

I: State Information

State Information

Plan Year

Start Year:

2014

End Year:

2015

State DUNS Number

Number

796567790

Expiration Date

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

Agency Name

Department of Public Welfare

Organizational Unit

Office of Mental Health and Substance Abuse Services

Mailing Address

Beechmont Bldg. #32, PO Box 2675

City

Harrisburg

Zip Code

17105

II. Contact Person for the Grantee of the Block Grant

First Name

Dennis

Last Name

Marion

Agency Name

Department of Public Welfare

Mailing Address

20 Azalea Drive, Room 211, Administration Bldg., DGS Annex

City

Harrisburg

Zip Code

17110-3593

Telephone

717-787-6443

Fax

717-787-5394

Email Address

dmarion@pa.gov

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

From

To

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

3/28/2013 4:08:54 PM

Revision Date

V. Contact Person Responsible for Application Submission

First Name

Jennifer

Last Name

Parker

Telephone

717-772-7283

Fax

717-772-7964

Email Address

jenparker@pa.gov

Footnotes:

I: State Information

Assurance - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

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

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

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

Name	<input type="text" value="Dennis Marion"/>
Title	<input type="text" value="Acting Deputy Secretary"/>
Organization	<input type="text" value="Office of Mental Health and Substance Abuse Services"/>

Signature: _____ Date: _____

Footnotes:

I: State Information

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 45 CFR Part 76, and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

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 45 CFR Part 76 by:

- 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).

For purposes of paragraph (f) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

3. Certifications Regarding Lobbying

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 (45 CFR Part 93).

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)

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.

Name	Dennis Marion
Title	Acting Deputy Secretary
Organization	Office of Mental Health and Substance Abuse Services

Signature: _____ Date: _____

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certification (Form 3)

Community Mental Health Services Block Grant Funding Agreements FISCAL YEAR 2014

I hereby certify that Pennsylvania agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:

- i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved;
- ii. Evaluating programs and services carried out under the plan; and
- iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")

(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.

(C) 24-hour-a-day emergency care services.

(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.

(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) 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 illness 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)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle 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) 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.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and

(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United States Code. [Audit Provision]

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and

(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and

(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);

(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and

(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name	<input type="text" value="Dennis Marion"/>
Title	<input type="text" value="Acting Deputy Secretary"/>
Organization	<input type="text" value="Office of Mental Health and Substance Abuse Services"/>

Signature: _____ Date: _____

Footnotes:

I: 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	<input type="text" value="Dennis Marion"/>
Title	<input type="text" value="Acting Deputy Secretary"/>
Organization	<input type="text" value="Office of Mental Health and Substance Abuse Services"/>

Signature: _____ Date: _____

Footnotes:

II: Planning Steps

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

Page 46 of the Application Guidance

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health 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 gender minorities as well as youth who are often underserved.

Footnotes:

STRENGTHS AND NEEDS OF THE SERVICE SYSTEM

Legislative Base

The mental health system in Pennsylvania is organized in conformance with the Mental Health/ Mental Retardation (MH/MR) Act of 1966, the Mental Health Procedures Act (MHPA) of 1976 as amended, and the Public Welfare Code. Primary authority for the Commonwealth's public mental health program derives from the MH/MR Act of 1966 and the MHPA of 1976, as amended. The location of the **Office of Mental Health and Substance Abuse Services (OMHSAS)** and the state hospitals within the Department of Public Welfare is established in the Pennsylvania Public Welfare Code.

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 the **Office of Mental Health and Substance Abuse Services (OMHSAS)** within the Department of Public Welfare (DPW), which is a multi-program human services agency. Through OMHSAS, the state develops programs and policy, licenses most of the service components, allocates funds for services, develops guidelines for county service planning, and administers and purchases the services for the managed Medicaid behavioral health care initiative. OMHSAS administers 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. Pennsylvania prides itself in its innovative efforts to support a robust mental health service system by investing nearly \$3.8 billion state and federal dollars per year towards mental health care in the state.

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 entered into an Intergovernmental Agreement with the University of Pittsburgh, a state affiliated university, to establish the Pennsylvania Youth and Family Training Institute beginning in September, 2007. The Youth and Family Training Institute is the centerpiece 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 youth and family teams as the primary determinants of service.

In addition to Mental Health, DPW programs include Income Maintenance (public assistance), Medical Assistance (Medicaid), Children, Youth, and Families (child welfare and juvenile justice), Developmental Programs (intellectual disabilities), Long Term Living, Child Development & Early Learning, and programs for persons who are blind, hearing impaired or need other social services. Programs in other state agencies, which have a relationship with the mental health system, include the Departments of Aging, Corrections, Education, and Health, and 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 two subcommittees for transition-age youth and 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.

Highlights of the Projected Mental Health Budget for FY 2013/14

- Community Mental Health Services: \$584.9 million, that include:
 - Base Funds for Community Programs
 - Children's programs
 - The Community/Hospital Integration Projects Program (CHIPPs)
 - Southeastern Integration Projects Program (SIPPs)
 - Behavioral health Services Initiative (BHSI) - Mental Health
 - Federal MH Block Grant
 - MH allocation of the federal Social Services Block Grant
 - Projects for Assistance in Transition from Homelessness (PATH) federal grant
 - Other federal grants
- State Hospitals: \$390.2 million
- OMHSAS Administered BHSI/D&A & Act 152: \$39.1 million
- Medicaid: \$2.93billion, including managed care and fee-for-service.
- Special Pharmaceutical Benefits Program (SPBP): \$2.3 million

Role of Counties

The Mental Health and Mental Retardation (MH/MR) 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/MR Administrators. The county commissioners hire and supervise the MH/MR 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 Mental Retardation 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/MR 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.

Implementation of behavioral health managed care was completed in July 2007, when the final set of counties moved to HealthChoices, Pennsylvania's managed care system. The success of the HealthChoices Behavioral Health (HC-BH) managed care program was built in partnership with county governments. County governments were given the right of first opportunity to bid on the HC-BH program to manage risk-based contracts. 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 2013, 1.852 million individuals are enrolled in HC-BH, with a projected funding of \$2.9 billion in fiscal year 2013/2014.

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, 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, TA in the development

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 DPW's jurisdiction, Intellectual Disabilities, Child Welfare, and Homeless Assistance Programs. For the mental health part, the counties had to describe how they intended to provide an array of services to meet the mental health needs of the county residents including children and adults in the least restrictive setting appropriate to those 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.

New Initiatives

Mental Health Matters

DPW/OMHSAS has launched a broad, long-term campaign called *Mental Health Matters* to help eliminate mental health stigma and prejudices that prevent people from reaching out for help. With this initiative, the Department hopes to increase awareness that mental health disorders are real and that they can be treated or managed just like physical illnesses. OMHSAS intends to build on the state's commitment to people seeking behavioral health solutions and increase awareness of where, when and how they and their families can seek help.

The Mental Health Matters campaign will build awareness through multiple efforts, for example:

- **Additional mental health first aid training:** Providing support to enable Counties to sponsor Mental Health First Aid (MHFA) and Youth Mental Health First Aid (YMHFA) training. The goal is to have MHFA and/or YMHFA available in all counties in the Commonwealth. Part of these efforts also would include training non-professionals such as librarians or soup kitchen volunteers to quickly identify a mental disorder and equip them with the means to help. This training is already provided to many police, medics and school counselors.

- **Families as first responders:** Empower families with the knowledge to identify the early signs of mental illness before a crisis occurs because families are truly on the front lines of mental health awareness.
- **Reduce suicides among veterans:** Pennsylvania has the second highest suicide rate for veterans: 16 a day. A collaborative public-private effort is underway to address the needs of our veterans returning from war.

Service Members, Veterans, Family Members Military Project

This is a project done in collaboration with other state agencies and other entities in the field.

The priorities for this project include:

- Suicide Prevention;
- Increasing training for providers;
- Improving behavioral health system to meet the needs of population;
- Developing referral system.

STATUTORY CRITERIA ADDRESSED IN THE STATE PLAN

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]

(a) Establishment of System of Care

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.

Quality Management

Data Strategy

An OMHSAS Data Strategy for Fiscal Years 2009-2011 was the framework that capitalized on the system’s data-oriented strengths, while implementing a multi-faceted approach to overcome data-related shortcomings. This document offered a description of the two-year course that OMHSAS charted to maximize the use of data in support of its organizational mission. The data strategy is outlined using five SMART goals (Strategic, Measurable, Actionable, Realistic, Timely). The goals include:

- **Realign Resources to Build Infrastructure:** Realign essential resources in order to build needed data infrastructure;
- **Enhance Data Consolidation:** Enhance the consolidation of data collection and storage processes in order to eliminate redundancies and maximize efficiencies;

- **Improve Data Integrity:** Improve the integrity of behavioral health data to make certain that the data is of an inherent high quality;
- **Enrich Information Sharing:** Enrich the capacity of, and opportunities for, information sharing that support the interests and needs of the varied stakeholders.

To align the data strategy with actions, 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 has also contracted with an External Quality Review Organization (EQRO) vendor to provide a 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.

Root Cause Analysis

Pennsylvania continues to progress towards a data driven recovery-oriented behavioral healthcare system. In order to assess its transformation towards recovery, OMHSAS employed the Plan-Do-Check-Act method of Quality Management.

OMHSAS has collaborated the EQRO vendor to demonstrate a quality improvement function by requiring that the BH-MCOs (Behavioral Health Managed Care Organizations) would perform a Root Cause Analysis if their average for a performance measure fell into three categories of evaluation. These categories are if the measure was statistically significantly:

- 1) lower than the prior year,
- 2) lower than the state BH-MCO average for that particular measurement, or
- 3) had remained the same when the one year was compared to the former year.

The performance measurements and the BH-MCO average results for the measurement years 2009, 2010 & 2011 follow:

Statewide BH-MCO averages (%)

Performance Measures	2009	2010	2011
Follow up after Hospitalization for Mental Illness-7 days (QI-1)	45.2	45.4	45.8
Follow up after Hospitalization for Mental Illness-30 days (QI-2)	65.4	66.2	66.8
PA Specific Follow up after Hospitalization for Mental Illness-7 days (QI-A)	58.6	57.5	57.6
PA Specific Follow up after Hospitalization for Mental Illness-30 days (QI-B)	74.8	74.1	74.7
Readmission within 30 Days of an Inpatient Psychiatric Discharge (REA)	12.3	12.4	12.3

The Statewide BH-MCO averages show consistent, non-significant improvement in 2009, 2010 and 2011 for Follow-up after a Mental Health Hospitalization in QI 1 & QI 2. The Statewide BH-MCO average for QI-A, QI-B and REA is a flat performance.

The RCAs required are labeled “X” by year and performance measure in the chart below, and in all instances except for one were triggered by a non-significant changes in the BH-MCO performance measures that were below the HC BH-MCO averages for that year.

BH-MCO	Calendar Year	QI-1	QI-2	QI-A	QI-B	REA
Community Behavioral Health	2009	X	X	X	X	
	2010			X	X	X
	2011	X	X	X	X	
Community Behavioral HC Network of PA	2009	X		X		
	2010	X		X	X	X
	2011					
Community Care Behavioral Health	2009					
	2010					
	2011					
Magellan Behavioral Health	2009					
	2010					X
	2011					X
Value Behavioral Health	2009					
	2010					
	2011					
Statewide RCAs by measure	2009	2	1	2	1	0
	2010	1	0	2	3	3
	2011	1		1		1
	Totals	4	1	5	4	4

OMHSAS in consultation with the EQRO is re-evaluating the RCA requirements. In 2013, meetings with the HC Quality Improvement Directors changed from semiannual meetings to quarterly meetings. One of the areas planned will be to discuss the barriers that are impeding significant improvements in these performance measures.

Additional Health Care Quality Measures for Medicaid-Eligible Adults

The Affordable Care Act (Section 1139B) requires the Secretary of Health and Human Services (HHS) to identify and publish a core set of health quality measures for adult Medicaid enrollees. The initial publishing of the Adult Core measures occurred in 2011, with the final measure specifications published in February 2013. Pennsylvania has made the decision to implement all the measures published by HHS.

The following list contains the measures and their OMHSAS implementation year:

Measure Name	OMHSAS measure	Timing
Screening for Clinical Depression and Follow-Up Plan	X	HEDIS 2014 (CY 2013)
Plan All-Cause Readmission	X	HEDIS 2013 (CY 2012)
Follow-Up After Hospitalization for Mental Illness	X	HEDIS 2013 (CY 2012)
Antidepressant Medication Management	X	HEDIS 2014 (CY 2013)
Adherence to Antipsychotics for Individuals with Schizophrenia	X	HEDIS 2015 (CY 2014)
Annual Monitoring for Patients on Persistent Medications	X	HEDIS 2013 (CY 2012)
Care Transition–Transition Record Transmitted to Health Care Professional	X (Chart Review)	HEDIS 2015 (CY 2014)
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	X	HEDIS 2014 (CY 2013)

Other QM Activities

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

➤ **Focused Studies**

- **Follow-up after Hospitalization for Mental Illness**– Annual.
- **(NEW 2013) All Cause Readmission within 30 Days of a Physical Health, Substance Abuse and/or Mental Health Inpatient Discharge**
 - Using the Physical Health (PH) & Mental Health (MH) encounter data, this study will look at the PH, MH, and Substance Abuse (SA) claim history of individuals readmitted to the hospital within a thirty day period after discharge. The areas studied will be polypharmacy, ambulatory care, demographic data, cost and specific PH diagnoses. Statistical analyses will occur to determine the relationships between the above factors and readmission rates.

- **Performance Improvement Projects** –Annual. The results are used for federal compliance & monitoring, and provide ongoing information to the County and BH-MCO regarding the relative impact of activities designed to improve health status and outcomes.
- **Performance Measures monitoring (other uses)** Annually, Semiannually, or as determined by the QM work plans submitted by the HC Contractors. Monitoring the various processes 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

- **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:
 - structure and operations standards established by the State,
 - validation of performance improvement projects,
 - validation of plan performance measures.
 - In addition, OMHSAS will implement additional voluntary EQR Protocols with BH-MCOs to meet Pennsylvania's data strategic goals & initiatives. These include the following:
 - BH encounter data validation
 - BH-MCO HEDIS© performance measure compliance
 - Informational System Capabilities Assessment
- **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 County/BH-MCO.
- **Behavioral Health Complaints, Grievances and Appeals Data** – Semi-annual/quarterly data; Used to track and trend denied service grievances and other problems within the system; Can also be used to identify problems with the County, BH-MCO or providers.
- **Health Status/ Outcomes** – Annually; Monitoring and reporting provide ongoing information to the County and BH-MCO regarding the relative impact of activities designed to improve health status and outcomes. At the OMHSAS level, the activity provides a systemic overview of activities at local levels and allows for the identification of areas for improvement and successful/ potential best practices. (This report is currently undergoing a revision as we have moved into a new waiver.)
- **Provider Self Report Data - Survey of Providers** – Annual; Activity 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.
- **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 review findings found to be less than full compliance can result in a Corrective Action Plan (CAP), which is followed until resolution. OMHSAS has implemented a PEPS web-based application to speed the collection of monitoring data and to increase the efficiency of the input of data and data retrieval for program monitoring needs.

(b) Available Services

Health, Mental Health, and Rehabilitation Services:

Medical Assistance for Workers with Disabilities (MAWD)

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 (ACT)

Over the past few years, OMHSAS has been strongly promoting the expansion of fidelity-based ACT programs in the state. Pennsylvania currently has 42 ACT or ACT-like programs (also called Community Treatment Teams – CTT) in the state. The ACT bulletin issued by OMHSAS in 2008 established the standards for the delivery of ACT services in the state. In late summer 2010, OMHSAS piloted a standard statewide licensing tool, with the intention of using the tool to license ACT teams across the state. This tool is currently being used to license all ACT teams across the state. Licensing began late 2011, and as of March 2013, 20 of 42 teams have been licensed.

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

Mental Health Crisis Intervention Services are immediate, crisis-oriented services designed to ameliorate or resolve precipitating stress. These services are provided to adults and children, and their families, who exhibit an acute presentation of disturbed thought, behavior, mood or social relationships.

The telephone crisis service must be available 24 hours a day, seven days a week. A crisis service may extend to petitioning for commitment but may not include the functions of review, approval or disapproval. These services are always considered to be on an emergency basis.

Rehabilitation Service:

Psychiatric rehabilitation assists persons, 18 years or older, with functional disabilities resulting from mental illness to develop, enhance, and/or retain: psychiatric stability; social competencies; personal adjustment; and/or independent living competencies so that they experience more success and satisfaction in the environments of their choice and function as independently as possible. These interventions should occur concurrently with necessary clinical treatments and should begin as soon as clinically possible, following diagnosis. A planned program of goal setting, functional assessment, identification of needed and preferred skills and supports, skill teaching, and managing supports and resources, is needed to produce the desired outcomes consistent with a person's wishes, ambitions, choice, and cultural environment.

From 2001 until 2013 Psychiatric Rehabilitation Services (PRS) in the Commonwealth operated under a set of standards developed in 2001. PRS providers and other key stakeholders have noted inconsistencies in the 2001 Standards. The new regulation, Chapter 5230, is carefully designed to improve consistency of PRS design, delivery and licensure and is in accordance with evidence-based and best practice approaches and with the principles and practices of the United States Psychiatric Rehabilitation Association (USPRA). Chapter 5230 is projected to be published in final-form in May 2013 with an effective date 90 days after publication.

PRS has expanded from 22 licensed providers in 2005, to 130 licensed providers in 2013. Pennsylvania has the largest chapter of the United States Psychiatric Rehabilitation Association (USPRA) in the country, the Pennsylvania Association of Psychiatric Rehabilitation Services (PAPRS). The Commonwealth also has the largest professional workforce of Certified Psychiatric Rehabilitation Practitioners (CPRP) in the nation.

Fairweather Lodge: Fairweather lodges are small groups of four to eight people who share a house and own a small business. Each group must select a business to operate, for which they develop and implement a business plan. Lodge businesses include transportation, Medicaid-funded peer supports, 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 35 Fairweather lodges with an additional 20 lodges in various stages of development. Pennsylvania is at the forefront of the development of a nationally endorsed certification plan and process to insure fidelity to the Fairweather lodge standards. Certification of all Pennsylvania lodges, regarding adherence to Fairweather lodge fidelity standards. Pennsylvania recognizes the importance of continued and consistent participation in

national outcome reporting by all Pennsylvania lodges. Currently several Pennsylvania lodges participate in national outcome reporting.

OMHSAS continues to promote the development of a statewide coalition of Fairweather lodge coordinators. The Fairweather lodge programs hold regional meetings to further the growth of the lodge principles and practices among the Pennsylvania lodges.

Clubhouse: Clubhouse is a community-based, social and vocational rehabilitation program based on the world famous Fountain House model. This model features work and membership as the primary methods for providing participants with increased opportunities in employment, housing, education, skill development, and social activities. Based on the successful model established by Fountain House in New York City in 1948, the unique feature of clubhouses is the focus on work as the primary rehabilitative tool through which members are engaged and recover functioning. Member participation and involvement in all aspects of clubhouse operation, functions, and decision-making, is integral to the clubhouse model. Peer support, education, self-determination, responsibility, and the opportunity to be employed in real work settings, are also of vital importance.

Membership in the Pennsylvania Clubhouse Coalition (PCC) is contingent upon a clubhouse having or moving toward International Center for Clubhouse Development (ICCD) certification and fidelity to the clubhouse principles. The PCC has the second greatest number of ICCD certified clubhouses of any state in the nation. PCC currently has 19 of 24 clubhouses ICCD certified, and 14 of those 19 are OMHSAS licensed. When the new regulation for Psychiatric Rehabilitation Services goes into effect in 2013, all clubhouses will be required to be OMHSAS licensed. OMHSAS is providing technical assistance and training in order to bring all PA Clubhouses, as well as all other all PRS agencies, into compliance with the new regulation

Facility Based Vocational Rehabilitation Services: Facility Based Vocational Rehabilitation Services are programs designed to provide remunerative developmental and vocational training within a community-based, specialized facility (sheltered workshop) using work as the primary modality. Sheltered workshop programs include vocational evaluation, personal work adjustment training, work activity training, and regular work training and are provided in facilities licensed under Vocational Facilities regulations.

Employment Services

The Employment Transformation Project

In 2007, OMHSAS began a pilot project providing 15 counties with consultation to help them implement the evidence-based practice of Supported Employment. In 2011, OMHSAS embarked on a different phase of the project, providing technical assistance and consultation with the help of four of the exemplary counties from the initial pilot projects. Those counties were Allegheny, Beaver, Cumberland/Perry and Montgomery and represented urban, suburban and rural interests. The four counties, with technical assistance and training from two state-contracted consultants from Temple University, provided technical assistance to five (5) additional counties/MH-ID joiners during FY 2011-2012, continuing to December 2012. The additional counties were Armstrong/Indiana (dropped out after change in county administration), Bucks, Delaware, Franklin/Fulton, and Northampton. Two more counties/joiners, Blair and

Luzerne/Wyoming, were also offered phone consultation/technical assistance, but chose not to pursue the opportunity. Throughout the project, these counties received assistance from the exemplary counties, Temple consultants, and OMHSAS. As part of the project, we also held monthly teleconferences which were then opened up to all stakeholders from July 2012 to December 2012. The exemplary counties have continued on their paths of making employment a priority, while the additional counties have all taken steps to increase knowledge of employment for the stakeholders in their counties and have made some policy/programmatic changes to begin the transformation.

Employment Development Initiative (EDI) Grant

In January 2012, OMHSAS was one of nine states to be awarded an Employment Development Initiative grant from SAMHSA/NASMHPD. OMHSAS contracted with consultants from Temple University Collaborative on Community Inclusion to facilitate and provide technical assistance for this project. As part of this project, we established an advisory committee that assisted in developing an OMHSAS guidelines document that clarifies the roles of certified peer specialists (CPS) in supporting the employment goals for individuals under the current Medicaid regulations. We will hold a webinar for all interested BH-MCOs, county staff, and provider staff in March 2013 to discuss these guidelines.

Additionally, OMHSAS contracted with consultants from Mental Health Association of SE Pennsylvania to develop a classroom CPS curriculum and with Recovery Opportunities, Inc. to develop an online CPS curriculum, both for enhancing employment support for individuals. The classroom curriculum was piloted with 30 CPS and CPS Supervisors in December 2012. The online curriculum was piloted with over 40 CPS and CPS Supervisors in January 2013.

We are currently in the process of working with Temple University Collaborative to develop a community of practice setting for CPSs, who support individuals in the area of employment. Temple University Collaborative is also in the process of assessing the effectiveness of the two curricula that were developed and piloted.

Medicaid Infrastructure Grant

In 2009, DPW recruited AHEDD, a private, non-profit organization that promotes the development and employment of people with disabilities, to serve as the grant administrator to assist in the coordination of key project activities associated with the Medicaid Infrastructure Grant (MIG). The MIG provides funding for programs that address the employment issues of individuals with disabilities. Throughout the past two years, AHEDD and DPW solicited requests for mini-grants from counties or agencies. The topics for these requests included: promotional activities for the employment of people with disabilities, and outreach and education activities targeted to students with disabilities and/or their families in order to assist them in seeking employment or postsecondary education. Throughout each request process, a workgroup of various stakeholders convened to determine which requests would provide for the most efficient use of funding and would impact the widest range of individuals. The mini-grants provided up to \$5000 for plans that addressed the specific topics. OMHSAS participated in this process, and the final round of mini-grants was given during the winter of 2011/2012, as the MIG funding has ended.

DPW utilized MIG funds to provide training to agencies, stakeholders, and individuals. The “Work Incentives Training: A Practical Introduction to the Work Incentives Available for People with Disabilities” that was held in various regions of the Commonwealth to reach a more diverse audience. As many of the trainings reached participant capacity, additional training dates were added to the agenda.

Housing Services

See Housing addressed under **IV. Narrative Plan** → **M. Recovery**

Educational Services

Supported Education

Through OMHSAS support, the Horizon House Inc. Technical Assistance team promotes the development and expansion of the Education Plus model Supported Education programs to selected partners across Pennsylvania. In 2008 this partnership led to the selection of a proposal from Northwest Human Services (NHS) Foundation Scholarship Program. The Mosaic House Education Plus Program in Berks County is a component of their Clubhouse program. Horizon House currently has two Education Plus programs, one for adults and one for transition-age youth.

The College Plus Program at Bucks County Community College (BCCC) Voice and Vision, Inc. (formerly Bucks County CSP), has educational specialists who work with students attending BCCC.

It is anticipated that the Education Plus model will provide a framework for markedly improved student performance, retention and graduation outcomes within the existing NHS Scholarship Program. The program tracks outcome information including grades, attendance, retention, and student satisfaction. Education PLUS hosts a combined graduation ceremony every year at the Philadelphia Community College for both Horizon House and Mosaic House participants. Horizon House has had numerous students who graduated with their degrees, including Master’s degrees, each year. Mosaic House has also begun to have progressively more students graduate each year, since its inception in 2007.

Substance Abuse Services:

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 new 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 Public Welfare, 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 such as the American Society of Addiction Medicine Patient Placement criteria (ASAM-PPC-2R) for children and adolescents under the age of 21. The Pennsylvania Client Placement Criteria (PCPC) is utilized for adults.

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.

Medical and Dental Services:

Medical Provisions

Medicaid covers a variety of services including hospital care (both inpatient and outpatient), nursing home care, physician services, laboratory and x-ray services, immunizations and other early and periodic screening, diagnostic and treatment (EPSDT) services for children, family planning services, health center and rural health clinic services, nurse midwife services, and nurse practitioner services.

Under the Fee-for-Service Program, individuals use their “ACCESS” card to pay for doctor visits, hospital care, and other types of healthcare, services, and items. Another program in Medicaid is ACCESS Plus, a Primary Care Case Management program. In this program recipients are assigned a Primary Care Provider (PCP), who is the care giver for basic services. If a specialist is needed the PCP would make referral to the necessary physician enrolled in the program. The third option is the enrollment in a managed care program.

Pennsylvania’s Medicaid benefit program is one of the most comprehensive in the country and extends eligibility to a number of optional populations, such as: (1) individuals who are in an institution, such as a nursing home, and whose income is under 300 percent of the FPL;

(2) individuals who would be eligible if institutionalized, but who are receiving care and home and community-based services (HCBS) waivers; (3) children with disabilities, regardless of their family's income and assets; (4) certain individuals with disabilities that work and have a family income of less than 250 percent of the FPL, who would qualify for SSI if they did not work; and (5) certain uninsured or low-income women who are screened for breast or cervical cancer through a program administered by the Centers for Disease Control and Prevention (CDC).

Pennsylvania also covers "medically needy" individuals. Medically needy individuals would be eligible for Medicaid under one of the mandatory or optional groups, except that their income and/or resources exceed the eligibility level. However, eligible medical expenses may be used to reduce their income, thus making them eligible for Medical Assistance.

Pennsylvania also has a 100% state-funded medical assistance program "General Assistance." Single individuals can qualify for coverage (subject to income and resource limits) under the General Assistance program if they are unable to work due to a temporary or permanent disability, are a pending SSI recipient, are blind, or fit into other General Assistance related categories.

Dental Provisions

The availability of dental benefits that a Medical Assistance (MA) recipient is eligible for varies according to the category of assistance. MA provides coverage for the following dental services:

- All medically necessary dental services for children under age 21
- Categorically needy individuals 21 years of age or older are eligible for all medically necessary dental services. Families who meet the financial eligibility requirements for Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI) or an optional state supplement are defined as categorically needy.
- Dental services are also provided for medically needy only adults for palliative treatment or if the condition of the patient requires services to be provided in a Short Procedure Unit (SPU), Ambulatory Surgical Center (ASC), or Inpatient Hospital.
- Beneficiaries in nursing homes and Intermediate Care Facilities for Persons with Mental Retardation (ICF-MR) are afforded the same coverage as adults.

Support Services

Suicide Prevention

Pennsylvania follows the National Action Alliance for Suicide Prevention in advancing suicide prevention throughout the Commonwealth. In 2006, Pennsylvania developed a state plan for suicide prevention among Adults and Older Adults. This Plan governs 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 State Police, as well as key stakeholder groups throughout the state including the Veterans Affairs. In 2012, the National Strategy for Suicide Prevention was revised. Pennsylvania's state plan for suicide prevention is in the process of being reviewed and updated to include what is in the current National Strategy.

The Pennsylvania Adult/Older Adult Suicide Prevention Coalition merged with Feeling Blue Suicide Prevention Council to become a 501(c)3 non-profit organization. The Coalition currently has 363 members, and has expanded its Board of Directors to include members from most regions of the state. The Board also has various Committees for Coalition members to serve on: Executive, Finance, Training, and Communications. The Communications Committee is fostering a relationship in facilitating the exchange of information between the Coalition and local county task forces.

The Coalition has expanded its infrastructure by creating a website, www.preventsuicidepa.org. The Coalition has also created a quarterly newsletter. The Coalition sponsored 30 Question Persuade and Refer (QPR) trainings since July 2011. Two regional Suicide Prevention Training Forums and one Strategic Planning for Suicide Prevention training were held in the second half of 2011. The Coalition is currently in the process of planning two events for 2013, an annual Statewide Conference and a Veterans Symposium. Supporting veterans is a priority of the Coalition. OMHSAS is also sponsoring a member of the Suicide Prevention Coalition to attend the 46th Annual Conference of the American Association of Suicidology to be held in Austin, Texas in April 2013.

In 2011 Pennsylvania was awarded a second Federal grant to continue statewide efforts to prevent youth suicide and promote early intervention. Awarded by SAMHSA, the grant provides Pennsylvania with \$477,706 for three years to continue efforts that promote early intervention, assessment services to at-risk youth, and collaboration among programs and services.

The new grant has expanded to include six counties in the southeast (Berks, Bucks, Chester, Delaware, Montgomery and Philadelphia) and two counties in the west (Allegheny and Westmoreland), in addition to Monroe County and the counties covered under the original grant (Lackawanna, Luzerne, and Schuylkill). Through the grant, called Youth Suicide Prevention in Primary Care (YSP-PC), the Department will continue to partner with Primary Care Offices to screen youth ages 14-24 and coordinate referrals with local behavioral health providers for community mental health treatments as well as provide immediate support and information and resources to families.

YSP-PC will give primary care providers the resources necessary to increase their knowledge of, and comfort with, assessing for suicide risk, increase the identification of youth at increased risk for suicide, and increase the number of youth referred from primary care who successfully engage in behavioral health treatment. The grant will expand YSP-PC to at least 30 primary care practices by the third year of the project, enabling over 7,500 youth to be screened annually.

In year one of the renewal grant, a new partnership was solidified with the newly established Pennsylvania Physical Health/Behavioral Health Learning Community (PH/BH LC). This statewide group consists of representatives from the State Departments of Welfare and Health; the state medical, psychiatric, psychological and social work associations; and a number of advocacy groups across the state. The vision of the PH/BH LC is to “advance Commonwealth wide efforts to improve the provider focused planning, policy development, communications,

and practice enhancing collaboration and coordination of care between behavioral health providers and primary care providers serving Pennsylvania residents of all ages.

Compeer

Compeer matches caring, sensitive and trained volunteers in one-to-one friendships with adults and older adults referred by mental health professionals. The PCC (Pennsylvania Compeer Coalition) has 9 active Compeer affiliates throughout the state. Representatives from PCC partnered with Compeer Incorporated and submitted an application to NREPP (National Registry for Evidence Based and Promising Practices) for potential national recognition as an evidence-based practice. The application is currently in the review process. Compeer Inc. is looking to begin a new pilot program called CompeerCorps “Vet to Vet” program, which is currently operating as a pilot program in several counties in New York. CompeerCorps fosters elements of mentoring, support and camaraderie. These elements provide natural supports and help lower the cost of treatment by reducing crisis services, intervention, and dependency on behavioral health systems for veterans who are affected by mental injury or illness. Pennsylvania is collaborating with Compeer Inc. to begin several pilot programs as well. A statewide Compeer retreat will be held in April 2013 where representatives from all Pennsylvania programs will be in attendance. The last retreat was held in April 2012. Those in attendance received training in *QPR (Question, Persuade and Refer) Gatekeeper Suicide Prevention, WRAP PALS, and Compeer: Where Recovery, Peer Support and Community Integration Unite.*

Family Support Services

Family Support Services refers to supportive services provided to persons with mental illness and their families. These services are designed to enable persons with mental illness to live at home with minimal stress or disruption to the family unit, or to enable the person to live independently in the community.

Peer Support Services

Pennsylvania’s peer specialist initiative continued to grow and develop over the past year. Currently, more than 2,500 individuals have met the 75-hour, 10-day training requirement to become Certified Peer Specialists (CPS) and nearly 1,000 individuals have been trained as supervisors of CPS. Pennsylvania currently has the largest cadre of CPS of all states. An estimated 55% to 60% 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 February 2013, Pennsylvania has 93 approved and licensed peer support service programs.

Pennsylvania has undertaken multiple peer support initiatives. Over the past year Pennsylvania has developed a one-day, five-hour documentation training course for CPS to enhance their Medicaid documentation skills. Moreover, Pennsylvania, in collaboration with the Temple University Collaborative on Community Inclusion, is administering a survey of 200-300 recipients of peer support services at targeted peer support providers. Pennsylvania intends to use the survey data to refine the delivery of peer support services in the Commonwealth. In addition, Pennsylvania’s Department of Corrections is instituting the 75-hour, 10-day CPS training program within its facilities and has trained roughly 100 CPS so far, 10 percent of whom are serving life sentences. Finally, Pennsylvania has developed two curricula—a one-day, face-

to-face training course and an online training course—for CPS in supporting individuals with employment goals. Pennsylvania has also produced a policy guidance paper for CPS that identifies Medicaid-reimbursable employment services.

Forensic Services

A Center of Excellence (CoE) for the development and improvement of programs serving adults with mental illness involved in the criminal justice system was established in 2010 through a joint grant to Drexel University and University of Pittsburgh Medical Center to act as a clearinghouse for information and resources related to criminal justice, mental health, and substance abuse. Activities and priorities of the CoE are guided by the Advisory Committee and include cross-systems mapping for counties. To date, 27 counties have successfully completed cross-systems mapping workshops and 6 counties are waiting to complete their session. In addition the CoE has completed a cross-systems mapping for the PA Department of Corrections as it relates to individuals with mental illness serving a state sentence. The CoE completed a survey of 33 county law enforcement and criminal justice offices. Of those surveyed, 56% identified needs focused on training for behavioral health issues.

In partnership with Pennsylvania Mental Health Consumers Association (PMHCA) and Drexel University, OMHSAS developed a forensic peer support curriculum and trained 100 individuals throughout the state. In addition, a total of 14 individuals have been trained as trainers. In collaboration with Pennsylvania Department of Corrections (DoC), a curriculum for Certified Peer Specialist training has been developed. A total of 5 trainings were conducted throughout various State Correctional Institutions and a total of 90 incarcerated individuals were trained as Certified Peer Specialists. In partnership with the Department of Corrections, OMHSAS is assisting in the development of a Train the Trainer program to help expand and sustain the Certified Peer Specialist program throughout all State Correctional Institutions.

Criminal Justice Mental Health Advisory Committee, 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*; and (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.

Based on the most recent Forensic Plans submitted by the counties in the state, forty-one (41) County MH/MR offices (out of 48) have services in all five intercepts. Forty-six (46) counties/joiners have initiatives pertaining to Intercept 1, while forty-three (43) counties/joiners have initiatives on Intercept 2. Forty-seven (47) counties/joiners have stated they have initiatives to address Intercept 3, forty-seven (47) counties/joiners have initiatives around Intercept 4, and forty-six (46) counties/joiners stated they have initiatives related to Intercept 5.

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.

The target population for MMHT consists of adults 21 years of age or older who meet the medical necessity guidelines for psychiatric outpatient services, and have a medical or psychiatric condition that impairs their ability to participate in psychiatric outpatient services, or have one or more significant psychosocial stressors that impair their ability to participate, or preclude participation, in psychiatric outpatient clinic services.

Adult Developmental Training (ADT)

Adult Developmental Training 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.

Services under the Individuals with Disabilities Education Act (IDEA)

Discussed under Criterion 3.

Case Management Services

In Pennsylvania, mental health case management services are categorized as Administrative Case Management and Targeted Case Management. Targeted Case Management includes Intensive Case Management, Resource Coordination, and Blended Case Management.

Administrative Case Management

Administrative Case Management refers to those activities and administrative functions undertaken to ensure intake of consumers 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

Targeted Case Management (TCM) is provided in the Commonwealth of Pennsylvania to adults with severe and persistent mental illness, and children with a serious emotional disturbance who are eligible for Medical Assistance under the State Plan as categorically needy (aged, blind, disabled-eligible for SSI, and families and children who are eligible for TANF), and medically needy (aged, blind, disabled, families and children). Consumers who meet the medical necessity criteria for targeted case management, but are not eligible for Medicaid and do not have other means to pay could be eligible for targeted case management services paid for from state funds. Targeted Case Management services are administered either directly by the County MH/MR administrations or by the providers contracted by the County MH/MR administrations. Targeted Case Management services are available in the entire state.

Authorized under Section 1915(g) of the Social Security Act, Case Management services are services that will assist mentally ill individuals 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: Intensive Case Management (ICM) provides assistance to persons with serious and persistent mental illness in a variety of ways and is intended to assist the consumer 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: Resource Coordination (RC) is targeted to individuals with serious and persistent mental illness who do not need the intensity and frequency of contacts provided through Intensive Case Management, but who do need assistance in accessing, coordinating, and monitoring resources and services. Resource Coordination 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 Blended Case Management 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 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 consumer 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 ways that consumers receive case management-like services that are not distinctly identified as Case Management, and are not currently captured by existing data collection systems as Case Management, including: community treatment teams, the case

management provided by primary therapists, and finally, case management-like activities provided by peers, friends, families, natural supports and other human service systems

OMHSAS believes Case Management is a core service, and a lot of emphasis is placed on training case managers. Two training institutes (Drexel University Behavioral Health Education, Penn State Education and Health Services, Western Psychiatric Institute and Clinic) provide core Case Management training, approved and required by the state, to all new case managers. A biennial “refresher” training for all case managers was also mandated beginning in 2012.

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

Co-occurring services continue to be supported as a collaborative effort between the Department of Public Welfare, Office of Mental Health and Substance Abuse Services and the Department of Health. This collaboration began in 1997 with the convening of a statewide stakeholder workgroup charged with developing recommendations for a system of care that would meet the needs of individuals diagnosed with a co-occurring substance use and psychiatric disorder. Four key areas were identified to transform the existing system: competent workforce, co-occurring training courses, clinical standards, and adolescent services. Pennsylvania has made progress in the aforementioned areas and continues to work towards true integration of the behavioral health system.

The state collaborated with the Pennsylvania Certification Board (PCB) to develop a co-occurring disorders certification process for clinical professionals. The Certified Co-Occurring Disorders Professional (CCDP) credential requires documentation of education, clinical experience, supervision, and completion of a written examination. Over 1,000 professionals in Pennsylvania have received this credential. In January of 2007, the International Certification and Reciprocity Consortium (IC&RC) announced it would offer an international and reciprocal certification for clinicians working with individuals with co-occurring substance use and psychiatric disorders. This international credential was based upon the Pennsylvania certification model. Professionals continue to meet the criteria and test for this credential. Training opportunities to enhance clinical skills related to co-occurring disorders continue to be provided by Drexel University, Western Psychiatric Institute, as well as other entities in a variety of locations across the state. Additionally, the state has provided web-based training opportunities in partnership with the Institute for Research, Education, and Training in Addictions (IRETA).

The Departments of Public Welfare, OMHSAS, and the Department of Health, Division of Drug and Alcohol Program Licensure issued a joint Bulletin outlining the core competency criteria for any licensed treatment program to achieve to be certified as a co-occurring competent program in the Commonwealth. The bulletin criteria could be applied to any level of care for either a mental health or substance use program. It allowed programs with a single license to expand their programs to serve individuals with a co-occurring disorder. Licensed facilities continue to use the Bulletin criteria to shape their programs to become competent to provide services to individuals with co-occurring disorders.

To continue to develop a true integrated treatment system that would create minimal burden on the existing provider network, the Departments, in conjunction with a statewide stakeholder workgroup, developed a set of integrated treatment regulations applicable to outpatient facilities. The goal is to have each Department promulgate the same set of regulations which will allow licensed facilities to provide integrated treatment under a single licensure framework. The draft regulations were completed at the end of the previous administration and were not promulgated. The draft regulations remain an interest for OMHSAS moving forward and are a part of the current regulatory review process requested by the new administration. Stakeholders continue to support the integrated treatment regulations.

Various regional coalitions continue to develop co-occurring programming resources and support training opportunities for professionals. The counties and MCOs have partnered to increase access to co-occurring services and supports across the state.

Other Activities Leading to Reduction of Hospitalization

Pennsylvania has two approaches to 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 reduction of available state mental hospital beds through the Community Hospital Integration Program Project (CHIPP) and other funding sources.

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 CHIPP's 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 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

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 January 2013, hospital census for the six state hospitals was 1421 (including both civil and forensic populations). This signifies a decrease of 32 from the census (1452) at the beginning of July 2012.
- 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, 3134 people have been discharged since inception (including those expected to be discharged through June 2013).
- By June 2013, total funding of \$3,234.2 million will have been distributed to support discharge and transition to community.
- During FY 2012/13, Community Hospital Integration Project Program (CHIPP) funding included annualizing 90 CHIPPs at Norristown State Hospital.
- The CHIPP/SIPP funding for FY 2012/13 is \$244.2 million.

Positive Practice Resource Team (PPRT)

The Positive Practice Resource Team (PPRT) is a joint initiative between OMHSAS and the Office of Developmental Programs (ODP) to serve those individuals with a dual diagnosis of mental health challenges and developmental delays. The goals of this initiative are twofold:

- To build capacity within the provider network in Pennsylvania to serve dually diagnosed individuals (MH/MR). This is accomplished by providing consultative/educational services to the provider network.
- To encourage state hospital diversion through the provision of consultative services that assist the provider in continuing to serve the consumer in their home environment.

All referrals for PPRT services are obtained through the consumer's county of residence. After a review of the present situation, a PPRT team is organized to assist the consumer, the provider and the county. All team members are state employees of either a Pennsylvania State Hospital or Pennsylvania State ODP Center. Team members, along with regional office staff (OMHSAS and ODP) and county staff meet with the consumer, the provider, and the county, to assess the present situation. The consumer's present crisis, barriers to obtaining services, medical concerns, and any other identified issues are assessed. A work plan for meeting the needs of the consumer is developed and shared with all team members. PPRT teams, on average, meet with the consumer/provider/county for 3-4 visits before concluding the referral. In the event that another crisis occurs, teams can be re-activated to serve the parties involved.

Since its inception in 2006, PPRT has served a total of 416 consumers with a dual diagnosis of intellectual disabilities and mental health challenges. In 2011 there were 64 referrals for PPRT services from across the Commonwealth. Of these 63 individuals, a possible

state hospital/state center admission was discussed or considered for 28 individuals. However, following PPRT intervention, 16 of these individuals were admitted to a state hospital/center. Due to a change in admission policy within the state hospitals, any individual who is identified as having an intellectual disability must have a PPRT referral prior to admission. There were 7 individuals in 2011 slated for admission to a state hospital/center (either by the county or a county judge) that was not a previous PPRT referral. These 7 individuals had a PPRT completed after the state hospital/center admission request. After PPRT involvement, 1 of these individuals was diverted from a state hospital/center admission and was able to continue residing in the community.

In 2012 there were 22 referrals for PPRT services from across the Commonwealth. Of these 22 individuals, a possible state hospital/center admission was discussed or considered for 10 consumers. However, following PPRT intervention, 7 consumers were admitted to a state hospital/center. These seven consumers include one consumer slated for an admission to a state hospital/center that did not have a previous PPRT. She was admitted to a State Center prior to referral being formulated. Due to changes in 2012, all consumers being considered for a state hospital admission must be assessed by qualified staff to determine if a state hospitalization is appropriate. There were 2 reviews done in 2012. One of these individuals was admitted to a State Hospital.

The State continues to refine and improve the referral process in response to input from the counties and the staff that serve on the team. OMHSAS has developed a plan of action for the county and the providers to follow for future crisis events. OMHSAS also developed a Pre-PPRT course of action for counties and providers to follow to ensure that all interventions and resources are utilized at the first signs of impending difficulties. OMHSAS currently has over 230 volunteer staff from the state hospitals/centers involved in the PPRT initiative. These professional staff members serve on PPRT teams in addition to their primary job commitments.

Money Follows the Person (MFP):

In 2010 – 2011, 8 individuals were transitioned from state hospitals into the community utilizing the MFP demonstration program. In 2011, OMHSAS applied for and received 100% federal funding for 3 full-time staff positions dedicated to MFP: one Human Services Program Specialist Supervisor to coordinate and oversee the MFP demonstration program within OMHSAS, one Adult Transition Coordinator to work with transitioning adults from State Hospitals, and one Youth Transition Coordinator to work with youth under 21 to transition from Psychiatric Residential Treatment Facilities (RTF).

OMHSAS continues to partner with the State Hospitals to review individuals for MFP eligibility on a regular basis. Currently, effort is being made to update the protocol for nursing home referrals from the state hospitals with the intention of diverting more individuals into community-based living.

A proposal to transition persons under the age of 21 in Psychiatric Residential Treatment Facilities (PRTF) through Pennsylvania's MFP program has been approved by CMS. OMHSAS is pursuing different options to move forward with this addition to the program.

Criterion 2: Mental Health System Data Epidemiology

(a) Estimate of Prevalence

The newest federal prevalence estimates released in July 2010 indicate that there are 538,690 adults aged 18 and older with Serious Mental Illness in Pennsylvania. This is 5.4% of the total civilian population of age 18 and over (9,975,732). The estimates also indicate that Pennsylvania has 143,892 children {age 9-17, *level of functioning* less than or equal to 60 (average of low and high)} with Serious Emotional Disturbance (SED).

The following tables show the number of distinct adults (age 18 and above) and children (age 17 and below) that received mental health services during the state FY periods indicated in the tables:

***Number of Adult Consumers Served Under HealthChoices (Managed Care)**

2010/11, Qtr 1	2010/11, Qtr 2	2010/11, Qtr 3	2010/11, Qtr 4	2010/11, Total
195,462	193,684	201,957	202,720	295,670

*** Number of Adult Consumers Served Under Fee-For-Service (FFS)**

2010/11, Qtr 1	2010/11, Qtr 2	2010/11, Qtr 3	2010/11, Qtr 4	2010/11, Total
20,347	19,108	22,504	20,158	62,504

*** Number of Child Consumers Served Under HealthChoices (Managed Care)**

2010/11, Qtr 1	2010/11, Qtr 2	2010/11, Qtr 3	2010/11, Qtr 4	2010/11, Total
101,886	106,599	108,725	112,704	155,650

*** Number of Child Consumers Served Under Fee-For-Service (FFS)**

2010/11, Qtr 1	2010/11, Qtr 2	2010/11, Qtr 3	2010/11, Qtr 4	2010/11, Total
4740	5123	5256	5001	13,862

* Fiscal Year **totals** are unduplicated within each payment stream (i.e. HealthChoices, FFS). There may be some duplication between the two payment streams in the FY totals.

* 2010/11 was the most recent FY for which complete information was available.

(b) Quantitative Targets

OMHSAS continues to encourage the trend towards moving funding from state administration to county administration. For the proposed 2013/14 budget, it is estimated that 87% of state dollars (\$3,434,292,571) will be under county administration, with only 13% of funds (\$509,963,494) under state administration. During FY 2012/13, Community Hospital Integration Project Program (CHIPP) funding included annualizing 90 CHIPPs at Norristown State Hospital.

As of January 1, 2013: 1.852 million people were enrolled in HealthChoices –Behavioral Health (HC-BH). The projected HC-BH funding for fiscal year 2013/14 is \$2.9 billion.

OMHSAS continues to research the possibility of using a different instrument and mechanism for collecting and reporting outcomes data. Currently, a customized version of the Mental Health Statistics Improvement Program (MHSIP) report card survey instrument is being utilized to survey adult consumers and family members. In 2012, we sent surveys to 5,000 adults, 5,000 families, and about 1,700 adult consumers of peer services. Our response rate for those mailings was about 30%. This was an increase from about 17% in previous years, due in part to our using reminder postcards that were sent a week after the initial mailing.

Medicaid Targets Specific to Children’s Services

Based on the expenditure data from the past fiscal year, it is estimated that \$1,046,972,033 of HealthChoices (Pennsylvania’s Medicaid managed Care Program) funding will be spent on inpatient, residential, and community based services for children in FY 2013/14. In addition to the Health Choices funding, it is estimated that \$27,335,231 Medicaid *fee for services* (FFS) dollars will be spent on inpatient, residential, and community based services for children. These numbers do not include services funded fully with state, local, or grant (federal or other) dollars. The following chart shows the breakdown of Health Choices and *fee for services* funding for various children’s services:

Service Name	HC Expenditures
Inpatient Psychiatric	\$75,195,334
Inpatient D & A	\$5,946
Non Hospital D & A	\$2,028,041
Outpatient Psychiatric	\$116,908,944
Outpatient D & A	\$8,850,139
Behavioral Health Rehab Services	\$553,107,374
RTF - Accredited	\$110,188,239
RTF - Non Accredited	\$35,339,445
Ancillary Support	\$668,365
Other	
Community Support	\$144,680,207
<i>Crisis</i>	\$2,518,042
<i>Family Based</i>	\$96,673,329
<i>ICM/RC</i>	\$43,457,414
<i>ICM-ACT</i>	\$2,031,422
Total	\$1,046,972,033
Service Name	FFS Expenditures
Inpatient Psychiatric	\$4,277,712
Inpatient D & A	\$10,785
Outpatient Psychiatric	\$6,966,507
Outpatient D & A	\$45,455

Behavioral Health Rehab Services	\$12,474,360
RTF - Accredited	\$1,852,186
RTF - Non Accredited	\$533,016
Ancillary Support	\$9,444
Community Support Services (CSS)	\$1,165,766
<i>Crisis</i>	\$67,537
<i>Family Based</i>	\$829,445
<i>ICM/RC</i>	\$268,784
Total	\$27,335,231

Criterion 3: Children’s Services

Child and Adolescent Service System Program (CASSP)

Pennsylvania is guided by the Child and Adolescent Service System Program (CASSP) 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. Each county or joinder has at least one 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.

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.

Pennsylvania System of Care Partnership

Pennsylvania has been awarded a federal grant to develop Systems of Care to serve youth ages 8-18 that have serious mental health needs, and their families. These youth are also involved with child welfare or juvenile justice, and are in, or at risk of, out-of-home placement. The \$9 million grant from SAMHSA covers 6 years and will be implemented in fifteen Pennsylvania counties. With this grant, Pennsylvania has joined 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) as the engagement and care planning process for 25 - 50 youth annually, with over 1,000 youth and families to be served during the course of the cooperative agreement with SAMHSA. 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.

The initial counties, Erie, York, Lehigh, Chester and Montgomery counties began in 2010 and in 2011 were joined by Philadelphia. In 2012, 5 additional counties, Crawford, Venango, Northampton, Northumberland and Greene were approved to be in the next wave of system of care counties. The goal is to eventually expand the structured approach of System of Care development to all Pennsylvania counties.

Early Childhood Mental Health

OMHSAS has been working with the Office of Child Development and Early Learning (OCDEL) and other program offices in the Department of Public Welfare to promote healthy social-emotional development in young children while also preventing challenging behaviors. One model that is being used is Early Childhood Mental Health (ECMH) consultation, which addresses current emotional and behavioral challenges with the purpose of preventing the need for more intensive intervention in the child's future. The project has been implemented statewide, through the regional offices of the Pennsylvania Key. Early care and learning facilities enrolled in OCDEL's Keystone STARS quality improvement program have access to the services of an early childhood mental health consultant.

The ECMH consultation project works closely with practitioners in early care and learning facilities to help them create environments that assist healthy social and emotional development, and minimize challenging behavior. They also observe and possibly refer individual children who are experiencing difficulties. The project enhances the practitioners' capacity to encourage development of positive relationships and create a learning environment that promotes positive behaviors. In the most challenging scenarios, and as appropriate, the county CASSP Coordinators help the ECMH consultants through the referral process to the mental health system. OMHSAS offers a child psychiatrist who is available to provide phone and e-mail clinical consultation services to the ECMH consultants. The psychiatrist is also available to provide professional development in early childhood mental health topics to the consultants. A contracted staff person from OMHSAS helps to promote early childhood mental health in various publications and on the web.

OMHSAS is also supporting the expansion throughout the Commonwealth of Parent-Child Interaction Therapy (PCIT), an evidence-based practice especially well-suited for work with young children and their families. OMHSAS staff are members of a statewide steering committee for a grant from the National Institute of Mental Health that will help to training clinicians from at least 70 agencies across the state in PCIT. Behavioral health managed care organizations are also assisting counties in providing training in 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 (EBP's)

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 EBPs 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 (MST)

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 14 providers of MST in Pennsylvania, operating a total of 48 teams. All of these programs are enrolled in Medical Assistance. MST providers are approved to bill Medical Assistance for youth served in 47 counties. 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 (FFT):

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 10 FFT sites 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 support counties in their efforts to better meet the respite needs of families.

The Pennsylvania State Budget for Fiscal Years 2007-2008, 2008-2009 and 2009-2010 included \$500,000 each year for all county MH/MR Programs to receive funds for respite services. The formula used to determine allocation of funds is based on the number of children served in counties’ behavioral health system in 2007. For example, if a county served 10% of the total number of children served in the state, that county received 10% of the available funds. In 2012-2013 the total respite allocation awarded was \$451,860 and no county received more than \$101,366. The chart below shows statistical data from FY 2011-2012 and the previous Fiscal Years:

	Fiscal Year 2011-2012	Fiscal Year 2010-2011	Fiscal Year 2009-2010
Amount of allocation spent	95 percent	94 percent	91 percent
Number of counties spending 90%-100% of allocation	37	36	34
Number of	1,137	1,694	1,369

unduplicated children served			
Number of hours of respite provided	57,304	51,047	67,185
Number of days/weeks of respite provided	256 days/night	508	524 days
Unspent allocation	3 counties/joinders spent less than half the money allocated to them (reasons for not spending the allocation included liability issues, criminal clearance issues, and lack of providers)	5 counties/ joinders spent less than half of the money allocated to them (reasons for not spending the allocation included delay in receipt of funds, lack of providers, and liability issues)	8 counties/joinders spent less than half of the money allocated to them (reasons for not spending the allocation included delay in receipt of funds, lack of providers, and liability issues)

The table below illustrates the final FY 2012-2013 Respite Allocation for each County:

County	Respite Allocation
Allegheny	\$41,496
Armstrong/Indiana	\$5,616
Beaver	\$6,447
Bedford/Somerset	\$4,500
Berks	\$13,872
Blair	\$5,887
Bradford/Sullivan	\$1,215
Bucks	\$10,023
Butler	\$4,617
Cambria	\$4,500
Cameron/Elk	\$4,500
Carbon/Monroe/Pike	\$7,246
Centre	\$4,519
Chester	\$6,353
Clarion	\$2,390
Clearfield/Jefferson	\$5,417
Columbia/Montour/Snyder/Union	\$4,500
Crawford	\$4,519
Cumberland/Perry	\$0
Dauphin	\$10,321
Delaware	\$13,980
Erie	\$9,622

Fayette	\$9,000
Forest/Warren	\$4,500
Franklin/Fulton	\$4,519
Greene	\$4,519
Huntingdon/Mifflin/Juniata	\$6,348
Lackawanna/Susquehanna	\$9,429
Lancaster	\$11,487
Lawrence	\$6,652
Lebanon	\$5,400
Lehigh	\$10,737
Luzerne/Wyoming	\$11,805
Lycoming/Clinton	\$5,078
McKean	\$5,020
Mercer	\$5,985
Montgomery	\$11,216
Northampton	\$8,719
Northumberland	\$5,021
Philadelphia	\$101,366
Potter	\$4,500
Schuylkill	\$4,500
Tioga	\$4,519
Venango	\$4,519
Washington	\$7,896
Wayne	\$4,519
Westmoreland	\$11,366
York/Adams	\$11,700
Total Amount Utilized	\$451,860

School Based Behavioral Health (SBBH)

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. 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 four years ago. Currently, over 200 schools in Pennsylvania are in some stage of the implementation process. As of spring 2012, SWPBIS has been fully implemented in 74 elementary schools, 13 middle schools, 10 high schools and 14 k-12 schools, and long-term high fidelity SWPBIS is likely to occur. In addition, the

Commonwealth has been supporting the growth of program-wide PBIS in the Early Childhood learning setting.

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.

Community Residential Rehabilitation Services

Community Residential Rehabilitation Services (CRRS) are transitional residential programs delivered in community settings. They provide short-term, out-of-home, therapeutic living environments in a family setting, with personal assistance and a full range of psychosocial rehabilitation services. CRRS are for children and adolescents who display severe interpersonal adjustment problems and who require an intensive, structured living environment. The child or adolescent must be under the age of 18, an un-emancipated minor, and have demonstrated, over a period of time, maladaptive interpersonal behavior that significantly impairs the child's functioning within the family and among peers.

Residential Treatment Facilities

Residential treatment facilities (RTF) provide a 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 a serious emotional disorder, 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 k-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 Health 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 IU's.) The Regional Coordinators are responsible for the oversight of county SAP operations, as well as of the Commonwealth Approved Trainers, 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. In addition, the SAP training model has recently changed to a k-12 training design. CAT's were required to submit a comprehensive k-12 training design and manual for review and approval by PNSAS staff for the 2012-2013 school year.

During the 2011-2012 school year, there were 70,032 students referred to the SAP program statewide. Of those students referred to the SAP process, 21,063 were referred for a MH, D&A or co-occurring assessment by a qualified professional or SAP Liaison

Services Provided Under Individuals with Disabilities Education Act (IDEA)

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, 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 (IEP)

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 Public Welfare 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 as well as children/adolescents (if the services are age appropriate for children/adolescents)].

(a) Homeless Outreach and Services

The following guiding principles direct the work of the Commonwealth's Interagency Council on Homelessness:

- Assure that the Commonwealth of Pennsylvania provides a continuum of services, coordinated and delivered by agencies, which offer homeless consumers choices in the manner and amount of assistance they will need to achieve and maintain their maximum level of independence.
- Seek creative ways to utilize current resources and to leverage new resources to prevent homelessness and to assist the homeless population.
- Assure access to supportive services and affordable housing in all areas of the state.
- Assure that the quantity and quality of affordable housing and services meets the needs of the homeless population.
- Assure that each state department and agency, in conjunction with the Council, devises plans and strategies designed to prevent homelessness and address the needs of the homeless population that are consistent with the vision statement and guiding principles.
- Assure that the state departments and agencies identify outcomes and strategies to monitor those outcomes.
- Develop and maintain state and local intergovernmental relationships to coordinate and manage resources to assure access by homeless families and individuals.
- Develop community partnerships with private sector businesses, foundations, lenders, civic organizations, hospitals, childcare, and community based social and treatment services to address local homeless needs.
- Assure the prevention of homelessness through improved discharge planning and other prevention techniques and by expanding the number of affordable accessible housing options.

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, particularly in the large metropolitan areas of Philadelphia and Pittsburgh. Every county mental health program has identified a housing specialist. The specialists receive technical assistance from OMHSAS.

Alignment with SAMHSA's Strategic Initiative #3: Military Families

OMHSAS supports Projects for Assistance in Transition from Homelessness (PATH) programs that have developed collateral contacts with local veterans' organizations to identify and enroll eligible homeless veterans. The PATH coordinator, during the site visits, strongly encourages all PATH providers to continue to make special efforts to reach veterans who are among the unsheltered homeless.

Additionally, counties have been working with their local VA and other agencies that service homeless veterans and their families in establishing partnerships in order to better serve homeless veterans within the community. In the attached IUPs, counties have highlighted many different and sometimes unique activities to service veterans and their families.

OMHSAS will provide support and leadership through a collaborative and comprehensive approach to increase access to appropriate services, prevent suicide, promote emotional health, and reduce homelessness among the veteran population. OMHSAS will continue to encourage the use of PATH funding to facilitate PATH-eligible innovative community-based solutions that foster access to evidence-based prevention, treatment, and recovery support services for military service members, veterans, and their families.

Alignment with SAMHSA's Strategic Initiative #4: Recovery Support

In November 2006, A Plan for Promoting Housing and Recovery-Oriented Services, was drafted with support from consumers, providers, County MH/MR programs and other stakeholders, to provide guidance to County MH/MR Programs for their planning, resource allocation and development of effective supportive housing models and modernization of housing approaches. The Plan spells out specific actions for OMHSAS, its state partners and County MH/MR Programs for housing policy and development. With this, many counties began partnering with various supportive housing programs within the county to provide PATH related services to its PATH consumers.

OMHSAS recognizes that in order for people to recover, people need a safe, stable place to live. Therefore many PATH programs provide rental assistance and security deposit payments for many of its PATH consumers to secure stable housing and receive the range of supports they need to manage mental illnesses or other disabilities.

OMHSAS also recognizes that in order for people to recover, individuals need to be full, participating members of their communities. Individuals with behavioral health conditions do not recover in isolation—they recover with families and in the community. Therefore, PATH counties have partnered with local drop-in centers and club houses to provide community based services to its

PATH consumers. This provides the much needed socially valued activity, adequate income, personal relationships, recognition and respect from others.

Our PATH programs have formed successful collaborations with other community agencies in an effort to promote rehabilitation and support, to increase and accelerate the likelihood of recovery for those with behavioral health illnesses. Some PATH funds programs employ a peer support specialist to assist PATH consumers in their recovery journey. Additionally, OMHSAS allocates funds to programs that provide linkage and referral services to PATH consumers.

Homeless Continuum of Care Steering Committee

Serving as the working body to support the efforts of the Interagency Council on Homelessness, DCED and DPW/OMHSAS continue to manage the statewide Homeless Steering Committee, which addresses programs and policies to assist the homeless in the Commonwealth. The state PATH coordinator also serves on this committee. This Committee works with and through the four rural Regional Homeless Advisory Boards (RHABs) which develop and maintain a Continuum in each region, representing 55 of the state's 67 counties. The Continuum of Care Steering Committee defines and addresses those barriers which could ultimately result in homelessness for individuals and their families.

Agenda for Ending Homelessness

The Commonwealth developed the "Agenda for Ending Homelessness in Pennsylvania" to govern the work of the Interagency Council and guide the efforts of the Homeless Steering Committee and local Continuums of Care. Pennsylvania's Agenda for Ending Homelessness is based upon three state-driven strategies. These strategies serve as the backbone for the implementation of the Plan's Action Steps, which will occur at both the state and local levels. Those strategies include:

- **To 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.
- **To 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.
- **To promote recovery-oriented housing and services for homeless individuals with serious mental illness, substance abuse and/or co-occurring disorders.** The Commonwealth of Pennsylvania and its Office of Mental Health and Substance Abuse Services 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.

Currently, 55 counties (out of a total of 67 counties in the state) have formed LHOTs in which representatives from the County Office of Mental Health, Public Housing Authority, and other public and private agencies meet regularly to plan for increased availability of accessible, affordable housing opportunities for people with mental illness. The major purpose of the 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) from the county department of mental health/mental retardation.

Homelessness Statistics

The following table shows the homelessness statistics for various regions of the state:

REGION	Number of Homeless with SMI
1. Southeast PA	
Philadelphia County	1230
Delaware County	136
Montgomery County	73
Bucks County	33
Chester County	129
Total Southeast PA	1601
2. Central PA	
Altoona/Central PA CoC (Adams, Bedford, Blair, Cambria, Centre, Clinton, Columbia, Cumberland Franklin, Fulton, Huntingdon, Juniata, Lebanon, Lycoming, Mifflin, Montour, Northumberland, Perry, Snyder, Somerset, and Union Counties)	88
Dauphin County	45
Lancaster County	84
York County	24
Total Central PA	241
3. Northeast PA	
Northeast PA CoC (Bradford, Carbon, Lehigh, Monroe, Northampton, Pike, Schuylkill, Sullivan, Susquehanna, Tioga, Wayne, and Wyoming Counties)	59
Luzerne County	50
Berks County	86
Lackawanna County	49
Total Northeast PA	244
4. Southwest PA	
Southwest PA CoC (Armstrong, Butler, Fayette,	193

Greene, Indiana, Washington, and Westmoreland Counties)	
Allegheny County	218
Beaver County	54
Total Southwest PA	465
5. Northwest PA	
Northwest PA CoC (Cameron, Clarion, Clearfield, Crawford, Elk, Forest, Jefferson, Lawrence, McKean, Mercer, Potter, Venango, and Warren Counties)	64
Erie County	103
Total Northwest PA	167
PA TOTAL HOMELESS WITH SERIOUS MENTAL ILLNESS	2,718

The data presented above was collected on a single night during the last week in January 2012, in most cases, the night of January 25, 2012. Each CoC in Pennsylvania provided the data that they assembled for submission to HUD on the 2012 HDX, the reporting software used to report on Housing Inventory and Populations and Subpopulations for the McKinney-Vento/HEARTH Continuum of Care (CoC) application process. 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, Safe Haven or were unsheltered on the night of the CoC's Point-in-Time count. It does not, however, include unsheltered homeless in the four regions. They will conduct their next unsheltered count in January 2013.

While the Homeless Subpopulations Chart in the HDX is the primary data source available at the present time, OMHSAS continues to recognize the following limitations:

1. This data is collected through a Point-in-Time count and does not reflect the total number of homeless individuals over the course of a year.
2. The data is based on HUD's very specific definition of homeless – those living in emergency shelters, transitional housing for the homeless, safe havens for homeless individuals and in places not intended for human habitation (unsheltered).
3. The data on the number of homeless who have serious mental illness is generally self-reported by the individuals being surveyed or by shelter staff or outreach workers. This can result in inaccuracies and varying assumptions about what constitutes serious mental illness.

We continue to strive toward generating a count of homeless with serious mental illness using the Homeless Management Information System (HMIS) in each CoC, however, currently the level of participation is not adequate for an accurate count. The PA Department of Community and Economic Development (DCED) has established an HMIS for the 55 Counties included in the four rural regions of the Commonwealth as well as York and Bucks Counties.

The other CoCs have established their own HMIS. The various CoCs have made significant progress in upgrading their systems to meet changing HUD data quality standards and in achieving full participation; however, they still do not have full coverage. In addition, 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 was introduced with the implementation of HPRP was a designation of people who are not homeless but received homeless prevention services. This will enable the HMIS to better report on people with mental illness who are at risk of homelessness and therefore PATH eligible. Further, in the coming year, we anticipate a higher level of participation in HMIS by PATH funded programs.

Finally, through the HMIS, we will be able to generate an unduplicated count of all homeless individuals with mental illness served throughout the year, rather just a point in time count.

Projects for Assistance in Transition from Homelessness (PATH)

Created under the McKinney Act, the **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. Since 2001, OMHSAS has employed a full time staff person to manage the PATH grant. The PATH Coordinator oversees all activities related to the PATH program and monitors County MH/MR Programs that receive PATH funds as well as the local programs they may sub-contract with. This staff person is also the OMHSAS point person for all homelessness-related activities.

OMHSAS contracts with 24 County MH/MR Program Offices to provide PATH services. Many of the MH/MR program offices that receive the PATH grant then sub-contract with local community providers to provide PATH services. More than 5,000 eligible individuals received PATH- funded services in FY 2011.

The counties and contracted providers have developed innovative PATH programs to best serve the needs of the SMI homeless population in their geographical areas, with some of the recent awardees adopting evidence-based practices like Critical Time Intervention (CTI). In general, the services provided for PATH eligible individuals include: outreach; screening and diagnostic treatment; habilitation/rehabilitation; community mental health services; alcohol 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.

Most of the PATH programs provide services to all PATH eligible adults, while there are a few programs that focus on transition-age youth that meet the PATH eligibility criteria. The age-wise breakdown of number of individuals served per the last completed state-wide PATH report is as follows:

<u>Age:</u>	<u># Served</u>
Less than 13	0
13-17	7

18-34	934
35-49	963
50-64	660
65-74	97
75 and older	201
Unknown	21

(b) 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 2010, nearly 3.5 million residents, or 27 percent of the state’s 12.7 million residents, lived in a rural county. From 2000 to 2010, rural Pennsylvania’s population grew about 2 percent. According to the U.S. Census Bureau’s 2011 American Community Survey, Public Use Microdata Sample (ACS-PUMS), in 2011, there were an estimated 15% of rural Pennsylvanians with disabilities. Among those, 51% had physical difficulties, followed by cognitive difficulties (43%), and independent living difficulties (34%).

From 2000 to 2010, rural Pennsylvania became more racially diverse. In 2000, there were about 157,200 residents, or 5 percent of the total population, who were non-white and/or Hispanic. In 2010, 260,300 rural residents, or 8 percent of the total population, were non-white and/or Hispanic. At the school district level, 235 of the state’s 501 public school districts are rural. In the 2009-2010 academic year, an estimated 451,137 students were enrolled in Pennsylvania’s 235 rural school districts. From 2006 to 2010, the number of rural students decreased 5 percent; Pennsylvania Department of Education’s enrollment projections predict that total enrollment in rural schools will decline by 7 percent from 2010 to 2020.

Rural counties frequently utilize satellite clinics, mobile teams, or other specialized services designed for that population. Several counties have shortages of dentists, psychiatrists, psychologists, and social workers. 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.

Telepsychiatry

Telepsychiatry is a service shown to be effective in rural settings. Telepsychiatry is the use of electronic communication and information technologies to provide or support clinical psychiatric care at distance. The service includes evaluating patients in crisis and in need of inpatient hospitalization, assessment, medication management, and psychotherapy. It is appropriate in situations where on-site services are not available due to distance, location, time of day, or availability of resources. These services would be provided by a psychiatrist or licensed psychologist within their scope of practice using real-time, two-way interactive audio-video transmission.

Currently, Pennsylvania has Telepsychiatry programs serving the counties listed below, several of which also serve children and adolescents.

Beaver County	Berks County	Carbon County
Monroe County	Pike County	Schuylkill County
Bucks County	Cambria County	Clarion County
Clearfield County	Elk County	Jefferson County
Erie County	Fayette County	Warren County
Greene County	Indiana County	Bradford County
Luzerne County	Lycoming County	Cameron County
McKean County	Wyoming County	McKean County
Potter County	Tioga County	Somerset County
York/Adams Counties	Chester County	Allegheny County
Mifflin County	Clinton County	Blair County
Dauphin County	Cumberland County	Perry County
Sullivan County	Lackawanna County	Susquehanna County
Wayne County		

(c) Services for Older Adults

Priorities for older adults are established and monitored through the Older Adult Advisory Committee of the State Mental Health Planning Council. Those priorities include systems collaboration, advocacy, training, and development of older adult services. The development of peer supports for older adults and Mobile Mental Health Treatment (MMHT) are consistent with OMHSAS' goals of supporting recovery and resiliency.

OMHSAS' objective for older adults is *“to assure that behavioral health services and supports recognize and accommodate the unique needs of older adults.”* The implementations of peer support services and Mobile Mental Health Treatment (MMHT) in 2007 were major milestones in providing access to recovery promoting services for older adults.

Transformation Transfer Initiative

In July 2008 OMHSAS piloted an older- adult competent, one day training class for Certified Peer Specialists (CPS) interested in learning more about working with older adults. This pilot was funded by a Transformation Transfer Initiative (TTI) grant from SAMHSA. An enhanced three day training class was also piloted for CPS who would like to specialize in working with older adults. Over the past year Pennsylvania has developed and expanded two 18 hour continuing education courses for CPS desiring to specialize in either Older Adult Peer Supports

In December 2011 Pennsylvania was awarded a third TTI Grant. The third phase of TTI was a collaborative process with New Jersey. The grant allowed a class of 20 Peer Specialists from New Jersey to be trained in the 18 hour Certified Older Adult Peer Specialist Curriculum. The grant also allowed for a class of 20 PA COAPS to be trained in Wellness Coaching which was developed by the University of Medicine and Dentistry, New Jersey.

Following the trainings, Pennsylvania created an internship for a COAPS/Wellness Coach in a Federally Qualified Health Center. Plans for a second COAPS/Wellness Coach internship are in development. The second internship will be housed in either the aging or housing arena. PA continues to work towards utilizing CPSs in non-traditional service settings.

Collaboration with Other Systems on Older Adults

OMHSAS continues to collaborate with the Department of Aging to provide support and involvement with the Pennsylvania Behavioral Health and Aging Coalition. A product of this collaboration is the regional Behavioral Health and Aging Forums. Five regional training forums were held in 2012. The forums focused on innovative and promising practices that county MH, Aging and Single County Authorities (SCAs) can utilize to better meet the mental health and substance use disorders needs of Older Adults.

Mental Health/Aging Memorandum of Understanding

Since 2006/07 all counties are required to create a Memorandum of Understanding (MOU) between the County Offices of Mental Health and County Offices of Aging to address the needs of older adults in behavioral health system. OMHSAS and the Department of Aging, in collaboration with the University of Pennsylvania, conducted trainings to help counties to work effectively to remove barriers and overcome obstacles that interfere with the collaborative process.

One of the most significant innovations in the development of supports for older adults is the ongoing work with “Share the Care,” the collaboration between the County Mental Health Offices and the Area Agencies on Aging (AAA) to improve consumer services and outcomes for older adults. Initially started in 2005, it was a complex care review process between Aging and OMHSAS to assist with complex care resolution in three specific counties. “Share the Care” has since evolved into a statewide initiative to foster MH/AAA partnership to address the broader needs of older adults with behavioral health and other social needs.

In 2010 as part of the “Share the Care” initiative, an MOU workbook was developed to offer technical assistance to counties in the development and/or revision of their MOUs. The

workbook was distributed to every County MH/MR Administrator and each Area Agency on Aging. The workbook is also available online at www.parecovery.org. Additionally, an MOU Evaluation Tool was developed and finalized in May, 2011. This tool will be used to evaluate each MOU and to help identify best and promising practices as well as counties in need of technical assistance.

Each County MOU was evaluated in August 2011 by a team of reviewers comprised of Aging, Mental Health and MH Planning Council members. The MOU evaluation tool was used to identify promising practices within counties. The tool also helped in identifying counties that may benefit from technical assistance to improve collaboration between MH, Aging and SCAs. Counties were made aware of the availability of T/A during the Regional Forums held in the spring of 2012, via emails sent to county programs via the PA Association of Area Agencies on aging, the PA Association of County Administrators of Mental Health and Developmental Services, and the PA County Drug and Alcohol Administrators Association. Counties were also offered TA during meetings of PBHAC, or at events in which PBHAC participated.

Six counties were selected and received technical assistance. The counties identified next steps to strengthen collaboration and improve services to Older Adults. Follow-up with the counties will occur at three and six months.

Pennsylvania Adult & Older Adult Suicide Prevention Plan

The Pennsylvania Adult and Older Adult Suicide Prevention State Plan governs the work of the state's suicide prevention task force which consists of multiple state offices including the Department of Aging, Department of Corrections, Department of Health, and State Police, as well as key stakeholder groups throughout the state including the Veterans Affairs.

Criterion 5: Management Systems

[Most of the discussions under this criterion apply to both adults as well as children/adolescents, while some apply exclusively to adults or children. The ones that apply only to one group are identified as such].

(a) Resources for Mental Health Providers

Financial Resources

The general state revenue funds, county funds, Medicaid dollars, Mental Health Block Grant, Substance Abuse Block Grant, Social Services Block Grant, PATH grant, and other federal grants comprise much of the funding pool that County MH/MR Programs use to provide services to their consumers.

Training Resources

OMHSAS sponsors technical assistance (TA) and training on a variety of areas to counties and provider agencies. Some examples are: Peer Specialist training, Case Management training, TA in the development of evidence-based practices like ACT, and TA for the development of housing options in the counties.

The State also contracts with three training institutes, namely, Drexel University Behavioral Health Education, Penn State Education and Health Services, and Western Psychiatric Institute and Clinic (WPIC) to provide an array of behavioral health training opportunities to community service providers, consumers, family members, and other stakeholders. Drexel University provides training in the Eastern region of the state, Penn State in the Central region, and WPIC in the Western region. The following is a list of some of the topics on which training is offered by one or more of these institutes:

- 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
- Forensic Psychiatry
- Assessment and Treatment Strategies
- Crisis Intervention
- Emergency Preparedness
- Evidence-Based Treatment for Addiction and Psychiatric Illnesses
- Motivation Interviewing Skills for Case Managers
- Cultural Competency
- Psychiatric Rehabilitation

The above list is not comprehensive. The training institutes develop new courses on advanced topics as the needed.

Direct Care Worker Initiative

Beginning in 2001-02, Pennsylvania started a long-term process to support provider efforts to recruit and retain direct care staff in Home and Community Based Programs for the elderly and persons with disabilities. This initiative is based on the belief that local communities can better understand the difficulties of recruiting and retaining staff, and thus be better able to develop strategies to remediate those difficulties. Funding was provided by both the Department of Aging and the Department of Public Welfare.

Direct care worker funding has been used by the counties to support various initiatives including: increasing wages or benefits; staff recognition awards or events; media campaign for recruitment; advertising; hiring incentives including sign-on bonuses and employee referral bonuses; longevity awards such as gift certificates; one time bonuses for attendance and performance; and voucher programs for personal expenses such as health care (not covered under health care plans), tuition, and child care.

Cultural Competency Resources

Pennsylvania's *Cultural Competence Strategic Plan* represents OMHSAS' approach to continue raising the level of clinical competency in the Commonwealth's Behavioral Health system and to continue creating the necessary supports needed to provide cultural competency training. OMHSAS has a long history of working to ensure that cultural competency is embedded into all activities within the system. State, regional and local training on cultural competency has been provided to OMHSAS employees, County Administrators, providers, consumers and families. OMHSAS has also used block grant dollars in the past to seed cultural competency pilot projects to address the major cultural groups (Asian, African-American and

Latino/Hispanic) experiencing service disparities. Pennsylvania also has a relationship with the Pennsylvania Association of Latino Organizations (PALO). PALO has provided training and technical assistance to Latino organizations and state mental hospitals on cultural competence.

OMHSAS also sponsored a three-day Cultural Competency training for direct service staff during 2010 in conjunction with Drexel University. More than 40 clinicians, case managers, rehabilitation staff, and peer specialists participated in the training. The training included a special emphasis on LGBTQI competencies and many of the participants identified as part of the LGBTQI community and/or were currently serving individuals from those communities. Participants in the training indicated that there was a great need for additional cultural competency training and, in particular, advanced training on LGBTQI issues.

LGBTQI Bulletins

In January 2011, OMHSAS issued two bulletins as a follow-up to the recommendations contained in “Issues of Access to and Inclusion in Behavioral Health Services for Lesbian, Gay, Bisexual, Transgender, Questioning and Intersex Consumers” by the *Keystone Pride Recovery Initiative* (KPRI). KPRI is a project to develop and establish procedures to help LGBTQI individuals seeking behavioral health services in Pennsylvania. The goal of KPRI is to ensure that individuals are not discriminated against based upon sexual orientation, gender identity, and gender expression, in the behavioral health system. KPRI partnered with OMHSAS to work towards the following: protecting LGBTQI consumers; ensuring culturally-appropriate places of care for LGBTQI consumers; and educating providers around unique issues facing LGBTQI consumers. OMHSAS Bulletin 11-01, “*Non-Discrimination Toward Lesbian, Gay, Bisexual, Transgender, Questioning and Intersex People,*” and OMHSAS Bulletin 11-02, “*Guidelines to Ensure Affirmative Environments and Clinically Appropriate Services for Lesbian, Gay, Bisexual, Transgender, Questioning and Intersex Consumers and Their Family Members,*” are intended to move the behavioral health system forward in addressing discrimination and the lack of appropriate services for these populations

KPRI is offering one day trainings “Creating Welcoming and Affirming Services for Persons Who Are Lesbian, Gay, Bi-sexual, Transgender, Questioning or Intersex (LGBTQI)” and three day trainings “Principles and Practice for Clinicians Working with the Lesbian, Gay, Bi-sexual, Questioning and Intersex Individuals (LGBTQI)” throughout Pennsylvania. A 2.5 hour online training titled “Welcoming and Affirming Practices: LGBTQI and Cultural Competency is also available.

Youth and Family Institute (*Children only*)

OMHSAS has entered into an Intergovernmental Agreement with The University of Pittsburgh to establish the Pennsylvania Youth and Family Institute. The Youth and Family Institute will be the centerpiece 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 will be responsible for extending the practice of Youth and Family Teams across the Commonwealth. It will do this through the provision and coordination of training and technical assistance to engage and empower youth and their families in the treatment and recovery process. The Youth and Family Team concept is based on the nationally recognized Wraparound Fidelity Index Model.

There are currently 11 counties involved in the High Fidelity Wraparound system, which include the 6 System of Care counties, as well as, Allegheny, Bucks, Delaware, Fayette, and Northumberland. Over 700 youth and their families have been served since the initiation of High Fidelity Wraparound in 2008.

(b) **Training of Emergency Health Services Providers**

(c)

OMHSAS is the statewide coordinating agency for mental health disaster 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*. The Plan, following every disaster, is continually revised and continues to provide a mechanism for state and county response to local, regional, and state level disasters and emergencies using an All Hazards Approach.

The Pennsylvania Mental Health ALL HAZARDS Plan for Disaster/Emergency Response requires the development of county mental health response plans by County Mental Health and Mental Retardation departments. County mental health response plans are flexible documents, which provide a foundation for mental health disaster and emergency response and service provision at the local level.

The Pennsylvania Mental Health ALL HAZARDS Plan for Disaster/Emergency Response specifies the Office of Mental Health and Substance Abuse Services as a supportive component in mental health response. OMHSAS provides County Mental Health and Intellectual Disability Programs assistance when the disaster/emergency situation extends beyond the available resources of the county. The Office provides technical assistance and ongoing training to counties in the development of county mental health response plans and in implementing their response program. The following is a discussion on the available training:

Emergency Service Provider Training

OMHSAS partners with the Pennsylvania Department of Health and with the Pennsylvania Emergency Management Agency to train emergency response providers to address the psychosocial consequences of disasters and emergencies. Using Department of Health funding from the Centers for Disease Control and Prevention (CDC), OMHSAS provides the following training to Emergency Service Providers.

- Psychological First Aid (PFA) training based on National Center for Post-Traumatic Stress Disorder (NCPTSD)
- Disaster Crisis Outreach and Referral Team (DCORT) Training
- Critical Incident Stress Management (CISM) for First Responders

In addition to Emergency Service Providers, the above training opportunities are also offered to other groups listed below by funds provided directly to the counties to promote community resiliency and recovery:

- Leaders of faith based communities

- Leaders of non-English speaking communities
- Consumers
- First responders
- Mental health, drug and alcohol treatment staff
- Others

Emergency Service Providers and local and state mental health DCORT have been attending regional task force meetings, and partnering in table top exercises, as well as full scale exercises. Collaborations and trainings continue.

(d) Intended Use of Block Grant Funds

Pennsylvania’s plan for use of its CMHS Block Grant allotment for federal fiscal year 2014 is based on a spending authority of \$14,559,000. Based on this, final allocations to county programs will total \$14,286,000, with \$273,000 set aside for grant administration. A total of \$13,478,470 is allocated for non-categorical activities and \$805,530 for special projects.

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

<ul style="list-style-type: none"> • Administrator’s Office • Community Services • Targeted Case Management • Outpatient • Day Treatment • Family-Based Mental Health • Resource Coordination • Administrative Management • Emergency Services • Housing Support Services • Crisis Intervention Services • Adult Developmental Training • Community Employment and Employment Related Services • Peer Support Services • Consumer-Driven Services • Transitional and Community Integration Services 	<ul style="list-style-type: none"> • Facility-Based Vocational Rehabilitation • Social Rehabilitation Services • Family Support Services • Community Residential Services • Children’s Psychosocial Rehabilitation Services • Children’s Evidence-Based Practices • Assertive Community Treatment (ACT) and Community Treatment Teams (CTT) • Psychiatric Rehabilitation Services
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Many of those services apply to both adults and children, although there are some services that are meant for adults only and some targeted towards children. A portion of the block grant money will also be used to support some special projects in some of the counties.

These special project areas include: *Mental Health Anti-Stigma, Network of Care, Consumer Surveys, and Training.*

When SAMHSA issued new guidance directing that the MHBG expenditures be directed towards the four purposes delineated in the guidance, OMHSAS used that opportunity to provide more structured guidance to the counties. Meeting the “four purposes” was not a challenge since the historic pattern of expenditures has always matched one or more of those purposes, even before those purposes were laid out in SAMHSA guidance.

We also strongly encouraged the counties to utilize the CMHSBG dollars to support the priorities identified in the state MHBG Plan. We also developed a new reporting form to be completed by counties to support the planning and reporting data needs for MHBG.

The following table shows the projected Block Grant allocations to the counties for fiscal year 2013-14:

Federal Community Mental Health Services Block Grant

County Program	Non-Categorical	Special Projects	Total
Bucks	258,581	0	258,581
Chester	215,432	0	215,432
Delaware	350,196	0	350,196
Montgomery	390,979	0	390,979
Philadelphia	2,203,831	0	2,203,831
Berks	262,337	0	262,337
Bradford/Sullivan	92,161	0	92,161
Carbon/Monroe/Pike	136,604	0	136,604
Lackawanna/Susquehanna	701,793	0	701,793
Lehigh	163,558	0	163,558
Luzerne/Wyoming	281,771	0	281,771
Northampton	135,673	0	135,673
Schuylkill	163,405	0	163,405
Tioga	48,440	0	48,440
Wayne	132,115	0	132,115
Bedford/Somerset	174,754	0	174,754
Blair	117,288	0	117,288
Cambria	634,283	0	634,283
Centre	104,253	0	104,253
Columbia/Montour/Snyder/Union	149,678	0	149,679
Cumberland/Perry	487,380	0	487,380
Dauphin	143,545	310,000	453,585
Franklin/Fulton	94,705	0	94,705
Huntingdon/Mifflin/Juniata	94,322	0	94,322
Lancaster	278,587	0	278,587
Lebanon	84,080	0	84,080
Lycoming/Clinton	139,481	0	139,481
Northumberland	105,063	0	105,063
York/Adams	289,143	0	289,143
Allegheny	1,336,833	5,250	1,342,083
Armstrong/Indiana	151,974	0	151,974
Beaver	194,379	0	194,379
Butler	193,295	0	193,295
Cameron/Elk	51,880	0	51,880
Clarion	77,680	0	77,680
Clearfield/Jefferson	410,582	0	410,582
Crawford	64,925	0	64,925
Erie	232,459	105,000	337,459
Fayette	204,868	0	204,868
Forest/Warren	40,837	0	40,837
Greene	128,264	0	128,264
Lawrence	597,660	0	597,660
McKean	58,235	0	58,235
Mercer	138,705	0	138,705
Potter	55,099	0	55,099
Venango	89,306	0	89,306
Washington	564,310	0	564,310

Westmoreland	453,741	0	453,741
Total	13,478,470	420,250	13,898,720

The following are the special projects to be funded with block grant funds:			
County	Allocation	Project Name	Description
Dauphin	\$310,000	Network of Care	<i>Network of Care</i> is a dynamic interactive website designed to assist individuals involved in community services. The website is designed to provide information about each county program and all of its providers, support efforts of consumers and families toward successful recovery, link to extensive resources about mental health, track bills in the Pennsylvania legislature and Congress, and make contact with legislators. OMHSAS has provided funding to implement <i>Network of Care</i> in all counties in the state.
Erie	\$105,000	Survey Project	The survey is a random sample of individuals served through Medical Assistance who received a mental health survey. It went to consumers receiving services through both fee-for-service and HealthChoices. The survey is conducted annually and goes to more than 20000 consumers/families of children/adolescents.
Allegheny	\$5,250	Training	Funding to support the expenses associated with the training and certification for MH case managers.
To be Finalized	\$387,280		

II: Planning Steps

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

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Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. 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 set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must 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 serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse 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 behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

UNMET NEEDS AND CRITICAL GAPS

In the Commonwealth's FY 2012-2013 Plan, eight priority service areas for adults with SMI and children with SED were identified using data obtained from the County Mental Health Plans and a document developed by the Children's Advisory Committee, "*Call for Change*." A stakeholder workgroup was convened with representation from each of the Planning Council subcommittees (Adult, Older Adult, Children's and Persons in Recovery) to identify and develop Pennsylvania's state priorities for the FY 2014-2015 Plan. The group chose to keep the original eight priority areas, as the unmet service needs identified remain salient, and add Olmstead planning as a new priority. The paragraphs below describe the process and data used to develop the eight priority areas identified in the FY 2012-2013 Plan.

Unmet Service Needs & Gaps For Adults

Counties utilized *Attachment K: Top Five New Funding Requests for Recovery-Oriented System Transformation Priorities* to identify prioritized funding needs designated to create, sustain or enhance services. A total of 251 funding requests were received that year, an increase from the 202 requests received in the year before that.

Out of the 251 total requests, the highest number of requests for new state dollars identified by the counties for the fifth year in a row was Housing/Housing Supports (40 total requests), followed by Recovery-Based Initiatives – (32 requests – not any particular service request, but a variety of recovery-oriented services), Forensic Services (24 requests), Employment Services (23 services), Peer Support Services (20 requests), Services for Older Adults (17), Transition-Age Youth (15 requests), and Co-occurring Disorder Services (15 requests). These data were used by in selecting four of the eight state planning priorities, namely:

- Promote independent living by increasing housing opportunities for persons with SMI
- Promote and support the provision of integrated treatment services
- To increase engagement and access to integrated services across systems for older adults.
- Support the workforce development of Certified Peer Specialists (CPS).

Unmet Service Needs & Gaps For Children

The Children's Behavioral Health Taskforce, made up of over 400 stakeholders, released a document titled "*Reaching for the Stars: A Message for Pennsylvania*" which identified many issues concerning the children's behavioral health system in Pennsylvania. Consistent with Pennsylvania's longstanding practice of integrating stakeholder recommendations into systems change, in 2009, representatives from counties and their behavioral health managed care organizations convened for a retreat on children's services. Staff from the Office of Mental Health and Substance Abuse Services, as well as youth and family representatives from the Children's Advisory Committee also participated. Representatives from Mercer Human Services Consulting, which has provided technical assistance for the HealthChoices initiative, served as retreat facilitators.

The consensus of the group was that while the current children’s behavioral health system is quite extensive, access as well as quality could be improved. A number of proposed recommendations came out of the retreat, including recommendations for administrative efficiencies and programmatic improvements. As a direct result of this retreat, the OMHSAS Children’s Bureau and the OMHSAS Children’s Advisory Committee developed a “*Call for Change – Transformation of the Children’s Behavioral Health System in Pennsylvania*”, which would serve as a strategic plan to guide the children’s behavioral health system toward the goals of improving access and streamlining the process for quality, effective behavioral health services for children and their families throughout the Commonwealth. It provides the principles on which transformation of the children’s behavioral health system can occur.

In addition to direct input from key stakeholders, this *Call for Change* also relied on analyses of the many multi-stakeholder initiatives and children’s services improvements that have been achieved over the past several years. Moreover, this document also incorporates findings from a review of the current literature on the state of the art in children’s behavioral health services. The *Call for Change* focuses on the following goals:

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

The planning priorities pertaining to children identified in this application are derived from some of the goals outlined in the Children’s *Call for Change*. The priority “**Youth and Family Involvement**” was selected based on goal 1 which calls for the development of a youth and family driven system. Similarly, the priorities “**Access to High Fidelity Wrap-Around**” and “**Reducing RTF Usage**” spring from goal 2 that strives to ensure that services are comprehensive, integrated, and provided in the least restrictive environment. The priority of “**Prevention**” will support goal 4 which aims to promote the development of a public health approach to social and emotional wellness.

II: Planning Steps

Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

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#	Priority Area	Priority Type	Population				
1	Supportive Housing	MHS	SMI, SED				
	<table border="1"> <thead> <tr> <th>#</th> <th>Performance Indicator</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Increase by 10% annually the number of individuals served by supportive housing</td> </tr> </tbody> </table>			#	Performance Indicator	1	Increase by 10% annually the number of individuals served by supportive housing
#	Performance Indicator						
1	Increase by 10% annually the number of individuals served by supportive housing						
2	Co-Occurring Services	SAT, MHS	SMI, SED				
	<table border="1"> <thead> <tr> <th>#</th> <th>Performance Indicator</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Increase by 150 annually the number of persons with SMI served by integrated treatment models</td> </tr> </tbody> </table>			#	Performance Indicator	1	Increase by 150 annually the number of persons with SMI served by integrated treatment models
#	Performance Indicator						
1	Increase by 150 annually the number of persons with SMI served by integrated treatment models						
3	Services to Older Adults	MHS	SMI				
	<table border="1"> <thead> <tr> <th>#</th> <th>Performance Indicator</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Increase by 10% annually the number of older adults receiving community-based mental health services</td> </tr> </tbody> </table>			#	Performance Indicator	1	Increase by 10% annually the number of older adults receiving community-based mental health services
#	Performance Indicator						
1	Increase by 10% annually the number of older adults receiving community-based mental health services						
4	Peer Support Services	MHS	SMI, SED				
	<table border="1"> <thead> <tr> <th>#</th> <th>Performance Indicator</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Certiifed peer specialists employed in the mental health field</td> </tr> </tbody> </table>			#	Performance Indicator	1	Certiifed peer specialists employed in the mental health field
#	Performance Indicator						
1	Certiifed peer specialists employed in the mental health field						

5	Olmstead Planning	MHS	SMI				
	<table border="1"> <tr> <th>#</th> <th>Performance Indicator</th> </tr> <tr> <td>1</td> <td>Reduce state hospital bed capacity by 90 individuals annually</td> </tr> </table>			#	Performance Indicator	1	Reduce state hospital bed capacity by 90 individuals annually
#	Performance Indicator						
1	Reduce state hospital bed capacity by 90 individuals annually						
6	Access to High Fidelity Wraparound	MHS	SED				
	<table border="1"> <tr> <th>#</th> <th>Performance Indicator</th> </tr> <tr> <td>1</td> <td>Increase the number of children, youth, and families receiving high fidelity wraparound by 25% annually</td> </tr> </table>			#	Performance Indicator	1	Increase the number of children, youth, and families receiving high fidelity wraparound by 25% annually
#	Performance Indicator						
1	Increase the number of children, youth, and families receiving high fidelity wraparound by 25% annually						
7	Prevention	MHP	SED				
	<table border="1"> <tr> <th>#</th> <th>Performance Indicator</th> </tr> <tr> <td>1</td> <td>Increase the number of children served by Keystone Mental Health consultants by 75 annually</td> </tr> </table>			#	Performance Indicator	1	Increase the number of children served by Keystone Mental Health consultants by 75 annually
#	Performance Indicator						
1	Increase the number of children served by Keystone Mental Health consultants by 75 annually						
8	Residential Treatment Facility (RTF) Usage	MHS	SED				
	<table border="1"> <tr> <th>#</th> <th>Performance Indicator</th> </tr> <tr> <td>1</td> <td>Increase the number of children and youth effectively served through community based approaches by decreasing the number of children/youth placed in accredited Residential Treatment Facilities (RTFs) by 10% annually</td> </tr> </table>			#	Performance Indicator	1	Increase the number of children and youth effectively served through community based approaches by decreasing the number of children/youth placed in accredited Residential Treatment Facilities (RTFs) by 10% annually
#	Performance Indicator						
1	Increase the number of children and youth effectively served through community based approaches by decreasing the number of children/youth placed in accredited Residential Treatment Facilities (RTFs) by 10% annually						
9	Youth and Family Involvement	MHS	SED				
	<table border="1"> <tr> <th>#</th> <th>Performance Indicator</th> </tr> <tr> <td>1</td> <td>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</td> </tr> </table>			#	Performance Indicator	1	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
#	Performance Indicator						
1	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						



III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures
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Planning Period - From SFY 2014 to SFY 2015

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			\$682,340,626	\$	\$78,248,400	\$	\$
a. Pregnant Women and Women with Dependent Children*			\$	\$	\$	\$	\$
b. All Other			\$682,340,626	\$	\$78,248,400	\$	\$
2. Primary Prevention**		\$2,612,919	\$	\$	\$55,941,102	\$	\$
3. Tuberculosis Services			\$	\$	\$	\$	\$
4. HIV Early Intervention Services			\$	\$	\$	\$	\$
5. State Hospital			\$	\$	\$625,830,000	\$	\$
6. Other 24 Hour Care		\$2,511,408	\$855,332,733	\$	\$368,772,499	\$9,089,863	\$
7. Ambulatory/Community Non-24 Hour Care		\$24,241,436	\$2,417,196,100	\$	\$576,119,650	\$39,611,099	\$
8. Administration (Excluding Program and Provider Level)		\$552,000	\$1,904,730,100	\$	\$69,605,358	\$7,850,571	\$
9. Subtotal (Row 1, 2, 3, 4 and 8)	\$	\$3,164,919	\$2,587,070,642	\$	\$203,794,860	\$7,850,571	\$
10. Subtotal (Row 5, 6, 7 and 8)	\$	\$27,304,844	\$5,177,259,374	\$	\$1,640,327,510	\$56,551,533	\$
11. Total	\$	\$29,917,763	\$5,859,600,000	\$	\$1,774,517,012	\$56,551,533	\$

* Prevention other than primary prevention

** States may only use MH Block Grant funds to provide primary prevention services to the priority populations of adults with serious mental illness and children with serious emotional disturbance.

Footnotes:
The amount listed under Medicaid Administration (8C) also includes estimates for Medicaid items/services that are not captured elsewhere in the table, not just for "Administration".

III: Use of Block Grant Dollars for Block Grant Activities

Table 3 State Agency Planned Block Grant Expenditures by Service

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Planning Period - From SFY 0 to SFY 0

Service	Unduplicated Individuals	Units	Expenditures
Healthcare Home/Physical Health			\$
General and specialized outpatient medical services	0	0	\$
Acute Primary care	0	0	\$
General Health Screens, Tests and Immunizations	0	0	\$
Comprehensive Care Management	0	0	\$
Care coordination and Health Promotion	0	0	\$
Comprehensive Transitional Care	0	0	\$
Individual and Family Support	0	0	\$
Referral to Community Services Dissemination	0	0	\$
Engagement Services			\$6,603,662
Assessment	31620	391224	\$6,603,662

Specialized Evaluations (Psychological and Neurological)	0	0	\$
Service Planning (including crisis planning)	0	0	\$
Consumer/Family Education	0	0	\$
Outreach	0	0	\$
Outpatient Services			\$8,704,934
Individual evidenced based therapies	75658	1294100	\$8,704,934
Group therapy	0	0	\$
Family therapy	0	0	\$
Multi-family therapy	0	0	\$
Consultation to Caregivers	0	0	\$
Medication Services			\$
Medication management	0	0	\$
Pharmacotherapy (including MAT)	0	0	\$
Laboratory services	0	0	\$
Community Support (Rehabilitative)			\$5,009,036

Parent/Caregiver Support	5084	579820	\$5,009,036
Skill building (social, daily living, cognitive)	0	0	\$
Case management	0	0	\$
Behavior management	0	0	\$
Supported employment	0	0	\$
Permanent supported housing	0	0	\$
Recovery housing	0	0	\$
Therapeutic mentoring	0	0	\$
Traditional healing services	0	0	\$
Recovery Supports			\$478,096
Peer Support	186	35534	\$478,096
Recovery Support Coaching	0	0	\$
Recovery Support Center Services	0	0	\$
Supports for Self Directed Care	0	0	\$
Other Supports (Habilitative)			\$

Personal care	0	0	\$
Homemaker	0	0	\$
Respite	0	0	\$
Supported Education	0	0	\$
Transportation	0	0	\$
Assisted living services	0	0	\$
Recreational services	0	0	\$
Trained behavioral health interpreters	0	0	\$
Interactive communication technology devices	0	0	\$
Intensive Support Services			\$870,468
Substance abuse intensive outpatient (IOP)	844	44762	\$870,468
Partial hospital	0	0	\$
Assertive Community Treatment	0	0	\$
Intensive home based services	0	0	\$
Multi-systemic therapy	0	0	\$
Intensive Case Management	0	0	\$

Out-of-Home Residential Services			\$3,299,820
Crisis residential/stabilization	1014	285722	\$3,299,820
Clinically Managed 24 Hour Care (SA)	0	0	\$
Clinically Managed Medium Intensity Care (SA)	0	0	\$
Adult Mental Health Residential	0	0	\$
Youth Substance Abuse Residential Services	0	0	\$
Children's Mental Health Residential Services	0	0	\$
Therapeutic foster care	0	0	\$
Acute Intensive Services			\$2,587,446
Mobile crisis services	73810	1094920	\$2,587,446
Peer based crisis services	0	0	\$
Urgent care services	0	0	\$
23 hour crisis stabilization services	0	0	\$
Medically Monitored Intensive Inpatient(SA)	0	0	\$
24/7 crisis hotline services	0	0	\$

Prevention (Including Promotion)			\$3,433,198
Screening, Brief Intervention and Referral to Treatment	27972	76802	\$3,433,198
Brief Motivational Interviews	0	0	\$
Screening and Brief Intervention for Tobacco Cessation	0	0	\$
Parent Training	0	0	\$
Facilitated Referrals	0	0	\$
Relapse Prevention/Wellness Recovery Support	0	0	\$
Warm Line	0	0	\$
System improvement activities			\$
Other			\$

Footnotes:

*Planned expenditures estimated for two fiscal years, FY 13/14 and FY 14/15.

