Appendix B
County Human Services Plan Template

The County Human Services Plan (Plan) is to be submitted using the template outlined below. It is to be submitted in conjunction with Appendices A and C (C-1 or C-2, as applicable) to the Department of Human Services (DHS) as instructed in the Bulletin 2022-01.

PART I: COUNTY PLANNING PROCESS

Describe the county planning and leadership team and the process utilized to develop the Plan for the expenditure of human services funds by answering each question below.

1. Centre County Planning Team includes the following departments: Mental Health/Intellectual Disabilities/Early Intervention - Drug & Alcohol, Office of Adult Services, Commissioners Office, Financial Management, Controllers' Office. Residents of Centre County can provide feedback throughout the year via any of the above noted offices and through advisory boards. The Centre County Planning Team reviews data, provider and consumer feedback, and discusses needs and gaps in our service continuum to determine our Block Grant plan. The Planning Team meets monthly to provide timely data, fiscal reporting, and needs.

2. Each department received input from their respective providers of Block Grant services in regards to service needs, programming, measures to be monitored, and funding. Centre County Planning Team meets monthly to discuss service gaps, needs, and funding levels. The county departments and providers of Block Grant services have a variety of program evaluations, surveys, and opportunities to discuss services throughout the fiscal year. Individual departments work directly with the providers on feedback, services, needs and funding throughout the year to scope the development of the Block Grant. Individuals who receive service are provided the opportunity to give feedback on the services throughout the year and during the public hearing process. Advisory Board and Board of Commissioners meetings held throughout the year that are open to the public provide the opportunity for input from the community. Community Support Program and Consumer/Family Satisfaction Teams provide consumers and family members the opportunity to provide feedback on services. Recovery-Oriented Systems Indicators (ROSI) meetings provide opportunities to provide feedback on visions and mission statements from programs and services within Centre County. Community providers have internal evaluation reports, surveys, and offer consumer feedback opportunities during and after services are completed. Departments conduct provider review meetings for services and on-site provider reviews are conducted annually. For the Intellectual Disabilities Program, satisfaction is determined through the Independent Monitoring for Quality (IM4Q) processes, with results shared with the Centre County Quality Council, Advisory Board, and incorporated into the Quality Management plan. The Team is represented at a number of community based councils and committees that discuss services in the county. Team members discuss the Block Grant at these meetings to garner information and feedback concerning services.

3. Centre County MH/ID EI Advisory Board and the Centre County Drug & Alcohol Planning Council provides feedback throughout the year on services and needs the community is experiencing. The plan is shared with members prior to the public hearing. Our plans are posted on our county website for public review throughout the year.

4. By providing services in the least restrictive setting, it creates a safety net for individuals and families and promote an interactive service system to maximize our providers and services. The departments stress the need for services that allow residents to be proactive in their needs, disabilities, and/or crises. With this information, the departments are able to shift funding as seen as appropriate. Social determents of health are a critical factor amongst all of the services we address with our clients. We develop individualized plans and services based on least restrictive services.

5. CCMH was able to take advantage of the Community Mental Health Services Block Grant (CMHSBG) funding opportunity offered by the Office of Mental Health and Substance Abuse Services (OMHSAS). CCMH was awarded grant funding dedicated to Mobile CIS expansion, so that Center for Community Resources (CCR) could look to secure additional full-time crisis and peer staff, expand the service array and train to respond to the community in a fuller, more expedited manner to the needs of this community. Ideally, Mobile CIS will be able to respond to the full county community's needs within 20 - 50 (distance dependent) minutes of a request. All response is crucial, but priority response is needed for law enforcement, individuals in crisis, youth, families, schools and students. This is one of the greatest areas of need consistently identified by this community. CCR has the service design to address this need. Thus far, we have worked with State College Borough Police to design scenarios and responses for mobile to assist law enforcement with. We are still working through staffing these additional positions so limited progress has been made for the first year of the program. An extension of this grant would be greatly appreciated and needed.
   CCMH was able to take advantage of the CMHSBG funding opportunity for another proposal to expand our crisis services. CCMH submitted a proposal to start building a Crisis Diversion infrastructure to include creating a Crisis Residential and Evaluation site, providing urgent OP appointments and transitional and follow-up care. CCMH's full vision includes the ability to create specialty psychiatric care in the community that would support emergency services to the degree of the ED presently. Providing whole health service-delivery in the community must mimic what is provided in institutional care to ensure that all basic needs are being met before, during and after crisis events for the individuals and families supported in this community. Community Services Group (CSG) is the identified provider as we are converting a CRR home into the Crisis Residential home. While awarded the grant in September 2021, progress has this program has been very limited. Working with our managed care company on service descriptions and rates, renovation process through local code and planning, and further work on the design of this program all have resulted in the first year of grant with limited spending. We would request an expansion date of this grant to go into 2024 to allow for maximum spending of the grant to allow service to occur in our community.

PART II: PUBLIC HEARING NOTICE

Centre County held two hybrid (virtual and in-person) public hearings pertaining to the FY 2022-2023 HSBG on July 27th and July 29th. Attached to the plan are copies of the notice in the local newspaper of the public hearings, the attendance list, and written testimony. Providers attended each hearing. An overview of the plan and budget were presented by County staff. Providers supported their services such as the 211 Coordinated Walk-In Center, family group decision making, and basic needs medical case management.

PART III: CROSS-COLLABORATION OF SERVICES

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

1. Employment:

There are approximately 10 providers qualified and willing to provide employment services in Centre County. These providers offer an array of employment services including Supported Employment (all phases), Advanced Supported Employment (all phases), Community Participation Supports, and Small Group Employment. One provider is currently completing the training requirements to become qualified to provide Benefits Counseling. Two providers currently maintain county contracts to provide employment services using HSBG monies.

Worklink is a two-year certificate program for individuals with intellectual disabilities or autism who seek a post-secondary education experience and training for employment. It is supported by a grant from the D.R.E.A.M. partnership and is in the Penn State College of Education. Two individuals from the first cohort successfully completed the program in Spring 2022. There are 5 individuals (including 3 from other AEs) completing their 1st year of the program, and 3 new students for Fall 2022.

Centre County AE has included a goal related to increasing the number of individuals achieving Competitive Integrated Employment in its Quality Management Plan. The ID Program Specialist reviews Employment data compiled Office of Developmental Programs as part of the Quality Management Plan quarterly reports. This information is also used to review trends in Centre County and assists with the planning for employment activities in the upcoming fiscal year and longer term. The long-range plan is to continue to track employment data and share information with providers, Supports Coordination, MH/ID Advisory Board, local transition council, and other interested stakeholders.

CCMH provides funding for vocational training, supported employment, Transitional Employment Placements and competitive employment through job coaching, psychiatric rehabilitation, case management and CRR services. CCMH and Intellectual Disabilities Employment Committees continue to join efforts to promote employment opportunities and outcomes for youth, transition-age, adult and older adult individuals.

Centre County MH/ID/EI-D&A Office rents space to OVR, so all agencies collaborate and are easily accessible. This is a satellite office for OVR given the distance to the OVR District Office in Altoona. Career Link is utilized readily by case managers in linking individuals with employment opportunities.

2. Housing:

Centre County is fortunate to have a continuum of housing services available for individuals and families who are experiencing homelessness or near-homelessness. Services that are offered and funded through the Homeless Assistance Program include Bridge (transitional) housing, rental & mortgage assistance, a Housing Program Specialist position (categorized under Innovative

Supportive Housing Solutions), and the Coordianted Entry Walk-In Center (categorized under Innovative Supportive Housing Solutions). Additional housing programs in Centre County that are not funded through the Human Services Block Grant, but are administered out of the Office of Adult Services, include the Emergency Rental Assistance Program (ERAP), Section 811 Housing, PHARE Rental Assistance, rapid re-housing, permanent supportive housing, and emergency shelter.

Centre County's Office of Adult Services is also actively involved with the Eastern PA Continuum of Care (CoC), South Central Regional Housing Advisory Board (RHAB), and the Coordinated Entry System (CES). Centre County is also working with contracted providers, local municipalities, and partner agencies to collect data, identify current and/or projected service gaps, and apply for grants to bring additional funding into the community.

Over the last year, Centre County has successfully expanded the existing rapid re-housing program through the Department of Housing & Urban Development (HUD), was awarded additional funds and contract extensions through the Department of Community and Economic Development (DCED) under the Emergency Solutions Grant (ESG) – CV1 and Emergency Solutions Grant (ESG) – CV2 for rapid re-housing and emergency shelter services, and most recently applied for Emergency Solutions Grant (ESG) funds through DCED to support the expansion of existing emergency shelter services and to create the Centre County Homeless Prevention Program.

In addition, Centre County continues to administer ERAP which has been a massive undertaking since March 2021. Over the last 17 months, the Office of Adult Services has received a total of 4,737 applications from 2,364 unique households. Without missing a beat, the department has and continues to receive 50-100 applications each week since the program opened. At this time, the majority of applications received are for recertification meaning that the tenant and/or landlord has been awarded funds for rental and/or utility assistance at least one time before. As rents continue to increase and affordable housing is more challenging to obtain, many tenants and landlords have become dependent on ERAP as if it is a rental subsidy versus an emergency rental assistance program.

Although new funding will increase Centre County's capacity to serve those with higher needs and barriers, it still does not address the affordable housing crisis which continues to be at the core of all needs identified by individuals and families served across the human services spectrum. According to the Washington Post, published on April 21st, 2022, Centre County has the highest average rent in the State of Pennsylvania ($1,812.00/month) and only saw a 4.90% rent increase since 2019. Compare that to more populated and urbanized areas that have a lower average rent and saw a rental increase of 10-17% since 2019. As a result, Centre County will continue to explore new and alternative housing programs to meet the affordability needs of all households with a fixed or limited income to prevent the experience of homelessness or near-homelessness.

In addition, Centre County Mental Health (CCMH) was able to expand the Supported Living (SL) Program offered through Eagle Valley increasing by 3 beds. They were able to provide a 1 and 2 bedroom program. Individuals discharging from Danville State Hospital (DSH) have been able to access SL if they need that level of care.

PART IV: HUMAN SERVICES NARRATIVE

MENTAL HEALTH SERVICES

The discussion in this section should take into account supports and services funded (or to be funded) with all available funding sources, including state allocations, county funds, federal grants, HealthChoices, reinvestment funds, and other funding.

a) Program Highlights:

- Centre County Mental Health (CCMH) was able to expand the Supported Living (SL) Program offered through Eagle Valley increasing by 3 beds. They were able to provide a 1 and 2 bedroom program. Individuals discharging from Danville State Hospital (DSH) have been able to access SL if they need that level of care.
- Centre County Children's Team Meetings have been successful in supporting youth and families learn about mental health services/supports, accessing those services/supports, and engaging with each other in a collaborative manner.
- Children's Collaborative Meetings have been going well and allow service providers, school districts, and community partners a forum to discuss services, linkage and education around services, supports needed, and ongoing discussion on ways to help support indivudals who need access to services across the lifespan.
- Community Support Program (CSP) has a strong voice in our community has advocated for their needs. Their feedback is often requested when new programmatic options are available in Centre County. They are able to provider their experiences with the service delivery system to help enact changes.
- Danville State Hospital (DSH) referrals increased during this fiscal year allowing indivduals the time and safe environment the support and time they needed to work through their mental health struggles. Ongoing communication with DSH staff and CCMH provided support for all involved to ensure a smooth discharge. This communication also allowed CCMH staff to keep up-to-date with COVID restrictions/changes within the state hospital system and vice versa.
- Centre County Crisis Intervention Team (CIT) held the 21th training session in June of 2022. CIT has now trained a total of 403 first responders. The next training is slated to be held in January of 2023.
- The Forensic Specialist completed 95 assessments at the correctional facility and 30 intakes to activate individuals in services during this fiscal year, thus far.
- During the COVID-19 shut down, the Forensic Specialist continued to support inmates and returning citizens via telehealth. All transitions were success despite this challenge given the solid partnership that exists with this CCCF-MH partnership.
- CCMH is hearing much more release activity coming out of the SCIs as well, not just the two local SCIs-this is back to more sporadic, several of them in the Commonwealth. The Forensic Specialist devotes her time and efforts to support these transitions as well, when Centre County is appropriately designated as home for each returning citizen. CCMH appreciates the SCI's efforts to enhance communication.
- The additional array of residential service options: Supportive Living, Community Residential Rehabilitation (CRR) and Enhanced Personal Care Home help maintain a level of fluidity between all sites and including the community. CCMH hopes to add the complement of Crisis Residential Services next FY.

- Centre County consistently focuses on the residential system at large to ensure that the array of residential and/or residential service options continue to meet the needs of the referrals, transitional and permanent.
- It is imperative to note a severe barrier to services is lack of staff for the following: Inpatient (IP) Psychiatric beds are not able to be utilized; Outpatient (OP) Service access is further restricted due to lack of licensed staff to provide; Intensive Behavioral Health Services (IBHS) have barely implemented due to lack of staff;; people are sitting in the Emergency Department (ED) for greatly extended periods of time due to high acuity and a high amount of service denials, some of which are based on not having the staff to handle the level of need; EDs have to provide commitment extension support.
- All MH Providers experience some level of staff recruitment and retention issues that impact their service-delivery.
- OP Providers are reporting significant difficulties in recruiting and retaining licensed practitioners. Many are requesting waivers and/or supplemental funding surrounding this issue. Recruitment and retention is reported as a significant barrier for provider service-delivery across all levels of care and service provisions.
- We will be seeking opportunities to deliver OP services in some of more rural areas.
- PeerStar continues to partner with Oasis LifeCare for the First Episode Psychosis Program being offered in Centre County, InSight.
- A Treatment (Mental Health) Court is a focus of Stepping Up Initiative. Centre County is currently in the development and planning stage of creating this court. The hope is to have the court operating in calendar year 2023.
- The Centre County Suicide Prevention Task Force continues to have a strong and active role in the community. The focus of the Task Force is to reduce stigma around mental illness and educate the community on suicide prevention resources and trainings.
- The leadership of this task force is provided by the Jana Marie Foundation who puts forth great effort, planning and tasking of the community to fight this public health issue and empower individuals of all ages to live their lives to the fullest potential despite the barriers that life throws. Centre County is able to further support anti-stigma and awareness efforts when funds are made available.
- CCMH looks to continue to coordinate suicide prevention efforts by further developing the network: crisis, SPTF, MHCC, CIT, MNMC, Coroner's Office, Jana Marie Foundation, Peer Support Providers, SP Trainers, CCMH, etc.
- CCMH collaborates steadily with MNMC's Emergency Department (ED) and Behavioral Health Unit (BHU), and Centre County CIS to ensure that crisis intervention and delegate services are being delivered according to the MHPA and the Centre County MH Administrator. CCMH hosts monthly crisis team meetings, but there is also a significant amount of day-to-day communication and interactions.
- CCMH is participating on the Child Death Review Team (CDRT) in Centre County. This group's scope has expanded to include a review of deaths in which the manner of death was determined to be suicide. This broadens the networking, depth of awareness and provides insight into the preventions that can be applied to prevent the likelihood of reoccurrence.
- CCMH has experienced significant transition in the Blended Case Management (BCM) Unit, again, this past year. Currently, CCMH budget for one Administrative Case Manager and nine Targeted Case Managers. We currently have three openings, which requires us to have a wait list.

