenditure reports.

Description of Data:

Data issues/caveats that affect outcome measures:

No baseline data available as this is a new process which is planned for Fall 2021 implementation.

Priority #: 2

Priority Area: Services to Older Adults

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Ensure ongoing satisfaction with behavioral health services for the Older Adult population (age 65 and over) measured by the maintenance of general satisfaction rate for individuals 65 and older for the MHSIPs survey.

Strategies to attain the goal:

Increase outreach to older adult population.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Older Adult MHSIPs responses for access rate of services

Baseline Measurement: 1.95

First-year target/outcome measurement: 1.95

Second-year target/outcome measurement: 1.95

Data Source:

OMHSAS Quality Management Mental Health Statistical Improvement Program Survey (MHSIPS)

Description of Data:

Baseline: CY 2020
Year 1:CY 2022
Year 2: CY 2023

Responses are reported on a 5-point Likert scale with a rating of 1=strongly agree (highest access of service access) and 5=strongly disagree (lowest rating of service access).

Data issues/caveats that affect outcome measures:

The impact of the COVID-19 PHE on older adult service access is not yet fully understood. Responses to the survey are typically received in the summer after the year of services. All of the responses to the 2021 have not yet been received as the summer is not over. OMHSAS will have full data from the 2022 surveys for the 2022 implementation report.

Priority #: 3

Priority Area: Family Peer Support Services

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Expand the availability of peer services by developing Family Peer Support Services

Strategies to attain the goal:

Collaborate with vendors who currently offer Family Peer Support Services to develop a statewide curriculum. Determine platform and vendor that will house and provide the Family Peer Support Training. Work with the Pennsylvania Certification Board to allow certification of the Family Peer Support Specialists. Establish policies for the use of Family Peer Support Services in the Pennsylvania Medicaid Program.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Planning and Implementation of Family Peer Support Services in Pennsylvania

Baseline Measurement: Family Peer support training and services offered in limited Pennsylvania counties

First-year target/outcome measurement: Develop draft policy for Family Peer Support Services in Pennsylvania

Second-year target/outcome measurement: Finalize curriculum for Family Peer Support Training

Data Source:

OMHSAS Policy Staff

Description of Data:

Year One: Work in partnership with Family Peer stakeholder workgroup to research and develop policy for Family Peer Support Services in Pennsylvania.
Year Two: Work in partnership with Family Peer stakeholder workgroup and the Pennsylvania Certification Board to develop a consistent statewide training that meets PCB Standards for certification.

Data issues/caveats that affect outcome measures:

Priority #: 4

Priority Area: Student Assistance Program

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Increase the number of Pennsylvania students with SED who are identified as needing services and referred for assessment in Pennsylvania Schools

Strategies to attain the goal:

Provide additional funding to Student assistance programs to enhance staffing and assessment tools

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of students assessed and referred to at least one mental health service

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

Student Assistance Program Joint Quarterly Reporting System, SFY21-22 Funding Opportunities for Community Mental Health Administrators CMHSBG Quarterly reporting survey (SAP Awards)

Description of Data:

Baseline: SFY17-18, SFY18-19, SFY19-20 average
Year One: SFY 21-22
Year Two: SFY 22-23

Since that data for SFY 20-21 does not become available until September, it is not included in the baseline calculations.

Data issues/caveats that affect outcome measures:

OMHSAS is working with SAP staff to finalize the data for baseline and projected targets.

Priority #: 5

Priority Area: Suicide Prevention

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Maintain suicide prevention efforts across the lifespan in Pennsylvania

Strategies to attain the goal:

To achieve these objectives, OMHSAS will directly promote the National Suicide Prevention Lifeline through awareness activities (e.g., tabling, resource dissemination) as well as through partnerships with state and local suicide prevention organizations (e.g., Prevent Suicide PA, county Suicide Prevention Task Forces). OMHSAS will also maintain partnership with contacts at the National Suicide Prevention Lifeline in reaching out to county crisis centers to encourage affiliation with the Lifeline. OMHSAS will also maintain partnership with contacts at the National Suicide Prevention Lifeline in reaching out to county crisis centers to encourage affiliation with the Lifeline.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: In-state call answer rate for calls originating in Pennsylvania

Baseline Measurement: 80%

First-year target/outcome measurement: 80%

Second-year target/outcome measurement: 80%

Data Source:

National Suicide Prevention Lifeline

Description of Data:

Baseline: SFY 2020-2021
Year 1: SFY 2021-2022
Year 2: SFY 2022-2023

Data issues/caveats that affect outcome measures:

Priority #: 6

Priority Area: Peer Run Crisis Respite Services

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Divert Individual from unnecessary emergency department utilization and inpatient admission through increased community based, peer run services

Strategies to attain the goal:

OMHSAS will be continuing to provide CMHSBG funding to the Path Home, a peer run crisis respite program serving the Columbia/Montour/Snyder/Union County Joinder. OMHSAS will be providing start up funding to one additional peer run crisis respite program through the County Funding opportunity offer with a combination of annual CMHSBG funding and CMHSBG COVID-19 relief funds from the Consolidated Appropriations Act of 2021.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of Hospital admissions 30 days post-discharge

Baseline Measurement: 9.7%

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

SFY21-22 Funding Opportunities for Community Mental Health Administrators CMHSBG quarterly reporting survey (Peer Run Crisis Respite Awards)

Description of Data:

Baseline: (baseline timelines is pending)
Year 1: SFY 21-22
Year 2: SFY 22-23
Percentage is determined by a ratio of the number of hospital admissions to the number of PRCR admissions.

Data issues/caveats that affect outcome measures:

OMHSAS is working with the currently funded PRCR to establish baseline data.

Indicator #: 2

Indicator: Peer Run Crisis Respite Admissions

Baseline Measurement: 103 Admissions

First-year target/outcome measurement: 125 Admissions

Second-year target/outcome measurement: 250 Admissions

Data Source:

SFY21-22 Funding Opportunities for Community Mental Health Administrators CMHSBG Quarterly reporting survey (Peer Run Crisis Respite Awards)

Description of Data:

Baseline: (Baseline timeline is pending)
Year 1: SFY 21-22
Year 2: SFY 22-23

First year outcome anticipates slight increase of CMSUs PRCR and anticipates the opening of the Allegheny PRCR opening near the end of SFY 21-22. Year two outcomes anticipate both PRCR serving clients for the full year.

Data issues/caveats that affect outcome measures:

Year one target anticipates small increase in current PRCR program. The newly funded PRCR program will be in the planning stage for the majority of SFY21-22 with limited admissions potentially in the final quarter of the year only. Year two target anticipates both programs being fully operational for the entire year two period.

Priority #: 7

Priority Area: Mobile Crisis Services

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Enhance the mental health crisis system through the expansion and enhancement of mobile crisis services

Strategies to attain the goal:

Provide funding to multiple county mental health administrations to expand and enhance current mobile crisis teams and develop new teams that adhere to the SAMHSA Toolkit.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Police responses to mental health crisis calls in counties participating in the CAA Mobile Crisis Funding Opportunity

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

SFY21-22 Funding Opportunities for Community Mental Health Administrators CMHSBG Quarterly reporting survey (Mobile Crisis Awards). Data includes 302 commitments/warrants as well as 911 police dispatched for mental health crisis calls.

Description of Data:

Baseline: SFY 20-21
Year 1: SFY 21-22
Year 2: SFY 22-23

Data issues/caveats that affect outcome measures:

OMHSAS is actively working with Counties to collect baseline data prior to the 9/1/21 federal submission of this application.

Indicator #: 2

Indicator: Individuals boarded in emergency departments (over 24 hours) waiting for psychiatric inpatient admission in counties participating in the CAA Mobile Crisis Funding Opportunity

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

SFY21-22 Funding Opportunities for Community Mental Health Administrators CMHSBG Quarterly reporting survey (Mobile Crisis Awards).

Description of Data:

Baseline: SFY20-21
Year 1 Target: SFY21-22
Year 2 Target: SFY22-23

Data issues/caveats that affect outcome measures:

OMHSAS is actively working with Counties to collect baseline data prior to the 9/1/21 federal submission of this application.

Indicator #: 3

Indicator: Peers employed in mobile crisis services in counties participating in the CAA Mobile Crisis Funding Opportunity

Baseline Measurement: 1

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

SFY21-22 Funding Opportunities for Community Mental Health Administrators CMHSBG Quarterly reporting survey (Mobile Crisis Awards).

Description of Data:

Baseline: SFY20-21
Year 1 Target: SFY21-22
Year 2 Target: SFY22-23

Data issues/caveats that affect outcome measures:

OMHSAS is currently working with counties to confirm baseline data reported. Target employment numbers will be developed based on CAA funding opportunity applications, which are currently under review.

Priority #: 8

Priority Area: First Episode Psychosis

Priority Type: MHS

Population(s): SMI, SED, ESMI

Goal of the priority area:

Connect individuals with early psychosis to services more timely, reducing duration of untreated psychosis, by increasing the number of individuals served and the number of admission referred from community sources.

Strategies to attain the goal:

Offer increased training and support through OMHSAS contracted Early Psychosis technical assistance center, HeadsUp, at the University of Pennsylvania. Implement screening pilot for primary care physicians in select counties (Philadelphia and surrounding suburban counties) and expand out to other areas of the state if successful. Increase the number of counties/joinders with access to FEP services by providing start up funding to additional program sites.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Community Based Referrals

Baseline Measurement: 1759

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

HeadsUp Technical Assistance Center Program Evaluation Data

Description of Data:

Baseline: July 1, 2021 (point-in-time count)
Year 1 Target: July 1, 2022 (point-in-time count)
Year 2 Target: July 1, 2023 (point-in-time count)
Data includes referrals from: Outpatient Mental Health Providers, Self/family or Caregivers, Other, Schools, Community organization, unknown, other agency programs and primary care physicians.

Data will include all FEP admissions statewide in the 17 CMHSBG funded FEP Programs referred from schools, self, families, community healthcare providers, and other community referral sources. Inpatient referrals and Emergency Room referrals will be excluded, along with any admission with an unknown referral source.

Data issues/caveats that affect outcome measures:

OMHSAS is working with FEP program evaluation at HeadsUp to establish the most timely baseline data and will have this completed for inclusion in the final application submitted by 9/1/21.

Indicator #: 2

Indicator: Number of individuals served statewide in all CMHSBG funded FEP CSC Programs

Baseline Measurement: 487

First-year target/outcome measurement: 500

Second-year target/outcome measurement: 530

Data Source:

PA's TA Center, Headsup's Quarterly report: Current numbers of individuals enrolled.

Description of Data:

Baseline: PIT Count: July 1st 2021
Year 1: PIT Count July 1st 2022
Year 2: PIT Count July 1st 2023

Data issues/caveats that affect outcome measures:

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2022/2023.
Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: Planning Period End Date:

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)[a]	J. ARP Funds (MHBG)[b]
1. Substance Abuse Prevention and Treatment										
a. Pregnant Women and Women with Dependent Children										
b. All Other										
2. Primary Prevention										
a. Substance Abuse Primary Prevention										
b. Mental Health Primary Prevention[c]		$0.00	$0.00	$0.00	$32,492,897.00	$1,221,851.00	$0.00			
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[d]		$3,558,284.00	$0.00	$0.00	$0.00	$0.00	$0.00			
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital			$0.00	$0.00	$590,242,960.00	$0.00	$0.00			
7. Other 24-Hour Care		$0.00	$1,040,598,972.00	$0.00	$77,472,592.00	$926,959.00	$0.00			
8. Ambulatory/Community Non-24 Hour Care		$18,595,689.00	$1,889,177,233.00	$0.00	$415,238,246.00	$5,684,359.00	$0.00	$21,763,439.00		$41,983,353.00
9. Administration (excluding program/provider level)[e] MHBG and SABG must be reported separately		$794,580.00	$323,250,959.00	$0.00	$16,891,243.00	$5,163,373.00	$0.00			
10. Crisis Services (5 percent set-aside)[f]		$1,179,882.00						$5,355,970.00		
11. Total	**$0.00**	**$24,128,435.00**	**$3,253,027,164.00**	**$0.00**	**$1,132,337,938.00**	**$12,996,542.00**	**$0.00**	**$27,119,409.00**	**$0.00**	**$41,983,353.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 – June 30, 2023, for most states.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025,** which is different from expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2021 - June 30, 2022, for most states

[c] While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

[d] Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside.

[e] Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

[f] Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

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Footnotes:

Planning Tables

Table 6 Non-Direct Services/System Development

MHBG Planning Period Start Date: MHBG Planning Period End Date:

Activity	FFY 2022 Block Grant	FFY 2022[1] COVID Funds	FFY 2022[2] ARP Funds	FFY 2023 Block Grant	FFY 2023[1] COVID Funds	FFY 2023[2] ARP Funds
1. Information Systems						
2. Infrastructure Support	$573,524.00		$175,000.00	$573,524.00		$175,000.00
3. Partnerships, community outreach, and needs assessment						
4. Planning Council Activities (MHBG required, SABG optional)	$6,245.84			$6,245.84		
5. Quality Assurance and Improvement						
6. Research and Evaluation	$1,150,000.00			$1,150,000.00		
7. Training and Education	$1,280,250.00			$1,280,250.00		
8. Total	**$3,010,019.84**	**$0.00**	**$175,000.00**	**$3,010,019.84**	**$0.00**	**$175,000.00**

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15,2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

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Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds.
The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

[22] BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, Bulletin of the World Health Organization, 2013; 91:102-123 **http://www.who.int/bulletin/volumes/91/2/12-108282.pdf**; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, World Psychiatry. Feb 2011; 10(1): 52-77

[23] Research Review of Health Promotion Programs for People with SMI, 2012, **http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper**; About SAMHSA's Wellness Efforts, **https://www.samhsa.gov/wellness-initiative**; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, JAMA; 2007; 298: 1794-1796; Million Hearts, **https://www.samhsa.gov/million-hearts-initiative**; Schizophrenia as a health disparity, **http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml**

[24] Comorbidity: Addiction and other mental illnesses, **http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses** Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, JAMA Psychiatry. 2014; 71 (3):248-254. doi:10.1001/jamapsychiatry.2013.3726; **https://www.samhsa.gov/find-help/disorders**

[25] Social Determinants of Health, Healthy People 2020, **http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39**; **https://www.cdc.gov/nchhstp/socialdeterminants/index.html**

[26] **https://www.samhsa.gov/behavioral-health-equity/quality-practice-workforce-development**

[27] **http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/**

[28] Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. **https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf**; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, **https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf**; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. **http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf**; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, **http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf**; American Psychiatric Association, **http://www.psych.org/practice/professional-interests/integrated-care**; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, **http://books.nap.edu/openbook.php?record_id=11470&page=210**; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, **http://nasadad.org/nasadad-reports**

[29] Health Care Integration, **http://samhsa.gov/health-reform/health-care-integration**; SAMHSA-HRSA Center for Integrated Health Solutions, (**http://www.integration.samhsa.gov/**)

[30] Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, **https://www.integration.samhsa.gov/operations-administration/telebehavioral-health**; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, **http://www.americantelemed.org/home**; National Telehealth Policy Resource Center, **https://www.cchpca.org/topic/overview/**;

[31] Health Homes, **http://www.integration.samhsa.gov/integrated-care-models/health-homes**

[32] New financing models, **https://www.integration.samhsa.gov/financing**

[33] Waivers, **http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html**; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, **http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf**

[34] What are my preventive care benefits? **https://www.healthcare.gov/what-are-my-preventive-care-benefits/**; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); **http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html**

[35] Medicare-Medicaid Enrollee State Profiles, **http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html**; About the Compact of Free Association, **http://uscompact.org/about/cofa.php**

[36] Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, **http://www.cbo.gov/publication/44308**

[37] BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

[38] TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

[39] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, **https://www.cibhs.org/sites/main/files/file-attachments/samhsa_bhwork_0.pdf**; Creating jobs by addressing primary care workforce needs, **https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n**

[40] About the National Quality Strategy, **http://www.ahrq.gov/workingforquality/about.htm**;

[41] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, **http://www.cms.gov/cciio/resources/letters/index.html**; Affordable Care Act, Indian Health Service, **http://www.ihs.gov/ACA/**

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

HealthChoices contracts establish the requirement for BH and PH to coordinate care for their clients. Physical health MCOs have a Special Needs Unit to serve and ensure individuals with special needs, including behavioral health, have care coordinated between their primary care provider and the other providers involved in their care. The Behavioral Health MCOs specifically serve a special need population and have a corresponding requirement to ensure a coordination of care between the providers of behavioral health services and individuals' physical health providers. All individuals have the right to decide the type and amount of coordination they wish to have.PH-BH coordination meetings occur regionally to problem solve and engage in efforts to ensure care coordination that fits local circumstances. Similarly, the monthly Managed Care Delivery System Sub-committee of the Medical Assistance Advisory Committee also works to discover, examine and advise on systemic issues of coordination of care. An outcome of this committee was the development of the Telephonic Psychiatric Consultation Service Program (TiPS). This is available at no cost to primary care practitioners. Pennsylvania also received a SAMHSA demonstration grant to develop Certified Community Behavioral Health Clinics (CCBHCs) which are designed for the effective service coordination. OMHSAS has also supported efforts on the local level to provide such programs as Behavioral Health Navigators, BH-PH integration programs, Community and School-Based programs, Community Treatment Teams, Coordinated Specialized Care for First Episode Psychosis, Mobile Medication Programs, and expanding Case Management programs. In addition, co-location of programs is more available now since the 2016 publication of a Medical Assistance Bulletin (MAB 99-16-04; Enrollment of Co-Located Providers) to explain how programs may co-locate and enroll. With the advent of COVID-19 the availability of services using technology, often referred to as telehealth or telemedicine, has expanded making services more widely available and accommodating to alternative locations.

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, and payment strategies that foster co-occurring capability.

Pennsylvania provides services and supports in large part through the HealthChoices program establishing requirements for coordinated approaches to care. Behavioral Health is carved out for purposes of management and ensuring that the Behavioral Health program achieves parity with the Physical Health services provided. This carve out, however, works to ensure cross-system collaboration in the provision of care with equity. The TiPS program mentioned in question one above is an example of physical health and behavioral health providers working together. Our SAMHSA Demonstration grant also mentioned above helped Pennsylvania create Certified Community Behavioral Health Clinics (CCBHCs). While some CCBHCs continue in Pennsylvania through their own grant arrangement, Pennsylvania has taken the step to incorporate the basis of the CCBHCs into the HealthChoices program under the name Integrated Community Wellness Center (ICWC). Also mentioned above are the local programs developed by the counties and supported by the commonwealth that are geared toward coordinating services,

especially those related to the current opioid crisis and dual diagnoses.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? (●) Yes ( ) No

b) and Medicaid? (●) Yes ( ) No

4. Who is responsible for monitoring access to M/SUD services provided by the QHP?

The health plans monitor and report to the state and the state has monitoring teams to review the health plan processes and results.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? (●) Yes ( ) No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education (●) Yes ( ) No

b) Health risks such as

ii) heart disease ( ) Yes (●) No

iii) hypertension ( ) Yes (●) No

iv) high cholesterol ( ) Yes (●) No

v) diabetes ( ) Yes (●) No

c) Recovery supports (●) Yes ( ) No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? (●) Yes ( ) No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? (●) Yes ( ) No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

No major issues identified. Changes that needed to be made as a result of the parity analysis have been made. The parity analysis report was submitted to Centers for Medicare and Medicaid Services (CMS).

10. Does the state have any activities related to this section that you would like to highlight?

Of the activities mentioned above, the CCBHCs were a remarkable success. Consumers have expressed a desire for the state to continue with the programs that were started. Pennsylvania took the step use the CCBHC model to create the ICWC to continue services with financial security and a basis for greater state leadership in the operation of the program. Also, the TiPS program has been extremely successful and expanding yearly. The Value-Based Purchasing (VBP) and Community-Based Care Management (CBCM) programs are working to integrate a system of care to include social determinates of health (SDH).

Please indicate areas of technical assistance needed related to this section

None requested.

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[45].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[47]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[48]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[43] **http://www.healthypeople.gov/2020/default.aspx**

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race	(•) Yes ( ) No
b) Ethnicity	(•) Yes ( ) No
c) Gender	(•) Yes ( ) No
d) Sexual orientation	( ) Yes (•) No
e) Gender identity	( ) Yes (•) No
f) Age	(•) Yes ( ) No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? (•) Yes ( ) No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? (•) Yes ( ) No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? (•) Yes ( ) No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) Standards? (•) Yes ( ) No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? (•) Yes ( ) No

7. Does the state have any activities related to this section that you would like to highlight?

OMHSAS has continued to support training for the Behavioral Health Workforce to better serve the LGBTQIA+ Community through partnership with the Gender and Sexuality Development Clinic at Children's Hospital of Philadelphia (CHOP) and through Keystone Pride Resource Institute (KPRI). In SFY20-21 CHOP expanded their training offerings to include an advanced course for practitioners who wanted more in depth information on serving the Transgender and Non-Gender Conforming population. The trainings included a panel discussion with individuals with lived experience interacting with the behavioral health system, which were noted as a particular powerful portion of the training. KPRI expanded their capacity to offer both their introduction curriculum and their advanced clinical training by holding a train-the-trainer training in Fall 2020.

Please indicate areas of technical assistance needed related to this section

None requested

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

[49] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[50] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[51] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[52] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? (●) Yes ( ) No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☑ Leadership support, including investment of human and financial resources.
- **b)** ☑ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☑ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☑ Provider involvement in planning value-based purchasing.
- **e)** ☑ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☑ Quality measures focused on consumer outcomes rather than care processes.
- **g)** ☑ Involvement in CMS or commercial insurance value based purchasing programs (health homes, accountable care organization, all payer/global payments, pay for performance (P4P)).
- **h)** ☑ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? (●) Yes ( ) No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? (●) Yes ( ) No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

Pennsylvania requires all CMHSBG-funded First Episode Psychosis (FEP) to utilize the Coordinated Specialty Care Model (CSC). FEP programs are also required to utilize Certified Peer Support (CPS) Specialist services.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

The Commonwealth of Pennsylvania has required all FEP sites receiving funding through the CMHSBG to seek specialized FEP Training and to utilize the Coordinated Specialty Care Model in the delivery of services. CSC is a comprehensive service model with includes coordination with primary care.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? (●) Yes ( ) No

5. Does the state collect data specifically related to ESMI? (●) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? (•) Yes ( ) No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

The Commonwealth of Pennsylvania continues to utilize the Coordinated Specialty Care Model.

8. Please describe the planned activities for FFY 2022 and FFY 2023 for your state's ESMI programs including psychosis?

Pennsylvania will continue to fund First Episode Psychosis at 17 existing program sites. The state is also focused on developing the sustainability of FEP beyond grant funding and will continue to work to develop FEP Services as a bundled case rate service billable as an in-lieu of service under Pennsylvania's 1915B Waiver. Two FEP Programs are currently operating under the bundled case rate and additional programs are exploring this as an option. Pennsylvania has contracted for six years with the University of Pennsylvania to conduct a statewide training and a statewide program evaluation, that has enhanced sustainability and fidelity. With funding support from the CMHSBG, The University of Pennsylvania has consolidated these efforts under Headsup (formerly known as the Pennsylvania Early Intervention Center (PEIC)). In addition to offering statewide training, program evaluation, and fidelity monitoring, Headsup is currently in the process of implementing screeners within Primary Care offices to increase referrals from non-hospital sources. Headsup has also created an Early Psychosis Mentor program, to answer questions submitted by clinicians treating patients with early psychosis in Pennsylvania. With the additional funding, Pennsylvania plans to streamline efforts to bring FEP to rural counties in Pennsylvania through targeted outreach.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

The state collects and reports data through the statewide program evaluation, contracted Headsup (formerly known as PEIC) at the University of Pennsylvania. A copy of the most recent Statewide Program Evaluation Report is attached. All CMHSBG-funded FEP programs are required to participate and to complete the same core battery of assessments and track the same functional outcomes. A copy of the Pennsylvania Core FEP Battery is attached and the most recent program evaluation report out are attached.

10. Please list the diagnostic categories identified for your state's ESMI programs.

Pennsylvania has not established a statewide diagnostic category list for the FEP Program sites at this time. Individual programs may limit admission based on diagnostic criteria.

Please indicate areas of technical assistance needed related to this section.

None Requested.

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Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? (•) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

N/A

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

Pennsylvania has implemented the Community Support Program (CSP), a coalition of mental health consumers, family members, and professionals working to help adults with serious mental illnesses and co-occurring disorders live successfully in the community. The CSP Plan facilitates open communication between consumers, providers, families and advocates regarding treatment services and supports offered to consumers to allow them to live successfully in the community. Treatment services and supports are coordinated on both the local system level as well as the individual consumer basis to reduce fragmentation and improve efficiency and effectiveness of service delivery. Coordination includes linkages with consumers, families, advocates and professionals at every level of the system of care.

The CSP Wheel

For over 20 years, the national Community Support Program (CSP) Principles have had a dramatic impact on the way systems planners conceptualize organizing services, supports and opportunities to help mental health consumers reach their full potential in our society.

The Wheel is designed to meet the needs of people with mental illness as well as those who suffer from co-occurring disorders (e.g., mental illness and substance use disorders). The central focus of community support programs is to facilitate the recovery process and personal growth of each mental health consumer.

Please see Attachments section of the application for a graphic depiction of the CSP Wheel.

4. Describe the person-centered planning process in your state.

In Pennsylvania, this process is known as Community Support Program (CSP) planning.

The CSP planning process includes individuals who are served in the Mental Health system and who are able and willing to participate in the process. A general principle guiding CSP planning is "Nothing about me without me!" The CSP planning process in Pennsylvania is consumer-centered and consumer-empowered. CSP planning also entails flexibility and coordination of treatment services and supports. Service providers are also accountable to the users of services and include consumers and families in planning, development, implementation, and monitoring and evaluation of services.

The Community Support System (CSS) which is integral to CSP planning includes the following components which are essential resources to recovery:

- Treatment and Support
- Family and friends
- Peer support
- Meaningful work
- Income support
- Community mobility

• Community groups and organizations
• Protection and advocacy
• Psychiatric rehabilitation
• Leisure and recreation
• Education
• Housing
• Healthcare

Individuals who participate in the CSP planning process undergo a Family Assessment completed by a family member or significant other of his or her choice. This assessment, in conjunction with other assessments conducted, are analyzed in preparation for the planning process. An opportunity is provided to the person to express his/her needs and wants for life in the community as well as participate fully in the development of the CSP. All CSP team members are allowed the opportunity to understand the person's unique strengths and challenges before developing preliminary strategies for assisting the person to move to the community. The CSP is developed with the intention of being congruent with the person's opinions and goals, and is constructed in such a way to encourage success.

Meetings are conducted as part of the CSP planning process. Assessments are completed and/or updated prior to each CSP meeting. Participants are expected to be present in person at the meeting. Exceptions may be made for family or significant others to participate via phone or Skype. Each meeting embraces a Positive Practice approach which supports the individual's strength sand focuses upon the services needed to safely support the individual's wishes and desires. CSP meeting participants include the person and anyone she/he wishes to invite, including, but not limited to family members and/or family representatives, members of the hospital treatment team, Peer Mentor/Specialist, advocates from the community, county representatives including case managers, potential providers, and administrators, the Facilitator and the Record, and others identified by the assessment summary and/or who were present in previous meetings. Community providers and case managers are required to attend the discharge CSP meeting.

There are role expectations placed on participants in the CSP planning meetings. The individual needs to offer as much information about her/himself as possible. They also validate the summary of information from the assessments, assist in the development of a strengths list, share information for each domain of the CSP, and ask questions about what has been done, what services are available, and provides information about any place she/he has visited or would like to visit. Family members and significant others assist in the presentation of additional and pertinent information about the person, assist in the development of the strengths list, and offer ideas about supports they believe are necessary. The Facilitator and Recorder are present to support the CSP Team members in order to focus on the tasks associated with the development of the CSP.

During the CSP meeting, participants discuss and share information and ideas relevant to each life domain and the services and supports needed for the individual to move to a community setting. The meeting concludes with the development of a specific plan and a list of tasks and assignments toward accomplishing the plan. A tentative date is then scheduled for a follow-up CSP meeting. During the follow-up CSP meeting, assigned tasks are reviewed with updates of any changes or pertinent information since the last meeting. Information is shared by the CSP Team members who may have already had discussions with the person. The goal is to locate or create service options which are congruent with the person's stated needs and wishes. A list of strengths are developed and risk factors are identified.

The final CSP meeting conducted is the discharge CSP meeting. The plan created during this meeting identifies the discharge activities of both the person who will be discharged and the staff. The person may have visited and used services in the community and will be asked to share her/his opinions of those services. The person may be encouraged to share the content of her/his Wellness Recovery Action Plan (WRAP) and/or Crisis/Safety Plan, but should not be pushed to do so. A checklist of tasks for the person to complete prior to discharge will be created and finalized. All Community Support plans are reviewed and approved by State Hospital CEOs.

At all times during the CSP planning process, the individual for whom the planning is being conducted is in charge.

Please indicate areas of technical assistance needed related to this section.

None Requested.

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Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

CMHSBG Planner and the CMHSBG Engagement and Monitoring Lead Staff are responsible for program integrity activities related to MHBG. They also collaborate with the Department's Bureau of Financial Operations to ensure integrity of the programs supported with MHBG funds.

The position of CMHSBG Engagement and Monitoring Lead Staff is a new position created in 2020. The individual hired to fill the position assumed duties in March 2021. This position focuses on engaging and monitoring CMHSBG subrecipients including County Mental Health Authorities and behavioral health providers to increase the availability of evidence-best services, evaluate the appropriateness of services provided through grant funds, and ensure compliance with state and federal requirements

The state clearly conveys the federal and state requirements and expectations regarding MHBG to counties when the funds are allocated. OMHSAS utilizes a reporting form that is completed by each county annually that identifies how the MHBG dollars are expended and for what purposes. For each service, the following data are collected:

a. Name of Service (cost center)
b. Category of Service

c. Number of Persons Served
d. Number of Service Hours
e. Amount Spent
f. MHBG Priority (as identified in the State MHBG Plan)
g. Relevant Purpose (from the "SAMHSA MHBG purposes")
h. Target Population

The information reported on this form helps the state to ensure that the MHBG expenditures are consistent with the requirements and guidance that SAMHSA and the state has provided.

Please indicate areas of technical assistance needed related to this section

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7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

   Pennsylvania does not have any Federally recognized Tribal Governments or Tribal lands within its borders. No consultation sessions were conducted by the state with federally recognized tribes.

2. What specific concerns were raised during the consultation session(s) noted above?

   Not applicable, as no consultation sessions with tribes were held.

3. Does the state have any activities related to this section that you would like to highlight?

   The state does not have any activities related to this section.

   Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The Commonwealth of Pennsylvania strives to provide residents with a full spectrum of community based services, with emphasis given to Evidence Based, Recovery Oriented, and Promising Practices. The strengths and needs section of this application includes an in depth overview of the community services available including outpatient, employment services, housing, crisis intervention, CPS and case management, as well as many specialty services such as ACT and FEP. Services are made available to individuals with co-occurring disorders by mental health providers, including by providers who are dually licensed for substance abuse services. Mental Health Providers without proper substance abuse licensure will make referrals to appropriate substance abuse providers as needed.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(•) Yes ( ) No
b)	Mental Health	(•) Yes ( ) No
c)	Rehabilitation services	(•) Yes ( ) No
d)	Employment services	(•) Yes ( ) No
e)	Housing services	(•) Yes ( ) No
f)	Educational Services	(•) Yes ( ) No
g)	Substance misuse prevention and SUD treatment services	(•) Yes ( ) No
h)	Medical and dental services	(•) Yes ( ) No
i)	Support services	(•) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(•) Yes ( ) No
k)	Services for persons with co-occuring M/SUDs	(•) Yes ( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

Availability of services varies by County.

3. Describe your state's case management services

In Pennsylvania mental health case management services are categorized as Administrative Case Management (ACM) and Targeted Case Management (TCM). TCM includes Intensive Case Management (ICM), Resource Coordination (RC) and Blended Case Management (BCM). Each of these services are fully described in the strengths and needs section of this application.

4. Describe activities intended to reduce hospitalizations and hospital stays.

As required by the Community Mental Health Block Grant, OMHSAS prioritizes CMHSBG funding to providing and developing community based mental health services. A strong spectrum of community services can be utilized to divert hospital admissions and for discharge planning.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	548,698	
2.Children with SED	162,817	

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Pennsylvania utilizes prevalence data from the National Research Institute (NRI). Pennsylvania does not track incidence data at this time.
For planning purposes, in addition to the prevalence data from the URS Table, OMHSAS utilizes a number of data sources and seeks broad stakeholder input, as outlined in Planning Step 2. These include:
• County level data from the County Human Services Plans
• OMHSAS Data (inclusive of both Medicaid and State funded services)
• Stakeholder feedback from the public meetings
• Consultation with subject matter experts for each priority area

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	(•) Yes ( ) No
b)	Educational services, including services provided under IDE	(•) Yes ( ) No
c)	Juvenile justice services	(•) Yes ( ) No
d)	Substance misuse preventiion and SUD treatment services	(•) Yes ( ) No
e)	Health and mental health services	(•) Yes ( ) No
f)	Establishes defined geographic area for the provision of services of such system	(•) Yes ( ) No

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population.

Managed Care provides many opportunities for rural counties. Under managed care, there are required services and access standards. In rural areas services must be available within 60 minutes of travel time. In addition, emergency services must be available in one hour, urgent services in 24 hours, and routine services in 7 days. Rural counties, in order to come into compliance with managed care standards are required to increase both the number and array of service providers.

Some rural areas of Pennsylvania have also developed partnerships with neighboring Counties/Mental Health Authorities to provide additional specialized services and trainings, such as Behavioral Health Alliance of Rural Pennsylvania (BHARP), which represents 23 rural counties in north central Pennsylvania. BHARP has provided extensive training on Trauma Informed Care to providers in their area, worked towards System of Care development, and hosts various cross-county workgroups on priority issues, such as housing.

b. Describe your state's targeted services to the homeless population.

Pennsylvania has a strong focus on housing and addressing homelessness, including the Department of Human Services Five Year Housing Plan, which OMHSAS assisted in developing. OMHSAS homeless services focus on the PATH (Projects Assisting in the Transition from Homelessness) Grant and SOAR (SSI/SSDI Outreach, Access, and Recovery) Initiative. Pennsylvania has PATH services available in 36 counties through 24 County MH/ID Program Offices, covering both urban and rural areas of the state. Services provided for PATH-eligible individuals include outreach, screening and diagnostic treatment, habilitation/rehabilitation, community mental health services, alcohol and/or drug treatment, staff training, case management, supportive and supervisory services in residential settings, referrals for primary health, job training, educational services and allowable housing services. Nationally, PA's SOAR program was again ranked #1 in quality in 2018. OMHSAS is currently focused on spreading SOAR beyond PATH counties into other geographic areas of the state. OMHSAS is also working to develop greater SOAR capacity for veterans (both the Veterans Administration and partnering nonprofits) and within the criminal justice system.

c. Describe your state's targeted services to the older adult population.

Two major priorities that OMHSAS supports for Older Adults are a series of specialized trainings through the Pennsylvania Behavioral Health and Aging Coalition and Certified Older Adult Peer Specialist (COAPS) Training. Pennsylvania Behavioral Health and Aging Coalition receives OMHSAS support to provide various trainings to mental health providers, many of which are focused on issues of aging including Dementia Live, Compassionate Touch, Ageless Grace Brain Health, and WISE. The COAPS training is a three day, continuing education training for CPSs who wish to specialize in peer services to the older adult population. CMHSBG funding has been utilized to support additional COAPS trainings throughout the Commonwealth to build capacity of this service.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

See Attachment for Criterion 5.

Footnotes:

Additional information on the Statutory Criterion is available in the Strengths and Needs Section of this application.

Criterion 2:
-Prevalence Data URS Table 1 (2019)
-Prevalence for Children with SED utilizes the average for Level of Functioning Score=60
-Incidence data is not available

9. Statutory Criterion for MHBG: Criterion 5

Financial Resources

County Mental Health Programs blend funding from a number of different sources in order to meet the needs of the individuals receiving services. These include general state revenue funds, county funds, Medicaid dollars, Community Mental Health Block Grant, Substance Abuse Block Grant, Social Services Block Grant, PATH grant, System of Care Grants and other federal grants.

OMHSAS continues to encourage the trend towards moving funding from state administration to county administration. For the proposed SFY19-20 budget, it is estimated that 89% of state dollars ($4,018,054,227) will be under county administration, with only 11% of funds ($492,449,209) under state administration. During SFY19-20, Community Hospital Integration Projects Program (CHIPP) funding includes the annualization of the SFY18-19 CHIPPs, as well as the new funding for 45 additional CHIPPs, bringing the total CHIPP allocation to a proposed cumulative $291.1 million with 3,581 CHIPPs completed since the inception of the program.

Staffing

The Community Mental Health Services Block Grant is primarily staffed by the CMHSBG Lead Staff Person and the CMHSBG Supervisor, who are both located in the OMSHAS Bureau of Policy, Planning and Program Development. The Children's CMHBSG Planner is located in the Bureau of Children's Behavioral Health Services. OMHSAS utilizes a wide array of additional staff to provide subject matter expertise and help to implement projects funded by CMHSBG.

Training Resources

OMHSAS sponsors technical assistance (TA) and training on a variety of topics for counties and provider agencies. Some examples are: Peer Specialist training, Case Management training, SSI/SSDI Outreach, Access, & Recovery (SOAR) training, and TA for the development of ACT, FEP, and housing options. The State also partners with the training institute at Western Psychiatric Institute and Clinic (WPIC) to provide training for Targeted Case Management.

OMHSAS makes trainings available through a number of partnerships (most recently including WPIC, Georgetown University, Copeland Center, and Children's Hospital of Philadelphia among other training providers). These trainings have included:

- Targeted Case Management
- Overview of Major Mental Disorders
- Foundational Concepts of Recovery
- Psychiatric Disorders of Children and Adolescents
- Wellness Recovery Action Plan
- Trauma
- Cognitive Behavioral Therapy
- Ethics
- Assessment and Treatment Strategies

- Crisis Intervention
- Emergency Preparedness
- Evidence-Based Treatments
- Motivation Interviewing Skills for Case Mangers
- Cultural Competency
- Transgender and LGBTQIA+
- Supported Education/Employment

Training for providers of emergency mental health services regarding SMI/SED

The Office of Mental Health and Substance Abuse Services (OMHSAS) is the statewide coordinating agency for Emergency Behavioral Health (EBH) response. *The Pennsylvania Mental Health Plan for Disaster/Emergency Response* was first published in September 1994. The next update occurred following the terrorist attacks of September 11, 2001. Subsequent to the 9-11 Disaster Response Plan, OMHSAS was given guidance by the SAMHSA to develop an *ALL HAZARDS PLAN*. Over time, and in alignment with federal guidance, the plan is now titled "*Office of Mental Health and Substance Abuse Services Emergency Behavioral Health Plan*". This EBH Plan is updated every two years and provides a mechanism for state response to local, regional, and/or state level disasters and emergencies using an All Hazards Approach.

In the commonwealth, each county has an EBH Coordinator who provides oversight and direction to their EBH Team. Each county functions at their own level, with some being more robust than others. The county EBH plans are intended to provide guidance for their response effort at the local level.

Office of Mental Health and Substance Abuse Services Emergency Behavioral Health Plan specifies the OMHSAS as a supportive component in emergency behavioral health response. The OMHSAS provides technical assistance and ongoing training to counties in the development of county EBH plans and in implementing their response program. The following is a discussion on the available training:

Persevere PA – The Commonwealth's Crisis Counseling Assistance and Training Program (CCP)

On May 14, 2020 the Immediate Services Program (ISP) Application was submitted to FEMA and SAMHSA in order to provide SAMHSA Approved Psychological First Aid (PFA) to the citizens of the Commonwealth. The application was approved with a total award of $309, 455. The CCP is intended to provide SAMHSA Approved Crisis Counseling to the citizens of the Commonwealth. Persevere PA provided SAMHSA Approved crisis counseling services to 17, 848 citizens of the Commonwealth.

Emergency Behavioral Health Trainings

OMHSAS, in partnership with the Pennsylvania Department of Health (PADOH), Bureau of Public Health Preparedness (BPHP), offers trainings to emergency response providers to address the psychosocial consequences of disasters and emergencies. COVID-19 significantly impacted

the EBH Training Program this year. In accordance with the Subgrant guidance, PADHS exceeded the required deliverables and provided nine virtual trainings in the Commonwealth. Disaster Crisis Outreach and Referral Team (DCORT), Psychological First Aid (PFA), Critical Incident Stress Management (CISM), and various Advanced Skills trainings were provided to first responders and other personnel in the virtual environment to increase their capability to respond to the psychosocial needs of others, relative to disasters and other public health emergencies. Using BPHP funding from the Centers for Disease Control and Prevention (CDC), OMHSAS provides the following training to Emergency Behavioral Health Responders:

- Psychological First Aid (PFA) training endorsed by Substance Abuse and Mental Health Services Administration (SAMHSA)

- Disaster Crisis Outreach and Referral Team (DCORT) Training

- Critical Incident Stress Management (CISM) for First Responders

    - Group Crisis Intervention: a core course in the CISM model designed to address the needs of small and large groups of people impacted by the crisis. This course provides the foundational theory of the effects of trauma; it also focuses of skill development in 3 basic intervention techniques, specifically, Crisis Management Briefings (CMB), Defusing and Critical Incident Stress Debriefings (CISD).

    - Assisting Individuals in Crisis: a core course in the CISM model designed to address the needs of individuals in crisis. This course provides the foundational theory of crisis communications and focuses on skill development using a specific protocol that can be adapted for use with suicidal individuals.

    - Assisting Individuals in Crisis and Group Crisis Intervention: combines the Group and Individual courses into a 3-day format. This training is especially recommended when a group is just starting a CISM team or when participants have time constraints but would like to develop skills for dealing with groups and individuals in crisis.

    - Advanced Group Crisis Intervention: this course is designed to provide guidance when dealing with complex crisis situations (i.e. completed suicides, line of duty death, mass casualty incidents, etc.). This course builds upon the skills developed in the Group Crisis Intervention course.

- Skills for Psychological Recovery

- Advanced Skills Trainings including:

    - Active Shooter 2.0 – The Evolution of the Active Shooter Risk and Community Response
    - Behavioral Management of CBRNE* Terrorism (Chemical, Biological, Radiological, Nuclear and Enhanced Conventional Weapons)

- Responder Safety and Preventing Collective Violence: Group, Crowd, and Mob Aggression
- Working with the Community in the Wake of Violent Events
- Mental Health Response to Mass Violence
- Extremism and Targeted Violence: The Evolving Threat Landscape Time
- Operational Stress Control & Strategies for Team Support: Psychological Force Protection for Crisis Responders
- Vehicular Terrorist Attacks: Prevention, Response & Recovery
- A Disaster Behavioral Health Responder's Guide to Intelligence
- Human Trafficking Recognition, Response & Recovery: Managing the Emotional Consequences of Human Trafficking
- Skills for Psychologic

Through the county Emergency Behavioral Health Teams, these training opportunities are also offered to partners and stakeholders to promote community resiliency and recovery.

EBH Coordinators are encouraged to attend Health Care Coalition and regional task force meetings, to partner in a variety of exercises, and to participate in committees and meetings as their schedule allows. Collaboration and training will continue.

Intended Use of Block Grant Funds

Intended use of CMHSBG Funding is addressed in the Strengths and Needs Section of this application.

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2020-FFY 2021? ○ Yes ◉ No

Please indicate areas of technical assistance needed related to this section.

NOTE: Please refer to previous section in Quality Management Introduction to see further explanation DHS expectations of future Quality Strategy that will consolidate the federal quality efforts across all Medicaid Managed Care programs.

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12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

57 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
58 *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? ○ Yes ◉ No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? ○ Yes ◉ No

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? ◉ Yes ○ No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ○ Yes ◉ No

5. Does the state have any activities related to this section that you would like to highlight.

1. OMHSAS developed a Psychiatric/Residential Treatment Facility Trauma-informed Care Implementation Survey to be completed by each OMHSAS certified residential treatment facility in the state in which respondents shared details about their progress towards implementing trauma-informed care in their programs and also identified which resources across the state they have been using to do so. We have been reviewing Survey Data to develop a strategy for providing feedback and technical assistance to each OMHSAS Certified residential treatment program. We have developed and shared with OCYF a Trauma Awareness focused benchmark document which we are currently cross-walking with survey items, while creating a PRTF Survey Feedback format which will include Recommendations and next steps for each facility to reach the goal of being designated at “Trauma Aware” by the end

of 2021 and of being able to continue developing further along the Trauma-informed Care Continuum. The Trauma-Awareness Benchmarks are based on a full scale Trauma-informed Care Audit Tool which will be used moving forward as we guide residential and mental health services through the continuum of trauma-informed practices towards achieving "Healing Centered Care" according to the Trauma-informed PA (TIPA) plan developed through the Office of Advocacy and Reform under Governor Wolf and which is being implemented by both government and community stakeholders through the HEAL-PA Action Committees.
2. OMHSAS is very involved with the HEAL PA Initiative and is representing DHS on a number of action committees, as well as on the National Governors Associations Pennsylvania ACES team.
3. While our current efforts are most focused on Residential Treatment Programs, eventually we will want to address trauma informed care in a more focused way in other OMHSAS programs. We have reviewed and provided technical assistance on a number of trauma-informed care trainings that are being provided in Intensive Behavioral Health Services Programs, and in July will be launching a study into how IBHS supervisors are viewing Trauma-Informed Care (using the Attitudes towards Trauma-informed Care Survey) in reference to providing IBHS services to children in the 0-8 age range and in response to the various TIC initiatives and training opportunities being offered across the state.
4. OMHSAS has been working on developing our capacity to provide effective and actionable technical assistance and training in the area of trauma-informed care, and we are currently developing a plan for how to use these capacities and resources most efficiently and strategically. We now have 7 individuals who have completed a "train the trainer" program through Lakeside Global Institute, and we are looking to keep our current training efforts focused on offices within DHS that are not yet able to access such training through other sources. Several "Trauma 101" trainings have been conducted with OMHSAS staff and there are plans for scheduling monthly opportunities for training.
5. The PA Cares Partnership has been curating speakers and programs for their Webinar Series which are very much focused on issues related to Trauma and Cultural, Racial, and Historical trauma and the impact of these factors on mental health in diverse and vulnerable populations. Speakers are addressing many issue related to complex trauma, attachment, resiliency, and so on.
6. OMHSAS clinical consultants participated in the creation of a video training with the Office of Children and Families in the Courts for dependency court judges and personnel. We will be participating in live "Trauma-Informed Dependency Court" training for Dependency Court Judges and Personnel across the state in 2022. The training will include an introduction and activities related to implicit bias, as well as training in how to interact in a trauma-informed manner with children and families in court and how to make the courtroom environment less stressful.
7. OMHSAS has also provided training in trauma-informed care principles to peer support professionals using a curriculum we adapted from the "Trauma-sensitive Schools" online curriculum. Several OMHSAS staff were involved in the curriculum development and presentations, which are ongoing as needed.

Please indicate areas of technical assistance needed related to this section.

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13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[59] Journal of Research in Crime and Delinquency: *: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**

[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? ○ Yes ◉ No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? ◉ Yes ○ No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? ○ Yes ○ No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? ◉ Yes ○ No

5. Does the state have any activities related to this section that you would like to highlight?

Pennsylvania's Projects for Assistance in Homelessness (PATH) grant highly recommends CIT coordination between its 40 providers and their respective communities. Numbers of CIT-trained officers and emergency personnel across the State continue to grow.

Pennsylvania as a whole has several methods in place to minimize the challenges and foster support for PATH clients with a criminal history. Most programs employ elements of diversion, specialized forensic case management, forensic peer support, trainings and/or developing working relationships with the local jails, state correctional facilities, local probation and parole officers, as well as landlords. Endeavors revolve around both paroled and maxing out individuals in both the county jails and state correctional institutions.

As a result of information collected during PATH site visits, the PA SPC has become involved with the statewide Forensics Interagency Task Force (FITF). The group's focus is to allay any avoidable hurdles in the reentry process. The SPC chairs the Housing Reentry sub-committee in its efforts to streamline reentry methodology from PA Department of Corrections procedures to housing options and supports. The SPC chaired the Housing sub-group of the Reentry Committee and presented at the 24th Annual

Forensics Rights and Treatment Conference Nov 30-Dec 1, 2016. The FITF core groups spoke on "Collaboration: The Essential Tools for System Change."

In 2017, the SPC completed the 40-hour Crisis Intervention Team (CIT) training in Franklin Co, PA. The SPC was then certified as a CIT trainer by the originators of the Memphis CIT model with focus on verbal de-escalation techniques and coordination with law enforcement to curb recidivism.

Allegheny County received one of six national technical assistance awards to advance SOAR use in the criminal justice environment. The TA will include all steps needed to implement, maintain, and increase SOAR use at the Allegheny County Jail. This project will enhance SOAR progress already being made by the Bucks Co Jail in the eastern part of the state.

Justice involved programs differ based on local needs within PA counties. Lehigh County has one of the premier workgroups in the state. Lehigh County, with 48% of its enrolled PATH consumers being criminally involved and/or having a criminal history, has developed a program called Team MISA (Mental Illness Substance Abuse). Team MISA is comprised of a variety of disciplines within the County, including the District Attorney's Office, Lehigh Valley Pre-Trial Services, MH/ID, SPORE, D&A, Lehigh County Prison (treatment, administration, and case managers), Probation/ Parole and the Public Defender's Office. The meeting is chaired by the first Assistant DA. The success of the group results from the collaboration and participation of department heads, as well as front line staff, at the table. The team meets weekly to discuss new referrals and any updates on ongoing cases that are involved in the criminal justice system. Members collect and present pertinent information from their office which the team discusses to develop the most appropriate plan to most appropriately address the individual's situation in the most clinically appropriate manner.

Other areas in the state are also forging their unique programs. The Center for Excellence has conducted several cross-county mappings to help areas identify and stimulate initiatives appropriate for localized areas. For example, in 2010, Delaware County's Office of Behavioral Health a Cross-System Mapping that was held for 45 county stakeholders. The mapping identified a number of system gaps, produced priority action steps, and resulted in many of the newest forensic initiatives being proposed and/or developed in the county. The Cross-System Strategic Planning Committee is the entity responsible for tracking intersystem program development and training initiatives. OBH also participates in the Criminal Justice Advisory Committee (CJAC), DelCo Cares initiative, MH Court Planning Team, and also works with the Regional Forensic Liaison on DOC/SCI max-out planning, and with Forensic Liaisons at GW Hill Prison for inmate re-entry planning. All PATH clients with criminal histories can access those programs in which they are eligible. The following lists specific efforts in the County:

Forensic ACT (FACT) Team The county is converting a CTT program to a FACT model with technical assistance from the University of Rochester Medical Center. The Rochester R-FACT model is an evidence-based forensic intervention model that collaborates with the MH Court.
MH Court The county implemented a new specialty MH Court in FY 13-14 to address the needs of the SMI/justice-involved population. There is a strong working relationship between the criminal justice and behavioral health systems in this new venture.
Forensic Peer Support The county developed a contract with Peerstar, LLC, to implement a forensic CPS program. This model is both a jail in-reach and community-based peer mentoring model that uses an evidence-based Yale Citizenship approach.
OBH Forensic
Specialist In FY 13-14, OBH hired a dedicated Forensic Specialist to help oversee the myriad of forensic initiatives targeted to the justice-involved population.
Behavioral
Health Liaisons OBH and Adult Probation/Parole jointly fund 4 behavioral health liaisons at the GW Hill prison to coordinate treatment in the prison and in the community at release.
DOC Max-out Tracking OBH staff, in conjunction with the Regional Forensic Liaison, track and develop release plans for the C and D roster priority max-out cases returning to DelCo.

Along a different vein, Dauphin County opened a judicial center for centralized booking several years ago. Pre-Trial staff screen admissions and request a MH assessment from Crisis Intervention Program staff or, if active, targeted mental health case managers. Recommendations are made to Magisterial District Justices in determining bail, release or incarceration.

Additionally, Service Access and Management Inc. in Huntingdon/Mifflin/Juniata is currently providing specialized forensic case management services for local and state correctional facilities for the Tri County Area. The Service Access and Management Inc. Base Service Unit Housing Specialist has worked in coordination with the Mifflin County Human Services Department to develop 6 Forensic Master Leasing Units which have been at capacity serving individuals in community reentry from institutional criminal justice settings. Individuals with criminal justice involvement have also been served in regular Master Leasing units. The Base Service Unit also works in close coordination with probation departments and parole departments to monitor and support these individuals in maintaining community tenure.

Criminal Justice Advisory Boards (CJABs) are another venue for discussion of forensic programs. In Crawford Co, The Crawford County Mental Health Awareness Program (CHAPS) Executive Director is an active member of the County's CJAB and is able to share challenges and suggest solutions to judges, probation, and other stakeholders. Also, CHAPS staff actively participates in a Mental Health Forensic Subcommittee, where best practices, barriers, and solutions are discussed. CHAPS has very positive

working relationships with our police departments, probation offices, and District Justices.

CHAPS has had significant success working with forensic related individuals. Some examples include: master leasing units for diversion or returning to the community, coordination with the jail to ensure a smoother re-entry to the community, writing letters and appearing in court to testify on behalf of clients, which result in jail diversion, and immediate engagement upon release from jail (utilizing a Mental Health Court Model).

All of these justice involved programs, despite difference approaches, share the same goal of reducing barriers for those reentering communities from incarceration. Without any formal tracking being completed in FY 16, PA estimates that 60% of its PATH client have criminal justice history.

Please indicate areas of technical assistance needed related to this section.

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15. Crisis Services - Required for MHBG

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- **a)** ☑ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☑ Psychiatric Advance Directives
- **c)** ☑ Family Engagement
- **d)** ☑ Safety Planning
- **e)** ☑ Peer-Operated Warm Lines
- **f)** ☑ Peer-Run Crisis Respite Programs
- **g)** ☑ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☑ Assessment/Triage (Living Room Model)
- **b)** ☐ Open Dialogue
- **c)** ☑ Crisis Residential/Respite
- **d)** ☑ Crisis Intervention Team/Law Enforcement
- **e)** ☑ Mobile Crisis Outreach
- **f)** ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☑ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☐ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☑ Follow-up crisis engagement with families and involved community members

f) ☑ Recovery community coaches/peer recovery coaches

g) ☑ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Pennsylvania has allocated a majority of the CMHSBG funding increase to bolster the state's crisis system. A request for Application was sent out to all counties with the multiple options, including funding for Mobile Crisis as well as Crisis Other. While the applications are not finalized, there were 45 unique requests for funding to bolster county crisis systems. Some projects include additional staffing, new crisis mobile teams, an an additional peer run crisis respite program. OMHSAS also plans to use the majority of the ARPA funding towards crisis programs.

Please indicate areas of technical assistance needed related to this section.

None requested.

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16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Block grant funding of recovery support services. (●) Yes ( ) No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? ( ) Yes (●) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Peer Support Services for individuals aged 14 and older. Peer Support Services (PSS) are specialized therapeutic interactions conducted by self-identified current or former consumers of behavioral health services who are trained and certified to offer support and assistance in helping others in their recovery and community-integration process. Peer support is intended to inspire hope in individuals that recovery is not only possible, but probable. The service is designed to promote empowerment, self-determination, understanding, coping skills, and resiliency through mentoring and service coordination supports that allow individuals with severe and persistent mental illness and co-occurring disorders to achieve personal wellness and cope with the stressors and barriers encountered when recovering from their disabilities.

Compeer. Compeer recruits, screens and matches trained volunteers and mentors in one-to-one supportive relationships with individuals who are striving for good mental health. Compeer volunteers provide support, friendship and mentoring during an individual's recovery process. These services are considered an additional support to traditional mental health services.
Psychiatric Rehabilitation Services. Psychiatric rehabilitation services (PRS) are collaborative, person-directed, individualized and are evidence-based in their approach. PRS focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social domains of their choice.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Certified Recovery Specialist. The Certified Recovery Specialist (CRS) credential is for individuals with personal, lived experience of their own recovery from drug and alcohol. The peer has been trained to help others move into and through the recovery process.

5. Does the state have any activities that it would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	(•) Yes ( ) No
Home and community based services.	(•) Yes ( ) No
Peer support services.	(•) Yes ( ) No
Employment services.	(•) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? (•) Yes ( ) No

Please indicate areas of technical assistance needed related to this section.

There are no technical assistance needs at this time.

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18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[65]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? (●) Yes ( ) No

b) The recovery and resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Juvenile justice? ( ) Yes (●) No

c) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? ( ) Yes (●) No

b) for youth in foster care? ( ) Yes (●) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

Pennsylvania has been awarded several grants from SAMHSA to develop Systems of Care to serve youth ages Birth to age 21 with serious mental health needs and their families. These youth are often involved with child welfare and/or juvenile justice and are in, or at risk of, out-of-home placement. Pennsylvania is part of the national movement to utilize organized, multi-level and multi-disciplinary systems, in partnership with youth and families, to more effectively serve multi-system youth with serious behavioral health challenges and their families.

The PA Care Partnership, the Statewide System of Care Grant, builds on and enhances cross-systems efforts that have been underway for several years to integrate and more effectively provide services to youth. The grant currently works with nine counties utilizing High Fidelity Wraparound (HFW), or another validated cross-system planning model, as the engagement and care planning process for youth involved in multiple systems.

The state also has a State Leadership and Management Team, which meets monthly cross-system participation and equal family and youth voice as voting members. The systems involved are mental health, education, child welfare services, juvenile justice services, early childhood, autism, substance use disorders, and county commissioners associations.

The Youth and Family Training Institute, a division of the University of Pittsburgh and Western Psychiatric Institute and Clinic of

UPMC, provides training and support, as well as evaluation of the HFW teams in each county. Additionally, they provide support and training to counties and providers related to data collection and analytics of the data for the cross-system planning models.

7. Does the state have any activities related to this section that you would like to highlight?

The PA Care Partnership provides technical assistance and training in the following domains.
a. Trauma-Informed Care, through the Lakeside Global Trauma Training and Train the Trainer program.
b. System of Care Implementation through the PA Care Partnership
c. Youth and Family Empowerment through the Youth and Young Adult Roadmap and the Family Roadmap
d. Coaching and Leadership through the Coach Approach to Adaptive Leadership and Adaptive Leadership for System Change
e. Family Engagement through the PA Parent and Family Alliance and the Family Support Partners

Please indicate areas of technical assistance needed related to this section.

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19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

Current activities, as described in the strengths and needs section, include training, screening, awareness/outreach, and infrastructure development. Improved collaboration among state agencies through the stateside Suicide Prevention Task Force has been a priority, as has collaboration with SAMHSA and the Suicide Prevention Resource Center through a variety of grant-related efforts and involvement in cross-state learning collaboratives.

3. Have you incorporated any strategies supportive of Zero Suicide? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? (●) Yes ( ) No

5. Have you begun any targeted or statewide initiatives since the FFY 2020-FFY 2021 plan was submitted? ( ) Yes (●) No

If so, please describe the population targeted.

Please indicate areas of technical assistance needed related to this section.

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20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ○ Yes ◉ No

2. Has your state identified the need to develop new partnerships that you did not have in place? ○ Yes ◉ No

If yes, with whom?

The Pennsylvania Office of Mental Health and Substance Abuse Services continues to work with partners including the Department of Aging, the Department of Corrections, the Department of Drug and Alcohol Programs, the Department of Health, various program offices within the Department of Human Services and all relevant public stakeholder groups including our county partnership, Behavioral Health Managed Care Organizations, Advocacy Groups, and other interested Pennsylvanians.

Please indicate areas of technical assistance needed related to this section.

None Requested

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21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC).SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[69]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

The Mental Health Planning Council (MHPC) consists of up to 75 members in three age group specific committees (Children, Adult, and Older Adult) representing mandatory state agencies, indviiduals with lived experience (of mental illness or co-occurring mental illness/substance use disorder), family members (including the parents of children with SED), advocacy agencies, providers, and local government officials. The MHPC holds public meetings once per quarter in order to discuss feedback on the mental health system throughout the state and provide substantive recommendations to the Deputy Secretary for the Office of Mental Health and Substance Abuse Services (OMHSAS) and additional ad hoc meetings as needed. The mental health planning council has a strong focus on ensuring that the behavioral health system in Pennsylvania is recovery and resiliency oriented and the recovery and resiliency services are prioritized.

In Pennsylvania In Pennsylvania, while OMHSAS has authority over Medicaid reimbursement for SUD services, the majority of oversight for the SUD system falls under a separate cabinet level agency, the Department of Drug and Alcohol Programs (DDAP). DDAP and OMHSAS work closely together on a number of initiatives and DDAP has an appointed representative to the MHPC.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? ○ Yes ◉ No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? ◉ Yes ○ No

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

MHPC quarterly meetings are open to the public and are well attended by interested stakeholders including individuals who have received services and their families. The MHPC provides counsel and guidance to the OMHSAS Deputy Secretary in order to ensure an infrastructure and full array of mental health and co-occurring services which comply with the mission, vision and guiding principles of OMHSAS, as well as core principles of the Community Support Program (CSP), Child and Adolescent Service System Program (CASSP), and Diversity, Equity and Inclusion principles. The MHPC also provides a forum for youth, adults, and family members with lived experience to work side-by-side with advocates, providers, administrators, and OMHSAS leadership to provide recommendations regarding important, statewide policy and programmatic issues. Quarterly MHPC meetings are open to the public and are generally well attended by individuals and family members from the public who offer additional perspectives on the need of the community. During the COVID-19 Public Health Emergency, all MHPC have shifted to a web based platform, which

has enhanced the ability of individuals from across the state to participate in the council meetings. Additional information regarding the structure and operation of the MHPC are included in the attached MHPC Advisory Protocol.

OMHSAS is currently working in partnership with the MHPC Executive Council to enhance the functionality and ensure that the council structure supports providing meaningful input from people in recovery, families, and other important stakeholders and that the MHPC is fully equipped to effectively advocate for individuals with SMI/SED.

The current membership of the Mental Health Planning Council does represent each region throughout Pennsylvania; a mix of rural, suburban, and urban counties; has excellent representation of individuals from the LGBTQIA community; and closely mirrors the racial/ethnic demographics of the state, both OMHSAS and the counsel are continually seeking to improve the representative nature of the council and ensure that we follow solid principles for diversity, equity, and inclusion in all operations.

Please indicate areas of technical assistance needed related to this section.

None requested

Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.[70]

[70]There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

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Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2022 End Year: 2023

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
January Abel	Providers	Recovery InSight Inc	Lancaster County PA,	jabel@recovery-insight.com
Summer Alonso	Providers		Chester County PA,	scalonso@icloud.com
Julie Barry	Parents of children with SED/SUD		Erie County PA,	jmickelbarry@gmail.com
Rebecca Bonner	Providers	The Bridgeway School	Philadelphia County PA,	rebecca.bonner@thebridgewayschool.org
Farida Boyer	Providers		Philadelphia County PA,	faridasaleemboyer@gmail.com
Tracy Carney	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Montour County PA,	carneyta@ccbh.com
Heidi Champa	State Employees	Pennsylvania Department of Aging	Dauphin County PA,	hchampa@pa.gov
Greg Cherpes	State Employees	DHS Office of Developmental Programs	Allegheny County PA,	gcherpes@pa.gov
Kathyann Corl	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Dauphin County PA,	episfrn@aol.com
Geraldine Coulson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Westmoreland County PA,	gerricoulson21gerricoulson21@gmail.com
Julie Dees	Providers		Montgomery County PA,	jdees@fsabc.org
Shashi Dehaen	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Montour County PA,	025services@gmail.com
Robert Diaz	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Berks County PA,	rdiaz@berkscc.org

Amanda Dorris	State Employees		Dauphin County PA,	adorris@pa.gov
Keith Elders	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Cambria County PA,	keithrelders@gmail.com
Beth Ellis	State Employees	PA Office of Special Programs	Dauphin County PA,	betellis@pa.gov
Marjorie Faish	State Employees	PA Office of Long Term Living	Dauphin County PA,	mfaish@pa.gov
Debbie Ference	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Butler County PA,	dference@namikeystonepa.org
Dave Fetterman	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Schuylkill County PA,	dfet@ptd.net
Ruth Fox	Parents of children with SED/SUD		Allegheny County PA,	rfox@alleghenyfamilynetwork.org
Kathleen Ganely	Others (Advocates who are not State employees or providers)	Peer Support and Advocacy Network	Allegheny County PA,	kganley@peer-support.org
Kimberly Gerlach	State Employees		Dauphin County PA,	kimbwillian@pa.gov
Sandra Goetze	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Butler County PA,	sgoetze@zoominternet.net
Beverly Haberle	Providers		Bucks County PA,	bhaberle@councilsepa.org
Shalawn James	Others (Advocates who are not State employees or providers)		Dauphin County PA,	shalawnjames@gmail.com
Anne Katona-Linn	Providers		Northumberland County PA,	akatonalinn15@gmail.com
Lisa Kennedy	Parents of children with SED/SUD		York County PA,	lmkennedy1@yahoo.com
Andrew Kind-Rubin	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Delaware County PA,	akindrubin@cgrc.org
Alex Knapp	Others (Advocates who are not State employees or providers)		Allegheny County PA,	acknapp.2014@gmail.com
Robin Kunkel	State Employees	DHS Office Medical Assistance Programs	Dauphin County PA,	ekunkel@pa.gov
Joe Labosky	Providers	Northumberland County BH/IDS	Northumberland PA,	joe.labosky@norrycopa.net
Kathy Laws	Parents of children with SED/SUD		Montgomery County PA,	kathylaws33@gmail.com
Diane Lichtman	Others (Advocates who are not State employees or providers)	Centre County and Central Region CSP	Allegheny County PA,	dsl456@gmail.com
Minta Livengood	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Indiana County PA,	livengoodminta@gmail.com
Karen Mallah	Providers	Community Care Behavioral Health (CCBHO)	Cumberland County PA,	mallahk@ccbh.com

Christine Michaels	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Allegheny County PA,	cmichaels@namiswpa.org
Dana Milakovic	State Employees	Pennsylvania Department of Education	Dauphin County PA,	damilakovi@pa.gov
Adam Miller	Parents of children with SED/SUD	Wellspan Philhaven	Lebanon County PA,	amillller60@wellspan.org
Thomas Mirabella	Others (Advocates who are not State employees or providers)	East Penn School District	Lehigh County PA,	tmirabella@eastpennsd.org
Karen Morton	Providers	Beacon Health Options	Dauphin County PA,	kmorton@merakey.org
Fred Nardei	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Beaver County PA,	taboo971@live.com
Andy Natalie	Providers	Threshold Rehabilitation Services	Berks County PA,	anatalie@trsinc.org
Sandy Paradis	State Employees	Pennsylvania Department of Drug and Alcohol Programs	Dauphin County PA,	sparadis@pa.gov
Hope Pesner	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Lancaster County PA,	hopepesner@gmail.com
Kathy Quick	Parents of children with SED/SUD	Pennsylvania Mental Health Consumers' Association	Schuylkill County PA,	kathy@pmhca.org
Brian Richardson	Providers	Greater Reading MHA	Berks County PA,	rich129555@gmail.com
Brian Satterfield	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Cumberland County PA,	briandstubbs@gmail.com
Nancy Scheible	Others (Advocates who are not State employees or providers)		Bucks County PA,	nscheible.advocacy@gmail.com
Tristan Schnoke	Others (Advocates who are not State employees or providers)		Schuylkill County PA,	Tristan@youthmovepa.org
Tina Scott	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Dr. Tina Scott LPC LLC	Delaware County PA,	therapywithdrtina@gmail.com
Jim Sharp	Providers	Rehabilitation and Community Providers Association	Dauphin County PA,	jsharp@paproviders.org
Karan Steele	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Westmoreland County PA,	karan.steele@beaconhealthoptions.com
Jill Stemple	State Employees	Pennsylvania Department of Human Services	Dauphin County PA,	jistemple@pa.gov
Michael Stolarik	Providers		Bucks County PA,	michael.stolarik@rhd.org
Michael Turk	Providers		Allegheny County PA,	turkma@comcast.net
Jill Valiant	Providers	Penn Foundation, Inc.	Bucks County PA,	jill.valiant@sluhn.org

Becky Van de Groef	Providers		Adams County PA,	rvandergroef@hoffmanhomes.com
Jackie Weaknecht	State Employees	PA Commission on Crime and Delinquency	Dauphin County PA,	jweaknecht@pa.gov
Mary Victoria Woodward	Providers	Naticoke/Berwick Counseling Services	Luzerne County PA,	mostvalwoman@yahoo.com

Footnotes:

State Education Agency- Dana Milakovic (PA Department of Education)

State Vocational Rehabilitation Agency- Kimberly Gerlach (Pa Department of Labor and Industry, Office of Vocational Rehabilitation)

State Criminal Justice Agency- Jackie Weaknect (Pennsylvania Commission on Crime and Delinquency)

State Housing Agency- Beth Ellis (DHS Housing Lead Staff)

State Social Services Agency- Amanda Dorris (DHS Office of Children, Youth, and Families)

State Health (MH) Agency- Jill Stemple (DHS Office of Mental Health and Substance Abuse Services)

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2022 End Year: 2023

Type of Membership	Number	Percentage
Total Membership	**59**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	10	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	7	
Parents of children with SED/SUD*	6	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	7	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**30**	**50.85%**
State Employees	11	
Providers	18	
Vacancies	0	
Total State Employees & Providers	**29**	**49.15%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	8	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	9	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**17**	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

The Pennsylvania Mental Health Planning Council (MHPC) works throughout the year, meeting once each quarter, to provide feedback to the state on the behavioral health system and is highly focused on recovery and resiliency oriented services. For the development of this plan the MHPC, which is comprised of three age group specific committees (Children, Adult, and Older Adult), selected up to three representatives to form a workgroup focusing on the Community Mental Health Services Block Grant Application. In particular, the MHPC CMHSBG Application Workgroup focused on reviewing the current CMHSBG priorities and providing the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) with recommendations for updating in the current application. This workgroup met throughout the Spring of 2020 and presented their recommendations to the larger MHPC at the

May 18, 2021 Quarterly meeting. Documentation of the workgroup's meetings (agenda and outcomes) are attached. OMHSAS Subject Matter Experts and Data staff participated throughout the workgroup process to provide the MHPC Workgroup relevant information on program areas as needed.

Footnotes:

OMHSAS and the MHPC Leadership strive to ensure the council is as representative of the population served as possible. Members range in age from 26-76, five members identify as military veterans, 7 members identify as part of the LGBTQIA+ community, and 9 members identify as having received SUD services. Of the 29 members who are professionals and state employees, 14 members identify also having lived experience.

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? ○ Yes ○ No

b) Posting of the plan on the web for public comment? ○ Yes ○ No

If yes, provide URL:

c) Other (e.g. public service announcements, print media) ○ Yes ○ No

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes: