Pennsylvania

UNIFORM APPLICATION
FY 2020/2021 Community Mental Health Services Block Grant Plan

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 07/19/2019 9.49.21 AM)

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

State Information

State Information

Plan Year

Start Year 2020

End Year 2021

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 Valerie

Last Name Vicari

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

Mailing Address PO Box 2675

City Harrisburg

Zip Code 17105

Telephone (717) 705-8167

Fax 717-772-2062

Email Address vavicari@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 Jill

Last Name Stemple

Telephone 717-409-3790

Fax 717-772-7964

Email Address jistemple@pa.gov

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

Footnotes:

COMMONWEALTH OF PENNSYLVANIA
OFFICE OF THE GOVERNOR

July 12, 2019

Ms. Odessa Crocker
Supervisory Grant Management Specialist
Substance Abuse and Mental Health Services Administration
Office of Financial Resources
Division of Grants Management
5600 Fishers Lane
Rockville, Maryland 20850

Dear Ms. Crocker:

The purpose of this correspondence is to formally designate Ms. Valerie Vicari, Acting Deputy Secretary for the Office of Mental Health and Substance Abuse Services, Department of Human Services, to sign on my behalf the set of agreements that certify Pennsylvania's compliance with the requirements for receiving grant funds under the Center for Mental Health Services' Community Mental Health Services Block Grant Program. This authorization is valid until it is modified or revoked.

Thank you for your attention to this matter.

Sincerely,

Tom Wolf

TOM WOLF
Governor

State Information

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

Fiscal Year 2020

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

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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.
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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.
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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: Valerie Vicari

Signature of CEO or Designee[1]: _____

Title: Acting 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.

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

Footnotes:

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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: Valerie Arkoosh

Signature of CEO or Designee[1]: _____

Title: Acting Deputy Secretary Date Signed: 07/08/2019
mm/dd/yyyy

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

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

Valerie Vicari

Title

Acting 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

Valerie Vicari

Title

Acting Deputy Secretary

Organization

DHS- Office of Mental Health and Substance Abuse Services

Signature: [signature] Date: 7/8/19

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, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system 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 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

FY20-21 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.

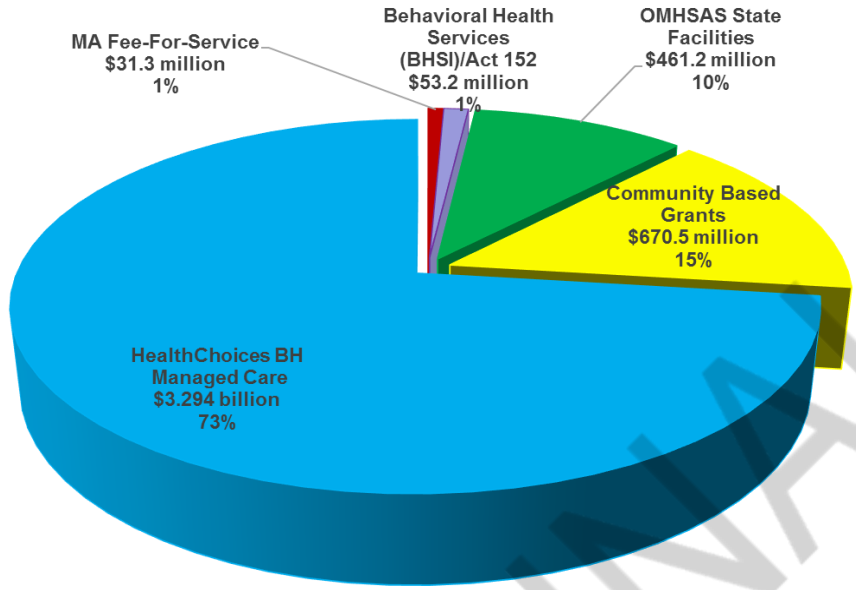
Role of State Government

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. The various program offices under DHS include:

- OMHSAS
- 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)

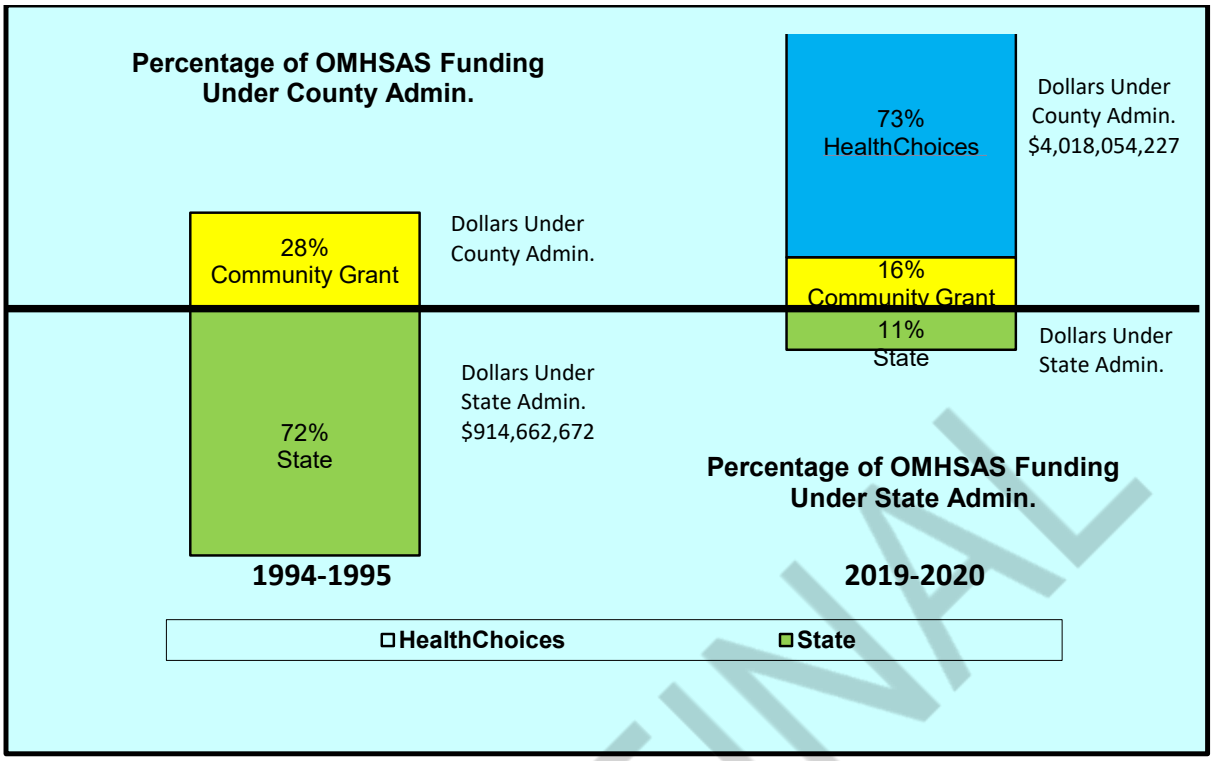
Through OMHSAS, the state develops programs and policy, licenses most of the service components, allocates funds for services, and develops guidelines for county service planning. OMHSAS administers behavioral health Medicaid, community mental health funds, Behavioral Health Services Initiative (BHSI) 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 2019/20 budget for behavioral health is $4.510 billion in state and federal dollars.



Total Funding: $4.510 billion

Additionally, as shown in the chart below, over the last two decades, 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.



Services for Children

The Bureau of Children's Behavioral Health Services (hereafter known as the 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 provides 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 2200 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 PA, 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 Departments of Aging, Corrections, Education, Drug & Alcohol, and Health, as well as the Office of Vocational Rehabilitation within the Department of Labor and Industry. 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. The State's Mental Health Planning Council is comprised of three distinct committees for adults, older adults, and children, as well as a subcommittee for persons in recovery.

State Mental Hospitals

OMHSAS directly operates six state mental 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 with special needs whose needs cannot be met by other community nursing facilities. Children and adolescents are not served in state hospitals. 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 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 closure of Allentown State Hospital in December 2010 is a continuation of the State's plan to create a more unified approach to funding community services and supports for those living with mental illness.

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, in January 2017, the state announced the plans to convert Norristown State Hospital's (NSH) campus into Southeast Forensic Treatment Center (SEFTC) over the course of 18 to 24 months. This plan is intended to improve and broaden the existing forensic services at NSH by repurposing current civil beds into transitional beds for individuals with remaining criminal justice oversight. OMHSAS will use person-centered service plans to either discharge individuals who can safely move to community-based service alternatives, or transfer them to Wernersville State Hospital.

Role of Counties

The Mental Health and Mental Retardation (MH/ID) Act of 1966 requires county governments to provide community mental health services, including short-term inpatient treatment, partial hospitalization, outpatient care, emergency services, specialized rehabilitation training, vocational rehabilitation, and residential arrangements. 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/MR 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/MR programs use to provide services to their consumers. 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 like Assertive Community Treatment, the Youth and Family Training Institute, and TA for the development of housing options in the counties.

County Human Services Planning Process

In 2012, as part of Department'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 part, the counties had 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 managed care in the 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 January 1st, 2019, 1.214 million individuals were enrolled in HC-BH, with a projected funding of $3.9 billion in fiscal year 2019/2020.

Community HealthChoices (CHC)

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. When implemented, CHC will improve services for hundreds of thousands of Pennsylvanians. CHC will use managed care organizations (CHC-MCOs) to coordinate physical health and long-term services and supports (LTSS) for participants. CHC will: (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 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). This is new for nursing facility residents and Aging Waiver participants who received behavioral health services through fee-for-service system. CHC-MCOs and BH-MCOs will work together to ensure that all participants receive the coordinated services they need. CHC will be rolled out in geographic zones, beginning in the Southwest of the State in January 2018.

New Initiatives

- OMHSAS drafted revisions to the Psychiatric Rehabilitation Services regulation in order to develop PRS for youth aged 14-17. A revised regulation expected to be promulgated in the next two years.
- OMHSAS is moving the credentialing of Certified Peer Specialists to the Pennsylvania Certification Board (PCB). As of September 1, 2019, in order to provide Medicaid-billable Peer Support Services, a CPS must attain and maintain CPS certification through the PCB.
- OMHSAS has been working with a selected county/joinder to develop a Peer Run Crisis Residential (PRCR) pilot program, with a goal of expanding this service to other counties in the next three years.
- In SFY18-19 OMHSAS provided startup funding to the Pennsylvania Early Intervention Center at the University of Pennsylvania (PEIC), which will support the work of local First Episode Psychosis Programs. In addition to continue providing program evaluation and training support to the statewide FEP Program, PEIC will be working to develop statewide consultation and tele-psychiatry to provide FEP expertise to primary care and psychiatry providers in areas of Pennsylvania without a specialized FEP Program. OMHSAS will continue to provide fiscal support to PEIC as it develops.

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

[The system/services discussed under this criterion apply to both adults as well as children (if the services are age appropriate for children). 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 family members, consumers, 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 his/her desires, choices, strengths and treatment needs.

Call for Change

In July 2004, the OMHSAS Adult Advisory Committee (now called the Mental Health Planning Council/MHPC) 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 November 2005, *A Call for Change*, was presented to the Adult Advisory Committee.

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 it's publication. During SFY18-19, OMHSAS contracted with Technical Assistance Collaborative (TAC) to conduct a series of listening sessions and an electronic survey to gather input from a broad array of stakeholders across Pennsylvania on the status of Pennsylvania's Recovery Oriented Mental Health System. A final draft of *Assessing the Transformation of Pennsylvania's Behavioral Health System* is currently in final draft format and anticipated to be finalized in SFY19-20. Once completed, both OMHSAS and the MHPC will be utilizing the information in this report to set future priorities for the Behavioral Health System.

Available Services: Mental Health and Rehabilitation Services

Medical Assistance for Workers with Disabilities

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 steady increase in the number of individuals with disabilities returning to competitive employment in the community workforce.

Assertive Community Treatment

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. OMHSAS surveys the ACT teams annually to get a graphical snapshot of key performance indicators including employment and inpatient hospitalizations. OMHSAS has sponsored monthly webinars for the ACT team leaders for the past two years on topics of interest to the ACT teams. The goals of the webinars are to enable the ACT teams to obtain more skills and have a forum for discussing issues they face in order to help them improve the service they deliver to individuals. OMHSAS also worked with one of the lead ACT experts in the country on a customized live interaction webinar covering ACT 101. The webinar allowed counties and primary contractors to have questions answered and also addressed implementing ACT in rural counties including how the benefits outweigh the costs in these communities. The 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. It is an integral part in helping keep fidelity to the national evidence-based practice of ACT, so OMHSAS arranged for one of the TMACT's original creators to provide a training on this fidelity tool. Additionally, OMHSAS sponsored a webinar series on the evidenced-based Individual Placement and Support model of Supported Employment for the ACT team leaders and vocational specialists.

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

Outpatient Services

Outpatient services are treatment-oriented services provided to consumers 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 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 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.

Mental Health Crisis Intervention (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 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 a consumer 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.

OMHSAS was the recipient of a Transformation Transfer Initiative (TTI) grant to infuse peer specialists into crisis intervention services. OMHSAS partnered with the Pennsylvania Peer Support Coalition to develop a three-day training for Certified Peer Specialist who are interested in working in the crisis intervention field. The training is delivered by the Pennsylvania Peer Support Coalition across the state. The curriculum includes introduction to crisis services, professional development, communication skills, suicide prevention/intervention, and self-care modules. Each attendee receives a participant manual with written materials, work sheets for skill building activities, and additional resources.

OMHSAS continues to review the current emergency services/crisis intervention system to ensure services and resources are available to individuals and their families. In Fiscal year 2018-2019, OMHSAS released a request for applications to all counties interested in developing a Peer Run Crisis Residential program. Peer Run Crisis Residential (PRCR) programs, often referred to as crisis respite programs, are an emerging form of acute crisis residential services that are completely staffed by persons with lived mental health recovery experience. The PRCR will provide temporary residential services to support individuals experiencing emotional distress or an emergent crisis situation in a home-like environment. OMHSAS is currently working with a four-county joinder in the Central region of the state to operationalize this program. The PRCR will serve individuals who are 18 years of age or older experiencing a mental health crisis with a maximum capacity of three individuals. The program will be staffed by Certified Peer Specialists and provide Peer Support Services that are trauma-informed based upon individual need.

Rehabilitation Service

Pennsylvania Psychiatric Rehabilitation Services (PRS) operate under Chapter 5230 the PRS Regulation promulgated in 2013. PRS has expanded from 22 licensed providers in 2005, to 116 licensed providers with 28 satellite locations at the present time. 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 are 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 also has 41 Fairweather lodges (FWL) which adhere to Fairweather lodge fidelity standards and participate in national outcome reporting. In 2016 OMHSAS assembled a FWL expansion team to develop FWLs for veterans and homeless veterans with serious mental illness and co-occurring substance use disorders. The team has developed 3 veteran specific lodges. A manual for Fairweather Training Lodges was created out of this project. This new resource is designed to help FWL coordinators prepare individuals for lodge life and provides many activities that the lodge can do together to help lodge members develop skills and find employment. Pennsylvania will host the National Fairweather Lodge Conference in the Harrisburg area in September of 2019.

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 if the right job and work environment is available. The goal 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 hopes to offer a State Plan Amendment to add Psychiatric Rehabilitation Services (PRS) as a Medicaid reimbursable service in both Managed Care and Fee-for-Service. The expansion of this service will provide a resource for individuals with SMI to develop job skills at their own pace and have support throughout the process. OMHSAS has drafted regulations for expansion of psychiatric rehabilitation services to accommodate the needs of youth and young adults.

OMHSAS is emphasizing training and certification to increase the number of Certified Peer Specialists (CPS), including additional sub-specializations for young adults and older adults. The goal is to increase the employment rate of CPS and continue to increase this work force.

OMHSAS is 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

DHS Five Year Affordable Housing Strategy

The DHS Five-Year Affordable Housing Strategy, released in May 2016, in partnership with Pennsylvania Housing Finance Agency and DCED, is a comprehensive plan to connect Pennsylvanians to affordable, integrated and supportive housing. It has since been updated and titled *Supporting Pennsylvanians Through Housing: 2017-18 Update*. DHS will leverage internal and external resources and collaborate with all levels of government and private agencies to make housing resources and services more accessible and available to a wide range of individuals served by DHS, which include:

- Individuals who live in institutions but could live in the community with housing services and supports
- Individuals and families who experience homelessness or are at-risk of homelessness
- Individuals who have extremely low incomes and are rent-burdened

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 consumer needs for housing by increasing the number of 811 apartments from 100 to 250. As of June 18, 2019, ____ three hundred and thirty-six (336) units have been created, which exceeds the goal.
- Deploy 300 units of public housing or Housing Choice Vouchers that Public Housing Authority partners committed in support of the 811program. As of June 18, 2019, three hundred and sixty-one (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.

- Sustain and increase funding by MCOs, health systems, government entities, and philanthropic organizations. In 2019, the Pennsylvania Departments of Drug and Alcohol Programs and Human Services awarded $15 million in federal SAMHSA grants for a new program to provide case management and housing support services for Pennsylvanians with an opioid used disorder. The sixteen pilot programs will assist individuals as they become and remain engaged in evidence-based treatment programs and will provide individuals with support services such as pre-tenancy and tenancy education services to maintain stable housing.

Since 2016, the number of regional housing coordinators has expanded eleven and a "team approach" has been implemented, providing a team of 3 to 4 regional housing coordinators per region (3 regions) along with a dedicated manager to better coordinate and direct their efforts regionally and statewide. Below is an overview of how the RHC role has expanded across PA DHS mental health and intellectual disabilities systems as provided by the Self-Determination Housing Project of Pennsylvania:

- 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 HUD, 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.

Permanent Supportive Housing

Pennsylvania's Department of Human Services (DHS), Office of Mental Health and Substance Abuse Services (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. Over the past ten years, this initiative has been

instrumental in County MH/IDD/SA and HealthChoices programs adopting County Program Housing Plans that in turn have led to the creation of exemplary housing programs across the state with participation from qualified housing organizations, consumers, providers and stakeholders.

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. Permanent Supportive Housing (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. It provides the opportunity for consumers to live in more integrated settings which are essential to their quality of life and community sustainability. Based on repeated cost comparisons, it enables Counties to reduce costs of 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.

Nearly all counties (66 of 67 counties) have made Reinvestment resources (capitation savings) available as part of the OMHSAS PSH strategy. OMHSAS has focused this initiative on the development of integrated housing which is typically either: scattered, clustered or single site housing such as shared housing, with three or less consumers living in a single-family setting or rental unit. 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 (originally issued November 27, 2006)*.

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, a **housing clearinghouse** to manage outreach and referral to PSH options, **housing support services** and **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. While OMHSAS and Counties take many steps to assure

housing meets this standard, it is difficult to find affordable housing in most Pennsylvania communities. 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%. With counties in Marcellus Shale impacted areas, rents are going up faster along with a notable decrease in the availability of any housing regardless of its cost or suitability. In the *State of the Nation's Housing-2017* report, the number of units costing over $2,000 per month jumped by 1.5 million and rental units less than $800 per month have declined. Also significant, 75% of renter households who meet income eligibility for rental assistance don't receive it. Counties are continually challenged by the lack of affordable housing in their area. The Pennsylvania Housing and Affordability and Rehabilitation Enhancement (PHARE) Act 105 of 201 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. Counties and their partners apply for funding to meet the needs of their communities through the PHARE if eligible specific to: Marcellus Shale Fund, Realty Transfer Tax Fund and National Housing Trust Fund.

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, and (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. Although supportive housing continues to be a pressing need identified by most Counties in Pennsylvania, county programs continue to develop and expand PSH through various partnerships and strategies to leverage funding. 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.

From August 2017 through June 2019, a total of $9,245,101 was allocated into the 7 categories of funding for PSH (not including the "other" category). Housing Support Services, Capital and Bridge Subsidy had the largest allotments totaling $7,013,885 combined.

The below chart 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 ($3,901,863)	$4,382,897
Total	**$170,767,094**

Through various partnerships at the federal, state and local level, with funding opportunities available, PSH will continue to grow in the Commonwealth. The Project Based Operating Assistance Program is a partnership between PHFA, OMHSAS and three participating County MH/ID programs. As of January 8, 2019, more than 88 properties (some with several owners of scattered sites) were engaged and 206 consumers have been accepted into housing through this program since 2008. The 811 PRA program is another example of collaborating partnerships at the federal, state and local level. The U.S Department of Housing and Urban Development provides the 811 grant to PHFA (the grantee) who partners with PA's Department of Human Services as the State Medicaid Agency. Other partners at the state and local level include: participating property owners, Self-Determination Housing Project (Regional Housing Coordinators), Local Lead Agencies, Public Housing Authorities and service providers. As of, June 18, 2019 54 Rental Assistance Contracts have been signed with 336 Committed 811 PRA units and 361Housing Choice Voucher (HCV) Commitments. A total of 266 consumers have moved into 811 PRA units successfully using 811 PRA funding (117) or HCV (149). Seventy-nine of the 117 consumers who moved in using the 811 PRA funding are individuals with serious mental illness.

Fairweather Lodge

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.

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).

Administrative Case Management
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

Targeted Case Management
TCM is provided in the Commonwealth of Pennsylvania to adults with severe and persistent mental illness (SPMI) 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 SPMI 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 sSPMI 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 and 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 institutes Drexel University Behavioral Health Education and Western Psychiatric Institute and Clinic provide 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.

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. The Department was funded and implemented in Fiscal Year 2012/13 state budget. The Department 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. The Department 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 the Department of Human Services, 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, Third Edition 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.

Services for Persons with Co-Occurring (Substance Abuse/Mental Health) Disorders

Co-occurring services continue to be supported the Department of Human Services, Office of Mental Health and Substance Abuse Services 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 American Society of Addiction Medicine (ASAM) criteria for placement, the bulletin is in the process of being revised for consistency with ASAM criteria. This is a joint initiative with the 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 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 December 2018, 2.618 million individuals were enrolled in Pennsylvania's Behavioral Health Medicaid Managed Care 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, etc.

- **Prescription Drugs**

- **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** like 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 "General Assistance (GA-MA). Individuals who do not qualify for Medicaid due to certain reasons other than the income limits 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

Certified Community Behavioral Health Clinics (CCBHC) - Section 223 of the Protecting Access to Medicare Act of 2014, created a two-year demonstration program for states to certify community behavioral health clinics. Certified clinics must meet specific criteria emphasizing high-quality care. In 2015, 24 states received planning grants to help them prepare for the demonstration programs. After receiving a planning grant, Pennsylvania worked with stakeholders to develop and submit an application to participate in the demonstration. The demonstration is part of a comprehensive effort to integrate behavioral health with physical health care, increase consistent use of evidence-based practices, and improve access to high-quality care for people with mental health and substance use disorders.

Pennsylvania began implementation in July 2017 as one of eight states selected to participate in the two-year Medicaid Demonstration. Under the demonstration, seven clinics will be

implementing a comprehensive array of behavioral and physical health services. Service recipients will benefit from increased access and availability of high-quality services resulting in improved health outcomes and quality of life. The clinics are located in Allegheny, Berks, Clearfield, Jefferson, McKean, Montgomery and Philadelphia Counties. The clinics are paid with an alternative payment day rate for all services provided. The selected clinics will gather and submit data to evaluate quality of services and individual consumer outcomes. The 21 quality measures collected through sources such as program records, Medicaid claims, managed care encounter data, and clinic cost reports will be utilized to evaluate the outcomes of the Demonstration. Pennsylvania plans to utilize information gained from the evaluation to inform broader quality improvements to the behavioral health services.

The CCBHC required measures for demonstration year (DY) 1 are not available at this writing as they must be submitted later to SAMHSA. However, the process measures tracked by the CCBHCs indicate that 19,379 individuals received at least one core service and the average number of days from the initial CCBHC until the initial evaluation was 8.5 days. All clinics (7/7) provided evidenced based practices (EBP). The highest delivered EBP as a percentage of CCBHC members receiving one core service was cognitive behavioral therapy (CBT, 43.8%) and trauma-focused interventions (5.8%). Eighty-one percent (81%) of CCBHC members with a positive depression screening had a documented follow-up plan in their record the same day. The members surveyed indicated that greater than or equal to 80% thought that their CCBHC was convenient, the appointments timely and available and were satisfied by the providers services.

The federal funding for the CCBHC Demonstration is ending as of 7/1/19. At this writing, continued funding is an open question with bills pending in Congress. As a primarily managed care state, OMHSAS is allowing the Primary Contractors and the BH-MCOs to determine whether the model meets the needs of their members and how they will find the providers for the delivery of their services.

Support Services

Suicide Prevention

Pennsylvania follows the National Action Alliance for Suicide Prevention's National Strategy (2012) in advancing suicide prevention throughout the Commonwealth and is presently in the process of revising a new statewide suicide prevention plan to take effect in 2020. This plan will govern the work of the state's suicide prevention activities involving multiple state offices including the Department of Aging, Department of Corrections, Department of Health, and Department of Education, as well as key stakeholder groups throughout the state including Prevent Suicide PA. To date, Pennsylvania has had separate Adult/Older Adult (2014) and Youth (2016) state plans. Efforts to revise and update the Pennsylvania state plan will continue to follow the National Strategy, but will integrate both the adult/older adult and youth initiatives with a set of unified goals and objectives.

In June of 2017, the creation of, Prevent Suicide PA (PSPA), was announced. A result of the merging of the Pennsylvania Adult/Older Adult Suicide Prevention Coalition and the Pennsylvania Youth Suicide Prevention Initiative (PAYSPI), Prevent Suicide PA will now serve as the statewide suicide prevention organization. A Board of Directors has been appointed, and an Executive Director has been hired.

Through statewide efforts, there were hundreds of suicide prevention gatekeeper trainings (e.g., Question-Persuade-Refer; QPR) conducted in the past year, with over 5,000 individuals trained. In May 2019, Prevent Suicide PA held their third annual Statewide Suicide Prevention Conference. Several of the breakouts sessions at the conference addressed Pennsylvania's high rate of suicide among our Veterans. In addition to trainings and education opportunities throughout the state, Prevent Suicide PA sponsored four large-scale suicide awareness nights in 2019 with the following sports teams: the Harrisburg Senators, the Philadelphia Phillies, the Pittsburgh Pirates, and the Hershey Bears. Prevent Suicide PA also developed website with information on resources, information and trainings available to Pennsylvania's citizenry and has created a PSA which interviews survivors of suicide.

In September of 2014 Pennsylvania was awarded a federal Garrett Lee Smith youth suicide prevention grant which focused on training, screening, and awareness in schools and colleges throughout the Commonwealth. The 5-year grant, Suicide Prevention in Schools and Colleges, was awarded by SAMHSA and provided Pennsylvania with $3.5+ million dollars to promote state-wide, systems-level change to advance suicide prevention efforts across the state, in close partnership with the Student Assistance Program (SAP) that is required in all schools. The grant ends in September 2019. To date, 64 Pennsylvania counties (95% of counties) have implemented youth suicide prevention activities in partnership with this project. Over 20,000 individuals have received training, and over 18,000 youth have been screened using a validated screening tool provided by the grant. The Higher Education Suicide Prevention Coalition (HESPC) was established in Year 1 of the project and has engaged over 50% of the 181 campuses since its inception. The grant project has also worked to sustain training efforts through the development of the Suicide Prevention Online Learning Center, which launched in December 2017 and has had over 6,000 registered users to date.

Pennsylvania's Office of Mental Health and Substance Abuse Services (OMHSAS) has also worked to improve partnerships with national crisis resources, including the National Suicide Prevention Lifeline and Crisis Text Line. OMHSAS is actively working to support the expansion of the number of county crisis centers that affiliate with the Lifeline to increase the in-state answer rate for Pennsylvania, which is presently at 37%. Additionally, OMHSAS established a 'keyword partnership' with Crisis Text Line to access aggregate data on users and trends.

On May 29, 2019, Governor Tom Wolf announced a "first-of-its-kind, statewide Suicide Prevention Task Force" which will merge siloed efforts into one, statewide suicide prevention plan. 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 will come together, bringing their diverse perspectives and experiences, in order to create a unified plan. The first official monthly meeting of the task force will be held on July 10, 2019.

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 oneto-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.
The Pennsylvania Compeer Coalition received a $45,000 grant from Pennsylvania's Office of Mental Health and Substance Abuse Services (OMHSAS) for the 2018/2019 state fiscal year. The primary purpose of this grant was for the Compeer programs of Pennsylvania to be strengthened through outreach, collaboration, and continued expansion of services to veterans and youth and young adults.

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 their credential to provide training of FPSS in Pennsylvania. 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.

In order to ensure that the implementation of FPSS reflecting the needs of families and other stakeholders, OMHSAS utilized a stakeholder advisory group comprised of a wide variety of interested parties (including MHPC members, family leaders, certified peer specialists, certified recovery specialists, and certified family recovery peer specialists, PA Mental Health Consumer Association, NAMI, provider agencies, PA Care Partnership, Family Organizations, Pennsylvania Certification Board (PCB) and OMHSAS staff). This group also helped develop and distribute the application for the Subject Matter Experts (SME) that are required by the PCB to develop the formal certification. The PCB brought together the SME group in June 2018 to provide input on the FPSS Certification. A group of family leaders and OMHSAS staff was brought together in July 2018 and to review the FPSS Certification draft and provide OMHSAS and the PCB with suggested edits.

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 families 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 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 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 – FPSS provides self-care and maintaining role

The Children's Committee of the OMHSAS Mental Health Planning Council (MHPC) had determined family peer navigators to be a committee priority. 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 priority as having been achieved.

The Children's Committee would like to identify effective, uniform and consistent ways for OMHSAS, counties, managed care companies and community providers to design, deploy and fund these resources in every community through a blend of Medicaid, Reinvestment, Block Grant and other funding streams to support and sustain FPSS in Pennsylvania. OMHSAS concurs with the recommendation of this workgroup and will continue to study FPSS services in order to:

- Promotes wellness, trust and hope;
- Increases communication and informed decision making and self-determination;
- Identifies and develops advocacy skills;
- Promote self-care and wellness/recovery skills;
- Increases access to community resources and the use of formal and natural supports, and;
- Reduces the isolation that family members experience and the stigma of emotional, behavioral and mental health disorders.
- Identify and analyze funding opportunities available to support accessible, sustainable, and scalable family to family support
- Identify and analyze supporting data regarding the efficacy of Family Peer programs
- Identify models (and any associated studies) used throughout the nation that support Family Peer role.

Family Engagement in First Episode Psychosis

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 to be an excellent resource for engaging program participants. 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.

<u>Peer Support Services</u>

Pennsylvania's peer specialist initiative has continued to grow and develop over the past two years. As of June 2019, 5,784 individuals have met the 75-hour training requirement to become Certified Peer Specialists (CPS) and 1,881 individuals have been trained as supervisors of CPS. Pennsylvania currently has the largest cadre of CPS of all states. An estimated 55to 60 percent of CPS are employed either full-time or part-time, primarily in Medicaid–funded peer support services; however, CPS are continuing to find other field-related employment opportunities and opportunities for career advancement. As of June 2019, Pennsylvania has 130 approved and licensed peer support service agencies.

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. The Certified Older Adult Peer Specialist (COAPS) Initiative continues to expand, and 247 individuals have completed the three-day continuing education training and are working with older adults. Other specialize areas of continuing education for CPS includes 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.

On December 12, 2016, OMHSAS issued revised standards for PSS ((http://www.dhs.pa.gov/publications/bulletinsearch/bulletinselected/index.htm?bn=OMHSAS-16-12&o=N&po=OMHSAS&id=12/12/2016). The revision 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. Eight individuals (2 from out-of-state) successfully completed the 10-day (75 hour class with certification test) modified CPS training for individuals who are deaf. Another training for deaf peers is being planned for late 2019.

Over the past two years, Pennsylvania has taken the steps necessary to place credentialing of Certified Peer Specialists under the Pennsylvania Certification Board (PCB). Certification identifies professionals who are specialists in a field, provides public protection and a grievance process for those harmed, and is based on industry standards and evidence-based practices. Prior to September 1, 2019, Medicaid-billable PSS is provided by CPSs who complete a CPS training curriculum delivered by one of two approved vendors. 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 June 2019, over 2,030 CPS had already been certified by the PCB during the 18-month grandparenting period. Pennsylvania will issue revised standards for PSS that reflect this change in the certification process and oversight.

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. This PRCR pilot 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 pilot will be licensed as a modified crisis residential program, and PRCR service will be MA-billable. The PRCR pilot is anticipated to begin serving individuals by September 2019. Pennsylvania will

continue to work with the county/joinder towards fiscal and programmatic sustainability of the PRCR pilot in FY19-20, 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. An OMHSAS CLC workgroup, with representation from central office, the state hospitals, and the regional field offices, has been established to pursue continued improvement of CLC services. The overarching goal of the CLC workgroup is to ensure that all counties are working towards increased CLC and utilizing the Culturally and Linguistically Appropriate Services (CLAS) Standards in order to offer the most appropriate CLC services and supports for their local population.

The workgroup identified a need to obtain baseline data regarding the status of CLC services across the state as an important step in planning. Strategies to develop this baseline data included expanding CLC Reporting from the Counties as a part of the Human Services Planning Process, expanding a CLC survey formerly utilized in System of Care counties to all counties statewide, and a separate CLC Self-Assessment Survey specific to OMHSAS Staff.

As a result of the information gathered through the Human Services Planning Process and the public and internal surveys, it was determined that there was a need for broad training around CLC for the mental health system, including OMHSAS staff. During SFY18-19 OMHSAS partnered with National Center for Cultural Competence at Georgetown University to provide CLC Training for the Behavioral Health System and Technical Assistance to OMHSAS. The professional development sessions are designed for leadership of behavioral health services in Pennsylvania to enhance their capacity to deliver culturally and linguistically competent care to individuals and families across the life span. OMHSAS will continue to prioritize increasing the knowledge and practice of CLC throughout the behavioral health system. The CLC Workgroup will be developing a plan to implement recommendations from the Georgetown Training and Technical Assistance in the coming year.

LGBTQIA+

In addition, OMHSAS recognizes the behavioral health disparities for the LGBTQIA+ population. In SFY18-19 OMHSAS partnered with the Gender and Sexuality Development Clinic at the Children's Hospital of Philadelphia (CHOP) to offer training to providers within the Behavioral Health System to better serve individuals who are transgender or non-binary. Three webinars were offered as well as 8 in-person sessions (2 per state region). Every training reached maximum capacity with substantial waitlists. Based on this, OMHSAS is planning to continue the partnership with CHOP SFY19-20 for additional in person trainings and more advanced webinars.

Keystone Pride Recovery Initiative (KPRI) was organized in 2008 with the mission to protect LGBTQI 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 are in the process of developing 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.

SERG Grant for Puerto Rican Evacuees

OMHSAS received a Supplemental Emergency Response Grant (SERG) fund during FY2018-2019. PA SERG efforts are designed to eliminate cultural and linguistic barriers to emergency mental health and substance abuse needs of evacuees, who relocated as a direct consequence of the 2017 Hurricanes that devastated Puerto Rico and surrounding territories.

Not only were there financial limitations, but there were also cultural, language, resource and documentation barriers. According to FEMA Disaster Assistance Region 3 reports, PA far outweighed both the next largest state's number of relocating families and overall number of household members, 1465 vs 256 and 3453 vs 481 respectively. The same report shows PA had 1129 applicants eligible for Transitional Shelter Allowance (TSA). TSA, even with multiple extensions, formally ends August 30, 2018, shifting financial and housing needs directly back to local and State agencies, whose resources are maxed similarly to those of the PA School System.

In addition to the financial strain on both the families of receiving relatives and the local schools, the effects of associated psychosocial stress have been identified. Language, cultural, resource and documentation barriers too easily lead to inability to obtain employment and/or meet basic needs. Inability to cope can lead to mental health issues, substance abuse, or both. As SAMHSA notes, Adverse Childhood Experiences "are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan….". The ability of educational staff to identify and effectively link children and families to appropriate resources is paramount for long-term stability.

Multiple agencies and academic, geographic and cultural jurisdictions were simultaneously significantly taxed. As the situation evolved, initial individual responses from these agencies and jurisdictions were occurring without organized statewide support. Eventually, the Pennsylvania Department of State organized multiple traveling resource fairs in impacted areas of the commonwealth. While these were helpful, there were still aspects of services what were left unanswered.

PA SERG efforts focus on public education on stress management and crisis mental health, public education on substance abuse prevention, information and referral sources, training and provider support, workforce/professional development, and marketing of available services.

Forensic Services

In partnership with Pennsylvania Mental Health Consumers Association (PMHCA) and Drexel University, OMHSAS developed a forensic peer support curriculum and trained 162 individuals throughout the state. In addition, a total of 43 individuals have been trained as trainers and 5 advanced level facilitators. In collaboration with Pennsylvania Department of Corrections (DoC), a curriculum for Certified Peer Specialist (CPS) training has been developed. Through grant funding, over 600 incarcerated individuals have been trained as Certified Peer Specialists and more than 400 are currently working in the State Correctional Institutions statewide as a CPS. Upon completion of grant funding, DOC has continued to support the CPS program by providing budgetary support for the effort. DOC continues to train incarcerated individuals on a regular basis and provide ongoing employment within the institutions for CPS.

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 34 of 67 PA counties have signed a Stepping Up Resolution.

U.S. Department of Justice's Bureau of Justice Assistance selected PA 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. Through this pilot project, CSG Justice Center will engage PA leaders in a collaborative planning process to identify ways for the state to support local jurisdictions in reducing the number of people with mental illnesses in the criminal justice system. The resulting action plan will inform broader strategic planning efforts for the MHJAC. The three proposed components of the planning process are: 1. Conduct a high-

level scan of state criminal justice and behavioral health policies, practices, and resources related to factors that often contribute to having large numbers of people with mental illnesses in local criminal justice systems; 2. Identify priorities and goals by examining the scan findings and determining priority areas of focus that have the greatest potential impact on reducing the number of people with mental illnesses in local criminal justice systems; 3. Develop an action plan to identify concrete action steps to make progress towards the goals established.

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. To date 1242 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.

The Reentry Committee of the Forensic Interagency Task Force (FITF) was established in September 2015. In Pennsylvania, the Department of Corrections and the Counties MH/ID that manage the treatment and support services for persons with mental health and substance abuse disorders have worked closely together to address reentry planning for many years with particular attention to persons with serious mental illness who are completing their maximum sentence. The Reentry Committee supported the importance of this historical connection and provided a structure for continued collaboration and coordination to identify needs and make recommendations for next steps. The Rentry Committee presented a final report to FITF on November 22, 2016 and FIFT accepted the recommendations of the report for 2017. Efforts continue in bimonthly overall FITF meetings to explore potential remedies to streamline the reentry process.

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 an in-plan Medicaid 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 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 (CHIPP) and other funding sources.

Community/Hospital Program Project

The Community/Hospital Program Project (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.

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 worth of startup funding.

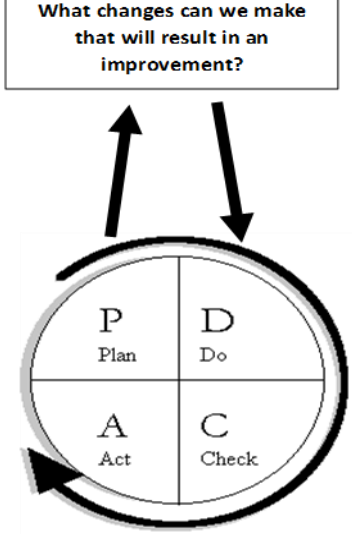
History of CHIPPs

- CHIPP builds community capacity and infrastructure through transition of funds to meet consumer needs in the community.
- 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 December 2016, hospital census for the six state hospitals was 1092 in civil, 228 in forensic, 147 in long term care (South Mountain) and 46 in the ACT 21 program; total for all levels of care 1503. This signifies a decrease of 57 from the census (1560) from December 2013. At that time civil census was 1160, forensic 132, long term care 141 and ACT 21, 38
- More than 87% of the state mental health budget is now spent on community- based services.
- With the closure of Allentown State Hospital in December 2010, only six state hospitals remain in Pennsylvania.
- Through CHIPP-funded opportunities, 3551 people have been discharged since inception
- The CHIPP/SIPP funding for SFY18-19 is $284 million.

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 2019 Medical Assistance Quality Strategy for Pennsylvania is being written now between programs and will be submitted to the Centers for Medicare and Medicaid Services (CMS) for approval in 2020. This will allow OMHSAS to position itself with respect to the goals, principles and values of DHS, and 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 measurement years 2014-2017 calendar years (CYs) are as follows:

Statewide averages (%)

Performance Measures	2014	2015	2016	2017
Follow up after Hospitalization for Mental Illness-7 days (HEDIS®) (QI-1)[1] ages 6 and above	47.2	45.5	43.5	39.1
Follow up after Hospitalization for Mental Illness-30 days (HEDIS®) (QI-2)[2] ages 6 and above	67.4	65.8	63.2	60.6
PA Specific Follow up after Hospitalization for Mental Illness-7 days (PA Specific Measure) [3] (QI-A) ages 6 and above	58.5	56.6	53.8	52.2
PA Specific Follow up after Hospitalization for Mental Illness-30 days (PA Specific Measure) [4] (QI-B) ages 6 and above	74.8	73	70.4	69.6
Readmission within 30 Days of an Inpatient Psychiatric Discharge (REA)	14.3	14.0	13.9	13.4
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)[5]	Initiation 30.3	27.5	30.5	46.3
	Engagement 20.5	19.5	26.0	34.6

The Statewide rate average results shows that:

- Follow-up after a Mental Health Hospitalization-statistically significant rate decreases for measures QI 1, QI 2, QI-A and QI-B between years 2014 -2017. (In this measure, a rate increase is good.)

- Readmission within 30 days of an Inpatient Psychiatric Discharge (REA)-no significant rate decrease was noted when comparing 2015 REA rates to 2014. However, a statistically significant rate decrease occurred when 2017 was compared to 2016 in CYs 2014-2017. (In this measure, a rate decrease is good).

- The IET measure shows a:

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

- statistically significant rate decrease in initiation when 2015 was compared to 2014 and a statistically significant rate increase in initiation when 2017 was compared to 2016 in initiation. (In this measure, a rate increase is good.)

- statistically significant rate decrease in engagement when 2015 was compared to 2014 and a statistically significant rate increase in engagement when 2017 was compared to 2016. (In this measure, a rate increase is good.)

- The External Quality Review validated rates for 2018 are not available at this time for reporting.

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 organization's (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).[6]

<u>2017 Performance Measure Goal Requirement</u>

[6] 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.

The following activities listed below describe five key components of quality improvement: goals, interventions, metrics, targets, transparency and feedback[7] as related to the new performance goal requirements for QI-1(ages 6 and above) and QI-2 (ages 6 and above).

Quality Activities	Goals	Intervention	Metrics	Targets	Transparency & Feedback
Performance Measurement reporting QI-1 and QI-2	Yearly Goal setting for HCBH Primary Contractors and BH-MCOs	BH-MCO Root Cause Analysis triggered by performance falling below the 75th Percentile on the HEDIS® MCO Medicaid reporting	Follow-up After Hospitalization for Mental Illness within Seven and Thirty Days After Discharge	Target based 75th Percentile on the HEDIS® Quality Compass MCO Medicaid reporting	The EQRO assesses the compliance of the performance measure protocol Results and compliance posted on DHS website in the BH-MCO BBA Technical Report OMHSAS reports the HCBH Primary Contractor results in the BH-MCO BBA Technical Report

Performance Improvement Project (PIP)

In 2014, OMHSAS ~~s~~elected to improve the Readmission within 30 days of an Inpatient Psychiatric discharge and those readmitted in 30 days of discharge due to a SUD diagnosis for its Performance Improvement Project. All BH-MCOs were required to do the same PIP. Technical Assistance has been provided by the EQRO quarterly since CY 2016 to effectively improve the results and meet this federal requirement.

The following activities listed below describe the five key improvement components to the PIP.

Quality Activities	Goals	Intervention	Metrics	Targets	Transparency & Feedback
PIP project "Successful Transitions from Inpatient Care to Ambulatory Care"	Reduce BH Readmissions and Substance Abuse (SA) Readmissions post-inpatient discharge Increase kept ambulatory follow-up appointments post-inpatient discharge Improve medication adherence post-inpatient discharge	PIP plan interventions as developed from the collaboration between the BH-MCO and the HCBH Primary Contractors specific to BH-MCO barrier analysis	BH Readmission within 30 days of MH inpatient discharge BH Readmission within 30 days of SA inpatient discharge Adherence to Antipsychotic Medications for Individuals with Schizophrenia Components of Discharge Management Planning	Improvement targets set by selected process measures; ~~and~~ PIP measures; and reassessment of the implementation plan process measures	Meetings held with each BH-MCO separately. Included are the EQRO, OMHSAS, and their HCBH Primary Contractor to review the PIP issues found. (Frequency is TBD.) One QM Directors' meeting a year will be in person and include all BH-MCOs and HCBH

					Primary Contractors to share results across the state. Quarterly/ Yearly PIP Report to EQRO and OMHSAS Compliance results reported in the BH-MCO BBA Technical Report and posted on DHS website

CY 2019 Activities related to Performance Improvement Project (PIP)

The PIP is ending in CY 2019 and a new PIP will start in 2020. A new PIP topic is under consideration by OMHSAS and no decision has been made at this writing.

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:

- **EQRO Focused Study -** Pennsylvania is one of eight states participating in a two-year Certified Community Behavioral Health Clinic (CCBHC) federal demonstration. This project requires the state to report on 13 measures, 9 measures at the CCBHC level, and the aggregate CCBHC level. In addition, there are process measurements reported by each CCBHC enrolled in the demonstration. The demonstration of a continuous quality improvement process by the CCBHCs are required. The CCBHC demonstration is ending 7/1/19 and as a primarily managed care state, OMHSAS allowing the Primary Contractors and the BH-MCOs to determine whether the model meets the needs of their members and how they will find providers for continued delivery of their services.

- **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.

The survey findings are used annually in the National Outcome Measures (NOMs) and Uniform Reporting System (URS) table data reporting required within the Community Mental Health Services Block Grant by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS). The findings are also utilized in various state data reporting, which are made available to internal and external stakeholders.

- **External Quality Review -** The EQR-related activities that must be 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 additional 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** – Annual reviews/quarterly data; results of the reviews entered into a database and summarized; findings used to complete the annual Program Evaluation Performance Summary (PEPS) for each HCBH Primary Contractor /BH-MCO.

- **Behavioral Health Complaints and Grievances Data** – Annual Reviews/Quarterly data; the results of the reviews can be used to track and trend: denied service, grievances, complaints and other problems within the system. The data can also be used to identify problems with Contractor oversight, BH-MCOs and/or providers.

- **Provider Self Report Data - Survey of Providers** – Annual; provides information related to the provider perspective as to how the BH-MCO manages the network. Analysis of 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) –** Annual; Periodic 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 found to be less than full 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 inputting data; and data retrieval for 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.

Behavioral Health Rehabilitation Services

Behavioral Health Rehabilitation Services (BHRS) are individualized, based on the specific needs of the child and family, and built on the strengths of the child and family. Specific BHR services available through Pennsylvania's expanded Medical Assistance Program for children up to age 21 include: mobile therapy, therapeutic staff support, behavioral specialist consultation and other unique services developed for individual children/adolescents. Children must be Medical Assistance eligible and a licensed practitioner must establish medical necessity for services. Interagency teams are utilized to review recommendations and plan services for the child and their family. Children and families must be included in the interagency team meeting. Nearly 68,000 children are served in BHRS each year.

Early Childhood Mental Health

OMHSAS, in collaboration with the Office of Child Development and Early Learning (OCDEL) and the Department of Health has been awarded a Project LAUNCH grant from SAMHSA to promote healthy social-emotional development in young children. A State Young Child Wellness Council has been established, as a subcommittee of the State Early Learning Council. Allegheny Count was selected as the demonstration site due to their commitment to early childhood and their willingness to work with the State. A local Young Child Wellness Council has been established to guide the local LAUNCH effort.

There are 5 Core LAUNCH Strategies: Ensuring young children at risk for poor social/emotional or cognitive outcomes are screened and provided services; Integrating physical health and behavioral health services, Providing Early Childhood Mental Health Consultation in Early Care and Education settings, Providing enhanced Home-visiting, and Family Strengthening and Parent Skill Building.

One of the treatment approaches that will be used is Parent-Child Interaction Therapy (PCIT), an evidence-based practice especially well-suited for work with young children and their families. OMHSAS has been the expansion throughout the Commonwealth of PCIT for the past 5 years. OMHSAS staff are members of a statewide steering committee for a grant from the National Institute of Mental Health that has supported training clinicians from 100 agencies in 60 counties across the state. Behavioral health managed care organizations, and commercial insurers are paying for PCIT.

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 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 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.

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.

Currently there are 12 MST providers serving 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.

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.

There are currently 8 FFT providers serving 12 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/MR 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. Currently, over 600 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 do not require 24-hour care, but do require more intensive and comprehensive services than are offered in outpatient clinic programs. 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 so that they may achieve, remain in school and advance. SAP teams use concrete, observable behaviors to identify student's barriers to learning. SAP team members do not diagnose, treat, or refer to treatment; however they may refer a student for a MH or D&A screening to assess the need for further treatment if needed. 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 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 Intermediate Units). The Regional Coordinators are responsible for the oversight of county SAP operations, as well as of the PA Approved SAP Training Providers, the statewide training network responsible for training school SAP teams. The Regional Staff members are the most direct source of information and SAP coordination at the County level.

73,394 students state wide were referred to school SAP core teams during FY 16/17. Of those students, 23,779 students were referred for drug and alcohol or mental health assessments. Of those students referred for assessment, 20,761 (87.31%) were assessed.

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.

Individualized Education Plans

An Individualized Education Plan (IEP) is a written education program developed for students eligible for special education services. The IEP addresses the student's needs and the educational supports and services required to meet those needs. The IEP is developed by an IEP team consisting of the student's parents, a regular education teacher, a special education teacher, a representative of the local education agency, a person qualified to interpret test results and other findings relevant to their student, and others who may have special knowledge or expertise about the educational services needed by the student. The collaborative efforts between the Departments of Education and Human Services have been promoting the practice of developing the IEP in conjunction with the Interagency Service Plan or Treatment Plan when appropriate for children and adolescents with serious emotional disturbance.

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

Created under the McKinney Act, the Projects for Assistance in Transition from Homelessness (PATH) Program is a federal formula grant that supports service delivery to individuals with serious mental illnesses, as well as individuals with co-occurring substance use disorders, who are homeless or at risk of becoming homeless.

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, are local government entities. 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.

Since 2001, Pennsylvania has employed a full-time State PATH Coordinator (SPC). The SPC oversees all activities related to the PATH program. The SPC monitors county MH/ID programs who receive PATH funds as well as the local programs with whom they sub-contract. Monitoring is done through site visits, quarterly plan review and fiscal reporting, quarterly conference calls, technical assistance and ongoing phone and email contacts, etc.

To further ensure compliance, each county has a County PATH Coordinator. The county PATH coordinators work very closely with the contracted agencies to develop and implement new programs and provide oversight to the existing programs. Thus, Pennsylvania has a two-tiered oversight mechanism, one at the county MH/ID level and another at the state level.

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

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 replaces the previous Homeless Steering Committee for overseeing broader planning responsibilities and coordination of all resources of the state in a manner to best serve the homeless population.

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. DCED and DHS/OMHSAS continue to chair this committee and the State PATH Contact is a member of this team. The HPCC is still in transitional stages and is to meet quarterly.

In 2018, the Governor's Policy Office also established an informal group called Health, Housing and Homelessness to review higher level policy issues related to its namesake on a statewide level. Their work is to parallel that of the Interagency Council to End Homelessness.

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. This includes 33 counties that are part of the Eastern PA CoC, and 20 counties in the Western PA CoC. Each CoC Board has quarterly meetings that are open to "everyone interested in working to prevent and end homelessness. This

includes affordable housing providers, landlords, service providers, employers, law enforcement, health care, clergy, philanthropists, and concerned citizens."

In place of a statewide Coordinated Entry (CE) plan, 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 who would benefit most from it. 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.

By coordinating entry we can prioritize 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

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.

Any local agency that is willing to dedicate time and administrative support to the LHOT may serve as facilitator. In many of the LHOTs, these roles are assumed by the County Mental Health Housing Specialist (who is also usually the county PATH coordinator if the county receives PATH funding). Many of these LHOTS are also involved in their Continuums of Care, thus providing more cooperation between providers and agencies. Technical assistance is provided by OMHSAS for LHOTs and to develop additional LHOTS.

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.

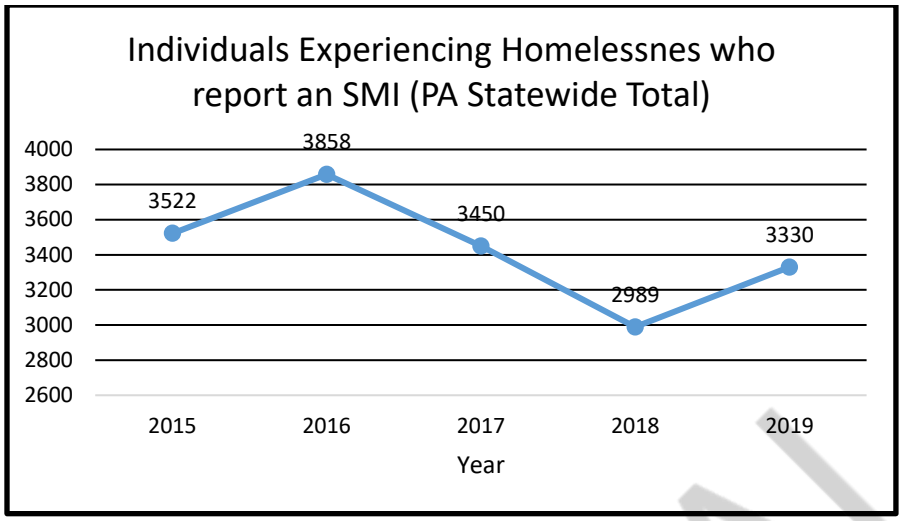
- Promote recovery-oriented housing and services for homeless individuals with serious mental illness, substance abuse and/or co-occurring disorders. PA OMHSAS has embraced the recovery model for the provision of housing and services to individuals served through the mental health system, including homeless 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 - 2019
1. Southeast PA	
Philadelphia County	1,808
Delaware County	90
Montgomery County	63
Bucks County	94
Chester County	58
Total Southeast PA	**2,113**
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	262

Berks County	136
Dauphin County	101
Lackawanna County	67
Lancaster County	80
Luzerne County	23
York County	58
Total Eastern PA	**727**
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	169
Allegheny County	211
Beaver County	16
Erie County	94
Total Western PA	**490**
PA TOTAL HOMELESS WITH SERIOUS MENTAL ILLNESS	**3,330**

The Point-In-Time Count (PIT Count) data was collected on a single night in January 2019 (in most cases January 23, 2019). The number of homeless people with serious mental illness reported for each CoC includes all people with serious mental illness who were in an Emergency Shelter, Transitional Housing, or Safe Haven program and those who were unsheltered on the night of each CoC's 2019 Point-in-Time count. The 2019 PIT Count showed an increase in individuals experiencing homelessness who report SMI, with 341 more individuals reporting SMI than in 2018, an 11% increase over 2018.



There were some changes in the homeless settings that individuals experiencing homelessness with serious mental illness reported from 2018 to 2019, including:

- 14% increase in individuals with a serious mental illness residing in emergency shelter (1480 to 1689)
- 21% decrease in individuals with a serious mental illness residing in transitional housing (644 to 509)
- 22% decrease in individuals residing in unsheltered situations (645 to 502).
    - During the 2019 Point-in-Time Count 80% of all unsheltered individuals with serious mental illness across the state were identified in the Philadelphia CoC (406 out of 502 individuals).
    - Other CoCs reporting significant levels of unsheltered individuals were Delaware County (31), Dauphin County (20), and Allegheny County (13).
    - The remaining 12 CoCs identified less than 10 unsheltered individuals with serious mental illness during the PIT Count.

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.

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. To date, 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 18/19.

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

- Ranked #1 in quality in 2018
- 79 day statewide average for benefit decision (national average of 96 days)

- 58 day average for benefit decision in Philadelphia SOAR program.
- Over 2000 decisions
- Over 1000 approvals
- Top 10 approval rates nationally

PA's SOAR initiative had two great advances SFY18-19. First, utilizing CMHSBG Funding, eighteen SSI/SSDI Outreach, Access and Recover (SOAR) leaders participated in the 2019 Statewide SOAR Leaders Summit. The summit focused on 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 expanding best practices in SOAR as well as synchronizing local lead efforts to assist the SOAR State Lead. Programs represented ranged from newly-funded Continuum of Care efforts, rural endeavors, and Veterans' initiatives, to nationally recognized urban programs. Topics covered included Online Course review, roles and responsibilities of SOAR Local Leads, State and national program updates, effective relationships with SSA, outcomes management, special populations, and SOAR funding/sustainability. In-depth face-to-face discussions from various perspectives led to the unification and reenergizing of all SOAR Local Leads both in their responsibilities and in sustaining and expanding SOAR in PA. As one participant noted, "The resources, perspectives, tools, and shared knowledge everyone provided were extremely beneficial towards, not only our program, but to everyone in the room."

Second, creation of a SOAR database is in the planning stages to be funded through CMHSBG. The database would feature essential SOAR provider information including location, scope of SOAR practice, organization name, and contact information to efficiently match those in need of SOAR Services with proper SOAR resources. Similar information on PATH providers would be included as well to heighten the effectiveness of the data to be queried.

The 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. To date, 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.

Pennsylvania has been able to increase our coordination with Veterans services for SOAR provision over the past two years. The PA SOAR Program has been coordinating with both VA Hospitals and Supportive Services for Veteran Families (SSVF) grantees to provide SOAR training for the who directly serve the Veteran population. To date, Lebanon VA had approximately 24 HUD-VASH Social Workers trained through the SOAR online course and Fundamentals in-person review. One of the staff for the Veterans Multi-Service Center, and SSVF grantee, attended the SOAR Leadership Academy and is now a local lead providing technical assistance and training to other SSVF grantees. This person will also function as the central state representative on the regional SOAR training team. Arrangements are being made to train the remaining VA Hospital and SSVF staff statewide.

Pennsylvania is also seeing an increase in SOAR usage within the Criminal Justice System. Allegheny County Jail continues to expand SOAR efforts as a result of Allegheny County

receiving one of six national technical assistance awards to advance SOAR use in the criminal justice environment. The program has implemented protocols and is progressing. This project will enhance SOAR progress already being made by the Bucks County Jail in the eastern part of the state.

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 2015, nearly 3.4 million residents, or about 27 percent of the state's 12.7 million residents, lived in a rural county. From 2010 to 2015, the rural population in Pennsylvania declined about 1 percent, while the urban population increased by 1.5 percent. From 2000 to 2015, rural Pennsylvania became more racially diverse. In 2000, there were about 157,201 residents, or 5 percent of the total population, who were non-white and/or Hispanic. In 2015, 294,801 rural residents, or 9 percent of the total population, were non-white and/or Hispanic. 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 2014-2015 academic year, an estimated 453,202 students were enrolled in Pennsylvania's rural school districts. From 2010 to 2015, the number of rural students decreased 6 percent; Pennsylvania Department of Education's enrollment projections predict that total enrollment in rural schools will decline by 7 percent from 2010 to 2020.

Data from the U.S. Census Bureau show that, in 2015, 18 percent of the rural population was 65 years old and older compared to 16 percent of the urban population. Also, the number of rural seniors increased by 11 percent during the period 2010 to 2015. It is estimated that by 2040, 25 percent of the total rural population will be 65 years old and older, which means that there will be more senior citizens than children and youth in rural Pennsylvania.

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 2016 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.

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.

First Episode Psychosis in Rural Counties

Prior to FY17-18 all eight of Pennsylvania's First Episode Psychosis Programs were located in primarily urban or large suburban settings. Recognizing the potential disparity this could create for the rural population of the state, OMHSAS chose to prioritize rural areas in the Request for Interest issued for two new First Episode Psychosis Programs in FY 17-18. As a result, a four county Mental Health Joinder (Columbia, Snyder, Montour, Union/CMSU) received funding to develop an FEP Team to serve the four-county area. The CMSU FEP Program has demonstrated excellent results over the past two years. OMHSAS will utilize lessons learned from this program to continue expanding FEP across the state, including additional rural counties.

In addition, OMHSAS provided funding through the CMHSBG to the Pennsylvania Early Intervention Center at the University of Pennsylvania (PEIC) to help support statewide access to FEP services. In addition to existing program evaluation and training that PEIC provides the state, they are in the process of developing tele-psych capacity. This tele-psych program will provide consultation to mental health providers and primary care physicians providing services to FEP Clients in counties without a specialized FEP CSC Team.

Tele-psych

Tele-psych is the use of electronic communication and information technologies to provide or support clinical psychiatric care and psychological care at distance. Tele-psych is a service that has shown to be effective for a variety of settings and particularly, in rural areas. The service *includes psychiatric diagnostic evaluations, psychological evaluation, pharmacology, consultations (with patient/family), and psychotherapy*. These services are provided by a psychiatrist or licensed psychologist within their scope of practice using real-time, two-way interactive audio-video transmission. It is appropriate in situations where on-site services are not available due to distance, location, time of day, or availability of resources.

Currently, Pennsylvania has Tele-psych programs serving all 67 counties, most of which also serve children and adolescents. About 25% only serve adults. The rest serve all populations with 20% specializing in children and adolescents.

Services for Older Adults

Persons aged 65 years and older represent the fastest growing age group in the United States. Estimates of behavioral health disorders in this population range from 15 to 25 percent of the

total population. However, 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.

In the Office of Mental Health and Substance Abuse Services, we continue to provide and enhance 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.

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 FY20-21 application on the FY2020 President's Budget which would bring Pennsylvania's allocation to $22,529,713 annually. However, the plan also takes into account the availability of carry over funding, and therefore plans for an annual budget of $24,223,792.

SFY19-20 CMHSBG Pennsylvania Budget	
Non-Categorical County Funding	$18,543,435
Categorical County Funding (Housing and Infant/Early Childhood Mental Health Training Funds)	$575,000

First Episode Psychosis	$3,146,107
Special Projects	$1,380,250
OMHSAS Administrative Costs	$579,000
Total FY19-20 CMHSBG Budget	**$24,223,792**

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	
3.1 Administrator's Office	3.17 Family-Based MH Services
3.2 Community Services	3.20 Administrative Management
3.4 Targeted Case Management	3.22 Housing Support Services
3.6 Outpatient	3.23 ACT and CTT
3.8 Partial Hospitalization	3.24 Psychiatric Rehabilitation Services
3.10 MH Crisis Intervention Services	3.25 Children's Psychosocial Rehabilitation
3.11 Adult Developmental Training	3.26 Children's EBPs
3.12 Community Employment Services	3.27 Peer Support Services
3.13 Facility Based Vocational Rehabilitation	3.28 Consumer Driven Services
3.14 Social Rehabilitation Services	3.98 Other Services*
3.15 Family Support Services	

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

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.

The following table shows the projected Block Grant allocations to the counties for SFY19-20 (including some funding not expended in SFY18-19):

County	Total County Non-Categorical Allocation	County Categorical Allocation (Training Funds)	First Episode Psychosis	Special Projects	Total Allocation
Allegheny	$1,529,185	$16,200	$521,000	$5,250	**$2,071,635**
Armstrong/Indiana	$197,276	$14,000	$0	$0	**$211,276**
Beaver	$213,174	$9,500	$0	$0	**$222,674**
Bedford/Somerset	$177,304	$14,000	$0	$0	**$191,304**
Berks	$514,303	$9,500	$0	$0	**$523,803**
Blair	$158,861	$9,500	$0	$0	**$168,361**

Bradford/Sullivan	$93,542	$14,000	$0	$0	**$107,542**
Bucks	$781,561	$16,200	$0	$0	**$797,761**
Butler	$229,828	$9,500	$0	$0	**$239,328**
Cambria	$637,157	$9,500	$0	$0	**$646,657**
Cameron/Elk	$52,880	$14,000	$0	$0	**$66,880**
Carbon/Monroe/Pike	$365,575	$18,500	$0	$0	**$384,075**
Centre	$192,488	$9,500	$0	$0	**$201,988**
Chester	$623,608	$9,500	$0	$0	**$633,108**
Clarion	$78,680	$9,500	$0	$0	**$88,180**
Clearfield/Jefferson	$413,119	$14,000	$0	$0	**$427,119**
CMSU	$212,764	$23,000	$197,948	$175,000	**$608,712**
Crawford	$110,956	$9,500	$0	$0	**$120,456**
Cumberland/Perry	$493,008	$14,000	$0	$0	**$507,008**
Dauphin	$335,125	$9,500	$87,943	$0	**$432,568**
Delaware	$698,724	$16,200	$187,216	$0	**$902,140**
Erie	$350,708	$9,500	$260,500	$0	**$620,708**
Fayette	$207,600	$9,500	$0	$0	**$217,100**
Forest/Warren	$61,914	$14,000	$0	$0	**$75,914**
Franklin/Fulton	$205,579	$14,000	$0	$0	**$219,579**
Greene	$129,264	$9,500	$0	$0	**$138,764**
HMJ	$146,539	$18,500	$0	$0	**$165,039**
Lackawanna/Susquehanna	$706,949	$14,000	$0	$0	**$720,949**
Lancaster	$649,306	$9,500	$0	$0	**$658,806**
Lawrence	$599,482	$9,500	$0	$0	**$608,982**
Lebanon	$166,960	$9,500	$0	$0	**$176,460**
Lehigh	$436,871	$9,500	$0	$0	**$446,371**
Luzerne/Wyoming	$436,493	$14,000	$260,500	$0	**$710,993**
Lycoming/Clinton	$194,186	$14,000	$0	$0	**$208,186**
McKean	$59,235	$9,500	$0	$0	**$68,735**
Mercer	$145,798	$9,500	$0	$0	**$155,298**
Montgomery	$999,843	$16,200	$0	$0	**$1,016,043**
Northampton	$372,169	$9,500	$0	$0	**$381,669**
Northumberland	$118,160	$9,500	$0	$0	**$127,660**
Philadelphia	$2,234,351	$16,200	$481,000	$0	**$2,731,551**
Potter	$56,099	$9,500	$0	$0	**$65,599**
Schuykill	$185,361	$9,500	$0	$0	**$194,861**
Tioga	$52,476	$9,500	$0	$0	**$61,976**
Venango	$90,406	$9,500	$0	$0	**$99,906**
Washington	$568,466	$9,500	$0	$0	**$577,966**

Wayne	$133,171	$9,500	$0	$0	**$142,671**
Westmoreland	$456,461	$9,500	$0	$0	**$465,961**
York/Adams	$670,474	$14,000	$1,150,000	$700,000	**$2,534,474**
TBD- ELMS Project	$0	$0	$0	$500,000	**$500,000**
Statewide Total	**$18,543,435**	**$575,000**	**$3,146,107**	**$1,380,250**	**$23,644,792**

CMHSBG Special Projects			
County	**Allocation**	**Project Name**	**Description**
Allegheny	$5,250	Case Management Training	Funding to support the expenses associated with the training and certification for MH case managers.
CMSU	$175,000	Peer Run Crisis Respite Pilot	These funds are supporting the startup costs for CMSU in the continued development and implementation of their Peer Run Crisis Residential pilot project.
York/Adam	$700,000	Training	The training funds in York/Adams County will be utilized to support a number of regional and statewide training efforts including around Value Based Purchasing, Transgender/Non-Binary Services, and Peer Run Crisis Services.
TBD	$500,000	ELMS Project	OMHSAS is seeking to develop an Electronic Learning Management System to consolidate online webinars and trainings into location.

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 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. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

A data-driven process must support the state's priorities and goals. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the **National Survey on Drug Use and Health** (NSDUH), the **Treatment Episode Data Set** (TEDS), the **National Facilities Surveys on Drug Abuse and Mental Health Services**, and the **Uniform Reporting System** (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. 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, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several **other data sets** that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the **Healthy People Initiative**[16] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

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

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

Footnotes:

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:

Promote independent living and unnecessary institutionalization of individuals by increasing housing opportunities and/or housing support services in community settings for persons of all ages with SMI or children with SED and their families.

Objective:

Increase by 3% annually the number of individuals served by supportive housing

Strategies to attain the objective:

Encourage HealthChoices Behavioral Health Primary Contractors to expand Supportive Housing initiatives via HealthChoices Reinvestment as available; Inform county partners about federal, state and county housing related funding opportunities known via face-to-face, phone and email communications; Support Olmstead planning process to meet the needs of consumers in the least restrictive setting possible; Continue to provide technical assistance to counties.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage increase of individauls receiving supportive housing services

Baseline Measurement: 19,244

First-year target/outcome measurement: 19,821

Second-year target/outcome measurement: 20,416

Data Source:

County Human Services Plans Housing Tables (statewide total)

Description of Data:

Baseline= FY18-19 Human Services Plans
Year 1= FY19-20 Human Services Plans
Year 2= FY20-21 Human Services Plans

Data issues/caveats that affect outcome measures::

Priority #: 2

Priority Area: Services to Older Adults

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

To increase engagement and access to services across systems for older adults.

Objective:

Annually increase the number Certified Peer Specialists (CPS) documenting Certified Older Adult Peer Specialist (COAPS) Training as a part of their CPS certification through the Pennsylvania Certification Board (PCB), in order to increase the number of older adults (age 65 and over) receiving services from Certified Peer Support Specialists.

Strategies to attain the objective:

Support the three day continuing education training for Certified Peer Specialists on serving the Older Adult Population; promote outreach and education for older adults; build interaction between services/systems; recruit and train additional professionals; partner with the PCB to develop the older adult endorsement process.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Unique Number of Individuals recieiving medicaid billable Certified Peer Support Specialist Services (65 and over)

Baseline Measurement: 356

First-year target/outcome measurement: 391

Second-year target/outcome measurement: 430

Data Source:

OMHSAS Data (Promise)

Description of Data:

Baseline= SFY17-18
Year 1= SFY18-19
Year 2= SFY19-20

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Number of individuals documenting completion of COAPS Training during CPS Certification under the Pennsylvania Certification Board (PCB)

Baseline Measurement: 0

First-year target/outcome measurement: 25

Second-year target/outcome measurement: 100

Data Source:

Pennsylvania Certification Board

Description of Data:

Baseline: September 1, 2019
Year 1= September 1, 2019-June 30, 2020
Year 2= SFY20-21

Data issues/caveats that affect outcome measures::

The "grandparenting" period for previously trained CPS to be receive PCB Certification closes on August 31, 2019. On September 1, 2019 the PCB will begin certifying new CPSs under the regular certification process. Because of this timing, year one will be reporting on less than a full fiscal year.

Priority #: 3

Priority Area: Peer Support Services

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Support the employability of Certified Peer Specialists (CPS) throughout the Commonwealth.

Objective:

Increase the number of certified peer specialists employed in the mental health field

Strategies to attain the objective:

Promote the use of CPSs for specific populations, including Youth and Young Adults, Forensics, Older Adults, and Veterans; Track employment outcomes for trained CPSs; Support CPSs in the workplace by providing technical assistance to employers about culture changes needed to ensure their success with CPS services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Peer Specialists becoming newly certified under the Pennsylvania Certification Board

Baseline Measurement: 0

First-year target/outcome measurement: 150

Second-year target/outcome measurement: 400

Data Source:

Pennsylvania Certification Board

Description of Data:

Baseline= September 1, 2019
Year 1= September 1, 2019- June 30, 2020
Year 2= SFY20-21

Data issues/caveats that affect outcome measures::

The "grandparenting" period for previously trained CPS to be receive PCB Certification closes on August 31, 2019. On September 1, 2019 the PCB will begin certifying new CPSs under the regular certification process. Because of this timing, year one will be reporting on less than a full fiscal year.

Indicator #: 2

Indicator: Percentage of Certified Peer Specialists that are employed in the behavioral health field increasing 3% annually

Baseline Measurement: 66%

First-year target/outcome measurement: 69%

Second-year target/outcome measurement: 72%

Data Source:

Pennsylvania Certification Board

Description of Data:

Baseline: Certified Peers as of 6/30/19 who indicate at application that they are employed (part or full time) in the behavioral health system
Year One: Certified Peers as of 6/30/20 who indicate at application that they are employed (part or full time) in the behavioral health system
Year Two: Certified Peers as of 6/30/21 who indicate at application that they are employed (part or full time) in the behavioral health system

Data issues/caveats that affect outcome measures::

Priority #: 4

Priority Area: Olmstead Planning

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Facilitate the community integration of individuals residing in state hospitals

Objective:

Reduce length of stay for individuals receiving service in State Hospital Facilities

Strategies to attain the objective:

Follow the Commonwealth's Olmstead Plan, Support the County Olmstead Planning Process

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Data Pending

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 5

Priority Area: Residential Treatment Facility Usage Reduction

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Improve the quality of and increase access to community based services in order to reduce the use of RTF placements.

Objective:

Increase the number of children and youth effectively served through community based approaches by decreasing the proportion of children and youth per 1,000 in RTF Census compared to eligible population by .18 annually.

Strategies to attain the objective:

Increase community connections and informal supports through the use of Youth/Family Teams and High-Fidelity Wraparound; Monitor use of respite services and solicit feedback from families as to the impact; Research, fund, and expand community evidence-based and promising practices; Cross Program Office collaboration/plan for increasing education and training to providers that serve ASD populations

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Proportion of RTF Census Per 1,000 Compared to Eligible Population

Baseline Measurement: .935

First-year target/outcome measurement: .755

Second-year target/outcome measurement: .575

Data Source:

Source= OMHSAS data (RTF Dashboard and Eligibles excel file)

Description of Data:

Baseline= CY2018
Year 1= CY2019
Year 2= CY2020

-Eligibles: Average number of eligibles for 12 months
-Eligible Population is all MA enrolled age 21 and under
-C p/1000: (Average Census/Average Eligibles)*1000

Data issues/caveats that affect outcome measures::

Priority #: 6

Priority Area: Youth and Family Involvement

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Increase youth and family involvement and influence in the mental health system in Pennsylvania.

Objective:

Maintain and expand the number of youth and family members involved in county collaboratives (Systems of Care), integrated county plan development, and local and statewide planning/advisory boards by 7% annually.

Strategies to attain the objective:

Recruit and maintain an active youth cohort as part of the OMHSAS Planning Council; Recruit and maintain an active youth and family member composition in the county collaboratives formed as part of Systems of Care; Support youth and family participation in state and county sponsored trainings and conferences; Support cross systems collaboration and integrated services delivery reflecting input from youth and family members.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of youth and family members involved in county collaboratives (System of Care), integrated plan development, and local and statewide advisory boards annually

Baseline Measurement: Data Pending

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

OMHSAS Children's Bureau

Description of Data:

Includes Mental Health Planning Council, System of Care, State Leadership and Management Team, and Youth/Young Adult Network

Data issues/caveats that affect outcome measures::

Priority #: 7

Priority Area: Early Childhood Intervention

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Targeted and ongoing workforce development for professionals from multiple disciplines that work with infants and their families is essential to ensure that professionals understand infant and early childhood mental health and are equipped to promote positive practices to support these children, prevent problems when risk is identified, and intervene when necessary.

Objective:

Increase the number of cross system professionals with training in infant/early childhood mental health and Endorsement®.

Strategies to attain the objective:

Public awareness, systems specific communications, and the provision of professional development opportunities on and about the need for our cross systems professionals to be infant/early childhood mental health informed (using knowledge, skills and reflective experiences to guide our work with infants, toddlers, and families in promoting social-emotional development and addressing mental health concerns), and CMHSBG Funded Training Scholarships for Counties.

The intent of the PA-AIMH Endorsement (IMH-E® and ECMH-E®) is to recognize and document the professional development of infant and family service providers within the diverse and rapidly expanding field, using an organized set of culturally sensitive, relationship-based infant mental health competencies. It is not a license or certification, but rather an overlay onto a person's professional credentials that recognizes evidence of a specialization in the field of infant/early childhood mental health. The Endorsement is one of the first and most comprehensive efforts in the country to identify best practice competencies at multiple levels and across disciplines and to offer a pathway for professional development in the infant, early childhood and family field.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Professionals who have achieved Endorsement®

Baseline Measurement: 53

First-year target/outcome measurement: 73

Second-year target/outcome measurement: 93

Data Source:

PA-AIMH Endorsement Application System (EASy)

Description of Data:

Number of endorsed professionals or professionals with endorsement applications in progress.
Baseline= 7/1/2019 Total
Year 1= 7/1/2020 Total
Year 2= 7/1/2021 Total

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Number of Professionals funded to attend Infant/Early Childhood Mental Health professional development training

Baseline Measurement: 0

First-year target/outcome measurement: 75

Second-year target/outcome measurement: 150

Data Source:

OMHSAS IECMH Reporting Survey

Description of Data:

Number of professionals who received funding to attend infant/early childhood mental health professional development training funded through CMHSBG County Scholarships.

Baseline= Newly funded project.
Year 1= SFY18-19
Year 2= SFY19-20

Data issues/caveats that affect outcome measures::

Survey results are dependent on county representatives inputting data into the survey system. SFY18-19 was the first year that CMHSBG Scholarship funds were given to the counties to promote IECMH professional development. Therefore, data may vary from the target outcome measurements listed above as this is a new priority of focus.

Priority #: 8

Priority Area: Suicide Prevention

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Increase suicide prevention efforts across the lifespan in Pennsylvania

Objective:

Increase utilization of the National Suicide Prevention Lifeline and increase Pennsylvania's capacity to answer calls in-state.

Strategies to attain the objective:

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. Increasing the number of call centers in PA affiliated with the Lifeline also aligns with Pennsylvania's draft statewide suicide prevention plan that will be completed by January 2020, as well as with goals of the Garrett Lee Smith Youth Suicide Prevention Grant, recently awarded to OMHSAS.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Pennsylvania based calls to the National Suicide Prevention Lifeline increase by 10% annually representing an increase in help-seeking behavior

Baseline Measurement: 74,090

First-year target/outcome measurement: 81,500

Second-year target/outcome measurement: 89,650

Data Source:

National Suicide Prevention Lifeline Data

Description of Data:

Baseline=CY2018
Year 1= CY2019
Year 2= CY2020

Data issues/caveats that affect outcome measures::

Pennsylvania would like to consider outreach texts to the Crisis Text Line in future tracking and is currently in the process of establishing a data agreement with the Crisis Text Line.

Indicator #:	2
Indicator:	Increase the percentage of calls originating in Pennsylvania that are answered in-state by 50% annually
Baseline Measurement:	30%
First-year target/outcome measurement:	45%
Second-year target/outcome measurement:	67.5%

Data Source:

National Suicide Prevention Lifeline

Description of Data:

Baseline=CY2018
Year 1= CY2019
Year 2= CY2020

Data issues/caveats that affect outcome measures::

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

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 2020/2021.

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	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
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*		$0	$0	$0	$64,342,371	$2,395,787	$0
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**		$6,292,214	$0	$0	$0	$0	$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			$0	$0	$939,944,594	$0	$0
7. Other 24 Hour Care		$0	$1,088,400,570	$0	$597,800,183	$18,271,440	$0
8. Ambulatory/Community Non-24 Hour Care		$37,609,212	$3,075,853,499	$0	$723,572,868	$22,668,522	$0
9. Administration (Excluding Program and Provider Level)***		$1,158,000	$2,423,745,931	$0	$106,339,984	$6,120,668	$0
10. Total	**$0**	**$45,059,426**	**$6,588,000,000**	**$0**	**$2,432,000,000**	**$49,456,417**	**$0**

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

Footnotes:

Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date: 07/01/2019 MHBG Planning Period End Date: 06/30/2021

Activity	FFY 2020 Block Grant
1. Information Systems	$0
2. Infrastructure Support	$1,135,692
3. Partnerships, community outreach, and needs assessment	$0
4. Planning Council Activities (MHBG required, SABG optional)	$12,369
5. Quality Assurance and Improvement	$0
6. Research and Evaluation	$2,300,000
7. Training and Education	$2,560,500
8. Total	**$6,008,561**

0930-0168 Approved: 06/07/2017 Expires: 06/30/2020

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.

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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.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, 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) which Pennsylvania is now working hard to sustain as the SAMHSA funding draws to a close. 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 QHPs? (●) Yes ( ) No

b) and Medicaid? (●) Yes ( ) No

4. Who is responsible for monitoring access to M/SUD services 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?

OMHSAS is currently working with a contractor (Mercer) to assist the state in both identifying and addressing any parity issues.

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 and consumers have expressed a desire for the state to continue with the programs that were started. The TiPS program has been extremely successful and expanding yearly. The VBP (Value-Based Purchasing) is working to an integrated system of care to include social determinates of health (SDH) and we are looking forward to examining results as we continue with the program.

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?

In SFY18-19 OMHSAS Funded a number of projects to address improve services for groups with health disparities:
• Cultural and Linguistic Competence Training/Technical Assistance (National Center for Cultural Competence at Georgetown University)
• Clinical Training for providers on Serving Transgender/Non-Binary (Gender and Sexuality Development Clinic at Children's Hospital of Philadelphia)
• LGBTQIA+ Trainings (KPRI)
Additional details regarding these training programs are included in the strengths and needs document.

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] **http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.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 focus on consumer outcomes rather than care processes.
- **g)** ☑ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, 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?

OMHSAS is utilizing CMHSBG funding to support a Value-Based Purchasing (VBP) Conference in August 2019. The focus of this two-day conference will be on whole person care. Presenters will include experts from the National Council, PA and other states and include topics on population health, physical & behavioral health integrated care, social determinants of health, and episodes of care as they relate to VBP. The target audience includes our Behavioral Health (BH) Primary Contractors, Behavioral Health Managed Care Organizations (BH-MCOs), BH providers and consumers/families of consumers. Scholarship funds are being made available to five consumers to ensure representation from this group.

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

None Requested

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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 encouraged to utilize Certified Peer Support (CPS) Specialist services and several sites have a CPS Provider as a member of their CSC teams.

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 2020 and FFY 2021 for your state's ESMI programs including psychosis?

Pennsylvania will continue to fund First Episode Psychosis at nine 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 four 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 the Pennsylvania Early Intervention Center (PEIC). In addition to offering statewide training, program evaluation, and fidelity monitoring, PEIC is currently in the process of developing a tele-psychiatry clinic that will be made available to counties without a specialized FSP-CSC Team. Primary Care and Mental Health Providers in those counties, including many rural counties, will be able to access the tele-psychiatry clinic for consultation when serving individuals with Early Serious Mental Illness.

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 PEIC at the University of Pennsylvania. 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:

Pennsylvania FEP Program Evaluation Requirements: Core Battery

#. Project Instrument	Assessor*	Time Estimate (Minutes)	Baseline	6 Month Follow-Up
1. Referral Tracking				
Administrative Page	C1	1	x	
Referral Tracking Form	C1	5	x	
2. Admission				
Administrative Page	C1	1	x	
Admission Form	C1	30	x	
3. Discharge				
Administrative Page	C1	1		
Discharge Form	C1	5		
4. Follow-Up**				
Administrative Page	C1	1		x
Follow-Up Form	C1	10		x
5. Self-Report Scales**				
Administrative Page	C1	5	x	x
Beck Collection	SR	10	x	x
PTSD Symptom Scale (PSS)	SR	15	x	x
MHSIP Youth Services Survey (YSS) - Patient	SR	5	x	x
Lehman Quality of Life Scale	SR	5	x	x
Psychosis Recovery Assessment Scale (QPR)	SR	5	x	x
SCORE Family Functioning	SR	5-10	x	x
Glasgow Antipsychotic Side-effect Scale (GASS)	SR	5	x	x
6. Family Self-Report Scales**				
MHSIP Youth Services Survey (YSS- F) - Caregiver	SR	5	x	x
6. Clinical Assessments**				
Administrative Page	C1	1	x	x
Cornblatt Role Function	C1	5-10	x	x
Cornblatt Social Function	C1	5-10	x	x
Extrapyramidal Symptom Rating Scale (ESRS)	C3	5	x	x
Brief Psychiatric Rating Scale v. 4 (BPRSv4)	C2	20	x	x
Medical Monitoring Form	C3	5	x	x
B-CATS (Trails A&B, Digit Symbol, Animal Fluency)	*C1*	*10*	*x*	*x*

SR = Self-Report
C1 = Bachelor's level or above
C2 = Treating clinician (Master's or above preferred, minimum bachelor's with clinician input/supervision)
C3 = Physician

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) Plan, 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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Footnotes:

Community Support Program (CSP) Wheel

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?

MHBG Planner is the person responsible for program integrity activities related to MHBG. The MHBG Planner also collaborates with the Department's Bureau of Financial Operations to ensure integrity of the programs supported with MHBG funds.

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

None requested

Footnotes:

Environmental Factors and Plan

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. While all CMHSBG priorities must meet this requirement, two priorities in particular serve the needs of individuals in hospitals or at risk of hospitalization.

Priority one, Supportive Housing, looks to increase supportive housing services, which are frequently required for discharge from

long term hospitalization, such as a state hospitalization. Priority four, Olmstead Planning, looks at this need even more directly, specifically focusing on State Hospital readmission rates and length of stay. State Hospital diversion/reduction is discussed in more detail under the Strengths and Needs and Olmstead Planning sections of this application.

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		
2.Children with SED		

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.

Data Pending

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 for 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 attached

Footnotes:

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 LGBTQI
- 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:

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. 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

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 2018-FFY 2019? ○ Yes ◉ No

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

None requested.

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Footnotes:

Environmental Factors and Plan

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.

• The Commonwealth of PA is currently working with Mercer Consulting to develop a project charter- EMBEDDING TRAUMA INFORMED CARE WITHIN RESIDENTIAL FACILITIES FOR CHILDREN AND YOUTH IN THE COMMONWEALTH OF PENNSYLVANIA. The goal of this charter is to embed TIC within all residential facilities licensed by the Pennsylvania Office of Children, Youth and Families (OCYF) under 55 Pa. Code Chapter 3800 (which includes PRTF's). DHS will be requiring these facilities to provide TIC training for their staff. In addition, to identify and recommend specific criteria these facilities must meet and a variety of available trainings that would satisfy the training expectations.
• The Commonwealth of PA is working with Lakeside Global Institute to develop trainer of trainer opportunities for System of Care

County stakeholders.

• The Office of Mental Health and Substance Abuse Services, Bureau of Children's Behavioral Health Services employs a consulting psychologist trained in both clinical and organizational trauma and provides technical assistance to providers and other stakeholders.

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

None requested

Footnotes:

Environmental Factors and Plan

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?

CIT:
PA Department of Corrections has implemented Memphis Model Crisis Intervention Team (CIT) training into their ongoing training for Corrections Officers. CIT is also used by local police in many locations in Pennsylvania. Franklin and Fulton Counties in particular have strongly utilized the CIT model with over 150 members trained in CIT who have served over 450 individuals in the past two years.

Co-Location Program:
The Co-Responder program in Chambersburg, Pa locates a mental health professional with the police department who can assist the police in diversion efforts. In the past FY, the co-location program has engaged 165 people in services, diverting them from the criminal justice system.

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

None requested

Footnotes:

Environmental Factors and Plan

15. Crisis Services - Requested

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 funded a pilot Peer Run Crisis Respite Center serving Columbia/Snyder/Montour/Union Counties through CMHSBG funding and is continuing to support the development of this program. Additional details are provided in the Strengths and Needs Section.

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

None requested

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Footnotes:

Environmental Factors and Plan

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.

The Certified Recovery Specialist (CRS) credential is for drug and alcohol peers in recovery who have 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?

To more formally recognize the value of peers in the workforce, Pennsylvania is moving to a new full peer certification offered by the Pennsylvania Certification Board (PCB). This new formal certification will be necessary to provide Medicaid billable peer support services. There is no initial cost to peers for obtaining the credential as the grandparenting fee is being underwritten by the Office of Mental Health and Substance Abuse Services (OMHSAS) utilizing CMHSBG funds.

The new CPS certification will be valid for two years. To avoid a lapse in certification, recertification should occur before the end of the two-year certification period. Recertification requires obtaining 36 hours of CEUs every two years and a $50 two-year recertification fee.

This new formal certification through the PCB is designed to help strengthen the profession and give CPSs a stronger voice, while maintaining the essence of peer support in delivering recovery oriented services. We urge you to complete the process now, during the grandparenting period, to ensure you can continue to do the great work that you do.

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

None requested

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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

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Counties are in the process of providing a status report on their current Local/Regional Olmstead Plan Implementation for Fiscal Year 2017/18 and the reports are due to OMHSAS July 19, 2019. This status report includes a section titled, Housing in Integrated Settings which includes questions about changes in their Housing Inventory of existing housing options, progress made towards integration of housing services, and progress made in outreaching to and forming collaborations or partnerships with housing partners during the status reporting timeframe. The Pennsylvania's Department of Human Services (DHS), Office of Mental Health and Substance Abuse Services (OMHSAS) continues to request funding to support Community Hospital Integration Project Program (CHIPP) each year. In FY 18/19, ten CHIPPs were supported and forty-five CHIPPs are in the requested Governor's budget for FY 19/20. OMHSAS monitors State Hospital utilization regularly. DHS continues to partner with the Pennsylvania Housing Finance Agency on the Section 811 Project Rental Assistance Program which provides supportive housing opportunities for eligible people with disabilities, including those with serious mental illness.

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

None requested

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Footnotes:

Environmental Factors and Plan

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.)

PA continues our system of care collaboration through our State Leadership and Management Team comprised of youth/young adults, family members and child serving system partners from across the state that provides guidance to our SOC (System of Care) grants (SOC expansion and implementation and Healthy Transitions). In addition, many of our system partners participate in our workgroups as related to various mental health programming. We also have several areas where we share work, such as the Student Assistance Program (a collaboration between Mental Health, Education and Drug and Alcohol programs), suicide prevention, the Fetal Alcohol Spectrum Disorders Workgroup, The Youth and Family Training Institute Advisory Board and several other short-term projects related to policy.

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

The mission of the PA MH CoP is to create the awareness and the connections that will allow us to learn from and with each other to improve practice in PA. Goals of the PA MH CoP include: building relationships, learning with and teaching one another; collaborating with partners to explore and identify issues where commonalities exist, sharing information and resources and gaining knowledge from both the successes and challenges shared. This collaborative process will serve to assist in better understanding one another and creating an environment where partners are open to and supportive of varying perspectives and opinions. The contributions from youth and families' lived experience will assist in driving the change that is necessary for service and systems transformation, thus resulting in the lives of youth and families being improved.

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

None requested

Footnotes:

Environmental Factors and Plan

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.

Pennsylvania has a new draft plan that is currently being reviewed by a statewide task force, with a final plan for 2020-2024 scheduled to be finalized in January 2020. Current activities, described above, include training, screening, and awareness/outreach. Improved collaboration among state agencies has also been a priority, as has collaboration with SAMHSA through a variety of grant-related efforts and national resources such as the National Suicide Prevention Lifeline and Crisis Text Line.

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 2018-FFY 2019 plan was submitted? ( ) Yes (●) No

If so, please describe the population targeted.

There are no current efforts around care transitions occurring at the state level. However, OMHSAS has submitted a proposal for continued Garrett Lee Smith funding that will work specifically on improving continuity of care and care transitions for youth at risk of suicide.

Pennsylvania has recently developed a statewide, multi-agency Suicide Prevention Task Force. Additional details are included in the strengths and needs section of this application.

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?

n/a

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilites Education Act.

Pennsylvania enjoys a large and diverse Advisory structure, comprised of an Adult, Children's, and Older Adult Committee, as well as a "Persons in Recovery" Subcommittee, with a cumulative membership of 75 individuals. The Advisory Committee (Mental Health Planning Council/MHPC) draws membership from consumers/survivors, family members, county officials, behavioral health providers, advocates, and other professional mental health and state agencies. The MHPC deliberates on issues and initiatives related to OMHSAS's mission that "Every individual served by the Mental Health and Substance Abuse Service system will have the opportunity for growth, recovery and inclusion in their community, have access to culturally competent services and supports of their choice, and enjoy a quality of life that includes family members and friends."

The Commonwealth recognizes the importance of bringing a multitude of stakeholders to the MHPC and has partnered with The Office of Medical Assistance Programs (the State's Medicaid Authority), The Office of Children, Youth and Families (the State's child welfare agency), The Office of Vocational Rehabilitation, The Pennsylvania Department of Corrections, The Pennsylvania Department of Education, The Bureau of Drug and Alcohol Services (the State's substance abuse agency), The Pennsylvania Housing Finance Agency, the Pennsylvania Department of Aging and the Department of Human Services Office of Social Programs (Housing).

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

None requested

Footnotes:

Environmental Factors and Plan

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?

While Pennsylvania does not have a fully integrated Behavioral Health Council, co-occurring issues are addressed at all levels of the council on each of the committees. In addition, as standing sub committee has been designated as the Persons-In-Recovery Group to handle more complex and long term issues related to SUD and Co-occurring disorder.

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.

Pennsylvania's Mental Health Planning Council (MHPC) meets quarterly. In addition to 75 appointed members, MHPC 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, substance use and behavioral health 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), Cultural Competency, and the Department of Drug and Alcohol Programs (DDAP). 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. Additional regarding the structure and operation of the MHPC are included in the attached MHPC Advisory Protocol.

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

None requested

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health 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.

The Office of Mental Health & Substance Abuse Services (OMHSAS)
Mental Health Planning Council

PROTOCOL

Introduction

In March 2004, members of the Office of Mental Health and Substance Abuse Services (OMHSAS) Mental Health Planning Council (MHPC) arrived at consensus on an advisory structure to ensure that:

1. Individuals who have received services, family members, and other stakeholders have the opportunity for meaningful, effective participation in advising OMHSAS.
2. Information is shared broadly and in a timely manner from stakeholders to OMHSAS and from OMHSAS to stakeholders.
3. Valuable networking opportunities are available among stakeholders.
4. There are productive partnerships between OMHSAS and the Planning Council.

The OMHSAS Mental Health Planning Council is comprised of three committees and one subcommittee: Children's Behavioral Health Committee, Adult Behavioral Health Committee, Older Adult Behavioral Health Committee, and Persons in Recovery Subcommittee. These committees will advise on a broad behavioral mandate to include, but not be limited to, mental health, substance abuse, behavioral health disorders, and cross-system disability.

The OMHSAS Mental Health Planning Council will directly advise the Deputy Secretary.

The OMHSAS Mental Health Planning Council will link to related state departments, advisory committees, and OMHSAS stakeholder workgroups.

The OMHSAS Mental Health Planning Council will assume the role of State Mental Health Planning Council within its scope of responsibility.

I. Purpose

The purpose of the OMHSAS Mental Health Planning Council shall be to provide counsel and guidance to Pennsylvania Department of Human Services' (DHS) OMHSAS in order to ensure an infrastructure and a full array of mental health, substance abuse, and behavioral health 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), Cultural Competency, and Department of Drug and Alcohol Programs (DDAP).

OMHSAS Mission

OMHSAS, in collaboration with other appropriate commonwealth offices, will ensure local access to a comprehensive array of quality mental health and substance abuse services that are reflective of the needs of Pennsylvania citizens, effectively managed and coordinated, and responsive to a dynamic and changing health care environment.

OMHSAS Vision

Every individual served by the mental health and substance abuse services system will have the opportunity for growth, recovery, and inclusion in their community, have access to culturally competent services and supports of their choice, and enjoy a quality of life that includes family and friends.

OMHSAS Guiding Principles

The mental health and substance abuse services system will provide quality services and supports that:

- Facilitate recovery for adults and resiliency for children.
- Are responsive to individuals' unique strengths and needs throughout their lives.
- Focus on prevention and early intervention.
- Recognize, respect, and accommodate differences as they relate to culture/ethnicity/race, religion, gender identity, and sexual orientation.
- Ensure individual human rights and eliminate discrimination and stigma.
- Are provided in a comprehensive array by unifying programs and funding that build on natural and community supports unique to each individual and family.
- Are developed, monitored, and evaluated in partnership with individuals who have received services, families, and advocates.
- Represent collaboration with other agencies and service systems.

State Mental Health Planning Council

It is the responsibility of all OMHSAS Mental Health Planning Council members to be cognizant of and actively participate in fulfilling expectations as representatives of the broad range of individuals served by OMHSAS, as well as to meet the three primary duties assumed by these committees as the State Mental Health Planning Council. The Federal Public Health Services Act defines the duties below, and in the excerpts from the Public Health Service Act (Attachment 1).

A. To review plans provided to the Council pursuant to Section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modification to the plans.

B. To serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems.

C. To monitor, review, and evaluate, not less than once every year, the allocation and adequacy of mental health services within the State.

See Attachment 1 for further information on the State Mental Health Planning Council.

II. Membership

A. The OMHSAS Mental Health Planning Council Advisory Committees will be composed of individual representatives of youth, adult, and older adult individuals who have been served by the behavioral health system, family members of such youth and adults, providers, advocates, professionals, their respective organizations, as well as governmental

organizations. At least 51% of the members will be individuals who have received services and family members. The size of each committee will be a minimum of 20 members, but not to exceed 25 members, who shall be appointed by the OMHSAS Deputy Secretary.

1. Receiving input from Youth and Young Adults is a priority of the OMHSAS MHPC and a Youth/Young Adult Workgroup is being established to identify the best youth-friendly way to ensure that their feedback is being received. It is the intention of the MHPC Executive Committee to ensure that the result of this workgroup includes prioritized seats on the council for Youth/Young Adult members.

2. The Persons in Recovery Subcommittee will be composed of up to three voting members in the Children's Behavioral Health Committee, up to three voting members in the Adult Behavioral Health Committee, and up to three voting members in the Older Adult Behavioral Health Committee. The Persons in Recovery Subcommittee members will be voting members in the committee they are appointed to.

B. The goal in appointing members is to reflect the cultural and demographic diversity of individuals served in the Commonwealth and to maintain an equitable representation among individuals who have received services, family, advocate, and professional representatives to the fullest extent possible, while assuring 51% membership of individuals who have received services and family members.

C. Members should be current residents of Pennsylvania or be able to document substantial current involvement in the Pennsylvania mental health system.

D. In order to fulfill the federal requirements for the Community Mental Health Services Block Grant, the MHPC will ensure representation from five service areas of the state (Medical Assistance, Social Services, Vocational Rehabilitation, Criminal Justice, and Mental Health). The MHPC has set aside 11 permanent state agency seats to meet this requirement and ensure representation among the committees. The OMHSAS representative for mental health will be expected to refrain from voting as appropriate due to conflict of interest.

E. In January of each year the Executive Committee of the OMHSAS Mental Health Planning Council, in collaboration with OMHSAS staff, shall be responsible for soliciting candidates for committee membership. Individuals are encouraged to apply for membership; in addition, representative constituent organizations may recommend individuals for membership. All candidates must complete a membership application form. Applications will be held as active candidates for two years from the date of receipt.

The Executive Committee shall submit recommendations to the Deputy Secretary of persons to be appointed as members of advisory committees. The number of names to be recommended for membership will be equal to or greater than the number of positions to be filled during each year. Appointment to membership will be confirmed by an appointment letter from the Deputy Secretary in May of each year.

F. Nominees appointed by the Deputy Secretary will serve a three-year term, beginning in July of the year in which the individual was appointed. Individuals may serve two full consecutive three-year terms. After serving two full consecutive terms, individuals must wait one year before becoming eligible to reapply to become a voting member.

G. In the event of a vacancy in membership, the unexpired portion of the term shall be filled by a person to be recommended by the Executive Committee and appointed by the Deputy Secretary. If an individual fills an unexpired term for a member that is unable to complete their term, that individual may then apply to complete two full consecutive three-year terms.

H. An orientation for newly appointed members will be conducted when new members are appointed. One co-chair and one advisory committee member will conduct outreach to new members that will address such matters as the composition and purpose of the committees, the public behavioral health system, service array, OMHSAS structure, and cultural competency.

I. New members will receive an appointment letter and an advisory committee orientation packet within one month after being appointed to an advisory committee.

III. Structure

Council Co-Chairs

A. The Mental Health Planning Council will have co-chairs, who must both have lived experience as a consumer and/or family member. MHPC members shall elect co-chairs of the Council for a two year term, who shall serve until a successor has been duly appointed. Co-chairs can be re-elected for a maximum of one additional two year term, after which there must be a minimum of a two year hiatus before being considered again for the position of co-chair.

- Co-chair positions can only be held by a member of the MHPC who has served at least one year as a regular member and attended the required 3 out of 4 meetings annually. Under no circumstance will Pennsylvania commonwealth employees serve in co-chair positions.

B. In January of each year, the Executive Committee shall be responsible for soliciting nominations of individuals who are qualified and willing to serve as a co-chair. One Council Co-chair position will be up for re-election annually. Election of co-chairs shall be conducted by ballot in the Joint Session of the final MHPC meeting of the state fiscal year (typically held in May or June), with the term of office to begin July 1. Election shall be by a simple majority vote of those present and voting, providing a quorum has been reached.

C. Responsibility of Co-Chairs:

- Establish joint session agendas and consult with committee co-chairs as needed for committee agendas.
- Chair joint sessions of the MHPC
- Participate in MHPC Executive Committee meetings.
- Provide timely review and necessary response to correspondence.
- Provide liaison with the Deputy Secretary and the OMHSAS staff.
- Determine, in conjunction with OMHSAS staff, the need for workgroups.
- Ensure correspondence necessary to the function of the MHPC is completed.

- Ensure obligations of the Federal Block Grant are met, including but not limited to participating in Block Grant review meetings and Block Grant conferences.
- Participate in additional activities as requested by the Deputy Secretary, such as OMHSAS Executive Committee strategic planning sessions.

D. Co-Chair Vacancy:

In the event of a vacancy in a Council Co-chair position, the unexpired portion of the term will be filled by a person selected in a Special Election.

- The Executive Committee will solicit nominations of individuals qualified and willing to serve as a co-chair.
- A ballot of nominees will be presented to the MHPC membership during a joint session.
- Election shall be by a simple majority of those present and voting, providing a quorum has been reached.

Committee Co-Chairs

A. Each committee will have co-chairs, one of which at all times will be an individual who has received services and/or family member. Committee members shall elect co-chairs of each committee for a two year term, who shall serve until a successor has been duly appointed. Co-chairs can be re-elected for a maximum of one additional two year term, after which there must be a minimum of a two year hiatus before being considered again for the position of co-chair.

- Co-chair positions can only be held by a member of the committee who has served at least one year as a regular member and attended the required 3 out of 4 meetings annually. Under no circumstance will Pennsylvania commonwealth employees serve in co-chair positions.

B. In January of each year*, the Executive Committee shall be responsible for soliciting nominations of individuals who are qualified and willing to serve as a co-chair. One co-chair position on each committee will be up for re-election annually. Election of co-chairs shall be conducted by ballot in the committee session of the final MHPC meeting of the state fiscal year (typically held in May or June), with the term of office to begin July 1. Election shall be by a simple majority vote of those present and voting, providing a quorum has been reached.

** Note: A special election was conducted in 2006 electing one co-chair for a one year term and one co-chair for a two year term to provide continuity in committee leadership.*

C. Responsibility of Co-Chairs:

- Establish committee session agendas.
- Chair committee meetings
- Participate in Executive Committee meetings.
- Provide timely review and necessary response to correspondence.
- Provide liaison with the Deputy Secretary and the OMHSAS staff.
- Determine, in conjunction with OMHSAS staff, the need for workgroups.

- Ensure correspondence necessary to the function of the committee is completed.
- Ensure obligations of the Federal Block Grant are met, including but not limited to participating in Block Grant review meetings and Block Grant conferences.
- Participate in additional activities as requested by the Deputy Secretary, such as OMHSAS Executive Committee strategic planning sessions.

D. Co-Chair Vacancy:

In the event of a vacancy in a committee co-chair position, the unexpired portion of the term will be filled by a person selected in a Special Election.

- The Executive Committee will solicit nominations of individuals qualified and willing to serve as a co-chair.
- A ballot of nominees will be presented to the committee membership where the vacancy is held.
- Election shall be by a simple majority of those present and voting, providing a quorum has been reached.

Executive Committee

An Executive Committee of the OMHSAS Mental Health Planning Council will be comprised of the Council Co-Chairs and Co-chairs of the Children's, Adult, and Older Adult Committees to provide a structure for the coordination of the OMHSAS Mental Health Planning Council's activities, concerns, and issues. The Executive Committee will be responsible for development of agendas, completing required correspondence, making recommendations of specific tasks, and assignment of workgroups to develop information and recommendations on these issues, and making decisions on behalf of the Committee between meetings. The co-chairs are to assure Committee members are informed of actions taken by the Executive Committee between regularly scheduled Committee meetings.

The Executive Committee will act as the Membership Committee, having the authority to recommend to the Deputy Secretary persons to be appointed to the three advisory committees.

Committee Workgroups

A. Committee Workgroup Structure and Membership

The formation and purpose of Committee Workgroups will be the determination of the Executive Committee in conjunction with OMHSAS Staff to assist in issue-focused, task-oriented, time-limited work of the committees. OMHSAS Mental Health Planning Council and non-OMHSAS Mental Health Planning Council members may be selected to participate in workgroups, to ensure the necessary representation and expertise needed to meet the goals of the workgroup. When establishing workgroups, attention will be given to workgroup membership composition, with the goal of achieving appropriate representation of stakeholders as well as geographical and cultural representation of members.

B. Committee Workgroups

- Individual Committee or Joint Session establishes need for workgroup by a vote of appointed members. Workgroups will be time limited and have a specific area of focus.

- A current Council or Committee Co-Chair will lead the workgroup or the leadership of the workgroup will be assigned by a co-chair to another appointed MHPC member who will report back to the co-chair and MHPC Executive Committee.

- Workgroup develops draft timeline and a defined work product.

- Timeline and draft work product are distributed to the committee for comment via email or at regularly scheduled meeting of the committee.

- Comments considered in final product, and final product distributed to the committee.

IV. Conduct of Business

A. The business and affairs of the OMHSAS Mental Health Planning Council and workgroups shall be managed by the Council and Committee Co-Chairs. Administrative support and technical assistance will be provided by OMHSAS.

B. Notice of meetings, including the agenda for the meeting, shall be distributed to the membership not less than five working days if written, or not less than 48 hours if electronically, prior to the meeting.

C. Voting – Only appointed committee members may vote on council/committee issues. Any action before the council/committees will be presented by formal motion, seconded, and voted on by members. For voting purposes, 1/3 of all voting committee members will constitute a quorum. A simple majority of the quorum will constitute approval of any motion.

Meetings and Attendance

The OMHSAS Mental Health Planning Council can only be effective if members attend regularly and participate in discussion, development of issue statements and recommendations, and respond to requests from OMHSAS.

Meetings will occur four times per year. During the last meeting of the calendar year meetings will be scheduled for the next calendar year. The Executive Committee has the prerogative of rescheduling meetings for legitimate reasons such as scheduling conflicts or weather.

Members must RSVP promptly when notified of meetings in order to allow for adequate copies of materials. All members are expected to attend at least 3 of the 4 regularly scheduled meetings annually. If members fail to RSVP and do not attend the required meetings, the Committee Co-Chair(s) will contact the member to determine their interest in continuing on the Committee. At the discretion of the Executive Committee, members may be dismissed for lack of attendance and unexplained absences.

Attendance alone does not make a good Council member. Assisting the co-chairs in keeping the council/committees focused on the task at hand, respectful participation in discussion, and support of consensus decisions are valuable assets in Council members.

VI) Staff Support

A. OMHSAS will provide adequate staff to ensure effective committee, subcommittee, and workgroup coordination.

B. OMHSAS staff leads the development and submission of the Block Grant proposal.

C. OMHSAS will provide, at a minimum, the following support functions:
1) Meeting arrangements
2) Distribution of mailings
3) Set-up for meetings
4) Records of expenses
5) Attendance and recording of meeting outcomes
6) Travel reimbursement
7) Inter-office distribution of committee business
8) Liaison with Council and Committee Co-chairs
9) Liaison with Executive Committees
10) Sunshine notification

D. OMHSAS staff will support council, committee and workgroup functions and business as required. This includes responding to requests for information on any pertinent issues. Appropriate OMHSAS staff are expected to attend committee meetings.

VII) Conflicts of Interest

A. Definitions
a. Covered Person: all appointed MHPC Members, Co-Chairs and Staff
b. Significantly Connected Person/Entity: an individual or entity connected personally and/or financially to a covered person including, but not limited to, family members and employers
c. Conflict of Interest: a situation in which a covered person or the significantly connected person/entity of a covered person has a personal or financial interest that compromises or could compromise their independence of judgement in exercising their responsibilities to the MHPC

B. Each covered person will perform their duties for the OMHSAS MHPC in good faith for the benefit of the OMHSAS MHPC, meaning that no person may take advantage of their position on the OMHSAS MHPC for personal advantage or the advantage a significantly connected person/entity. While it is expected that the work of the OMHSAS MHPC members will broadly contribute to an improved mental health system, from which covered persons and significant people/entities may generally benefit, no covered person shall direct MHPC activity to specifically benefit themselves and/or significantly connected people/entities.

C. Potential conflicts of interest related to the MHPC include, but are not limited to, voting on MHPC business, voting on recommendations to the Deputy Secretary, and reviewing applications for MHPC membership appointments.

D. All Covered persons must avoid both actual conflicts and the appearance of conflicts of interest.

   a. If a covered person has an actual or potential conflict of interest, they may voluntarily recuse themselves from deliberations, voting, or any other MHPC activity related to the conflict of interest by reporting the conflict to a member of the MHPC Executive Committee.

   b. If a covered person has a potential conflict of interest and they do not wish to voluntarily recuse themselves, they may report the potential conflict of interest to any member of the MHPC Executive Committee immediately upon discovering the potential conflict. The potential conflict of interest will be reviewed by the MHPC Executive Committee and a determination returned to the individual within two weeks. The individual with a potential conflict of interest will refrain from taking any action related to the potential conflict during the review period.

   c. Any person, public or covered, who is concerned that a covered person may have an unreported potential conflict of interest can inform a member of the MHPC Executive Committee of their concern. The covered person will be contacted by the MHPC Executive Committee to provide background information. The MHPC EC will then review the potential conflict and advise the covered person within two weeks of their determination. The individual with a potential conflict of interest will refrain from taking any action related to the potential conflict during the review period.

VIII) <u>Travel and Reimbursement</u>- *Provided for individuals who have received services and family members.*

A. If individuals are members based on organization nomination, the member organizations are expected to pay for attending members' expenses for participation at Council meetings.

B. For individuals who are participants and not connected to an organization that has adequate resources to support reimbursement, expenses for ordinary travel and lodging for OMHSAS Mental Health Planning Council meetings will be reimbursed by the Commonwealth, subject to the specific guidelines for these reimbursements and availability of funds.

C. Commonwealth rules for documentation, utilization of vouchers, and adherence to state rates apply in all cases.

See Attachment 2 for further policy and procedures outlining Travel and Reimbursement.

IX) <u>Sunshine Laws</u>

A. Council meetings are subject to the Sunshine Law and notification under the law.

B. The general public, interested individuals, and organizations are welcome to attend Council meetings. Members of the public, commonly referred to as "Sunshine Attendees," may participate in public comment periods. At the discretion of the Co-Chairs, "Sunshine Attendees" may participate in general meeting discussions. "Sunshine Attendees" may not participate in any votes held by the MHPC.

X) Protocol Revision

A. This protocol will be reviewed annually by the Executive Committee, and recommended amendments will be submitted to the committees for approval if changes are indicated.

Updated: The annual protocol review conducted by the Mental Health Planning Council Executive Committee on 11/5/18 and suggested changes were presented to the full MHPC at the 12/10/18 meeting. Amendments were made at the meeting. The MHPC voted to approve the annual protocol update with the meeting revisions.

Attachment 1

Excerpts from the

PUBLIC HEALTH SERVICE ACT

STATE MENTAL HEALTH PLANNING COUNCIL

(a) In General – A funding agreement for a grant under section 1911 is that the State involved will establish and maintain a State mental health planning council in accordance with the Conditions described in this section.

(b) Duties – A condition under subsection (a) for a Council is that the duties of the Council are:
- (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
- (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance and other individuals with mental illnesses or emotional problems; and
- (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State

(c) Membership
- (1) In General – A condition under subsection (a) is that the Council be composed of residents of the State, including representatives of
  - (A) the principal State agencies with respect to –
    - (i) mental health, education, vocational rehabilitation, criminal justice, housing and social services; and
    - (ii) the development of the plan submitted pursuant to title XIX of the Social Security Act;
  - (B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services
  - (C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
  - (D) the families of such adults or families of children with emotional disturbance.

- (2) Certain Requirements – A condition under subsection (a) for a council is that –
  - (A) with respect to the membership of the Council, the ratio of parents of children with a serious

emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of The Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State Employees or providers of mental health services.

(c) Definition-For purposes of this section, the term "Council" Means a State mental health planning council.

Attachment 2

MHPC Travel Reimbursement Protocol

Overview

- Travel, meal, and lodging reimbursement is provided for individuals who received services/ family members/persons in recovery for Mental Health Planning Council meetings.
- If individuals are members based on organization representation, the member organizations are expected to pay for attending members' expenses.
- In order to receive reimbursement, Council members must complete and return the BCPO 3310 form that was sent to them with their appointment letter.
- You must attach itemized register receipts, hotel/ motel receipts, and any vehicle rental invoices to your request for reimbursement (do not simply attach a general credit card slip).
- General credit card receipts that are not itemized will not be accepted.
- Submission of all reimbursement requests must occur within **60 days after a meeting**.
- As long as OMHSAS makes the rental vehicle and hotel reservations, they will be made with no up-front cost to the traveler. However, the traveler may be required to submit a personal credit card for incidentals.
- Any questions about reimbursement protocol should be directed to the OMHSAS staff person making the arrangements. Individuals should not attempt to contact Enterprise or the hotel/ motel.
- OMHSAS is only able to reimburse individuals for their expenses; no advance payments will be given.

Transportation

- If you are traveling 75 miles or fewer (round trip), you may travel in your personal vehicle. You will be reimbursed at the current U.S. General Services Administration's (GSA) per mile rate ($0.545 as of January 1, 2018). The most up to date rate can be found at: https://www.gsa.gov/travel/plan-book/transportation-airfare-rates-pov-rates-etc/privately-owned-vehicle-pov-mileage-reimbursement-rates
- If you are traveling more than 75 miles (round trip), OMHSAS will offer to arrange a rental car for you. The car may not be used for non-Commonwealth business, and must be picked up and returned by the agreed-upon, designated times. Your travel time will be taken into consideration, but we ask that rental vehicles are returned directly following the MHPC meeting.
- If you are traveling more than 75 miles (round trip) and you choose to use your personal vehicle, you can only be reimbursed the lowest GSA mileage rate ($0.17 as of January 1, 2018).

Lodging

- Hotel/ Motel: If you are travelling 200 miles or more (round trip), you are eligible to stay at a hotel/ motel. OMHSAS will offer to arrange hotel/ motel accommodations for you for the night before the MHPC meeting takes place.
- You will not be reimbursed for hotel/motel arrangements unless OMHSAS makes the arrangements for you.
- Hotel rooms booked for Commonwealth business are tax exempt. Individuals are required to present a tax exempt form when checking in, to ensure that the state tax charge is taken off the bill.
- Additional night stays in the hotel/ motel, beyond what is covered for the Council meeting, will not be paid for, or arranged by, OMHSAS.
- Any incidental expenses incurred at the hotel will be the responsibility of the individual. Reimbursements are not provided for alcohol, phone calls, room service, or rented movies/ games.

Meals

Non-Overnight Status

- If you are travelling 100 miles or more (round trip), you are eligible to be reimbursed for one meal, up to $8.00.

Overnight Travelers

- The maximum reimbursement is not to exceed the GSA rate ($50/day as of October 1, 2018 including tax and tip), when qualified for overnight travel (200 miles or more, round trip).
- A day for reimbursement purposes is a 24 hour period. It is not based on a calendar date. Any travel not in a 24 hour block will be pro-rated into three hour periods. Funding is not transferrable between travel days.
- Reimbursements are not provided for alcohol.
- Allowance for subsistence are not flat rates and only amounts actually expended may be claimed. Itemized receipts must be provided.

Additional Travel Information

The MHPC Travel Reimbursement Protocol is based on the Commonwealth Travel Policy. The Commonwealth Travel Policy will be utilized to make determinations on travel reimbursement not specifically covered in the MHPC Travel Reimbursement Protocol. Current Commonwealth Travel Policy is available at: http://www.oa.pa.gov/Policies/Documents/m230_1.pdf

*All rates listed in the MHPC Reimbursement Protocol are based on the U.S. General Services Administration (GSA) rate and are subject to change. The GSA Per Diem tool is available at: https://www.gsa.gov/travel-resources

Footnotes:

The Office of Mental Health & Substance Abuse Services (OMHSAS)
Mental Health Planning Council

PROTOCOL

Introduction

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The OMHSAS Mental Health Planning Council will assume the role of State Mental Health Planning Council within its scope of responsibility.

I. Purpose

The purpose of the OMHSAS Mental Health Planning Council shall be to provide counsel and guidance to Pennsylvania Department of Human Services' (DHS) OMHSAS in order to ensure an infrastructure and a full array of mental health, substance abuse, and behavioral health 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), Cultural Competency, and Department of Drug and Alcohol Programs (DDAP).

OMHSAS Mission

OMHSAS, in collaboration with other appropriate commonwealth offices, will ensure local access to a comprehensive array of quality mental health and substance abuse services that are reflective of the needs of Pennsylvania citizens, effectively managed and coordinated, and responsive to a dynamic and changing health care environment.

OMHSAS Vision

Every individual served by the mental health and substance abuse services system will have the opportunity for growth, recovery, and inclusion in their community, have access to culturally competent services and supports of their choice, and enjoy a quality of life that includes family and friends.

OMHSAS Guiding Principles

The mental health and substance abuse services system will provide quality services and supports that:

- Facilitate recovery for adults and resiliency for children.
- Are responsive to individuals' unique strengths and needs throughout their lives.
- Focus on prevention and early intervention.
- Recognize, respect, and accommodate differences as they relate to culture/ethnicity/race, religion, gender identity, and sexual orientation.
- Ensure individual human rights and eliminate discrimination and stigma.
- Are provided in a comprehensive array by unifying programs and funding that build on natural and community supports unique to each individual and family.
- Are developed, monitored, and evaluated in partnership with individuals who have received services, families, and advocates.
- Represent collaboration with other agencies and service systems.

State Mental Health Planning Council

It is the responsibility of all OMHSAS Mental Health Planning Council members to be cognizant of and actively participate in fulfilling expectations as representatives of the broad range of individuals served by OMHSAS, as well as to meet the three primary duties assumed by these committees as the State Mental Health Planning Council. The Federal Public Health Services Act defines the duties below, and in the excerpts from the Public Health Service Act (Attachment 1).

A. To review plans provided to the Council pursuant to Section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modification to the plans.

B. To serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems.

C. To monitor, review, and evaluate, not less than once every year, the allocation and adequacy of mental health services within the State.

See Attachment 1 for further information on the State Mental Health Planning Council.

II. Membership

A. The OMHSAS Mental Health Planning Council Advisory Committees will be composed of individual representatives of youth, adult, and older adult individuals who have been served by the behavioral health system, family members of such youth and adults, providers, advocates, professionals, their respective organizations, as well as governmental

organizations. At least 51% of the members will be individuals who have received services and family members. The size of each committee will be a minimum of 20 members, but not to exceed 25 members, who shall be appointed by the OMHSAS Deputy Secretary.

1. Receiving input from Youth and Young Adults is a priority of the OMHSAS MHPC and a Youth/Young Adult Workgroup is being established to identify the best youth-friendly way to ensure that their feedback is being received. It is the intention of the MHPC Executive Committee to ensure that the result of this workgroup includes prioritized seats on the council for Youth/Young Adult members.

2. The Persons in Recovery Subcommittee will be composed of up to three voting members in the Children's Behavioral Health Committee, up to three voting members in the Adult Behavioral Health Committee, and up to three voting members in the Older Adult Behavioral Health Committee. The Persons in Recovery Subcommittee members will be voting members in the committee they are appointed to.

B. The goal in appointing members is to reflect the cultural and demographic diversity of individuals served in the Commonwealth and to maintain an equitable representation among individuals who have received services, family, advocate, and professional representatives to the fullest extent possible, while assuring 51% membership of individuals who have received services and family members.

C. Members should be current residents of Pennsylvania or be able to document substantial current involvement in the Pennsylvania mental health system.

D. In order to fulfill the federal requirements for the Community Mental Health Services Block Grant, the MHPC will ensure representation from five service areas of the state (Medical Assistance, Social Services, Vocational Rehabilitation, Criminal Justice, and Mental Health). The MHPC has set aside 11 permanent state agency seats to meet this requirement and ensure representation among the committees. The OMHSAS representative for mental health will be expected to refrain from voting as appropriate due to conflict of interest.

E. In January of each year the Executive Committee of the OMHSAS Mental Health Planning Council, in collaboration with OMHSAS staff, shall be responsible for soliciting candidates for committee membership. Individuals are encouraged to apply for membership; in addition, representative constituent organizations may recommend individuals for membership. All candidates must complete a membership application form. Applications will be held as active candidates for two years from the date of receipt.

The Executive Committee shall submit recommendations to the Deputy Secretary of persons to be appointed as members of advisory committees. The number of names to be recommended for membership will be equal to or greater than the number of positions to be filled during each year. Appointment to membership will be confirmed by an appointment letter from the Deputy Secretary in May of each year.

F. Nominees appointed by the Deputy Secretary will serve a three-year term, beginning in July of the year in which the individual was appointed. Individuals may serve two full consecutive three-year terms. After serving two full consecutive terms, individuals must wait one year before becoming eligible to reapply to become a voting member.

G. In the event of a vacancy in membership, the unexpired portion of the term shall be filled by a person to be recommended by the Executive Committee and appointed by the Deputy Secretary. If an individual fills an unexpired term for a member that is unable to complete their term, that individual may then apply to complete two full consecutive three-year terms.

H. An orientation for newly appointed members will be conducted when new members are appointed. One co-chair and one advisory committee member will conduct outreach to new members that will address such matters as the composition and purpose of the committees, the public behavioral health system, service array, OMHSAS structure, and cultural competency.

I. New members will receive an appointment letter and an advisory committee orientation packet within one month after being appointed to an advisory committee.

III. Structure

Council Co-Chairs

A. The Mental Health Planning Council will have co-chairs, who must both have lived experience as a consumer and/or family member. MHPC members shall elect co-chairs of the Council for a two year term, who shall serve until a successor has been duly appointed. Co-chairs can be re-elected for a maximum of one additional two year term, after which there must be a minimum of a two year hiatus before being considered again for the position of co-chair.

- Co-chair positions can only be held by a member of the MHPC who has served at least one year as a regular member and attended the required 3 out of 4 meetings annually. Under no circumstance will Pennsylvania commonwealth employees serve in co-chair positions.

B. In January of each year, the Executive Committee shall be responsible for soliciting nominations of individuals who are qualified and willing to serve as a co-chair. One Council Co-chair position will be up for re-election annually. Election of co-chairs shall be conducted by ballot in the Joint Session of the final MHPC meeting of the state fiscal year (typically held in May or June), with the term of office to begin July 1. Election shall be by a simple majority vote of those present and voting, providing a quorum has been reached.

C. Responsibility of Co-Chairs:

- Establish joint session agendas and consult with committee co-chairs as needed for committee agendas.
- Chair joint sessions of the MHPC
- Participate in MHPC Executive Committee meetings.
- Provide timely review and necessary response to correspondence.
- Provide liaison with the Deputy Secretary and the OMHSAS staff.
- Determine, in conjunction with OMHSAS staff, the need for workgroups.
- Ensure correspondence necessary to the function of the MHPC is completed.

- Ensure obligations of the Federal Block Grant are met, including but not limited to participating in Block Grant review meetings and Block Grant conferences.
- Participate in additional activities as requested by the Deputy Secretary, such as OMHSAS Executive Committee strategic planning sessions.

D. Co-Chair Vacancy:

In the event of a vacancy in a Council Co-chair position, the unexpired portion of the term will be filled by a person selected in a Special Election.

- The Executive Committee will solicit nominations of individuals qualified and willing to serve as a co-chair.
- A ballot of nominees will be presented to the MHPC membership during a joint session.
- Election shall be by a simple majority of those present and voting, providing a quorum has been reached.

Committee Co-Chairs

A. Each committee will have co-chairs, one of which at all times will be an individual who has received services and/or family member. Committee members shall elect co-chairs of each committee for a two year term, who shall serve until a successor has been duly appointed. Co-chairs can be re-elected for a maximum of one additional two year term, after which there must be a minimum of a two year hiatus before being considered again for the position of co-chair.

- Co-chair positions can only be held by a member of the committee who has served at least one year as a regular member and attended the required 3 out of 4 meetings annually. Under no circumstance will Pennsylvania commonwealth employees serve in co-chair positions.

B. In January of each year*, the Executive Committee shall be responsible for soliciting nominations of individuals who are qualified and willing to serve as a co-chair. One co-chair position on each committee will be up for re-election annually. Election of co-chairs shall be conducted by ballot in the committee session of the final MHPC meeting of the state fiscal year (typically held in May or June), with the term of office to begin July 1. Election shall be by a simple majority vote of those present and voting, providing a quorum has been reached.

** Note: A special election was conducted in 2006 electing one co-chair for a one year term and one co-chair for a two year term to provide continuity in committee leadership.*

C. Responsibility of Co-Chairs:

- Establish committee session agendas.
- Chair committee meetings
- Participate in Executive Committee meetings.
- Provide timely review and necessary response to correspondence.
- Provide liaison with the Deputy Secretary and the OMHSAS staff.
- Determine, in conjunction with OMHSAS staff, the need for workgroups.

- Ensure correspondence necessary to the function of the committee is completed.
- Ensure obligations of the Federal Block Grant are met, including but not limited to participating in Block Grant review meetings and Block Grant conferences.
- Participate in additional activities as requested by the Deputy Secretary, such as OMHSAS Executive Committee strategic planning sessions.

D. Co-Chair Vacancy:

In the event of a vacancy in a committee co-chair position, the unexpired portion of the term will be filled by a person selected in a Special Election.

- The Executive Committee will solicit nominations of individuals qualified and willing to serve as a co-chair.
- A ballot of nominees will be presented to the committee membership where the vacancy is held.
- Election shall be by a simple majority of those present and voting, providing a quorum has been reached.

Executive Committee

An Executive Committee of the OMHSAS Mental Health Planning Council will be comprised of the Council Co-Chairs and Co-chairs of the Children's, Adult, and Older Adult Committees to provide a structure for the coordination of the OMHSAS Mental Health Planning Council's activities, concerns, and issues. The Executive Committee will be responsible for development of agendas, completing required correspondence, making recommendations of specific tasks, and assignment of workgroups to develop information and recommendations on these issues, and making decisions on behalf of the Committee between meetings. The co-chairs are to assure Committee members are informed of actions taken by the Executive Committee between regularly scheduled Committee meetings.

The Executive Committee will act as the Membership Committee, having the authority to recommend to the Deputy Secretary persons to be appointed to the three advisory committees.

Committee Workgroups

A. Committee Workgroup Structure and Membership

The formation and purpose of Committee Workgroups will be the determination of the Executive Committee in conjunction with OMHSAS Staff to assist in issue-focused, task-oriented, time-limited work of the committees. OMHSAS Mental Health Planning Council and non-OMHSAS Mental Health Planning Council members may be selected to participate in workgroups, to ensure the necessary representation and expertise needed to meet the goals of the workgroup. When establishing workgroups, attention will be given to workgroup membership composition, with the goal of achieving appropriate representation of stakeholders as well as geographical and cultural representation of members.

B. Committee Workgroups

- Individual Committee or Joint Session establishes need for workgroup by a vote of appointed members. Workgroups will be time limited and have a specific area of focus.

- A current Council or Committee Co-Chair will lead the workgroup or the leadership of the workgroup will be assigned by a co-chair to another appointed MHPC member who will report back to the co-chair and MHPC Executive Committee.

- Workgroup develops draft timeline and a defined work product.

- Timeline and draft work product are distributed to the committee for comment via email or at regularly scheduled meeting of the committee.

- Comments considered in final product, and final product distributed to the committee.

IV. Conduct of Business

A. The business and affairs of the OMHSAS Mental Health Planning Council and workgroups shall be managed by the Council and Committee Co-Chairs. Administrative support and technical assistance will be provided by OMHSAS.

B. Notice of meetings, including the agenda for the meeting, shall be distributed to the membership not less than five working days if written, or not less than 48 hours if electronically, prior to the meeting.

C. Voting – Only appointed committee members may vote on council/committee issues. Any action before the council/committees will be presented by formal motion, seconded, and voted on by members. For voting purposes, 1/3 of all voting committee members will constitute a quorum. A simple majority of the quorum will constitute approval of any motion.

Meetings and Attendance

The OMHSAS Mental Health Planning Council can only be effective if members attend regularly and participate in discussion, development of issue statements and recommendations, and respond to requests from OMHSAS.

Meetings will occur four times per year. During the last meeting of the calendar year meetings will be scheduled for the next calendar year. The Executive Committee has the prerogative of rescheduling meetings for legitimate reasons such as scheduling conflicts or weather.

Members must RSVP promptly when notified of meetings in order to allow for adequate copies of materials. All members are expected to attend at least 3 of the 4 regularly scheduled meetings annually. If members fail to RSVP and do not attend the required meetings, the Committee Co-Chair(s) will contact the member to determine their interest in continuing on the Committee. At the discretion of the Executive Committee, members may be dismissed for lack of attendance and unexplained absences.

Attendance alone does not make a good Council member. Assisting the co-chairs in keeping the council/committees focused on the task at hand, respectful participation in discussion, and support of consensus decisions are valuable assets in Council members.

VI) Staff Support

A. OMHSAS will provide adequate staff to ensure effective committee, subcommittee, and workgroup coordination.

B. OMHSAS staff leads the development and submission of the Block Grant proposal.

C. OMHSAS will provide, at a minimum, the following support functions:
1) Meeting arrangements
2) Distribution of mailings
3) Set-up for meetings
4) Records of expenses
5) Attendance and recording of meeting outcomes
6) Travel reimbursement
7) Inter-office distribution of committee business
8) Liaison with Council and Committee Co-chairs
9) Liaison with Executive Committees
10) Sunshine notification

D. OMHSAS staff will support council, committee and workgroup functions and business as required. This includes responding to requests for information on any pertinent issues. Appropriate OMHSAS staff are expected to attend committee meetings.

VII) Conflicts of Interest

A. Definitions
a. Covered Person: all appointed MHPC Members, Co-Chairs and Staff
b. Significantly Connected Person/Entity: an individual or entity connected personally and/or financially to a covered person including, but not limited to, family members and employers
c. Conflict of Interest: a situation in which a covered person or the significantly connected person/entity of a covered person has a personal or financial interest that compromises or could compromise their independence of judgement in exercising their responsibilities to the MHPC

B. Each covered person will perform their duties for the OMHSAS MHPC in good faith for the benefit of the OMHSAS MHPC, meaning that no person may take advantage of their position on the OMHSAS MHPC for personal advantage or the advantage a significantly connected person/entity. While it is expected that the work of the OMHSAS MHPC members will broadly contribute to an improved mental health system, from which covered persons and significant people/entities may generally benefit, no covered person shall direct MHPC activity to specifically benefit themselves and/or significantly connected people/entities.

C. Potential conflicts of interest related to the MHPC include, but are not limited to, voting on MHPC business, voting on recommendations to the Deputy Secretary, and reviewing applications for MHPC membership appointments.

D. All Covered persons must avoid both actual conflicts and the appearance of conflicts of interest.

   a. If a covered person has an actual or potential conflict of interest, they may voluntarily recuse themselves from deliberations, voting, or any other MHPC activity related to the conflict of interest by reporting the conflict to a member of the MHPC Executive Committee.

   b. If a covered person has a potential conflict of interest and they do not wish to voluntarily recuse themselves, they may report the potential conflict of interest to any member of the MHPC Executive Committee immediately upon discovering the potential conflict. The potential conflict of interest will be reviewed by the MHPC Executive Committee and a determination returned to the individual within two weeks. The individual with a potential conflict of interest will refrain from taking any action related to the potential conflict during the review period.

   c. Any person, public or covered, who is concerned that a covered person may have an unreported potential conflict of interest can inform a member of the MHPC Executive Committee of their concern. The covered person will be contacted by the MHPC Executive Committee to provide background information. The MHPC EC will then review the potential conflict and advise the covered person within two weeks of their determination. The individual with a potential conflict of interest will refrain from taking any action related to the potential conflict during the review period.

VIII) <u>Travel and Reimbursement</u>- *Provided for individuals who have received services and family members.*

A. If individuals are members based on organization nomination, the member organizations are expected to pay for attending members' expenses for participation at Council meetings.

B. For individuals who are participants and not connected to an organization that has adequate resources to support reimbursement, expenses for ordinary travel and lodging for OMHSAS Mental Health Planning Council meetings will be reimbursed by the Commonwealth, subject to the specific guidelines for these reimbursements and availability of funds.

C. Commonwealth rules for documentation, utilization of vouchers, and adherence to state rates apply in all cases.

See Attachment 2 for further policy and procedures outlining Travel and Reimbursement.

IX) <u>Sunshine Laws</u>

A. Council meetings are subject to the Sunshine Law and notification under the law.

B. The general public, interested individuals, and organizations are welcome to attend Council meetings. Members of the public, commonly referred to as "Sunshine Attendees," may participate in public comment periods. At the discretion of the Co-Chairs, "Sunshine Attendees" may participate in general meeting discussions. "Sunshine Attendees" may not participate in any votes held by the MHPC.

X) Protocol Revision

A. This protocol will be reviewed annually by the Executive Committee, and recommended amendments will be submitted to the committees for approval if changes are indicated.

Updated: The annual protocol review conducted by the Mental Health Planning Council Executive Committee on 11/5/18 and suggested changes were presented to the full MHPC at the 12/10/18 meeting. Amendments were made at the meeting. The MHPC voted to approve the annual protocol update with the meeting revisions.

Attachment 1

Excerpts from the

PUBLIC HEALTH SERVICE ACT

STATE MENTAL HEALTH PLANNING COUNCIL

(a) In General – A funding agreement for a grant under section 1911 is that the State involved will establish and maintain a State mental health planning council in accordance with the Conditions described in this section.

(b) Duties – A condition under subsection (a) for a Council is that the duties of the Council are:
- (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
- (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance and other individuals with mental illnesses or emotional problems; and
- (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State

(c) Membership
- (1) In General – A condition under subsection (a) is that the Council be composed of residents of the State, including representatives of
  - (A) the principal State agencies with respect to –
    - (i) mental health, education, vocational rehabilitation, criminal justice, housing and social services; and
    - (ii) the development of the plan submitted pursuant to title XIX of the Social Security Act;
  - (B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services
  - (C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
  - (D) the families of such adults or families of children with emotional disturbance.

- (2) Certain Requirements – A condition under subsection (a) for a council is that –
  - (A) with respect to the membership of the Council, the ratio of parents of children with a serious

emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of The Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State Employees or providers of mental health services.

(c) Definition-For purposes of this section, the term "Council" Means a State mental health planning council.

Attachment 2

MHPC Travel Reimbursement Protocol

Overview

- Travel, meal, and lodging reimbursement is provided for individuals who received services/ family members/persons in recovery for Mental Health Planning Council meetings.
- If individuals are members based on organization representation, the member organizations are expected to pay for attending members' expenses.
- In order to receive reimbursement, Council members must complete and return the BCPO 3310 form that was sent to them with their appointment letter.
- You must attach itemized register receipts, hotel/ motel receipts, and any vehicle rental invoices to your request for reimbursement (do not simply attach a general credit card slip).
- General credit card receipts that are not itemized will not be accepted.
- Submission of all reimbursement requests must occur within **60 days after a meeting**.
- As long as OMHSAS makes the rental vehicle and hotel reservations, they will be made with no up-front cost to the traveler. However, the traveler may be required to submit a personal credit card for incidentals.
- Any questions about reimbursement protocol should be directed to the OMHSAS staff person making the arrangements. Individuals should not attempt to contact Enterprise or the hotel/ motel.
- OMHSAS is only able to reimburse individuals for their expenses; no advance payments will be given.

Transportation

- If you are traveling 75 miles or fewer (round trip), you may travel in your personal vehicle. You will be reimbursed at the current U.S. General Services Administration's (GSA) per mile rate ($0.545 as of January 1, 2018). The most up to date rate can be found at: https://www.gsa.gov/travel/plan-book/transportation-airfare-rates-pov-rates-etc/privately-owned-vehicle-pov-mileage-reimbursement-rates
- If you are traveling more than 75 miles (round trip), OMHSAS will offer to arrange a rental car for you. The car may not be used for non-Commonwealth business, and must be picked up and returned by the agreed-upon, designated times. Your travel time will be taken into consideration, but we ask that rental vehicles are returned directly following the MHPC meeting.
- If you are traveling more than 75 miles (round trip) and you choose to use your personal vehicle, you can only be reimbursed the lowest GSA mileage rate ($0.17 as of January 1, 2018).

Lodging

- Hotel/ Motel: If you are travelling 200 miles or more (round trip), you are eligible to stay at a hotel/ motel. OMHSAS will offer to arrange hotel/ motel accommodations for you for the night before the MHPC meeting takes place.
- You will not be reimbursed for hotel/motel arrangements unless OMHSAS makes the arrangements for you.
- Hotel rooms booked for Commonwealth business are tax exempt. Individuals are required to present a tax exempt form when checking in, to ensure that the state tax charge is taken off the bill.
- Additional night stays in the hotel/ motel, beyond what is covered for the Council meeting, will not be paid for, or arranged by, OMHSAS.
- Any incidental expenses incurred at the hotel will be the responsibility of the individual. Reimbursements are not provided for alcohol, phone calls, room service, or rented movies/ games.

Meals

Non-Overnight Status

- If you are travelling 100 miles or more (round trip), you are eligible to be reimbursed for one meal, up to $8.00.

Overnight Travelers

- The maximum reimbursement is not to exceed the GSA rate ($50/day as of October 1, 2018 including tax and tip), when qualified for overnight travel (200 miles or more, round trip).
- A day for reimbursement purposes is a 24 hour period. It is not based on a calendar date. Any travel not in a 24 hour block will be pro-rated into three hour periods. Funding is not transferrable between travel days.
- Reimbursements are not provided for alcohol.
- Allowance for subsistence are not flat rates and only amounts actually expended may be claimed. Itemized receipts must be provided.

Additional Travel Information

The MHPC Travel Reimbursement Protocol is based on the Commonwealth Travel Policy. The Commonwealth Travel Policy will be utilized to make determinations on travel reimbursement not specifically covered in the MHPC Travel Reimbursement Protocol. Current Commonwealth Travel Policy is available at: http://www.oa.pa.gov/Policies/Documents/m230_1.pdf

*All rates listed in the MHPC Reimbursement Protocol are based on the U.S. General Services Administration (GSA) rate and are subject to change. The GSA Per Diem tool is available at: https://www.gsa.gov/travel-resources

Environmental Factors and Plan

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: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
January Abel	Providers	Recovery InSight Inc		jabel@recovery-insight.com
Don Altemus	Others (Advocates who are not State employees or providers)			don.altemus@gmail.com
Judy Baker	Parents of children with SED/SUD			ASPEMOM@verizon.net
Julie Barry	Parents of children with SED/SUD			jmickelbarry@gmail.com
Rebecca Bonner	Providers	The Bridgeway School		rebecca.bonner@thebridgewayschool.org
Farida Boyer	Providers			faridasaleemboyer@gmail.com
Donnel Brown	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			tovahcenter@gmail.com
Tony Card	Others (Advocates who are not State employees or providers)			tcard@allied-services.org
Tracy Carney	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			carneyta@ccbh.com
Greg Cherpes	State Employees	DHS office of developmental programs		gcherpes@pa.gov
Kathyann Corl	Providers			kcorl@keystonehumanservices.org
Geraldine Coulson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			gerricoulson21gerricoulson21@gmail.com
Julie Dees	Providers			julie.dees@pennmedicine.upenn.edu
Barbara Deppen	State Employees	PA Department of Aging		bdeppen@pa.gov
	Individuals in Recovery (to include			

Robert Diaz	adults with SMI who are receiving, or have received, mental health services)			rdiaz@berkscc.org
Keith Elders	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			keithrelders@gmail.com
Beth Ellis	State Employees	PA Office of Special Programs		c-beellis@pa.gov
Marjorie Faish	State Employees	PA Office of Long Term Living		mfaish@pa.gov
Debbie Ference	Family Members of Individuals in Recovery (to include family members of adults with SMI)			dference@namikeystonepa.org
Ruth Fox	Parents of children with SED/SUD			rfox@alleghenyfamilynetwork.org
Tammi Gabriel-Berrong	Parents of children with SED/SUD			gabrielberrongt@magellanhealth.com
Gloria Gallagher	State Employees	PA Bureau of Drug & Alcohol Programs		glgallaghe@pa.gov
Kathleen Ganely	Others (Advocates who are not State employees or providers)	Peer Support and Advocacy Network		kganley@peer-support.org
Sandra Goetze	Family Members of Individuals in Recovery (to include family members of adults with SMI)			sgoetze@zoominternet.net
Keith Graybill	State Employees	Juvenile Court Judge's Commission		kgraybill@pa.gov
Beverly Haberle	Providers			bhaberle@councilsepa.org
Shalawn James	Others (Advocates who are not State employees or providers)	MHAPA		Sjames@mhapa.org
Zachary Karenchak	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			Zack@youthmovepa.org
Anne Katona-Lee	Providers			akatonalinn15@gmail.com
Amy Kelly	Parents of children with SED/SUD	Devereux Advanced Behavioral Health		amy.kelly@devereux.org
Lisa Kennedy	Parents of children with SED/SUD			lmkennedy1@yahoo.com
Andrew Kind-Rubin	Family Members of Individuals in Recovery (to include family members of adults with SMI)			akindrubin@cgrc.org
Christian Kohler	Providers			kohler@upenn.edu
Bernadette Kozen	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			bakkozenccxi@gmail.com
Mike Kraffick	Individuals in Recovery (to include adults with SMI who are receiving, or have received,			mkrafick@aicdac.org

	mental health services)			
Cathy Kromer	Providers			ckromer@northamptoncounty.org
Eric Kunkel	State Employees	OMAP, Bureau of Policy, Analysis and Planning		ekunkel@pa.gov
Kathy Laws	Parents of children with SED/SUD			kathylaws33@gmail.com
Diane Lichtman	Others (Advocates who are not State employees or providers)	Centre County and Central Region CSP		dsl456@gmail.com
Minta Livengood	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			livengoodminta@gmail.com
Tanya Mack	Providers			tmack@berkscc.org
Karen Mallah	Providers	Community Care Behavioral Health (CCBHO)		mallahk@ccbh.com
Christine Michaels	Family Members of Individuals in Recovery (to include family members of adults with SMI)			cmichaels@namiswpa.org
Adam Miller	Parents of children with SED/SUD	Wellspan Philhaven		amillller60@wellspan.org
Thomas Mirabella	Others (Advocates who are not State employees or providers)	East Penn School District		tmirabella@eastpennsd.org
Karen Morton	Providers	Merakey		kmorton@merakey.org
Meghan Murray	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			mmurray@stepstorecovery.com
Fred Nardei	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			taboo971@live.com
Andy Natalie	Providers	Threshold Rehabilitation Services		anatalie@trsinc.org
Hope Pesner	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			hpesner@juno.com
Arlene Prentice	Providers	Pennsylvania Certification Board		alpdst@yahoo.com
Devin Reaves	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			devin.reaves@gmail.com
Rey Remone	Parents of children with SED/SUD	Pennsylvania Compeer Coalition		rremone@sphs.org
Brian Richardson	Providers	Greater Reading MHA		brianrichardson@grmha.com
Nancy Scheible	Others (Advocates who are not State employees or providers)			nscheible@penndelmhc.org

Tina Scott	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Dr. Tina Scott LPC LLC		therapywithdrtina@gmail.com
Pam Smith	State Employees	Pennsylvania Department of Education		pammsmi@pa.gov
Robena Spangler	Providers	Rehabilitation Community Providers Association		robspangle@pa.gov
Karan Steele	Family Members of Individuals in Recovery (to include family members of adults with SMI)			karan.steele@beaconhealthoptions.com
Jill Stemple	State Employees	PA OMHSAS		jistemple@pa.gov
Fred Terling	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			fredterling@comcast.net
Michael Turk	Providers	Chartiers Center		mturk@chartierscenter.org
Jill Valient Horan	Providers	Penn Foundation, Inc.		jhoran@pennfoundation.org
Becky Van de Groef	Providers			rvandergroef@hoffmanhomes.com
Jackie Weaknecht	State Employees	PA Commission on Crime and Delinquency		jweaknecht@pa.gov
Rachelle Weiss	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	The Copeland Center		rweiss@copelandcenter.org
Keegan Wicks	Providers	RASE Project		keeganw@raseproject.org
Joshua Wilder	Others (Advocates who are not State employees or providers)			joshualwilder@gmail.com
Kimberly Williams	State Employees	PA Office of Vocational Rehabilitation (OVR)		kimbwillian@pa.gov
Mary Victoria Woodward	Providers	Naticoke/Berwick Counseling Services		mostvalwoman@yahoo.com

*Council members should be listed only once by type of membership and Agency/organization represented.

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Footnotes:

Required State Agency Representatives

State Education Agency: Pennsylvania Department of Education, Pam Smith
State Vocational Rehabilitation Agency: Office of Vocational Rehabilitation, Kimberly Williams
State Criminal Justice Agency: Pennsylvania Commission on Crime and Delinquency, Jacqueline Weaknecht
State Housing Agency: Office of Social Programs, Beth Ellis
State Social Services Agency: Office of Children, Youth and Families, Vacant as of 7/1/19 due to staff turnover
State Health (MH) Agency: Office of Mental Health and Substance Abuse Services, Jill Stemple

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	**75**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	15	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	6	
Parents of children with SED/SUD*	9	
Vacancies (Individuals and Family Members)	4	
Others (Advocates who are not State employees or providers)	8	
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	**42**	**56.00%**
State Employees	11	
Providers	21	
Vacancies	1	
Total State Employees & Providers	**33**	**44.00%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	11	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	11	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**22**	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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Footnotes:

22 Total Members of the MHPC Identified as being a member of a diverse racial, ethnic or LGBTQIA+ group.
-8 identified as members of the LGBTQIA+ Community
-14 identified as members of a diverse racial or ethnic community (including African American, Hispanic/Latinx, and Bi-racial)

Members are requested to provide this information on their application for the MHPC, but it is not a required field. Of the current members:

-24 members did not include information about LGBTQIA+ on their application
-1 member did not include information about race/ethnicity on their application

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

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Footnotes:

-This plan was discussed at the MHPC meeting on May 28, 2019. MHPC meetings are open to the public under the PA Sunshine Law and members of the public were given the opportunity to comment on the CMHBSG during this meeting, as well as appointed members.

A two week Public Comment Period opened for this application from July 19, 2019 through August 2, 2019. On 7/19/19 the public comment draft of this application was emailed to the MHPC Listserv, the OMHSAS Public Listserv, and was posted on the DHS website.