- CCMH was able to take advantage of the Community Mental Health Services Block Grant (CMHSBG) funding opportunity offered by the Office of Mental Health and Substance Abuse Services (OMHSAS). CCMH was awarded grant funding dedicated to Mobile CIS expansion, so that Center for Community Resources (CCR) could look to secure additional full-time crisis and peer staff, expand the service array and train to respond to the community in a fuller, more expedited manner to the needs of this community. Ideally, Mobile CIS will be able to respond to the full county community's needs within 20 - 50 (distance dependent) minutes of a request. All response is crucial, but priority response is needed for law enforcement, individuals in crisis, youth, families, schools and students. This is one of the greatest areas of need consistently identified by this community. CCR has the service design to address this need. Thus far, we have worked with State College Borough Police to design scenarios and responses for mobile to assist law enforcement with. We are still working through staffing these additional positions so limited progress has been made for the first year of the program. An extension of this grant would be greatly appreciated and needed.
- CCMH was able to take advantage of the CMHSBG funding opportunity for another proposal to expand our crisis services. CCMH submitted a proposal to start building a Crisis Diversion infrastructure to include creating a Crisis Residential and Evaluation site, providing urgent OP appointments and transitional and follow-up care. CCMH's full vision includes the ability to create specialty psychiatric care in the community that would support emergency services to the degree of the ED presently. Providing whole health service-delivery in the community must mimic what is provided in institutional care to ensure that all basic needs are being met before, during and after crisis events for the individuals and families supported in this community. Community Services Group (CSG) is the identified provider as we are converting a CRR home into the Crisis Residential home. While awarded the grant in September 2021, progress has this program has been very limited. Working with our managed care company on service descriptions and rates, renovation process through local code and planning, and further work on the design of this program all have resulted in the first year of grant with limited spending. We would request an expansion date of this grant to go into 2024 to allow for maximum spending of the grant to allow service to occur in our community.

b) <u>Strengths and Needs by Populations:</u>

Please identify the strengths and needs of the county/joinder service system specific to each of the following target populations served by the behavioral health system. When completing this assessment, consider any health disparities impacting each population. Additional information regarding health disparities is available at https://www.samhsa.gov/health-disparities.

1. Older Adults (ages 60 and above)

- Strengths:
  - CCMH continues collobration meetings with Aging, Adult Services, ID, and Drug and Alcohol to discuss individual needs as well as programtic changes within our respective departments.
  - Project SHARE (**S**enior Center and Mental **H**ealth **A**ctivites, **R**esources, and **E**ducation) continues to provide talks regarding mental health specific to older adults in the Senior Resource Centers.

- Open and ongoing communication between CCMH and Aging staff.
- The Senior Center Directors have reached out regarding topics for SHARE based on the needs of the individuals attending the center.
- CCMH staff are actively involved in various meetings/committees/groups that benefits older adults including forensic, housing, employment, and community events which allows for supportive opportunities for all involved
- Centre County has seen an increase in the number of grandparents raising, caring for, or supporting their grandchildren. CCMH Program Specialist (CASSP Coordinator) is able to provide resources, provider linkage, and other supports to both the family and staff at both Office of Aging and Children and Youth Services. Grandparents have participated in Children's Team Meetings and are provided with a plan of action with services and supports listed with contact information.
- There is one male older adult incarcerated in the Centre County Correctional Facility at this time.

- Needs:
  - Stigma continues to be a major barrier within the older adult population so ongoing collaboration with providers and our senior centers is needed.
  - Ongoing collaboration within the human services departments is vital.
  - More therapy options geared towards older adults. Finding a therapist for someone who has Medicare is very difficult.
  - Affordable housing is an ongoing need.
  - It has been difficult to find personal care home or nursing home levels of care for individuals diagnosed with a mental illness, especially if they have co-occuring or dual diagnosis.

2. Adults (ages 18 to 59)

- Strengths:
  - Strawberry Fields, Inc. (SFI) Community Residential Rehabilitation (CRR) continues to be a highly utilizied program. They operate a Bellefonte CRR program that has served 3 gentleman. During the fiscal year 1 gentleman passed away and another was transferred to a nursing home. They are in the process of training staff and will be able to fill those 2 beds with individuals who need this level of care. This will bring the total number of CRR beds at SFI to 14.
  - 20 individuals utlizied CRR. It should be noted 2 individuals transitioned from Community Services Group (CSG) to SFI CRR. There were a total number of 24 individuals on the referral list with 3 indivduals being admitted to CRR; 1 admitted to Supported Living; 1 admitted to DSH. 1 individual was removed from the referral list as they passed on 2 opportunities for admission.
  - Adult Mental Health First Aid and Question, Persuade and Refer (QPR) classes are being offered readily within the community as the result of efforts by a local provider, PeerStar, and the Jana Marie Foundation.
  - CCMH has two county/block grant-funded Representative Payee options to offer individuals. A third Representative Payee option is also available in the county for individuals to access independently. This service also supports individuals who are involved with our Intellectual Disabilities, Drug and Alcohol, Children and Youth, Aging, Adult Services and Housing partners.

- Mobile and Site-Based Psychiatric Rehabilitation services continue to be utilized on an increased basis within the county. These services are supported with Supplemental Service funding made available through CCBH and county/block grant funds. These services are widely used by individuals involved with all of our county block grant partners.
- Mobile Psychiatric Rehabilitation has had a positive impact in the expanse rural areas of this county.
- CCMH is experiencing a rise in the number of SCI contacts informing of an inmates potential release date. CCMH appreciates the communication as it helps with coordination of care and readiness upon the returning citizen's release.
- Located in Centre County are two State Correctional Institutions (SCIs). CCMH supplies only 302 commitment support to the local SCIs. If 302s are approved, the inmate is transferred to another facility for MH Care as Rockview and Benner do not have MH Units for treatment needs.
- Centre County continues to provide housing support for individuals with mental illness with Housing Contingency funding provided through county/block grant funds and through health choices reinvestment.
- DeClutter services are utilized by individuals and families that need direct housing support. They can be very useful in helping people to maintain their independent housing and housing vouchers.
- CCMH provides funding for vocational training, Supported Employment (SE), Transitional Employment Placements (TEP) and competitive employment through job coaching, psychiatric rehabilitation, case management and CRR services.
- BCM Services provided thru CCMH are presently provided as desired by the individual receiving them and the BCM providing them – a hybrid of in-person and telehealth per regulations.
- Strawberry Fields, Inc. also provides BCM with the following of the telehealth bulletin.

- Needs:
  - Centre County has seen an increase in the number of individuals utilizing DSH and have symptoms that are more acute and could benefit from a Long-Term Structured Residence (LTSR). This would also be a need for a transition age as intense symptoms are being seen in that age population as well.
  - Centre County's CIS needs to expand its service provision to meet the needs of the community. In particular, family, schools, medical personnel and law enforcement report significant barriers and delays when accessing CIS. Staff expansion is a must for the needed community response. CCMH is in the process of submitting a CMHSBG Grant Application dedicated to this need.
  - Amendment to the Mental Health Procedures Act that allows for Physician Extenders, specifically Certified Psychiatric Physician Assistants (PA) in Centre County's case, to provide oversight to involuntary commitments (testimony, treatment and monitoring)
  - Secure contracts with Outpatient Providers that accept Medicare and the Medicare rate for payment of services. This is needed for individuals that are only insured under Medicare to save additional out-of-pocket expenses and

individuals that are dual-eligible (Medicare and Medical Assistance (MA)), so that MA funding can provide full supplement for the payment of the service.
- Centre County will continue to explore options to expand psychiatric service-delivery in the community. CCMH and CCBH will continue to collaborate in the expansion process to support county/block grant funded, CCBH-eligible and third party insured individuals.
- A discussion regarding the review of a partial hospitalization program has been discussed due to the wait times for outpatient and the extended stays in our ED. Partial could provide an increased level of care to support individuals in the community.
- CCMH continues to seek transportation linkage options for individuals that do not have access to public transportation to meet their basic needs.

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

- Strengths:
  - Centre County Youth Service Bureau offers a homeless shelter and Independent Living (IL) program. Through the IL program youth and young adults are able to be linked with a youth advocate who will work on skills to help the youth gain independence in the community.
  - CCMH participate in annual and ongoing meetings focusing on the needs of young adults who are transitioning from high school and need access to mental health services/supports through the adult system, transportation needs, and housing needs. Families are an integral part of these meetings.
  - Clubhouse and Psychiatric Rehabilitation programs support this age population
  - Clubhouse is able to offer a Temporary Employment Program (TEP) which allow members to access various employment opportunities in the community, assist with resumes, skill building for job interviews, and access to ongoing job coaching with the Office Of Vocational Rehabilitation (OVR) if needed.
  - Center County Children's Team meetings have been a way to assist young adult with accessing and understanding the adult mental health system. Meetings are done collaboratively with school personnel, families, providers, and community partners.
  - Centre County continues to hold Children's Collabortive meetings which education the community partners, agencies, school districts, providers, etc. on services/supports and how to work collaboratively within our respective systems. Meetings plan themselves based on the current needs of those in attendance.
  - Children's Advisory Board meets on a quarterly basis and had been focused on guiding the Children's Collaborative Meetings.
  - During the height of the pandemic Centre County Community Support Program (CSP) continued to meet via a virtual platform. During these meetings providers and individuals utilizing services were able to share the successes and struggles of living through the pandemic. CSP also offered speakers to present on various topics from different agencies. Housing was a big concern for the group during

this time and they were educated on the resources by a speaker from the Office of Adult Services.
    - The MH Forensic Program Specialist participates in transition-age youth meetings with the county forensic, court, legal, behavioral health and children and youth partners.
- Needs:
    - Affordable housing options that are close to education and employment opportunities.
    - Access to transportation, mainly in the more rural areas of the county. CATA has decreased their routes in the State College and Bellefonte areas over the past few years so access to the bus system is a struggle in these areas.
    - Children's Advisory Board needs a new focus that would encourage partnerhsips with both youth/young adults and families to ensure their voices are present to discuss the ongoing service needs/supports in the community.
    - CCMH currently has had 5 transition-age individuals incarcerated in the Centre County Correctional Facility thus far this FY. There are 3 at this time.

4. **Children (under age 18)-** *Counties are encouraged to include services like Student Assistance Program (SAP), respite services, and Child and Adolescent Service System Program (CASSP) coordinator services and supports, System of Care (SOC) as well as the development of community alternatives and diversion efforts to residential treatment facility placements.*

    - Strengths:
        - Children's Collaborative meetings continue to bring together early childhood, school districts, and community partners to discuss ongoing needs and supports. This allows all to empower youth/young adults and families to take a lead role in developing the services/supports that will best support them.
        - Children and Adolescent Serivce System Program (CASSP) Principles continue to guide all services/supports within the service delivery system.
        - Centre County Youth Service Bureau (CCYSB) has been a strong partnership with CCMH and continues to facilitate Children's Team Meetings. This partnership has allowed for ASAP team meetings and access to Family Group Decision Making (FGDM) conferences. Ongoing meetings between CCMH and the facilitator happen throughout the year to discuss updating paperwork, educating the community on team meetings, statistics gathering, and ongoing support to the residents of Centre County. Team meetings have been utilized to assist young adults and their families transtioning from the children's mental health system/servies to the adult system. Plans of Action are created to allow everyone to have a copy of the plan with service contact information, goals, and team members contact information for easy access. Strengths of the individual and family are highlighted as well as any needs and barriers to accessing services.
        - There were a total of 32 team meetings held which included 17 initial meetings and 15 follow-up meetings. Referrals have come from service providers, community supports, and school districts. There have been an increase in the number of school district staff present at team meetings as well as more

extended family participation. Meetings have been held virtually allowing more school staff to be present as they do not have to travel. Team meetings have also identified an increased need for families/caregivers needs to get connected with services, which the team was able to assist.

- A major accompoishment was participation of a primary care physician at a team meeting. This allowed the team to have input and feeback from the physical health side which was lacking the past.
- The communication between CCYSB and CCMH has been a major strength during the pandemic to ensure ease of referrals, team meetings, ongoing service/support activation with waiting lists, and overall support of the youth/young adults and their families.
- Centre County has low Residential Treatment Facility (RTF) utilization with 12 individuals utilizing this level of care during the FY. One individual was a transfer from another county as the family moved to Centre County in January 2022. There were a total of 4 discharges. We have seen a higher number of families not willing have their child come home due to past aggression. Centre County CYS has had to step in and take custody. These have not been easy situations for indvividuals, families, or staff. Kinship care, foster care, and changes in RTF were utilized. We had no individuals utilize Therapeutic Foster Care (TFC) during this fiscal year.
- CCMH Program Specialist (CASSP Coordinator) maintains ongoing supportive and collaborative communication with various human services agencies, especially Centre County Children and Youth Services. Particiation in team meetings, communication regarding high risk individuals, ongoing meetings with families outside of team meetings, linkage with services, and education regarding services/supports has been an overall strength and became even stronger during the pandemic.
- Student Assistance Program (SAP) completed 181 screenings.
- Centre County YSB trained a new liaison to provide support on a part-time basis.
- A new truancy SAP process was piloted in one of the elementray schools offering additional support to all.
- Eight individuals utilized respite service with 5 of those new to respite.
- Jana Marie Foundation offers various trainings including Youth Mental Health First Aid, which through a grant, they were able to train the Bald Eagle Area School District entire 9th grade student body. They had positive response from students, parents, and staff. They also support the community and school districts by empowering students through artful expressions to find their voices to speak about their needs.
- The transition from Behavioral Health Rehabilitative Services (BHRS) to Intensive Behavioral Health Services (IBHS) created some barriers in the children's behavioral system due to licensing requirements and significant recruitment and retention issues being reported by all BHRS and/or IBHS Providers. There continues to be extensive waiting lists for this level of care. As a result, youth and families have struggled accessing medically necessary services. This has created additional waiting lists for alternative levels of care such as Family Based Mental Health Services.

- Needs:
    - Ongoing input and collaboration between school districts and the mental health provider system to ensure barriers, services access issues, and ongoing support for everyone is in place.
    - Centre County needs the input of children, adolescents, and their families to guide and ensure services/supports are in place.
    - Over the fiscal year there has been implementation issues withing the Intensive Behavioral Health Services (IBHS) system as the program has seen a massive change. This has caused other services to have extensive waiting lists. Centre County could benefit from additional services such as Partial Hospital Programs (PHP) or Multi-Systemic Therapy (MST), to name a few, to increase the services offered to children, adolescents, and their families.
    - Summer therapeutic activies are also needed.
    - Partial Hospitalization program for youth expanded across our county and school districts could be considered with a our managed care company.

Please identify the strengths and needs of the county/joinder service system (including any health disparities) <u>specific</u> to each of the following special or underserved populations. If the county does not currently serve a particular population, please indicate and note any plans for developing services for that population.

5. Individuals transitioning from state hospitals

- Strengths:
    - Communication between DSH and CCMH Liaison was integral in allowing for discharge planning and smooth discharges, participation in team meetings, admission changes/restrictions due to COVID, and overall hospital functions during the pandemic. CCMH has supported 12 individuals at DSH. Our bedcap is seven and there are currently eleven Centre County individuals at DSH.
    - Centre County residents admitted to DSH were 6 (4 males and 2 females); discharged were 3 males with 2 admitted to Supported Living and 1 admitted to Juniper Village Assisted Living; 2 diversions (1 male and 1 female); a total of 12 referrals were made. At the end of the fiscal year Centre County had 11 individuals at DSH and there are 3 people who have been referred from inpatient to DSH.
    - Diversions from state hospital are always a priority and require ongoing team meetings and communication between community partners and state hospital staff.
    - Liaison activities span from referral to discharge and can be time consuming which is needed to support all involved.
    - Visits to DSH have been prohibited during the pandemic but communication has been ongoing during this time.
    - Prior to discharge DSH staff assist individuals with applying for Medical Assistance and Social Security. This is has been going well as individuals are then able to have medical insurance and funds in a more timely manner. During the transition period following discharge, CCMH is able to providing funding for service activation until Medical Assistance is active.

- Needs:
    - Increased housing supports. Individuals tend to be discharged to central region of the county but have natural supports in their hometowns which are in the more rural areas of the county.
    - Transportation for individuals who reside in the rural areas of the county to be able to access their services.
    - Not being able to access new dollars through Community Hospital Integration Project Program (CHIPP) opportunities remains a barrier to needed community mental health services infrastructure building. Our bed cap does not allow us to give up a bed for another CHIPP, thus we are not able to utilize that funding stream.

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

- Strengths:
    - CCMH contracts with a local provider, Crossroads Counseling, that provides outpatient psychiatric and therapy services to individuals that are diagnosed with a co-occurring disorder. This provider carries a mental health and drug and alcohol license. Crossroads is certified as a Trauma-Informed Care Center through managed care on the D&A side of services.
    - There is a strong mental health and drug and alcohol partnership in Centre County. Both maintain a strong presence in Student Assistance Program (SAP), Children's Collaborative Advisory Board, County Jail Re-Entry meetings, Criminal Justice Advisory Board and Behavioral Health Alliance of Rural Pennsylvania workgroup meetings, just to name a few.
    - CCMH and Drug and Alcohol share office space which enhances collaboration and access to services to the individuals we serve.
    - Co-occurring services are delivered to individuals that are incarcerated in the county jail via individual and group treatment options.
    - Individuals under this population access Centre County's DUI and Drug Court Programs.
- Needs:
    - CCMH will look for service expansion opportunities to further support individuals that are diagnosed with mental health and drug and alcohol disorders.
    - Advance co-occurring initiatives in conjunction with partners from Centre County D&A as available through block grant opportunities, retained revenue, reinvestment and HealthChoices.

7. Criminal justice-involved individuals- *Counties are encouraged to collaboratively work within the structure of County Criminal Justice Advisory Boards (CJABs) to implement enhanced services for individuals involved with the criminal justice system including diversionary services that prevent further involvement with the criminal justice system as well as reentry services to support successful community reintegration.*

- Strengths:
  - CCMH contracts with a provider who renders individual outpatient and consultation services to individuals who are incarcerated at the CCCF. These services are provided with HSBG funds .
  - Currently, there are 21 individuals who are active with CCMH and are incarcerated.
  - CCMH's Forensic Program Specialist is on-site at CCCF daily and as needed.
  - CCMH tries to engage individuals in treatment that are coming into contact with law enforcement in an attempt to divert from incarceration. These efforts have always been in place, but have increased significantly with the growth of Crisis Intervention Team (CIT) in Centre County.
  - The CIT Coordinator position falls under the responsibility of the Centre County Criminal Justice Planning Office.
  - The MH Program Specialist participates in the Re-Entry Coalition, BARJ (Balance and Restorative Justice), Children's Roundtable, Transition-Age Youth, CIT Steering Commitment Meeting, Project Point of Light Team Meetings, Stepping Up Initiative and a Mental Health Review Meeting at CCCF. Administration participats in CJAB.
  - Centre County is dedicated to the Stepping Up Initiative with all of its county and community partners – Criminal Justice Planning, Commissioners, CCCF, Court Personnel, etc. These meetings were suspended due to COVID.
- Needs:
  - Individuals that are incarcerated consistently request assistance in finding housing and support for their return to the community. Individuals are often eliminated from the Housing Authority support due to their criminal justice involvement. CCMH frequently supports individual's transitions from CCCF with Community Residential Rehabilitation (CRR) and Supported Living services. CCMH needs to find funding avenues to secure additional housing options for this population.
  - Master Leasing and/or Bridge Housing grant opportunities need to continue to be explored by Centre County's Housing Specialist. Communication continues with the Specialist for this need.

8. Veterans

- Strengths:
  - CCMH has been able to enhance its partnerships with Veterans Affairs through committee work in Suicide Prevention Task Force, Zero Suicide Initiative, Mental Health Community Committee, American Foundation for Suicide Prevention, local trainings and participation in the Veterans Affair's (VA's) Mental Health Summits.
  - The development of the VA's Multi Service Centers, mobile services (peer and case management) and Outpatient Clinics provide local access and services to veterans, which provides a great deal of mobility assistance in rural communities.

- CIT training offers first responders insight into supporting veterans in crisis and provides service linkage options for veterans that they encounter in their day-to-day interactions.

- Needs:
  - CCMH benefits from receiving up-to-date information and education on the resources and services that the Veteran's Affairs/Administration (VA) has to offer. The VA has been implementing additional services that CCMH can offer as resources to local veterans. CCMH will continue to partner with VA staff to secure this information and build the partnership that exists.
  - Share knowledge, insight and resources surrounding suicide prevention initiatives.
  - Continue to partner in the development of trainings in the community that our mutual populations desire.

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

- Strengths:
  - LGBTQI expertise is growing in the area especially within the residential, outpatient and inpatient settings. These services and school districts through the Children's Collaborative meetings communicate their development, enhancements and skill-building as needed to know how to better support individuals who identify themselves in this category.
  - Staff at MH/ID EI D&A participated in a virtual training with the Keystone Pride Resource Center. Staff responded with positive feedback. Forms, interviewing techniques, etc. have been updated to reflect suggestions from the training.
- Needs:
  - Develop avenues to engage individuals with the LGBTQI community that exist at Penn State University, local school districts and local inpatient units.
  - Develop peer support training opportunities for this population through the process.
  - Enhanced Training and Skill-enhancing activities.

10. Racial/Ethnic/Linguistic Minorities (RELM) including individuals with Limited English Proficiency (LEP)

- Strengths:
  - CCMH has an array of providers that are racially, ethnically and linguistically competent in their service delivery that people of all ages are able to access with their private or public insurance and/or county/block grant funds.
  - Penn State University brings people to Centre County with a wide variety of backgrounds and minorities which CCMH recognizes and supports competently with delivered services.
  - CCMH has the ability to link individuals to Mid-State Literacy which enhances minorities' independence, support and engagement in the community.

- CCMH is increasing its awareness with the expertise that local school districts have had to develop to support all of their students through Children's Collaborative Meetings that are being held in Centre County.
- This awareness is also being brought to the early education providers through these meetings which further enhances abilities by the time a youth starts Kindergarten.

- Needs:
  - Develop linkage options for individuals who need interpreter services. This is an area of increasing need in Centre County given the transient population – student, university, homeless, young adult, etc.
  - Develop health education materials that are language-appropriate with our partners at PSU, Mount Nittany Health and local school districts.

c) <u>Strengths and Needs by Service Type:</u>

1. Describe telehealth services in your county:

a. How is telehealth being used to increase access to services?
   - *Telehealth is being utlizied by providers under the bulletin offered by DHS and OMHSAS. Outpatient, psy rehab, case management are just an example of services that providers are conducting as needed through telehealth.*

b. Is the county implementing innovative practices to increase access to telehealth for individuals in the community? (For example, providing technology or designated spaces in the county for telehealth appointment.) **(limit of one page).**
   - *Case management has been provided the technology for staff to work with individuals via telehealth. We have also dedicated an office space to conduct virtual meetings.*

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

☒ Yes ☐ No

If yes, please describe how this is occurring. If no, indicate any plans to embed TIC in FY22-23. *Centre County works with our providers and managed care company regarding trauma informed care initiatives. We have a variety of providers who complete training and hire staff with experience within trauma. Case management staff receive trainings regarding trauma informed care and seek out additional tools for individuals they are working with.*

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

☐ Yes ☒ No

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

   ☒ Yes ☐ No

   Based on recommendations from the Taskforce on Mental Health Crisis Services, enhanced trainings have been offered to our emergency services and crisis services providers. In FY 22-23, we will expand that training to our case management providers.

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

   ☒ Yes ☐ No

   Suicide Prevention Task Force

   - This coalition's membership is strong and active and holds a presence within the community. This group raises MH Awareness, collects data and impacts the stigma associated with mental health through its events and campaigning.
   - The Jana Marie Foundation leads the way with SP efforts in this community, has been instrumental in this collaboration and is genius in developing activities that promote awareness and engagement.
   - This coalition is currently focused on raising awareness through marketing with local veterans clubs and restaurant establishments and developing Public Service Announcements and a social media campaign.
   - The task force has a Facebook Page that allows for sharing of resources and events. Everyone is encouraged to like and share the page to help reach a larger audience and to increase viewership of the page.
   - Mental Health First Aid (MHFA) for both adults and youth and Question, Persuade and Refer (QPR) trainings are being offered throughout the community.
   - SPTF has rack cards, business cards, and brochures that talk about the task force and ways to get involved.
   - QPR Training is being planned for local bars/bartenders/VFWs/Legions to help them identify signs of people they encounter that may be struggling.
   - Created a "Red Folder" to help community members recognize when someone is struggling with their mental health, what to do and how to link with resources that can help, supporting warm hand-offs.
   - SPTF meets monthly, at minimum, and provides several annual events including Suicide Prevention Day/Month, JAM Fest and a variety of fundraisers.

   American Foundation for Suicide Prevention (AFSP) on-going activities and support

   - Centre County is fortunate to be part of an active AFSP Chapter. The leadership and volunteerism within this Chapter is strong and knowledgeable.
   - The Chapter networks heavily locally, regionally and commonwealth-wide and engages the community regularly in local activities such as the annual Out of the Darkness Walk, holding anti-stigma events, bringing speakers to the area to highlight mental health, showcasing films that generate discussion surrounding mental health and educating the community at-large.

Creating A Safe Environment (C.A.S.E.)

- An initiative that is new in Centre County that unites several key groups to focus on firearm safety:
  - Suicide Prevention is Everyone's Business: A Toolkit for Safe Firearm Storage in Your Community (afsp.org)
  - Firearm Safety in Times of Community Stress v.9.3.20 (va.gov)

6. Employment First:

The Employment First Act (Act 36 of 2018) requires county agencies to provide services to support competitive integrated employment for individuals with disabilities who are eligible to work under federal or state law. For further information on the Employment First Act, see the Employment-First-Act-three-year-plan.pdf.

a. Please provide the following information for your county employment point of contact (POC).
- Name(s): Jennifer Chessie
- Email address(es): jachessie@centrecountypa.gov

b. Please indicate if your county follows the SAMHSA Supported Employment Evidence Based Practice (EBP) Toolkit:
☐ Yes ☒ No

c. Please complete the following table for all county mental health office-funded supported-employment services.

County MH Office Supported Employment Data			
• Please complete all rows and columns below with **FY 20-21** data. • If no data available, list as **N/A**. • If data is available, but no individuals were served within a category, list as **zero (0)**. Include additional information for each population served in the **Notes** section. (for example, 50% of the Asian population served speaks English as a Second Language or number served for ages 14-21 includes juvenile justice population).			
Data Requested		**County Response**	**Notes**
i.	Total Number Served	7	
ii.	# served ages 14 up to 21	0	
iii.	# served ages 21 up to 65	7	
iv.	# of male individuals served	4	
v.	# of females individuals served	3	
vi.	# of non-binary individuals served	N/A	
vii.	# of Non-Hispanic White served	7	
viii.	# of Hispanic and Latino served	0	
ix.	# of Black or African American served	0	
x.	Asian	0	
xi.	# of Native Americans and Alaska Natives served	0	
xii.	# of Native Hawaiians and Pacific Islanders served	0	
xiii.	# of multiracial (two or more races) individuals served	0	

xiv.	# of individuals served who have more than one disability	2	
xv.	# of individuals served working part-time (30 hrs. or less per wk.)	7	
xvi.	# of individuals served working full-time (over 30 hrs. per wk.)	0	

Data Requested		County Response	Notes
xvii.	lowest hourly earned wage of individuals served (ex: minimum wage)	$9.75	
xviii.	highest hourly earned wage of individuals served	$14.17	
xix.	# of individuals served who are receiving employer offered benefits; (i.e., insurance, retirement, paid leave)	0	

7. Supportive Housing:

a. Please provide the following information for the county housing specialist/point of contact (POC).
- **Name(s): Natalie Corman**
- **Email address(es): nwcorman@centrecountypa.gov**

DHS' five- year housing strategy, Supporting Pennsylvanians Through Housing is a comprehensive plan to connect Pennsylvanians to affordable, integrated and supportive housing.
This comprehensive strategy aligns with the Office of Mental Health and Substance Abuse Services (OMHSAS) planning efforts, and OMHSAS is an integral partner in its implementation.

Supportive housing is a successful, cost-effective combination of affordable housing with services that helps people live more stable, productive lives. Supportive housing works well for people who face the most complex challenges—individuals and families who have very low incomes and serious, persistent issues that may include substance use, mental illness, and HIV/AIDS; and may also be, or at risk of, experiencing homelessness.

b. SUPPORTIVE HOUSING ACTIVITY *includes Community Hospital Integration Projects Program funding (CHIPP), Reinvestment, County base-funded projects and others that were planned, whether funded or not.* ***Identify Project Name, Year of Implementation, and Funding Source for all housing projects operationalized in SFY 20-21 and 21-22. Next, enter amounts expended for the previous state fiscal year (SFY 20-21), as well as projected amounts for SFY 22-23. If this data isn't available because it's a new program being implemented in SFY 21-22, do not enter any collected data. Please note: Data from projects initiated and reported in the chart for SFY 21-22 will be collected in next year's planning documents.***

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

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

1. Project Name	2. Year of Implementation	3. Funding Sources by Type (Including grants, federal, state & local sources)	4. Total Amount for SFY20-21 (only County MH/ID dedicated funds)	5. Projected Amount for SFY22-23 (only County MH/ID dedicated funds)	6. Actual or Estimated Number Served in SFY20-21	7. Projected Number to be Served in SFY22-23	8. Number of Targeted BH United		9. Term of Targeted BH Units (e.g., 30 years)
811 Project	2017	HUD, DHS, PHFA	$0	$0	15	20			Lifetime
Totals					15	20			
Notes:									

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

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

1. Project Name	2. Year of Implementation	3. Funding Sources by Type (include grants, federal, state & local sources)	4. Total $ Amount for SFY20-21	5. Projected $ Amount for SFY22-23	6. Actual or Estimated Number Served in SFY20-21	7. Projected Number to be Served in SFY22-23	8. Number of Bridge Subsidies in SFY	9. Average Monthly Subsidy Amount in SFY20-21	10. Number of Individuals Transitioned to another Subsidy in SFY20-21

Totals									
Notes:									

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

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

1. Project Name	2. Year of Implementation	3. Funding Source by Type (include grants, federal, state & local sources)	4. *Total* $ Amount for SFY20-21	5. Projected $ Amount for SFY22-23	6. Actual or Estimated Number Served in SFY20-21	7. Projected Number to be Served in SFY22-23	8. Number of Owners/ Projects Currently Leasing	9. Number of Units Assisted with Master Leasing in SFY20-21	10. Average Subsidy Amount in SFY20-21
Totals									
Notes:									

4. Housing Clearinghouse for Behavioral Health	☐ Check if available in the county and complete the section.

An agency that coordinates and manages permanent supportive housing opportunities.

1. Project Name	2. Year of Implementation	3. Funding Source by Type (include grants, federal,	4. *Total* $ Amount for SFY20-21	5. Projected $ Amount for SFY22-23	6. Actual or Estimated Number Served in SFY20-21			7. Projected Number to be Served in SFY22-23	8. Number of Staff FTEs in SFY20-21

		state & local sources)							
Totals									
Notes:									

5. Housing Support Services (HSS) for Behavioral Health				☒ Check if available in the county and complete the section.					
HSS are used to assist consumers in transitions to supportive housing or services needed to assist individuals in sustaining their housing after move-in.									
1. Project Name	2. Year of Implementation	3. Funding Sources by Type (include grants, federal, state & local sources)	4. *Total* $ Amount for SFY20-21	5. Projected $ Amount for SFY22-23	6. Actual or Estimated Number Served in SFY20-21			7. Projected Number to be Served in SFY22-23	8. Number of Staff FTEs in SFY20-21
Representative Payee	2009	County MH/HSBG			25			25	2
DeClutter	2009	County MH/HSBG			17			20	2
Totals					42			45	4
Notes:									

6. Housing Contingency Funds for Behavioral Health	☒ Check if available in the county and complete the section.

Flexible funds for one-time and emergency costs such as security deposits for apartment or utilities, utility hook-up fees, furnishings, and other allowable costs.

1. Project Name	2. Year of Implementation	3. Funding Sources by Type (include grants, federal, state & local sources)	4. *Total* $ Amount for SFY20-21	5. Projected $ Amount for SFY22-23	6. Actual or Estimated Number Served in SFY20-21			7. Projected Number to be Served in SFY22-23	8. Average Contingency Amount per person
BHARP	2011	Reinvestment		$31,014.29	5			30	$1,000.00
Totals				$31,014.29	5			30	$1,000.00
Notes:									

7. Other: Identify the Program for Behavioral Health	☐ Check if available in the county and complete the section.

Project Based Operating Assistance (PBOA) is a partnership program with the Pennsylvania Housing Finance Agency in which the county provides operating or rental assistance to specific units then leased to eligible persons; **Fairweather Lodge (FWL)** is an Evidenced-Based Practice where individuals with serious mental illness choose to live together in the same home, work together and share responsibility for daily living and wellness; **CRR Conversion** (as described in the CRR Conversion Protocol), **other.**

1. Project Name (include type of project such as PBOA, FWL, CRR Conversion, etc.)	2. Year of Implementation	3. Funding Sources by Type (include grants, federal, state & local sources)	4. *Total* $ Amount for SFY20-21	5. Projected $ Amount for SFY22-23	6. Actual or Estimated Number Served in SFY20-21			7. Projected Number to be Served in SFY22-23
Totals								

Notes:	

c) <u>Recovery-Oriented Systems Transformation:</u>

i. Provide a brief summary of the progress made on the priorities listed in the FY21-22 plan.
   a. Priority 1 <u>Crisis Residential Services</u> – the fuller Crisis Diversion Services infrastructure plan has been granted for CMHSBG
   b. Priority 2 <u>Suicide Prevention Coordinator</u> – on-going discussions as to how best develop and sustain this position

ii. Based on the strengths and needs reported in section (b), please identify the top three to five priorities for recovery-oriented system transformation efforts the county plans to address in FY22-23 at current funding levels.

*For **<u>each</u>** transformation priority, please provide:*

a. A brief narrative description of the priority including action steps for the current fiscal year.
b. A timeline to accomplish the transformation priority including approximate dates for progress steps and priority completion in the upcoming fiscal year. Timelines which list only a fiscal or calendar year for completion are not acceptable and will be returned for revision.
c. Information on the fiscal and other resources needed to implement the priority. How much the county plans to utilize from state allocations, county funds, grants, HealthChoices, reinvestment funds, other funding and any non-financial resources.
d. A plan mechanism for tracking implementation of the priorities.

1. (Identify Priority)

☒ Continuing from prior year ☐ New Priority

a. Narrative including action steps:
   - CCMH has looked at, discussed and researched this service for the past couple of years based upon it being identified as a service gap in Centre County by individuals who utilize services, families, providers, the local hospital and crisis intervention services.
   - CCMH has held multiple discussions locally and regionally to identify potential partners in and surrounding Centre County. Discussion have occurred with adjacent counties, BHARP, CCBH, MNMC – ED and BHU staff, MNH, Crisis Intervention and Emergency Services and local providers and individuals.
   - The service entails multiple facets and approaches to this service being delivered to include assessment and housing services and supports. It reflects opportunities that exist for diversion from the emergency department, inpatient units and incarceration. Law Enforcement, CIT, Mobile Crisis Intervention Services and the community will have another access point which will alleviate some of the pressure that is being felt in the local hospital and county correctional facility.
   - Development of this service is happening in a variety of areas: renovations, service descriptions, budget and rate setting, data collection, and overall policy and procedures for the service.

b. Timeline: (provide a quarterly breakdown of priority; activities, goals, and deliverables)
   - Transition occured by 12-17-2021
   - Renovation: Fall 2022 (10-12 weeks)
   - Service Description Approval: August/September 2022
   - Rate Setting Approval: September/October 2022
   - Licensing OMHSAS: end of 2022
   - Operational: Beginning of 2023

c. Fiscal and Other Resources:
   - Several funding streams are being explored at this time. They include: CCBH – supplemental and MA, MA FFS, retained revenue, county/block grant funds, reinvestment thru BHARP, grant opportunities, and avenues to generate revenue.
   - Reimbursement thru private insurance will be sought once data reflects a reduction in emergency and inpatient services.

d. Tracking Mechanism: (example: quarterly and annual goals met; deliverables provided-)
   - Grant requires a variety of data collections which include listed below. We will also review data collection once services are implemented to compare data against baseline.
   - Utilization of services by Crisis Intervention, CIT and the community in general
   - Diversion from MNMC ED
   - Diversion from inpatient
   - Diversion from incarceration
   - Linkage to community-based services (outpatient, psychiatric rehabilitation, case management, peer support, etc.)
   - Stability and engagement of individuals utilizing the service
   - Transitions to permanent or transitional housing

2. (Identify Priority)

☒ Continuing from prior year ☐ New Priority

a. Narrative including action steps:
   - As deaths by suicide have risen, the Centre County Mental Health Community is focused on enhancing prevention efforts and raising mental health awareness. The Mental Health Community Committee (MHCC) created a website and event calendar for collaboration in marketing and disseminating information related to mental health awareness, education, training and marketing events/activities. MHCC and all of its membership continue to provide mental health trainings that promote awareness and educate the community on the service-delivery system and available services and supports, educate the community on how to access services and how to handle mental health emergencies when they are encountered and how to support someone dealing with mental health needs. The Suicide Prevention Task Force and focus on suicide prevention efforts to reduce and hopefully ultimately eliminate deaths by suicide. As this critical public health issue is being acknowledged and addressed, the need for a Coordinator has become evident. A Suicide Prevention Coordinator in Centre County could ensure that all efforts are working in harmony and that the energy is focused

appropriately and in a pertinent and collaborative manner. CCMH will review the creation of such a position within the county with retained revenue funding provided through the block grant and/or additional mental health funding allocation through state budget. All block grant partners will benefit from having a coordinator as it is known that suicide itself does not discriminate; it impacts people of all ages, gender, race and societies.

b. Timeline: (provide a quarterly breakdown of priority; activities, goals, and deliverables)
If this is identified as a priority for implementation in FY 2022-2023, the Coordinator position will:
    - Review of position goals and job description: Fall 2022
    - Pending funding allocation, employment of position by end of 2022
    - Oriented to the position and committee involvement will begin January 2023
    - Program evaluation/impact will be assessed to see if there is benefit to keeping the Coordinator position in place for the following FY 2023-2024

c. Fiscal and Other Resources:
Retained Revenue; County/block grant funds

d. Tracking Mechanism: (example: quarterly and annual goals met; deliverables provided)
    - Suicide Prevention Coordinator's involvement in CIT, American Foundation for Suicide Prevention, Suicide Prevention Task Force, MHCC, Senior Centers, Youth and Family activities, Transition-age Youth activities and overall county coordination efforts.
    - Community-wide education
    - Stigma reduction
    - individual engagement
    - Reduction in the number of deaths by suicide locally
    - Enhanced partnership with Jana Marie Foundation

d) Existing County Mental Health Services

Please indicate all currently available services and the funding source(s) utilized.

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

Note: HC= HealthChoices

e) Evidence-Based Practices (EBP) Survey*:

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

Evidenced-Based Practice	1. Is the service available in the County/ Joinder? (Y/N)	2. Current number served in the County/ Joinder (Approx.)	3. What fidelity measure is used?	4. Who measures fidelity? (agency, county, MCO, or state)	5. How often is fidelity measured?	6. Is SAMHSA EBP Toolkit used as an implementation guide? (Y/N)	7. Is staff specifically trained to implement the EBP? (Y/N)	8. Additional Information and Comments
Assertive Community Treatment	NO							
Supportive Housing	YES	14	Permanent housing sustainment or chosen transition	Provider Agency	Annually and per transition	NO	NO	
Supported Employment	NO							Include # Employed
Integrated Treatment for Co-occurring Disorders (Mental Health/SUD)	YES	90	Clinical Supervision and Quality Compliance	Provider Agency	Weekly	YES	YES	
Illness Management/ Recovery	NO							
Medication Management (MedTEAM)	YES IN OP ONLY	40	Increased Community Tenure	Provider Agency	Every 3 to 9 months per individual	NO	YES	HSBG/HC Funded
Therapeutic Foster Care	NO							
Multisystemic Therapy	NO							
Functional Family Therapy	NO							
Family Psycho-Education	YES	7				YES	YES	FEP

***Please include both county and HealthChoices funded services.**

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

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

Recovery-Oriented and Promising Practices	1. Service Provided (Yes/No)	2. Current Number Served (Approximate)	3. Additional Information and Comments
Consumer/Family Satisfaction Team	Yes	170	
Compeer	No		
Fairweather Lodge	Yes	4	
MA Funded Certified Peer Specialist (CPS)- Total**	Yes	30	
CPS Services for Transition Age Youth (TAY)	Yes	2	
CPS Services for Older Adults (OAs)	Yes	2	
Other Funded CPS- Total**	Yes	15	
CPS Services for TAY	Yes	2	
CPS Services for OAs	Yes	2	
Dialectical Behavioral Therapy	Yes	0	
Mobile Medication	No	0	
Wellness Recovery Action Plan (WRAP)	No		
High Fidelity Wrap Around	No		
Shared Decision Making	No		
Psychiatric Rehabilitation Services (including clubhouse)	Yes	100	
Self-Directed Care	No		
Supported Education	Yes	4	
Treatment of Depression in OAs	Yes	10	
Consumer-Operated Services	No		
Parent Child Interaction Therapy	No		
Sanctuary	No		
Trauma-Focused Cognitive Behavioral Therapy	Yes	8	
Eye Movement Desensitization and Reprocessing (EMDR)	Yes	4	
First Episode Psychosis Coordinated Specialty Care	Yes	7	
Other (Specify)			

g) Certified Peer Specialist Employment Survey:

Certified Peer Specialist" (CPS) is defined as:

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

In the table below, please include CPSs employed in any mental health service in the county/joinder including, but not limited to:

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

Name and email of county CPS Point of Contact (POC)	Natalie W Corman nwcorman@centrecountypa.gov
Total Number of CPSs Employed	**14**
Average number of individuals served (ex: 15 persons per peer)	**100**
Number of CPS working full-time (30 hours or more)	**7**
Number of CPS working part-time (under 30 hours)	**7**
Hourly Wage (low and high)	$13.39 - $19.08
Benefits (Yes or No)	**Y (FT)**

h) Involuntary Mental Health Treatment

1. During CY2021, did the County/Joinder offer Assisted Outpatient Treatment (AOT) Services under PA Act 106 of 2018?
   - ☒ No, chose to opt-out for all of CY2021
   - ☐ Yes, AOT services were provided from date: _____ to date: _____ after a request was made to rescind the opt-out statement
   - ☐ Yes, AOT services were available for all of CY2021

2. If the County/Joinder chose to provide AOT, list all outpatient services that were provided in the County/Joinder for all or a portion of CY2021 (check all that apply):
   - ☐ Community psychiatric supportive treatment
   - ☐ ACT
   - ☐ Medications
   - ☐ Individual or group therapy
   - ☐ Peer support services
   - ☐ Financial services
   - ☐ Housing or supervised living arrangements
   - ☐ Alcohol or substance abuse treatment when the treatment is for a co-occurring condition for a person with a primary diagnosis of mental illness
   - ☐ Other, please specify: _____

3. If the County/Joinder chose to opt-out of providing AOT services for all or a portion of CY2021:
   a. Provide the number of written petitions for AOT services received during the opt-out period. #_____0_____
   b. Provide the number of individuals the county identified who would have met the criteria for AOT under Section 301(c) of the Mental Health Procedures Act (MHPA) (50 P.S. § 7301(c)). #_____9_____

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

	i. AOT	**ii. IOT**
I. Number of individuals subject to involuntary treatment in CY2021		173
II. Number of inpatient hospitalizations following an involuntary outpatient treatment for CY2021		3
III. Number of AOT modification hearings in CY2021	N/A	
IV. Number of 180-day extended orders in CY2021		44

V. Total administrative costs (including but not limited to court fees, costs associated with law enforcement, staffing, etc.) for providing involuntary services in CY2021		$200,819.36

i) CCRI Data reporting

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

File/Report Name	Description	Date Format Transfer/Mode	Due Date	Reporting Document
837P Reporting	Reports each time consumer has an encounter with county/provider. Format/data based on HIPAA compliant 837P format	ASCII files via FTP	Due within 90 calendar days of the county/joinder accepting payment responsibility; or within 180 calendar days of the encounter	HIPAA implementation guide and addenda. PROMISe™ Companion guides.

Have all available claims paid by the county/joinder during CY 2021 been reported to the state as a pseudo claim? ☒Yes ☐ No

INTELLECTUAL DISABILITY SERVICES

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

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

With that in mind, please describe the continuum of services to registered individuals with an intellectual disability and autism within the county. In a narrative format, please include the strategies that will be utilized for all individuals registered with the county, regardless of the funding stream. In completing the chart below regarding estimated numbers of individuals, please include only individuals for whom Base or HSBG funds have been or will be expended. Appendix C should reflect only Base or HSBG funds except for the Administration category. Administrative expenditures should be included for both base and HSBG and waiver administrative funds.

**Please note that under Person-Directed Supports (PDS), individuals served means the individual used Vendor Fiscal/Employer Agent (VF/EA) or Agency with Choice (AWC) for at least one service during the fiscal year. The percentage of total individuals served represents all funding streams. The percentage might not add to 100 percent if individuals are receiving services in more than one category.*

Centre County MH/ID/EI-D&A currently uses HSBG monies to fund the following services including:

- In-Home and Community Supports
- Transportation (both public and mile)
- Community Participation Services (Chapters 2380 and 2390)
- Behavioral Support Services
- Employment Services
- Community Habilitation
- Residential Services (licensed)
- Licensed Day Habilitation for Older Adults
- Respite
- Homemaker
- Home Accessibility Adaptations
- Representative Payee services
- ASL Interpreter Services

Family Driven monies are used for:

- Family Aide
- Family Support Services/Individual Payment
- Recreation/Leisure
- Home Rehabilitation
- Vehicle Accessibility Adaptations

	Estimated/ Actual FY 21-22	Percent of total Individuals Served	Projected in FY 22-23	Percent of total individuals served
Supported Employment	12	2.7%	15	3.4%
Prevocational Services	1	<1%	1	<1%
Community Participation	1	<1%	2	<1%
Base Funded Supports Coordination	23	6%	30	7%
Residential (6400)/unlicensed	0	0%	0	0%

Lifesharing (6500)/unlicensed/Supported living	0	0%	0	0%
In-Home and Community Supports	8	1.8%	12	2.7%
PDS/AWC	0	0%	0	0%
PDS/VF	0	0%	0	0%
Family Driven/FSS/Base NOS	19	7%	25	7%
Transportation	1	<1%	4	1%

*HSBG monies are used for representative payee services for 8 individuals and ASL interpreters for 2 individuals not included in the numbers above.

Supported Employment:

There are approximately 13 providers qualified and willing to provide employment related services in Centre County. These providers offer an array of employment services including Supported Employment (all phases), Advanced Supported Employment (all phases), Community Participation Supports, Small Group Employment, and Transportation. During FY 2021-2022, one local provider became qualified to provide Benefits Counseling. Two providers currently maintain county contracts to provide Supported Employment services using HSBG monies. Three providers currently maintain county contracts to provide Community Participation Supports using HSBG monies.

Worklink is a two-year certificate program for individuals with intellectual disabilities or autism who seek a post-secondary education experience and training for employment. It is supported by a grant from the D.R.E.A.M. partnership and is in the Penn State College of Education. Two of the original four participants from 2019/2020 successfully completed the program at the conclusion of the Spring 2022 semester. WorkLink classes were online during FY 2020-2021 due to COVID-19 Pandemic. The second cohort of three students, plus the new cohort of 5 students starting in August 2021 (including the first 3 students registered with other Administrative Entities) finished their first-year coursework at the end of the Spring 2022 semester. Three additional students have been accepted into the WorkLink program for the Fall 2022 semester. The AE and SCO, along with WorkLink staff continue to meet with parents and participants throughout the year to monitor implementation and progress in addition to obtaining feedback for improvement.

Centre County AE continues to participate in the local Employment Coalition which dovetails with the local transition council. The Employment Coalition is chaired by an Administrative Entity Program Specialist and the Director of Employment Services of a local provider agency. The membership of the Employment Coalition consists of representatives from Administrative Entity, school districts (including the IU), Careerlink, OVR, other Centre County offices, local service providers, Supports Coordination Organization, and family members.

The Employment Coalition, in conjunction with Central Intermediate Unit 10, has hosted three online training sessions since January 2021. These training sessions were recorded and can be viewed on the Central Intermediate Unit 10 website. The sessions included an overview of the Penn State University WorkLink program (January 2021), and an overview of ODP Employment Services (March 2021). Most recently, an OVR overview was recorded in January 2022. The next planned online

session will be a discussion of the Americans with Disabilities Act (ADA), when and how to disclose disability to an employer, and reasonable accommodations that can be requested. This session will occur in the Fall 2022. The Employment Coalition has identified these topics for future sessions:

- Parent Panel on Transition from school to employment
- SSI/WIPA overview
- ID/Autism system overview
- Adult Mental Health system overview

Central Region ODP, along with Centre AE and the PA Family Network have offered technical assistance for six Supported Employment and CPS providers on the LifeCourse Community of Practice philosophy and tools. The initial focus on this technical assistance was to provide additional tools for CPS providers to help CPS recipients move toward and obtain competitive integrated employment.

This began with Introduction to the Deeper Dive virtual sessions presented by Central Region ODP. These sessions occurred on January 31, 2022, February 4, 2022, and February 8, 2022. In March and April 2022, the second part of this technical assistance was completed with individualized virtual sessions with each provider to discuss plans to incorporate LifeCourse tools into organizational practices. An organizational Trajectory Exercise was completed. During these follow up meetings, each agency was asked to identify an individual in services willing to connect with the PA Family Network to learn more about LifeCourse and then hold team meetings to implement LifeCourse tools.

In FY 2021-2022, representatives from the AE participated in a virtual transition night for students and families from a local school district. An overview of eligibility requirements, funding, and services was given. In previous years, AE, and SCO staff as well as representatives from OVR, MATP, secondary education programs, Careerlink, and other community/civic programs participated in “in-person” information nights.

County AE staff participate in employment related activities and trainings including the Annual Transition Conference, Experience Employment Connection sessions, SELN events, Charting the LifeCourse Employment Innovation Area calls, and quarterly employment calls with ODP Central Region Office. These ongoing activities will provide networking opportunities as Centre County continues to explore, develop, and expand employment. Centre County AE also participates in the local Transition Coordinating Council and the Right to Education Task Force meetings in conjunction with Central Intermediate Unit 10.

Centre County AE has included a goal related to increasing the number of individuals achieving Competitive Integrated Employment in its Quality Management Plan. The ID Program Specialist reviews Employment data compiled Office of Developmental Programs as part of the Quality Management Plan quarterly reports. This information is also used to review trends in Centre County and assists with the planning for employment activities in the upcoming fiscal year and longer term. The long-range plan is to continue to track employment data and share information with providers, Supports Coordination, MH/ID Advisory Board, local transition council, and other interested stakeholders.

Lastly, local OVR counselors utilize MH/ID office space. This arrangement affords the SCO better coordination with OVR for intakes. The counselors are also a valuable resource for both the SCO and AE.

Supports Coordination:

The AE and SCO Assistant Administrators participate in weekly administrative meetings with the agency Administrator and administrative counterparts for Mental Health and Drug & Alcohol units. Both entities are part of the Communities of Practice/Charting the LifeCourse collaboration (Central 8) with Northumberland, CMSU and Lycoming/Clinton counties. Centre AE staff participate in the Front Door Innovation Workgroup and Central Region Supporting Families Quarterly meetings.

Centre AE has a program specialist who has completed the Charting the LifeCourse Front Door to Supports/No Wrong Door Ambassador Series. The Life Trajectory and Integrated Star have been incorporated into the intake process. These initial LifeCourse documents are completed by the AE and given to the assigned Supports Coordinator for their initial meeting and ISP development.

Centre SCO staff meet bi-weekly throughout the year. Part of each meeting is a review of waiver capacity, status of ODP initiatives, residential openings, and service needs. In addition, supports coordinators can review any individual on their caseload. Special attention is given to individuals with known life events including upcoming graduates, individuals aging out of other systems (e.g., CYS, EPSDT), hospital/nursing home -admissions/discharges, and individuals involved in the legal system. Information from these meetings related to transitions, openings, discharges, and changes in need are communicated directly to the AE for planning purposes. Conversely, waiver opportunities, residential openings and new service providers are communicated to the SCO for review. New providers are invited to attend the bi-weekly meeting to discuss Centre County service needs and agency capacity. Agenda items are solicited from the AE for these meetings and AE personnel are available to attend these meetings as needed and/or requested.

Centre County continues to conduct bi-weekly virtual meetings with local providers, including HCQU and DDTT staff to assess staffing needs, share ideas/resources, and maintain communication related to the various updates. Virtual bi-weekly meetings will continue throughout 2022/2023. In addition to regularly scheduled provider meetings, Centre County AE meets quarterly with local providers of licensed day services (both Community Habilitation and Pre-Vocational) to review and discuss Community Participation Services (CPS) to increase the community experience for participants. Providers are encouraged to share information, resources and successes related to service provision. These meetings will continue in 2022/2023 at the request of the providers with a focus on employment.

Individuals who choose not to participate in traditional services or pursue competitive employment are supported and encouraged by ISP teams to explore other options in their community that support community integration. The AE has ensured that SCO, residential providers, individuals, families, and other stakeholders understand the options available under the service definitions in the proposed waivers.
It is the hope, that as in-person events continue to increase in frequency, annual transition/agency nights will be scheduled and local organizations, groups and agencies that are not part of the ID service system will participate and highlight community groups and events that are integrated.

Centre County AE reviews the various funding sources and service options at the time of intake to ensure that individuals and families are introduced to self-determination/participant directed services (PDS) options. The AE attends planning meetings/ISPs with the supports coordinator when participant directed services are initially discussed to ensure that the individual/family understand the

service model structure, service definitions and responsibilities. The use of Supports Broker service is encouraged when an individual/family is interested in participant directed services.

Centre County AE offers choice of Supports Coordination Organizations and currently has relationships with 4 SCOs.

Lifesharing/Supported Living:

Centre County has seen some in growth Lifesharing placements. There is currently a total of 5 Lifesharing placements, 3 licensed and 2 unlicensed. The provider of unlicensed Lifesharing makes their services available for respite as needed and appropriate. There are no local providers qualified to provide Supported Living at this time. The AE continues to discuss the development of supported living residential service with various providers and has explored the use of technology with the SCO and providers.

The existing Lifesharing providers and the SCO promote the option for family members to be paid as Lifesharing providers. PUNS data and information from the SCO will be used to identify individuals and families in need of this service.

A representative from the AE continues to participate in Lifesharing activities at the local and regional level.

Cross Systems Communications and Training:

Centre County AE and SCO regularly participate in local trainings and meetings to gain knowledge of other service systems/resources. Training on the ID/A system has been provided to other county offices and other local entities by county ID staff as requested. In addition, staff from other county offices has provided overviews of services at both the SCO unit meetings and larger agency meetings.

A representative from the agency gives an overview of Intellectual Disabilities for local law enforcement entities during training for the local Crisis Intervention Teams (CIT). Centre County AE and SCO had the opportunity to participate in training titled “Creating Welcoming Services for LGBTQ Individuals and Their Families” in April 2022.

AE and SCO staff participate in quarterly Human Services meetings that include staff from AAA, Adult Services, CYS, Mental Health, Early Intervention and Drug & Alcohol offices. Services and personnel updates are given, and high-profile cases are reviewed. The AE and SCO work with other stakeholders (MCO, Education system, RTF staff, Probation, CYS, ODP, county housing office, Adult Services, MH providers, etc.) when transitioning young adults from facility settings to the community.

The AE and SCO is also a part of the Children’s Advisory Board (formerly CASSP). In the FY 2021/2022 meetings continued virtually. The Children’s Advisory Board has continued to support the Children’s Collaboration whose mission is to identify and increase services for children in Centre County. These meetings bring together county agencies (MH/ID, Early Intervention, and CYS), MH and EI providers, and school representatives (pre, public and private). The group continued to meet quarterly and offer opportunities for information sharing and training to increase knowledge of

resources and improve the array of services for children in Centre County. Topics in FY 2021/2022 included presentations from local providers highlighting MH and D&A services supports available for children and young people, an overview of IBHS, and an overview of Intellectual Disabilities/Autism eligibility.

The SCO, with the support of the AE, present complex cases to members of the Children's Advisory Board, using the CASSP principles, to garner the input from various service systems to better serve both the individual and family. Centre County AE and SCO collaborate internally with Centre County Mental Health and case management to address the needs of individuals dually diagnosed including team meeting participation, sharing resources, and coordinating referrals. Other groups/services used to support individuals with complex concerns include DDTT, HCQU, CSRU, and PPC. AE staff participate in scheduled team meetings and calls for identified complex cases.

In FY 2021/2022, Centre AE has experienced an increase in individuals choosing to graduate from high school prior to turning 21 years old and/or aging out of CYS custody/RTF placement and in need of residential services. The ongoing DSP shortage has impacted the availability of local residential capacity. The new online residential vacancy process is an asset in conducting provider searches outside one's county/joinder.

The AE conducts bi-weekly virtual provider meetings. Waiver capacity, ODP initiatives/communications, available funding, staffing issues, and service needs are part of the agenda. HCQU and DDTT staff attend and provide updates as appropriate. AE staff schedule an introductory meeting with all providers new to the ID system in Centre County. Part of this discussion includes service needs, waiting list information, and referral processes. After meeting with AE staff new providers are scheduled to attend a bi-weekly unit meeting (attended by both SCO and AE staff). The new provider gives an overview of the services they are qualified and willing to provide, capacity, and referral processes.

A representative from the AE regularly attends the local Transition Council meetings held throughout the school year which is also attended by representatives from the local IU and school districts. This venue has allowed the AE to develop relationships school personnel and has enabled the office to better address the needs of transition age youth. The SCO and AE staff participate in IEP meetings as invited to plan transition activities and address changes in needs for individuals still in the school system. The Centre County AE and SCO collaborate in planning each year to address the needs of identified graduates via waiver capacity management.

Early Intervention Services (Infant/Toddler, birth through 3 years old) service coordination is part of the county offices. EI Service Coordination have participated in trainings related to Communities of Practice/Charting the LifeCourse. Early Intervention Service Coordination and EI providers are familiar with Charting the LifeCourse information which is used at transition meetings to assist families with planning. The EI Coordinator is a member of the Children's Advisory Board.

Emergency Supports:

Centre AE maintains contracts/letters of agreement with local agencies to use non-waiver funding to provide services. Individuals are approved and authorized for services based on the needs identified through the Office of Developmental Programs (ODP) Prioritization of Urgency of Needs for Services (PUNS) process. In addition, Centre AE also administers Family Driven/Family Support Services

(FD/FSS) voucher program used to address various and unique needs of individuals not in the ID/A waiver programs.

The PUNS Management Report is reviewed regularly by AE and SCO staff to assist with the planning for waiver enrollment when waiver opportunities are available, either through maintenance capacity or ODP initiatives.

Centre County MH/ID/EI-D&A contracts with a local provider for after-hours emergencies. This provider has a call down list of county administrative personnel to contact if an emergency occurs outside of normal work hours. AE personnel monitor incident management in HCSIS during weekends and holidays to review incidents submitted by providers.

Centre AE maintains FD/FSS funds to address the needs of individuals not enrolled in waiver programs. A portion of these dollars are not authorized in plans but are maintained in reserve to address unanticipated needs. Each fiscal year Centre AE earmarks HSBG funds to specifically address unanticipated emergency respite needs. Utilization of FD/FSS funds and respite funds as well as other unallocated and underutilized funds are monitored monthly by AE, SCO and Fiscal personnel and could be accessed in the event of an unanticipated emergency.

In the event of an individual requires emergency services the following activities will occur:

- An assessment to determine the immediate health and safety needs of the individual and the immediate action to provide health and safety.
- The notification of appropriate entities as required or needed to ensure the immediate health and safety of the individual: Adult Protective Services (APS), Office of Developmental Programs (ODP), Office of Aging, Children and Youth Services (CYS), Department of Health, local law enforcement, and necessary medical or mental health services.
- If residential services are necessary, local resources will be utilized, including identified respite providers, local shelters, and personal care homes. Program capacity at the local level will be considered in addition to the use of ODP's Residential Vacancy List, if needed. The availability and appropriateness of local family will also be evaluated. If appropriate and necessary, ODP's procedure for Unanticipated Emergencies will be implemented to assist with planning and funding.
- Non-residential emergencies can be varied as they can include everything except housing. An assessment of the situation by the AE and SCO would need to occur to determine the type of resources needed to address the emergency. AE and SCO personnel would be responsible to identify and coordinate resources, human services supports and funding to assist with the individual.

Centre County MH/ID/EI-D&A maintains a contract with a local MH provider for mobile crisis, walk-in crisis, and telephone crisis services. In addition, a contracted entity provides delegate services and works closely with the local Crisis Intervention Team (CIT) and hospital emergency department. Centre County AE also contracts with Advocacy Alliance to conduct certified investigations as needed and required.

Administrative Funding:

Centre County MH/ID/EI-D&A is part of a local Communities of Practice/Supporting Families/Charting the LifeCourse collaborative along with Northumberland, CMSU and Lycoming/Clinton counties

(Central 8). The ID Program Specialist 1 completed the Charting the LifeCourse Front Door to Supports/No Wrong Door Ambassador Series. The intake process has been updated to incorporate the Integrated Star and Trajectory plan to summarize information to be given to the SCO to assist with service planning and ISP development.

Centre County AE has chosen to continue to maintain oversight of the Centre County Human Rights Team (HRT), working with local providers to review and approve restrictive procedure plans in accordance with the applicable licensing chapters and the AE Operating Agreement. The Centre County HRT continued to meet virtually each month in FY 2021/2022. The Centre County Human Rights Committee (HRC) was formed in FY 2019/2020 with members from local providers. There has been changes in membership over the past year. The HRC will continue to review BSPs/RPPs for quality components.

The HCQU nurse is a member of the local Human Rights Team and conducts incident management reviews related to hospitalizations, emergency room visits and any other incident as warranted/requested. Both the SCO and AE attend the annual HCQU meeting. The annual report generated by the HCQU is shared with all SCO and AE staff, and providers. The AE continues to formally track referrals in order to identify ongoing training needs/trends for individuals, families and providers. This information will be used to identify training gaps to be addressed in AE, SCO and provider Quality Plans as warranted. In 2021/2022, the HCQU participated in the Provider Risk Assessment process providing technical assistance as requested by the AE during a Phase 2 review of a local provider. The HCQU Director also participates in the bi-weekly provider meetings, providing information on available training and resources.

Centre County AE reviews IM4Q considerations regularly in HCSIS. Reports are reviewed as necessary at the bi-weekly SCO unit meetings. Follow up activities are discussed to ensure that considerations are addressed. Both AE and SCO staff dialogue directly with the local program when there are questions or clarification needed regarding considerations or their resolution. A representative of the IM4Q is invited to provider meetings and the MH/ID Advisory Board to present IM4Q data. The IM4Q project was invited to the HSBG public hearings. Centre County AE participates in the Regional quarterly IM4Q meetings and the IM4Q Management Committee.

All local providers are invited to attend the biweekly provider meetings to network, discuss service needs/gaps, share resources, and discuss strategies to address staffing needs. AE staff attends team meetings to provide support and assist with the identification of resources for individuals with complex needs. All providers are forwarded information on training that is available and pertinent. Local resources such as HCQU, DDTT, Children's Collaborative, CSRU and PPC are available to assist teams supporting individuals with higher levels of need. The AE has identified 2 providers who are qualified and willing to provide an enhanced level of habilitation (LPN) to support individuals living independently who need support around nutrition, understanding diagnoses, and engaging in follow-up appointments.

Risk Management/Mitigation is an important component of every incident (whether it meets the definition to be filed or not). Part of the bi-weekly unit meetings includes a review of issues or concerns and follow up activity. The SCO monitors corrective actions related to risk and moves identified concerns to Centre County AE in accordance with their policy. The AE and SCO meet weekly to complete Administrative Reviews of certified investigations. Risk management is looked both at the individual level, related to specific issues, and at the provider level via the Provider Risk Assessment process. The AE and SCO completed Provider Risk Assessment process for 5

residential providers assigned to Centre County and provided feedback to other AEs as requested. Centre AE also chose to complete a provider risk assessment on a local agency that provides only unlicensed services as a quality component to the process. The Centre County AE participates in the regularly scheduled ODP Regional Risk Management meetings.

An important piece of incident management review is the identification and mitigation of risk. There have been instances where the AE required providers to add corrective actions to an incident that specifically addresses the identified risk, training needs and policy updates. The SCO monitors corrective actions as well as updating the ISP to include risk mitigation strategies.

The county housing coordinator (through Centre County Adult Services) is available to participate in agency meetings and provider meetings to explain housing programs that are available in Centre County. The information related to eligibility, availability and the application process is explained in detail. The housing coordinator emails updates and information to key county staff for distribution to case management staff, including the SCO as it relates to funding and housing opportunities.

Participant Directed Services (PDS):

Centre County AE has over 50 individuals using Participant Directed Services (both models) – all waiver funded. These 2 service models continue to be popular due to the flexibility afforded individual and their teams. A representative from the AE attends team meetings to assist the SC, individual and families in understanding the service models so that informed choices can be made. Interested participants are encouraged to consider using the Supports Broker service to assist with setting up and managing services. One of the barriers for base funded PDS is the cost of the administration fee.

In the past year, Centre AE conducted an audit of VF/EA services notes and progress reports. Feedback on the paperwork was provided to the assigned SCs to be shared with the Common Law Employer (CLE). The AE provided training to the SCO on the VF/EA service model and provided a list of resource documents. In 2022/2023, Centre AE plans to conduct a second audit of service notes and add AWC service note reviews to the process. The monitoring and improvement of documentation of PDS service models may be added to the Quality Management plan.

PALCO reports are shared by the regional PDS leads to the AE and are distributed to SCOs to assist with monitoring. Centre County AE participates in quarterly PDS calls with ODP Central Region Office. ODP Central Region PDS leads are knowledgeable and helpful when questions or concerns arise.

Community for All:

Centre County MH/ID/EI-D&A currently has 1 individual residing in a state center and no one residing in a state hospital. There is currently 1 individuals residing in a nursing facility, 3 individuals residing in private ICF facilities and 3 individuals in personal care homes. HSBG monies continue to be used to provide supports for individuals in personal care homes, as needed and appropriate, to keep them engaged in their community.

The AE and SCO work with other stakeholders (MCO, Education system, RTF staff, CYS, Juvenile Probation, DDTT, CSRU, ODP, etc.) when transitioning young adults from facility settings (RTF/APS) to the community. This includes regular participation in team meetings, community placement search/referrals, liaison to Central Region ODP, updating the ISP as needed, and management of waiver capacity. Internally, the SCO and MH case management collaborate to identify primary case management responsibilities for individuals who are dually diagnosed.

HOMELESS ASSISTANCE PROGRAM SERVICES

Please describe the continuum of services to individuals and families within the county who are experiencing homelessness or facing eviction. An individual or family is facing eviction if they have received either written or verbal notification from the landlord that they will lose their housing unless some type of payment is received.

Centre County is fortunate to have a continuum of housing services available for individuals and families who are experiencing homelessness or near-homelessness. Services that are offered and funded through the Homeless Assistance Program include Bridge (transitional) housing, rental & mortgage assistance, a Housing Program Specialist position (categorized under Innovative Supportive Housing Solutions), and the Coordianted Entry Walk-In Center (categorized under Innovative Supportive Housing Solutions). Additional housing programs in Centre County that are not funded through the Human Services Block Grant, but are administered out of the Office of Adult Services, include the Emergency Rental Assistance Program (ERAP), Section 811 Housing, PHARE Rental Assistance, rapid re-housing, permanent supportive housing, and emergency shelter.

Centre County's Office of Adult Services is also actively involved with the Eastern PA Continuum of Care (CoC), South Central Regional Housing Advisory Board (RHAB), and the Coordinated Entry System (CES). Centre County is also working with contracted providers, local municipalities, and partner agencies to collect data, identify current and/or projected service gaps, and apply for grants to bring additional funding into the community.

Over the last year, Centre County has successfully expanded the existing rapid re-housing program through the Department of Housing & Urban Development (HUD), was awarded additional funds and contract extensions through the Department of Community and Economic Development (DCED) under the Emergency Solutions Grant (ESG) – CV1 and Emergency Solutions Grant (ESG) – CV2 for rapid re-housing and emergency shelter services, and most recently applied for Emergency Solutions Grant (ESG) funds through DCED to support the expansion of existing emergency shelter services and to create the Centre County Homeless Prevention Program.

In addition, Centre County continues to administer ERAP which has been a massive undertaking since March 2021. Over the last 17 months, the Office of Adult Services has received a total of 4,737 applications from 2,364 unique households. Without missing a beat, the department has and continues to receive 50-100 applications each week since the program opened. At this time, the majority of applications received are for recertification meaning that the tenant and/or landlord has been awarded funds for rental and/or utility assistance at least one time before. As rents continue to increase and affordable housing is more challenging to obtain, many tenants and landlords have

become dependent on ERAP as if it is a rental subsidy versus an emergency rental assistance program.

Although new funding will increase Centre County's capacity to serve those with higher needs and barriers, it still does not address the affordable housing crisis which continues to be at the core of all needs identified by individuals and families served across the human services spectrum. According to the Washington Post, published on April 21st, 2022, Centre County has the highest average rent in the State of Pennsylvania ($1,812.00/month) and only saw a 4.90% rent increase since 2019. Compare that to more populated and urbanized areas that have a lower average rent and saw a rental increase of 10-17% since 2019. As a result, Centre County will continue to explore new and alternative housing programs to meet the affordability needs of all households with a fixed or limited income to prevent the experience of homelessness or near-homelessness.

Bridge Housing Services:

Bridge Housing is a short-term, transitional housing option (12-18 months) that offers subsidized rental assistance and wrap-around case management services to homeless individuals and families; allowing them the opportunity to work towards self-sufficiency and permanent housing. Centre County currently operates 5-8 units amongst two providers: Centre Safe and Housing Transitions. Providers secure and maintain leases on the majority of units; however the tenant-based rental model is available for clients who may be in a better position to secure permanent housing upon entrance into the program. For most clients, the provider-based model is an appropriate option as they require additional supports towards obtaining permanent housing on their own.

The Office of Adult Services meets with program staff on a monthly basis and supervisory/program staff on a bi-monthly basis to discuss client needs, vacancies, applications, service gaps, community collaborations, and upcoming funding opportunities. In addition, an annual self-audit is conducted to review client files, invoices, and provider policy and procedure. The Office of Adult Services also requires that each provider submit a monthly report that identifies the number of individuals/households served, need(s) identified, Federal Poverty Level (FPL) of each household, unmet need or number of clients that could not be served (due to lack of funding or ineligibility), and current wait lists. All of this data is then collected and analyzed to determine trends and service gaps; positioning Centre County to further understand the needs of its most vulnerable residents and apply for additional grant funds as they become available.

Bridge Housing in Centre County has been successful for many individuals and families that are experiencing homelessness and are residing in either the domestic violence emergency shelter at Centre Safe or the family shelter, Centre House, at Housing Transitions. For many clients enrolled in Bridge Housing, they have been able to exit the program once they obtain a Housing Choice Voucher and secure permanent housing. Others have been able to secure steady and higher paying employment so that, upon exiting the program, they can afford permanent housing on their own without a rental subsidy.

In addition to the rental subsidy and supports offered by Bridge Housing, providers report that their clients have other areas of high need that include: food insecurity, budget counseling, behavioral

health counseling, and education. These unmet needs, and many more, often contribute to an individual or family's inability to obtain and secure permanent housing. Case managers then work with their clients to address these needs or obstacles that often fuel housing insecurity. For example, case managers can refer their clients, who are experiencing food insecurity, to their local food pantry and other food assistance programs, such as WIC, if appropriate. For budget counseling, clients can be connected to a local financial care program that is funded through the Human Services Block Grant. Case managers can also encourage their clients to contact the Centre County MH/ID/EI – D&A department to explore and understand the various behavioral health services and programs that could be available to them. Lastly, clients could learn more about CareerLink and/or the Office of Vocational Rehabilitation for educational and/or employment training opportunities.

There are no proposed changes to the Bridge Housing program for FY 2022-2023.

Case Management:

Effective FY 2021-2022, Housing Case Management is no longer be funded through HAP. Funding for this service was reallocated to add the Coordinated Entry Walk-In Center at Housing Transitions. This program is funded under Innovative Supportive Housing Services.

Rental Assistance:

The Rental & Mortgage Assistance Program (RAP) provides rent or mortgage assistance to eligible homeless or near-homeless Centre County residents. This program is administered by the Office of Adult Services. RAP recipients are either self-referred or referred by human service agencies countywide. Once screened for eligibility, clients are invited to complete an intake. Office of Adult Services' staff are then responsible for communicating with the landlord or mortgage company regarding the requested amount of assistance needed to resolve the immediate crisis. Once all involved parties are in agreement regarding the assistance available, funds will be released to the landlord or mortgage company. Each month, $9,800.00 is allocated for eligible households. With the influx of rental assistance funding through other federal and state funding sources, we continue to see a need for RAP funding but have adjusted to the multiple funding streams and matching services to the individual to best meet their need(s).

Since the RAP program is administered by the Office of Adult Services, the Director meets with appropriate staff on a monthly basis to discuss client needs, service gaps, community collaborations, and upcoming funding opportunities. An annual self-audit is also completed to review client files, invoices, and discuss potential improvement for the coming year. It is also required that appropriate staff submit a monthly report that identifies the number of individuals/households served, need(s) identified, Federal Poverty Level (FPL) of each household, unmet need or number of clients that could not be served (due to lack of funding or ineligibility), and current wait lists. All of this data is then collected and analyzed to determine trends and service gaps; positioning Centre County to apply for additional grant funds as they become available.

There are no proposed changes to the services provided through the Rental & Mortgage Assistance Program for FY 2022-2023.

Emergency Shelter:

Centre County does not use funding from the Human Services Block Grant for emergency shelter. Alternatively, emergency shelters receive different sources of funding from federal, state, and local sources. Currently, Centre County has three permanent homeless shelters and one weather-related shelter:

- Centre House (Housing Transitions): provides shelter and services for men, women, and children;
- Centre Safe: provides shelter and services for women and children fleeing domestic violence;
- Centre County Youth Services Bureau: provides shelter and services for males and females ages 12-18;
- Out of the Cold Centre County: faith-based initiative that provides shelter between October-May on rotation amongst 12-15 churches in Centre County. The sites provide beds for 20+ individuals (men and women), ages 18+.

Innovative Supportive Housing Services:

Centre County uses funds from the Human Services Block Grant to support the Housing Program Specialist (HPS), a position within the Office of Adult Services. The HPS coordinates efforts and educates residents, county human service departments, the Centre County Housing Authority, and community agencies to help our most vulnerable residents to secure safe, appropriate, and affordable housing. These services can range anywhere from helping to navigate the local rental housing market to explaining landlord/tenant law. The HPS also manages with waitlist for Section 811 Housing and leads the Centre County Housing Options Team, is actively involved with the following groups: Eastern PA Continuum of Care, South Central Regional Housing Advisory Board, Centre County Reentry Coalition, and MH/ID Provider meetings.

Since the HPS is a position under the Office of Adult Services, the Director meets with appropriate staff on a monthly basis to discuss client needs, service gaps, community collaborations, and upcoming funding opportunities.

There are no proposed changes to the services provided by the Housing Program Specialist for FY 2022-2023.

In Centre County, Human Service Block Grant funds are also utilized to support the 211 Coordinated Entry Walk-In Center. The Homeless Housing Service Coordinator (HHSC) provides coordinated entry referral services for individuals and families experiencing homelessness or who meet the

definition of homelessness according to the Department of Housing and Urban Development (HUD). The HHSC assists individuals and families who are experiencing homelessness, or who are defined as homeless by HUD in Centre County, to enter the CoC Coordinated Entry System's (CES) By Name List (BNL). The HHSC evaluates eligibility for individuals and families who walk-in or call walk-in site to enter the BNL or make referrals to other resources if they do not qualify as homeless. The HHSC can also meet with those experiencing homelessness at other agencies or other agreed upon locations to complete the information needed for the VI-SPDAT assessment. Following the completion of the assessment, the HHSC can coordinate between agencies to prevent duplication of services and ensure that households on the BNL receive timely outreach services.

Homeless Management Information Systems:

The Office of Adult Services received two licenses via the Eastern PA Continuum of Care (CoC) in January 2019. Effective July 1st, 2019, data is entered into HMIS for all clients receiving assistance from the Rental & Mortgage Assistance Program; a program funded under the Human Services Block Grant.

SUBSTANCE USE DISORDER SERVICES

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

Please provide the following information:

1. **Waiting List Information:**

Services	# of Individuals*	Wait Time (days)**
Withdrawal Management	0	0-2 days
Medically-Managed Intensive Inpatient Services	0	3-5 days
Opioid Treatment Services (OTS)	0	3-7 days (depending on the provider)
Clinically-Managed, High-Intensity Residential Services	0	3-5 days
Partial Hospitalization Program (PHP) Services	0	0-2 days
Outpatient Services	0	3-5 days
Other (specify)	N/A	N/A

*Average weekly number of individuals

**Average weekly wait time per person

Wait time to access treatment services continues to vary at each level of treatment. For each inpatient residential request, staff continues to contact a variety of treatment providers (as approved by the individual) to find the earliest possible bed date. In some cases, a delay in accessing residential treatment is based on individual choice. Once an individual is authorized for a particular level of care and a treatment date is set, case management staff will notify the provider if the individual needs or wishes to change that date for any reason. If a bed date/appointment time is

available sooner, the provider may contact the individual directly and admit them sooner without having to seek additional authorization from the SCA.

At the outpatient level of care, individuals may contact the provider directly to arrange for services. The SCA monitors access to services at this level of care to assure that clients have ongoing availability that is timely. When the start of treatment is delayed, this again is most often due to client choice (by provider report).

Overdose Survivors' Data: Please describe below the SCA plan for offering overdose survivors

# of Overdose Survivors	# Referred to Treatment	Referral method(s)	# Refused Treatment
1,442	7	Referral offered by medical staff	1,435

Centre County SCA continues to offer 24/7 direct referrals to individuals experiencing an overdose through ongoing relationships with Mount Nittany Medical Center (MNMC) and the Center for Community Resources, whose staff provide support services after regular business hours and on nights/weekends/holidays. The Center for Community Resources is a licensed mental health mobile crisis provider under contract with Centre County Mental Health/ Intellectual Disabilities/Early Intervention - Drug and Alcohol for walk in crisis assessment and mobile assessment.

Standard Business Hours

If an individual presents at Mount Nittany Medical Center's Emergency Department (ED) during standard business hours having experienced an overdose, they are first medically cleared. The ED staff determine if they are interested in treatment services and if so, call for case management at the hospital to work with them on connecting them to services. MNMC Case management staff will contact the SCA and request assistance. Sufficient information will be collected and a referral to detox services will be made. If the individual is sufficiently stable, a full drug and alcohol assessment will be completed. This assures that they can easily make the transition from detox to rehab, if appropriate.

If there is a delay in access to this level of care due to capacity of contract providers to accept the admission, MNMC case management staff will be notified so that they can arrange for the needs of the individual on a medical basis (as appropriate). SCA staff will maintain daily contact with the individual during the waiting period, while making ongoing phone calls to determine if an opening has come available. If the provider is willing, the SCA will grant approval and allow the provider to proceed with contacting the individual directly when an opening occurs, knowing that the authorization for admission is in place.

After Hours/Weekends

If an individual presents at the ED after hours or on a weekend, having experienced an overdose and is requesting non-hospital detoxification services, they are first medically cleared by the ED medical staff. ED staff will determine if the individual is interested in treatment services and if so, call for case management staff at the hospital to come and assist with accessing services. MNMC case management staff will then contact Center for Community Resources (CCR) staff who will gather

sufficient information to make the referral and will call all approved providers looking for bed availability. CCR staff have the authority to contact contracted treatment providers on the SCA's behalf to arrange for a non-hospital detoxification admission, and then approve an after-hours non-hospital detox admission until the next business day. CCR staff will submit an after-hours detox request form and copies of all paperwork to the SCA office the morning of the next business day so that follow up can occur with the individual and the detox provider.

If there is a delay in access to this level of care due to capacity of contract providers to accept the admission, CCR staff will notify MNMC case management and ED staff so that they can arrange for the needs of the individual on a medical basis (as appropriate). CCR staff will maintain daily contact with the individual until the next business day when SCA staff will take over.

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

LOC American Society of Addiction Medicine (ASAM) Criteria	# of Providers	# of Providers Located In-County	# of Co-Occurring/Enhanced Programs
4 WM	2	0	0
4	2	0	0
3.7 WM	23	0	0
3.7	7	0	4
3.5	39	0	16
3.1	13	0	0
2.5	1	0	0
2.1	2	2	2
1	3	3	1

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

   Centre County continues to offer the availability of Medication-Assisted Therapies (MAT) to individuals who are uninsured and need financial assistance. Currently, the SCA funds both Suboxone and Vivitrol services through both of its outpatient treatment providers (Crossroads Counseling and Quest Services) and offers Vivitrol services to individuals who are referred from the Centre County Correctional Facility. During the coming year, the SCA will be working with the Correctional Facility to consider opportunities to increase opportunities for access to MAT services for individuals being housed at the facility.

   Centre County maintains contracts for methadone maintenance with State College Medical, Pyramid Healthcare (Altoona) and Discovery House (Clearfield). This affords individuals with Opiate Use Disorder with multiple options and the availability of these services close to their home.

The COVID-19 pandemic continues to impact the delivery of drug and alcohol services in Centre County. Providers are still re-engaging clients in services and are offering services using a hybrid model – both in-person and telehealth models as clinically appropriate. While providers continue to utilize the telehealth model for this ambulatory level of care, the SCA will continue to monitor its use to assure that access to services and best practices for its use are followed.

The Centre County DUI Court and Centre County Drug Court programs continue to see very active participation. Both programs are now sustainable utilizing local dollars and ongoing available grant funding. The treatment court teams continue to work collaboratively to identify strategies that will support the individuals who participate, to help them build the skills they need to be successful on their recovery path. Ongoing funding to sustain these programs is a priority for this office and for Centre County.

Centre County continues to see high patters of methamphetamine and cocaine use by individuals seeking services of this office. Staff also see use of various synthetic drugs that can be purchased online or at local convenience stores. The SCA will continue to support its providers with training and educational materials to address the needs of these individuals who have needs around these types of addictions, as well as those who continue to use heroin, opiates, and fentanyl-based substances. Funding and training will continue to be critical needs as we meet the changing demands of the individuals who may be using these substances.

In addition to treatment, Centre County continues to emphasize the importance of case management services, as a support to individuals with substance use disorders. Funding received through the Department of Drug and Alcohol Programs, HSBG Block Grant, and other funding sources have been key to offering increased support and resources to individuals who are in the early stages of recovery, are newly discharged from inpatient levels of care, and are managing multiple treatment-related needs that can interfere with their ability to be successful in long-term recovery.

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

   The SCA continues to work collaboratively with Dr. Kassandra Botti and staff at Mount Nittany Medical Center to assure availability of Narcan for first responders throughout the county. Dr. Botti/Mount Nittany serves as the Central Coordinating Entity for Narcan through a grant from the Pennsylvania Commission on Crime and Delinquency. Centre County is fortunate that all its police departments are trained and carrying Narcan for emergency situations. In addition, the Centre County Sheriff's Department, Centre County Probation/Parole, and the Centre County Correctional Facility is trained and has Narcan for emergency situations.

   Additional requests have come through and have been referred to Dr. Botti to be considered for orders of Narcan, as appropriate. Most recently, the local Heroin and Opiate Prevention and Education (HOPE) Initiative is looking at opportunities to partner with community organizations to provide Narcan to individuals and family members, to assure the availability of this life-saving support to those in need.

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

Warm Handoff Data (calendar year 2021 data):

# of Individuals Contacted	**1,442**
# Opioid Overdose	**26**
# **of Individuals who Entered Treatment**	**7**
# **of individuals who have Completed Treatment**	**Unknown**

Data is for Calendar 2021, which is the most recent data available. The number of individuals completing treatment is not known to the SCA, since not all individuals who are referred to treatment from the ED are necessarily referred by to the SCA for follow up care.

Mount Nittany Medical Center is the only hospital facility located within Centre County. Mount Nittany staff have access to the following providers and/or services to help transition opioid overdose survivors to specialty substance use disorder treatment:

- Hospital-based case managers
- SCA case management staff
- Center for Community Resources (contracted crisis provider authorized to make after-hours/weekend detox admission arrangements)
- Center of Excellence resources, now offered by all three contracted outpatient providers - Crossroads Counseling, Inc., Quest Services, and State College Medical. This service includes the use of Certified Recovery Specialists as a key component in its effectiveness.

If an overdose patient presents at Mount Nittany Medical Center's Emergency Department (ED) during standard business hours (Mon–Fri), medical staff will initially treat and stabilize. Once the individual is medically cleared for admission to withdrawal management services, the ED staff determine if they are interested in treatment services and if so, call for case management at the hospital to work with them on connecting them to services. MNMC Case management staff will contact the SCA and request assistance for those who need SCA funding. An SCA case manager will gather sufficient information to begin a bed search among providers contracted to provide medically monitored inpatient withdrawal management services (3.7 WM). If the individual is sufficiently stable, a full drug and alcohol assessment will be completed to assure they can easily make the transition from WM to rehab if appropriate.

If there is a delay in access to this level of care due to capacity of contract providers to accept the admission, MNMC case management / ED staff will be notified so that they can arrange for the individual's medical needs (as necessary). If an overdose patient is discharged from the ED prior to placement in an appropriate facility, SCA staff will attempt to maintain daily contact with the person while making ongoing phone calls to determine if an opening has come available. The SCA also permits its contracted 3.7WM providers to proceed with contacting

the overdose survivor directly when a bed becomes available, knowing that the authorization for admission is in place.

In the interim, the survivor would be offered access to services through a Center of Excellence of their choosing. At each COE, the individual would have access to a treatment team which would include a therapist, a wellness nurse, a Certified Recovery Specialist (CRS) and if appropriate, MAT services as prescribed by a contracted physician. If the overdose survivor is unable or unwilling to access services through a Center of Excellence, SCA staff educate the individual about the full range of treatment and support services available in Centre County and will make referrals for any requested services.

The warm-hand-off protocol for evenings, weekends and holidays is much the same. However in lieu of SCA case management staff, MNMC case managers and ED staff would contact Center for Community Resources (CCR) staff who will gather sufficient information to make the referral and will call all approved providers looking for bed availability. CCR staff has the authority to contact contracted treatment providers on the SCA's behalf to arrange for 3.7 WM admissions. They are also authorized to assure SCA funding for 3.7 WM admissions until the next business day. CCR staff will submit an after-hours detox request form and copies of all relevant paperwork to the SCA office no later than the morning of the next business day so that a case manager knows to immediately follow up with the individual and the detox provider.

If there is a delay in access to this level of care due to capacity of contract providers to accept the admission, CCR staff will notify MNMC case management / ED staff so that they can arrange for the medical needs of the individual (as appropriate). If an overdose survivor is discharged from the ED prior to a bed being secured, CCR staff will maintain contact with the individual until the next business day when SCA staff will take over.

One of the primary challenges Centre County continues to encounter with its warm handoff process is that many opioid overdose survivors refuse transport to the Emergency Department after a naloxone reversal. This seems to be especially true when naloxone is administered by a police officer. Anecdotal reports from local law enforcement officers indicate that very few survivors agree to be transported to the ED for further treatment – and that most leave the scene as quickly as possible.

Community conversations with opioid users indicate they hold little trust in anyone who plays a role in the criminal justice system. Many fear that despite the Good Samaritan law, interacting with police will result in charges being filed against the victim and/or witness. This fear is not completely unfounded as Pennsylvania's Good Samaritan law does not protect the individual from felony charges. Sadly, some witnesses have expressed specific concern about being charged with "Drug Delivery Resulting in Death" should the overdosed individual fail to be resuscitated. Others fear that contact with law enforcement will result in the involvement of Children and Youth Services or jeopardize their public housing.

The Centre County HOPE (Heroin & Opioid Prevention & Education) Initiative received funding to implement a pilot program with two local police departments. Under this program, the day after the overdose, the officer who administered the naloxone will partner with a Certified Recovery Specialist (CRS) and attempt to make face-to-face contact with the survivor. In theory, the CRS would be able to engage the individual in conversation as they should be seen as a non-threatening presence. This initial dialogue would create a conduit which the

overdose survivor may use whenever s/he is ready to explore the option of treatment and/or support services.

The pandemic was a significant barrier to getting this project started. When given the opportunity a significant portion of this grant was reallocated to other projects. However the police chiefs specifically asked that this portion of the grant be maintained. They see value in making these contacts and want follow up to occur for these individuals. While the program is still only starting, conversations have happened with a local provider who maintains CRS staff and plans have been initiated for this effort to begin.

Centre County continues to include data collection on all substances that create life-threatening overdose situations, as part of its warm-handoff policy. While it has always been the policy of the SCA to support treatment referrals and admissions for individuals who experience an overdose regardless of substance used, broad data collection allows us to better understand the trends that are occurring and help us to plan for the needs that exist in this community. This will continue going forward.

SCA staff also supports patients of Mount Nittany through level of care assessments and direct referrals to drug and alcohol treatment. The medical severity and complexity of these cases continues to challenge the resources available, with Level 4 (Medically Managed Intensive Inpatient Services) facilities not always able to accept them and Level 3.5 (Clinically-Managed, High-Intensity Residential Services) facilities unable to meet their needs. Having secured contracts with a broad array of providers at all levels of residential care, these referrals have been less difficult to make.

Centre County SCA continues to work with the Department of Drug and Alcohol Programs, the Office of Mental Health and Substance Abuse Services, and Community Care Behavioral Health to support providers in becoming aligned under the ASAM guidelines. The Department will continue to review the requests of providers who are prepared to meet the unique needs of individuals who need a 3.7 ASAM provider (i.e. those who have significant psychiatric and/or physical health conditions secondary to their substance use disorder treatment needs). As this process continues, it will be important to determine if there are any gaps remaining in the system and if so, work with the provider network to meet any identified needs to assure that all individuals can be served.

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

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

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

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

Adult Services:

Program Name: Homemaker Services Case Management
Description of Services: The Homemaker Services Case Management program provides support to low-income, disabled individuals age 18+. Referrals to this program are often made from county human services departments, local non-profits, and faith-based entities. Clients who are referred to this program are often assessed for the Homemaker Services Program (HSP). If enrolled in the HSP, they will continue to receive long-term case management and service coordination to ensure that their basic needs are met and living conditions are safe and appropriate. Clients who are not interested or eligible in the HSP may still receive long-term case management and service coordination. This service is administered by Housing Transitions.
Service Category: Service Planning/Case Management - a series of coordinative staff activities to determine with the client what services are needed and to coordinate their timely provision by the provider and other resources in the community.

Program Name: Homemaker Services Program
Description of Services: The Homemaker Services Program (HSP) provides non-medical personal care and chore assistance services to low-income, disabled individuals age 18-59 who are not eligible for Community Health Choices. Existing clients who turn 60 may be grandfathered into the HPS if there are no other comparable services available. To be deemed eligible, individuals must have either a chronic physical disability or a temporary health condition/limitation that impacts their ability to maintain their home and/or own basic self-care. The number of hours and length of time that clients are eligible for are based on the results of their level of care assessment. This program is intended to offer relief to those who have little or no support from family and friends. Centre County has four providers contracted to offer this service: Angels on Call, Arcadia, Caregivers America, and Helpmates, Inc. Providers were selected through a Request for Proposal (RFP) process and contracts are scheduled to expire on June 30th, 2025. This service is overseen by both the Office of Adult Services and the Homemaker Services Case Manager at Housing Transitions.
Service Category: Homemaker - Activities provided in the person's own home by a trained, supervised homemaker if there is no family member or other responsible person available and willing to provide the services, or relief for the regular caretaker.

Generic Services:

Program Name: 24-Hour Information and Referral Hotline
Description of Services: Centre County's 24-Hour Information & Referral Hotline (aka COMMUNITY HELP LINE) is the first step to connecting residents with basic needs-related programs that provide financial assistance and other resources for rent, housing/shelter, utilities, transportation, food, and medical bills/access to healthcare and insurance. Hotline staff and volunteers are also knowledgeable of resources available to help individuals and loved ones struggling with mental health, physical health, and substance abuse issues. In addition to information & referral services, hotline staff and volunteers are also trained mandated reporters and have the ability to provide short-term counseling and emotional support to residents who are experiencing a crisis and/or who just need someone to talk to. In order for residents to access this service, they can either call the local or 1-800 number, text, or send an instant message through the provider's website. This service is administered by Centre Helps.
Service Category: Information & Referral - The direct provision of information about social and other human services, to all persons requesting it, before intake procedures are initiated. The term also includes referrals to other community resources and follow-up.

Please indicate which client populations will be served (must select at least **two**):

☑ Adult ☑ Aging ☑ CYS ☑ SUD ☑ MH ☑ ID ☑ HAP

Specialized Services:

Program Name: Basic Needs Case Management
Description of Services: Basic Needs Case Management offers short-term financial assistance coordination and service navigation to individuals ages 18+ and their families. Clients who contact or are referred to this service often need assistance with paying rent, utilities, or other basic needs that one single agency or program is unable to resolve alone. Therefore, the case manager helps package monies from county human service departments, non-profit organizations, and faith-based entities in order to help the household prevent homelessness, utility termination, and any other challenges that may impact safety and daily living. While working to resolve the immediate crisis, the case manager will help clients navigate existing programs that they may be eligible for. These services include: SNAP, LIHEAP, WIC, P-CAP, and local food pantries. The case manager will also develop reasonable short-term and long-term goals with clients that focus on obtaining and maintaining sufficient employment, securing affordable housing, and/or prioritizing spending. The ability or effort to meet these goals is often an indicator to how frequently clients may be able to receive financial assistance at the time of intake and at any point in the future. The Basic Needs Case Management program is often times, by default, the service of last resort and, through strong community partnerships, able to provide unique and creative resolutions in order to resolve incredibly complex situations. This program is administered by Centre Helps.

Program Name: Basic Needs Medical Case Management
Description of Services: Basic Needs Medical Case Management is a component of our county's free medical and dental clinic. This program provides short-term case management to all of the clinic's clients and community members who require assistance with medical and health insurance navigation, enrollment support, and referrals to other community resources. This requires the case manager to be well-versed in health care and health insurance options. They also need to be able to help interpret and effectively communicate these options to clients so they can best manage their health and personal finances. The case manager must also maintain strong partnerships with community agencies as other issues such as housing, utilities, and food security are often identified needs amongst clients. In extenuating circumstances, the case manager may advocate for financial assistance on behalf of their clients for needs such as hearing aids and dentures. This program is administered by Centre Volunteers in Medicine.

Program Name: Financial Care Case Management
Description of Services: The Financial Care Case Management program offers budget counseling (short-term services) and money management (long-term services) to clients ages 18+ who are struggling to manage their personal finances, pay bills, and prioritize expenses. Of our most vulnerable clients, many struggle with budgeting skills due to lack of education and experience. Often times, they are also living on a fixed income which does not allow for much financial change or flexibility. A Financial Care Coordinator can then meet with the client and review income, bills, and current living situation. This service is often part of a client's service plan or goal setting established by county human service departments, non-profit organizations, and/or faith-based entities. This program is administered by Interfaith Human Services.

Program Name: Adult Services Case Management
Description of Services: To provide case management for residents of Centre County, ages 18+ and their families, and assist with the administration of rental assistance programs. Staff provides case management to individuals/families involved with county human service departments, local human service agencies, the court system, correctional facility, or self-referrals. Staff will assist the Housing Program Specialist with the administration of rental assistance programs by conducting phone interviews and completing intakes. Staff offer supports and referrals to individuals/families who are experiencing a life transition and need assistance navigating the human service system by assessing challenges and barriers to receiving services. Staff work to build and maintain relationships with existing service providers to help individuals/families access food, receive financial assistance, resolve homelessness or near-homelessness, and prevent utility termination. Staff advocate for individuals who are involved with the correctional facility and/or court system; have a mental illness, substance use disorder, and/or intellectual and development issues. Case management activities include: client needs assessment, service coordination and client advocacy, goal setting, service follow-up, reassessment of needs, case notes, data entry, filing, client confidentiality.

Interagency Coordination:

Interagency coordination funding is administered by the Office of Adult Services in an effort to maintain strong relationships and partnerships with both contracted providers and community agencies. By attending community meetings, the department stays informed of available programming, potential service gaps, and funding opportunities. The listing below highlights the county and community-facilitated groups that Office of Adult Services staff currently attends:

- Local Interagency Coordinating Council - Early Intervention
- Pennsylvania Association of County Human Services Administrators
- Regional Housing Advisory Board/Continuum of Care
- Centre County Re-entry Coalition
- Centre County Council for Human Services
- Food Pantry Meetings
- Centre County Housing Options Team
- MH/ID Provider Meeting

Funding is spent on salaries and benefits for Office of Adult Services staff.