*Individuals served, unit quantity, and MHBG expenditures compiled and totaled for each service grouping. For example, estimates under "Assessment" are aggregates for all services (as applicable) under the service grouping "Engagement Services."

III: Use of Block Grant Dollars for Block Grant Activities

Table 6b MHBG Non-Direct Service Activities Planned Expenditures
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Planning Period - From SFY 2014 to SFY 2015

Service	Block Grant
MHA Technical Assistance Activities	\$ <input type="text"/>
MHA Planning Council Activities	\$ <input type="text"/>
MHA Administration	\$ <input type="text" value="552,000"/>
MHA Data Collection/Reporting	\$ <input type="text"/>
MHA Activities Other Than Those Above	\$ <input type="text" value="1,615,060"/>
Total Non-Direct Services	\$2167060
<p>Comments on Data:</p> <div style="border: 1px solid black; padding: 5px;"> <p>*Planned expenditures span a two year planning period. *MHA Activities Other Than Those Above include special projects funded through CMSHBG dollars. Descriptions of these projects (MH Anti-Stigma, Network of Care, Training, and Survey Project) can be found under "Strengths and Needs of the Service System."</p> </div>	

Footnotes:

IV: Narrative Plan

C. Coverage M/SUD Services

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Narrative Question:

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Exchange) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations of MHPAEA?
5. What specific changes will the state make in what is bought given the coverage offered in the state's EHB package?

Footnotes:

The state is not completing this optional form at this time.

The state is not completing this optional form at this time.

IV: Narrative Plan

D. Affordable Insurance Exchange

Page 67 of the Application Guidance

Narrative Question:

Affordable Insurance Exchanges (Exchanges) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?
2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?
3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing third party Medicaid, the CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?
4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?
5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.
6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.
7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2012 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.
8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Footnotes:

The state is not completing this optional form at this time.

IV: Narrative Plan

E. Program Integrity

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Narrative Question:

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

At this point in time, many states will know which mental health and substance abuse services are covered in their benchmark plans offered by QHPs and Medicaid programs. SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required 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. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Encounter/utilization/performance analysis; and
 - f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

Footnotes:

E. Program Integrity

1. Does the state have a program integrity plan regarding MHBG?

Response: Yes, the state clearly conveys the federal and state requirements and expectations regarding MHBG to counties. We have in the past, based on the then prevailing federal guidance, allowed the counties the latitude to plan the MHBG expenditures, provided they ensured compliance with all statutory and regulatory requirements. Also, services and supports for which MHBG dollars could not be expended were always clearly communicated to the counties.

When SAMHSA issued new guidance directing that the MHBG expenditures be directed towards the four purposes delineated in the guidance, OMHSAS used that opportunity to provide more structured guidance to the counties. Meeting the “four purposes” was not a challenge since the historic pattern of expenditures has always matched one or more of those purposes, even before those purposes were laid out in SAMHSA guidance. We also strongly encouraged the counties to utilize the CMHSBG dollars to support the priorities identified in the state MHBG Plan. We also developed a reporting form (see the attachment) to be completed by counties to support the planning and reporting data needs for MHBG. A statewide conference call was also held to convey the new requirements and to provide clarifications. In October 2012, counties reported based on the new reporting requirements.

2. Does the state have a specific staff person that is responsible for the state agency’s program integrity activities?

Response: Yes, the state’s MHBG Planner is the person responsible for program integrity activities. This individual also collaborates with the Department’s Bureau of Financial Operations to ensure integrity of the programs supported with Block Grant funds.

3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:

- a. Budget review;
- b. Claims/payment adjudication;
- c. Expenditure report analysis;
- d. Compliance reviews;
- e. Encounter/utilization/performance analysis; and f.

Audits.

Response: As indicated in E (1), OMHSAS utilizes a new reporting form (see the attachment) to capture the data elements required by SAMHSA for MHBG. The data

reported by counties in the form inform us how the block dollars are expended and for what purposes. For each service, the following data are collected:

1. Name of Service (cost center)
2. Category of Service
3. Relevant Purpose (from the “four purposes”)
4. Number of Persons Served
5. Target Population
6. Number of units of Service
7. Limited English Proficiency Services, if any
8. Reimbursement Method
9. Amount Spent

Additionally, the form also asks the counties to report if any MHBG dollars were spent on the priorities identified in the State’s MHBG Plan. By reviewing this form, we will know how the block dollars are used and if those expenditures are consistent with the requirements and guidance the state has provided. Our review of last year’s expenditures reported using this form did not reveal any transgressions or inconsistencies.

Over and above the monitoring by the CMHSBG Planner, the Bureau of Financial Operations is available to do audits of CMHSBG-funded programs, if and when requested by OMHSAS.

4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?

Response: Since Pennsylvania has a county based mental health service system, most of the MHBG dollars are allocated by the state to counties, who in turn contract with local agencies to provide services (some counties may provide certain services directly). The counties, through the MHBG reporting form, reports on reimbursement method for each service. The reimbursement methods and rates used by a county would depend on the type of service (cost center) and are generally the same for any class of service within a county, regardless of the source of funding (MHBG, state funds, etc.).

5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

Response: The state provides the counties with a list of cost centers (services or supports) on which MHBG dollars can be expended, provided those expenditures meet one or more of the “four purposes” specified in SAMHSA MHBG guidance. Each cost center corresponds to a specific service or support (or like services and supports) with clearly defined attributes (either by regulations or by other means). Most of these services are also licensed by the state. The counties report on MHBG expenditures based on cost centers, and this allows the state to ascertain the exact nature of service delivered.

We may also start site visits by the MHBG planner to guide and support the counties to find the best utilization of MHBG dollars.

6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

Response: Historically Pennsylvania has not used MHBG dollars to pay for insured persons for a service that would be covered by the insurance (Medicaid or private insurance). If MHBG funds are used to pay for an individual receiving Medicaid, that would be for a service/support not covered by state in-plan or supplemental Medicaid services. If MHBG funds are used to pay for a Medicaid reimbursable service, then it would be for someone who does not have Medicaid or other insurance.

INSTRUCTIONS

Cost Center Key

Community Mental Health Block Grant Funds may be spent in any of the cost centers identified below. Service categories along the left side of the "Reporting Form" tab of this workbook have been cross-walked and matched with the most appropriate cost center(s). The drop-down menu in the "Cost Center" column will provide only those cost center(s) that are applicable to each service category. Enter only one cost center per line.

- Administrators Office (3.1)
- Community Services (3.2)
- Targeted Case Management (3.4)
- Outpatient (3.6)
- Partial Hospitalization (3.8)
- Mental Health Crisis Intervention Services (3.10)
- Adult Developmental Training (3.11)
- Community Employment and Employment Related Services (3.12)
- Facility-Based Vocational Rehabilitation (3.13)
- Social Rehabilitation Services (3.14)
- Family Support Services (3.15)
- Community Residential Services (3.16)
- Family- Based Mental Health (3.17)
- Administrative Management (3.20)
- Emergency Services (3.21)
- Housing Support Services (3.22)
- Assertive Community Treatment (ACT) Teams and Community Treatment Teams (CTT) (3.23)
- Psychiatric Rehabilitation (3.24)
- Children's Psychosocial Rehabilitation Services (3.25)
- Children's Evidence Based Practices (3.26)
- Peer Support Services (3.27)
- Consumer-Driven Services (3.28)
- Transitional and Community Integration Services (3.29)
- Other (3.98) ** Please Explain

SAMHSA's Four Purposes

Historically, SAMHSA has allowed states to use these funds in a generally unrestricted, flexible manner. SAMHSA has redesigned the CMHSBG program to focus on prevention, recovery supports and other services that will supplement services covered by Medicaid, Medicare and private

insurance. The new guidelines require that the CMHSBG funds be directed toward four purposes:

1. Fund priority treatment and support services for individuals without insurance, or for whom coverage is terminated for short periods of time.
2. Fund priority treatment and support services not covered by Medicaid, Medicare, or private insurance and that demonstrate success in improving outcomes and/or supporting recovery.
3. Funding primary prevention- universal, selective, and indicated prevention activities for persons not identified as needing treatment.
4. To collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services and to plan the implementation of new services on a nationwide basis.

Identify the purpose that best fits the cost center and enter it under the “Relevant SAMHSA Purpose” column. If more than one purpose applies, choose the best purpose. Any additional comments may be placed under the “Notes” section of each category.

Persons Served

Identify the total number of unduplicated persons served in each reported cost center.

Target Population

Identify the appropriate population served in each reported cost center. If more than one population applies, enter any additional populations under the “Notes” section of each category.

Units of Service

Identify the total number of units of service provided for each cost center.

LEP Services

Identify, if any, the type of language assistance services provided to individuals with limited english proficiency (LEP)- interpretation, translation, or none.

Reimbursement Method

Identify the appropriate reimbursement method used in each reported cost center according to the definitions provided below. If more than one method applies, indicate any additional methods/strategies under the “Notes” section of each category.

Encounter- Based: includes fee-for-service and other strategies that pay individuals or organizations a specific amount for a unit of service.

Grant/Contract: includes annual or periodic payments to individuals or organizations that provide services or system improvements.

Risk-Based: includes, but is not limited to, capitated or case rate payment.

Innovative Financing: includes, but is not limited to, pay-for-outcomes or payment for an episode of care.

Other Reimbursement: please describe the methodology and the services and activities purchased using this strategy.

Amount Spent

Indicate the total amount of CMHSBG funds spent for each cost center in a particular category.

% of Total Funding

This cell auto populates based upon figures entered in “Total CMHSBG Allocation” cell and “Amount Spent” column.

CMHSBG State Priorities

Indicate whether your County is spending CMHSBG funding on any of the eight priority areas identified and, if desired, provide a brief narrative on the types of projects or initiatives funded. These eight priority areas are identified in Pennsylvania’s most recent CMHSBG application.

County:								
Total CMHSBG Allocation (Enter in cell B3):								
Category	Cost Center * see below	Relevant SAMHSA Purpose * see instructions	Number of Persons	Target Population	# of Units of Service	LEP Services	Reimbursement Method	Amount Spent
Healthcare Home/Physical								
General and specialized outpatient medical services; Acute primary care; General health screens; Comprehensive care management; Care coordination; Comprehensive transitional care; Individual and family support; referral to community services	Notes:							
Engagement Services								
Assessment; Specialized Evaluation; Services planning; Consumer/Family education; Outreach	Notes:							
Outpatient Services								
Individual evidenced-based therapies; group therapy; family therapy; multi-family therapy; consultation to caregivers	Notes:							
Medication Services								
Medication management; Pharmacotherapy; Laboratory services	Notes:							
Community Support								
Parent/Caregiver support; Skill building; Case management; Behavior management; Supported employment; Permanent supported housing;	Notes:							

Recovery housing; Therapeutic mentoring; Traditional healing services								
Recovery Supports								
Peer support; Recovery support coaching; Recovery support center services; Supports for self directed care								
	Notes:							
Other Supports								
Personal care; homemaker; Respite; Supported education; Transportation; Assisted living services; Recreational services; Interactive communication technology devices; Trained behavioral health interpreters								
	Notes:							
Intensive Support Services								
Substance abuse intensive outpatient services; Partial hospitalization; Assertive Community Treatment; Intensive home-based treatment; Multi-systemic therapy; Intensive case management								
	Notes:							
Out-of-Home Residential								
Crisis residential/stabilization; Clinically managed 24hr care; Clinically managed medium intensity care; Adult mental health residential; Children's mental health residential; Youth substance abuse residential; therapeutic foster care								
	Notes:							
Acute Intensive Services								
Mobile crisis; Peer-based crisis; Urgent care services; 23 hr crisis stabilization; 24/7 crisis hotline								
	Notes:							

Prevention								
Screening, brief intervention, referral and treatment; Brief motivational interviews; Screening and brief intervention for tobacco cessation; Parent training; Facilitated referrals; Relapse prevention/ Wellness recovery support; Warm line								
Notes:								
System Improvement								
Notes:								
Other								
Notes:								

CMHSBG State Priorities		Please indicate in the boxes below whether your county is spending CMHSBG funds on any of the eight state priority areas identified below. If you would information, you may do so in the "notes" section.						
	Yes/No							
Supportive Housing								
Promote independent living by increasing housing opportunities for persons with SMI		Notes:						
Co-Occurring Services								
Promote and support the provision of integrated services across systems for individuals with co-occurring disorders		Notes:						
Services to Older Adults								
Increase engagement and access to integrated services across systems for older adults		Notes:						
Peer Support Services								
Support the workforce development of Certified Peer Specialists (CPS) throughout the Commonwealth		Notes:						
Access to High Fidelity Wraparound								
Ensure that the high fidelity wraparound service model of Youth/Family Teams is available to children and youth with SED and their families		Notes:						
Prevention								
Increase the opportunities for social and emotional wellness for families and youth in Pennsylvania		Notes:						
Residential Treatment Facility Usage								
Improve the quality of and increase access to community based services to reduce RTF placements		Notes:						
Youth and Family Involvement								
Increase youth and family involvement in all levels of participation in the mental health service system		Notes:						
*Note: Priorities are not listed in any order of importance								

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IV: Narrative Plan

F. Use of Evidence in Purchasing Decisions

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Narrative Question:

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 mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:

- 1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?
- 2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?
 - a) What information did you use?
 - b) What information was most useful?
- 3) How have you used information regarding evidence-based practices?
 - a) Educating State Medicaid agencies and other purchasers regarding this information?
 - b) Making decisions about what you buy with funds that are under your control?

Footnotes:

F. Use of Evidence in Purchasing Decisions

- 1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?

Response: Yes, the Bureau of Policy, Planning and Program Development within OMHSAS created a new staff position in 2009 to serve as the lead for adult behavioral health evidence-based practices (EBPs). This position devotes 100% of its time in the implementation or expansion of: (a) Assertive Community Treatment (ACT); (b) Supported Employment (SE); (c) Illness Management Recovery (IMR); and (d) Family Psychoeducation. This individual also coordinates with other bureaus/staff in OMHSAS on other EBPs and promising practices like Supported Housing, Supported Education, Suicide Prevention, and Peer Support Services. Additionally, this individual also coordinates with OMHSAS Children's Bureau on issues related to EBPs targeted towards children.

- 2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?

Response: Yes, OMHSAS utilizes a variety of mechanisms to collect data on EBPs to help guide our policy directions in this area. The County Mental Health Plans that the counties used to submit annually to OMHSAS until 2011 (have since been replaced with Human Services Plans) contained section(s) that specifically collected information regarding EBPs that was not collected through our traditional data systems. This information, coupled with the information collected by other data sources and through targeted studies, has been used in making many policy decisions regarding EBPs.

For example, a few years ago, OMHSAS commissioned a study to do the cost and outcome analyses of the ACT programs in the state. This study, done on the more than 40 ACT programs in the state unambiguously demonstrated the programs that are closer to the fidelity cost much less and yielded better outcomes. This information prompted OMHSAS to adopt statewide standards and roll out technical assistance and monetary support to enhance the quality of the ACT programs in the state. We continue to conduct similar studies on a fairly regular basis.

Supported employment is another EBP that has received focused attention in the recent years. Information on peer services and supported employment activities collected from counties was used in drafting policy guidance for counties and in designing a training regimen specifically meant for certified peer specialists to assist in their role in supporting the employment goals of the peers they serve.

It was data collected from counties as part of the County Planning process that prompted us to start focusing on the EBP of IMR. Another example is a project that is currently underway, wherein OMHSAS is collaborating with Temple University to administer a one-time survey of 200-300 recipients of peer support services to ascertain what areas they have worked with their peer support specialists and what benefits they have derived from

receiving peer support services. We will also be investigating whether there is a significant difference between a recipient's utilization of high-cost mental health services prior to receiving peer support services and afterward. We intend to use the conclusions gleaned from the data to refine the delivery of peer support services in the Commonwealth.

b) What information was most useful?

Response: The outcomes and cost information were most useful to support decision making.

3) How have you used information regarding evidence-based practices?

a) Educating State Medicaid agencies and other purchasers regarding this information?

Response: OMHSAS (state's Mental Health Authority) also oversees the behavioral health side of Medicaid fee-for-service and managed care, which affords a fair amount of flexibility in designing programs that are evidence-based and promising. OMHSAS as well as the Office of Medical Assistance Programs (OMAP) that has overall responsibility for Medicaid are both part of the Department of Public Welfare under the same cabinet secretary ensuring better coordination in purchasing decisions.

b) Making decisions about what you buy with funds that are under your control?

See the response to 3(a)

IV: Narrative Plan

G. Quality

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Narrative Question:

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections – Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

- 1) What additional measures will your state focus on in developing your State BG Plan (up to three)?
- 2) Please provide information on any additional measures identified outside of the core measures and state barometer.
- 3) What are your states'specific priority areas to address the issues identified by the data?
- 4) What are the milestones and plans for addressing each of your priority areas?

Footnotes:

G. Quality

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant- funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use- Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
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Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections– Community Connections	Percent in TX employed, in school, etc. (TEDS)	Clients w/ SMI or SED who are employed, or in school

1. What additional measures will your state focus on in developing your State BG Plan (up to three)?

Response (see the table below):

	Prevention	Substance Abuse Treatment	Mental Health Services
Community			Percentage of community funds allocated to peer/consumer-delivered services.
Community			Number of adults receiving services from Certified Peer Specialists.

- 2) Please provide information on any additional measures identified outside of the core measures and state barometer.

Response: The two additional measures will assist us in measuring the recovery-oriented focus of our community-based system of care.

- 3) What are your state's specific priority areas to address the issues identified by the data?

Response: Increasing the use of peer support and consumer-driven services, in a meaningful and measurable manner.

- 4) What are the milestones and plans for addressing each of your priority areas?

Response: Annual assessments, using analysis and reporting of the data; providing reports to key stakeholders on the measures' findings.

IV: Narrative Plan

H. Trauma

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Narrative Question:

In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Footnotes:

H. Trauma

Trauma informed care (TIC) is a major initiative in the Commonwealth of Pennsylvania. The Commonwealth has developed and published an informational bulletin that directly references TIC strategies and practices to assist providers and their staff in developing trauma informed treatment programs. The informational bulletin encourages programs to understand each individual's past trauma history and utilize assessment tools to assist in identifying trauma. Pennsylvania has also developed a core competency document for our Alternative to Coercive Techniques initiative that promotes trauma informed care principles as a part of the individual planning for each youth. In addition, as part of our commitment to trauma informed care, the Commonwealth has funded two pilots that provided an opportunity for several residential providers to be trained in two nationally recognized TIC models- the Sanctuary Model and Trauma Focused- Cognitive Behavioral Therapy.

IV: Narrative Plan

I. Justice

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Narrative Question:

The SABG and MHBG 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.

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.^{42,43} Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths 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 utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.⁴⁴

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility 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

Please answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?
2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?
4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?
5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

42 The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman, 2000.

43 A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs U.S. Department of Justice, Renee L. Bender, 2001.

44 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, McNeil, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.

Footnotes:

I. Justice

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?
2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

Response: Pennsylvania currently has a total of 95 Problem Solving Courts (as of December, 2012). Of the total courts, 16 are Adult Mental Health Courts, 1 Juvenile Mental Health Court, 15 Veterans Courts, 2 Recovery Courts, 1 Co-Occurring Court, 28 Adult Drug Courts, 9 Juvenile Drug Courts, 1 Juvenile Pre-Adjudication Court and 1 Re-Entry Drug Court. Pennsylvania has utilized the various Problem Solving Courts across the state to divert individuals from incarceration and provide screening and treatment services for those identified by the criminal justice system. Department of Public Welfare (DPW), Office of Mental Health and Substance Abuse Services (OMHSAS) and the Pennsylvania Commission on Crime and Delinquency (PCCD) are involved in a collaborative effort to facilitate the implementation of Mental Health Treatment Courts throughout Pennsylvania as well as Problem Solving Courts as funding is available.

3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?

Response: In Pennsylvania, OMHSAS works collaboratively with the PA Department of Corrections (DOC) to ensure that individuals with mental illness and/or substance use disorders receive services and supports necessary to reentry into the community. Under the Enhanced Re-Entry Initiative, counties are invited to participate in selected planning meetings where specific candidates will be returning to their communities upon release. The group collectively coordinates placements options, benefits accessibility, as well as structured activities that an individual may need upon re-entry.

4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?

Response: The information requested is not available at this time.

IV: Narrative Plan

J. Parity Education

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Narrative Question:

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. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?
2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?)
3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

Footnotes:

The State is choosing not to complete this optional section at this time.

IV: Narrative Plan

K. Primary and Behavioral Health Care Integration Activities

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Narrative Question:

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?
2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?
3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?
4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.
5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.
6. Describe how your behavioral health providers are screening and referring for:
 - a. heart disease,
 - b. hypertension,
 - c. high cholesterol, and/or
 - d. diabetes.

Footnotes:

K. Primary and Behavioral Health Care Integration Activities

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?

Response: Through our Medicaid programs, there are many coordination activities that have either been underway or are starting. OMHSAS has supported the coordination of services. The SMI Innovations Project is an ongoing initiative in two areas of Pennsylvania. This is a partnership to improve PH/BH coordination that has developed care homes to address engagement and care using navigators. There are wellness recovery teams and mobile services to reach individuals where they are in their community. The project also focuses on integrated care plans to facilitate exchange of information and to address emergency room over utilization and hospitalization.

OMHSAS and the Office of Medical Assistance Programs (OMAP), in coordination with the managed care organizations are working together to create a data set for the sharing of information to enhance coordination of PH/BH services. This will move the system forward with coordination of both medical and behavioral health complex cases or to assist in coordination of benefits.

The Commonwealth, with the PH and BH MCOs, also holds regional quarterly PH/BH meetings to review and discuss common areas for coordination. Topics covered during the meetings include: emergency room use, updates to program changes that may impact the other system, and payment metrics review. There are also ongoing regional joint initiatives that are set and reviewed annually to address joint system needs.

2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?

Response: Yes, the behavioral health Medicaid program, through the managed care organizations, has many initiatives to coordinate care. The goal of these initiatives is to increase coordination with physical health services in the coordination of medication. The University of Pittsburgh Medical Center for High Value Health Care in coordination with Community Care Behavioral Health was recently awarded one of the Patient-Centered Outcomes Research Institute (PCORI) grants. This is one of 25 awards across the country. This proposal was chosen out of 500 proposals.

3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?

Response: Yes. There is ongoing coordination. FQHCs have been providers

in the Medicaid HealthChoices Program since its inception and the number of providers has grown.

4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.

Response: DPW works with the Department of Health (DOH) who is responsible for maintaining an online statewide listing of tobacco cessation counseling services. Established in 2002, the Pennsylvania's DOH Pre-Approved Tobacco Cessation Registry is utilized as a resource and referral system at the state, regional and local levels. Clinicians and health care delivery systems providing cessation counseling services are required to submit an application for DOH review and approval to be included in the Registry. Clinicians and health care delivery systems interested in reimbursement from DPW Medical Assistance programs for cessation services are required to indicate their interest on the application.

5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.

Response: The Pennsylvania Medicaid program covers:

- NRT Gum
- NRT Patch
- NRT Nasal Spray
- NRT Lozenge
- NRT Inhaler
- Varenicline (Chantix)
- Bupropion (Zyban)
- Group Counseling
- Individual Counseling
- Quitline

Medications are limited to original prescription plus five refills. Counseling is limited to 10 sessions of at least 15 minutes. Counseling is also limited to 70 days of counseling per year. Prior authorization may be required. Please note that this information reflects coverage that the Pennsylvania Department of Public Welfare requires all managed care organizations (MCO's) to provide.

6. Describe how your behavioral health providers are screening and referring for:
 - a. heart disease,
 - b. hypertension,
 - c. high cholesterol, and/or
 - d. diabetes.

Response: The BH-MCOs coordinate with the special needs units of the PH-MCOs plans. When there is a health concern, including the above areas, there is an expected coordination of care with the member's consent.

IV: Narrative Plan

L. Health Disparities

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Narrative Question:

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). 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, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, 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, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

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 being served or 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. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?
4. How will you use Block Grant funds to measure, track and respond to these disparities?

Footnotes:

L. Health Disparities

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?

Response: We are able to track consumers by race, ethnicity, age and gender only. There is no designation for sexual orientation or tribal connection in our Client Information System or in the Home and Community Services Information System. Neither system allows for transgender designation.

2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?

Response: Our state's Client Information System contains a language preference code by which Medicaid consumers can request documents in their preferred language. In addition, managed care companies are required to have documents in any language that accounts for at least 5% of the population. Pennsylvania's Office of Mental Health and Substance Abuse Services (OMHSAS) has a contract with a translator company that can be used to interpret on the spot by telephone; this agency can also translate documents as requested.

3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?

Response: If disparities were identified, plans to address the disparities would be accomplished thru workgroups involving OMHSAS policy staff and interested stakeholders (e.g., county governments, Behavioral Health Managed Care Organizations and providers). There would also have to be a financial component of these discussions to accommodate the system changes that would have to occur to be able to capture and track these subpopulations with more detail.

4. How will you use Block Grant funds to measure, track and respond to these disparities?

Response: We do not have plans at this time to use Block Grant funds to measure and track any disparities, as we are currently using state employees and Data Infrastructure Grant funds for those activities.

IV: Narrative Plan

M. Recovery

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Narrative Question:

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, 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.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?
2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?
3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?
4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).
5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?
7. Does the state have an accreditation program, certification program, or standards for peer-run services?
8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?
2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?
4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?
2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

supportive community?

Footnotes:

M. Recovery

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

Response: Yes.

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

Response: Yes.

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

Response: Yes.

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in *The Good and Modern Continuum of Care Service Definitions*, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

Response: Yes.

5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

Response: Yes.

6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?

Response: Yes.

7. Does the state have an accreditation program, certification program, or standards for peer-run services?

Response: Yes.

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Response:

- Through the Transformation Transfer Initiative (TTI) Federal grant, Pennsylvania, in consortium with the University of Pennsylvania, has developed and implemented a two-day advanced training for Certified Peer Specialists (CPS) in older adult services. In addition, under TTI Pennsylvania collaborated with New Jersey to train CPS in New Jersey's Wellness Coaching curriculum.
- Pennsylvania, in collaboration with the Temple University Collaborative on Community Inclusion, is administering a survey of 200-300 recipients of peer support services at targeted peer support providers. Pennsylvania intends to use the survey data to refine the delivery of peer support services in the Commonwealth.
- Pennsylvania has developed a one-day, five-hour documentation training course for CPS to enhance their Medicaid documentation skills. The course will be rolled out in 2013.
- Pennsylvania has developed two curricula—a one-day, face-to-face training course and an online training course—for CPS in supporting individuals with employment goals. In addition, Pennsylvania has produced a policy guidance paper for CPS that identifies Medicaid-reimbursable employment services.
- Pennsylvania's Department of Corrections (DOC) is instituting Pennsylvania's 75-hour, 10-day CPS training course within DOC facilities and has trained roughly 100 CPS so far, 10 percent of whom are serving life sentences.
- Pennsylvania will promulgate regulations for Psychiatric Rehabilitation Services (PRS) in 2013. The regulations require that PRS providers adhere to evidence-based practices and best practices for PRS.
- Pennsylvania continues to expand Fairweather Lodge services. Over the past decade, the number of Lodges in Pennsylvania has expanded from one to 35 with 20 Lodges currently under development. In addition, Pennsylvania's Office of Mental Health and Substance Abuse Services is conducting preliminary discussions with Pennsylvania's Department of Corrections and Bureau of Probation and Parole about dedicating a Lodge or series of Lodges to individuals with mental illness and criminal history.

Involvement of Individuals and Families

The Commonwealth's public behavioral health system affords consumers and family members the opportunity for involvement at many levels: the shaping of policy and program development; the implementation of service delivery; and systems management evaluation. OMHSAS solicits input and feedback from consumers and family members through participation in task-oriented workgroups.

To maximize the caliber of consumer and family participation in the behavioral health system, OMHSAS continues to promote opportunities for education and training. In May of 2012, OMHSAS staff attended the Community Support Program (CSP) Network Day to educate representatives from Pennsylvania's regional CSPs on their role in the county planning process. OMHSAS also provides information on available services, ongoing initiatives, opportunities to participate in trainings, and professional resources on www.parecovery.org; www.pa-co-occurring.org; and <http://networkofcare.org>.

Consumers and family members also have the opportunity to attend bi-monthly Advisory Committee meetings as "sunshine members," meaning they cannot vote on committee issues but do have the opportunity to provide comments and feedback. The Deputy Secretary of OMHSAS attends Advisory Committee meetings to present information on pertinent issues and initiatives related to the behavioral health system.

The Commonwealth seeks to support and expand consumer involvement in, and access to; recovery resources and services, self-help programs, and support networks. OMHSAS continues to allocate a portion of Community Mental Health Block Grant funds for special projects, such as "Open Minds, Open Doors," an anti-stigma project in Berks County, that promote access to recovery-oriented resources, services, and support networks. The Pennsylvania Peer Support Coalition is a statewide network of individuals who use their own recovery journey to help support others.

Housing

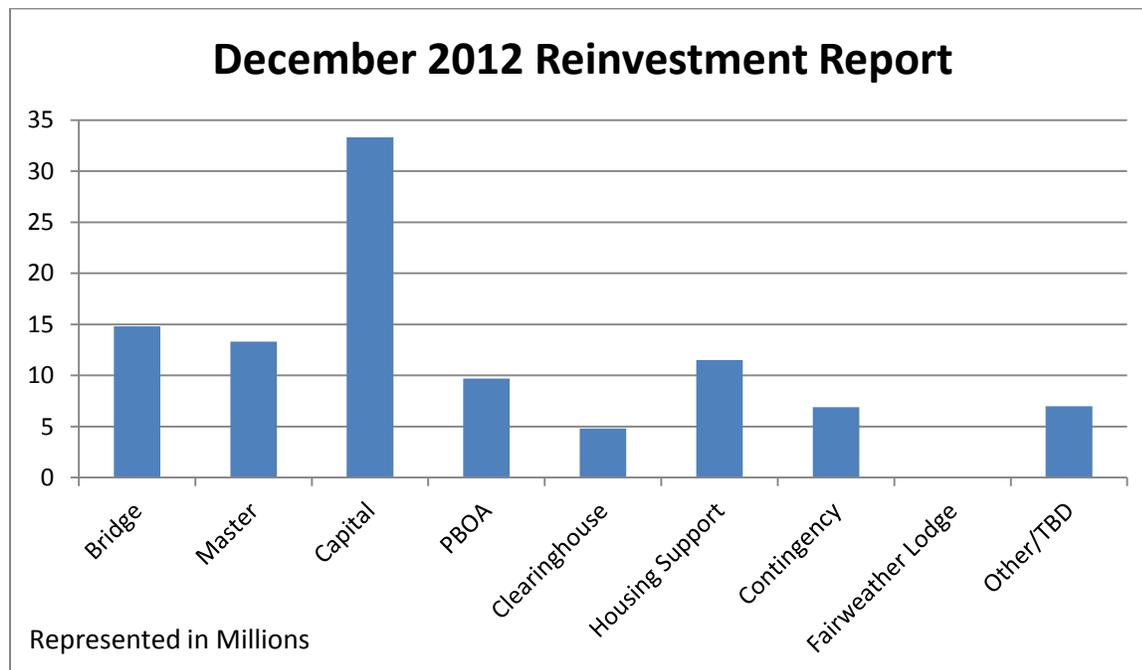
The Commonwealth of Pennsylvania's Department of Public Welfare Office of Mental Health and Substance Abuse Services (OMHSAS) has implemented an OMHSAS Permanent Supportive Housing Initiative utilizing local, state and federal resources to expand affordable, supportive housing and residential programs for adults. Over the past five years, this initiative has been instrumental in County MH/IDD/SA (Counties) and Health Choices 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. 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 CRRS and LTSRs, acute and institutional care. The OMHSAS Initiative was critical to the state's ability to make a competitive application for 811 PRA resources and is essential for OMHSAS and Counties to meet their Olmstead integration obligation.

Fifty three counties have made Reinvestment resources (capitation savings) available as part of the OMHSAS PSH Initiative. 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.

PSH is typically created by utilizing and combining fund 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 limited technical assistance and training for this program.



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. In 2010, the average cost of a one bedroom market rate rental in Pennsylvania was

99% of an individual's monthly SSI check. In four metropolitan areas, fair-market rents are above 100% with southeast Pennsylvania being at 129%. 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.

The goals of the OMHSAS PSH Initiative are: (1) to create affordable supportive housing for people with disabilities, specifically OMHSAS/DPW target populations, and (2) to use Health Choices Reinvestment, CHIPPS or base funding to access and leverage mainstream housing resources and create partnerships with state and local housing and community development entities. The data collected in April 2012, mid-implementation, indicate Counties are having remarkable success achieving these goals and meeting the vast majority of their own local housing targets. There are some indicators the program when fully implemented may exceed expectations. The following table shows details of the state's investments in supportive housing as of December 2012:

PA Supportive Housing Investments - December 2012										
County/Joinder	Bridge	Master Lease	Capital	PBOA	Mgt Clrhse	Hsg. Support	Contingency	Fairweather	Other/TBD	Total \$
								Lodge		
Allegheny	\$ 1,959,633	\$ 2,504,000	\$ 2,426,129		\$ 366,370	\$ 3,513,517	\$ 400,000		\$ 1,733,650	\$ 12,903,299
Arm/Indiana		\$ 72,188			\$ 14,185	\$ 206,000	\$ 250,000			\$ 542,373
Butler									\$ 65,061	\$ 65,061
Beaver	\$ 987,500		\$ 800,000		\$ -	\$ 174,235	\$ 120,000			\$ 2,081,735
Fayette	\$ 500,000	\$ 113,400			\$ 389,800		\$ 230,000			\$ 1,233,200
Lawrence	\$ 261,339				\$ 250,000		\$ 12,000			\$ 523,339
Washington	\$ 903,000	\$ 150,000				\$ 705,198	\$ 175,000		\$ 571,317	\$ 2,504,515
Westmoreland					\$ 61,000	\$ 180,000	\$ 79,656	\$ 220,929		\$ 541,585
Cumb/Perry			\$ 1,224,000		\$ 204,000					\$ 1,428,000
Dauphin			\$ 64,000			\$ 32,696		\$ 32,000		\$ 128,696
Lancaster			\$ 167,778							\$ 167,778
Lebanon		\$ 75,977								\$ 75,977
York/Adams		\$ 2,340,336	\$ 2,500,000	\$ 2,102,935	\$ 168,284	\$ 1,685,656	\$ 318,373			\$ 9,115,584
Berks	\$ 3,400,000		\$ 1,500,000		\$ 728,655	\$ 842,423	\$ 225,000			\$ 6,696,078
Lack/Susq			\$ 200,000				\$ 42,980			\$ 242,980
Lehigh	\$ 785,962	\$ 1,264,160	\$ 5,150,000	\$ 1,000,000	\$ 580,000	\$ 540,161	\$ 740,161		\$ 2,030,629	\$ 12,091,073
Luzerne/Wyoming		\$ 128,924								\$ 128,924
C-M-Pike		\$ 1,930,000					\$ 250,000			\$ 2,180,000
Bucks		\$ 220,000	\$ 135,000							\$ 355,000
Chester		\$ 983,054	\$ 1,650,746		\$ 586,183	\$ 400,000	\$ 300,000			\$ 3,919,983
Delaware	\$ 529,563	\$ 458,017	\$ 50,000		\$ -		\$ 132,500	\$ 50,000	\$ 1,130,260	\$ 2,350,340
Montgomery		\$ 3,017,760	\$ 1,540,000	\$ 716,250	\$ 993,180	\$ 530,825	\$ 450,000			\$ 7,248,015
Philadelphia	\$ 5,000,000		\$ 15,000,000	\$ 5,918,323	\$ 500,000	\$ 1,000,000	\$ 2,826,000			\$ 30,244,323
23 Counties	\$ 513,040	\$ 134,600	\$ 959,081			\$ 1,744,225	\$ 434,708		\$ 1,495,626	\$ 5,281,280
Total Reinvestment	\$ 14,840,037	\$ 13,392,416	\$ 33,366,734	\$ 9,737,508	\$ 4,841,657	\$ 11,554,936	\$ 6,986,378	\$ 302,929	\$ 7,026,543	\$ 102,049,138

Summary data for the Fifty three counties reveals:

- Counties have invested approximately \$102 million in the OMHSAS approved housing strategies including \$33.4 million in capital funds, \$32 million in Bridge and Master Leasing subsidies and \$9.7 million in PBOA between 2006 and 2012.

- Counties have allocated \$4.8 toward establishing management clearinghouses, a vital service in the new 811 PRA program; \$11.6 in start-up services, \$7million in Contingency funds and nearly \$3.5 million being reallocated or newly allocated but not yet designated to one of the aforementioned categories.
- Health Choices investments have leveraged between three and four times the Reinvestment amount in other housing resources including other capital such as HOME funds, ACT 137 and Low Income Housing Tax Credits as well as federally funded tenant- and project-based vouchers.
- Initially, counties expected to serve over 3,300 consumers when funds were fully expended. As of April 2012, fully or partially reinvestment-funded housing programs had served an estimated 3031 households¹. Since programs will be expanding and some units are set aside for 20-30 years, it is likely Counties will serve significantly more households than expected. This is due in large part to Counties utilizing beneficial leveraging strategies and some counties using funds for helping consumers get into housing including paying deposits and move in expenses even as funds for rental subsidies were already committed or not available.
- Ten (10) county programs and the 23 County program have committed funds to capital projects. Eight (8) county programs have expended all or a portion of their available funds, and through the end of FY 2012, 126 units were filled. One county recently awarded funds for its first project and another five projects will be leasing up this year. Two counties have not been able to secure any partners yet to award funds. Of the funds awarded to 26 projects², the average number of years funds will be set aside is 25.3 years³. Individuals who got these set aside units either had their rent reduced to 30% of their income or received tenant based or project based rental subsidies. The costs for capital projects may appear high but given the requirement developers set aside units for 15 to 30 years, the overall cost per unit over time is lower than the cost for rental subsidies alone.
- Four county programs have committed funds for PBOA (project based operating subsidies) scattered in multi-family rental projects with tax credit support or available on the rental market prior to this Initiative. One hundred and fifty six (156) people have been placed in 76 different multi-family rental projects and there has only been a 7% turnover of tenants retaining those units. PHFA manages this program on behalf of OMHSAS for a 1% fee. The benefit of this program is that when available these units are rented well below market rate rent extending the funds available for rental. These properties also tend to be well maintained and managed.
- Counties have committed funds for 686 bridge rental subsidies. Of that number 223 have just been funded and are being placed in service this fiscal year. Of the 463 placed in service before FY 2012, 1655 persons have been served and 796 or 48% of those persons have already been awarded Section 8 certificates, earned enough to pay for their own

¹ approximately 66% of consumers got some type of rental assistance and contingency support and approximately 33% got only contingency support. These numbers do not include capital projects funded but not placed in service in FY 2012 or new rental arrangements funded but still in process of being established.

² 3 projects were single site and 23 were set aside units in a larger multi- family project.

³ One project has only a 10 year commitment of funds bringing this overall average down by nearly 2 percentage points.

housing or moved to other locations. This positive trend toward securing permanent rental assistance points to the potential for utilizing mainstream resources.

- Likewise another 11 County Programs have arranged for 331 people to get rental units through master leasing programs. Master leasing is beneficial for people who cannot get a lease on their own on the other hand it is not a pathway to getting federal or other funds for rental assistance over the long term. Thus sustainability of master leasing units is more challenging. Several counties do not use mater leasing because they report they can find ways to help get their own units without this step or they are leery of assuring sustainability.
- Approximately 2,340 individuals have received contingency funds to enable them to move into affordable housing and cover their moving expenses, pay security and utility deposits, cover rent arrearages and acquire needed household items.
- Eleven (11) County Programs have developed Clearinghouses to manage housing access across multiple rental programs and to match people with the housing of their choice and the optimal housing available. Clearinghouses employ staff who know their local housing market, housing regulations and fair housing requirements and have relationships with landlords and property managers. Staff manage the Master Leasing, PBOA and Bridge an leasing in Capital Project set asides. In some counties they manage other programs as well such as HAP and McKinney Vento Shelter Plus Care. Several clearinghouses are managed by Public Housing Authorities (PHAs). The North West 9 Counties are entering into an arrangement this fiscal year with Clarion County PHA to manage rental arrangements for all the counties in this geographic area. PHFA is also contributing HOME funds to this arrangement. This model is ideally suited to assist Counties to meet their Olmstead obligations and will be utilized by DPW and PHFA if awarded 811 PRA funds.
- Counties vary significantly in the percentages of those served who come from their targeted populations, i.e. people in institutions and CRRs, people who are homeless, youth aging out and forensic population.

Pennsylvania has made significant strides to address the unnecessary institutionalization of Pennsylvanians who have a mental illness in state-operated psychiatric hospitals. As elsewhere in the nation, the census of Pennsylvania's state hospitals has declined dramatically in the last 40 years -- from 35,100 in 1966 to less than 1,600 in 2010. Our progress mirrors the national trend which recognizes 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, are at risk for institutionalization including the homeless, criminal justice, and veterans, and other who live in congregate settings. We have been successful in our endeavor for the past 20 years and will continue that success throughout the state.

IV: Narrative Plan

N. Prevention

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Narrative Question:

As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
5. How is the state's budget supportive of implementing the Strategic Prevention Framework?
6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)
7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

Footnotes:

Does not apply to MHBG

IV: Narrative Plan

O. Children and Adolescents Behavioral Health Services

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Narrative Question:

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 over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health 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, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?
3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Footnotes:

O. Children and Adolescents Behavioral Health Services

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?

Response: Pennsylvania has a System of Care Cooperative Agreement with SAMHSA to establish systems of care in 15 counties and we received an expansion planning Grant that led to the development of a plan to establish systems of care in all counties throughout the Commonwealth.

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

Response: The System of Care expansion plan identifies that the practice model for systems of care will be research-based, individualized care planning practice models such as High Fidelity Wraparound which involve youth and families in equal partnership with systems and natural supports

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

Response: The System of Care State Leadership Team consists of top officials from Child Welfare, Juvenile Justice, Drug & Alcohol, Education, and Mental Health, along with an equal number of youth and family representatives. A memorandum of Agreement guides the multi-system efforts.

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

Response: The Youth and Family Training Institute provides training, coaching, monitoring, and credentialing for staff involved in High Fidelity Wraparound. In addition, Pennsylvania has supported the development of Multi-Systemic Therapy, Functional Family Therapy, and Parent Child Interaction Therapy, each of which has its own training requirements.

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Response: The Bureau of Quality Management in OMHSAS has this responsibility.

IV: Narrative Plan

P. Consultation with Tribes

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Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation 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.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between 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.

For the context of the Block Grants 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. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order 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. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Footnotes:

P. Consultation with Tribes

Pennsylvania does not have any Federally recognized Tribal Governments or Tribal lands within its borders.

IV: Narrative Plan

Q. Data and Information Technology

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Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Footnotes:

Q. Data and Information Technology

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;

List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;

Provide information regarding its current efforts to assist providers with developing and using EHRs;

Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and

Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Response:

Pennsylvania has made significant progress in preparing for client level reporting. We are scheduled to submit the crosswalk to NRI within the next 2 months; our first Basic Client Information (BCI) data file submission will be in December 2013. Our first State Hospital Readmission (SHR) data file submission will be in March 2014.

In addition to being able to submit data for our HealthChoices Behavioral Health (Medicaid managed care) and Medicaid Fee-For-Service populations, work continues on building capacity to report on services received by our county base-funded mental health consumers. By the end of 2013, we should have the majority of current consumers enrolled in our information system. The next milestone after that will be to have all counties capable of, and submitting, encounters into the system. At that point, we will be able to have the capacity to provide unique client-level data for all populations.

OMHSAS leverages several enterprise information systems. The main one is the Client Information System (CIS), which receives all authorizations, closings, and changes for the entire Medicaid population. This system also houses other Department of Public Welfare programs. The eligibility information from CIS and claims/encounters payment information is combined and maintained in the Provider Reimbursement Operations Management Information System in electronic format (PROMISE). The Home and Community Services Information System (HCSIS) contains incident management information, Community and Hospital Integration Projects Program (CHIPP) information, state mental hospital closure consumer data, and is the vehicle by which county base consumer information is added to CIS.

Pennsylvania currently pays Fee for Service claims and processes managed care encounters via the PROMISE system. This system has been in place for many years, and there are no barriers to its successful continuation. The current challenge for us is implementing the batch enrollment system so that county base consumers may be enrolled in CIS and their future expenditures captured by a HIPAA-compliant 837._

Health Information Technology (HIT) efforts are led by the state Department of Public Welfare's Office of Medical Assistance Programs. OMHSAS is represented on the HIT Interagency Steering Team. Through December 2012, Pennsylvania ranked sixth nationally in the dollar amount of Electronic Health Record (EHR) incentive payments allocated to Medicaid providers (source: Centers for Medicare and Medicaid Services). Eligible Professionals (EPs) received approximately 46% of the total payments, while eligible hospitals received approximately 54% of the incentive dollars.

IV: Narrative Plan

R. Quality Improvement Plan

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Narrative Question:

In the FY 2012/2013 Block Grant application, 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, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in 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. In an attachment, states must submit a CQI plan for FY 2014/2015.

Footnotes:

Quality Management Program Overview

**Commonwealth of Pennsylvania
Department of Public Welfare
Office of Mental Health and Substance Abuse Services**

**August 6, 2003
Revised February 17, 2004**

Revised February 17, 2003`

Commonwealth of Pennsylvania
Department of Public Welfare
Office of Mental Health and Substance Abuse Services

Background

The Office of Mental Health and Substance Abuse Services (OMHSAS) is responsible for managing state mental hospitals, providing funding and oversight for the State/County Community Mental Health Program, and contracting for mental health and substance abuse services for Medical Assistance (MA) eligible individuals under the HealthChoices Behavioral Health Services managed care contracts.

The state mental hospitals, funded through the Mental Health Services Appropriation, provide a wide range of inpatient services to Pennsylvanians with mental illness. The state mental hospital system is comprised of nine state mental hospitals and one restoration center.

The Mental Health and Mental Retardation Act of 1966 and subsequent revisions, established the basis for a comprehensive public service delivery system under the direction of state and county government. The Community Mental Health Services program is administered by 46 single or multi-county administrative units. This system aims to deliver a comprehensive array of prevention, treatment, rehabilitation and support services to all those in need within the limits of available resources.

Pennsylvania's community mental health system began more than 35 years ago with a limited array of services, focused primarily on clinical treatment. Over the years, services have continued to expand and evolve based upon a combination of federal, state, county and private resources and directed by best practice.

In February 1997, OMHSAS implemented the HealthChoices Behavioral Health Services program, a mandatory MA behavioral health managed care program, which marked the beginning of unified systems for delivery of community mental health services. This program, through capitation-based contracts with counties or managed care organizations, established funding for behavioral health services for MA eligible clients. HealthChoices began in the southeast region of the state. HealthChoices expanded into the southwest region in January 1999. In October 2001 the program was expanded into the Lehigh/Capital region. Continued expansion into other regions is planned.

OMHSAS provides significant leadership in the provision of drug and alcohol services and coordinates its responsibilities with the Health Department's Bureau of Drug and Alcohol Programs (BDAP). With the initiation of HealthChoices in February 1997, OMHSAS is responsible for the financial review and program monitoring of substance abuse services in concert with BDAP. Drug and alcohol services to both MA eligible persons (Act 152) and individuals who have lost MA eligibility due to the change in eligibility requirements are administered by 50 Single County Authorities.

Revised February 17, 2003`

OMHSAS recognizes that quality is first about people. Quality management is dedicated to ensuring that services and supports are organized and managed in a way that facilitates recovery in adults and resiliency in children. We will actively seek out and listen to the voices of adults, families, and individuals with substance use disorders to understand what is working and what needs to be improved.

A major goal of the OMHSAS is to have unified systems of treatment and supports in each of the 67 Pennsylvania counties. The President's New Freedom Commission report: "Achieving the Promise: Transforming Mental Health Care in America" articulates the same challenge for the nation's mental health and drug and alcohol treatment system.

Local treatment systems must be organized and managed to facilitate recovery for adults and resiliency for children. Planning and funding decisions are increasingly based on data analysis and outcomes achieved for person served. OMHSAS expects to see expanded implementation of evidence based practices and quality initiatives to ensure continuous improvement. As the treatment system becomes more accountable stakeholders will be able to determine how well their county is doing with available resources.

Measuring progress toward a unified local treatment system which facilitates recovery for adults and resiliency for children and adolescents requires an integrated approach to quality management that will examine the interface between community-based services, state mental hospitals, and cross-system linkages that are necessary to effectively serve special populations. Quality management will include the identification and use of evidence-based practices ensuring excellence in mental health and drug and alcohol treatment services and supports.

This integrated approach to quality management will advance the OMHSAS goal of achieving a unified system of services and supports where financial resources are aligned to achieve this goal. To that end OMHSAS has developed standards and criteria for the provision of quality outcome oriented behavioral health services.

The year 2003 began the transition for OMHSAS. New leadership is committed to more effective operations that are responsive to the voice of our stakeholders. A re-organization of functions and duties is underway that focuses on streamlining the administration of the behavioral health and drug and alcohol delivery systems. This, coupled with new Federal requirements for managed care, has given OMHSAS a mandate to broaden our Quality Management initiatives. The OMHSAS Quality Management Plan provides the framework for the expansion of our activities and evolution of our new structure.

The OMHSAS Vision:

"Every person with a serious mental illness and/or substance use disorder, and every child and adolescent who has a substance use disorder and/or has a serious emotional disturbance will have the

Revised February 17, 2003`

opportunity for growth, recovery and inclusion in their community, have access to the services and supports of their choice, and enjoy a quality of life that includes family and friends.

Revised February 17, 2003`

Quality Management Mission Statement

The mission of the Quality Management program is to support the OMHSAS goal of public accountability by including individuals with serious mental illness and or substance use disorders, children, adolescents, and their families in every step of the process, using proven methodologies and evidenced based practices, to positively influence health outcomes and member satisfaction in an integrated behavioral health delivery system.

Goals, Objectives and Guiding Principles

Goals of the Quality Management Program

In support of the overall goals and objectives of the Office of Mental Health and Substance Abuse Services, the Quality Management (QM) program focuses on the following goals:

- Ensure that the program is consistent with and enhances the mission, vision and values OMHSAS has outlined for the behavioral health system,
- Ensure that all affected stakeholders, including Department of Public Welfare (DPW) staff, consumers, families, individuals with substance abuse disorders, counties, Behavioral Health Managed Care Organizations (BH-MCO), providers, and advocates have an opportunity for input,
- Promote services and programs provided to consumers, families and individuals with substance use disorders that are of the highest possible quality and represent best practices, through systematic monitoring and evaluating of a defined set of indicators,
- Maintain a comprehensive program that assesses quality across all OMHSAS funded programs and services, monitors for compliance with regulatory and contractual requirements and identifies opportunities for improvement,
- Monitor satisfaction with program performance, and
- Ensure that OMHSAS' internal practices are monitored and opportunities for improvement are identified.

Quality Management Objectives

In support of the QM program goals, the following objectives have been established:

- Evaluate the quality and effectiveness of behavioral health programs by systematically monitoring and evaluating the quality of care, services and member satisfaction,
- Obtain input from affected stakeholders, including DPW staff, consumers, families, individuals with substance use disorders, counties, BH-MCOs, providers, and advocates,
- Develop and implement a QM work plan that identifies specific activities, measures and indicators that are the focus of the QM program for that year,
- Identify, collect and analyze data from the counties, vendors and providers, monitor the source, and quality of the data, that identifies both best practices and opportunities for improvement of services,
- Disseminate information so that the outcomes of quality activities are reflected in program changes,
- Conduct follow-up activities that determine the effectiveness of improvement activities, and

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- Continuously monitor the adequacy and effectiveness of the QM program and the work plan, making revisions as required and guaranteeing that the plan reflects the highest standards.

Guiding Principles

In the OMHSAS behavioral health care delivery system, the following quality principles are considered:

- The Quality Management Plan (QMP) overview is not a static document, but rather is dynamic and a reflection of best practices in quality assessment and performance improvement,
- QM activities are collaborative and involve all affected groups. The QMP reflects input from DPW staff, consumers, families individuals with substance use disorders and provider organizations,
- The process is consistent with the mission, vision and values of OMHSAS and reflects the importance of cultural competency in programs and services;
- Quality is the responsibility of each bureau of OMHSAS. High functioning organizations incorporate measurement activities into daily work processes, strive to remove barriers to quality activities and provide staff at all levels the opportunity to participate in quality management activities,
- The program focuses on those measures that reflect the greatest potential for positive change to the system and is a valid reflection of quality services and is realistically linked to improved consumer functioning,
- All components of the system, both internal and external to OMHSAS, have a “customer service” focus.

OMHSAS Structure

Each bureau shares the common goal of supporting mental health consumers, families and individuals with substance use disorders in growth, development and recovery. Collaboration with each other assures that we are listening to the voices of those we serve, and those with whom we share responsibility and accountability, to meet the standard of excellence. We recognize that we are each other’s customers and must work towards ensuring quality services in support of recovery for adults and resiliency for children and adolescents. The organization structure supports collaboration across all bureaus.

Organizational responsibilities and lines of authority are displayed on the organizational chart included as Appendix 1.

Quality Management Structure

The Quality Management program is committed to the goal of establishing an integrated system of service delivery. This document presents the comprehensive quality management strategy of OMHSAS. Recognizing that many activities overlap and are interconnected, this document is presented in multiple sections. The first section outlines the overarching QM strategy for all funding sources followed by a section related to HealthChoices, community services and state hospitals.

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Organizational Responsibilities

The OMHSAS Division of Quality Management is responsible for the development, oversight and direction of the quality management program. The Quality Management Plan (QMP) serves as a foundation for OMHSAS quality management activities.

The Division of Quality Management collaborates with the OMHSAS Medical Director and other bureaus in providing expertise, leadership and direction for clinical care in the provision of mental health services including psychiatric and nursing treatment and care in community-based service system and within the state hospitals.

The QMP provides the framework for OMHSAS to assess and improve the quality of administrative services, clinical systems, clinical care and member services for the citizens of Pennsylvania. The plan includes a clear definition of the role of the program and its relationships to other OMHSAS agencies/areas, and stakeholders. It also articulates the relationship between OMHSAS and any entities to which it delegates QM/PI activities.

The QMP defines and integrates the roles of the various OMHSAS bureaus as part of the QM team and describes the inter-relationships with other programs, including community-based fee for service Mental Health (MH) and Drug and Alcohol (D&A). QM strategies include Quality Assessment (QA) and Performance Improvement (PI) activities encompassing both the internal operations of the system and more global system responsibilities, including HealthChoices, hospital and community based programs. All of these activities are of importance and will be addressed in individual sections of the QMP.

The goal of OMHSAS is to improve programs and services in order to facilitate positive outcomes for consumers, families, and individuals with substance use disorders. Through the oversight of the QM program, OMHSAS' leadership provides direction and resources in the effort to measure the system's progress toward reaching its strategic goals.

Quality Management Committee

The QMC is responsible for providing direction to the QM process, and recommending changes in program structure or administration based on findings identified through QM activities. The committee is charged with coordinating and communicating quality management issues internally among OMHSAS Bureaus and externally with various stakeholders.

The QMC is co-chaired by the OMHSAS Medical Director and the Director of the Quality Management Division with a plan to transition the co-chair responsibility from the Director of the Quality Management Division to a consumer committee member. Membership in the committee includes representatives from:

- Bureau of Children's Services
- Division of Evaluation and MIS
- Division of Medicaid and Financial Review
- Division of Drug and Alcohol Services
- Bureau of Policy and Program Development

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- Bureau of Consumer and Family Affairs

Key activities of the QMC include:

- Develop OMHSAS QM work plan,
- Review quality and performance information received from the program components, which include HealthChoices, Medicaid FFS, county based, and state hospital programs.
- Solicit and consider input from various stakeholder groups as an integral component in the quality planning process
- Review External Quality Review (EQR) reports,
- Review results of clinical audits or studies conducted,
- Track and trend relevant data from various sources,
- Identify issues for focused studies,
- Recommend areas to be prioritized and resources required,
- Ensure that system-wide trends are identified and analyzed, and that follow-up and resolution occur, and
- Conduct annual evaluation of effectiveness of the QMP and work plan.

The QMC will employ work groups to address specific issues. The work group will be comprised of representatives from the committee and/or others designated by the committee based on interest or expertise.

OMHSAS Executive Council

The Executive Council provides senior leadership for the OMHSAS program, policy and financial direction. The Deputy Secretary for the OMHSAS is the Chair for the Executive Council, which meets twice monthly. All major program, policy and financial decisions are brought before this Council to ensure a team approach to managing the time and resources of the Office. On a monthly basis the Executive Council reviews the status of quality management activities and provides direction to the Quality Management Committee (QMC). Additionally, the Executive Council reviews and approves the recommendations of the quality management committee.

Membership of the Executive Council includes:

- Deputy Secretary for the Office of Mental Health and Substance Abuse Services
- Executive Assistants to the Deputy Secretary
- Director of the Office of the Medical Director
- Director of the Bureau of Hospital Operations
- Director for the Bureau of Financial Management and Administration
- Director of the Bureau of Children's Services
- Director of the Bureau of Policy and Program Development
- Director of the Bureau of Consumer and Family Affairs
- Director of the Division of Quality Management
- Director of the Division of Medicaid and Financial Review

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- Director of the Division of Drug and Alcohol Services
- Director of the Division of Eastern Operations
- Director of the Division of Western Operations

PeopleStat

PeopleStat is a Department wide quality and program management model established to improve management and performance of DPW programs. The goals are to:

- Increase accountability and program performance and improvement,
- Improve decision-making throughout all levels of the Department
- More directly link expected performance with requested program activity funding levels
- Focus performance on customer service, promote the effective use of human and financial resources and
- Support strategic planning for long term program improvement and quality assurance

PeopleStat will develop and implement Department wide performance measures, ensure that the Department's business goals and priority projects are accomplished through periodic accountability meetings, and provide consulting services and technical assistance to ensure continuous quality improvement.

Advisory Groups

OMHSAS advisory groups provide OMHSAS input and guidance from community stakeholders. Participation of stakeholders in the quality management process is critical to the success of the program. OMHSAS or other DPW staff facilitates the exchange of information between the groups and OMHSAS operations, including the quality management activities, support each group.

Advisory groups include:

- OMHSAS Mental Health Planning Council – Assists OMHSAS with development, review and approval of State Plan for Federal Community Mental Health Block Grant. Coordinates activities of standing committees, including Executive Committee of the Planning Council, CASSP Advisory Committee, CSP Advisory Committee, Cultural Competence Advisory Committee, and Joint Committee on the Mental Health of Older People.
- Behavioral HealthChoices Stakeholders Advisory Committee – Provides forum for information sharing and problem resolution related to HealthChoices.
- Medical Assistance Advisory Committee – Provides OMAP/OMHSAS with advice to assist the State in provision of MA services.
- Consumer sub-committee of the MAAC –Provides feedback from consumers, families and individuals with substance use disorders and welfare rights organizations
- Managed Care Sub-Committee of the MAAC – Provides feedback from managed care stakeholders in both physical and behavioral health and providers organizations.
- Mental Illness and Substance Abuse Consortium – Provides assistance to OMHSAS in development of programs for persons with co-occurring conditions.
- Provider Advisory Committee advises OMHSAS on issues related to service delivery and provider management.

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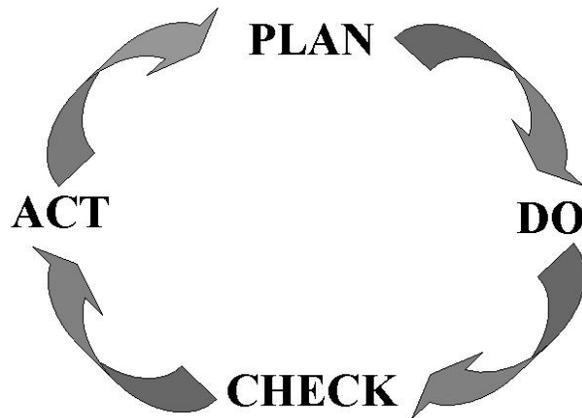
Quality Management Process

OMHSAS has adopted a philosophy of Total Quality Management (TQM) and Continuous Quality Improvement (CQI) based upon Deming's 14-point program for management adapted to the health care industry, and JCAHO guidelines. The OMHSAS quality management approach places emphasis on improving outcomes by identifying administrative and systems issues, refining the processes necessary to achieve the desired outcome and evaluating improvement over time. The overall process includes:

- Delineating the scope of the services to be monitored and improved.
- Identifying the important aspects of the services whose quality should be examined and improved.
- Identifying indicators that will be used to monitor the quality, accessibility and appropriateness of the important aspects of services.
- Establishing thresholds for the review of indicators that become "flags" signaling the need for further analysis of the causes for the data reported to DPW.
- Collecting data pertaining to each indicator and comparing the aggregate level of performance with the threshold for analysis. If the threshold is not reached, further analysis may not be necessary.
- Initiating analyses of other important aspects of services when thresholds have been reached.
- Taking actions to improve the aspects of services.
- Reporting the findings to the organizations and stakeholders involved, including a report of findings to DPW on a regular schedule. Monitoring and analysis are continued in order to identify any future deficiencies in services and to improve quality.

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OMHSAS uses and recommends the basic methodology of Plan, Do, Check, and Act as the foundation for all QA/PI activities.



The four stages of the QM cycle are as follows:

- Plan:** The first stage of the cycle identifies areas or processes for improvement. Areas for improvement will be identified with input from all stakeholders associated with the process.
- Do:** The second stage of the cycle implements the activities identified in the planning stage. The activities must be objective, measurable, evidenced based and outcomes oriented. Stakeholders in the QM process work closely together to ensure that the activities identified in the planning stage occur in an efficient, timely manner.
- Check:** The third stage of the cycle focuses on assessment of the results of implemented activities. Performance is reviewed to determine how actual performance compares to standards/benchmarks defined during the planning phase and monitored during implementation.

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Act: The final stage of the cycle focuses on the development and initiation of activities for increasing or sustaining improvement. Performance improvement projects must be timely, measurable and progressive.

Information on the success of the project, in the aggregate, is periodically summarized and communicated in sufficient time to provide operational information on quality of care. The annual review of performance reinitiates the continuous quality improvement process beginning with the planning stage of the QM cycle.

Data Sources/Information Management

OMHSAS collects data necessary to measure the performance of programs and plans under its purview. The data includes financial, operational/process and clinical measures, as well as outcome data. In the development of these data sources, OMHSAS has relied on internal resources, stakeholder input, provider input and recommendations of national groups and accreditation organizations.

Data sources include, but are not limited to:

- Aggregate Encounter Reports,
- Person Level Encounter Reports,
- Claims Data,
- POMS and CCR/POMS Reports,
- Early Warning Reports,
- Quarterly Monitoring Reports
- Focused Studies,
- Monitoring Team Reports,
- Consumer/Family Satisfaction Surveys,
- Readiness Reviews,
- Hospital Service reports
- Drug Usage Utilization reports
- Seclusion and Restraint reports
- Risk Management reports
- Incident reports
- Financial reports
- Best Practice reports – PennMAPS
- CHIPP/SIPP reports
- Performance Measurement reports
- Licensing Reports, and
- Data from other agencies.

Quality Management Developmental Activities

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Purpose of the QMP and QM work plan

The purpose of the QMP is to:

- Articulate the OMHSAS philosophy of quality and its components,
- Define activities which reflect system performance,
- Determine the frequency and scope of measurement or oversight activities,
- Identify key staff or groups responsible for measurement and oversight,
- Outline the structure for dissemination of information and feedback to key stakeholders, and
- Establish the mechanisms for corrective action or remediation.

The purpose of the QM work plan:

- Identify quality assessment and improvement activities,
- Build upon analysis of existing measures,
- Identify new measures which broadly reflect the performance of OMHSAS programs and services, and
- For the identified measures, define scope and frequency of measurement, responsible staff and feedback mechanisms.

Development of Quality Management Annual Work plan

On an annual basis, a QM work plan is developed that defines the:

- Scope of the activities for the coming year,
- Specific areas to be reviewed,
- Type of study or activity,
- Relevant indicators to be measured,
- Goals or benchmarks for the measures,
- Timeframes, and
- Staff responsible.

The work plan areas of focus may include additional monitoring of areas already under review, refinement of existing measures or new measures based on input from QM constituencies.

In the third quarter of the year, the review of current indicators as well as recommended new measures will be brought to the QMC. The QMC will review the measures to ensure that they are consistent with OMHSAS' goals for that year. The review will include an assessment of the scope, relevance, and effectiveness of indicators, interventions and recommendations. It ensures that the work plan incorporates the principles of cultural competence, CSP, and CASSP as well as including measures relevant to the Health Department's Bureau of Drug and Alcohol Program goals. The Committee will evaluate measurement methodology to ensure consistent, reliable results. Based on areas of interest or concern that may develop during the year, the Work plan can be modified as needed.

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After indicators are identified and approved by the committee, the work plan will be developed and submitted to Executive Council for approval.

Developing Indicators

Indicator development is based on addressing the following:

- What do stakeholders say is important?
- What is our current level of performance?
- How stable are our current processes?
- What areas could be improved?
- How important will the changes be and how difficult will they be to achieve -“utility” and “burden”?
- What should our improvement priorities be?
- Have strategies or specifications to stabilize or improve performance been developed?
- Have specifications for new or redesigned processes been met?
- Have strategies to stabilize or improve performance been effective?

Indicators are developed based on a review of national accreditation and regulatory groups’ recommendations that delivery systems should collect data to support both improvement priorities and continuing measurements of the following:

- Access to, and availability of care and services,
- Appropriateness of care and services,
- Continuity and coordination of care and services,
- Confidentiality,
- Provider Network,
- Provider Profiling,
- Utilization Management,
- Evidence based –practices,
- Cultural competence of programs and services,
- Consumer, family and individuals with substance use disorders perception of and satisfaction with services,
- Provider perceptions of and satisfaction with programs and services,
- Member complaints, grievances and appeals,
- Outcomes related to functional, physical, and psychological status of members,
- Effectiveness of preventive services and health promotion programs,
- Medication usage practices,
- Appropriateness of seclusion and restraint procedures
- Adverse clinical events,
- Adequacy and quality of provider network,
- Financial performance of the delivery system,
- Risk management activities, and
- Quality control activities

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The measures adopted are subject to review and revision as necessary.

Standards/Benchmarks

Implementation of quality standards and benchmarks is an essential means of evaluating the success of the behavioral health program. Many plans and programs nationally have evaluated and/or implemented performance improvement measures, but differences in program structure, covered services, administration, financing, and enrolled populations make meaningful cross-state comparisons difficult. For that reason, it has been necessary for DPW to evaluate existing measures and customize them to the needs of OMHSAS programs. OMHSAS uses expert opinion, historic service patterns and performance, national “best practices” standards and where available national benchmarks as a means of program evaluation.

Distribution of Findings

An important objective of the QM process is to ensure that data is used to encourage and stimulate continuous improvement throughout the system.

QM is responsible for aggregating the data from the various measurement systems and preparing reports summarizing the findings. Some reports will be prepared on a routine basis. Other reports will be produced as new findings or trends emerge. Information will be disseminated to all interested parties.

Annual Review of QM Program

On an annual basis the Division of Quality Management will prepare a written review of the QM program for review and approval by the QMC. The evaluation will be sent to the Executive Council and the Deputy Secretary for OMHSAS for review and approval.

The summary will address:

- The extent to which the QM goals have been met
- The impact of QM activities on improving the quality and effectiveness of care and services provided to individuals within the behavioral health system,
- Proposed modification, continuation or elimination of current activities,
- Identify opportunities for continued improvement, and
- Development of the QM work plan.

OMHSAS Annual Report

The OMHSAS prepares the Annual Report that highlights the accomplishments of various programs for the previous year. The report, available to the public, presents summaries for all HealthChoices zones. Information is gathered from the various monitoring and reporting instruments used throughout the year. Sections of the report present summaries of:

- The current program status
- Distribution of eligibles
- Diagnoses by region, gender and age
- Person level encounter data
- Regional penetration rates
- Financial expenditures
- Consumer satisfaction survey results

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- Complaints, Grievances, Fair Hearings
- Reinvestment plans
- Quality Initiatives
- Performance Outcome Measurement System
- External Quality Reviews
- HealthChoices program outcomes
- Future Initiatives
- County Accomplishments

The Bureau of Financial Management and Administration prepares an Annual Report of the financial impact of the behavioral health programs including HealthChoices.

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Section I

HealthChoices

Background

On February 1, 1997, the Commonwealth of Pennsylvania's DPW introduced a new integrated and coordinated health care delivery system, known as HealthChoices. HealthChoices is the largest Medicaid program administered by the Department and consists of three components. The OMAP administers two components - the Physical Health Program and the Independent Enrollment Assistance Program. The OMHSAS administers the third component - the Behavioral Health Program.

The purpose of the program is to provide medical, psychiatric and substance abuse services to MA recipients. The HealthChoices mandatory managed care program is currently being phased in across the Commonwealth. The needs of the high risk populations included in the HealthChoices managed care program requires broad-based coordination to assure appropriate access, service utilization and continuity of care for persons with serious mental illness and or addictive diseases. Because of the cross-cutting coordination needs of MA recipients, the unique structure of the behavioral health and human services delivery systems administered by the counties, and their over 30 years experience in administering behavioral health services programs, it was determined that county governments would be offered the right-of-first opportunity to enter into a capitated contract with the Commonwealth.

HealthChoices is operational in the Southeast, Southwest and Lehigh/Capitol zones and provides care to over 900,000 Medicaid eligible Pennsylvanians in 25 counties. The following chart outlines the oversight structure of the HealthChoices program for each county within the three regions where the HealthChoices program has been implemented to date:

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HealthChoices Oversight

County	Oversight	MCO/ASO	Comments
Bucks	Bucks Co. Behavioral Health	Magellan, Inc. of PA (MBH)	Full Risk Sub-Contract
Chester	Chester Office of Behavioral Health	Community Care Behavioral Health Organization (CCBHO)	Full Risk Sub-Contract
Montgomery	Montgomery Office of Behavioral Health	Magellan, Inc. of PA	Full Risk Sub-Contract
Delaware	DelCare	Magellan, Inc of PA	Full Risk Sub-Contract
Philadelphia	City of Philadelphia	Community Behavioral Health (CBH)	County Operated 501C-3 Behavioral Health Organization; County retains Full Risk
Allegheny	Allegheny County HealthChoices, Inc (ACHI)	Community Care Behavioral Health Organization (CCBHO)	Full Risk Sub- Contract
Beaver	Beaver County	ASO w Value Behavioral Health of PA (VBH-PA)	ASO contract with VBH of PA; County retains Full Risk
Fayette	Fayette - Allegheny County HealthChoices, Inc (ACHI)	ASO w Value Behavioral Health of PA	ASO contract with VBH of PA; County retains Full Risk
Greene	OMHSAS	Value Behavioral Health of PA	
Southwest 6: Westmoreland, Washington, Indiana, Armstrong; Butler, Lawrence Counties	Southwest Behavioral Management, Inc. Each County also has limited oversight responsibilities	Value Behavioral Health of PA	Full Risk Sub-Contract
Berks	Berks County	Community Care Behavioral Health Organization (CCBHO)	Full Risk Sub-Contract
York/Adams	York/Adams Counties	Community Care Behavioral Health Organization	Full Risk Sub-Contract
Lehigh	Lehigh County	Magellan Inc. of PA	Full Risk Sub-Contract
Northampton	Northampton County	Magellan Inc. of PA	Full Risk Sub-Contract
Capital 5: Dauphin, Cumberland, Perry, Lancaster, Lebanon	Capital Area Behavioral Health Collaborative	Health Assurance Community Behavioral Care Network of Pa (CBHNP)	Full Risk Sub-Contract

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Introduction

The goal of the HealthChoices Program is to improve accessibility, continuity, and quality of mental health and substance abuse treatment services for Pennsylvania's MA populations, while containing the program's rate of cost increases. OMHSAS has assigned to the Bureau of Operations and Quality Management the responsibility for oversight of the HealthChoices Program.

This section of the OMHSAS QM plan will articulate the specific quality assessment and performance improvement oversight and monitoring activities of the HealthChoices Program.

Structure

The overall structure for coordination, communication, and review of the QM Program is described in the "Structure" section of the QM Plan.

QM structure specific to the HealthChoices Program is as follows:

HealthChoices Steering Committee

The HealthChoices Steering Committee is responsible for the implementation and management of the HealthChoices behavioral health services under the purview of OMHSAS. The steering committee meets twice monthly. The group establishes annual priorities, reviews progress, recommends policies for approval, reviews and recommends approval of reinvestment plans, coordinates with other offices, and ensures timely communication of behavioral health issues. Quality improvement activities include review of HealthChoices quality management reports, discussion of areas of concern or interest to OMHSAS Bureaus, suggestions for modifications and adjustments to the QM plan, and recommendations for sanctions as necessary to address performance issues. Some members of the steering committee participate in the Joint Management Committee that includes representatives of other Offices within DPW, as well as participants from other programs that serve OMHSAS constituents. Members include:

- Office of the Medical Director
- Director for the Bureau of Financial Management and Administration
- Director of the Bureau of Children's Services
- Director of the Bureau of Operations and Quality Management
- Director of the Division of Quality Management
- Director of the Division of Medicaid and Financial Review
- Director of the Division of Substance Abuse Services
- Director of the Division of Evaluation and MIS
- Director of the Division of Eastern Operations
- Director of the Division of Western Operations

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Reporting/Monitoring Oversight Activities

Periodic and ongoing oversight activities are a required component of the HealthChoices program to ensure that the counties and BH-MCO's comply with the standards established by the Commonwealth and CMS. Items selected for periodic and ongoing oversight reflect clinical and non-clinical services and administrative functions provided by the delivery system. The critical elements required by the Request for Proposal (RFP), Contract and Program Standards and Requirement documents form the basis for review. The elements include:

- Access and service availability
- Coordination and continuity of care
- Medical necessity
- In-plan services
- Provider and member enrollment/disenrollment
- Credentialing and recredentialing
- Utilization management
- Member rights and services
- Complaints, grievances and appeals
- Confidentiality
- Quality management
- Information systems and
- Executive management

The monitoring and oversight activities are the first level of performance assessment and are used to identify areas for performance improvement.

Readiness Reviews

Readiness reviews are conducted by OMHSAS subsequent to the award of a contract for a HealthChoices behavioral health program and when there are major changes in the program model or changes in sub-contractors. The readiness reviews focus on the critical issues necessary for the plan to provide services on the first day of operations. OMHSAS, Office of Children Youth and Families, Mental Retardation, and BDAP staff as well as consumers, families and individuals with substance use disorders conduct readiness reviews using a Readiness Assessment Instrument (RAI). The RAI outlines the critical elements required by the RFP and the evidence necessary to demonstrate compliance.

OMHSAS Monitoring Team Activities

Each of the four regions in the Commonwealth has Monitoring Teams located in the field office. The Monitoring Teams led by the Team Leader interface with the HealthChoices plans (for those regions where HealthChoices has been implemented), as well as with other programs funded by DPW. Monitoring Teams produce regular reports as well as file notes regarding their activities. Information from Monitoring Teams is provided to QM in order to incorporate the findings into QM initiatives and planning. Activities of the monitoring teams include:

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- Participate in readiness reviews,
- Monitor the program requirements annually,
- Meet regularly (at least monthly) with HealthChoices plans,
- Meet on ad hoc basis with plans regarding specific issues or concerns,
- Review program reports and data,
- Collaborates with the Division of Quality Management in the monitoring of progress of corrective and performance improvement plans,
- Interface with local advisory committees or workgroups,
- Review CCR/POMS data with the plans, and
- As requested, monitor the investigatory process and resolution for complaints.

Monitoring Reports

Monitoring of the HealthChoices program begins during the start-up phase of each new HealthChoices zone with the Early Warning Reports (EWP), aggregate encounter data, transition monitoring reports and weekly monitoring meetings with each county.

Data Validation Reports

The Division of Evaluation and MIS performs numerous quality checks on the data received from the HealthChoices Counties and produces the following reports:

- PLE submission analysis
- Comparison of Category of Service and Category of Aid
- Aggregate to PLE comparison
- Analysis of Inpatient Begin and End Dates
- First and Second level edit analysis
- Analysis of 'unknowns' in consumer data

Early Warning Care Monitoring Program Reports (EWP)

The EWP is designed to detect implementation problems through the monitoring of a limited set of indicators that evaluate access to services, quality and appropriateness of services, BH-MCO functions, and stakeholder feedback. During the initial start-up phase, data is reported weekly, monthly and then quarterly. The report includes:

- Service authorization
- Residential Treatment utilization
- Minority authorization
- Service denials
- Complaints/grievances
- Rate of re-hospitalization
- Rate of involuntary admissions
- Claims payment
- Consumer/Family satisfaction
- Provider satisfaction

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- Stakeholder feedback
- BH-MCO functions/changes

Quarterly Monitoring Report

Following the first year of implementation as the program matures, ongoing monitoring of the indicators occurs quarterly. The report includes:

- Service utilization
- Minority utilization
- Service denials
- complaints/grievances
- Rate of re-hospitalization
- Rate of involuntary admissions
- Claims payment
- Consumer/Family satisfaction
- Provider satisfaction
- Stakeholder feedback
- BH-MCO functions/changes

Utilization Reports

In the second year, person level encounter data is validated and utilization reports are produced annually. Data is provided by the counties and is aggregated, analyzed and reviewed by the Division of QM, Bureau Directors, Monitoring Teams Leaders, counties and the BH-MCOs. Areas for improvement as well as best practices are identified. Counties and BH-MCOs initiate action to improve performance.

Internal Management Reports

The Internal Management Report provides a quarterly analysis of service patterns for each County and BH-MCO. The purpose of the report is to provide key information to OMHSAS senior management regarding critical aspects of HealthChoices services. The current quarter's information is compared to the previous quarter and previous year. The included areas are:

- Service utilization for in-plan services
- Service denials
- Claims processing
- Member complaints
- Demographics

Complaints, Grievances and Appeal Reports

The Division of Evaluation and MIS develop complaint and grievance reports. The Division of Complaints and Grievances develop appeal reports based on information provided by the Counties and the BH-MCOs. The reports reflect the number and types of complaints, grievances and appeals, as well as the timeliness of resolution. These reports help to identify trends suggesting inadequate or inappropriate service delivery. The Division of Complaints

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and Grievances coordinates with the Monitoring Team for follow-up needed to resolve individual complaints or trends requiring improvement.

Consumer/Family Satisfaction Teams

HealthChoices requires that each plan institute mechanisms to evaluate the satisfaction of members with the services provided by the BH-MCOs. Counties/BH-MCOs are required to establish a Consumer/Family Satisfaction Teams (CFSTs) to assess satisfaction through face-to-face interviews with people who have received services. CFSTs are staffed by consumers, families and individuals with substance use disorders, and are considered an excellent means to obtain information that would be unavailable through written or telephonic surveys. Quarterly reports are submitted to OMHSAS. Results of the CFST reviews and surveys are incorporated into the QM planning process.

Medical Record Reviews

Annually a medical record review on a sample of care management charts at each county/BH-MCO across the identified levels of care is conducted. The chart review has three (3) sections: general information, medical necessity, and quality of care. The general information section documents demographics, referral source, and provider location. The medical necessity section reviews the degree to which medical necessity was documented for the initial admission, the length of treatment, and, for selected levels of care, the intensity of treatment. The quality of care section reviews documentation on the following eight (8) clinical dimensions:

- Adequacy of clinical history
- Adequacy of diagnostic formulation
- Assessment for dual diagnosis
- Care manager efforts to assess and enhance the quality of care
- Appropriateness of discharge planning
- Adequacy of post-discharge follow-up
- Appropriateness of physician review when risk factors were present
- Appropriateness of actions taken when care was denied (e.g., informing members of their rights to appeal)

Additionally, OMHSAS staff conducts medical record reviews to validate findings from other quality improvement activities.

Provider Profiling

OMHSAS is instituting the Provider Profiling Score Card to assist with implementation and monitoring of a provider profiling requirement under performance-based contracting (PBC) and will be monitored as a component of the ACES.

The purpose of the Provider Profiling Score Card is to allow the County/Behavioral Health Managed Care Organization (BH-MCO) to conduct a self-assessment of their performance on the PBC provider profiling requirement. The self-assessment will evaluate the percentage of targeted providers who were managed appropriately through quarterly provider profiling.

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The elements included in the self assessment include:

- Provider Profiles are completed quarterly.
- Provider Profiles include at a minimum:
 - Access measures (e.g., appointment availability),
 - Utilization/efficiency measures (e.g., average length of stay (ALOS), readmission rates),
 - Quality measures (e.g., customer satisfaction, complaints and grievances, critical incidents, outcomes), and
 - Process measures (e.g., compliance with utilization management (UM) protocols, quality management (QM) protocols, quality of assessments, treatment plans)
- There is a profiling strategy that includes:
 - How providers will be selected for profiling (e.g., definition of high volume or problem providers),
 - How the profiling data will be reported and utilized to improve access, efficiency, and the quality of care, and
 - How profiled data will be integrated with other existing managed care functions.
- There is a strategy for benchmarking provider performance that includes:
 - How benchmarks will be established,
 - How outliers will be determined, and
 - What action(s) will be taken with providers identified as outliers?

Performance Based Contracting

OMHSAS has developed a performance based contracting approach to evaluating and improving the quality of service for HealthChoices members. Under this approach, a HealthChoices Performance Report (HPR) is generated for the county/BH-MCO based upon its performance measured against OMHSAS performance targets.

The first HPRs will be published in the first quarter of 2004 and will be based on calendar year 2001 and 2002 Person Level Encounter (PLE) data and will include a set of performance indicators related to access, process and quality outcomes. Clinical targets will be set in the future for each HealthChoices Counties.

Clinical targets are developed based on:

- Each contractor's baseline for each performance indicator
- Benchmarking data from other states' experience, research-based "gold standard" Performance Improvement attainment and other HealthChoices contractor data.
- Expected impact of improving care management, network management, and quality management policies and procedure.
- Input from the various HealthChoices stakeholders.

Utilization targets are developed based on:

- Benchmarking utilization rates from other states' experience, research-based "expected" utilization rates and other HealthChoices contractor data.
- Each contractor's baseline for each utilization measure
- Expected impact of improving care management, network management, and quality management policies and procedure.

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- Input from the various HealthChoices stakeholders.

Initial utilization targets are for adults with serious mental illness (SMI) receiving inpatient care and will be incorporated in the rate setting process in the future. Future targets may be set for other clinical sub-populations, specifically children and adolescents.

Performance Improvement Plan (PIP) Development

Each County/BH-MCO will develop an annual PIP subject to OMHSAS review and approval. The PIP is directed to the attainment of Performance Improvement and utilization targets.

The PIP design should describe how the County/ BH-MCO will achieve and sustain over time, significant improvement in clinical and non-clinical areas that are expected to have a favorable effect on service outcomes and member satisfaction. Counties/BH-MCO's will periodically report the status and results of the PIP to OMHSAS during the evaluation year.

Focused Studies

Periodically, DPW may identify issues that surface during the course of internal and external program oversight and monitoring. OMHSAS, County or BH-MCO staff may conduct studies. OMHSAS QM reviews information from focused studies in order to use the findings to develop QM initiatives and planning. Areas for review could include:

- Operations
- Clinical
- Financial
- Information Systems
- OMHSAS internal practices

Annually, OMHSAS reviews the impact and effectiveness of the County/BH-MCOs Quality assessment and performance improvement activities.

External Quality Review (EQR)

As required by the 1915(b) CMS Waiver, OMHSAS must conduct or arrange for an annual independent assessment of the timeliness, outcomes and accessibility of services covered under each County/BH-MCO contract within the HealthChoices program. The OMHSAS provides an independent assessment of plan components through a contract with an EQR organization. Results of the assessments are provided to the counties and may become the basis for performance improvement activities. Findings from these assessments are incorporated into QM initiatives and planning..

Previously, Pennsylvania's EQR activities consisted of the review of performance indicators to assess the quality of services delivered. With the changes brought about by the Balanced Budget Act of 1997, EQR activities will consist of the required mandatory activities outlined in the External Quality Review of Medicaid Managed Care Organizations; Final Rule. Under the final rule, three mandatory activities are required.

Each of the mandatory activities described in §438.358 will be carried out using methods consistent with the protocols identified by CMS under the final rule. Additionally, the

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OMHSAS strategy for completion of each of the mandatory activities and ensuring that the EQRO has the necessary information to complete the required detailed technical report described in §438.364 include:

- Validation of performance improvement projects. This includes an annual review of the data collection process, analysis techniques, and instructions or tools used for implementing each project. The EQRO has the responsibility for validation of performance improvement projects following methods consistent with the CMS protocols.
- Validation of the County/BH-MCO's performance measures. This includes an annual review to ensure that appropriate populations are accounted for and that the measures are calculated in accordance with the specifications developed by OMHSAS. Again, the EQRO is responsible for validating MCO performance measures through methods consistent with CMS protocols.
- Review of the County's/ BH-MCO's compliance with OMHSAS structural and operational standards. Information included in the annual external quality review must be derived from an assessment of compliance with standards that occurred within the last three years. For this activity, the OMHSAS will furnish the EQRO with information based on compliance reviews conducted within the past three years, while recognizing that the EQRO must annually review the access to, timeliness of, and quality outcomes of services provided by the BH-MCOs. This will be accomplished through the provisions in §438.360 - Nonduplication of mandatory activities. Monitoring results performed by OMHSAS staff according to methods consistent with the CMS protocol will be used to provide the EQRO with the necessary information

Nonduplication of mandatory external quality review activity

As described in the preceding section, the OMHSAS will use the provisions of §438.360 to fulfill its obligation for the compliance with standards mandatory activity. After careful review of the OMHSAS monitoring standards, it was determined that sufficient information exists for all areas required within the structural and operational review. Additionally, quality reviews performed by contractors other than the EQRO may be used if needed to supplement and/or reinforce this source.

The EQRO will be provided the necessary information to address the subparts included within scope of the MCO compliance:

- Enrollee Rights and Protections
- Quality Assessment and Performance Improvement
 - Access Standards (availability of services, coordination and continuity of care, coverage and authorization of services)
 - Structure and Operational Standards (Provider selection, Enrollee information, confidentiality, enrollment and disenrollment, grievance systems, sub contractual relationships and delegation)

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- Measurement and Improvement Standards (Practice guidelines, Quality assessment and performance improvement program, Health information system)
- Grievance System

Current EQR study topics include:

- Inpatient Hospitalization for Schizophrenia
- Attention Deficit Hyperactivity Disorder
- Residential Treatment Facilities
- Behavioral Health Rehabilitative Services
- Antipsychotic Medication Prescribing Practices
- Encounter Data Validation

Review of the County’s/ BH-MCO’s compliance with OMHSAS structural and operational standards.

The Quality Strategy includes monitoring of the Medicaid contract provisions that are outlined in the County/BH-MCO contracts. The provisions incorporate the established Standards for Access to Care, Structure and Operations and Quality Management and Improvement.

Annual Compliance Evaluation Summary (ACES)

ACES is a computer-driven, ongoing, monitoring tool used to evaluate the Counties/BH-MCOs compliance with state and federal regulations, and the requirements of the HealthChoices Program. It provides a standardized means to track the progress of county/BH-MCO HealthChoices operations from pre-implementation through system maturity. In addition to tracking compliance with the requirements of HealthChoices, ACES provides a master file of supporting documentation. The major areas of focus are: access and service availability, coordination and continuity of care, medical necessity, in-plan services, provider and member enrollment/disenrollment, credentialing and recredentialing, utilization management, member rights and services, complaints, grievances and appeals, confidentiality, quality management, information systems, and executive management. Contract monitoring teams use various program and financial management reports to identify contract specific issues that may require more intensive review.

County/BH-MCO Requirements

The OMHSAS monitors the County/ BH-MCO compliance with Federal and State statutes; the Quality Management Standard in subparts D, E, and parts of subparts of F, I, J 438.200s and contracts and program requirements including those listed below:

- Provider selection;
- Enrollee information;
- Availability of services, including emergency services
- Continuity and coordination of care
- Enrollee rights;
- Confidentiality and accuracy of enrollee information;
- Enrollment;

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- Grievance systems;
- Sub-contractual relationships and delegation;
- Practice guidelines;
- Health information systems;
- Mechanisms to detect both under and over utilization of services;
- Quality improvement;
- Utilization management;
- Member services;
- Provider services;
- Record keeping;
- Access standards;
- Data reporting.

State standards are established at the time of the contract through various contract conditions. Compliance is initially established at the time of readiness review. Compliance is subsequently reviewed through periodic routine activities and reports described in the Quality Management Plan and through the Annual Compliance and Evaluation Summary (ACES) process. Those areas evaluated include:

Standards for Access to Care

The HealthChoices standards for access to care are consistent with those specified in 42 CFR §§438.206-438.210 and include:

Availability of Services

Delivery Network:

Contract requirements state:

The BH-MCO must maintain a network of appropriate providers that is sufficient to provide adequate access to all services covered under the contract. The County must require that in establishing and maintaining the network, the BH-MCO must consider the following:

- The anticipated Medicaid enrollment,
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular BH-MCO,
- The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services,
- The numbers of network providers who are not accepting new Medicaid patients, The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.

The County and its BH-MCO must provide access to all covered services for Members through a network of qualified professionals and facilities. The Provider network must have the following features in place and documented:

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- Sufficient Provider capacity and expertise for all covered services, for timely implementation of services, and for reasonable choice by Members of a Provider(s) within each level of care.
- Represent the cultural and ethnic diversity of Members and their neighborhoods.
- Clinical expertise and Cultural Competency in responding to Members with special needs.
- Timely access to covered services and needed specialists including but not limited to the evaluation and treatment of: child and adolescent psychiatric, substance abuse and behavioral disorders; including disorders arising out of psychological and sexual abuse; co-existing psychiatric and substance abuse disorders; psychiatric or substance abuse disorders among older adults (particularly those with co-existing medical conditions); persons with mental retardation with co-existing substance abuse or mental health disorders; persons with psychiatric or substance abuse disorders who are also homeless, pregnant or have HIV/AIDS.
- Inclusion of Providers trained and experienced in working with the priority and Special Needs Populations covered under the plan.
- Evidence of a cooperative relationship between the BH-MCO and its Provider network, for example, inclusion of Providers by the BH-MCO in the development of clinical protocols and Provider profiling.
- The numbers of network Providers who are not accepting new Members.
- The anticipated MA enrollment.
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific MA populations represented in the BH-MCO.
- The number and types, in terms of training, experience, and specialization of Providers required to furnish the contracted MA services.
- The geographic location of Providers and Members considering distance, travel time, the means of transportation ordinarily used by Members, and whether the location provides physical access for Members with disabilities.

If 5% or more of the MA recipients in a County Assistance Office or a district office within the county speak a language other than English as a first language, the County or its BH-MCO must make available in that language all information that is disseminated to English speaking Members. This information includes, but is not limited to, Member handbooks, hard copy Provider directories, education and outreach materials, marketing materials, written notifications, etc. Interpreter services must be available, as practical and necessary, by telephone and/or in person to ensure Members are able to communicate with the County or its BH-MCO and Providers, and receive covered benefits in a timely manner.

The BH-MCO shall provide timely access to diagnostic, assessment, referral, and treatment services for Members for the following benefits:

- Inpatient psychiatric hospital services, except when provided in a state mental hospital.
- Inpatient drug and alcohol detoxification.
- Psychiatric partial hospitalization services.
- Inpatient drug and alcohol rehabilitation.

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- Non-hospital residential detoxification, rehabilitation and half-way house services for drug/alcohol abuse or dependence.
- Psychiatric outpatient clinic, licensed psychologist and psychiatrist services.
- Behavioral health rehabilitation services (BHRS) for children and adolescents with psychiatric, substance abuse or mental retardation disorders.
- MH residential treatment services for children and adolescents (JCAHO accredited and non-JCAHO).
- Outpatient D&A services, including Methadone Maintenance Clinic.
- Methadone and LAAM (Levo-Alpha-Acetyl-Methadol) when used to treat narcotic/opioid dependency and dispensed by an in-plan drug and alcohol services Provider.
- Clozapine support services as well as laboratory and diagnostic studies and procedures ordered by behavioral health physicians.
- Crisis intervention services (telephone and mobile with in-home capability).
- Family-based mental health services for children and adolescents.
- Targeted mental health case management (intensive case management and resource coordination).

Second Opinion

Contract requirements state:

Each Member has the right to request a second opinion from a qualified health care professional within the Provider network. The County's BH-MCO must provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the Member to obtain one outside the network, at no cost to the Member.

Out-of Network Providers

Contract requirements state:

Each County must require that if the BH-MCO's network is unable to provide necessary medical services covered under the contract to a particular enrollee, the BH-MCO must adequately and timely cover these services out of network for the enrollee, for as long as the County/BH-MCO is unable to provide them. Out-of-network providers must coordinate with the BH-MCO with respect to payment. The BH-MCO must ensure that cost to the enrollee is no greater than it would be if the services were furnished within the network.

In situations where a network provider is not available to provide an In-Plan Service, the County and its BH-MCO must have procedures to coordinate with Out-of-Network Providers and must ensure that cost to the Members (if any) is no greater than it would be if the services were furnished by a network Provider.

Credentialing

Contract requirements state:

Each County must include a requirement that the BH-MCO demonstrate that its providers are credentialed.

Credentialing and re-credentialing requirements

Contract requirements state:

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The County must require that the BH- MCO follow the established process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the BH-MCO.

Provider Enrollment - Credentialing/Recredentialing

Contract requirements state:

In maintaining the Provider network, the County or its BH-MCO must establish written credentialing and recredentialing policies and procedures. The County or its BH-MCOs must adhere to credentialing requirements under the Pennsylvania Department of Health regulations at 28 Pa. Code, Sections 9.761 and 9.762 for all In-Plan Services provider types as well as for Providers of Supplemental Services in the BH-MCO Provider network. Provider types interested in participating as a Provider within the network must obtain credentialing from the County or its BH-MCO (who will ensure the service is within the Provider's scope of practice) and approval from a county who wishes to offer the service. The County or its BH-MCO must submit a program description to OMHSAS for review. Upon approval of the service description, OMHSAS will determine the code that will be used in the HC Program only, and the Provider will report encounter data for this service under their existing Provider type designation. Credentialing policies and procedures must include, but not be limited to, the following criteria:

- Applicable license or certification as required by Pennsylvania law.
- Verification of enrollment in good standing with Medicaid (Providers of Supplemental Services must be enrolled in the MA program).
- Verification of an active MA Provider Agreement.
- Evidence of malpractice/liability insurance.
- Disclosure of any past or pending lawsuits/litigations.
- Board certification or eligibility, as applicable.

Except as provided by 42 CFR 438.12(b), the County or its BH-MCO may not discriminate for the participation, reimbursement or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the County or its BH-MCO declines to include individual or groups or Providers in its network, it must give the affected Providers written notice of the reason for its decision.

The Provider credentialing policies and procedures must not discriminate against Providers that serve high risk populations or specialize in conditions that require costly treatment.

A County or its BH-MCO may not prohibit, or otherwise restrict a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient, for the following:

- any information the Member needs in order to decide among all relevant treatment options.
- for the risk, benefit and consequences of treatment and non-treatment.
- for the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

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Timely access

Contract requirements state:

Each County must require that the BH-MCO meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of need for services.

- The BH-MCO must require that network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees. The BH-MCO must require that services are available 24 hours a day, 7 days a week, when medically necessary. The County must require that the BH-MCO:
 - establish mechanisms to ensure that network providers comply with the timely access requirements;
 - monitor regularly to determine compliance;
 - take corrective action if there is a failure to comply.
- The County or its BH-MCO is required to maintain 24 hour telephone accessibility, staffed at all times by qualified personnel, to provide information to Members and Providers, and to provide screening and referral, as necessary.
 - There must be 24 hour capacity for service authorization.
 - There must be 24 hour access to a physician for psychiatric and drug and alcohol clinical consultation and review.
 - All Member and Provider calls must be answered within 30 seconds.
 - Separate Member and Provider telephone lines are permitted.
 - The Member line must be answered by a live voice at all times.
 - BH-MCOs serving multiple counties in a Project Area may establish a regional network with one telephone line for Member calls and one line for Provider calls.
 - Separate record keeping must be established for tracking and monitoring of both Provider and Member phone lines.
 - The Provider network must provide face-to-face treatment intervention within one hour for emergencies, within 24 hours for Urgent situations, and within seven days for routine appointments and for specialty referrals.
 - Upon the initial face-to-face intervention, the implementation of treatment services must adhere to the prescribed treatment plan, including the start date and frequency of treatment services.
 - Prior Authorization of emergency inpatient and emergency outpatient services is not permitted.
- The County or its BH-MCO must have a notification process in place with Providers for the referral of a Member to another Provider, if a selected Provider is not able to schedule the referred Member within the access standard.
- The County and its BH-MCO must maintain a Provider network which is geographically accessible to Members. All levels of care must be accessible in a timely manner. The access standard for ambulatory services to which the Member travels is at least two (2) Providers for each In-Plan Service:
 - Within 30 minutes travel time in Urban areas.

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- Within 60 minutes travel time in Rural areas.
- The access standard for inpatient and residential services is at least two Providers for each In-Plan Service, one of which must be:
 - Within 30 minutes travel time in Urban areas.
 - Within 60 minutes travel time in Rural areas.

Cultural Considerations

Contract requirements state:

Each County/BH-MCO must participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

The County and its BH-MCO must provide access to all covered services for Members through a network of qualified professionals and facilities. The Provider network must have the following features in place and documented:

- Represent the cultural and ethnic diversity of Members and their neighborhoods.
- Clinical expertise and Cultural Competency in responding to Members with special needs.

If 5% or more of the MA recipients in a County Assistance Office or a district office within the county speak a language other than English as a first language, the County or its BH-MCO must make available in that language all information that is disseminated to English speaking Members. This information includes, but is not limited to, Member handbooks, hard copy Provider directories, education and outreach materials, marketing materials, written notifications, etc. Interpreter services must be available, as practical and necessary, by telephone and/or in person to ensure Members are able to communicate with the County or its BH-MCO and Providers, and receive covered benefits in a timely manner.

Assurances of Adequate Capacity and Services

Contract requirements state:

The County and its BH-MCO must provide access to all covered services for Members through a network of qualified professionals and facilities. The Provider network must have the following features in place and documented:

- Sufficient Provider capacity and expertise for all covered services, for timely implementation of services, and for reasonable choice by Members of a Provider(s) within each level of care.
- Represent the cultural and ethnic diversity of Members and their neighborhoods.
- Clinical expertise and Cultural Competency in responding to Members with special needs.
- Timely access to covered services and needed specialists including but not limited to the evaluation and treatment of: child and adolescent psychiatric, substance abuse and behavioral disorders; including disorders arising out of psychological and sexual abuse; co-existing psychiatric and substance abuse disorders; psychiatric or substance

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abuse disorders among older adults (particularly those with coexisting medical conditions); persons with mental retardation with co-existing substance abuse or mental health disorders; persons with psychiatric or substance abuse disorders who are also homeless, pregnant or have HIV/AIDS.

- Inclusion of Providers trained and experienced in working with the priority and Special Needs Populations covered under the plan.
- Evidence of a cooperative relationship between the BH-MCO and its Provider network, for example, inclusion of Providers by the BH-MCO
- in the development of clinical protocols and Provider profiling.
- The numbers of network Providers who are not accepting new Members.
- The anticipated MA enrollment.
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific MA populations represented in the BH-MCO.
- The number and types, in terms of training, experience, and specialization of Providers required to furnish the contracted MA services.
- The geographic location of Providers and Members considering distance, travel time, the means of transportation ordinarily used by Members, and whether the location provides physical access for Members with disabilities.

The County must require that the BH-MCO submit the documentation assuring adequate capacity and services as specified by the State, and specifically as follows, but no less frequently than:

- At the time it enters into a contract with the State.
- At any time there has been a significant change (as defined by the State) in the BH-MCO's operations that would affect adequate capacity and services, including--
- Changes in services, benefits, geographic service area or payments, or;
- Enrollment of a new population in the BH-MCO.

The County or its BH-MCO must notify the Department promptly of any changes to the composition of its Provider networks that affect the County or its BH-MCO's ability to make available all In-Plan Services or respond to the special needs of a Member or population group in a timely manner.

Coordination and Continuity of Care

Primary care and coordination of health care services

Contract requirements state:

The County must require that the BH-MCO implement procedures to ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.

Primary care and coordination of health care services

Contract requirements state:

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The county must require that the BH-MCO implement procedures to coordinate the services the MCO, BH-MCO, or PAHP furnishes to the enrollee with the services the enrollee receives from any other MCO, BH-MCO, or PAHP.

Both behavioral health clinicians and PCPs have the obligation to coordinate care of mutual patients. Consistent with state and federal confidentiality laws and regulations, both must:

- Ascertain the Member's PCP, and/or relevant physical health specialist, or behavioral health clinician and obtain applicable releases to share clinical information.
- Make referrals for social, vocational, education, or human services when a need for such service is identified through assessment.
- Provide health records to each other, as requested.
- Comply with the agreement between the BH-MCO and the PH-MCO to assure coordination between behavioral and physical health care including resolution of any clinical dispute.
- Be available to each other for consultation.

The County must require that the BH-MCO implement procedures to ensure that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164.

Confidentiality

Contract requirements state:

Each BH-MCO must ensure that for medical records and any other health and enrollment information that identifies a particular enrollee, each entity establishes and implements procedures consistent with confidentiality requirements in 45 CFR parts 160 and 164

The County or its BH-MCO must have written policies and procedures which comply with federal and state law and regulations for maintaining the confidentiality of data, including clinical records/Member information

Enrollees with special health care needs

Assessment:

Contract requirements state:

The County must require that the BH-MCO implement mechanisms to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.

Each BH-MCO must implement procedures to share with other MCOs, BH-MCOs, and PAHPs serving the enrollee the results of its identification and assessment of any enrollee with special health care needs (as defined by the state) so that those activities need not be duplicated. The BH-MCO must ensure through its Provider Agreements that its Providers interact and coordinate services with the HC PH-MCOs and their PCPs.

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For Priority Populations, a clearly defined program of care which incorporates longitudinal and disease state management is expected. In addition, evidence of a coordinated approach for those persons with co-existing mental health and drug and alcohol conditions as well as for older adults with psychiatric and substance use disorders, particularly those with co-existing physical impairments, and other special needs populations who experience mental health and/or drug and alcohol disorders (e.g., persons with mental retardation, homeless persons, persons discharged from correctional facilities, persons with HIV/AIDS and physical disabilities) must be demonstrated.

Treatment plans:

Contract requirements state:

The County or its BH-MCO is required to coordinate service planning and delivery with human services agencies.

- The County or its BH-MCO is required to have a letter of agreement with:
 - Area Agency on Aging.
 - County Juvenile Probation Office (including the same components as the agreement with the CCYA in II-4.B.4)).
 - County Drug and Alcohol Agency, including:
 - A description of the role and responsibilities of the SCA.
 - Procedures for coordination with the SCA for placement and payment for care provided to Members in residential treatment facilities outside the HC Zone.
 - County offices of MH and MR, including coordination with the Health Care Quality Unit (HCQU).
 - Each school district in the county.
 - County and state criminal justice systems.

Procedures for the development of adequate Provider networks to serve Special Needs Populations and coordination of specialized service plans between the BH-MCO service managers and/or service Provider(s) and the PH-MCO PCP for Members with special health needs (e.g. children and adolescents in medical foster care, older adults with coexisting physical and behavioral health disorders).

Direct Access to Specialists

Contract requirements state:

For enrollees determined to need a course of treatment or regular care monitoring, the BH-MCO must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs.

Coverage and Authorization of Services

Coverage:

Contract requirements state:

The BH-MCO may not deny or reduce the amount, duration, or scope of a required service solely because of a Member's diagnosis, type of illness or condition. If a service for which the request for authorization is denied is viewed by the prescriber and the Member as an Urgent or Emergency Service, the County's BH-MCO must have a process for expedited review of such Grievances to occur within 24 hours of the request.

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The County and its BH-MCO must publish and distribute a Member handbook, upon approval by the Department, to all Members within 5 days of enrollment and make it available to other interested parties, upon request. In addition, the County's BH-MCO must notify all Members of their right to request and obtain information related to the provider network, benefits, Member rights and protections, and Grievance, Appeal and fair hearing procedures at least once a year. The handbook must be printed at no higher than a fourth grade reading level, delineating a Member's rights and responsibilities, as well as covering the following information.

- the amount, duration and scope of In-Plan Services and an explanation of any service limitations or exclusions;

The County and its BH-MCO must require that network Providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid Fee-for-Service, if the Provider serves only Medicaid Members.

The County or its BH-MCO must have policies and procedures to monitor that the access standards are met by each Provider in each level of care. The BH-MCO must monitor the network to assure that Providers conform to expected referral and utilization patterns, conditioned upon accepted local and national practice, and deliver services that result in expected treatment outcomes based upon empirical data.

The County or its BH-MCO must have Department approved written UM policies and procedures that include protocols for prior approval, determination of medical necessity, Concurrent Review, denial of services, hospital discharge planning, Provider profiling, and Retrospective Review of claims. As part of its UM function, the County or its BH-MCO must have processes to identify over, under, and type of service utilization problems and undertake corrective action.

UM practices should focus on the evaluation of the necessity, level of care, appropriateness, and effectiveness of behavioral health services, procedures, and use of facilities.

Medically Necessary Services

Contract requirements state:

The County or its BH-MCO must have Department approved written UM policies and procedures that include protocols for prior approval, determination of medical necessity, Concurrent Review, denial of services, hospital discharge planning, Provider profiling, and Retrospective Review of claims. As part of its UM function, the County or its BH-MCO must have processes to identify over, under, and type of service utilization problems and undertake corrective action.

UM practices should focus on the evaluation of the necessity, level of care, appropriateness, and effectiveness of behavioral health services, procedures, and use of facilities.

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Authorization of services

Contract requirements state:

The County's BH-MCO must have a service authorization system that includes verification of eligibility and a coordinated, expedited decision-making process for admission, continued stay and discharge for all In-Plan Services. The County or its BH-MCO's service authorization system must include procedures for informing Providers and Members of authorization decisions.

Notice of adverse action

Contract requirements state:

Any time the County's BH-MCO denies a request for authorization for service, the County's BH-MCO must notify the Member or the parent/custodian of a child or adolescent, in writing. The written notification must include:

- Specific reasons for the denial with references to the program provisions;
- A description of alternative services recommended on the basis of placement criteria, e.g., Adult Placement Criteria for Drug and Alcohol services.
- A description of the Member's right to file a Grievance and/or request a DPW Fair Hearing.
- Information for the Member describing how to file a Grievance and/or request a DPW Fair Hearing.
- An offer by the BH-MCO to assist the Member in filing a Grievance and/or DPW Fair Hearing.

Timeframe for decisions

Contract requirements state:

The County/BH-MCO must provide for the following decisions and notices:

Standard authorization decisions

For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if--

- The enrollee, or the provider, requests extension; or
- The County/BH-MCO justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest

Expedited authorization decisions

Contract requirements state:

For cases in which a provider indicates, or the County/BH-MCO determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the County/BH-MCO must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service.

Contract requirements state:

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If a service for which the request for authorization is denied is viewed by the prescriber and the Member as an Urgent or Emergency Service, the County BH-MCO must have a process for expedited review of such Grievances to occur within 24 hours of the request.

The County/BH-MCO may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the County/BH-MCO justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest

Additional Information – special needs

Enrollees with special health care needs

Assessment:

Contract requirements state:

Each BH-MCO must implement procedures to share with other MCOs, BH-MCOs, and PAHPs serving the enrollee the results of its identification and assessment of any enrollee with special health care needs (as defined by the state) so that those activities need not be duplicated. The BH-MCO must ensure through its Provider Agreements that its Providers interact and coordinate services with the HC PH-MCOs and their PCPs.

Treatment plans:

Contract requirements state:

The BH-MCO will have procedures for the development of adequate Provider networks to serve Special Needs Populations and coordination of specialized service plans between the BH-MCO service managers and/or service Provider(s) and the PH-MCO PCP for Members with special health needs (e.g. children and adolescents in medical foster care, older adults with coexisting physical and behavioral health disorders).

State Standards for Structure & Operations

The HealthChoices standards for structure and operations are consistent with those specified in 42 CFR §§438.214 - 438.230 and include:

Selection and Retention of Providers

Contract requirements state:

The County/ BH-MCO must have written policies and procedures for selection and retention of providers.

OMHSAS has a uniform credentialing and re-credentialing policy. The County/ BH-MCO is required to follow this documented process for credentialing and re-credentialing of providers who have signed contracts or participation agreements with the BH-MCO

Contract requirements state:

Provider Enrollment - Credentialing/Re-credentialing

In maintaining the Provider network, the County or its BH-MCO must establish written credentialing and re-credentialing policies and procedures. The County or its BH-MCOs

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must adhere to credentialing requirements under the Pennsylvania Department of Health regulations at 28 Pa. Code, Sections 9.761 and 9.762 for all In-Plan Services provider types as well as for Providers of Supplemental Services in the BH-MCO Provider network. Provider types interested in participating as a Provider within the network must obtain credentialing from the County or its BH-MCO (who will ensure the service is within the Provider's scope of practice) and approval from a county who wishes to offer the service. The County or its BH-MCO must submit a program description to OMHSAS for review. Upon approval of the service description, OMHSAS will determine the code that will be used in the HC Program only, and the Provider will report encounter data for this service under their existing Provider type designation. Credentialing policies and procedures must include, but not be limited to, the following criteria:

- Applicable license or certification as required by Pennsylvania law.
- Verification of enrollment in good standing with Medicaid Providers of Supplemental Services must be enrolled in the MA program.
- Verification of an active MA Provider Agreement.
- Evidence of malpractice/liability insurance.
- Disclosure of any past or pending lawsuits/litigations.
- Board certification or eligibility, as applicable.

Nondiscrimination

The contract must require that the County's/BH-MCO's provider selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

Contract requirements state:

The Provider credentialing policies and procedures must not discriminate against Providers that serve high risk populations or specialize in conditions that require costly treatment.

Excluded providers

The contract must ensure that the County/ BH-MCO may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.

Contract requirements state:

Prohibited Affiliations with Individuals Debarred by Federal Agencies:

The County and its BH-MCO may not knowingly have a relationship with the following:

- An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (A) above.

For the purpose of this section, "relationship" means the following:

- A director, officer or partner of the County or its BH-MCO.

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- A person with beneficial ownership of five percent (5%) or more of the BH-MCO's equity.
- A person with employment, consulting or other arrangement with the County's or its BH-MCO's obligations under this Agreement.

Enrollee Information

The MCO and BH-MCO must have written policies regarding the enrollee rights specified in this section.

Contract requirements state:

Each BH-MCO must comply with any applicable Federal and State laws that pertain to enrollee rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees.

Dignity and privacy. Each managed care enrollee is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.

Contract requirements state:

Each Member will be treated with respect and with due consideration for his or her dignity and privacy;

Receive information on available treatment options. Each managed care enrollee is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.

Contract requirements state:

Each Member will receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand;

Participate in decisions. Each managed care enrollee is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.

Contract requirements state:

Each Member will participate in decisions regarding his or her health care, including the right to refuse treatment unless the individual meets criteria for involuntary treatment under the MH/MR Act of 1966;

Free from restraint or seclusion. Each managed care enrollee is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

Contract requirements state:

Each Member has the right to be free from any form of restraint or seclusion used as a means

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of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of seclusion and restraint;

Copy of medical records. Each managed care enrollee is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164.

Contract requirements state:

Each Member may request and receive a copy of his or her medical records and request that they be amended or corrected in accordance with the Federal Privacy Law;

Free exercise of rights. Each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO, BH-MCO, PAHP or PCCM and its providers or the State agency treat the enrollee.

Contract requirements state:

Each Member is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the County, its BH-MCO, Providers or any state agency treats the Member;

Compliance with other Federal and State laws. Each BH-MCO must comply with any other applicable Federal and State laws (such as Title VI of the Civil Rights Act of 1964, etc.) and other laws regarding privacy and confidentiality.

Contract requirements state:

Procedures for the exchange of relevant enrollment and health-related information among the BH-MCO, the PH-MCO, the PCP, and BH and PH service Providers in accordance with federal and state confidentiality laws and regulations (e.g., periodic treatment updates with identified primary and relevant specialty Providers).

Confidentiality. Each contract must ensure that for medical records and any other health and enrollment information that identifies a particular enrollee, each County/BH-MCO establishes and implements procedures consistent with confidentiality requirements in 45 CFR parts 160 and 164.

Contract requirements state:

Policy and procedures for obtaining releases to share clinical information and providing health records to each other as requested consistent with state and federal confidentiality requirements.

Enrollment

Enrollment Process.

Contract must specify procedures for enrollment and reenrollment.

Contract requirements state:

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Enrollment in a BH-MCO occurs simultaneously with a Member's enrollment in a PH-MCO. No active selection is made by the Member. Rather, Members are notified of their enrollment in the BH-MCO operating in their county of residence upon enrollment (voluntary or assigned) in a PH-MCO. The BH-MCO must establish mechanisms to inform the County Assistance Office of any change or update to the Member's residency or eligibility status within 10 days of the date of learning of the change.

As Members are enrolled in a specific PH-MCO and BH-MCO, information about the Member is forwarded to the MCOs. The Department has sole authority for determining whether individuals or families meet eligibility criteria. The Department performs eligibility determinations using trained staff in County Assistance Offices (CAOs) located throughout the Commonwealth.

The BH-MCO must have in effect written administrative policies and procedures for newly enrolled Members. The BH-MCO must also have a transition plan and procedure for providing behavioral health services for newly enrolled Members. The Department provides the BH-MCO with enrollment information for its Members including the beginning and ending effective dates of enrollment. The effective benefit start date typically occurs several weeks after enrolling in the HealthChoices Program. It is the responsibility of the BH-MCO to take necessary administrative steps consistent with the dates determined and provided by the Department to determine periods of coverage and responsibility for services.

Disenrollment Requirements.

Applicability.

The provisions of this section apply to all managed care arrangements whether enrollment is mandatory or voluntary and whether the contract is with an MCO, BH-MCO, PAHP, or a PCCM.

Contract requirements state:

Reasons for Disenrollment

- The Department may terminate a Member from the BH-MCO on the basis of:
 - Member's loss of Medical Assistance eligibility.
 - Placement of the Member in a nursing facility for more than 30 consecutive days.
 - Placement of the Member in any state facility, including a state psychiatric hospital, other than a state operated ICF/MR.
 - Placement of the Member in a Juvenile Detention Center for more than 35 consecutive days.
 - Change in permanent residence of the Member which places the Member outside the BH-MCO's service area.
 - Change in Member's status to a recipient group which is exempt from the HC Program.
 - Determination by the Department that the Member is eligible for the Health Insurance Premium Payment Program (HIPP).

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- The Member becoming ventilator-dependent in an acute or rehabilitation hospital for more than 30 consecutive days.
- Member's enrollment in the Pennsylvania Department of Aging (PDA) waiver.
- Member's enrollment in the Michael Dallas Model waiver.
- The County or its BH-MCO shall not terminate any Member from the HC-BH Program.
- A Member's termination from enrollment becomes effective on a date specified by the Department. The County and its BH-MCO must have policies and procedures to comply with any Department enrollment termination and for the Member's continuity of care

Grievance Systems

The contract must define action as the:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner, as defined by the State*;
- Failure of an MCO or BH-MCO to act within the timeframes; or
- For a rural area resident with only one MCO or BH-MCO, the denial of a Medicaid enrollee's request to obtain services outside the network**:
 - from any other provider (in terms of training, experience, and specialization) not available within the network
 - from a provider not part of the network who is the main source of a service to the recipient - provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the enrollee is given a choice of participating providers and is transitioned to a participating provider within 60 days.
 - Because the only plan or provider available does not provide the service because of moral or religious objections.
 - Because the recipient's provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the network.
 - The State determines that other circumstances warrant out-of-network treatment.

Contract requirements state:

Denial of Services - A determination made by a BH-MCO in response to a Provider's or Member's request for approval to provide a service of a specific amount, duration and scope which:

- disapproves the request completely, or

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- approves provision of the requested service(s), but for a lesser amount, scope or duration than requested, or
- disapproves provision of the requested service(s), but approves provision of an alternative service(s), or
- reduces, suspends, or terminates previously authorized service.

Note: A denial of a request for service must be based upon one of the following four reasons, along with an explanation for the reason, which must be explicitly stated on the notice of action:

- The service requested is not a covered service.
- The service requested is a covered service but not for this particular recipient (due to age, etc.)
- The information provided is insufficient to determine that the service is medically necessary.
- The service requested is not medically necessary.

Service Authorization process: Procedure - Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

Service Authorization process: Provider notice of adverse action - The contractor must notify the requesting provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider need not be in writing.

Service Authorization process: Enrollee notice of adverse action. - Each contractor must notify the enrollee in writing of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

Notice of Action – The BH-MCO must give the enrollee written notice of any action (not just service authorization actions) within the timeframes for each type of action.

Notice of Adverse Action: Content - The notice must explain:

- The action the BH-MCO or its contractor has taken or intends to take;
- The reasons for the action;
- The enrollee's or the provider's right to file an appeal;
- If the State does not require the enrollee to exhaust the BH-MCO level appeal procedures, the enrollee's right to request a State fair hearing;
- Procedures for exercising enrollee's rights to appeal or grieve;
- Circumstances under which expedited resolution is available and how to request it;
- The enrollee's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

Notice of adverse action: Language and format -the notice must be in writing and must meet the language and format requirements:

Language-

- The state must establish a methodology for identifying the prevalent, a significant

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- number or percentage, of non-English languages spoken by enrollees and potential enrollees throughout the State;
- The state must make available written information in each prevalent non-English language;
 - The state must require BH-MCO, to make its written information available in the prevalent non-English languages in its particular service area;
 - The state must make oral interpretation services available for all languages and require each BH-MCO to make those services available free of charge; and
 - The state must notify enrollees and potential enrollees, and require each MCO, BH-MCO, to notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services.

Format- Written material must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.

Timeframes for notice of action: Termination, suspension or reduction of services - BH-MCO gives notice at least 10 days before the date of action when the action is a termination, suspension, or reduction of previously authorized Medicaid-covered services, except:

- the period of advanced notice is shortened to 5 days if probable recipient fraud has been verified
- By the date of the action for the following:
 - in the death of a recipient;
 - a signed written recipient statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information);
 - the recipient's admission to an institution where he is ineligible for further services;
 - the recipient's address is unknown and mail directed to him has no forwarding address;
 - the recipient has been accepted for Medicaid services by another local jurisdiction;
 - the recipient's physician prescribes the change in the level of medical care;
 - an adverse determination made with regard to the preadmission screening requirements for NF admissions on or after January 1, 1989; or
 - the safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for 30 days (applies only to adverse actions for NF transfers).

Timeframes for notice of action: Denial of payment - BH-MCO gives notice on the date of action when the action is a denial of payment.

Timeframes for notice of action: Standard Service Authorization denial -The BH-MCO gives notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if the enrollee, or the provider, requests extension; or the BH-MCO justifies a need for additional information and how the extension is in the enrollee's interest (upon State request).

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If the BH-MCO extends the timeframe, the contractor must give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

Timeframes for notice of action: Expedited Service Authorization denial –For cases in which a provider indicates, or the BH-MCO determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the BH-MCO gives notice must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service.

Extension -The BH-MCO may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the BH-MCO justifies a need for additional information and how the extension is in the enrollee's interest (upon State request).

Timeframes for notice of action: Untimely Service Authorization Decisions- BH-MCO gives notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions.

Grievance system- The BH-MCO contract must require a grievance system for enrollees meeting all regulation requirements, including a grievance process, an appeal process, and access to the State's fair hearing system. The contract must have requirements separately addressing each of these functions. This checklist details each process separately and outlines the specific requirements for that process.

The contract must distinguish between grievance system, grievance process, and a grievance.

- The grievance system includes a grievance process, an appeal process, and access to the State's fair hearing system. Any grievance system requirements apply to all three components of the grievance system not just to the grievance process.
- A grievance process is the procedure for addressing enrollee's grievances.

A grievance is an enrollee's expression of dissatisfaction with any aspect of their care other than the appeal of actions, (which is an appeal).

Contract requirements state:

Grievance -A request to have a BH-MCO or utilization review entity reconsider a decision solely concerning the Medical Necessity and appropriateness of a health care service. A grievance may be filed regarding a BH-MCO decision to 1) deny, in whole or in part, payment for a service if based on lack of Medical Necessity; 2) deny or issue a limited authorization of a requested service, including the type or level of service; 3) reduce, suspend, or terminate a previously authorized service; 4) deny the requested service but approve an alternative service.

Grievance system:

General Requirements- The BH-MCO must:

- give enrollees any reasonable assistance in completing forms and other procedural

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steps not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

- Acknowledge receipt of each grievance and appeal.
- Ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making and who are health care professionals with clinical expertise in treating the enrollee's condition or disease if any of the following apply:
 - a denial appeal based on lack of medical necessity.
 - a grievance regarding denial of expedited resolutions of an appeal.

Contract requirements state:

Complaint and Grievance System

The County's BH-MCO must establish Complaint and Grievance mechanisms through which Members and Providers can seek redress against the BH-MCO. The County or its BH-MCO may not take any adverse action against a Provider for assisting a Member in the understanding of or filing of a Complaint or Grievance under the Member Complaint and Grievance system.

Counties may impose additional requirements on its BH-MCO as are deemed appropriate for effective management.

Member Complaint and Grievance System

The County's BH-MCO must develop, implement, and maintain a Complaint and Grievance system which provides for settlement of Member Complaints and Grievances at the most efficient administrative level. The Complaint and Grievance system must conform to the conditions set forth in the contract.

- The County's BH-MCO must provide Members and parents/custodians of children and adolescents (for CISC, both parents, if whereabouts are known and county CCYA must receive information) with documents that plainly and clearly outline rights and responsibilities as Members, including the right to file a Complaint or Grievance and/or to request a DPW Fair Hearing. This information must include a toll-free telephone number for Members to facilitate the communication of a Complaint or Grievance.
- The County and its BH-MCO must ensure that any Subcontractor, with authority to approve and disapprove service requests, complies with the Complaint and Grievance procedures and reporting requirements established by the County or its BH-MCO.
- Denials of service or coverage must be in writing, notifying the Member or parent/custodian of a child or adolescent of the reason for the denial, alternative treatments available, the right to file a Grievance and/or request a DPW Fair Hearing and the process for doing so.
- The County's BH-MCO must integrate its Complaint and Grievance system with the QM process in terms of review, corrective action, resolutions, and follow-up.
- The County's BH-MCO must have a data system in place capable of processing, tracking, and aggregating data to discern trends in Complaints and Grievances.
- The County's BH-MCO must provide all required Member Complaint and Grievance information to the Independent Enrollment Assistance Program.

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- The County's BH-MCO's Grievance system may not be a prerequisite to or replacement for the Member's right to appeal to the Department (in accordance with 42 CFR 431, Subpart E) when the Member is adversely affected by an administrative decision rendered by the County's BH-MCO. The County and its BH-MCO must cooperate with and adhere to the Department's procedures and decisions.
- Complaints or Grievances concerning the Recipient Restriction Program must be directed to the Office of Medical Assistance Programs, Bureau of Program Integrity, for resolution.
- Complaints or Grievances resulting from any action taken by oversight agencies responsible for fraud, abuse, and prosecution activities must be directed to the respective agency. Oversight agencies include the Department's Office of Medical Assistance Programs, Bureau of Program Integrity, the Office of the Attorney General's Medicaid Fraud Control Section, the Pennsylvania State Inspector General, and HHS/CMS's Office of Inspector General, and the United States Justice Department.

Denial of Services

The County's BH-MCO must have a procedure that allows Members to grieve denials of requests for authorization for services. Individuals responsible for denying services or reviewing Grievances of denials, must have the necessary and appropriate clinical training and experience. All denials must be made by a physician or, in some cases, by a licensed psychologist. Denials of inpatient care must be approved by a physician. Qualifications of individuals must be consistent with all applicable Commonwealth laws and regulations.

The BH-MCO may not deny or reduce the amount, duration, or scope of a required service solely because of a Member's diagnosis, type of illness or condition. If a service for which the request for authorization is denied is viewed by the prescriber and the Member as an Urgent or Emergency Service, the County's BH-MCO must have a process for expedited review of such Grievances to occur within 24 hours of the request.

Any time the County's BH-MCO denies a request for authorization for service, the County's BH-MCO must notify the Member or the parent/custodian of a child or adolescent, in writing. The written notification must include:

- Specific reasons for the denial with references to the program provisions;
- A description of alternative services recommended on the basis of placement criteria, e.g., Adult Placement Criteria for Drug and Alcohol services.
- A description of the Member's right to file a Grievance and/or request a DPW Fair Hearing.
- Information for the Member describing how to file a Grievance and/or request a DPW Fair Hearing.
- An offer by the BH-MCO to assist the Member in filing a Grievance and/or DPW Fair Hearing.

Grievance System: Information to providers and subcontractors- The BH-MCO must provide the following grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time they enter into a contract:

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- the enrollee’s right to a state fair hearing, how to obtain a hearing, and representation rules at a hearing;
- the enrollee’s right to file grievances and appeals and their requirements and timeframes for filing;
- the availability of assistance in filing;
- the toll-free numbers to file oral grievances and appeals;
- the enrollee’s right to request continuation of benefits during an appeal or State fair hearing filing and, if the BH-MCO’s action is upheld in a hearing, the enrollee may be liable for the cost of any continued benefits; and any State-determined provider appeal rights to challenge the failure of the organization to cover a service

Contract requirements state:

Provider Complaint System

The County’s BH-MCO must develop, implement and maintain a Provider complaint system which provides for informal mediation and settlement of Provider complaints at the lowest administrative level and a formal complaint process when informal resolution is not possible.

The Provider complaint system must demonstrate a fundamentally fair process for Providers; adequate disclosure to Providers of Provider rights and responsibilities at each step of the process; and sound and justified decisions made at each step.

The Department's Bureau of Hearings and Appeals is not an appropriate forum and shall not be used by Providers to appeal decisions of the County or its BH-MCO.

Grievance System: Record keeping and reporting. BH-MCOs must maintain records of grievances and appeals.

Contract requirements state:

The BH-MCO must maintain a log of all complaints and grievances, which includes, at a minimum, identifying information about the member, the nature of the complaint or grievance, and the date received.

Appeal- The contractor must define appeal as the request for review of an “action”

Contract requirements state:

Complaint: A dispute or objection filed with the BH-MCO regarding a participating health care provider or the coverage, operations, or management policies of a BH-MCO, including but not limited to: 1) a denial because the requested service is not a covered benefit; 2) failure of the BH-MCO to meet the required timeframes for providing a service; 3) failure of the BH-MCO to decide a complaint or grievance within the specified timeframes; 4) a denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program; 5) a denial of payment after a service(s) has been delivered because the service is not a covered benefit. The term does not include a grievance.

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Appeal process: Authority to file - an enrollee may file a BH-MCO level appeal. A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal.

Contract requirements state:

First Level Complaint Process

A BH-MCO must permit a member or member's representative, which may include the member's provider, with proof of the member's written authorization for the representative to be involved and/or take action on the member's behalf, to file a complaint either orally or in writing. An oral complaint filed about the following:

- a denial because the requested service is not a covered benefit, or
- the failure of the BH-MCO to meet the required timeframes for providing a service, or
- the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or
- a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
- a denial of payment after a service has been delivered because the service is not a covered benefit.

Appeal process: Timing- The enrollee or provider may file an appeal within a reasonable timeframe that cannot be less than 20 days and not to exceed 90 days from the date on the notice of action.

Contract requirements state:

If the complaint is about the following:

- a denial because the requested service is not a covered benefit, or
- the failure of the BH-MCO to meet the required timeframes for providing a service, or
- the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or
- a denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
- a denial of payment after a service(s) has been delivered because the service is not a covered benefit.

the member must file the complaint within 45 days from the date of the incident complained of or the date the member receives written notice of the decision. For all other complaints, there is no time limit for filing a complaint.

Appeal process: Procedures- The enrollee or provider may file an appeal either orally or in writing and must follow an oral filing with a written, signed, appeal.

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Contract requirements state:

- The BH-MCO must operate a toll-free telephone service for members to file complaints and grievances and to follow up on complaints and grievances filed by members. The phone service will be operated 24 hours a day, 7 days a week with appropriately trained staff. Answering machines or taped messages are not acceptable.
- The BH-MCO must designate and train sufficient staff to be responsible for receiving, processing, and responding to member complaints and grievances in accordance with the requirements.

Appeal process: Procedures – The BH-MCO must:

- ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the enrollee or the provider requests expedited resolution;
- provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing;
- allow the enrollee and representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records;
- consider the enrollee, representative, or estate representative of a deceased enrollee as parties to the appeal.

Contract requirements state:

Upon receipt of the complaint, the BH-MCO must send the member and member's representative, if the member has designated one, an acknowledgment letter using the template supplied by the Department or, if the complaint is about the following:

- a denial because the requested service is not a covered benefit, or
- the failure of the BH-MCO to meet the required timeframes for providing a service, or
- the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or
- a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
- a denial of payment after a service has been delivered because the service is not a covered benefit
- using the template supplied by the Department.

If the complaint is about the following:

- a denial because the requested service is not a covered benefit, or
- the failure of the BH-MCO to meet the required timeframes for providing a service, or
- the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or
- a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania

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- Medical Assistance Program, or
- a denial of payment after a service has been delivered because the service is not a covered benefit

the member must be afforded a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The BH-MCO must be flexible when scheduling the review to facilitate the member's attendance. If the member cannot appear in person at the review, an opportunity to communicate with the first level complaint review committee by telephone or videoconference must be provided. The member may elect not to attend the first level complaint meeting but the meeting must be conducted with the same protocols as if the member was present.

The member and/or anyone the member chooses may present the member's position to the first level complaint review committee.

- The BH-MCO must ensure that members have access to all relevant documentation pertaining to the subject of the complaint or grievance.

Appeal process: Resolution and notification. The BH-MCO must resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes not to exceed 45 days from the day the BH-MCO receives the appeal.

Contract requirements state:

The first level complaint review committee must complete its review of the complaint as expeditiously as the member's health condition requires, but no more than 30 days from receipt of the complaint, which may be extended by 14 days at the request of the member.

Extension -The BH-MCO may extend the timeframes by up to 14 calendar days if the enrollee requests the extension; or the BH-MCO shows that there is need for additional information and how the delay is in the enrollee's interest (upon State request).

Contract requirements state:

The first level complaint review committee must complete its review of the complaint as expeditiously as the member's health condition requires, but no more than 30 days from receipt of the complaint, which may be extended by 14 days at the request of the member.

Requirements following extension- for any extension not requested by the enrollee, the BH-MCO must give the enrollee written notice of the reason for the delay.

Appeal Process: Format and content of resolution notice - the BH-MCO must provide written notice of disposition. The written resolution notice must include:

- The results and date of the appeal resolution.
- For decisions not wholly in the enrollee's favor:
 - The right to request a State fair hearing,
 - How to request a State fair hearing,
 - The right to continue to receive benefits pending a hearing,
 - How to request the continuation of benefits, and

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If the BH-MCO's action is upheld in a hearing, the enrollee may be liable for the cost of any continued benefits

Appeal and State Fair Hearing Process: Continuation of benefits- The BH-MCO must continue the enrollee's benefits if:

- The appeal is filed timely, meaning on or before the later of the following:
 - Within 10 days of the BH-MCO mailing the notice of action.
 - the intended effective date of the BH-MCO's proposed action.
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The authorization period has not expired; and
- the enrollee requests extension of benefits.

Contract requirements state:

A member who files a request for a fair hearing to dispute a decision to discontinue, reduce or change a service that the member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the fair hearing, if the request for a fair hearing is hand delivered or post-marked within ten days from the date on the written notice of decision.

Appeal and State Fair Hearing process: Duration of continued or reinstated benefits- If the BH-MCO continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

- The enrollee withdraws the appeal.
- The enrollee does not request a fair hearing within 10 days from when the BH-MCO mails an adverse BH-MCO decision.
- A State fair hearing decision adverse to the enrollee is made.

The authorization expires or authorization service limits are met.

Appeal and State fair hearing process: Enrollee responsibility for services furnished while the appeal is pending- the BH-MCO may recover the cost of the continuation of services furnished to the enrollee while the appeal was pending if the final resolution of the appeal upholds the BH-MCO's action.

Appeal and State fair hearing process: Effectuation when services were not furnished- the BH-MCO must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires if the services were not furnished while the appeal is pending and the BH-MCO, or the State fair hearing officer reverses a decision to deny, limit, or delay services.

Contract requirements state:

Provision of and Payment for Services Following Decision

If the BH-MCO or the Bureau of Hearings and Appeals reverse a decision to deny, limit, or delay services that were not furnished during the complaint, grievance or fair hearing process, the BH-MCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

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Appeal and State fair hearing process: Effectuation when services were furnished - the BH-MCO or the State must pay for disputed services, in accordance with State policy and regulations, if the BH-MCO, or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal as pending.

Contract requirements state:

If the BH-MCO or the Bureau of Hearings and Appeals reverses a decision to deny authorization of services, and the member received the disputed services during the complaint, grievance or fair hearing process, the BH- MCO must pay for those services.

Expedited Appeals Process – General. Each BH-MCO must establish and maintain an expedited review process for appeals, when BH-MCO determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

Contract requirements state:

Expedited Complaint Process

The BH-MCO must conduct expedited review of a complaint prior to the first level complaint decision, if a member or the member's representative, which may include the member's provider, with proof of the member's written authorization for the representative to be involved and/or take action on the member's behalf, provides the BH-MCO with a certification from his or her provider that the member's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular complaint process. This certification is necessary even when the member's request for the expedited complaint is made orally. The certification must include the provider's signature.

Expedited Appeals Process – Authority to File. The enrollee or provider may file an expedited appeal either orally or writing. No additional enrollee follow-up is required.

Contract requirements state:

A request for an expedited review of a complaint may be filed either in writing or orally. Oral requests must be committed to writing by the BH-MCO. The member's signature is not required.

Expedited Appeals Process – Procedures - The contractor must inform the enrollee of the limited time available for the enrollee to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.

Contract requirements state:

Upon receipt of an oral or written request for expedited review, the BH-MCO must inform the member of the right to present evidence and allegations of fact or of law in person as well as in writing and of the limited time available to do so.

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Expedited Appeal process: Resolution and notification - the BH-MCO must resolve each expedited appeal and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes not to exceed 3 working days after the BH-MCO receives the appeal.

Contract requirements state:

The BH-MCO must issue the decision resulting from the expedited review in person or by phone to the member, the member's representative, if the member has designated one, and the member's provider within either 48 hours from receiving the provider's certification or three business days from receiving the member's request for an expedited review, whichever is shorter. In addition, the BH-MCO must mail written notice of the decision to the member, the member's representative, if the member has designated one, and the member's provider within two days of the decision using the template supplied by the Department.

Extension. The BH-MCO may extend the timeframes by up to 14 calendar days if the enrollee requests the extension; or the BH-MCO shows that there is need for additional information and how the delay is in the enrollee's interest (upon State request).

Contract requirements state:

The first level grievance review committee must complete its review of the grievance and make a decision as expeditiously as the member's health condition requires, but no more than 30 days from receipt of the grievance, which may be extended by up to 14 days at the request of the member.

Requirements following extension- for any extension not requested by the enrollee, the BH-MCO must give the enrollee written notice of the reason for the delay.

Contract requirements state:

The BH-MCO must send a written notice of the first level complaint decision to the member, member's representative, if the member has designated one, service provider and the prescribing provider, if applicable, within five business days of the first level complaint review committee's decision, using the template supplied by the Department or, if the complaint is about the following:

- a denial because the requested service is not a covered benefit, or
- the failure of the BH-MCO to meet the required timeframes for providing a service, or
- the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes

Expedited Appeal Process: Format of resolution notice – in addition to written notice, the BH-MCO must also make reasonable efforts to provide oral notice.

Contract requirements state:

If the provider certification is not included with the request for an expedited grievance review, the BH-MCO must inform the member that the provider must submit a certification as to the reasons why the expedited review is needed. The BH-MCO must make a reasonable effort to obtain the certification from the provider. If the provider certification is not received within three business days from the member's request for an expedited review,

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the BH-MCO shall decide the grievance within the standard timeframes. The BH-MCO must make a reasonable effort to give the member prompt oral notice that the grievance is to be decided within the standard timeframe, and must send written notice within two days of the decision to deny expedited review, using the template supplied by the Department.

Expedited Appeal Process: Punitive action The BH-MCO must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports an enrollee's appeal.

Contract requirements state:

The BH-MCO must ensure that punitive action is not taken against a provider who either requests an expedited resolution of a grievance or supports a member's request for expedited review of a grievance.

Expedited Appeal Process: Action following denial of a request for expedited resolution- if the BH-MCO denies a request for expedited resolution of an appeal, it must—

- Transfer the appeal to the standard timeframe of no longer than 45 days from the day the BH-MCO receives the appeal with a possible 14-day extension (see 438.408(b)(2)); and
- Give the enrollee prompt oral notice of the denial (make reasonable efforts) and a written notice within two calendar days.

Contract requirements state:

Expedited Grievance Process

The BH-MCO must conduct expedited review of a grievance at any point prior to the second level grievance decision, if a member or the member's representative, with proof of the member's written authorization for the representative to be involved and/or take action on the member's behalf, provides the BH-MCO with a certification from his or her provider that the member's life, health or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular grievance process. This certification is necessary even when the member's request for the expedited complaint is made orally. The certification must include the provider's signature.

- A request for expedited review of a grievance may be filed either in writing or orally. Oral requests must be committed to writing by the BH-MCO. The member's signature is not required.
- Upon receipt of an oral or written request for expedited review, the BH-MCO must inform the member of the right to present evidence and allegations of fact or of law in person as well as in writing and of the limited time available to do so.
- A member who files a request for expedited review of a grievance to dispute a decision to discontinue, reduce or change a service that the member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the grievance, if the request for expedited review of a grievance is hand delivered or post-marked within ten days from the date on the written notice of decision.

The expedited review process is bound by the same rules and procedures as the second level

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grievance review process with the exception of time frames, which are modified as specified in this section.

- Grievances requiring expedited review must be decided by an individual who meets the qualifications required of an individual who makes a medical necessity decision and who was not involved in any previous level of review or decision making on the subject of the grievance.
- The BH-MCO must issue the decision resulting from the expedited review in person or by phone to the member, the member's representative, if the member has designated one and the member's provider within either 48 hours from receiving the provider's certification, or three business days from receiving the member's request for an expedited review, whichever is shorter. In addition, the BH-MCO must mail written notice of the decision to the member, the member's representative, if the member has designated one, and the member's provider within two days of the decision using the template supplied by the Department.
- The member or the member's representative, with proof of the member's written authorization for the representative to be involved and/or take action on the member's behalf, may file a request for an expedited external grievance review with the BH-MCO within two business days from the date the member receives the written notice of the BH-MCO's expedited grievance decision.
- The BH-MCO must follow Department of Health guidelines relating to submission of requests for expedited external reviews.
- The member may file a request for a fair hearing within 30 days from the date on the written notice of the BH-MCO's expedited grievance decision.

State Fair Hearing Process: BH-MCO notification of State Procedures. [Note: The State may delegate some of the State Fair Hearings responsibilities to the BH-MCOs (e.g., notices but not the hearing itself). Some explanation of the State Fair Hearing procedures is required of the contractor in the provider and enrollee information per 438.414 and 438.10(g)(1) regardless of any State delegation. Please see 42 CFR 431 Subpart E for all State Fair Hearing requirements.]. In addition, the SFH description must be included in enrollee and provider information within the BH-MCO Contract.

If the BH-MCO takes action and the enrollee requests a State fair hearing, the State (not the BH-MCO) must grant the enrollee a State fair hearing. The right to a state fair hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the enrollee and provider by the BH-MCO (if they have delegated authority) or by the State (if the State has not delegated that authority). Other information for beneficiaries and providers would include:

- An enrollee may request a State fair hearing. The provider may request a State fair hearing only if the State permits the provider to act as the enrollee's authorized representative.
- The State must permit the enrollee to request a State fair hearing within a reasonable time period specified by the State, but not less than 20 or in excess of 90 days from whichever of the following dates applies--
 - If the State requires exhaustion of the BH-MCO level appeal procedures and the enrollee appeals directly to the State for a fair hearing, from the date on the BH-MCO's notice of action.

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- The State must reach its decisions within the specified timeframes:
 - Standard resolution: within 90 days of the date the enrollee filed the appeal with the BH-MCO if the enrollee filed initially with the BH-MCO (excluding the days the enrollee took to subsequently file for a State fair hearing) or the date the enrollee filed for direct access to a State fair hearing.
 - Expedited resolution (if the appeal was heard first through the BH-MCO appeal process): within 3 working days from agency receipt of a hearing request for a denial of a service that:
 - ◆ Meets the criteria for an expedited appeal process but was not resolved using the BH-MCO’s expedited appeal timeframes, or
 - ◆ Was resolved wholly or partially adversely to the enrollee using the BH-MCO’s expedited appeal timeframes.
 - Expedited resolution (if the appeal was made directly to the State Fair Hearing process without accessing the BH-MCO appeal process): within 3 working days from agency receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.

Contract requirements state:

Provider Complaint System

If the complaint is about the following:

- a denial because the requested service is not a covered benefit, or
- the failure of the BH-MCO to meet the required timeframes for providing a service, or
- the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or
- a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
- a denial of payment after a service has been delivered because the service is not a covered benefit.

The member may file a request for a fair hearing within 30 days from the date on the written notice of the BH-MCO’s first level complaint decision.

State Fair Hearing: Parties- the parties to the State fair hearing include the BH-MCO as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.

Contract requirements state:

The BH-MCO is a party to the hearing and must participate in the hearing. The BH-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The failure of the BH-MCO to participate in the hearing will not be reason to postpone the hearing.

Grievance. The contract must define a grievance as an expression of dissatisfaction about any matter other than an “action”.

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Contract requirements state:

A member or the member's representative may request a fair hearing within 30 days from the date on the initial written notice of decision and within 30 days from the date on the written notice of the BH-MCO's first or second level complaint or grievance notice of decision, for any of the following:

- the denial, in whole or in part, of payment for a requested service if based on lack of medical necessity;
- the denial of a requested service on the basis that the service is not a covered benefit;
- the denial or issuance of a limited authorization of a requested service, including the type or level of service;
- the reduction, suspension, or termination of a previously authorized service;
- the denial of a requested service but approval of an alternative service;
- the failure to provide services in a timely manner, as defined by the Department;
- the failure of the BH-MCO to decide a complaint or grievance within the timeframes specified;
- a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program.
- a denial of payment after a service has been delivered because the service is not a covered benefit

Grievance process: Procedures- The contract must explain if enrollee is allowed to file a grievance only with the contractor or if the enrollee can also file a grievance directly with the State.

Contract requirements state:

Department's Fair Hearing Process

A member does not have to exhaust the complaint or grievance process prior to filing a request for a fair hearing.

Grievance process: Authority to file a grievance. An enrollee may file a grievance either orally or in writing. A provider may file a grievance if the State permits the provider to act as the enrollee's authorized representative.

Contract requirements state:

A member or the member's representative may request a fair hearing within 30 days from the date on the initial written notice of decision and within 30 days from the date on the written notice of the BH-MCO's first or second level complaint or grievance notice of decision, for any of the following:

Grievance process: Disposition and notification The BH-MCO must dispose of each grievance and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes not to exceed 90 days from the day the BH-MCO receives the grievance.

Contract requirements state:

The first level grievance review committee must complete its review of the grievance and make a decision as expeditiously as the member's health condition requires, but no more than 30 days from receipt of the grievance, which may be extended by up to 14 days at the request of the member.

Grievance Process: Format of disposition notice The State must establish the method BH-MCOs will use to notify an enrollee of the disposition of a grievance.

Contract requirements state:

- The BH-MCO must send a written notice of the first level complaint decision to the member, member's representative, if the member has designated one, service provider and the prescribing provider, if applicable, within five business days of the first level complaint review committee's decision, using the template supplied by the Department or, if the complaint is about the following:
 - a denial because the requested service is not a covered benefit, or
 - the failure of the BH-MCO to meet the required timeframes for providing a service, or
 - the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or
 - a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
 - a denial of payment after a service has been delivered because the service is not a covered benefit using the template supplied by the Department.

Subcontractual relationships and delegation

Each contract must ensure that the County/ BH-MCO oversees and is held accountable for any functions and responsibilities that it delegates to any subcontractor.

The contract must require a written agreement between the County/ BH-MCO and the subcontractor that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

Each contract must ensure that the County/ BH-MCO monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.

Each contract must ensure that the County/ BH-MCO evaluates the prospective subcontractor's ability to perform the activities to be delegated.

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Each contract must ensure that the County/ BH-MCO identifies deficiencies or areas for improvement, the County/BH-MCO and the subcontractor must take corrective action.

Contract requirements state:
Subcontractual Relationships and Delegation

The County and its BH-MCO must ensure that each contract specifies the following:

- That the County or its BH-MCO evaluates the prospective Subcontractor's ability to perform the activities to be delegated.
- A written agreement between the County/BH-MCO and the Subcontractor that specifies the activities and reporting responsibilities delegated to the Subcontractor; and provides for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate.
- Ensure that the County/BH-MCO monitors the Subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the Department, consistent with industry standards or State MCO laws and regulations.
- Ensure that when the County/BH-MCO identifies deficiencies or areas for improvement, the County/BH-MCO and the Subcontractor must take corrective action.

Additional Information

Grievance System: Record keeping and reporting. BH-MCOs must maintain records of grievances and appeals.

Contract requirements state:

The County's BH-MCO must have a data system in place capable of processing, tracking, and aggregating data to discern trends in Complaints and Grievances.

State Standards for quality measurement and Improvement

The HealthChoices standards for quality measurement and improvement are consistent with those specified in 42 CFR §§438.236 - 438.242 and include:

Practice guidelines. Each contract must require an MCO and when applicable a BH-MCO or PAHP to adopt practice guidelines that meet the following requirements:

Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

Consider the needs of the enrollees;

Are adopted in consultation with contracting health care professionals; and

Are reviewed and updated periodically as appropriate.

Dissemination of guidelines

Each contract must require that the County/ Bh-MCO disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

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Application of guidelines

Each contract must ensure that decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.

Quality assessment and performance improvement program

Each contract must ensure that the County/ BH-MCO have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees.

Contract requirements state:

Utilization Management and Quality Management

The County or its BH-MCO agrees to implement a Continuous Quality Improvement (CQI) process. The County or its BH-MCO agrees to fully comply with the Department's Quality Management and Utilization Management standards. The County or its BH-MCO must provide that compensation to individuals or entities that conduct Utilization Management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Member. In the event that CMS specifies performance measures and topics for performance improvement projects to be required by the Department in their contracts with the County, it's BH-MCO and its Subcontractors must agree to cooperate fully in implementing these performance measures and projects.

Quality assessment and performance improvement program

CMS, in consultation with States and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by States in their contracts with MCOs and BH-MCOs.

Quality assessment and performance improvement program. Each contract must require that the County/ BH-MCO have in effect mechanisms to detect both underutilization and overutilization of services.

Contract requirements state:

As part of it's UM function, the County or its BH-MCO must have processes to identify over, under, and type of service utilization problems and undertake corrective action.

Quality assessment and performance improvement program. Each contract must ensure that the County/ BH-MCO has in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

Performance measurement

Each contract must require that on an annual basis the County/ BH-MCO must:

- Measure and report to the State its performance, using standard measures required by the State;
- Submit to the State, data specified by the State, that enables the State to measure the County/BH-MCO's performance; or
- Perform a combination of the activities listed above.

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Contract requirements state:

The County or its BH-MCO must adhere to Department of Health Regulation 28 Pa. Code Chapter 9, Subchapter G. The County or its BH-MCO must have written policies and procedures to monitor use of services by its Members and to assure the quality, accessibility, and timely delivery of care being provided by its network. Such policies and procedures must:

- Conform to state Medicaid plan QM requirements.
- Assure a UM/QM committee meets on a regular basis.
- Provide for regular UM/QM reporting to the County or its BH-MCO management and its Provider network (including profiling of Provider utilization patterns) as well as reports of joint UM/QM activities/studies conducted with the HealthChoices PH-MCOs.
- Provide opportunity for consumer (including representation for consumers in Special Needs Populations), Persons in Recovery and family (including parents/custodians of children and adolescents) participation in program monitoring.

The County or its BH-MCO must have Department approved written UM policies and procedures that include protocols for prior approval, determination of medical necessity, Concurrent Review, denial of services, hospital discharge planning, Provider profiling, and Retrospective Review of claims. As part of its UM function, the County or its BH-MCO must have processes to identify over, under, and type of service utilization problems and undertake corrective action.

UM practices should focus on the evaluation of the necessity, level of care, appropriateness, and effectiveness of behavioral health services, procedures, and use of facilities.

The BH-MCO must have a written Quality Management (continuous quality improvement) plan to monitor, assure, and improve the quality of care delivered over a range of clinical and health service delivery areas. Emphasis should be placed on, but need not be limited to, high volume and high risk services and treatment and behavioral health rehabilitation services for children and adolescents.

As a part of the QM plan, the BH-MCO should address, at a minimum, the effectiveness of the services received by Members, the quality and effectiveness of internal processes, and the quality of the Provider network. Among those areas to be considered in service delivery are access to services, the appropriateness of service manager authorizations, the authorization appeal process, adverse incidents, and the quality of service manager planning. Internal processes include but are not limited to telephone responsiveness; overall utilization patterns and trends; treatment outcomes; and Complaint, Grievance and fair hearing tracking processes. Provider monitoring includes but is not limited to utilization patterns, treatment outcomes, cooperation, and Member satisfaction. The QM plan shall also include mechanisms to incorporate recommended enhancements resulting from the Department's monitoring and external evaluations and audits.

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Performance Improvement Projects

Performance improvement projects

Each contract must ensure that the County/ BH-MCO conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. The performance improvement projects must involve the following:

- Measurement of performance using objective quality indicators.
- Implementation of system interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

Contract requirements state:

The County or its BH-MCO is required to conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.

The performance improvement projects must involve the following:

- Measurement of performance using objective quality indicators.
- Implementation of system interventions to achieve improvement in quality.
- Evaluation and initiation of activities for increasing or sustaining improvement.

Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects, in the aggregate, to produce new information on quality of care every year.

Performance improvement projects

Each contract must require that the County/ BH-MCO report the status and results of each project to the State as requested.

Contract requirements state:

The County is required to report the status and results of each project to the Department, as requested.

Performance improvement projects

Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

Contract requirements state:

Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects, in the aggregate, to produce new information on quality of care every year.

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Program review by the State. The State may require that a BH-MCO have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program. If the State imposes such a requirement, it should be included in the contract.

Contract requirements state:

The County or its BH-MCO agrees to implement a Continuous Quality Improvement (CQI) process. The County or its BH-MCO agrees to fully comply with the Department's Quality Management and Utilization Management standards.

The County and its BH-MCO are required to submit an annual evaluation which documents and trends key QI and UM indicators, activities and opportunities for improvement while also demonstrating both member and practitioner input.

To measure the program's performance in the areas of access to care, outcomes, and satisfaction, the County and its BH-MCO must comply with the Department's program performance reporting requirements. The County or its BH-MCO must establish all coordination agreements and procedures necessary to collect the required data elements from the Providers, Members, etc.

The County or its BH-MCO must provide quarterly reports summarizing the findings, and actions taken in response to the findings of the consumer/family satisfaction teams as well as an annual report summarizing the findings and follow-up actions taken pursuant to the annual Member satisfaction survey.

Health information systems

Each contract must ensure that the County/BH-MCO maintains a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.

Health information systems

Each contract must require that the County/ BH-MCO collects data on enrollee and provider characteristics as specified by the State and on services furnished to enrollees through an encounter data system or other methods as may be specified by the State.

Health information systems

The contract must require that the County/ BH-MCO ensures that data received from providers is accurate and complete by

- Verifying the accuracy and timeliness of reported data;
- Screening the data for completeness, logic, and consistency; and
- Collecting service information in standardized formats to the extent feasible and appropriate.

Health information systems

The contract must require that the County/ BH-MCO make all collected data available to the State and upon request to CMS.

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Management Information System

The Department requires an automated management information system (MIS). There are numerous components required for the complete system. They are service authorization, Member Complaint and Grievance, Provider complaint, Provider profiling, claims processing including TPL identification, Member enrollment, financial reporting, Utilization Management, encounter data, performance outcomes, Quality Management, and suspected/substantiated fraud and abuse. Of these components, service authorization, Provider profiling, claims processing (including TPL) encounter data and Member enrollment must be integrated.

The County and its BH-MCO's MIS must be compatible with the Department's Pennsylvania Open Systems Network (POSNet).

The County and its BH-MCO must comply with the policy and procedures governing the operation of the Department's Pennsylvania Open Systems Network (POSNet), as defined in the document POSNet Interface Specifications contained in the HealthChoices Library.

The County and its BH-MCO must comply with all changes made to the POSNet Interface Specifications by DPW, or modifications made to the specifications by the Office of Medical Assistance or the Office of Mental Health and Substance Abuse Services.

The County or its BH-MCO is required to maintain an automated Provider directory. Upon request, the County or its BH-MCO is required to provide this directory to the Department via POSNet or via diskette.

The MIS must include mechanisms to incorporate recommended enhancements resulting from the Department's monitoring and external evaluations and audits.

The County and its BH-MCO must agree to assist the Department in its validation of utilization data by making available medical records and its claims data. The validation may be completed by Department staff and independent, external review organizations.

(Optional for PCCM, BH-MCO & PAHP unless specified). The State must establish and specify intermediate sanctions that may be imposed when an MCO acts or fails to act as follows:

- Fails substantially to provide medically necessary services that the MCO is required to provide, under law or under its contract with the State, to an enrollee covered under the contract.
- Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
- Acts to discriminate among enrollees on the basis of their health status or need for health care services.
- Misrepresents or falsifies information that it furnishes to CMS or to the State.
- Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.

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- Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208 and 422.210.
- Has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information (applies to MCO & PCCM; voluntary for BH-MCO & PAHP).
- Has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations*.
- Has violated any of the other applicable requirements of sections 1932 or 1905(t)(3) of the Act and any implementing regulations* (applies to PCCM).

Intermediate Sanctions: Types. The types of intermediate sanctions that a State chooses to impose must be specified and may include:

- Civil monetary penalties in the following specified amounts:
 - A maximum of \$25,000 for each determination of failure to provide services; misrepresentation or false statements to enrollees, potential enrollees or health care providers; failure to comply with physician incentive plan requirements; or marketing violations.
 - A maximum of \$100,000 for each determination of discrimination; or
 - Misrepresentation or false statements to CMS or the State.
 - A maximum of \$15,000 for each recipient the State determines was not enrolled because of a discriminatory practice (subject to the \$100,000 overall limit above).
 - A maximum of \$25,000 or double the amount of the excess charges, (whichever is greater) for charging premiums or charges in excess of the amounts permitted under the Medicaid program. The State must deduct from the penalty the amount of overcharge and return it to the affected enrollee(s).
- Appointment of temporary management for an MCO as provided in 42 CFR 438.706.
- Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll.
- Suspension of all new enrollments, including default enrollment, after the effective date of the sanction.
- Suspension of payment for recipients enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

Additional sanctions allowed under state statute or regulation that address areas of noncompliance.

Sanctions

Contract requirements state:

The Department may impose sanctions for non-compliance with any requirement under contract. The sanctions which are imposed will depend on the nature and severity of the breach, which the Department, in its reasonable discretion, will determine. Sanctions will be imposed in a progressive fashion and, with the exception of gross violations, will begin with Section 14.1.A. below:

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- Require the submission and implementation of a corrective action plan.
- Impose monetary fines of up to \$1,000 per day per violation.
- Suspend all or a portion of payments.
- Terminate the Agreement in accordance with Section 8.1 hereof, upon notice to the County.

Sanction by CMS: Special Rules for MCOs and Denial of Payment.

The contract must specify that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with the requirements in 42 CFR 438.730. (See intermediate sanctions above)

Quality Management Plans

Contract requirements state:

In addition to those activities conducted by DPW and OMHSAS, each HealthChoices County is required to have a quality improvement plan that assesses the quality of its HealthChoices BH-MCO and its services. These plans are the direct responsibility of County staff, but information gained from these efforts is considered to be an important part of the OMHSAS QM and oversight of the HealthChoices program. The OMHSAS QM staff and field office Monitoring Teams work with the Counties and the BH-MCOs on their QM plans as a part of the monitoring process.

Each County/BH-MCO is required to have an ongoing quality assessment and performance improvement program of the services it furnishes members.

Each County/BH-MCO must have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas that involve the following:

- Measurement of performance using objective quality indicators
- Implementation of system interventions to achieve improvement in quality
- Evaluation of the effectiveness and
- Planning and initiation of activities for increasing or sustaining improvement

These projects must be designed to achieve through ongoing measurement and intervention significant improvement sustained over time in clinical and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction.

Each County/BH-MCO is required to prepare a written QM (continuous quality improvement) plan to monitor, assure, and improve the quality of care delivered over a range of clinical and health service delivery areas. Emphasis should be placed on, but need not be limited to, high volume and high-risk services and treatment and behavioral health rehabilitation services for children and adolescents. The plan must detail the organizational structure related to QM and related activities. The plan defines the structure of the QM process, and includes the organizational structure - committees, integration and relationships with other organizational components.

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As a part of the QM plan, the BH-MCO must address, at a minimum, the effectiveness of the services received by MA recipients, the quality and effectiveness of internal processes, and the quality of the Provider network. Among those areas to be considered in service delivery is access to services including culturally and ethnically appropriate services, availability of services, including emergency and post stabilization of services, continuity and coordination of care, the appropriateness of service manager authorizations, the authorization appeal process, adverse incidents, and the quality of service manager planning. Internal processes include but are not limited to telephone responsiveness; network capacity, overall utilization patterns and trends; treatment outcomes, enrollee information, enrollee rights, confidentiality and accuracy of enrollee information, health information systems, availability of second opinions from a qualified healthcare professional, and Complaint, Grievance and Fair Hearing tracking processes.

Provider monitoring includes but is not limited to provider selection, evidence-based practices, credentialing, sub-contractual relationships and delegation, risk and incidents management, utilization patterns, treatment outcomes, cooperation, and member satisfaction. The QM plan shall also include mechanisms to incorporate recommended enhancements resulting from the Department's monitoring and external evaluations and audits. The QM plan should address the monitoring of out of network providers.

QM specific topics include focused studies and surveys; medical records audits, oversight of activities, performance improvement plans and required documentation. Counties/BH-MCOs are required to review and revise the QM plan at least annually and submit to OMHSAS for review.

Quality Management Work Plans

Annually, the counties/BH-MCOs are required to prepare a work plan that details the projected QM activities for the coming year. The work plan focuses on quality or performance improvement goals and objectives, performance measures, special studies, responsible personnel and timeframes for completion and reporting. Work plans are submitted to OHMSAS for review.

Meetings and Reporting

Counties and BH-MCOs are required to hold regular Quality Management Committee and Monitoring Team meetings that include representatives from the county, the BH-MCO, OMHSAS, consumers, families, individuals with substance use disorders and providers. Results from QM activities such as performance measure indicator monitoring and the results of special studies are reported and included in the meeting minutes. Minutes are submitted to OMHSAS for review.

Annual Quality Management Summary

Counties/BH-MCOs are required to prepare an annual summary of their Quality Management and Performance Improvement activities. The purpose of the summary is for the County/BH-MCO to conduct a self-evaluation of the impact and effectiveness of its quality management and performance improvement program. This summary relates the results of monitoring and evaluation of the various indicators, results of Performance Improvement Plans, innovations and accomplishments and other topics related to improving

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service and member satisfaction. The summary should provide the basis for revision to the QM program plan and work plan. The annual summary is submitted to OMHSAS for review.

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Section II

State/County Community Mental Health Program

Background

The Commonwealth of Pennsylvania has a county-based system of mental health and substance abuse services, with county government responsible for the provision of mental health and substance abuse services to citizens within their subdivision. The Mental Health and Mental Retardation 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. The state is divided into 88 service areas based on population. These service areas are grouped into 46 single or multi county units under the direction of county mental health administrators. All county administrators also function as the directors of the county Mental Retardation programs and in 35 counties, as Drug and Alcohol Program Administrators. Counties managed as a multi-county group are referred to as “Joinders”.

Introduction

Each county mental health program is required to report data to OMHSAS that is similar to HealthChoices. Beginning in CY 2004 counties will be required to identify a quality management process as an integral part of the county mental health planning process. The County mental health planning process is designed to move counties toward using the CCR/POMS data and other data the county analyzed as part of the county planning process to define needs and develop the estimate of cost to meet those needs. In addition, the County Plan guidelines promote evidence-based practices as outlined in the CSP and Recovery Principles for adults and CASSP principles for children and adolescents. The planning process will include stakeholder and public input into the design and implementation of the County Mental Health plan.

Additionally, a portion of the County Mental Health plan is a regional Service Area Plan that focuses on the needs of the SMI population served in the community and state mental hospitals.

The Service Area Plan is designed to develop a strategy to shift the mental health delivery system away from reliance on large institutions and toward an array of treatment services and supports in the community. The purpose of the plan is to develop a recovery oriented community service system that is responsive to the treatment and support needs of people in state hospitals and persons who may potentially need state hospitalization. The plan determines the role of the state hospital within the service area.

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Structure

The overall structure for coordination, communication, and review of the QM Program is described in the “Structure” section of the QM Plan.

QM structure specific to the Community Mental Health Program is as follows:

Counties and the state mental hospitals routinely conduct continuity of care meetings to problem solve, discuss bed use management, methods for improving community tenure, complex cases, and service delivery development. The meetings provide information that will assist the Counties and state mental hospitals in the development of the County Mental Health Plan, service area plan and Community Hospital Integration Projects Program (CHIPP) requests.

The Quality Management section of the County Mental Health Plan provides a brief description of the county’s quality management program, defines the program structure, processes, content and includes:

- Delineation of program responsibility.
- Description of the activities employed to engage consumers, families and other stakeholders in the development of the Quality Management plan.
- Identification of monitoring activities
- Process of reviewing, analyzing, identifying barriers and or gaps in the service delivery system
- Description of quality management activities to monitor progress toward meeting the service area plan performance goals
- Description of quality improvement activities planned or undertaken as a result of monitoring activities directed toward enhancing the service delivery system
- Description of efforts to monitor individual outcomes through the Performance Outcome Measurement System
- Plans for development or expansion of consumer and family satisfaction activities
- Activities to offer assurance of contracted service provider credentialing, including adherence to all applicable regulations or standards through licensure, certification and/or accreditation.
- Monitoring of unserved/over served/underserved/high users
- Plan to monitor/reduce critical incidents
- Plan to incorporate the findings from the use of CASSP Bulletin/CSP Indicators Rating Scale in the Quality Management Plan
- Monitoring of the Service Area Plan performance goals
- Description of future quality management/improvement activities

The QM section of the County Mental Health Plan will be reviewed by QM staff in conjunction with the OMHSAS field office staff based on the established review criteria and provide comments/recommendations to the field office staff and support as necessary.

Annually, the County Mental Health Plan provides the opportunity for counties to present information on how they are providing the best care and treatment, in the most efficient and effective manner in the least restrictive environment to those persons who are most in need. Specific items to be included are:

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- A brief description of the trends and issues that were identified through the analysis of data from the county profile, other relevant sources, service area planning and stakeholder input,
- A summary of the issues identified through the quality assurance process with a particular emphasis on any changes that if made, could improve the quality of or access to treatment programs, services and supports,
- A synopsis of the plan for new, revised or enhanced services, and
- Issues and actions needed to move the treatment, service, and supports provided to adults toward a recovery-oriented service system.

QM presents a summary to the Quality Management Committee of the significant findings from the county submissions.

Reporting/Monitoring Oversight Activities

CCR/POMS

Consolidated Consumer Reports (CCR) and Performance Outcomes Measurement System (POMS) Reports are derived from the person level encounter reporting data, as well as from the consumer registry, quarterly status reports and secondary data sources. POMS (HealthChoices services) and CCR/POMS (community base funded services) measures are intended to assess the outcome of service rather than solely the cost or amount of service. In addition to measuring performance using structure and process indicators, OMHSAS will be capturing information related to outcomes using 27 specific outcome measures. These measures have been identified through a process involving OMHSAS staff as well as Advisory Board members, and include measures that would be relevant for both adults and children.

CHIPP/SIPP

The Service Area Plan will include data related to The Community Hospital Integration Projects Program (CHIPP). CHIPP is a program designed to promote the discharge of persons with a long-term history of hospitalization or otherwise complex service needs that have been unable to be supported successfully in the community. Once a county has been notified of a CHIPP award, monthly status reports are required until all identified CHIPP individuals have been discharged. Following discharge, the county is required to report the progress of these individuals to the OMHSAS Division of Operations Field Office, Bureau of Financial Management and Administration, the state hospital and the Bureau of Hospital Operations. A separate program called the Southeast Integration Projects Program (SIPP) was implemented in the five southeastern counties (Bucks, Chester, Delaware, Montgomery, and Philadelphia) in fiscal year 1997-1998. This program was an initiative that originated as a result of the closure of Haverford State Mental Hospital and the subsequent June 1998 court order to place people in community settings. It operates in a manner similar to the CHIPP program, but provides counties the capacity to provide more specialized services to persons with a broader range of service needs.

Reports are provided every six months in the second and third year of the project and then annually. The reports monitor the quality of services delivered within the community and the managed care environment. The reports include:

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- Major Incidents within 24 hours of occurrence
- Name of person placed
- CCRS client identification number
- State hospital discharged from
- Name of assigned ICM
- Location of where person is living
- County and MA funded services received by the person
- Cost of services provided (CHIPP/SIPP funds)
- Summary of feedback from the Consumer/Family Satisfaction Team

Community Mental Health Block Grant Progress Reports

The OMHSAS Division of Evaluation and MIS produces a number of reports regarding Block Grant Initiatives. The Programs Outcomes Unit has responsibility for the analysis of outcome data.

The Community Mental Health Services Block Grant Progress Reports (published at least quarterly, to address the Mental Health Block Grant data tables or performance indicators) are as follows:

- OMHSAS Progress Report 2003: Inpatient Psychiatric Hospitalization – Adult Consumers
- OMHSAS Progress Report 2003: Greene County Adult Consumer Rating of Behavioral Health Services
- OMHSAS Progress Report 2003: Greene County Family Rating of Behavioral Health Services
- OMHSAS Progress Report 2003: PATH Grant – FY 2002 Update
- OMHSAS Progress Report 2002: Seclusion and Restraint
- OMHSAS Progress Report 2002: Community Mental Health Inpatient Days
- OMHSAS Progress Report 2002: PATH GRANT
- OMHSAS Progress Report 2002: CHIPPS Beds Allocation
- OMHSAS Progress Report 2002: Family Member Perception of Care – HealthChoices Southeast
- OMHSAS Progress Report 2002: Consumer Participation in Treatment Planning – HealthChoices Southeast
- OMHSAS Progress Report 2001: Adult Consumer Perception of Care – HealthChoices Southeast
- Future reports: State Mental Hospital Length of Stay and Length of Residence, CCR POMS Summary Findings, Community Profiles of Persons Served
- Community Mental Health Services Ad Hoc Reports (published as needed or upon request, to address the Mental Health Block Grant criterion, data tables, performance indicators, OMHSAS Pilot Projects, or to respond to topical OMHSAS issues)
- Involvement with the Criminal Justice System: Using Existing Administrative/Operational Data to Measure Service System Performance
- OMHSAS Study of Pre and Post September 11, 2001 - Criminal Justice Involvement by Young Adult Mental Health Service Recipients in Somerset and Bedford Counties

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- Mental Health Consumers in Trouble with the Law in Connecticut, Vermont and Pennsylvania
- Early Identification and Outreach Program (EIOP) for Isolated Older Pennsylvanians with or at-risk for Developing Mental Illness: One Year Project Update
- State Mental Hospital Patients Aged 60+: A Two-Year Comparative Study
- Community Mental Health Services for Persons Aged 65+: A Comparative Study of CCRS, MA Fee-For-Service and HealthChoices Behavioral Health Data
- Future reports: EIOP Project Update, Mental Health Service Utilization pre and post September 11, State Mental Hospital End of Fiscal Year Census, Blended Case Management Pilot Project, Transition Services Pilot Project

Satisfaction Survey Reports (published as needed but at least annually, to address the Mental Health Block Grant data reporting requirement on consumer and family member perception of care, or to respond to topical OMHSAS issues)

- Substance Abuse Service Recipients Evaluation of Behavioral HealthChoices Southeast Pennsylvania: FY 2001 Technical Report
- Families of Child and Adolescent Consumers Evaluation of Behavioral HealthChoices Program, Southeast Pennsylvania FY 2000: Executive Summary
- Families of Child and Adolescent Consumers Evaluation of Behavioral HealthChoices Program, Southeast Pennsylvania FY 2000: Technical Report
- Adult Consumers' Evaluation of Behavioral HealthChoices Program, Southeast Pennsylvania FY 2000: Executive Summary
- Adult Consumers' Evaluation of Behavioral HealthChoices Program, Southeast Pennsylvania FY 2000: Technical Report
- Future reports: Greene County HealthChoices Behavioral Health 2002, Statewide Medical Assistance Fee For Service 2003, Blended Case Management Model Pilot Project 2003

Community Mental Health Services Block Grant Uniform Reporting System (URS) Data Table Report (published at least annually, to address the Mental Health Block Grant data tables reporting requirement)

- Profile of the State Population by Diagnosis
- Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity
- Profile of Persons served in the community mental health setting by homeless status
- Profile of persons served in the state psychiatric hospitals and other inpatient settings
- Profile of Adult Clients by Employment Status
- Profile of Clients by Type of Funding Support
- Profile of Client Turnover
- Profile of Mental Health Service Expenditures and Source of Funding
- Profile of Community Mental Health Block Grant Expenditures for Non-Direct Service Activities
- Public Mental Health System Service Inventory Checklist
- Profile of Agencies Receiving Block Grant Funds Directly from the State MHA
- Summary Profile of Client Evaluation of Care
- State Mental Health Agency Profile

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- Future data tables: Developmental Measures (e.g., persons receiving supported housing, profile of unmet need), and Optional Measures (e.g., involvement in criminal justice system, school attendance)

Community Mental Health Services Block Grant Performance Indicators Report (published at least annually, to address the Mental Health Block Grant Performance Indicators reporting requirement)

- Length of Stay in State Mental Hospitals
- Community Mental Health Inpatient Days
- Community Mental Health Inpatient Rehospitalization
- Overall Service Utilization Rates
- Co-Occurring Mental Health and Substance Abuse Utilization Rates
- Homeless Served by PATH Grant
- Rural Utilization Rates
- CHIPPS Beds Allocation
- Block Grant Allocation to Children
- Future performance indicators will be decided upon by OMHSAS with input from the Mental Health Planning Council

OBRA (aka, Nursing Home Reform Act) Reports (published as needed but at least annually, to address the Pre-Admission Screening “PAS” and Resident Review “RR” of adults with mental illness considered for/placed in nursing facilities)

- PAS/RR by Field Office
- PAS/RR Statistical Cross-Reference
- PAS/RR Comparison by Age Group
- Future report: PAS Referrals made by State Mental Hospitals

State Mental Hospital Mortality Reports (published as needed but at least annually, to address the mortality rates of adults with mental illness who are residents of the state mental facilities)

- Number of Deaths by Age Range
- Number of Deaths by Gender
- Number of Deaths by Cause of Death
- Average Length of Stay of Deceased Patients
- Mean Length of Stay of Deceased Patients
- Mortality rates per 100,000 Bed Days

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Section III

State Mental Hospitals

Background

The Bureau of Hospital Operations oversees and directs the nine state-owned and operated mental health hospitals and one restoration (long-term care) center, including three maximum-security forensic units for persons with serious mental illness who are charged with or convicted of criminal offenses.

Introduction

The Bureau reviews and analyzes management reports and clinical information related to state hospital/restoration center utilization, in order to anticipate and resolve emerging problems. It administers systemic risk management and performance improvement initiatives and data tracking systems to identify areas needing improvement and to identify and replicate best treatment practices. The Bureau uses these results to establish system-wide standards and policies for treatment and clinical functions, which adhere to or exceed accepted best practice. The Bureau maintains multi-hospital Joint Commission for Accreditation of Health Care Organizations (JCAHO) accreditation, Medicare and Medicaid certification.

In order to ensure that inpatient hospital/restoration center treatment is provided in environments that foster consumer empowerment, dignity and recovery, consistent with Community Support Program (CSP) principles, the Bureau works collegially with consumers, family members, ombudspersons and advocates to improve the quality of life for hospital patients. Each hospital has an advocate to represent the interests of the patients. The advocate at each hospital attends the executive staff meetings of the hospital.

Since all patients are admitted to state hospitals through the County Mental Health system, the Bureau collaborates with county, local hospital and community provider staff, constituents and other stakeholders to establish effective community/hospital linkages and continuity of care for patients discharged back into the community. The Bureau collaborates with other OMHSAS bureaus and divisions in planning, developing and implementing future Community/Hospital Integration Project Program (CHIPP) initiatives as a resource for expanding community-based care.

Structure

The overall structure for coordination, communication, and review of the QM Program is described in the “Structure” section of the QM Plan.

Facilities must be accredited by JCAHO and in keeping with JCAHO terminology; Quality Management/Performance Improvement activities at the facility level are addressed under the title of Performance Improvement. These activities are embodied in each facility’s Performance Improvement Plan and directed by hospital-based Chief Performance Improvement Officers and the local Quality Management /Performance Improvement Committees comprised of clinical and administrative leadership. Each facility details its program in a Performance Improvement Plan and reviews the success of its initiatives

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annually. Based upon the results, the plan is subsequently revised. Each facility may develop and monitor local indicators to address high-volume/high risk or problem-prone aspects of care or identified opportunities to improve care or services.

Performance related information is exchanged through regularly scheduled meetings of the Performance Improvement officers, Chief Executive Officers and Chiefs of hospital operating divisions such as Clinical Services, Nursing and Social/Rehabilitative Services.

As noted in the State/County Community Mental Health Program section, Counties and the state mental hospitals routinely conduct continuity of care meetings to problem solve, discuss bed use management, methods for improving community tenure, complex cases, and service delivery development. The meetings provide information that will assist the Counties and state mental hospitals in the development of the County Mental Health Plan, service area plan and Community Hospital Integration Projects Program (CHIPPP) requests.

Reporting/Monitoring Oversight Activities

Pennsylvania State Mental Hospital Performance Measurement System (PaSMH-PMS)

At the Bureau level, activities include the PaSMH-PMS which tracks individual facility and system performance on a set of key quality/risk management indicators. A subset of these indicators is reported to the JCAHO ORYX performance measurement system. To allow common-size comparison, indicators are adjusted to reflect the rate of occurrence per 1000 patients. Additionally, some indicators are risk-adjusted to reflect population characteristics. Subsets of the system relate to general psychiatric, forensic psychiatric and long-term care populations. Facilities report monthly data and control/comparison charts are generated and distributed to facility and Bureau staff. The PaSMH-PMS indicators are:

- Medication errors
- Suspected adverse drug reactions
- Use of more than 1 anti-cholinergic agent for patients age 65 and older
- Falls where an injury is sustained
- Fractures
- Patient choking incidents
- Patient deaths
- Patient elopements
- Seclusion incidents
- Seclusion hours
- Behavioral restraint incidents
- Behavioral restraint hours
- Patient to patient assaults where an injury occurs
- Patient to staff assaults where an injury occurs
- Patient to staff assaults where an injury occurs resulting in lost time
- Injury to new staff
- Injuries to new staff resulting in lost time
- Patient complaints

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National Association of State Mental Health Program Directors (NASMHPD) National Research Institute (NRI)

The Bureau's facilities are also part of the NASMHPD'S NRI performance measurement system. Data on specific indicators is reported to NRI and used for national benchmarking. NRI indicators are:

- Client Injury rate
- Percentage of clients restrained
- Percentage of clients secluded
- Restraint hours
- Seclusion hours
- Med error rate
- 30 day readmission rate
- Elopement rate

Risk Management

The Bureau's facilities report incident data to the OHMSAS Risk Management incident reporting system. Many of the Risk Management categories are comparable to those of the PaSMH-PMS system. Monthly reports are generated and distributed to key OMHSAS staff. Additional categories include:

- Substance abuse
- Criminal acts
- Communications misuse
- Contraband possession
- Family concerns
- Missing property/thefts
- Treatment errors
- Property damage
- Seizures
- Sudden acute illnesses
- Suicide attempts
- Community Incidents (while on leave)

Drug Usage Review System (DURS)

The Bureau's facilities participate in joint initiatives with the OMHSAS Office of the Medical Director. The OMHSAS DURS is designed to perform a variety of computerized review functions at the facility and system level. The system allows review of drug use by facility, by patient, by drug class and by provider. Cost analysis within categories is available. At the OMHSAS level, DURS facilitates comparison of key factors between facilities. The Division of Quality Management supplies technical and administrative support.

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Pennsylvania Medication Administration Protocol for Schizophrenia (PennMAPS)

Hospitals and the Office of the Medical Director have implemented PennMAPS. PennMAPS is a computer driven best practice initiative based on the Texas program TMAPS. This algorithm based best practice defines administration practices for the initiation and progression of drug therapy for patients diagnosed with schizophrenia. The Division of Quality Management supplies technical support.

CHIPP/SIPP

The Service Area Plan will include data related to The Community Hospital Integration Projects Program (CHIPP). CHIPP is a program designed to promote the discharge of persons with a long-term history of hospitalization or otherwise complex service needs that have been unable to be supported successfully in the community. Once a county has been notified of a CHIPP award, monthly status reports are required until all identified CHIPP individuals have been discharged. Following discharge, the county is required to report the progress of these individuals to the OMHSAS Bureau of Operations and Quality Management, Field Office, Bureau of Financial Management and Administration, the state hospital and the Bureau of Hospital Operations. A separate program called the Southeast Integration Projects Program (SIPP) was implemented in the five southeastern counties (Bucks, Chester, Delaware, Montgomery, and Philadelphia) in fiscal year 1997-1998. This program was an initiative that originated as a result of the closure of Haverford State Mental Hospital and the subsequent June 1998 court order to place people in community settings. It operates in a manner similar to the CHIPP program, but provides counties the capacity to provide more specialized services to persons with a broader range of service needs.

Reports are provided every six months in the second and third year of the project and then annually. The reports monitor the quality of services delivered within the community and the managed care environment. The reports include:

- Major Incidents within 24 hours of occurrence
- Name of person placed
- CCRS client identification number
- State hospital discharged from
- Name of assigned ICM
- Location of where person is living
- County and MA funded services received by the person
- Cost of services provided (CHIPP/SIPP funds)
- Summary of feedback from the Consumer/Family Satisfaction Team

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Office of Mental Health & Substance Abuse Services

OMHSAS Bureau Functions

Deputy Secretary for OMHSAS

- Leads and directs the public policy and administration of the Commonwealth of Pennsylvania's public mental health and substance abuse system.
- Leads and directs the reform of the existing system to a quality-focused, consumer and family centered, cost effective, managed mental health and substance abuse care system.
- Supervises the following positions: Executive Secretary, Special Assistant to the Deputy Secretary, Medical Director, and Bureau Directors for Operations and Quality Management, Hospital Operations, Policy and Program Development, Consumer and Family Affairs, Children's Services, and Financial Management and Administration.
- Directs and chairs the OMHSAS Executive Staff Council.

Executive Assistant to the Deputy Secretary

- Organizes, facilitates, and oversees OMHSAS workflow and staff in fulfillment of the OMHSAS stated mission, goals and priorities.
- Supervises, on an indirect basis, all Bureau Directors.
- Acts on behalf of the Deputy Secretary at his/her request.
- Ensures effective and efficient collaboration among OMHSAS bureaus and divisions.
- Serves as OMHSAS representative to other DPW offices, other state agencies and to community organizations at the request of the Deputy Secretary.
- Assists the Deputy Secretary in the formulation and analysis of public policy and system change recommendations.

Office of the Medical Director

- Directs and provides statewide clinical mental health and substance abuse services leadership to all DPW Program Offices

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- Directs and provides medical oversight of hospitals and managed care organizations.
- Directs and provides clinical coordination between physical and mental health and substance abuse care benefit plans.
- Reviews and approves clinical care procedures in the Unified System of Care in coordination with other OMHSAS bureaus and divisions including:
 - Medical necessity criteria;
 - Level of care criteria;
 - Prior authorization, concurrent and retrospective review; and
 - Quality evaluation and program improvement
- Directs all medical staff serving within the OMHSAS
- Evaluates and recommends clinical staff training needs and requirements.
- Consults with counties, State Mental Hospitals, managed care organizations, and health maintenance organizations.
- Consults for specialty services, such as, forensic, long-term nursing care, children, and the elderly.
- Reviews and approves clinical research protocols in coordination with other Bureaus and Divisions.
- Directs and provides clinical consultation and technical assistance with counties, state hospitals, managed care organizations, and health maintenance organizations.
- Consults and collaborates with the Bureau of Children's Services and the Division of Drug and Alcohol Programs regarding clinical programs and programs for special populations.
- Reviews and approves clinical research protocols with the Bureau of Operations and Quality Management and Division of Quality Management
- Supervises and monitors the state hospitals' pharmacy operations.
- Develops and communicates policy to community mental health facilities, programs, and managed care organizations regarding pharmacy issues.
- Directs and leads the development and oversight of the psychotropic drug formulary.
- Leads, directs and maintains the Drug Utilization Reporting System (DURS) that provides monthly drug usage reports from the state hospital pharmacies.
- Directs and communicates policy for the State contracting, procurement, utilization management and coordination of pharmaceuticals with other State agencies, such as, the Department of General Services for cost-effective drug pricing.
- Promotes a unified systems approach for the implementation of PennMap drug utilization review in state hospital and county mental health systems.

Division of Quality Management

- Designs, develops and implements all OMHSAS monitoring policies, program design and processes for tracking mental health services to ensure the highest standards of treatment and care are practices, services are of the highest quality,

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risk management procedures are in place and in practice, and on-going continuous quality improvement and utilization review process are fully engaged in all providers of mental health services throughout the Commonwealth.

- Develops and implements clinical and outcome evaluation of mental health services provided throughout the Commonwealth.
- Collaborates with the OMHSAS Medical Director, Bureaus of Operations and Quality Management, and Hospital Operations in providing expertise, leadership and direction for clinical care in the provision of mental health services in community-based service system and within the state hospitals.
- Coordinates the Quality Management program in state hospitals and reports on the quality management outcomes for the hospital division.

Bureau of Consumer and Family Affairs

- The Division of Complaints and Grievances plays the primary role in Quality Management/ Performance Improvement activities related to service denials, member complaints, grievances and appeals.
- The Division conducts qualitative reviews on service denials, supporting case documentation and coordinates case reviews with practitioners from the Office of the Medical Director. The division provides training to counties and BH-MCOs on important aspects of the denials, grievance and appeals process.
- The Division of Consumer Affairs provides the link to the consumer, families and individuals with substance use disorders stakeholder groups.

Bureau of Children's Services

- Develops and coordinates a comprehensive statewide system of mental health services for children & adolescents.
- Collaborates with all child-serving systems at the federal, state, and local levels. This includes active collaboration with DPW Offices of Children, Youth and Families, Medical Assistance Programs, Mental Retardation, and the Department of Education, Department of Health, the Juvenile Court Judges' Commission and the Pennsylvania Commission on Crime & Delinquency.
- Plans and monitors the implementation of a full array of children's mental health services.
- Provides OMHSAS leadership in collaborating with the Children's Cabinet chaired by the Secretary of Public Welfare.
- There are two divisions in this Bureau: Policy & Program Development and Community Services.

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Bureau of Operations and Quality Management

- Implements and monitors the HealthChoices contracts for the managed care behavioral health program.
- Conducts annual reviews of HealthChoices behavioral health programs.
- Monitors, reviews, and manages the county mental health and substance abuse services delivery system.
- The Monitoring Teams led by the Team Leader interface with the HealthChoices plans (for those regions where HealthChoices has been implemented), as well as with other programs funded by DPW.
- Monitoring Teams produce regular reports as well as file notes regarding their activities. Information from Monitoring Teams is provided to Quality Management in order to incorporate the findings into QM initiatives and planning.
- Directs and designs required licensure activities to monitor implementation and compliance to program standards and medical necessity criteria of all community-based mental health programs.
- Design and implements technology systems,
- Maintains the primary behavioral health data system
- Develops performance and measurement criteria, standards and reporting requirements.
- Conducts data analysis and special studies

The Bureau is organized into four divisions: The Division of Western Operations, the Division of Eastern Operations, the Division of Program Standards and Licensing, and the Division of Evaluation and MIS.

Bureau of Policy & Program Development

- Develops program standards and clinical criteria in county programs, managed care organizations, and provider agencies as part of the OMHSAS managed care-monitoring teams.
- Responsible for policies and actions that will impact the service continuum and result in effective collaboration in service delivery for persons presenting either substance abuse or co-occurring mental health (MH) and substance abuse (SA) service need.
- Directs the development of the expansion of managed care across the Commonwealth with the development of managed care Requests for Proposal (RFP), and along with other state agencies, directs the development of the Medicaid managed care waivers.
- Leads the development for any new program activities.
- Facilitates communication and collaboration in planning and policy development with the DOH Bureau of Drug and Alcohol Programs and other Commonwealth agencies.

Revised February 17, 2004

- Responsible to conduct projects and initiatives that resolve policy and operational problem areas and builds consensus within the MH and SA service systems.
- Responsible for community-based program and state hospitals policy and program development for cross system/special need populations including, but not limited to, forensic services, co-occurring mental health and mental retardation services, mental health aging services, hearing and mobility impaired services, and cultural competency services, exclusive of children's services.

Bureau of Hospital Operations

- Oversees and directs the effective and efficient management of the OMHSAS state-owned and operated mental health hospitals and restoration center, including supervision of the state hospital superintendents.
- Directs the effective and efficient management of the OMHSAS state-owned and operated mental health hospitals and restoration center.
- Manages the overall state hospital staff complement and ensuring the hospitals/center operates within the level of funds budgeted and allotted.
- Directs and monitors the continued progress in reducing the state hospital patient census and the utilization of the hospitals/center to optimum levels.
- Directs and manages for OMHSAS all statewide labor relations activities, including contract negotiations, grievance/appeal process, and investigations pertaining to the state mental hospitals.
- Plans all activities associated with the implementation of policy related to planning and service programs, including all service area planning efforts and Unified System planning.

Bureau of Financial Management and Administration

- Develops, implements, monitors and continually improves of all OMHSAS administrative, financial, budgetary and personnel policies, procedures, regulations and performance standards.
- Develops and implements management strategies for oversight and monitoring the financing of the Unified System and HealthChoices.
- There are two divisions in this Bureau: Budget & Administrative Services, and Medicaid and Financial Review.

Revised February 17, 2004

IV: Narrative Plan

S. Suicide Prevention

Page 82 of the Application Guidance

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#) available on the SAMHSA website at [here](#).

Footnotes:

Pennsylvania Adult Suicide Prevention Plan



Department of Public Welfare

Department of Health

Department of Aging

To the Citizens of Pennsylvania:

We are pleased to present the Pennsylvania Adult and Older Adult Suicide Prevention Plan. Suicide claims the lives of over 1300 Pennsylvanians each year; that is an average of 3.5 lives each day. It is estimated that each suicide directly affects six people; therefore, over 7800 Pennsylvanians become survivors of suicide each year.

Former U.S. Surgeon General David Satcher presented the Call to Action to Prevent Suicide in 1999 in which he stated that the problems of suicide and suicide prevention are critical public health priorities for our nation. The National Strategy for Suicide Prevention debuted in 2001.

The Advisory committee of the Office of Mental Health and Substance Abuse Services (OMHSAS) prioritized a state suicide prevention plan as one of the major goals for OMHSAS. A workgroup was formed and began to meet in July 2005. This prevention plan is a collaborative effort between those dedicated individuals from both the public and private sectors of our state. The workgroup is striving to raise awareness about suicide and its prevention so that fewer Pennsylvanians experience the pain and grief resulting from the suicide death of a loved one.

On behalf of the Commonwealth of Pennsylvania we would like to thank the many who have put time and energy into this important initiative.

Estelle Richman
Secretary of Public Welfare

Nora Dowd Eisenhower
Secretary of Aging

Calvin B. Johnson
Secretary of Health

Lifekeeper Promise

**Someone we love
Did not keep their life
In pain and anguish
They ended their strife**

**In this lifetime on Earth
We'll see them no more
Yet we carry them always
In our soul, in our core**

**Now we're left here
And we must stay
We have Life to live
To the fullest each day**

**For we are the Lifekeepers
A promise we make
To celebrate their Lives
Our own not to take**

**We are the Lifekeepers
Truth Bearers, Peace Seekers
We are the Wounded
We are the Healed
We are the Lifekeepers
Our commitment now sealed**

written by Sandy Martin

About Adult Suicide: A Parent's Perspective

One of the realities of suicide prevention in the Commonwealth of Pennsylvania, and in all of its counties and municipalities, is that there will be no significant impact on the occurrence of suicide unless preventative efforts are pervasively and aggressively directed at adults, particularly adult males. One of the ironies of suicide prevention is that, with very few exceptions, little suicide prevention is directed at adults, and, outside of the military, the correctional system, and the Veterans Administration, there have been few meaningful attempts to reduce the incidence of suicide among men. This plan speaks to that need. It is a positive, long-awaited, and necessary step towards addressing the problem of adult suicide in every community in Pennsylvania.

I care a lot about adult suicide prevention. I even have some data on adult suicide on a bulletin board hanging next to my desk at my office. On this single sheet of paper are statistics downloaded many years ago from the Centers for Disease Control (CDC) web site. The data tables report US suicides for 1996 by age and gender. There's a small checkmark next to the total deaths for males ages 25-29. That year 2361 men in that age group completed suicide. I knew the guy on the end. His name was Paul, our oldest child, and he was 28 when we lost him in November 1996.

I look at those numbers every work day and I think about Paul. For a few moments the enormity of his loss and the severity of its after effects hit me, and the pain, the sadness, and the regrets sweep over me. Most of the time I quickly get back to the present and move on with my day. Yet I have not moved on or gotten over our loss, but somewhere in the intervening years I did recover from it. This is not the same thing as "healing," a term that, in my mind, equates a traumatic loss to a cut finger. I have rebuilt my life around my loss and I now live a "new normal," though one touched every day by the heavy shadow of suicide.

I often think of those grieving the other 2360 young men who completed suicide that sad year. Alone they may have left 14,000 to 19,000 people behind – parents, siblings, spouses, children, partners, and others who reflect the true scale and cost of adult suicide to society. I wonder if they too have achieved some measure of recovery. I wonder how many are dealing with depression, grief reactions, and other byproducts of suicide loss. I think of those still beset by guilt and those who continuously ask "why" or "what if" and those who forever replay things said or not said. I wonder how many are aware that their loss has increased their own risk of suicide. I wonder how many subsequent suicides, youth, adult, and elder, are linked to those yellowing CDC statistics.

As I turn away I am again reminded that there is nothing final about any suicide and I am reenergized to do something about it as the source of so much loss of life and so much enduring suffering. This plan aids that task. It defines the problem of adult suicide and outlines a broad strategy for government agencies at every level, community groups, educational institutions, the criminal justice system, businesses, health care and behavioral health providers, human service agencies, and individual citizens to play a role in reducing the incidence of suicide among the adult residents of our state. This

document can increase public awareness of the risk and preventability of suicide, drive greater knowledge of the warning signs of suicide, and, hopefully, spur development of more prevention, crisis intervention, and postvention resources to help those beset by suicidal thoughts and behavior and those coping with the aftermath of suicide. Let's do it!

Tony Salvatore
Springfield, PA
March 2006

Introduction

Both national and State suicide statistics reinforce the need for suicide prevention efforts. In 2003 PA had 1330 deaths by suicide; this is an average of over 3 deaths by suicide every day. About twice as many Pennsylvanians died by suicide than homicide. It is estimated that each suicide directly affects 6 people; in 2003 over 7800 Pennsylvanians became survivors of suicide. Suicide is one of the most preventable deaths, yet tragically most of these deaths still occur. In recognition of the problem, PA formed an Adult/Older Adult Suicide Prevention workgroup in July 2005 to develop a State Plan. The workgroup decided to use the “National Strategy for Suicide Prevention: Goals and Objectives for Action” as a template. PA has adopted the 11 National Goals and adaptations of the objectives.

Benefits of a State Plan

- Raise awareness and help make suicide prevention a statewide priority. This can help direct resources of all kinds to the issue
- Provide opportunities to use public-private partnerships and the energy of survivors to engage people who may not consider suicide prevention part of their mission. A state plan supports collaboration across a broad spectrum of agencies, institutions groups, and community leaders as implementation partners.
- Link information from many prevention programs to avoid unintentional duplication and share information about effective prevention activities.
- Direct attention to measures that benefit all people in PA and, by that means, reduce the likelihood of suicide, before vulnerable individuals reach the point of danger.

Putting the plan to work

The keystone of the plan is implementation; this is where you can make a difference. In addition to the work of state agencies, implementing the plan will require broad participation and collaboration from individuals and groups in local communities. Professionals and community volunteers must work side-by-side, and public agencies and private organizations will have to expand their partnerships to make a difference in suicide prevention.

Several broad public health themes are valuable considerations as groups and individuals move forward in designing and strengthening suicide prevention activities.

- Draw attention to a wide range of actions so that specific activities can be developed to fit the resources and areas of interest of people in everyday community life as well as professionals, groups, and public agencies. Suicide prevention is everyone’s business.
- Seek to integrate suicide prevention into existing health, mental health, substance abuse, education, and human service activities. Settings that provide related services, such as schools, workplaces, clinics, medical offices, correctional and detention centers, eldercare facilities, faith communities, and community centers are all important venues for seamless suicide prevention activities.

- While population-based interventions are applicable without regard to risk status, it does not mean that one size fits all. The cultural and developmental appropriateness of suicide prevention activities derived from the plan are a vital design and implementation consideration.
- Seek to eliminate disparities that erode suicide prevention activities. Health care disparities are attributable to such differences as race or ethnicity, gender, education or income, disability, age, stigma, sexual orientation, or geographic location.
- Emphasize early interventions to promote protective factors and reduce risk factors for suicide. Progress depends on measures that address problems early so that fewer people become suicidal.

The five-step public health model is outlined here. It links defining the problem, identifying risk and protective factors, developing and testing interventions, implementing, and evaluating interventions. The steps can and often do occur at the same time and depend on one another.

Step 1: Defining the problem

Surveillance is the ongoing process of collecting information about the “who, what, when, where, how, and how many” of suicide. For example:

- In 2002 there were 1,326 deaths by suicide in PA
- In 2002 firearms accounted for 68.7% of deaths by suicide for those aged 65 and older
- In 2002 suicide was the second leading cause of death for ages 25-34 years in PA

Step 2: Identifying Causes through Risk and Protective Factors Research

Risk factors may be thought of as leading to or being associated with suicide. Protective factors reduce the likelihood of suicide. They enhance resilience and may serve to counterbalance risk factors. The following risk and protective factors are identified in the *National Strategy Prevention for Suicide: Goals and Objectives for Action*.

RISK FACTORS FOR SUICIDE

Biological, Psychological and Social Risk Factors

- Previous suicide attempt
- Mental disorders-particularly moods disorders such as depression and bipolar disorder, anxiety disorders, schizophrenia, and certain personality disorder diagnoses
- Alcohol and substance abuse disorders
- Family history of suicide
- History of trauma or abuse
- Hopelessness
- Impulsiveness and/or aggressive tendencies
- Some major physical illnesses

Environmental Risk Factors

- Job or financial loss
- Relational or social loss
- Easy access to lethal means
- Local clusters of suicide that have a contagious influence

Socio-cultural Risk Factors

- Lack of social support and sense of isolation
- Stigma associated with help-seeking behavior
- Barriers to accessing health care, especially mental health and substance abuse treatment
- Certain cultural and religious beliefs—for instance, the belief that suicide is a noble resolution of a personal dilemma
- Exposure to the influence of others who have died by suicide, including media exposure

PROTECTIVE FACTORS FOR SUICIDE

- Effective clinical care for mental, physical, and substance use disorders
- Easy access to a variety of clinical interventions and support for help-seeking
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Learned skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation

Step 3: Develop and Test Interventions

Interventions are actions or programs which can reduce the impact of risk factors or support protective factors. Definitive pilot studies are frequently missing for many types of social and mental health interventions. Therefore, program planners may incorporate “promising” interventions into community plans before the evidence base is fully developed.

Step 4: Implement Interventions

Principles to keep in mind:

- Suicide prevention programs should coordinate with other prevention efforts, such as substance abuse.
- Programs must address the needs of people in each stage of life.
- Programs must be culturally sensitive.
- Prevention programs are more effective when they are long-term, with opportunities for reinforcement of attitudes, behaviors, and skills.
- Each community must develop a program that meets local needs and builds on local strengths

- Program planning should represent the community with respect to age, ethnicity, faith, occupation, sexual orientation, socioeconomic status, and cultural identity.

Step 5: Evaluate Effectiveness

A community should build in an evaluation to determine whether any intervention selected works under local conditions. Determining the costs associated with sustaining programs and comparing those costs to the benefits of the programs is another important aspect of evaluation.

- **Pennsylvania Strategy for Adult Suicide Prevention: Goals and Objectives**

Goal 1: Promote Awareness that Suicide is a Public Health Problem that is Preventable

In a democratic society, the stronger and broader the support for a public health initiative, the greater its chance for success. If the general public understands that suicide and suicidal behaviors can be prevented, and people are made aware of the roles individuals and groups can play in prevention, the suicide rate can be reduced.

The objectives established for this goal are focused on increasing the degree of cooperation and collaboration between and among public and private entities that have made a commitment to public awareness of suicide and suicide prevention. They include:

- Developing public education campaigns
- Sponsoring national/statewide conferences on suicide and suicide prevention
- Organizing special-issue forums, and
- Disseminating information through the internet.

ACTION IDEAS:

- Develop information materials that can be distributed. Materials should describe suicide risk and protective factors, available community resources, and how to join in prevention efforts.
- Hold regional forums to present the Plan and provide information and encouragement.

Goal 2: Develop Broad-based Support for Suicide Prevention

Because there are many paths to suicide, prevention must address psychological, biological, and social factors if it is to be effective. Collaboration across a broad spectrum of agencies, institutions, and groups—from schools to faith-based organizations to health care associations is a way to ensure that prevention efforts are comprehensive. Such collaboration can also generate greater and more effective attention to suicide prevention than these groups working alone. Public/private partnerships that evolve from collaboration are able to blend resources and build upon each group's strengths. Broad-based support for suicide prevention may also lead to additional funding, through governmental programs as well as private philanthropy, and to the incorporation of suicide prevention activities into the mission of organizations that have not previously addressed it.

The objectives established for this goal are focused on developing collective leadership and on increasing the number of groups working to prevent suicide. They will help ensure that suicide prevention is better understood and that organizational support exists for implementing prevention activities. The objectives include:

- Organizing a State interagency committee to improve coordination and to ensure implementation of the Pennsylvania Strategy
- Establishing public/private partnerships dedicated to implementing the Pennsylvania Strategy

- Increasing the number of professional, volunteer, and other groups that integrate suicide prevention activities into their ongoing activities, and
- Increasing the number of faith based communities that adopt policies designed to prevent suicide.

ACTION IDEAS:

- Visit leaders of community groups, such as churches, United Way, senior centers, etc.. to engage their participation and support in integrating suicide prevention into ongoing programs. This should include other prevention programs, such as substance abuse, gambling addiction, child abuse, etc...
- Recruit and train at least one member of each community in PA to be a community organizer for suicide prevention.

Goal 3: Develop and Implement Strategies to Reduce the Stigma Associated with Being a Consumer of Mental Health, Substance Abuse, and Suicide Prevention Services

Suicide is closely linked to mental illness and to substance abuse, and effective treatments exist for both. However, the stigma of mental illness and substance abuse prevents many persons from seeking assistance; they fear prejudice and discrimination. The stigma of suicide itself, the view that suicide is shameful and/or sinful, is also a barrier to treatment for persons who have suicidal thoughts or who have attempted suicide. Family members of suicide attempters often hide the behavior from friends and relatives, and those who have survived the suicide of a loved one suffer not only the grief of loss but often the added pain stemming from stigma.

Historically, the stigma associated with mental illness, substance abuse, and suicide has contributed to inadequate funding for preventive services and to low insurance reimbursements for treatments. It has also resulted in the establishment of separate systems for physical health and mental health care. One consequence is that preventive services and treatment for mental illness and substance abuse are much less available than for other health problems. Moreover, this separation has led to bureaucratic and institutional barriers between the two systems that complicate the provision of services and further impede access to care. Destigmatizing mental illness and substance use disorders could increase access to treatment by reducing financial barriers, integrating care, and increasing the willingness of individuals to seek treatment.

The objectives established for this goal are designed to create the conditions that enable persons in need of mental health and substance abuse services to receive them. They include:

- Increasing the number of suicidal persons with underlying mental disorders who receive appropriate mental health treatment, and
- Transforming public attitudes to view mental and substance use disorders as real illnesses, equal to physical illness, that respond to specific treatments and to view persons who obtain treatment as pursuing basic health care.

ACTION IDEAS:

- Develop a public awareness campaign including, educational presentations, around mental illness.

- Ensure that mental health services are culturally competent.

Goal 4: Develop and Implement Suicide Prevention Programs

Research has shown that many suicides are preventable; however, effective suicide prevention programs require commitment and resources. The public health approach provides a framework for developing preventive interventions. Programs may be specific to one particular organization, such as a university or a community health center, or they may encompass an entire State. A special emphasis of this goal is that of ensuring a range of interventions that in concert represent a comprehensive and coordinated program.

The objectives established for this goal are designed to foster planning and program development work and to ensure the integration of suicide prevention into organizations and agencies that have access to groups of individuals for other purposes. The objectives also address the need for systematic planning at both the State and local levels, the need for technical assistance in the development of suicide prevention programs, and the need for ongoing evaluation. Objectives include:

- Increasing the proportion of local communities with comprehensive suicide prevention plans
- Increasing the number of evidence-based suicide prevention plans in schools, colleges, work sites, correctional institutions, aging programs, and family, youth and community service programs, and
- Developing technical support centers to build the capacity across the state to implement and evaluate suicide prevention programs.

ACTION IDEAS:

- Identify a lead organization to coordinate efforts.
- Assess existing plans to identify areas for improvement.

Goal 5: Promote Efforts to Reduce Access to Lethal Means and Methods of Self-Harm

Evidence from many countries and cultures shows that limiting access to lethal means of self-harm may be an effective strategy to prevent self-destructive behaviors. Often referred to as “means restriction,” this approach is based on the belief that a small but significant minority of suicidal acts are, in fact, impulsive and of the moment; they result from a combination of psychological pain or despair coupled with the easy availability of the means by which to inflict self-injury. Thus, a self-destructive act may be prevented by limiting the individual’s access to the means to self-harm. Evidence suggests that there may be a limited time effect for decreasing self-destructive behaviors in susceptible and impulsive individuals when access to the means for self-harm is restricted.

Controversy exists about how to accomplish this goal because restricting means can take many forms and signifies different things to different people. For some, means restriction may connote redesigning or altering the existing lethal means of self-harm currently available, while to others it means eliminating or limiting their availability.

The objectives established for this goal are designed to separate in time and space the suicidal impulse from access to lethal means of self-harm. They include:

- Educating health care providers and health safety officials on the assessment of lethal means in the home and actions to reduce suicide risk
- Implementing a public information campaign designed to reduce accessibility of lethal means
- Improving firearm safety design, establishing safer methods for dispensing potentially lethal quantities of medications and seeking methods for reducing carbon monoxide poisoning for automobile exhaust systems, and
- Supporting the discovery of new technologies to prevent suicide.

ACTION IDEAS:

- Encourage medical personnel to routinely ask about the presence of lethal means of self-harm in the home.
- Educate family members on how to appropriately store and secure lethal means of self-harm.

Goal 6: Implement Training for Recognition of At-Risk Behavior and Delivery of Effective Treatment

Studies indicate that many health professionals are not adequately trained to provide proper assessment, treatment, and management of suicidal patients, nor do they know how to refer clients properly for specialized assessment and treatment. Despite the increased awareness of suicide as a major public health problem, gaps remain in training programs for health professionals and others who often come into contact with patients in need of these specialized assessment techniques and treatment approaches. In addition, many health professionals lack training in the recognition of risk factors often found in grieving family members of loved ones who have died by suicide (suicide survivors).

Key gatekeepers-people who regularly come into contact with individuals or families in distress- need training in order to be able to recognize factors that place individuals at risk for suicide, and to learn appropriate interventions. Key gatekeepers include teachers, clergy, police officers, primary health care providers, mental health care providers, correctional personnel, and emergency health care personnel.

The objectives established for this goal are designed to ensure that health professional and key community gatekeepers obtain the training that will help them prevent suicide. They include:

- Improving education for nurses, physician assistants, physicians, social workers, psychologists, and other counselors
- Providing training for clergy, teachers and other educational staff, correctional workers, and attorneys on how to identify and respond to persons at risk for suicide, and
- Providing educational programs for family members of persons at elevated risk.

ACTION IDEAS:

- Include workshops on suicide prevention at annual meeting of professional associations.

- Encourage directors of education at professional schools in PA to include suicide prevention training in the curriculum.

Goal 7: Develop and Promote Effective Clinical and Professional Practices

One way to prevent suicide is to identify individuals at risk and to engage them in treatments that are effective in reducing the personal and situational factors associated with suicidal behaviors (e.g., depressed mood, hopelessness, helplessness, alcohol and other drug abuse, among others). Another way to prevent suicide is to promote and support the presence of protective factors, such as learning skills in problem solving, conflict resolution, and nonviolent handling of disputes. By improving clinical practices in the assessment, management, and treatment for individuals at risk for suicide, the chances for preventing those individuals from acting on their despair and distress in self-destructive ways are greatly improved. Moreover, promoting the presence of protective factors for these individuals can contribute importantly to reducing their risk.

The objectives established for this goal are designed to heighten awareness of the presence or absence of risk and protective conditions associated with suicide, leading to better triage systems and better allocation of resources for those in need of specialized treatment. They include:

- Changing procedures and/or policies in certain settings, including hospital emergency departments, substance abuse treatment centers, specialty mental health treatment centers, and various institutional treatment settings, designed to assess suicide risk
- Incorporating suicide risk screening in primary care
- Ensuring that individuals who typically provide services to suicide survivors have been trained to understand and respond appropriately to their unique needs (e.g., emergency medical technicians, firefighters, police, funeral directors)
- Increasing the numbers of persons with mood disorders who receive and maintain treatment
- Ensuring that persons treated for trauma, sexual assault, or physical abuse in emergency departments receive mental health services
- Fostering the education of family members and significant others of persons receiving care for the treatment of mental health and substance abuse disorders with risk of suicide.

ACTION IDEAS:

- Work with hospital associations to develop tracking procedures for mental health follow-up.
- Distribute suicide risk posters for emergency rooms.
- Provide staff in – service training on suicide prevention.
- Sponsor depression screening days.
- Promote guidelines for aftercare treatment programs.
- Organize suicide survivors in the community to provide seminars.

Goal 8: Improve Access to and Community Linkages with Mental Health and Substance Abuse Services

The elimination of health disparities and the improvement of the quality of life for all Americans are central goals of Healthy People 2010. Some of these health disparities are attributable to differences of gender, race or ethnicity, education, income, disability, stigma, geographic location, or sexual orientation. Many of these factors place individuals at increased risk for suicidal behaviors.

Barriers to equal access and affordability of health care may be influenced by financial, structural, and personal factors. Financial barriers include not having enough health insurance or not having the financial capacity to pay for services outside a health plan or insurance program. Structural barriers include the lack of primary care providers, medical specialists or other health care professionals to meet special needs or the lack of health care facilities. Personal barriers include cultural or spiritual differences, language, not knowing when or how to seek care, or concerns about confidentiality or discrimination. Reducing disparities is a necessary step in ensuring that all Americans receive appropriate physical health, mental health, and substance abuse services. One aspect of improving access is to better coordinate the services of a variety of community institutions. This will help ensure that at-risk populations receive the services they need, and that all community members receive regular preventive health services.

The objectives established for this goal are designed to enhance inter-organizational communication to facilitate the provision of health services to those in need of them.

They include:

- Exploring the benefits for health insurance plans to cover mental health and substance abuse care on par with coverage for physical health care
- Implementing utilization management guidelines for suicidal risk in managed care and insurance plans
- Integrating mental health and suicide prevention into health and social services outreach programs for at-risk populations
- Defining and implementing screening guidelines for schools and correctional institutions, along with guidelines on linkages with service providers, and
- Implementing support programs for persons who have survived the suicide of someone close.

ACTION IDEAS:

- Work with county health and social service agencies to address the need for all staff who make visits and/or provide case management services to the elderly to be trained to make appropriate referrals to mental health services.
- Provide training for group facilitators and community meeting spaces for suicide survivor support groups.

Goal 9: Improve Reporting and Portrayals of Suicidal Behavior, Mental Illness, and Substance Abuse in the Entertainment and News Media

The media-movies, television, radio, newspapers, and magazines-have a powerful impact on perceptions of reality and on behavior. Research over many years has found that media representation of suicide may increase suicide rates, especially among youth. “Cluster suicides” and suicide contagion” have been documented, and studies have shown that both news reports and fictional accounts of suicide in movies and on

television can lead to increases in suicide. It appears that imitation plays a role in certain individuals engaging in suicidal behavior.

On the other hand, it is widely acknowledged that the media can play a positive role in suicide prevention, even as they report on suicide or depict it and related issues in movies and on television. The way suicide is presented is particularly important. Changing media representation of suicidal behaviors is one of several strategies needed to reduce the suicide rate.

Media portrayals of mental illness and substance abuse may also affect the suicide rate. Negative views of these problems may lead individuals to deny they have a problem or be reluctant to seek treatment- and untreated mental illness and substance abuse are strongly correlated with suicide.

The objectives established for this goal are designed to foster consideration among media leaders of the impact of different styles of describing or otherwise depicting suicide and suicidal behavior, mental illness, and substance abuse, and to encourage media representations of suicide that can help prevent rather than increase suicide. They include:

- Establishing a public/private group designed to promote the responsible representation of suicidal behaviors and mental illness on television and in movies
- Increasing the number of television programs, movies and news reports that observe recommended guidelines in the depiction of suicide and mental illness, and
- Increasing the number of journalism schools that adequately address reporting of mental illness and suicide in their curricula.

ACTION IDEAS:

- Identify survivors and community advocates who will be active participants in the monitoring group.
- Include survivors and advocates in curriculum development.

Goal 10: Promote and Support Research on Suicide and Suicide Prevention

All suicides are highly complex. The volume of research on suicide and its risk factors has increased considerably in the past decade and has generated new questions about why individuals become suicidal or remain suicidal. The important contributions of underlying mental illness, substance use, and biological factors, as well as potential risk that come from certain environmental influences are becoming clearer. Increasing the understanding of how individual and environmental risk and protective factors interact with each other to affect an individual's risk for suicidal behavior is the next challenge. This understanding can contribute to the limited but growing information about modifying risk and protective factors change outcomes pertaining to suicidal behavior. The objectives established for this goal are designed to support a wide range of research endeavors focused on the etiology, expression, and maintenance of suicidal behaviors across the lifespan. The enhanced understanding to be derived from this research will lead to better assessment tools, treatments, and preventive interventions. The objectives include:

- Increasing funds for suicide prevention research
- Evaluating preventive interventions, and

- Establishing a registry of interventions with demonstrated effectiveness for prevention of suicide or suicidal behavior.

ACTION IDEAS:

- Develop and distribute user-friendly toolkits on program evaluation.
- Increase the number of jurisdictions in PA that will collect and provide information on suicides.

Goal 11: Improve and Expand Surveillance Systems

Surveillance has been defined as the systematic and ongoing collection of data.

Surveillance systems are key to health planning. They are used to track trends in rates, to identify new problems, to provide evidence to support activities and initiatives, to identify risk and protective factors, to target high risk populations for interventions and to assess the impact of prevention efforts.

Data on suicide and suicidal behavior are needed at national, state and local levels.

National data can be used to draw attention to the magnitude of the suicide problem and to examine differences in rates among groups (e.g., ethnic groups), locales (e.g., rural vs. urban) and whether suicidal individuals were cared for in certain settings (e.g., primary care, emergency departments). State and local data help establish local program priorities and are necessary for evaluating the impact of suicide prevention strategies.

The objectives established for this goal are designed to enhance the quality and quantity of data available on suicide and suicidal behaviors and ensure that the data are useful for prevention purposes. They include:

- Developing and implementing standardized protocols for death scene investigations
- Increasing the number of hospitals that code for external cause of injuries
- Supporting pilot projects to link and analyze information on self-destructive behavior from various, distinct data systems.

ACTION IDEAS:

- Implement a violent death reporting system that includes suicide and collects information not currently available from death certificates.
- Develop a set of community level indicators for progress in suicide prevention.

What is Suicide Postvention?

Postvention describes any form of post-trauma support. Postvention should occur after a suicide. It is the attempt to reduce the negative consequences that may affect those close to the victim after a suicide has occurred.

Postvention includes all interventions that attempt to reduce the negative consequences that may affect those close to the victim after a suicide has occurred. Postvention should begin as soon as possible after the suicide loss.

A suicide is a critical incident. Suicide loss is a crisis. It is an acute response on the part of those close to the victim. It disrupts psychological and physical well being, overrides coping mechanisms, and causes extreme stress and distress.

Postvention is basically a special form of crisis intervention. Its purpose is to deliver acute psychological support, lessen the distress, and help restore coping ability. Effective postvention requires some skill training and an orientation to the effects of a suicide loss.

Postvention is carried out to facilitate the recovery of individuals emotionally devastated by a suicide. Recovery involves eventually rebuilding a normal life around the loss. This may take help and that help is provided through postvention.

There are four objectives to any postvention effort:

- Ease the trauma and related effects of the suicide loss
- Prevent the onset of adverse grief reactions and complications
- Minimize the risk of suicidal behavior
- Encourage resilience and coping

Postvention involves (i) providing aid and support with the grieving process and (ii) assisting those who may be vulnerable to anxiety and depressive disorders, suicidal ideation, self-medicating, and other harmful outcomes of severe grief reactions.

Some communities have specialized postvention resources to deliver short-term on-site support and referrals to other community services. However, these resources remain an unmet need in most areas.

Suicide postvention can take two forms. In proactive postvention the program is advised of a suicide (usually by the Medical examiner or Coroner) and reaches out to the family. In reactive postvention referrals and self-referrals are made to the program.

Here are some strategies for meeting this need:

- **Victim Services Model:** This approach extends the mission of a victim services unit to include suicide postvention. Such entities serve those affected by very traumatic events. They could readily assist those traumatized by suicide.
- **Medical Examiner's Office-based Model:** Postvention is offered by some Medical Examiner's Offices (e.g., Philadelphia). The ME staff are involved with all suicides and are often in contact with the next-of-kin or others close to the victim.
- **Crisis Center Model:** The American Association of Suicidology, which accredits crisis centers, promotes their involvement in suicide postvention. These services offer a natural "fit" with their roles in crisis intervention, linkages to mobile crisis services, and working relationships with police and EMTs.
- **Agency/Church Model:** In some areas social service and mental health agencies and faith-based groups have developed postvention capabilities. These entities may offer support on a long- term basis.

- Trauma Response Model: Postvention may also be offered by community or faith-based groups that help after sudden deaths or disasters. The Tragedy Response Unit Support Team (T.R.U.S.T.) in Blue, Bell, PA is an example.

Each approach has advantages and disadvantages. However, any of these approaches could go far in meeting a critical unmet need in the community.

Populations at Risk

Although suicide reaches across all populations, certain groups experience an increased suicide risk. Tendencies, such as choice of lethal means, also vary among certain groups. Sections addressing some of the issues of these groups are included.

Looking Ahead

The Pennsylvania Strategy for Suicide Prevention creates a framework for suicide prevention for Pennsylvania. It is designed to encourage and empower groups and individuals to work together. The stronger and broader the support and collaboration on suicide prevention, the greater the chance for the success of this public health initiative. Suicide and suicidal behaviors can be reduced as the general public gains more understanding about the extent to which suicide is a problem, about the ways in which it can be prevented, and about the roles individuals and groups can play in prevention efforts.

The Pennsylvania Strategy is comprehensive and sufficiently broad so that individuals and groups can select those objectives and activities that best correspond to their responsibilities and resources. The plan's objectives suggest a number of roles for different groups. Individuals from a variety of occupations need to be involved in implementing the plans, such as health care professionals, police, attorneys, educators, and clergy. Institutions such as community groups, faith-based organizations, and schools all have a necessary part to play. Sites for suicide prevention work include jails, emergency departments and the workplace. Survivors, consumers, and the media need to be partners as well, and governments at the Federal, State and local levels are key in providing funding for public health and safety issues.

Ideally, the Pennsylvania Strategy will motivate and illuminate. It can serve as a model and be adopted or modified by local communities as they develop their own suicide prevention plans. The Pennsylvania Strategy articulates the framework for statewide efforts and provides legitimacy for local groups to make suicide prevention a high priority for action.

The Pennsylvania Strategy encompasses the development, promotion and support of programs that will be implemented in communities across the state designed to achieve significant, measurable, and sustainable reductions in suicide and suicidal behaviors. This requires a major investment in public health action.

Now is the time for making great strides in suicide prevention. Implementing the Pennsylvania Strategy for Suicide Prevention provides the means to realize success in reducing the toll from this important public health problem. Sustaining action on behalf of all Pennsylvanians will depend on effective public and private collaboration because suicide prevention is truly everyone's business.

This is a working document. It is expected to change and further develop over time as new opportunities, participants, research, and conditions arise. Whether you have been involved in the initial development of the plan or are just now joining, you can make a difference by contributing to the plan's continued development.

AT RISK POPULATIONS

Military Suicide Prevention

The Department of Defense (DOD) and all branches of the service are addressing this silent killer by working with researchers, psychologists, psychiatrists, mental health professionals, doctors and others from a wide array of related disciplines.ⁱ Each service is represented on the DOD Suicide Prevention and Risk Reduction Committee and has developed individualized suicide prevention programs that are available on their websites.

Army

According to Army Deputy Chief of Staff's website the army suicide prevention mission is designed to improve readiness through the development and enhancement of the Army Suicide Prevention Program policies designed to minimize suicide behavior; thereby preserving mission effectiveness through individual readiness for Soldiers, Department of the Army civilians and their families.ⁱⁱ

<http://www.armyg1.army.mil/hr/suicide.asp>

Air Force

The Air Force Suicide Prevention Program (AFSPP) website states their prevention program mission and goals seeks to: Reduce the number and rate of active duty Air Force suicides, Advocate a community approach to suicide prevention, Provide assistance and guidance to organizations and individuals administering various components of the AFSPP and Identify factors contributing to the incidence of suicide and develop a response to reduce the impact of such factors.ⁱⁱⁱ

<https://www.afms.mil/afspp>

Marine Corps

The US Marines Corps Community Services provides a wide range of services to help Marines do everything necessary to complete their mission. The Community Services suicide prevention program website offers downloadable information on warning signs and has details on how to get help.^{iv}

<http://www.usmc-mccs.org/suicideprevent/index.cfm>

Navy

The Department of the Navy website includes their suicide prevention policy and states the Navy has a department wide prevention and training program. The Navy suicide prevention web site is designed to provide information on Navy Policy, Navy Training, and research in the area of suicide prevention training. In response to The U.S. Surgeon Call to Action Report, which pushed for the development of strategies to prevent suicide and the suffering that it causes, the Navy and Marine Corps joined forces to develop a plan to better address suicide prevention efforts.^v

<http://www.npc.navy.mil/CommandSupport/SuicidePrevention/>

Coast Guard

The Coast Guard website states that their suicide prevention program is intended to provide training that focuses on awareness and prevention of suicide, with a team

approach. Each of the members of the Coast Guard is directed to make it their individual responsibility to become aware of signs and symptoms of suicide.^{vi}

http://www.uscg.mil/hq/g-w/g-wk/wkw/EAP/suicide_prevention.htm

ⁱ United States Department of Defense. DOD Suicide Prevention Awareness Campaign Held. Retrieved March 3, 2006, from http://www.defenselink.mil/releases/2002/b11252002_bt599-02.html.

ⁱⁱ Army G-1 Human Resources Policy. Suicide Prevention Mission . Retrieved March 3, 2006, from <http://www.armyg1.army.mil/hr/suicide.asp>.

ⁱⁱⁱ U.S. Air Force. Air Force Suicide Prevention Program. Retrieved March 3, 2006, from <https://www.afms.mil/afssp>.

^{iv} Marine Corps Community Services. Suicide Prevention Program. Retrieved March 3, 2006, from <http://www.usmc-mccs.org/suicideprevent/ml/index.cfm>.

^v Navy Personnel Command. Navy Suicide Prevention Program. . Retrieved March 3, 2006, from <http://www.npc.navy.mil/CommandSupport/SuicidePrevention>.

^{vi} U.S. Coast Guard Health & Safety Directorate. Suicide Prevention. Retrieved March 3, 2006, from http://www.uscg.mil/hq/g-w/g-wk/wkw/EAP/suicide_prevention.htm

Law Enforcement Suicide Prevention

Suicide is a silent epidemic that permeates all walks of life and all types of people; it does not discriminate. There are certain populations however that are at an elevated risk for suicide. One of these populations is law enforcement personnel. The rate of suicide for police officers is 3 – 4 times higher than the general population and more active law enforcement officers die by suicide than homicide. It is estimated that 300 police officers end their lives each year, although data is often hard to obtain. One Philadelphia police department was unwilling to share their data when requested and we can only assume many more follow suit. The stigma surrounding suicide continues to be an obstacle for preventing suicide therefore more attempts to raise awareness, particularly among law enforcement personnel, need to be made.

Police are at an elevated risk for

- Divorce
- Post Traumatic Stress Disorder (PTSD)
- Alcoholism

These factors greatly enhance their risk of suicide. Stress factors, symptoms of PTSD and alcoholism as well as depression and suicidality all require recognition and early detection. Effective methods of helping officers with these issues need to incorporate as part of any law enforcement suicide prevention program.

Not surprisingly the leading cause of suicide for police is by firearms, and most suicides are completed at home. Although law enforcement officers have daily access to firearms, restriction to access of them can still be included as part of a suicide prevention training. There are other components of suicide prevention which are gaining more popularity across the country. These methods include

- Include (gatekeeper) suicide prevention training to the curriculum of cadets in the police academy
- Create peer support groups among the departments
- Encourage help seeking behavior

Dr. Joseph Violanti , a leading researcher and expert in police suicide, strongly advocates peers, supervisors and administrators learn how to detect, intervene and refer a suicidal officer (for help) as part of their training. He believes developing a program that includes psychological assessment, tracking high risk officers, access to firearms, family involvement and training would ultimately lead to a reduction of suicide among police officers.

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Suicide Prevention and Adults with Serious Mental Illness

In *Achieving the Promise: Transforming Mental Health Care in America*, the President's New Freedom Commission on Mental Health (2003) noted: "Suicide is a serious public health challenge that has not received the attention and degree of national priority it deserves." This is of concern because suicide gravely impacts those with mental illness.

Mental illness does not cause suicide. Rather those with mental illness are exposed to more risk factors that raise their vulnerability to suicidal behavior. Ironically, the public largely believes that suicide happens mainly to those who are mentally ill. This is one of the many myths of suicide.

Much of what is known about suicide comes from studies of those with mental illness. In *Night Falls Fast: Understanding Suicide* (2000), Kay Redfield Jamison tells us that the gap between what we know about suicide and its use in prevention is "lethal." Dr. Jamison is sadly right.

Here is a summary of the incidence of suicide among those with serious mental illness (SMI) such as Major Depressive Disorder, Bipolar Disorder, and Schizophrenia:

- 5% of overall SMI population completes suicide (vs. 1.5% in general population)
- Schizophrenia is involved in up to 15% of all suicides (as many as 4000 deaths yearly)
- Individuals with Schizophrenia are at more than 30 times higher risk of suicide than the general population
- 9% - 15% of Major Depressive Disorder sufferers eventually die by suicide
- Major Depressive Disorder sufferers have 21 times more suicide deaths than the general population
- 10%-15% of those with Bipolar Disorder will complete suicide
- 50% of those with Bipolar Disorder will attempt suicide at least once in their lifetime

These are some of the suicide risk factors for those with serious mental illness:

- Episodes of hopelessness, anxiety, and depression
- Young age of onset and early stage of illness
- Inadequate treatment and treatment reductions
- Frequent exacerbations/remissions
- Post-relapse improvement periods
- Psychiatric hospitalization(s) (especially the first 30 days after discharge)
- Co-occurring alcohol and other substance use and abuse

Of course, those with mental illness also have risk factors related to race and ethnicity, gender, age, a history of abuse or suicidal behavior, access to firearms, work, school, or

legal problems, and others. This accumulation of risk is what accounts for the prevalence of suicide among consumers and which necessitates preventative measures on their behalf.

These are key protective factors that counter the onset and progression of suicidality:

- Treatment adequate to need
- A caring personal support system
- Means restriction/removal (i.e., no guns, controlling medications)
- Ability to seek/accept professional help
- Availability/accessibility of help
- Mutual support for those at-risk

Given what we know about suicide and mental illness, what can we do?

All behavioral health providers, both public and private, should:

- Know the risk factors, warning signs, and myths of suicide
- Be able to talk about suicide with clients and patients
- As applicable, identify hazards in facilities that may be used to complete suicide
- Be trained in crisis intervention
- Educate families about suicide risk

Here are some specific suggestions for county mental health systems: Assure that all providers recognize suicide as a preventable community mental health problem.

1. Assure that county suicide prevention plans (i) exist, (ii) speak to the risk of adult sufferers of serious mental illness, and (iii) are being implemented.
2. Assure that county mental health plans recognize the need for aftercare and supports for suicide attempters to deter future suicidal behavior.
3. Assure that all mental health providers screen for suicidality at admission, after serious life events or losses, and after changes affecting treatment.
4. Assure that modalities such as cognitive behavioral therapy, which have been found to reduce suicidal behavior, are available.
5. Assure the availability of groups that offer mutual support and “safe places” for chronically suicidal individuals (e.g., “Suicide Anonymous”).

There is much that needs to be done, but these steps would make a real difference.

In closing, bear in mind that nothing is more detrimental to recovery from mental illness than suicidality and nothing shatters mental health wellness like losing someone to suicide. Mental health consumers are far more likely to have experience the loss of someone they know to suicide because of the high incidence of suicide among those with serious mental illness. For this reason providers should see that consumers who

experience the suicide of a loved one or close friend have access to grief support resources.

Recommendations for a VA Strategy for Suicide Prevention

The VA's strategy for suicide prevention should include **universal** components designed to activate the system as a whole for the prevention of suicide and to ensure that mental health and substance use disorders in primary and medical specialty patients are identified and treated effectively; **targeted** components designed to prevent suicide and identify periods of increased risk in veterans known to have mental health or substance use disorders; and **indicated** components designed to address the needs of veterans acutely or chronically at increased risk for suicide. The program addresses five basic principles:

Universal Components:

1. The system as a whole must act to ensure that all providers, consumers, and families understand the personal suffering and public health impact of mental health and substance use disorders, and that they recognize that suicide is usually a potentially preventable complication of psychiatric illness. The system must also ensure that access to behavioral health care is readily available to all Veterans who need it in a manner that is destigmatized. In the universal component emphasis will be placed in promoting awareness of demographic factors to suicide risk. These include:
 - Presence of psychiatric illness
 - Presence of and communication of a plan
 - Comorbid substance use disorders
 - Age 65 and older or younger for chronic substance use, bipolar or schizophrenia
 - Lack of social supports (marital status)
 - Family history
 - History of abuse
 - Presence of hopelessness
2. For Veterans in primary care, medical specialty services, and long term care, there must be systematic screening to identify those with mental health and substance use disorders, followed by strategies to ensure that diagnostic evaluations are completed, and that effective treatment is made available that address the patient's safety. Adequate assessment for suicide risk must be performed and clinician actions must be documented.

Targeted Components:

3. For Veterans with diagnosed mental disorders, treatment strategies must include evidence-based elements designed to prevent suicide. These should include specific pharmacologic strategies, reduction of access to means for self-harm, decrease patient isolation, involve family and other supports when clinically

indicated, provide ongoing monitoring for periods of increased suicide risk, and adjustment of treatment when they are present.

Indicated Components:

4. During periods when Veterans are at increased acute or subacute risk for suicide, systems must have the capacity to ensure that care of increased frequency, intensity, and comprehensiveness can be provided, including inpatient services when appropriate.
5. For veterans at high chronic or persistent risk for suicide including those with previous suicide attempts, treatment should directly target suicidal risk as well as the underlying disorders.

More specifically, the VA Strategy for Suicide Prevention should include:

1. Educating all providers about suicide prevention from the perspective of their roles within the Veterans Health Administration, specifically addressing the associations of suicide with mental health and substance use disorders, aging, pain, chronic medical illness, social isolation, and other risk factors, and the possibilities for prevention.
2. Activating and engaging the entire community, including families, Veterans Support Organizations, Veterans Benefits Administration staff, and Veterans themselves as well as the public in destigmatizing mental health and substance use disorders, in recognizing these conditions and other risk factors, and in facilitating behavioral health treatment for those who need it.
3. Screening of Veterans in primary care and medical specialty settings, and long term care for mental health and substance use disorders, followed by diagnostic evaluations and implementation of treatment, either through collaborative/integrated care models or by referral to behavioral health services. This strategy is likely to be of specific value for those who have recently entered the VHA system, for older Veterans, those with serious medical illnesses or disability, and those with chronic pain.
4. Implementing and evaluating strategies for the evaluation of Veterans with mental health and substance use disorders to identify those predisposing factors that increase the risk of suicide (e.g, social isolation, impulsivity) as well as ongoing monitoring to identify periods when they are acutely (or subacutely) at increased risk for suicide.
5. Ensuring access to care that is more frequent, intensive, or comprehensive, including inpatient services when necessary, for Veterans during periods of increased risk for suicide.

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6. Promoting of evidence-based strategies for suicide prevention into the care of all Veterans with mental health and substance use disorders including use of pharmacological treatment strategies shown to reduce the risk of suicide such as opiate maintenance treatment (e.g., buprenorphine or methadone), lithium for bipolar disorder, and clozapine for treatment of schizophrenia especially in veterans within the first 5-10 years after diagnosis.
 7. Developing and implementing strategies for reducing access to lethal means and methods of self-harm for Veterans with mental health or substance use disorders, especially for those at increased risk for suicide. These should focus on issues including firearm hygiene and attention to the manner in which medications are packaged.
 8. Developing and validating comprehensive strategies for identifying veterans with histories of suicidal behaviors that place them at high chronic risk. These should include strategies for linking with community agencies and providers to allow for identifying episodes that do not directly lead to care within the VHA, as well as for integrating information from diverse sources within the VA system. Activities should include evaluating the clinical and preventive benefits versus the privacy risks of flagging charts to facilitate the identification and close monitoring of those at chronically elevated risk of suicide.
 9. Evaluating the feasibility of establishing registries of suicide attempts to guide care planning, resource allocation, and quality management activities.
 10. Providing treatment that addresses suicidality as well as treatment of the underlying disorder for those who have attempted suicide. For those who receive acute care within VA facilities for suicide attempts or accidental overdoses, the risk of suicide should be evaluated and interventions to decrease risk should be initiated before discharge. For those who have attempted suicide in the past, as well as for others at high risk, psychotherapy that specifically addresses suicidality should be provided as well as comprehensive treatment related to the underlying disorder.
 11. Ensuing that the VA accesses comprehensive data on suicide in the population it serves obtaining the causes of death for all veterans from the states or the National Death Index on an ongoing basis, and that it utilizes these data together with that from within the VHA in quality improvement initiatives and the evaluation of the outcomes of specific programs.
 12. Prioritizing the develop of research infrastructures as well as MERIT , HSR&D, and Cooperative Studies projects devoted to expanding the evidence-base on strategies for suicide prevention.

Suicide and Alcohol Use, Misuse, and Abuse

When it comes to suicide, alcohol brings about many of things that heighten the danger. It increases impulsivity and decreases inhibition. It increases negative self-image and decreases self-esteem. It also deepens depression and social isolation.

Suicide risk increases with the intake and length of time alcohol is consumed. However, suicide risk can rise even without chronic drinking or dependence. It is probably not an overstatement to say that suicide risk increases with the first drink.

Nationally, an average of 25% of all suicides (about 7500 deaths yearly) are alcohol-related. Studies have found that 20%-35% of suicide victims used alcohol just prior to death. One study in Erie, NY determined that 33% of victims used alcohol.

Alcohol use is common among suicide attempters. Research shows that 65% used alcohol; 50% used alcohol just prior to the attempt. Many attempts occur during binge drinking episodes. Alcohol-induced impulsivity may be a factor in this behavior.

Among those who are alcohol dependent, 18% complete suicide. Suicide is 120 times more prevalent among adult alcoholics than in the general population. Alcohol also plays a major role in suicides among youths and elders.

The gender differential applies to suicides associated with alcohol misuse: men make up 80% of the victims, women 20%. According to the Centers for Disease Control (CDC), in 2001 alone, alcohol-related suicides accounted for 236,873 years of potential life lost.

The principal risk factors for suicide linked to alcohol use include:

- Interpersonal loss
- Employment/financial loss
- Family history of suicide
- Family history of alcoholism in primary relatives
- Current/past treatment for alcoholism
- Early onset of drinking
- Relapse
- High alcohol intake
- Alcohol dependence

Alcohol misusing victims typically have four or more of following factors: major depressive disorder, prior thoughts of suicide, continued drinking, poor social supports, unemployment, and living alone.

Co-occurring alcohol abuse and mental illness significantly increases risk

Those who misuse alcohol and prescription drugs misusers have a 40 times greater risk of suicide. Such co-morbidities lessen the likelihood of help and intervention.

Department of Corrections Suicide Prevention

Suicide is the third leading cause of death in prisons throughout the country, following natural causes and AIDS (Metzner, et. al., 1998). Since 1995, when there was a sharp increase in the rate of suicides among inmates in Pennsylvania, the Department of Corrections has enhanced its suicide prevention efforts. There are videotapes and brochures provided for inmates and staff trainings. Department officials also have developed a risk indicators checklist that is administered to all offenders upon entering the system. Since these initiatives were implemented, the suicide rate has declined even though the inmate population has increased. The Department compared the suicide rate with a U.S. population of similar size, adjusted for age, gender and race distribution in the community, and found that inmates fare relatively well by this measure compared to a comparable unincarcerated U.S. population. In fact, the suicide rate in the PA DOC is actually lower.

Risk Factors Among Inmates

- Mental illness: although inmates on the mental health/mental retardation roster comprises approximately 17% of the PA prison population, they comprise approximately 60% of the suicides
- Substance abusers: approximately 70% of inmates who completed/attempted suicide had histories of substance abuse
- Male: males account for approximately 95% of the PA prison population, and they comprised approximately 98% of the suicides.
- Caucasian: although Caucasians comprise only 34% of the PA prison population, they comprise over 50% of the suicides
- Elderly: due to mandatory sentencing and a reduction in parole, the PA prison population has been getting older. Depression is underdiagnosed among the elderly, and we are carefully monitoring our older offenders.
- Sex offenders: this population is a growing risk, probably related to the increased difficulty in obtaining parole
- Lifers/long term offenders: although lifers comprise 17% of the PA prison population, they comprise 40% of the suicides
- Parole violators: these are offenders who are returned to prisons after failing to adjust in the community. In some case, they may still be under the influence of alcohol or other drugs. Our speculation is that these individuals panic when they realize that their likelihood of being re-paroled might be remote
- Administrative segregation: although this population had a high rate in the past, it has decreased since new policies have been implemented

Strategies to Reduce DOC Suicides

- Training: required that all staff receive at least 2 hours of initial training followed by 1 hour of annual refresher training
- Updating policies and procedures
- Expand mental health treatment for inmates

-
- When possible, divert inmates with mental illnesses from placement in administrative segregation
 - Disseminate suicide prevention and mental health information to the inmate population
 - Increase the comprehensiveness of clinical reviews conducted following all suicides and frequency of reviews following serious gestures
 - Enhance services for non-mentally ill inmates: programs on substance abuse (AA, NA, etc...) sex offender treatment, children's visitation centers, etc.

Information for this section is taken from articles written by Lance Couturier, Ph.D., Pennsylvania Department of Corrections.

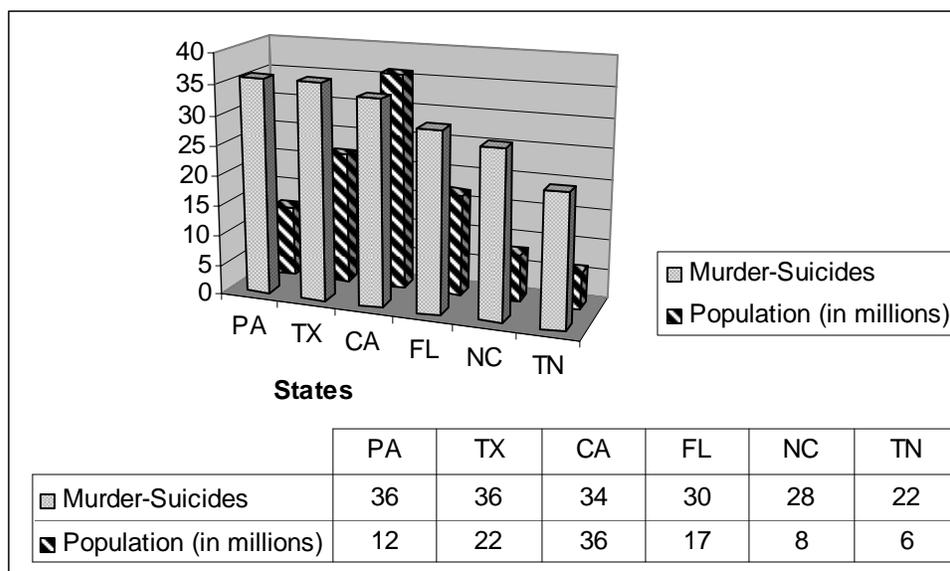
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Murder-Suicide

An often overlooked yet disturbing trend is the prevalence of murder-suicides, not only in the United States, but particularly in Pennsylvania. A new study by the Violence Prevention Center has determined there are at least 10 murder-suicides each week in the U.S. and approximately 1,000 to 1,500 deaths per year. The study was conducted from January 1, 2005 to July 1, 2005 and the results are disturbing.¹ Pennsylvania is one of six states with more than 10 murder-suicides in the six-month period of the study:

Pennsylvania 18	Florida 15
Texas 18	North Carolina 14
California 17	Tennessee 11

If you plot the number of murder-suicides vs. the population of these states, one can see Pennsylvania has a disproportionate amount of murder-suicides.



Also, in the previous report for the first six months of 2004 Pennsylvania had 17 murder-suicides per month. Whether this increase will continue has yet to be determined, but clearly this is becoming a major health problem for Pennsylvania.

There is no database and tracking system to fully report this information therefore it is likely these numbers are underestimated and there is no way to determine the number of people affected by murder-suicide. This traumatic event has the potential to severely impact not only family members, friends, and acquaintances but even the entire community, especially if a mass murder occurred.

Several trends have been identified with murder-suicide in this report. The most common method of death was by firearms, approximately 92%, and the majority of the offenders (over 90%) are male. The most common form of murder-suicide (74%) involved an intimate partner, such as a spouse, girlfriend/boyfriend, common-law spouse or ex-spouse. Because the offender is often male, approximately 94% of the deaths were females killed by their intimate partner. On average, the offenders are several years older than their partners; the average difference in age is 6 years. Most murder-suicides occur in the home (77%) with the majority taking place in the bedroom.

These murder-suicides can be characterized by the following traits and circumstances: the offender is typically male between the ages of 18 and 60, usually depressed, in a long-term relationship marked with discord and often domestic violence, with feelings of jealousy and the belief their sexual partner has been unfaithful sexually (real or imagined). When a triggering event such as a separation or threatened separation occurs, he becomes enraged, murders the partner then kills himself.

There is also a sub-category of intimate partner murder-suicides involving a male “family annihilator,” where the perpetrators not only kill their partner, but also their children and other family members before killing themselves. These offenders are also often depressed, have financial or other problems and feel the family is better off dead than to remain living and having to deal with his problems. Another theory is that these individuals view the family as an extension of themselves; they are depressed, paranoid, and suicidal, and the only way to kill themselves is to kill their families as well.²

While the majority of the murder-suicides are perpetrated by males, there are female offenders. These women usually kill their children, then themselves, and rarely, if ever, kill their intimate partner as well. The most common choice of a weapon is a firearm used approximately 63% of the time.

Unfortunately, there are no studies specific to law enforcement officers involved in murder-suicides. However, because the rate of suicide is higher in law enforcement officers than the general public, and there were several incidences involving police during the duration of the report, the conclusion was drawn that police officers also have a higher rate of murder-suicide. Access to firearms and the nature of the officers (control over and responsibility for others) contribute to this belief.

Finally, there may be a correlation between the death penalty and the murder-suicide rate. States with the death penalty tend to have more homicides and murder-suicides than states without the death penalty. Looking at the number of people on death row, and the number of murder-suicides per month, there may be a trend:

State	Murder-suicides per month	# of Inmates on Death Row
PA	18	231
TX	18	409
CA	17	649
FL	15	388
NC	14	190
TN	11	108

Interviews with inmates and details of the crimes seem to indicate that many of the homicides were meant to be murder-suicides but the offender “chickened out.” Also, in a paper presented at the World Conference on Violence and the Future of Society, Katherine van Wormer and Chuk Odiah from the University of Northern Iowa have proposed there be another category of suicide, or suicide by execution where the offenders purposely and knowingly commit their crimes in states that have the death penalty, or commit another homicide while in prison to bring about the death penalty.³ Again, there is insufficient data to confirm these beliefs.

In conclusion, the number of murder-suicides occurring in Pennsylvania is disproportionately high per our population and merits further attention. The number of people and communities affected by this traumatic event is also significant. Support for these individuals is necessary. One can only speculate at the traumatic impact on children or loved ones by witnessing, being in the proximity of, or finding the bodies after a murder-suicide. A database or method of tracking murder-suicides would help us to better understand these deaths and lead to prevention strategies. Finally, restricted access to firearms, especially when a history of depression, suicidal gestures and/or domestic violence has been reported, has the potential to greatly reduce the number of murder-suicides in Pennsylvania.

¹ American Roulette: Murder-Suicide in the United States by the Violence Policy Center, 2005

² Palermo, G. B. (1994) Murder-suicide – An extended suicide. *International Journal of Offender Therapy and Comparative Criminology* 8, (3), 205-216.

³ van Wormer, Katherine, MSSW, PhD, and Odiah, Chuk, M.Sc, PhD: Paper presented at the World Conference on Violence and the Future of Society, Dublin, Ireland, August 20-23, 1997.

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PENNSYLVANIA OLDER ADULT SUICIDE PREVENTION PLAN

Older Adults and Suicide: Pennsylvania's Strategic Plan

INTRODUCTION

In the United States, the highest rates of suicide are found among older adults. Suicidal behavior in late life is intentional and lethal, especially among older white males. The risk of dying is greater in suicide attempts made by the elderly. Risk factors can be identified; interventions and prevention can be successful. However, increasing awareness of the similarities with and the differences from adult suicide is essential for an effective plan. As the elderly population increases over the next several decades, the number of late life suicides will dramatically sky-rocket; "Baby Boomers" already have substantially higher suicide rates than the World War II and other generations before them.

The five-step public health model of prevention has been utilized here to identify the problem of suicide in older adults, identifying risk and protective factors, developing and testing interventions, implementing and evaluating interventions. It should be noted that detection of potential suicide in late life is complicated by the assumption that many of the symptoms, feelings, and circumstances in older persons are not genuine problems but the mistaken belief that these are part of the normal aging process or confused with a physical problem.

- Step 1: Defining the Problem
 - According to the CDC suicide rates increase with age and are among the highest in those 65

and older. In 2001, 5393 Americans over age 65 committed suicide, 85% were men.

- Substance Abuse and Mental Health Services Administration, (SAMHSA) older adults represent 13% of the population, however account for over 18% of all suicidal deaths.
- Older adults have more suicide completions than any other age group. The ratio of attempts to completions drops with age (4:1 in late life).
- For all women, and for men of other races, suicide rates reach their peak earlier in life.
- In Pennsylvania the highest rate of suicide is in older white men: for ages 75 – 79 there are, 32.1 suicides per 100,000, ages 80 - 84 there are 35.5 suicides per 100,000 and for ages 85 plus there are 33.2 suicides per 100,000. (Pennsylvania Department of Health, Suicide: Total number of Deaths and average annual age-specific death rates by sex and race, 1999-2003).
- Many older adults who commit suicide have recently visited a primary care physician: 20 % on the same day, 40% within one week and 70% within one month of the suicide. (National Suicide Prevention Statistics)
- Older adults who commit suicide are more likely to have suffered from a depressive illness than individuals who kill themselves at a younger age.
- Older adults suffer from a more “chronic” form of depression compared to those who suffer from depression early in life.
- The older adult population is the fastest growing population in Pennsylvania and our nation.

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- Step 2: Identifying Cause through Risk and Protective Factors Research

Risk Factors for Suicide in Older Adults

- Biological, Psychological and Social Risk Factors
 - Depression (including late-onset depression)
 - Those elders with co-morbid disorders, especially Depression, Diabetes, heart disease and stroke
 - Somatic complaints
 - Severe pain
 - Frailty and perceived health decline
 - Medications (amount and type)
 - Burdened caregivers of older adults
 - Inflexibility
 - Low self-esteem, feelings of loss of dignity or control - sense of “being a burden”
 - Anxiety, agitation, traumatic grief
 - Isolated older adults – “lack of belongingness”
 - Marital Status (Widowed, divorced)
 - Race (White)
 - Gender (Male)
 - Increased age
 - Substance abuse
 - Loss of meaning, sense of hopelessness

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- Family/ personal history of suicidality
 - Ongoing stress, high degree of perceived stress
 - Past history of mental illness
 - Previous suicide attempts
 - History of violence
- Environmental Risk Factors
 - Financial loss
 - Elders residing in care facilities
 - Desensitized to the violence of suicide
 - Availability of lethal agent
 - Social-cultural Risk Factors
 - Isolation
 - Poor social support
 - Living alone
 - Abuse
 - Family conflict
 - Loss (of relationship, role, functional capacity or support, health, work, mobility, finances), cumulative loss
 - Barriers to accessing health care, especially mental health and substance abuse treatment

Protective Factors for Suicide

- Effective clinical care for mental, physical and substance abuse disorders

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- Easy access to a variety of clinical interventions and supports in a variety of settings
 - Restricted access to highly lethal means of suicide
 - Support through ongoing medical and mental health care relationships
 - Learned skills in problem solving, conflict resolution, and nonviolent handling of disputes
 - Cultural and religious beliefs that discourage suicide and support self-preservation
 - Readily available social supports, including close friends and confidants
- Steps 3 & 4: Develop, institute and implement interventions, which can reduce the impact of risk factors or support protective factors.
 - Principles to keep in mind:
 - Suicide preventions programs should coordinate with other preventions efforts, such as substance abuse
 - Programs must address the needs of people in each stage of life
 - Programs must be culturally sensitive
 - Prevention programs are most effective when they are long-term, with opportunities for reinforcement of attitudes, behaviors and skills
 - Each community must develop a program that meets local needs and builds on local strengths

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- Program planning should represent the community with respect to age, ethnicity, faith, occupation, sexual orientation, social economic status and cultural identity.
 - Treatment of depression in late life can decrease suicidal risk

There are evidenced based practices for older adults that address depression, suicide and substance abuse. These three programs have been evaluated nationally, work in a variety of community-based settings and coordinate with other services including primary care mental health and substance abuse.

- PRISMe (SAMHSA) – Primary Care Research in Substance Abuse and Mental Health for the Elderly
 - PROSPECT (NIMH)- Prevention of Suicide in Primary Care: Elderly Collaborative Trial
 - IMPACT (Hartford Foundation)- Improving Mood Promoting Access to Collaborative Treatment
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- Step 5: Concurrent Review - Evaluate Effectiveness- A community should build in an evaluation to determine whether the selected intervention will work under local conditions. Determining the costs associated with sustaining programs and comparing those costs to the benefits of the programs is another important aspect of evaluations.

Pennsylvania Strategy for Older Adult Suicide

Prevention: Goals and Objectives

- Goal 1: Promote awareness that suicide is a preventable public health problem. Increase cooperation and collaboration between public and private entities to encourage public education campaigns, sponsor conferences on suicide and suicide prevention programs and organize special-issue forums to disseminate information on older adults and suicide.
 - Action ideas:
 - Develop public education campaigns
 - Educational materials for the Community at large
 - Educational materials for families and seniors
 - Educational materials for the “faith-based communities”
 - Sponsor statewide conferences on suicide and suicide prevention
 - Develop informational materials specifically directed to older adults. Ensure the materials include suicide risk and protective factors, community resources and address the specific issues of older adults.
 - Target organizations that serve older adults, including AARP, area agencies on aging, senior centers, retirement

programs, senior high rises, and primary care.

- Hold regional forums to present the Older Adult Suicide Prevention Plan and provide information and encouragement for outreach and coordinate planning across systems.

- Goal 2: Develop Broad-based support of Suicide Prevention.

The Initiative must address the psychological, biological and social factors affecting older adults. Encourage collaboration across the broad spectrum of aging mental health agencies, institution, private and faith-based organizations. Organizations that build cooperative relationships can blend resources, such as mental health suicide prevention in senior centers; preventative suicide education in retirement planning or at AARP sponsored programs. The objectives established for this goal are focused on developing collective leadership and on increasing the number of groups working to prevent suicide. This will ensure that suicide prevention is better understood and that organizational support exists for implementing prevention activities. Their objectives include:

- Organize a Statewide interagency committee made up of the Pennsylvania Department of Aging, Pennsylvania Department of Health, Office of Mental Health and Substance Abuse Services, Pennsylvania Medical Society, Pennsylvania Community Providers Association, Pennsylvania Psychological Association, Pennsylvania Psychiatric

Society and the Pennsylvania Behavioral Health and Aging Coalition.

- Establish public/ private partnerships dedicated to implementing the Pennsylvania Older Adult Suicide Prevention Strategy including AARP and other retirement programs, county aging offices, mental health providers, primary care physician's offices, hospital discharge planners, emergency room staff, and representatives from the arena of long-term care, faith-based organizations and insurance companies.
- Increase the number of professional, volunteer, and other groups that integrate suicide prevention activities into their ongoing activities including area agencies on aging, AARP, senior centers, and senior high rises.
- Increase the number of faith communities that adopt policies designed to prevent suicide.

- Action ideas:
 - Visit leaders of community groups, such as churches, United Way organizations, senior centers, etc... to engage their participation and support in integrating suicide preventions into ongoing programs. Include other prevention program such as substance abuse, gambling, etc...
 - Recruit and train at least one member of each aging county system to be a

community organizer for suicide preventions.

- Complete an annual mailing to hospital discharge planners, primary care offices that include the statistics of suicide in older adults, user-friendly assessment scales, and community resources.

- Goal 3: Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services.

Suicide is closely linked to mental illness and substance abuse and specifically in older adults to loss, isolation and chronic illness. However, the stigma of mental illness and substance abuse prevents many older individuals from seeking assistance. The stigma of suicide itself, the view that suicide is shameful and/ or sinful, is also a barrier to treatment of persons who have suicidal thoughts who have attempted suicide. Historically, the stigma associated with mental illness, substance abuse, and suicide has contributed to inadequate funding for prevention services and to low insurance reimbursements for treatments. It has also resulted in the establishment of separate systems for physical health and mental health care. One consequence is that preventive services and treatment for mental illness and substance abuse are much less available to older adults. Moreover, this separation has led to bureaucratic and institutional barriers between the two systems that complicate the provision of services and further impede access to care. Destigmatizing mental illness and substance use disorders could increase access to treatment by reducing

financial barriers, integrating care and increasing the willingness of individuals to seek treatment.

- Action ideas:
 - Develop a public awareness campaign including educational presentations around aging and behavioral health issues.
 - Insure prevention activities are culturally and developmentally sensitive.
 - Seek to eliminate disparities that erode suicide prevention activities.
 - Emphasize early interventions to promote protective factors and reduce risk factors for suicide.
 - Utilize Wellness models and Peer-to-Peer programs to normalize the behavioral health aspects of aging.

- Goal 4: Develop and implement suicide prevention programs.

Research has shown that many suicides are preventable; however effective suicide prevention programs require commitment and resources. The public health approach provides a framework for developing preventative interventions. Programs may be special to one organization, such as a senior center; county aging office or they may encompass an entire State. The goal is to ensure a range of interventions that in concert represent a comprehensive and coordinated program.

The objectives established for this goal are designed to foster planning and program development work and to ensure the integration of suicide prevention into organizations and agencies that have access to groups of individual for other purposes. The objectives also address the need for systematic planning at the State and Local levels, the need for technical assistance in the development of suicide prevention programs, and the need for ongoing evaluation.

- Objectives include:
 - Increasing the proportion of local communities with comprehensive suicide prevention plans
 - Increasing the number of evidence-based suicide prevention plans in community service programs, area agencies on aging, primary care sites, senior centers, and high rises.
 - Develop technical support centers to build the capacity across the state to implement and evaluate suicide prevention programs.

- Action ideas:
 - Identify lead organizations to coordinate efforts
 - Identify any current older adult suicide prevention plans across the State.

- Goal 5: Promote efforts to reduce access to lethal means and methods of self-harm.

Evidence from many counties and cultures show that limiting access to lethal means of self-harm may be an effective strategy to preventing self-destructive behaviors. Often referred to as “means restriction,” this approach is based on the belief that a small but significant minority of suicidal acts is, in fact, impulsive. They result from a combination of psychological pain or despair coupled with the easy availability of the means by which to inflict self-injury. Thus, limiting the individual’s access to the means of self-harm may prevent a self-destructive act. Evidence suggests that there may be a limited time effect for decreasing self-destructive behaviors in susceptible and impulsive individual when access to the means for self-harm is restricted. Controversy exists about how to accomplish this goal. For some, means restriction may connote redesigning or altering the existing lethal means of self-harm currently available, by educating family members or other care provider on limiting their availability.

- The objectives established for this goal are designed to separate the individuals from the lethal means of self-harm. They include:
 - Educating health care providers and safety officials on the assessment of lethal means in the home and care facilities and the actions need to reduce suicide risk in older adults.
 - Implement a public information campaign designed to reduce accessibility of lethal means.
 - Improving firearm safety design, establishing safer methods for

dispensing potentially lethal quantities of medications and safer methods for reducing carbon monoxide poisoning for automobile exhaust systems, and

- Supporting the discovery of new technologies to prevent suicide.

- Action ideas:
 - Encourage medical-personnel, staff routinely interacting with seniors, aging care managers, community high rise social workers, staff in the arena of long-term care, to routinely ask about the presence of lethal means of self-harm in the home.
 - Educate family members on how to appropriately store and secure lethal means of self-harm.

- Goal 6: Implement training for recognition of at-risk behavior and delivery of effective treatment.

Studies indicate that many health professionals are not adequately trained to provide proper assessment, treatment, and management of suicidal patients, nor do they know how to refer clients properly for specialized assessment and treatment. Despite the increased awareness of suicide as a major public health problem, gaps remain in training programs for health professionals and others who often come into contact with patients in need of these specialized assessment techniques and treatment approaches. Develop interventions that are proactive as in mailing “at risk” individuals contact cards,

develop and provide individuals with “crisis cards” that instruct individuals in a series of action steps to prevent the action of suicide. In addition, many health professionals lack training in the recognition of risk factors often found in grieving family members of loved ones who have died by suicide (suicide survivors).

Key gatekeepers, people who regularly come into contact with individuals or families in distress, need training in order to be able to recognize factors that place individuals at risk for suicide, and to learn appropriate interventions. Key gatekeepers include primary care physicians, health care office staff, aging caseworkers, senior center staff and high-rise staff, social workers and nursing staff working in the arena of long-term care, clergy, police officers, emergency health care personnel, and seniors themselves.

- The objectives established for this goal are designed to ensure that health professional and key community gatekeepers obtain the training that will help them prevent suicide. They include:
 - Improving education for nurses, physician assistants, physicians, social workers, emergency room staff, home health care providers, aging case workers, clergy, police officers, psychologists, and other counselors
 - Outreach to senior centers, high rises, retirement communities and the arena of long term care to ensure individuals

having contact with seniors are aware of risk factors of suicide in older adults

- Providing training for seniors themselves through senior center training and educational programs with AARP and other retirement organizations on how to identify and respond to persons at risk for suicide
- Providing educational programs for family members of persons at elevated risk.

- Action Ideas

- Include workshops on suicide prevention at annual meeting of professional associations
- Specifically target primary care physicians for education about risk factors, identification of depressive symptoms, and effective treatment of depression (medication and therapy).
- Provide educational programs through the County Agency on Aging to outreach to Aging staff, Senior Centers and high rises.
- Include workshops on suicide prevention at the annual meetings of the long-term care associations
- Encourage directors of education at professional schools in PA to include suicide prevention training in the curriculum.

- Goal 7: Develop and promote effective clinical and professional practices.

One way to prevent suicide is to identify individuals at risk and to engage them in treatments that are effective in reducing the personal and situational factors associated with suicidal behaviors (e.g.: loss, physical problems, depressed mood, hopelessness, helplessness, alcohol and other drug abuse, among others). Another way to prevent suicide is to promote and support the presence of protective factors, such as learning skills in problem solving, conflict resolution, and nonviolent handling of disputes. By improving clinical practices in the assessment, management, and treatment for individuals at risk for suicide, the chances for preventing those individuals from acting on their despair and distress in self-destructive ways are greatly improved. Moreover, promoting the presence of protective factors for these individuals can contribute importantly to reducing their risk.

- The objectives established for this goal are designed to heighten awareness of the presence or absence of risk and protective conditions associated with suicide, leading to better triage systems and better allocation of resources for those in need of specialized treatment. They include:
 - Changing procedures and/or policies in certain settings, including hospital emergency departments, substance abuse treatment centers, specialty mental health treatment centers, the arena of long-term care, and various institutional treatment settings, designed to assess suicide risk
 - Incorporating suicide risk screening in primary care

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- Ensuring that individuals who typically provide services to suicide survivors have been trained to understand and respond appropriately to their unique needs (e.g., emergency medical technicians, firefighters, police, funeral directors)
 - Increasing the numbers of older adults suffering from mood disorders who receive mental health treatment.
 - Ensuring that persons treated for trauma, sexual assault, or physical abuse in emergency departments receive mental health services
 - Fostering the education of family members and significant others of persons receiving care for the treatment of mental health and substance abuse disorders with risk of suicide.

 - Action ideas:
 - Work with hospital associations to develop tracking procedures for mental health follow-up.
 - Work with medical schools, nursing programs and allied health training programs so geriatric behavioral health issues are addressed in curriculums.
 - Distribute suicide risk posters for emergency rooms.
 - Provide staff in service training on suicide prevention.
 - Sponsor depression screening days.
 - Promote guidelines for aftercare treatment programs.
 - Organize suicide survivors in the community to provide seminars.

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- Promote factors for successful aging in variety of settings and among various mental health and health care professionals including home health; such factors would include combating depression, maintaining active engagement with life, increasing social support, improving nutrition, improving sleep hygiene, increasing exercise, establishing connections and relationships).
 - Promote principles of mental health recovery (including resilience)
 - Promote education among professionals on effective clinical practices for suicide screening and identification, treatment, and prevention (i.e., use of role playing and safety plans)
 - Promote hopefulness about the treatment of depression in late life and possibility of successful aging even in the presence of physical and mental illness
- Goal 8: Improve access to and build community linkages with mental health and substance abuse services.

The elimination of health disparities and the improvement of the quality of life for all Americans are central goals of Healthy People 2010. Some of these health disparities are attributable to differences of gender, race or ethnicity, education, income, disability, stigma, geographic location, or sexual orientation, however age remains the largest

disparity in regards to behavioral health service provision. This factors in and of itself places older adults at increased risk for suicidal behaviors. Barriers to equal access and affordability of health care may be influenced by financial, structural, and personal factors. Financial barriers include not having enough health insurance or not having the financial capacity to pay for services outside a health plan or insurance program. Structural barriers include the lack of understanding of age specific behavioral health needs across disciplines, lack of training of primary care providers in recognizing of age specific behavioral health needs, lack of willingness of mental health providers to serve older adults, lack of medical specialists or other health care professionals to meet special needs of older adults or the lack of health care facilities. Personal barriers include ageism, cultural or spiritual differences, language, not knowing when or how to seek care, or concerns about confidentiality or discrimination. Reducing disparities is a necessary step in ensuring that all Americans receive appropriate physical health, mental health, and substance abuse services. One aspect of improving access is to better coordinate the services of a variety of community institutions. This will help ensure that at-risk populations receive the services they need, and that all community members receive regular preventive health services. The objectives established for this goal are designed to enhance inter-organizational communication to facilitate the provision of health services to those in need of them. They include:

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- Exploring the benefits for health insurance plans to cover mental health and substance abuse care on par with coverage for physical health care
 - Implementing utilization management guidelines for suicidal risk in managed care and insurance plans
 - Integrating mental health and suicide prevention into health and social services outreach programs for at-risk populations
 - Defining and implementing screening guidelines for primary care, senior centers, and the arena of long term care, along with guidelines on linkages with service providers, and
 - Implementing support programs for persons who have survived the suicide of someone close.
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- Action ideas:
 - Work with county health and social service agencies to address the need for all staff who make visits and/or provide case management services to the elderly to be trained to make appropriate referrals to mental health services.
 - Support the Memorandums of Understanding between the County Mental Health and Aging Systems ensuring cross system training, teamwork and case review stressing the need for outreach and education to seniors on suicide prevention.

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- Provide training for group facilitators and community meeting spaces for suicide survivor support groups
 - Goal 9: Improve reporting and portrayals of suicide behavior, mental illness and substance abuse in the entertainment and news media.

The media-movies, television, radio, newspapers, and magazines-have a powerful impact on perceptions of reality and on behavior. Research over many years has found that media representation of suicide may increase suicide rates, especially among youth. “Cluster suicides” and “suicide contagion” have been documented, and studies have shown that both news reports and fictional accounts of suicide in movies and on television can lead to increases in suicide. It appears that imitation plays a role in certain individuals engaging in suicidal behavior. On the other hand, it is widely acknowledged that the media can play a positive role in suicide prevention, even as they report on suicide or depict it and related issues in movies and on television. The way suicide is presented is particularly important. Changing media representation of suicidal behaviors is one of several strategies needed to reduce the suicide rate. Media portrayals of mental illness and substance abuse may also affect the suicide rate. Negative views of these problems may lead individuals to deny they have a problem or be reluctant to seek treatment- and untreated mental illness and substance abuse are strongly correlated with suicide.

The objectives established for this goal are designed to foster consideration among media leaders of the impact

of different styles of describing or otherwise depicting suicide and suicidal behavior, mental illness, and substance abuse, and to encourage media representations of suicide that can help prevent rather than increase suicide. They include:

- Establishing a public/private group designed to promote the responsible representation of suicidal behaviors and mental illness on television and in movies
- Increasing the number of television programs, movies and news reports that observe recommended guidelines in the depiction of suicide and mental illness, and
- Increasing the number of journalism schools that adequately address reporting of mental illness and suicide in their curriculums.
- Action ideas:
 - Identify survivors and community advocates who will be active participants in the monitoring group.
 - Include survivors and advocates in curriculum development
- Goal 10: Promote and support research on suicide and suicide prevention.

All suicides are highly complex. The volume of research on suicide and its risk factors has increased considerably in the past decade and has generated new questions about why individuals become suicidal or remain suicidal. The important contributions of underlying mental illness, substance use, and

biological factors, as well as potential risk that come from certain environmental influences are becoming clearer. Increasing the understanding of how individual and environmental risk and protective factors interact with each other to affect an individual's risk for suicidal behavior is the next challenge. This understanding can contribute to the limited but growing information about modifying risk and protective factors change outcomes pertaining to suicidal behavior.

The objectives established for this goal are designed to support a wide range of research endeavors focused on the etiology, expression, and maintenance of suicidal behaviors across the lifespan. The enhanced understanding to be derived from this research will lead to better assessment tools, treatments, and preventive interventions. The objectives include:

- Increasing funds for suicide prevention research
 - Evaluating preventive interventions, and
 - Establishing a registry of interventions with demonstrated effectiveness for prevention of suicide or suicidal behavior.
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- Action ideas:
 - Develop and distribute user-friendly toolkits on program evaluation.
 - Increase the number of jurisdictions in PA that will collect and provide information on suicides.

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- Goal 11: Improve and expand surveillance.
Surveillance has been defined as the systematic and ongoing collection of data. Surveillance systems are key to health planning. They are used to track trends in rates, to identify new problems, to provide evidence to support activities and initiatives, to identify risk and protective factors, to target high risk populations for interventions and to assess the impact of prevention efforts.
Data on suicide and suicidal behavior are needed at national, state and local levels. National data can be used to draw attention to the magnitude of the suicide problem and to examine differences in rates among groups (e.g., ethnic groups), locales (e.g., rural vs. urban) and whether suicidal individuals were cared for in certain settings (e.g., primary care, emergency departments). State and local data help establish local program priorities and are necessary for evaluating the impact of suicide prevention strategies.

The objectives established for this goal are designed to enhance the quality and quantity of data available on suicide and suicidal behaviors and ensure that the data are useful for prevention purposes. They include:

- Developing and implementing standardized protocols for death scene investigations
- Increasing the number of hospitals that code for external cause of injuries
- Supporting pilot projects to link and analyze information on self-destructive behavior from various, distinct data systems.

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- Action ideas:
 - Implement a violent death reporting system that includes suicide and collects information not currently available from death certificates.
 - Develop a set of community level indicators for progress in suicide prevention.

Looking Ahead

The Pennsylvania Strategy for Suicide Prevention, as it includes a plan for Older Adults, creates a framework for suicide prevention for Pennsylvania. It is designed to encourage and empower groups and individuals to work together. The stronger and broader the support and collaboration on suicide prevention, the greater the chance for the success of this public health initiative. Suicide and suicidal behaviors can be reduced as the general public gains more understanding about the extent to which suicide is a problem, about the ways in which it can be prevented, and about the roles individuals and groups can play in prevention efforts.

The Pennsylvania Strategy is comprehensive and sufficiently broad so that individuals and groups can select those objectives and activities that best correspond to their responsibilities and resources. The plan's objectives suggest a number of roles for different groups. Individuals from a variety of occupations need to be involved in implementing the plans, such as aging service personal, health care professionals, police, attorneys, educators, and clergy, to name a few. Institutions such as the aging community, senior groups, AARP, faith-based

organizations, long-term care, and the system of higher education all have a necessary part to play. Sites for suicide prevention work include senior centers, nursing homes, primary care, emergency departments, and other venues seniors may frequent. Survivors, consumers, and the media need to be partners as well, and governments at the Federal, State and local level levels are key in providing funding for public health and safety issues.

Ideally, the Pennsylvania Strategy will motivate and illuminate. It can serve as a model and be adopted or modified by local communities as they develop their own suicide prevention plans. The Pennsylvania Strategy articulates the framework for statewide efforts and provides legitimacy for local groups to make suicide prevention a high priority for action.

The Pennsylvania Strategy encompasses the development, promotion and support of programs that will be implemented in communities across the state designed to achieve significant, measurable, and sustainable reductions in suicide and suicidal behaviors. This requires a major investment in public health action.

Now is the time for making great strides in suicide prevention. Implementing the Pennsylvania Strategy for Suicide Prevention provides the means to realize success in reducing the toll from this important public health problem. Sustaining action on behalf of all Pennsylvanians will depend on effective public and private collaboration, because suicide prevention is truly everyone's business.

This is a working document. It is expected to change and further develop over time as new opportunities, participants, research, and conditions evolve. Whether you have been involved in the initial development of the plan or are just now joining, you can make a difference by contributing to the plan's continued development.



PENNSYLVANIA YOUTH SUICIDE PREVENTION FIVE-YEAR ACTION PLAN

August 2007-July 2012

The Suicide Prevention Monitoring Committee ensures implementation of the following 11 goals taken from the PA Youth Suicide Prevention Plan developed in 2001. The first 5 year action plan (2002-2007) emphasized the first four goals in both statewide and county activities. A planning meeting held in October 2007 recommended continuing to prioritize the first 3 goals and objectives of the first 5 year plan while making increased commitments to Goals 6, 7, and 8. Since many of the tasks listed in the first 5 year plan have been completed, new tasks and activities are currently being developed.

GOALS:

- Goal 1:** Promote Awareness that Youth Suicide is a Public Health Problem that is Preventable
- Goal 2:** Develop Broad-based Support for Youth Suicide Prevention
- Goal 3:** Develop and Implement Strategies to Reduce the Stigma Associated with Being a Youth Consumer of Mental Health, Substance Abuse, and Suicide Prevention Services
- Goal 4:** Identify, Develop, and Implement Youth Suicide Prevention Programs
- Goal 5:** Promote Efforts to Reduce Access to Lethal Means and Methods of Self-Harm
- Goal 6:** Implement Training for Recognition of At-Risk Behavior and Delivery of Effective Treatment
- Goal 7:** Develop and Promote Effective Clinical and Professional Practices
- Goal 8:** Improve Access to and Community Linkages with Mental Health and Substance Abuse Services
- Goal 9:** Improve Reporting and Portrayals of Suicidal Behavior, Mental Illness, and Substance Abuse in the Entertainment and News Media
- Goal 10:** Promote and Support Research on Youth Suicide and Youth Suicide Prevention
- Goal 11:** Improve and Expand Surveillance Systems

Goal 1: Promote Awareness that Youth Suicide is a Public Health Problem that is Preventable.

OBJECTIVES	TASKS	ACTIVITIES TO DATE: January 2008
1. Develop public education campaigns	Develop fact sheets and place them on various state websites. Include information about depression, suicide and other behavioral health problems in the curriculum for education conferences	
2. Encourage a variety of organizations to add youth suicide prevention topics to their conferences/meetings, sponsor conferences and organize special issue forums	Sponsor an annual statewide suicide prevention conference. Provide suicide prevention fact sheets for use at organizations addressing this topic at other types of conferences and forums.	Held the first statewide Suicide Prevention Conference in September 2007. Planning committee is planning the second Suicide Prevention Conference to be expanded to two days in September 2008.
3. Increase awareness of Youth Suicide Prevention programs, activities, and information, including disseminating information through the internet.	Provide consistent updates to the newly acquired website domains: www.paspi.org and www.paspi.info	Child Death Review has purchased the domains for the next 4 years for use by the PA Suicide Prevention Initiative. A webmaster has been chosen. Meeting to discuss management of the website to be held in February.

Goal 2: Develop Broad-based Support for Youth Suicide Prevention

OBJECTIVES	TASKS	ACTIVITIES TO DATE: January 2008
1. Continue to support the state interagency committee to improve coordination and to ensure implementation of the state action plan	Hold sufficient Monitoring Committee and Subcommittee meetings to ensure implementation of the goals and objectives in the plan.	Monitoring Committee meetings held at least quarterly. Subcommittees held as needed. Suicide Prevention in Primary Care Subcommittee assisted in preparation of proposal for Garrett Lee Smith Youth Suicide Prevention grant opportunity.
2. Continue to support public/private partnerships dedicated to implementing the PA strategy	Provide opportunities for adequate communication among partners. Collaborate with organizations and Universities to promote Suicide Prevention trainings and activities	Members of the Monitoring Committee have provided resources for hosting meetings. Child Death Review has provided conference call resources to enable regular communication.

3. Increase the number of professional, volunteer, faith community, and other groups that integrate youth suicide prevention activities into their programs, and adopt policies to prevent youth suicide	Contact other states to get additional ideas.	
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Goal 3: Develop and Implement Strategies to Reduce the Stigma Associated with Being a Youth Consumer of Mental Health, Substance Abuse, and Suicide Prevention Services

OBJECTIVES	TASKS	ACTIVITIES TO DATE: January 2008
1. To increase treatment of the underlying mental health and/or substance abuse issues many suicidal youth experience by decreasing stigma associated with treatment	Tasks to be determined	
2. To transform public attitudes to view mental and substance abuse disorders as real illnesses, equal to physical illness, that respond to specific treatments, and to view youth who obtain treatment as pursuing basic health care	Tasks to be determined	

Goal 4: Identify, Develop, and Implement Youth Suicide Prevention Programs

OBJECTIVES	TASKS	ACTIVITIES TO DATE: January 2008
1. Increase the proportion of local communities with comprehensive suicide prevention plans	Identify a contact person for suicide prevention in every county.	Decision made to pursue the possibility of utilizing contacts in the county Child Death Review Teams.
2. Increase the number of evidence-based suicide prevention programs in schools, colleges, and family, youth and community service programs	Continue to encourage the use of TeenScreen, Signs of Suicide (SOS), Yellow Ribbon, and QPR.	
3. Develop technical support activities to build the capacity across the state to implement and evaluate suicide prevention programs	Tasks to be determined.	

Goal 5: Promote Efforts to Reduce Access to Lethal Means and Methods of Self-Harm

OBJECTIVES	TASKS	ACTIVITIES TO DATE: January 2008
1. Educate parents, health care providers, health and safety officials, and school personnel on: the assessment of lethal means in the home, school, and community, and identifying actions to reduce the means of self-harm in their environments	Identify resource persons who can facilitate education in community settings.	STAR Center has identified some resources and they will be pursued.
2. Implement a public information campaign designed to reduce accessibility of lethal means	To be determined.	

Goal 6: Implement Training for Recognition of At-Risk Behavior and Delivery of Effective Treatment

OBJECTIVES	TASKS	ACTIVITIES TO DATE: January 2008
1. Improve education for nurses, physician assistants, physicians, social workers, psychologists, addictions and other counselors	Promote the use of resources on the SPRC website.	
2. Provide training for clergy, teachers and other educational staff, corrections workers, staff of child-serving systems such as children and youth case workers, child welfare personnel, juvenile justice personnel, and attorneys on how to identify and respond to youth at risk for suicide	Expand prevention programs in juvenile detention centers. Identify particular risks for suicide in specific communities and barriers to help-seeking.	“Feeling Blue” has been providing QPR training statewide.
3. Provide training for leaders of youth, community and faith-based organizations and groups, child care providers, athletic associations, "adult mentors" and "peer mentors" on how to identify and respond to youth at risk for suicide	Promote the use of suicide prevention programs including QPR.	“Feeling Blue” has been providing QPR training statewide.
4. Provide educational programs for family members of youth at elevated risk	To be determined.	
5. Provide educational programs for all students for recognition of at-risk behavior and how to respond.	To be determined.	

Goal 7: Develop and Promote Effective Clinical and Professional Practices

OBJECTIVES	TASKS	ACTIVITIES TO DATE: January 2008
1. Change procedures and/or policies in certain settings, including primary care settings, hospital emergency departments, substance abuse treatment centers, specialty mental health treatment centers, and various institutional treatment settings, to include screening and assessment of youth suicide risk	Develop grant proposal to support the use of screening in primary care settings,	SAMHSA grant proposal submitted.
2. Ensure that individuals who typically provide services to youth suicide survivors have been trained to understand and respond appropriately to their unique needs (e.g., emergency medical technicians, firefighters, police, funeral directors)	Encourage use of resources from SPRC website.	
3. Increase the numbers of youth who receive support and continued treatment services (including consistent follow-up) for mood disorders and other behavioral health disorders difficult to detect such as substance abuse	To be determined.	
4. Ensure that youth treated for trauma, sexual assault, or physical abuse in all healthcare settings, including in emergency departments receive consultation, referral, mental health services, and/or support services. These support services may include domestic violence centers, rape crisis centers, etc	Encourage local task forces to promote the use of resources available on the SPRC website.	
5. Foster the education by providers of mental health and substance abuse services for family members and significant others of youth receiving care for the treatment of mental health and substance abuse disorders on the risk of suicide.	Develop grant proposal to support the training of behavioral health professionals to work with families.	SAMHSA grant proposal submitted.

Goal 8: Improve Access to and Community Linkages with Mental Health and Substance Abuse Services

OBJECTIVES	TASKS	ACTIVITIES TO DATE: January 2008
1. Explore the benefits for health insurance plans to cover mental health and substance abuse care on par with coverage for physical health care	To be determined.	
2. Implement utilization management guidelines for suicidal risk in managed care and insurance plans	To be determined.	
3. Integrate culturally competent mental health and suicide prevention into health and social services outreach programs for at-risk populations.	Continue to support the foundational efforts through OMHSAS for culturally competent care.	
4. Defining and implementing screening guidelines for schools, colleges, state professional organizations, and corrections institutions, along with guidelines on linkages with service providers	To be determined.	
5. Implementing support programs for youth who have survived the suicide of someone close	To be determined.	

Goal 9: Improve Reporting and Portrayals of Suicidal Behavior, Mental Illness, and Substance Abuse in the Entertainment and News Media

OBJECTIVES	TASKS	ACTIVITIES TO DATE: January 2008
1. Increase the number of local television programs and news reports that observe recommended guidelines in the depiction of suicide and mental illness	To be determined.	
2. Increase the number of journalism schools that adequately address reporting of mental illness and suicide in their curricula	To be determined.	
3. Promote awareness of the influence of the entertainment industry	To be determined.	

Goal 10: Promote and Support Research on Youth Suicide and Youth Suicide Prevention

OBJECTIVES	TASKS	ACTIVITIES TO DATE: January 2008
1. Promote youth suicide prevention research	Support the work of the Suicide Prevention in Primary Care Subcommittee. Support the work of members of Monitoring Committee who are doing research.	The Suicide Prevention in Primary Care Subcommittee has assisted in developing the r
2. Evaluate preventive interventions	Support the evaluation component of the Suicide Prevention in Primary Care Project recommended by the Suicide Prevention in Primary Care Subcommittee.	Evaluation component developed as part of the grant proposal to SAMHSA for the Suicide Prevention in Primary Care Project.
3. Establish a registry of interventions with demonstrated effectiveness for prevention of suicide or suicidal behavior.	Utilize existing registry from Suicide Prevention Resource Center (SPRC) and create link to www.sprc.org from newly acquired state website.	Members of Monitoring Committee consistently and regularly check the SPRC website. Many resources from website are being utilized in local communities. Some resources will be used in the Suicide Prevention in Primary Care Project.

Goal 11: Improve and Expand Surveillance Systems

OBJECTIVES	TASKS	ACTIVITIES TO DATE: January 2008
1. Improve analysis and availability of statewide child death review data.	Create regular opportunities for review of child death review data and analyze for trends.	Monitoring Committee reviewed Child Death Review data in October 2007.
2. Increase the number of hospitals that code for external cause of injuries	To be determined.	
3. Produce an annual report on youth suicide	Develop an outline and format for report to be completed in June of each year.	
4. Encourage the development of pilot projects to link and analyze information on self-destructive behavior from various, distinct data systems.	Request information from partners on Monitoring Committee.	Juvenile Detention Centers Association of PA (JDCAP) has collected data on increasing suicide in detained youth. Data are available at jdcap .

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T. Use of Technology

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Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Footnotes:

T. Use of Technology

Currently, Pennsylvania has Telepsychiatry programs serving the counties listed in the table below; several of these programs also serve children and adolescents. Telepsychiatry is the use of electronic communication and information technologies to provide or support clinical psychiatric care at distance. The service includes evaluating patients in crisis and in need of inpatient hospitalization, assessment, medication management, and psychotherapy. It is appropriate in situations where on-site services are not available due to distance, location, time of day, or availability of resources. Telepsychiatry is a service shown to be effective in rural settings. These services are provided by a psychiatrist or licensed psychologist within their scope of practice using real-time, two-way interactive audio-video transmission.

Beaver County	Berks County	Carbon County
Monroe County	Pike County	Schuylkill County
Bucks County	Cambria County	Clarion County
Clearfield County	Elk County	Jefferson County
Erie County	Fayette County	Warren County
Greene County	Indiana County	Bradford County
Luzerne County	Lycoming County	Cameron County
McKean County	Wyoming County	McKean County
Potter County	Tioga County	Somerset County
York/Adams Counties	Chester County	Allegheny County
Mifflin County	Clinton County	Blair County
Dauphin County	Cumberland County	Perry County
Sullivan County	Lackawanna County	Susquehanna County
Wayne County	Lehigh	

IV: Narrative Plan

U. Technical Assistance Needs

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Narrative Question:

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:

The state is not requesting any technical assistance at this time.

IV: Narrative Plan

V. Support of State Partners

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Narrative Question:

The success of a state's MHBG and SABG 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. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information exchanges (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.⁴⁵ This could include, but is not limited to:

- The State Medicaid Agency 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 the expanded Medicaid population.
- The state justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders 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 actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, 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. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

⁴⁵ SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

Footnotes:

V. Support of State Partners

Pennsylvania enjoys a large and diverse Advisory structure. Comprised of an Adult, Children's, and Older Adult Committee, as well as "*Persons in Recovery*" and Transition-Age Youth Subcommittees, the cumulative membership exceeds 90 individuals. The Advisory Committee draws membership from consumers/survivors, family members, county officials, behavioral health providers, advocates, and other professional mental health and state agencies. The Committee 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 Committee 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, and the Pennsylvania Department of Aging.

IV: Narrative Plan

W. State Behavioral Health Advisory Council

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Narrative Question:

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. SAMHSA encourages states to expand and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that 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 (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council.

Footnotes:

W. State Behavioral Health Advisory Council

1. What planning mechanism does the state use to plan and implement substance abuse services? How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?

Response: Pennsylvania's Mental Health Planning Council has a subcommittee charged with bringing the issues and needs relevant to the co-occurring population before the Adult, Older Adult, and Children's committees. Members of the Persons in Recovery subcommittee are voting members that sit on each of three aforementioned committees. The Bureau of Drug and Alcohol Programs (the State's substance abuse agency) also has representation on the Advisory Committee and is able to advise on initiatives, regulations, and licensure as it pertains to integrated treatment for individuals with co-occurring disorders.

2. Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.

Response: Yes. A stakeholder workgroup was convened with representation from each of the committees (Adult, Older Adult, Children's and Persons in Recovery) to identify and develop Pennsylvania's state priorities. In order to solicit feedback from the entire Planning Council (over 90 members), an email was sent out via the listserv inviting members to provide input and ideas around the priority areas that were then presented to the workgroup.

3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?

Response: The Commonwealth's Mental Health Planning Council has a "*Persons in Recovery*" (PIR) subcommittee whose primary focus is on substance use issues and co-occurring psychiatric and substance use issues. They are currently engaged in promoting recovery awareness for both disorders and exploring opportunities to increase public awareness of the resources available in the state to support prevention, treatment and recovery from substance use and co-occurring disorders. At each quarterly committee meeting, a representative from the Persons in Recovery (PIR) subcommittee provides an update on the work and initiatives currently in progress. At the September meeting, the PIR subcommittee engages the entire Planning Council in "Celebrating Recovery," which promotes further awareness and education of substance abuse issues in recognition of SAMHSA's National Recovery Month. This provides an opportunity to showcase the work that has been accomplished in the state at agency, county, and individual levels. The PIR subcommittee has been part of the Planning Council for the past two years and continues to identify substance use and co-occurring issues that impact the work of the Council. The PIR

sub-committee provides voices for individuals in recovery, family members, and recovery organizations across the state.

4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

Response: Yes.

5. Please describe the duties and responsibilities of the Council.

Response: The responsibilities of the Mental Health Planning Council are outlined in the OMHSAS Advisory Committee Protocol. The protocol states, “It is the responsibility of all Committee members to be cognizant of and actively participate in fulfilling expectations as representatives of the broad range of individuals served by PA Office of Mental Health & Substance Abuse Services – Advisory Committees’ Protocol 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; and
- C. To monitor, review, and evaluate, not less than once every year, the allocation and adequacy of mental health services within the State.

The document can be accessed in its entirety at:

http://www.parecovery.org/advisory_materials/Advisory_Committee_Protocols.pdf

IV: Narrative Plan

Behavioral Health Advisory Council Members

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Start Year:
 End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Marilyn Baker	Family Members of Individuals in Recovery (to include family members of adults with SMI)		PO Box 1024 Paoli, PA 19301 PH: 610-296-0377	mvbaker@verizon.net
Carol Baker	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		PO Box 5837 Belleville, PA 17004 PH: 717-645-5622	carol63@kftinc.net
Jazmin Banks	Family Members of Individuals in Recovery (to include family members of adults with SMI)		PO Box 23144 Philadelphia, PA 19124 PH: 215-744-0402	jazmin.banks@comcast.net
Susan Bartholomew-Palmer	Family Members of Individuals in Recovery (to include family members of adults with SMI)		63 Covell St. Wilkes-Barre, PA 18702 PH: 570-262-6760	barth@epix.net
Bernadette Bianchi	Others (Not State employees or providers)		2040 Linglestown Rd. Ste. 109 Harrisburg, PA 17110 PH: 717-651-1725	bernadetteb@pccyfs.org
Darlene Black	State Employees		1401 N. 7th St. Harrisburg, PA 17105 PH: 717-787-3987	dablack@pa.gov
Thomas Brandon	Family Members of Individuals in Recovery (to include family members of adults with SMI)		28 Pennsylvania Ave. Brookville, PA 15825 PH: 814-849-3228	tpbrandon@windstream.net
Diana Brocious	Family Members of Individuals in Recovery (to include family members of adults with SMI)		431 Dever Hollow Rd. Templeton, PA 16259 PH: 800-947-4941	pafamilies@comcast.net
Gail Cash	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1038 Newton Ave. Erie, PA 16511 PH: 814-899-0997	irishngail@verizon.net
Tim Connors	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		37 State Rd Apt A-11 Media, PA 19063 PH: 814-943-0414	tconnors@mhasp.org
Maria DeFelice	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		36 S. Queen Street York, PA 17403 PH: 717-843-6973	mdefelice@mhay.org
Shelley Dorfi	Providers		2201 E. State St. Hermitage, PA 16148 PH: 724-342-3323	sdorfi@cccmer.org
John Farmer	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2101 Chestnut St., Unit #1602 Philadelphia, PA 19103 PH: 800-688-4226	jfarmer@mhasp.org
Maureen Feeny-Byrnes	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		PO Box 311 Norristown, PA 19403 PH: 610-278-3626	mfeenyby@montcopa.org

Cheryl Floyd	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	1800 State Street Harrisburg, PA 17103 PH: 717-545-8929	info@themiraclegroup.org
Lisa Fox	Providers	5180 Cambells Run Rd Pittsburgh, PA 15205 PH: 412-788-8219	lfox@thebradleycenter.org
Hikmah Gardiner	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	1101 Market St., 7th Fl Philadelphia, PA 19107 PH: 215-685-5315	hikmah.gardiner@phila.gov
William Garrow	Others (Not State employees or providers)	93 East High St, B-Level Waynesburg, PA 15370 PH: 724-852-1510	bgarrow@swpa-aaa.org
Jim Gavin	Providers	One Chatham Ctr Ste. 700 Pittsburgh, PA 15219 PH: 412-454-2146	gavinjg@ccbh.com
Sandra Goetze	Family Members of Individuals in Recovery (to include family members of adults with SMI)	416 E. New Castle Zelienople, PA 16063 PH: 724-452-4279	sgoetze@zoominternet.net
Keith Graybill	State Employees	PA Judicial Center 601 Commonwealth Ave, Suite 9100, PO Box 62425 Harrisburg, PA 17120 PH: 717-705-9006	kgraybill@pa.gov
Beverly Haberle	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	252 W Swamp Rd Suite 12- 14 Doylestown, PA 18901 PH: 215-345-6644	bhaberle@bccadd.org
Marge Hanna	Family Members of Individuals in Recovery (to include family members of adults with SMI)	17 Naylor Court Quakertown, PA 18951 PH: 215-773-9313	hanname@ccbh.com
Denise Holden	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	1820 Linglestown Rd Suite 101 Harrisburg, PA 17110 PH: 717-232-8535	sasirase@aol.com
Darryl Holts	Others (Not State employees or providers)	429 Fourth Ave Pittsburgh, PA 15219 PH: 412-258-2129	dholts@drnpa.org
Robin Horst-Spencer	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	5907 Penn Ave, Suite 215 Pittsburgh, PA 15206 PH: 412-361-0142	messagecarriers50@gmail.com
Anthony House	Providers	PO Box 6600 Harrisburg, PA 17112 PH: 717-671-6541	ahouse@cbhnp.org
Paulette Hunter	Family Members of Individuals in Recovery (to include family members of adults with SMI)	PO Box 4056 Allentown, PA 18105 PH: 610-770-9394	phcollaboration@aol.com
Crystal Karenchak	Others (Not State employees or providers)	490 Washington St. St. Marys, PA 15857 PH: 814-834-9551	madmqueenck@netscape.net
Lynn Keltz	Others (Not State employees or providers)	4501 Derry St Harrisburg, PA 17111 PH: 717-564-4930	lynn@pmhca.org
George Kimes	Providers	2101 N. Front St. Bldg 3 Ste. 200 Harrisburg, PA 17110 PH: 717-364-3280	george@paproviders.org
Michael Lane	Providers	PO Box 8600 Harrisburg, PA 17105 PH: 717-561-3317	mlane@haponline.org
	Individuals in Recovery (to include	2100 N. 49th Street, Apt.	

Elsie Lewis	adults with SMI who are receiving, or have received, mental health services)	311 Philadelphia, PA 19131 PH: 215-878-3465	elsiefreemanlewis@msn.com
David Lilley	Others (Not State employees or providers)	748 Sale Barn Road Bloomsburg, PA 17815 PH: 570-784-3830	dlilley@cmsu.org
Randall Loss	State Employees	1521 N 6th Street Harrisburg, PA 17102 PH: 717-787-5136	rloss@pa.gov
Crystal Lowe	Others (Not State employees or providers)	525 S. 29th Street Harrisburg, PA 17104 PH: 717-541-4214	crystal@p4a.org
Wendy Luckenbill	Family Members of Individuals in Recovery (to include family members of adults with SMI)	240 South 5th St. Womelsdorf, PA 19567 PH: 717-364-2255	wluckenbill@mhapa.org
Sallie Lynaugh	Family Members of Individuals in Recovery (to include family members of adults with SMI)	1414 N. Cameron St. Ste. C Harrisburg, PA 17103 PH: 570-366-7725	slynaugh@gmail.com
Claudia Madrigal	State Employees	OMAP-DGS Annex Complex, Petry Building Harrisburg, PA 17110 PH: 717-346-0709	cmadrigal@pa.gov
Joseph Martin	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	66 East St. #3 Carlisle, PA 17013 PH: 717-386-6428	josephalexmartin@gmail.com
Rebecca May-Cole	Others (Not State employees or providers)	525 S. 29th Street Harrisburg, PA 17104 PH: 717-541-4219	Rebecca@olderpa.org
Gloria McDonald	Family Members of Individuals in Recovery (to include family members of adults with SMI)	612 Walnut Street Meadville, PA PH: 814-333-4357	gloriamcd@zoominternet.net
Fred McLaren	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	8510 Trumbauer Dr Wyndmoor, PA 19038 PH: 215-450-2855	fmclarencsp@gmail.com
Sharon Miller	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	McKnight Plaza, Suite 200 Pittsburgh, PA 15237 PH: 412-366-3788	smiller@namiswpa.org
Wesley Mitchell	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	PO Box 642 Phoenixville, PA 19460 PH: 717-889-6456	wa6mitchell@yahoo.com
Richard Morycz	Providers	3811 O'Hara St. Geriatrics Pittsburgh, PA 15213 PH: 412-246-5298	moryczrk@upmc.edu
Gelene Nason	Others (Not State employees or providers)	211 N. Front St. Harrisburg, PA 17101 PH: 717-780-3874	gnason@phfa.org
Deb Neifert	Others (Not State employees or providers)	17 N. Front St. Harrisburg, PA 17101 PH: 717-232-7554	dneifert@pacounties.org
Connell O'Brien	Others (Not State employees or providers)	2101 N. Front St. Bldg 3 Ste. 200 Harrisburg, PA 17110 PH: 717-364-3280	connell@paproviders.org
Marie Onukiavage	Family Members of Individuals in Recovery (to include family members of adults with SMI)	2 Margaret Ave. Archbald, PA 18403 PH: 570-876-3553	marieo@namipascranton.org
Deb Ormsby	Family Members of Individuals in Recovery (to include family members of adults with SMI)	710 King St. Petersburg, PA 16669 PH: 814-641-7581	dlofnetp@uplink.net

Ronald Owen	Family Members of Individuals in Recovery (to include family members of adults with SMI)	104 Richmond Drive Pittsburgh, PA 15215 PH: 412-855-2268	rowenlands@comcast.net
Bette Peoples	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	140 N Elm St. Butler, PA 16001 PH: 724-283-1704	grapevine@zoominternet.net
Joan Schmehl	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	5 W. Cherokee St. Emmaus, PA 18049 PH: 610-967-3834	joanminnie@unreachablestars.com
Deborah Shoemaker	Others (Not State employees or providers)	777 E. Park Dr. Harrisburg, PA 17105 PH: 800-422-2900	dshoemaker@pamedsoc.org
Sharon LeGore	Family Members of Individuals in Recovery (to include family members of adults with SMI)	PO Box 450 Mechanicsburg, PA 17055 PH: 717-730-2020	ssmith@momstell.org
Elizabeth Starks	Family Members of Individuals in Recovery (to include family members of adults with SMI)	427 E. Airy Street Norristown, PA 19401 PH: 267-507-3486	E_L_Starks@yahoo.com
Denise Stewart	Providers	206 Eddystone Ave. 2nd Fl Eddystone, PA 19022 PH: 610-565-3044	stewartdv@co.delaware.pa.us
Patrice Terrance	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	310 Central City Plaza New Kensington, PA 15068 PH: 724-224-1600	patricet356@gmail.com
Sue Walther	Others (Not State employees or providers)	1414 N. Cameron St. Harrisburg, PA 17103 PH: 717-346-0549	swalther@mhapa.org
Julie Weaver	Providers	320 Highland Drive Mountville, PA 17554 PH: 717-285-7121	weaverj@csgonline.org
Lloyd Wertz	Others (Not State employees or providers)	1618 Mahantongo Street Pottsville, PA 17901 PH: 267-414-4870	lwertz@pmhcc.org
Jodi Wilson	Family Members of Individuals in Recovery (to include family members of adults with SMI)	PO Box 202 Sheffield, PA 16347 PH: 814-726-8406	jodikay68@yahoo.com
David Wooledge	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	1101 Peach Street Erie, PA 16508 PH: 814-452-4462	woledge001@juno.com
Mark Zisselman	Providers	5501 Old York Rd. Philadelphia, PA 19141 PH: 215-456-8091	zisselmanm@einstein.edu
Harry Barr	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		hdb1948@yahoo.com
Amy Comarnitsky	State Employees	555 Walnut St, 6th Floor Harrisburg, PA 17101 PH: 717-425-5115	acomarnits@pa.gov
Mary Diamond	Others (Not State employees or providers)	777 E. Park. Dr. PO Box 8820 Harrisburg, PA 17105 PH: 800-422-2900	DMARY422@aol.com
Thomas Laton	Providers		latontm@upmc.edu
William Lelik	State Employees		wlelik@pa.gov

Footnotes:

IV: Narrative Plan

Behavioral Health Council Composition by Member Type

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Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	71	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	21	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	17	
Parents of children with SED*	0	
Vacancies (Individuals and Family Members)	<input type="text" value="0"/>	
Others (Not State employees or providers)	16	
Total Individuals in Recovery, Family Members & Others	54	76.06%
State Employees	6	
Providers	11	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="0"/>	
Total State Employees & Providers	17	23.94%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	0%
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="0"/>	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

IV: Narrative Plan

X. Comment on the State BG Plan

Page 90 of the Application Guidance

Narrative Question:

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG 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 the Secretary of HHS.

Footnotes:

X. Comment on the State Plan

Pennsylvania provides several opportunities for the public to comment on the State Plan. The web-based sites listed below allow individuals to view and comment on the Commonwealth's Community Mental Health Services Block Grant Plan. The websites are accessible to the general public and allow comments to be sent directly to the state Mental Health Block Grant Planner.

OMHSAS also sends the draft Plan through a listserv that includes: County MH/ID Administrators, County MH Directors, Advisory Committee members (State Mental Health Planning Council), local Community Support Program groups, Consumer/Family Satisfaction Teams, local provider groups, training partners, Managed Care Organizations, OMHSAS staff, and other individuals registered to receive information through the listserv.

Websites:

www.parecovery.org

www.pacounties.org

Hardcopies may be obtained by contacting:

Jennifer Parker

Bureau of Policy, Planning, and Program Development

Office of Mental Health and Substance Abuse Services

Beechmont Building, P.O. Box 2675

Harrisburg, PA 17105

(717) 772-7283 phone

(717) 772-7964 fax



COMMONWEALTH OF PENNSYLVANIA
OFFICE OF THE GOVERNOR
HARRISBURG

THE GOVERNOR

March 15, 2013

Ms. Barbara Orlando
Grants Management Specialist
Substance Abuse and Mental Health Services Administration
Division of Grants Management, OPS
1 Choke Cherry Road, Room 7-1091
Rockville, Maryland 20857

Dear Ms. Orlando:

The purpose of this correspondence is to formally designate Mr. Dennis Marion, Acting Deputy Secretary for Mental Health and Substance Abuse Services, Department of Public Welfare, 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 CORBETT
Governor

The Pennsylvania Mental Health Planning Council

**Children's Committee
Adult Committee
Older Adult Committee**

March 27, 2013

Mr. Dennis Marion, Deputy Secretary
Office of Mental Health and Substance Abuse Services
Department of Public Welfare
PO Box 2675
Harrisburg, PA 17105-2675

Dear Mr. Marion:

The Pennsylvania Mental Health Planning Council has reviewed the FY 2014/2015 Community Mental Health Services Block Grant Application and Plan. The priorities outlined in this plan were developed through a stakeholder workgroup and identify specific areas where continued work is needed to move the system forward.

The Planning Council continues to work with OMHSAS to ensure that individuals served by Pennsylvania's behavioral health service system have access to programs and supports that facilitate recovery. Our signatures verify that we have had the opportunity to review the Plan.

Sincerely,


Bernadette Bianchi
Co-Chair, Children's Committee


Lynn Keltz
Co-Chair, Adult Committee

I: State Information

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 45 CFR Part 76, and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion—Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

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 45 CFR Part 76 by:

- 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), ?; (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

3. Certifications Regarding Lobbying

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 (45 CFR Part 93).

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)

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.

Name	Dennis Marion
Title	Acting Deputy Secretary
Organization	Office of Mental Health and Substance Abuse Services

Signature: _____

Date: _____

2-27-13

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certification (Form 3)

Community Mental Health Services Block Grant Funding Agreements FISCAL YEAR 2014

I hereby certify that Pennsylvania agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:

- i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved;
- ii. Evaluating programs and services carried out under the plan; and
- iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

- (A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
- (B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
- (C) 24-hour-a-day emergency care services.
- (D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
- (E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) 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 illness 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)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle 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) 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.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.
(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and

(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United States Code. [Audit Provision]

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and

(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and

(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);

(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and

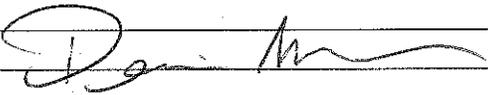
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name	Dennis Marion
Title	Acting Deputy Secretary
Organization	Office of Mental Health and Substance Abuse Services

Signature:  Date: 2-27-13

Footnotes:

I: State Information

Assurance - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

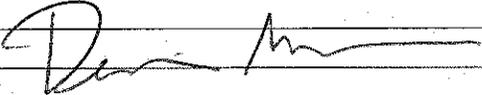
Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

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

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

Name	Dennis Marion
Title	Acting Deputy Secretary
Organization	Office of Mental Health and Substance Abuse Services

Signature:  Date: 2-27-12

Footnotes: