DRAFT
DELAWARE COUNTY
COUNTY HUMAN SERVICES PLAN
FY 2019-20

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INTRODUCTION
Delaware County (DelCo) Department of Human Services (DHS) was established in 1976 under the Home Rule Charter as an umbrella department responsible for the administration and delivery of coordinated human services. The Administrators of Children and Youth Services (CYS), Behavioral Health (Mental Health [MH], Drug and Alcohol [D&A], Adult and Family Services [AFS]), Intellectual & Developmental Disabilities (IDD), Early Learning Resource Center (ELRC), Early Intervention (EI), Fiscal Services, and Information Technologies report to the Director of the Department of Human Services.

The DHS Director meets monthly with administrators of the categorical programs, Information Technologies, Fiscal Services, and the Contract Department, which provides an opportunity to coordinate service planning, funding, and delivery; administrative support; and fiscal management. In this forum, departmental initiatives are announced and programming updated, issues and special needs which cross program lines are examined, resources are managed to meet the greatest needs, and information, funding and service gaps are identified.
APPENDIX A

ASSURANCE OF COMPLIANCE place holder

The Delaware County Commissioners will act on our FY 2019-20 Human Service Block Grant Plan at the June 26th Council Meeting.

To be inserted after signing
I. COUNTY PLANNING PROCESS

Under the leadership of the DHS Director, the Department is committed to using the funds to provide services to our residents in the least restrictive setting that is most appropriate to their needs.

For planning purposes, administrators, managers, coordinators, and direct service staff from DHS participate in a great variety of countywide and community-based planning groups, committees, and coalitions, all of which include consumer and community participants. In many cases, DHS has a leadership or supporting role. Service areas include behavioral health, homelessness, employment, forensics, early intervention, family support, child care, aging, education, health care, and emergency food assistance.

County Planning Team and Stakeholder Involvement
The County Core Planning Team is led by the Human Services’ Director and the County BH/IDD Administrator. The Team is representative of each categorical service and includes leadership from the County Offices:

- Mental Health
- Drug & Alcohol
- Intellectual & Developmental Disabilities
- Adult and Family Services
- Fiscal

The Core Team began drafting the FY 19-20 County Human Service Plan on April 15th and submitted their initial draft on May 15th. Notice of the Public Hearings, scheduled for May 20th and June 11th, was publicized in the Daily Times, on the HSA website, and widely distributed to our stakeholder community. The Plan, once completed was made available similarly. Existing stakeholder groups include:

- Children’s Cabinet
- DelCo System of Care Leadership Team
- DelCo Early Childhood MH Advisory Board
- Mental Health/Intellectual & Developmental Disabilities Advisory Board
- Drug &Alcohol Planning Council
- Voice & Vision
- Overdose Coalition
- Community Support Program
- National Alliance on Mental Illness (NAMI)
- Homeless Services Coalition
- Delaware County Advocacy & Resource Organization
- Magellan Behavioral Health (MBH)
- All Adult & Family Services (AFS), Drug & Alcohol (D&A), Intellectual & Developmental Disabilities (IDD), Homeless Services, and Mental Health (MH) providers
- Office of Developmental Programs (ODP) and Office of Mental Health and Substance Abuse Services (OMHSAS) Field Offices

Feedback from stakeholders was received/reviewed and then incorporated into the final Plan.
DHS’ extensive, ongoing engagement with consumers, providers, and community groups within and across systems provides multiple opportunities to share and receive information, and promote collaboration, coordination, and cooperation to maximize resources and facilitate access.

DHS also joins with the United Way organizations serving DelCo in coordinating need assessments and service planning for the County. The cumulative overview of needs and resources is evaluated by the DHS director, Financial officers, and administrators of each office. Recommendations are discussed and categorical allocations decided upon. These recommendations are presented to the County Executive Director, and finally to County Council, for public comment and final approval.

**Programmatic and/or Other Funding Changes**

The information in this Plan focuses primarily on base-funded services, but it is important to note that there are a variety of additional funding streams that make the county's comprehensive array and continuum of services possible.

The largest flexible funding stream is Medical Assistance (MA)/HealthChoices (HC) funding. Most if not all children’s’ treatment services are funded through MA/HC as most children are eligible. We are fortunate to be partnered with MBH in our HC program as they have a proven record of seeking out and developing evidenced-based services with proven positive outcomes regardless of whether or not mandated to do so. As result of Medicaid expansion we have been able to significantly expand services to ensure a full continuum of care is available to our residents. The majority of service expansion has been focused on Substance Use Disorder (SUD) treatment and other resources for individuals suffering from addiction. In 2018 we provided SUD treatment to a total of 9,914 individuals (County and Magellan funded). In addition, we were able to provide rental assistance to 148 individuals residing in one of our Recovery houses.

In addition to expansion of SUD services, there are a number of adult programs/services that are the result of collaborative efforts and that were specifically created to address the multisystem needs of the homeless or near homeless, the forensic population (including treatment courts), the dually diagnosed, those with co-occurring disorders, individuals with comorbid physical health disorders and the aging population with behavioral health needs. Using Reinvestment funds to seed these collaborative initiatives has been invaluable.

In FY 18/19, the 3% Retained Earnings from FY 17/18 are being used to supplement IDD, specifically base funding services for an additional 125 individuals waiting to convert to waiver or ineligible for waiver, to supplement P/FDS, for Family Support Services, and assist with supported employment activities. Retained earnings are also being used to maintain shelter programs, increase rental assistance, and provide emergency shelter for DelCo residents.
II. PUBLIC HEARING NOTICE

Public Hearings were held on May 20, 2019 at Welcome House Club House in Upper Darby and on June 11, 2019 at the Government Center in Media. Both locations are easily accessible through public transportation. Notice of the Hearings was published in the local paper, on the County Website, sent through notices to all Stakeholder Groups, and at multiple community meetings. The Notice also identified locations in the county where the Plan would be available for review prior to the Hearings.

A summary of the Public Hearings is attached, B 3 along with the signature pages of attendees B 6. Submitted written testimony is included in B 4. The PowerPoint used at the hearings is included in B 5.

This plan will be approved by County Council at their regularly scheduled meeting on June 26, 2019. Please see A 1 for signatures.
SUMMARY OF PUBLIC HEARING COMMENTS
May 2, 2018 at Welcome House in Upper Darby

In attendance from the public: see complete sign-in sheet B 6.
SUMMARY OF PUBLIC HEARING COMMENTS
June 11, 2019 at Delaware County Government Center in Media

In attendance from the public: see complete sign-in sheet B 6.
SUMMARY OF MH/IDD ADVISORY BOARD MEMBERS’ COMMENTS
Delaware County
Department of Human Services

DELAWARE COUNTY
COUNTY HUMAN SERVICES PLAN
PUBLIC HEARING

PowerPoint Presentation

FUNDING
- Provided based on categorical allocation in the following areas:
  - Mental Health Base Funds
  - Intellectual and Developmental Disabilities Base Funds
  - Act 142 Drug and Alcohol Funds
  - Behavioral Health Service Initiative Funds
  - Human Services Development Fund
  - Homeless Assistance Program

INDIVIDUALS SERVED
- Over 30,000 individuals have been assisted with services in:
  - Mental Health
  - Intellectual & Developmental Disabilities
  - Homelessness Assistance
  - Drug & Alcohol
  - Human Services and Supports
FUNDING
- Provided based on categorical allocation in the following areas
  - Mental Health Base Funds
  - Intellectual and Developmental Disabilities Base Funds
  - Act 152 Drug and Alcohol Funds
  - Behavioral Health Service Initiative Funds
  - Human Services Development Fund
  - Homeless Assistance Program

CONSUMERS SERVED
- Over 30,000 individuals have been assisted with services in
  - Mental Health
  - Intellectual and Developmental Disabilities
  - Homelessness Assistance
  - Drug and Alcohol
  - Human Services and Supports
APPENDIX B 5
COUNTY HUMAN SERVICES PLAN  FY 2019-20

STATE BUDGET FOR FISCAL YEAR 2019/20

PLANNING TEAM
Sandy Garrison, Human Services Director and CFO
Jonna Di Stefano, Administrator OBI/DD
Donna Holiday, Deputy Administrator MH
Susan Proulx, Deputy Administrator OI/DD
Anne Jennings, Administrator D&A
Chris Selbert, Deputy Administrator Adult & Family Services
Jackie Hartney, Human Services Fiscal Officer
Sandy Moseroy, Human Services Fiscal Officer
MH/DD/DD Advisory Boards

STAKEHOLDERS
- Children's Cabinet
- DeCo System of Care Leadership Team
- DeCo Early Childhood MH Advisory Board
- MH/DD Advisory Board
- D&A Planning Council
- Delware County Advocacy and Resource Organization
- Delaware County
- Voice & Vision
- Community Support Program
- Homeless Services Coalition
- Magellan Behavioral Health
- AITA, D&A, SSD, & MH Providers
- OEP & CMHSSAS Field Offices
- IAAM
- Overtake Coalition
- ALERT
MENTAL HEALTH

Delaware County MH Outcomes

- Blended Case Management for Displaced (With SM)
  - Specialized Initial Critical Intervention (CIP) on evidence-based model.
  - Phased transition, time-limited, phased approach, focused, decreasing intensity over time, community-based, no early discharge.
  - Face-to-face engagement occurs within 24-48 hrs of referral.
  - 68 members served by Cross’ Home of Last resort (Jan-March 2019)

MENTAL HEALTH

Delaware County MH Outcomes

- Blended Case Management for Displaced (With SM) cont.
  - A decrease of 46% in average days homeless.
  - Increased employment and SSL.
  - A decrease of 14% in hospital admissions when members are engaged in the Home of Last resort.
  - 19 discharged to Peer Support, Traditional CO, Housing programs.

MENTAL HEALTH

Increase Community Awareness & Support: Youth & Adult

- Youth: 23 Community Members Certified
- Youth Suicide Prevention: Question, Persuade, Refer (QPR Certified)
- Adult: 135 Community Members trained (Includes County Jail Staff)

Supported Employment

- Individual Placement & Support (IPS) Principles are implemented
- 284 adherence problems: 23% have seen improvement
- 212 participants, newly enrolled
- 211 currently working, 25 seeking employment, 21 building skills

MENTAL HEALTH

COMMUNITY FORENSIC SERVICES

Forensic Assertive Community Team (FACT)

- The FACT model is an evidence-based model that has collaborated closely with the MH treatment community. In the June 1, 2018 to December 31, 2018 time period, 25% of FACT members were retained, 25% had a psychiatric hospitalization, 25% had an ER visit and 25% of FACT members had D&A involvement.
- The team’s number of enrolled participants has been between 76.6 – 81.3%.
- The retention among Sax participants has been 0.05 – 0.06%.
- Delaware’s number of enrolled participants has been between 78.6 – 81.3%.
- The retention among Sax participants has been 0.05 – 0.06%.
MENTAL HEALTH

Transitional Age Youth (TAY)
- Program highlights recent achievements and
  programmatic improvements that have enhanced the
  behavioral health system and serve to direct its future.
- TAY Certified Peer Specialist (CPS) Services for youth
  ages 14-17. Child and Family Focus (CFF) was selected
  to hire a team of young adult CPS staff that will support
  transitional age youth in the community.

MENTAL HEALTH

Question, Persuade, Refer (QPR) - is a
suicide prevention gatekeeper training that is
available to Human Services Staff, Providers,
Stakeholders and other county Systems to
increase their capacity for identifying those
at risk and linking them to the proper
supports.

MENTAL HEALTH

The GEO Transitional Housing program
continues to be a successful program
working with this specific population. The
program is currently an all-male facility and
the capacity is 18. The referral sources
continue to vary such as Adult Probation &
Parole, State Correctional Facilities,
behavioral health providers, etc.

ADULT & FAMILY SERVICES

Homeless Assistance System Goals
- Reduce the number who become homeless
- Reduce the length of time people remain homeless
- Exit people into permanent housing situations
  whenever possible
- Reduce homelessness
  + Promote financial security
ADULT & FAMILY SERVICES

Homelessness System Goals

INTELLECTUAL and DEVELOPMENTAL DISABILITIES

Strategies for 19/20

- Bring 2 to 4 or more people back into the community from large congregate care settings, thus decreasing need for block grant funds.
- Decrease placements, especially from block grant funds.
- Use emergency and one-time base/block grant funds to maintain people in community.
- Utilize Unanticipated Emergency Waiver Capacity from the State for emergencies, decreasing use of base funds.

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

Strategies for 19/20

- Promote Everyday Lives and Community of Practice/EnCoarse - hold events and include system partners (H, school districts, etc.)
- Increase number of people employed in the community and collect accurate statistics on people working.
- Increase the use of Telehealth as a service option in Delaware County.
- Re-establish goal for 75 to 100 people served as this seems to be the average number for the past two years. The focus is on family, not quantity.
- Hold a minimum of 4 community trainings for families and the people we serve. Families are thirsty for information and resources.

DRUG & ALCOHOL

Outcomes and Initiatives

Goals:
- Offer all services on the D&A Continuum of care to address the opioid epidemic.
- Treatment Services Expansion:

<table>
<thead>
<tr>
<th>Level of Care</th>
<th># of Beds/Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Base</td>
<td>25</td>
</tr>
<tr>
<td>Hospital Level</td>
<td>50</td>
</tr>
<tr>
<td>Sub-acute</td>
<td>50</td>
</tr>
<tr>
<td>Residential</td>
<td>120</td>
</tr>
<tr>
<td>Recovery/Support</td>
<td>258</td>
</tr>
</tbody>
</table>

Funded 2018: 10,429 residents served (1,360 County, 9,069 NVR)
DELAWARE COUNTY
COUNTY HUMAN SERVICES PLAN
FY 2019-20

APPENDIX B 5

DRUG & ALCOHOL

OUTCOMES & ADDITIONAL INITIATIVES
- Provided ASAM training to all Delaware County provider agencies
- Added MAT Recovery Housing to D&K Continuum
- 24 beds (Male and Female)
- Expanded our Warm Handoff by adding an additional CRS and Mobile Assessor
- Hosted 5 Community Day/Dorg Take Back Events
- Assisted individuals with Co-Oys and Debt Collectibles
- Added Nurture Families parenting program for residents of MVP Recovery Homes.

DRUG & ALCOHOL

CERTIFIED RECOVERY SPECIALIST (CRS) MOBILE PROVIDES WARM HANDOFF TO OUR EMERGENCY DEPARTMENTS

Contact number: 610-619-8616

The Project: Chester County Medical Center activities via 24/7 Warm Hand-Off service. Mobilizing a 24/7 Handoff and a team of CRS’s under clinical supervision. Projects funded 7/1/19/14

- The Monarch Health System with a total of seven emergency departments in our county, (Chester, PCMR, PMC, Springfield, Mercy PA, Radnor, and Bryn Mawr)

<table>
<thead>
<tr>
<th>Individual Engagements</th>
<th>Type of Case</th>
<th>Untreated</th>
<th>Trained</th>
<th>Reduced Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1151</td>
<td>227 Overdose</td>
<td>954 Nons. Overdose</td>
<td>371</td>
<td>816</td>
</tr>
</tbody>
</table>

OUR COMMITMENT

Delaware County Human Services is committed to high quality, cost-effective, least restrictive services that foster resiliency and recovery. These services are designed and developed with input from multiple systems and stakeholder groups.

DELTAWRE COUNTY
COUNTY HUMAN SERVICES PLAN

COMMENTS/QUESTIONS

Delaware County
Human Services Plan 19/20
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Public Hearing sign in page
Public Hearing sign in page
III. CROSS-COLLABORATION OF SERVICES

There are a number of services that cross multiple systems and required intense collaboration which are enhanced by the sharing of resources, but those that are a focus for DelCo are employment and housing.

Housing

As is the case with most PA counties, DelCo has a dire shortage of housing opportunities particularly for individuals with disabilities and criminal backgrounds. Although our County is rich with housing resources, we are still unable to meet the demand which continues to grow. Lack of housing is often a deterrent to community reintegration and often results in a resident’s inability to move on from a more intensive level of care (LOC) and/or from prison or a shelter. As a department that is fully integrated, HSA has always approached the housing shortage non-categorically in that we share the existing housing resources, ensure the most appropriate resource is accessed, and combine funding to ensure cost is not a barrier. Our goal is and always has been to have a fluid system that promotes movement to the least restrictive level of care and independent living when appropriate.

DelCo is fortunate to have access to multiple funding sources for housing resources and support services including multiple HUD and PCCD grants, CHIPP/ACLU funding, CYS, D&A, MH/IDD base funds, HSDF funds, HC, and Reinvestment funds all of which contribute to our efforts to meet the needs for housing in our community.

There are a number of regular meetings that occur and coalitions that exist in the county to address housing and homelessness, the longest standing being the Homeless Services Coalition (HSC), which has been coordinating homeless services since 1991. With over 100 members and a shared mission, public and private organizations have invested their time and efforts in the HSC for the very purpose of collaboration, identifying, and addressing gaps in housing resources. Meeting attendance, sub-committee participation, and partnerships in new programs are activities that ensure information sharing, discussion of gaps, outcomes evaluation, and developing gap implementation plans. Consumer participation brings their voice to the table. County offices participate in and function as an advisory to the HSC. Goals of the HSC include:

- Reducing the number of people who become homeless via expedited assessment, housing counseling, and emergency financial assistance
- Reducing the length of stay in shelters for those who do become homeless by maintaining an array of transitional housing and rapid-rehousing programs
- Reducing homeless recidivism by providing support, treatment, tracking, and follow-up services to those who become stability housed
- Promoting financial security by providing opportunities for employment and income growth

Homeless or near-homeless priority populations include chronically homeless individuals, veterans, families with children, transition aged youth, vulnerable adults, the elderly and homeless children. Honing in on specific referrals for housing, the
County facilitates monthly Community Residential Services (CRS) meetings wherein vacancies in existing housing resources are identified and referrals from all categoricals are reviewed for appropriateness. A wait list is maintained and updated regularly.

A number of housing resources have been created over the past several years and are detailed in various sections of this Plan. As noted earlier, our goal is to maintain a fluid system that promotes movement to the least restrictive LOC and independent living when appropriate, recognizing that for some, independent living is not an option or involves restrictions relative to the individuals standing in the community. Once such example is an individual who has a criminal background. In an effort to circumvent HUD restrictions on funding individuals with criminal histories and landlords’ resistance to renting to this population, OBH has developed a number of Master leasing options and transitional housing resources to provide the individual the opportunity to live independently with court oversight.

We have also added education specialists, employment specialists, and housing locators (available to those seeking housing independently but with County oversight) that are available throughout the system.

While it seems unlikely we will ever fully meet the demand for housing in DelCo, we do believe we have maximized our resources to give residents the best opportunities for independent living.

DelCo Crisis Response System to address Housing Crises developed by the HSC:

- ACCESS help – Countywide access for persons experiencing a housing crisis to enter the system and seek guidance and a solution to their problem.
- ASSESS the Situation – A standardized assessment process and tool to determine the housing status of each households seeking assistance. The assessment yields a referral to homeless prevention resources, shelter diversion or shelter referral.
- ASSIGN a solution – All households will have an Immediate Needs Plan developed which includes their housing stability plan, identification of other needs and the plan to address those needs.

Employment
We believe that employment is the cornerstone of self-fulfillment, independence, recovery, and stability. DelCo has been committed to support employment opportunities for our residents as a part of the employment transformation initiative and recognizes that employment can play a very important role in an individual’s recovery journey. However, we also recognize that employment opportunities are sometimes difficult to identify and even harder to access.

Demonstrating our commitment to creating a systems-change regarding how employment services for the behavioral health population are viewed and delivered, we created the Supported Employment Advisory Committee (SEAC) to act as the organizational body that will ensure effective integration of various service
enhancements. The SEAC is facilitated by the OBH Quality Improvement Unit with support from other categorical program staff and includes the OBH Community Support Program (CSP) liaison as well as education and employment-oriented agencies, managed care representatives, consumers, and governmental and community entities associated with business and industry. There are also key provider agencies leading the initiative all of whom have demonstrated a strong commitment to recovery, have many years of experience providing Psychiatric Rehabilitation Clubhouse and/or Community Employment services, and are also committed to making employment a focus within their service arenas.

To enhance this supported employment (SE) initiative, DelCo created a Reinvestment Plan to hire a consultant who assisted with developing and delivering a systemic Supported Employment training and funds for providers to hire a .5 FTE Certified Peer Specialist (CPS) to assist with SE implementation. All contracted provider agencies were offered a one-time, monetary incentive for hiring a CPS in a vacant, non-billable position (e.g., residential specialist) within their agency to promote the mindset that “work is everyone’s business.

DelCo has effectively educated the entire behavioral health system on the principles and practices of SE so that all individuals may receive support in their employment endeavors through service they receive, and effectively strengthened relationships and linkages with community employers and other entities involved in the business community (e.g., Chamber of Commerce, OVR, Rotary, etc.) to ensure that policies and procedures at both the system and agency level support individuals in achieving their employment goals by removing barriers and streamlining processes.

The concept of employment is newer to the IDD system but has been embraced in HSA regardless of the many challenges. Significant barriers exist with regard to promoting employment and increasing the number of individuals employed and making at least minimum wage. OVR will need an infusion of resources needed to support the State’s Employment First Initiative although progress has been made. Individuals and families, who have been in “the system” for a number of years, often have fear and trepidation regarding employment in the community. Here too the County has made progress working with individuals and families ensuring them that employment is an option, not a requirement. The job market holds fewer opportunities in the current economic context, with other individuals competing for those same jobs. While some businesses are keenly aware of the value of hiring people with intellectual disabilities and have included many of our individuals in their workplaces, there are many businesses that do not hire individuals with IDD and need information and encouragement to make those first steps.

DelCo has a broad stakeholder group of IDD, families, OVR, school districts, sheltered workshops, and employment providers who have developed a three-year strategic plan to change the culture. Additionally, in 2013 we created the Employment Forum which included members representing the county, schools, several transitional/supported employment providers, the county SCO, OVR, ODP, DRN, and family members. The forum also created a website www.delcoemploymentforum.wordpress.com, which
features information for individuals and businesses about employment and is linked to the DelCo Human Services website.

Funding to support these IDD efforts within the community has come primarily from base funding/block grant. In-kind and volunteers have been invaluable. We are in the process of searching for opportunities to leverage additional funds for this initiative.
IV. HUMAN SERVICES NARRATIVE

MENTAL HEALTH SERVICES

Introduction
The Delaware County Office of Behavioral Health (OBH) administers contracts for MH base funds which are described in this section of the County Human Services Plan and represent approximately 70% of the county's total Human Services Block Grant allocation. Additionally, OBH oversees the HealthChoices contract for Medical Assistance behavioral health services provided by MBH, the county's long-standing Behavioral Health Managed Care Organization. OBH, Magellan, and a diverse group of intra and inter-system stakeholders jointly continue to strategically plan the development, implementation, funding, and monitoring of services targeted to Delaware County (DelCo) citizens with Serious Mental Illness (SMI).

This MH Plan lays out the direction that the county is undertaking, in concert with Magellan and its intra and inter-system stakeholders, to assure that persons with mental illness have access to community-based services that are accountable, demonstrate positive outcomes, and promote recovery and community inclusion. Key MH themes in this FY 19-20 County Human Service Plan are ongoing commitments to: promoting intra and inter-system collaboration; serving priority target populations; developing evidence-based services and promising practices; identifying systemic risks and creating strategic plan solutions; promoting recovery-oriented system transformation priorities; and braiding all available funding streams and planning opportunities to maximize limited financial resources.

Integrating all funding and planning opportunities is an important strategy for OBH, Magellan, and local stakeholders in this challenging fiscal environment. Planning opportunities include: Reinvestment; CHIPP; Forensic Cross-System Mapping; Affordable Housing; Supported Employment; PATH Intended Use; Continuum of Care Strategy; 10-Year Plan to End Homelessness; Consolidated Plan; and, Disaster Crisis Outreach & Referral Team Coordination (DCORT). Integrated planning assures that services: are recovery-oriented; employ evidence-based or promising practice models; use expert partnerships; and leverage non-mental health funding streams. Through successful plan integration and braiding of available funding streams, the county will be positioned to: maintain key areas of current infrastructure; minimize the impact of continued allocations without COLA’s; support ongoing transformation of the public mental health system; and, proactively meet future inter-system challenges as they arise.

To promote MH system enhancements during FY 18-19, a variety of funds were procured: MH Matters county and regional grants; and annualized CHIPP funds. Combined with existing MH base, MA, and other local, state and federal funds, a modest level of recovery-oriented innovation and system enhancement will still be possible in DelCo in FY 19-20.
A. Program Highlights

There have been a number of significant activities, events, and developments in FY 18-19 that have had immediate impact on the county’s behavioral health system and that will also serve as a basis for future strategic planning initiatives. Included are new stakeholder initiatives, new evidence-based practices, new funding opportunities, and new collaborative partnerships. The table below highlights 11 of these recent developments, and describes the current impact and projects the future strategic planning between OBH, Magellan, and intra/inter-system stakeholders for continued program development and behavioral health system enhancement. Several of these developments are being tracked in a Quality Improvement initiative to measure outcome performance (see Section D.)

<table>
<thead>
<tr>
<th>Recent Development</th>
<th>Immediate Impact</th>
<th>Future Strategic Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 18-19 CHIPP Plan</td>
<td>DelCo had one civil discharged from NSH during this FY to a lesser restrictive setting within DelCo. DelCo OBH has also discharged 3 individuals from the forensic unit of NSH. These individuals have been able to utilize our step-down programs (Forensic RTFA, Transitional Housing, and/or Master Leasing SLS options). There continues to be coordination with OBH and Norristown State Hospital (NSH) staff on future discharge planning. CHIPP funding DelCo OBH opened a community-based competency restoration program in January 2019. This program was developed to serve 6 to 8 males currently incarcerated and on the waiting list for the Regional Forensic Psychiatric Center. The program provides an opportunity for further stabilization, medication monitoring, and curriculums in competency restoration in a community setting. In addition, OBH has collaborated with a behavioral health provider in the development of a residential program designed to meet the needs of the Older Adult population. The focus of this program being to support the recovery and wellness of individuals in their own living environment, facilitate community engagement, coordination of other resources (COSA, waiver,</td>
<td>Many of the new SLS and housing options targeted to the forensic population will aid in the ongoing efforts to reduce the incarceration rate for persons with mental illness. New SLS sites serve as a step-down option for Transitional Housing Program residents. FY 19-20, DelCo OBH working collaboratively with the criminal justice partners in the development of a community-based Restoration of Competency program which will also include a residential component.</td>
</tr>
<tr>
<td>Recent Development</td>
<td>Immediate Impact</td>
<td>Future Strategic Plan</td>
</tr>
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<td>----------------------------------------------------------------------------------</td>
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<tr>
<td><strong>Transitional Housing Program FY’18-'19</strong></td>
<td>The GEO Transitional Housing program continues to be a successful program working with this specific population. The program is currently an all-male facility and the capacity is 18. The referral sources continue to vary such as Adult Probation &amp; Parole, State Correctional Facilities, behavioral health providers, etc. The expected length of stay has changed due to issues in securing benefits and housing issues. Therefore, the expected length of stay is within 12 to 18 months timeframe.</td>
<td>FY’19-20, Delco OBH will continue to collaborate with our criminal justice partners, regional forensic liaisons, and MH liaisons at the prison targeting this population in efforts of continued discharges, and increased community tenure. This transitional forensic housing program will continue to operate as a community re-entry resource for those individuals maxing out of SCI and/or being released from the county correctional facility. The expected length of stay will decrease to 9-12 month timeframe by working closely with community providers in re-entry processes.</td>
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<tr>
<td><strong>Mental Health First Aid</strong></td>
<td>County provides Mental Health First Aid- Adult, Youth, Higher Education, Military, Veterans &amp; Family, and Public Safety Models which are available.</td>
<td>FY 19-20 MHFA trainings are planned for various groups including human service offices (CYS, OIDD, OEI, ELRC) and other community groups. The Youth Model is offered 6 times a year for those stakeholders involved with children including Juvenile Detention Center, Juvenile Justice, and Community Based Providers. Family members and school staff are also offered an opportunity to attend.</td>
</tr>
<tr>
<td><strong>System of Care (SOC)</strong></td>
<td>The DelCo System of Care (SOC) Children’s Cabinet and Coalition provide the oversight to the SOC initiatives including YMHFA, QPR, Multisystem trainings and the Trauma Informed Care trainings; involving youth and family in program development review and on advisory boards; and, enhancing youth leadership opportunities. The Trauma Informed Care Initiative continues to focus on the annual organizational assessments to determine strengths and needs within Human Services, Juvenile Court, Juvenile Detention, Domestic Relations, and Department of Emergency Services. A new grant opportunity has been applied for on May 1, 2019 for a 3-year System of Care.</td>
<td>FY 19-20-The DelCo SOC Children’s Cabinet and Coalition continues to support the use of High-Fidelity Wraparound as the outcomes have shown a decrease in out of home placements in all systems which we expect will continue. The Delaware County System of Care Children’s Cabinet and Coalition continues to support the Trauma Informed Care Initiative within Human Services, JPO, Juvenile Detention Center, Domestic Relations, and Department of Emergency Services. TIC strategic plans will continue to be assessed and modified by each department’s TIC Change. Expansion of this initiative will</td>
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<tr>
<td>Recent Development</td>
<td>Immediate Impact</td>
<td>Future Strategic Plan</td>
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<tr>
<td>Grant via the PA Care Partnership and if</td>
<td>Grant via the PA Care Partnership and if received will allow us to enhance our efforts.</td>
<td>be offered to other County Departments but most importantly to our Youth &amp; Families. If we receive the SOC grant funds, increased annual trainings in Trauma 101, 102 and 103 will also be offered. Trauma 105 for Youth and Trauma 106 for Families will also be offered to youth and parents/caretakers in the community. The development of a Certified Parent Peer Support model is being explored along with a Parent Resource Book and support group for juvenile offender’s females.</td>
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<tr>
<td>efforts.</td>
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<tr>
<td>Transition Age Certified Peer Specialist</td>
<td>TAY CPS Services for youth ages 14-17. Child and Family Focus (CFF) was selected to hire a team of young adult CPS staff that will support people in the community. OBH and Magellan will continue to implement and provide oversight to the TAY CPS provider to enact Minimum Practice Standards, Minimum Training standards and a Provider Readiness Review. Census as of March 2019 is at 7 with 3 referrals in process. Magellan and Delco continue to work with CFF to outreach for more referrals. In May the program developed a one page description to provide to the community and families for better understanding of what the CPS program offer.</td>
<td>FY 19-20- OBH and Magellan will continue to provide oversight and technical support to Child and Family Focus (CFF) to ensure Minimum Practice Standards, Minimum Training standards, and a Provider Readiness Review.</td>
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<td>(CPS)</td>
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</table>
| Enhanced Mobile Crisis Services            | In FY 18-19 the DelCo Crisis Connections Team (DCCCT) continued to provide 24-hr / 7 day a week Mobile Crisis Services in the County. The Peer Warm Line expanded its hours of operation to meet the needs of the individuals served.  

This FY also saw a focus on improving and refining the needed response and requirements for children and adolescents needing mobile crisis while in the school. Collaborative work resulted in the development of a response procedure for Mobile crisis and schools. The DCCCT continued to impact crisis/hospitalization rates for Delaware County by providing crisis.  | Thus, far in FY 18-19, DCCCT has provided more than 1,600 outreach contacts. The mobile service is the centerpiece of the county’s effort to continue reduction of involuntary commitments to hospital treatment. DCCCT is also being marketed to colleges and universities and to police departments through CIT training. |
<table>
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<tr>
<th>Recent Development</th>
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<th>Future Strategic Plan</th>
</tr>
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<tbody>
<tr>
<td><strong>Expanded Assertive Community Treatment (ACT) Team</strong></td>
<td>OBH and Magellan developed an expansion of the ACT services. Horizon House operates two ACT teams, increasing their capacity to add a new 100-person team, 30% of which is targeted to a TAY Caseload. The TAY receive additional support through an employment group that meets weekly in the office. This has been beneficial as young adults can share concerns and resources surrounding their age specific issues.</td>
<td>The team increased to full staffing as the census nears full capacity. TAY continue to be served with the goal of 30% census. Those that graduate from TA status have continued to receive ACT services. ACT continues to accept new referrals as they near the 100-full census, targeting the 30% TAY population.</td>
</tr>
<tr>
<td><strong>Natale RTF-A Dual-Diagnosis Unit</strong></td>
<td>The opening of Natale’s Dual-diagnosis unit created 4 new beds at the RTF-A level of care (LOC), directly addressing the MH/IDD crisis/inpatient access for those that can receive voluntary treatment. Thereby, this has decreased the number of individuals presenting at a crisis center and seeking voluntary inpatient psychiatric hospitalization.</td>
<td>Referrals to the DDTT have been prioritized for DelCo residents. OBH and Magellan continue to promote and educate providers, agencies and systems regarding the ability of the Dual Diagnosed unit to accept individuals not yet at a LOC requiring AIP, or as a step-down from an AIP LOC to further stabilize and treatment plan prior to returning to the community.</td>
</tr>
<tr>
<td><strong>Dual-Diagnosis Treatment Team for MH/ID</strong></td>
<td>The DDTT has been able to work with dual-diagnosed (MH/IDD) individuals who are either living at home and at-risk of placement in a residential setting and/or have worked directly with residential programs to assist in treatment planning and interventions with staff, directly addressing the concerns regarding the need for staff training. This has had a direct result in those individuals who may have been at-risk of failing a residential placement or even being able to keep a person at home. Initial outcomes for the intensive, team-approached treatment in the person’s setting have shown to provide stability and progress toward the individual’s treatment goals.</td>
<td>Continue to work toward a DelCo full-census of up to 11 individuals (total census of up to 22 individuals is shared with another county for fiscal sustainability). The DDTT is developed to be an 18-month team approached program. OBH, Magellan, and ODDP regularly monitor and assess individuals to ensure supports and plans are stable and in place prior to discharge. The team has continued to accept new referrals and has approached the original census of 10. The County and Magellan approved an increase in the census up to 15 to allow continued referrals and access to services. The new census will continue to be monitored.</td>
</tr>
<tr>
<td><strong>Forensic Assertive Community Treatment (FACT) Team</strong></td>
<td>R-FACT model is an evidence–based model that has collaborated closely with the MHTC Court and ACT provider. Community Forensic Interventions, LLC</td>
<td>FY 19-20 OBH personnel will continue to work with the consultants to provide technical assistance to improve communication with the criminal justice</td>
</tr>
<tr>
<td>Recent Development</td>
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<td>Future Strategic Plan</td>
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<tr>
<td>consultants continued to work on the development of the R-FACT team.</td>
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<td>partners, FACT, and the MHTC’s overall productivity.</td>
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<tr>
<td>In the June 1, 2018 to December 31, 2018 time period, 3% of FACT members were arrested, 8% had a psychiatric hospitalization, 2% had an ER/Hospital visit and no FACT members had D&amp;A Inpatient stay.</td>
<td></td>
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</tr>
<tr>
<td>QPR</td>
<td>Question, Persuade, Refer (QPR) is a suicide prevention gatekeeper training that is available to Human Services staff, providers, stakeholders and other county systems to increase their capacity for identifying those at risk and linking them to the proper supports.</td>
<td>FY 19-20 - QPR will be offered to Human Services staff as well as our County System Partners and stakeholders at least 6 times a year.</td>
</tr>
<tr>
<td>First Episode Program On My Way</td>
<td>The program is a community-based treatment team approach for those 15-30 years old who will receive medication management, case management, therapy, vocational rehabilitation, and education to both the individual and the family regarding signs, symptoms, treatment options, and recovery. CFF has named their program, “On My Way.”</td>
<td>FY 19-20 planning includes development of a parenting group, alumni group and a “Step-down” Group. Grant and county funding are being used to work with TAY referred but have lost MA, to continue Dr. Herford’s technical assistance and increase Dr. Lawrence time by another day. OBH and Magellan meet with CFF regarding implementation and oversight to monitor referrals, access, and treatment.</td>
</tr>
<tr>
<td>From July to April there have been 25 referrals with 13 successful admissions. On Feb. 27th and implementation oversight was conducted with Magellan and OBH. Clinical and claims findings were presented on March 15th in an action plan. A response with Action Steps from On My Way program was received and accepted on March 22nd. One member has successfully graduated is attending college and has restarted that college’s music program. Plans are in the works to develop a parenting group, alumni group and a “Step-down” Group. Grant and county funding are being used to work with TAY referred but have lost MA, to continue Dr. Herford’s technical assistance and increase Dr. Lawrence time by another day. OBH and Magellan meet with CFF regarding implementation and oversight to monitor referrals, access, and treatment.</td>
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</table>
## Recent Development

**Homeless BCM Program**

In FY 18-19, DelCo continued support of community-based efforts that serve homeless individuals with Serious Mental Illness (SMI). Included within these efforts are support services that target an individual’s housing needs and provides supports in a person’s recovery process. The DelCo Division of Adult and Family Services, Continuum of Care (CoC), supports a Blended Case Management (BCM) unit specially trained in a Critical Time Intervention (CTI) evidence-based model. Since its inception over 75 individuals have been served by the unit.

In FY 19-20 the DelCo OBH and the Division of Adult and Family Services and Magellan will continue to have regularly scheduled meetings which support the BCM program. Supports provided on an ongoing basis include: providing program feedback as needs and circumstances are identified, review of current census, recent admissions and discharges, providing staff updates including the introduction of new program staff, group discussions on any participants that need to be highlighted, reviewing any new community resources which may be available for participants to utilize, and the review of any billing and claim issues.

**Supported Employment**

Over 2018 outcomes were collected from 2 of our providers, Merakey and CareLink’s IPS programs. Both programs numbers have been stable throughout the year with few variations. This shows that our independent employment providers are holding onto members for a substantial period and providing the long-term support needed to ensure individuals maintain successful employment.

DelCo’s three ACT teams had or will receive employment training that focuses on the whole team. Each 5-day training is focused on skills building for the employment specialist to learn job development and tools for assessing, engaging, and supporting members. Teams receive training on how to support the employment specialist and the individual. Once all teams have been fully trained conversations to decide what time frame monitoring will begin to occur will be held at the county level. ACT teams have been asked and accepted to take part in DelCo’s Vocation Provider’s collaborative. This Collaborative has begun to work on promotional materials such as a letter, brochure, and business cards that specialists could use to engage perspective employers. 2019 will begin to add skills building materials and guest speakers. These two new additional areas will offer resources that can be used to enhance skills and knowledge for the providers.
B. Strengths and Unmet Needs

Older Adults: (Persons aged 60 and above)

In FY 18, the estimate of 560,000 of the population being over age 65 represented 16% of the total county population. Increasing numbers of elderly residents’ present challenges to the County Office of Services for the Aging (COSA) and for OBH as well. The GATEWAY program, jointly operated by COSA, and AAA/MH funding, continues to be the primary resource for outreach and referral to older SMI adults. OBH continues to maintain Specialized Personal Care Home (SPCH) beds for the elderly/medically fragile population. And more recently, the addition of the “Aging in Place” Supportive Housing Initiative was added to our continuum of services to address the needs of this unique population. However, for those who require Nursing Facility placement, finding facilities to accept Medical Assistance (MA) Seriously Mentally Ill (SMI) referrals remains a significant challenge. Personal Care Home (PCH) licensing regulations also restrict serving people who are eligible for Nursing Facilities, making “aging in place” particularly challenging for those CRS programs.

<table>
<thead>
<tr>
<th>Strengths</th>
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<tbody>
<tr>
<td>GATEWAY</td>
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<tr>
<td>Longstanding, jointly-funded, inter-system partnership between COSA and OBH that provides outreach, assessment, engagement, and referral to senior citizens with behavioral health needs in the community. In the first 3 quarters of the FY 18/19 100 aging individuals were served through the Gateway Program.</td>
</tr>
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</table>

| Aging/Disability Resource Center (ADRC)        |
| Partnership between OBH, COSA, and other organizations serving older adults that provides training, screening, outreach, and linkages to housing and other community-based services combined with the City of Philadelphia. Community HealthChoices program began January 1, 2019, resources and outreach continue to be conducted to inform the aging population. |

| Supportive Housing Services                    |
| The development of the “Supportive Housing Aging in Place” residential facility. This program is designed to meet the needs to this unique population and afford them the opportunity to “age in place” within their own community safely. If provides individuals with high-level mobility and personal care needs in a barrier-free environment. |

| Therapeutic Counseling                         |
| Therapeutic counseling is provided for identified homebound older adults with behavioral health needs who otherwise would go untreated. The capacity of the program is twenty-five. |

| Older Adult Task Force                         |
| DelCo specific group of OBH, COSA and providers offers case reviews and develops best practice service plans to meet the needs of older adults with SMI. |

| Unmet Needs                                    |
| Nursing Facility Access                       |
| Nursing Facilities (NF) continue to resist accepting older adult SMI referrals. The process of linking with COSA for assessments and Office of Mental Health and Substance Abuse Services (OMHSAS) for Omnibus Budget Reconciliation Act (OBRA) approval are relatively smooth, however it often takes months to obtain any NF placement. |

| Persons with Dementia                         |
| GATEWAY and other services that encounter older adults with dementia present challenges to service provision, particularly when out-of-home placement is needed. |
## Strengths

<table>
<thead>
<tr>
<th>Funding</th>
<th>Housing remains an essentially MH base-funded service, and is potentially at-risk in the current economic and budget environment. Money Follows the Person (MFP) did not materialize as a viable funding stream for state hospital discharges.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older Adult Hoarding Task Force</td>
<td>Additional services beyond case reviews are needed. Individuals need intensive counseling, case management and house restoration services.</td>
</tr>
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</table>

### Adults (Persons aged 18 - 59)

Adults remain the majority of persons served in the county’s behavioral health system. Given the broad age range and sheer numbers of persons represented by the adult population, it is not surprising that a substantial number of initiatives and resources are directed toward this group. It should be noted however, that there are several specific subsets of adults identified and described in the Special/Underserved population section below. Therefore, the descriptions herein are more generic in nature.

<table>
<thead>
<tr>
<th>Supported Living Service (SLS)</th>
<th>OBH has emphasized development of SLS apartment-based housing subsidies for some time. FY 19-20, CHIPP funding added an additional Bridge and Master Lease subsidies.</th>
</tr>
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<tbody>
<tr>
<td>Long-Term Care Access</td>
<td>CHIPP funding has afforded the opportunity of the development of several diversionary programs. As a result, there has been a decrease in the wait time for individuals accessing treatment at the state hospital.</td>
</tr>
<tr>
<td>Psychiatric Rehabilitation</td>
<td>OBH and Magellan continue to fund a comprehensive network of PRS services. In addition to 5 site-based PRS programs, there are 2 mobile (MPR) programs, and 2 PRS assessors, one at each BSU to provide PRS assessment and referral. OBH and Magellan meet with the assessors and providers throughout the year to review program developments, county specific trends and issues, and overcome barriers to access. Illness Management Recovery (IMR) is an evidenced based practice that has been implemented successfully to the 2 mobile MPR programs. In 2018, a Psych Rehab collaborative was created for providers to share information, offer resource and other information. All Psych Rehab providers are requested to take part in the collaborative. Currently, participants are 3 site-based Psych Rehab, 2 Mobile Psych Rehabs (MPR), Club Houses, Assessors, and Vocational Providers. 1 MPR program use the Illness Management and Recovery (IMR) EVP, with individual participants and are working with DelCo’s IMR consult creating a Budgeting IMR handout that will fit into the curriculum. The other MPR program has asked for information on IMR to see if this practice will fit into their site. Meetings will be held internally to formulate outcome monitoring of all programs. DelCo will create a survey with our CST team to learn why an individual may refuse Psych Rehab services. This could be one-time survey or an ongoing process depending on the results of the initial survey.</td>
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## Strengths

### Certified Peer Specialist (CPS) Initiative

OBH and Magellan continue to develop CPS resources throughout the county. Several specializations have been added and are well attended. Including curriculums for special populations such as Geriatric, Trauma, Forensic, LGBTQ and Integrated Health Care. The Crisis Services Training for CPS was very successful. Many other resources continue to be available such as the Peer Development Network. The response from CPS has been positive regarding professional skills training on documentation skills, organizational skills, as well as ethics and boundaries. In FY 19-20 OBH will continue to provide opportunities for providers to talk with recently graduated CPSs who are seeking employment. OBH will also continue to enhance the CPS Advisory so that community stakeholders have the chance to provide feedback.

OBH and Magellan continue to make available online and in person resources available via the CPS Supervisors meetings. Many other resources continue to be available such as the Peer Development Network. A CPS enhancement workgroup was developed in January to assess and improve the success of those accepted into the Certification Training, in areas of job and volunteer readiness. The group is made up of OBH, Magellan, Mental Health Partnership Training Division, CPS employers, CPS, and various stakeholder agencies. The focus has been the development of a description of the program to present to candidates to better inform what the class entails, revision of all phases of the application packet, developing/referrals programs to assist those who do not make eligibility for attending the training and continue to keep within the new regulations for peers to be certified through the PCB.

### Illness Management & Recovery (IMR)

IMR is the cornerstone of DelCo OP treatment at 7 sites across the MH and D&A service continuum.

There are 7 providers with 13 programs using the IMR practice or one of its specialized curriculums. Four of the 7 are D&A providers using Enhanced IMR. This curriculum uses the core IMR program with the additional IDDT elements. One provider has implemented E-IMR in their entire practice designating 1 hour per 3-hour group as an IMR session and 1 goal IMR specific goal. This program is also working on a Pregnancy hand out to use with their individuals who are pregnancy and in recovery.

The other 2 programs hold a group’s 1-2 time per week per LOC. One provider is reestablishing E-IMR as a step down (IOP to OP) “seminar” style that would last 6 weeks. All D&A groups are open meaning any individual can join in at any time. Due to this style of group plus one D&A provider enacting IMR in its whole practice, the census ebbs and flows with the number across 4 providers averaging about 150-200, depending on the time of year.

Three of the 7 providers are MH providers who have been encouraged by DelCo’s IMR consultant to move from IMR to Integrated IMR. This curriculum incorporates both physical health and mental health education which teaches individuals to look at themselves as a whole person as opposed to just a person with a mental illness. One module talks about medication and the importance of understanding how one affects the other along with symptoms. All 3 providers hold one group per week or conducts the practice on an
**Strengths**

- **Individual Basis Depending on the Individual Preference.** Providers that offers a one or two time per week group do so in a closed style, meaning the group runs its whole course before new individuals can join. Each group size is 10 which gives a total average census of 30-40 depending on graduation to other LOCs.

- **Integrated Healthcare**
  The Learning Community continued in 2018 with combined leadership and planning from OBH and Magellan. The focus continues to be provider networking, best practices, data collection and outcomes as well as regulatory updates. All 3 BCM providers participate monthly in face to face or teleconference meetings to strengthen implementation and collaboration. Collaborative efforts continue to support integrated care and expectations as outlines by the Integrated Care Plan Pay for Performance initiative as well. Magellan has letters of agreement in place with all required physical health managed care organizations. Coordination calls are being conducted on joint members and hospital admissions continue to be mutually shared. Providers are getting data files which can be used to increase member engagement in integrated care as well as better understanding risk stratifications for those currently consented. Providers are also being asked to assist with member identification for joint collaboration calls to include the provider, Magellan, and the assigned physical health MCO. To date, these calls are occurring monthly. Available IHC programs also include a Health Home with a PCP & Pharmacy on site as well as Nurse Navigator at the BCM units.

- **Delaware County Open Door to Education (DCODE)**
  Since 2010, DelCo OBH has contracted with DelCo Community College to provide DCODE: a 9-week course to allow adults with a self-identified MH diagnosis to attend classes 2 days per week. Classes focus on identifying current skills and developing a goal plan toward educational or vocational achievement. Focus groups were conducted in 2016 after over 100+ individuals successfully completed the initial DCODE class. This resulted in the development of the first DCODE II class, held in the fall of 2017. The DCODE II was developed to further assist those that had begun DCODE with no specific goal or focus. DCODE II was developed to further enhance skills and develop individualized action plans for participants toward their education/vocation achievement. OBH continues to support this program within the continuum of opportunities for individuals to further their educational and vocational goals.

- **Supportive Housing Services**
  The development of the “Supportive Housing Aging in Place” residential facility. This program is designed to meet the needs to this unique population and afford them the opportunity to “age in place” within their own community safely. If provides individuals with high-level mobility and personal care needs in a barrier-free environment.

- **BCM Homeless**
  Specialized Case Management for Homeless with SMI. DelCo developed a specialized BCM unit trained in the CTI model. This unit uses a time limited evidenced based intervention that mobilizes support to facilitate community integration and continuity of care. The BCM will address homelessness with the SMI population in a phased approach in collaboration with OBH, Magellan, and Adult and Family Services. Since its inception, over 75 individuals have been served.
## Unmet Needs

<table>
<thead>
<tr>
<th>Nursing Facility Access</th>
<th>Nursing Facilities (NF) continue to struggle with accepting older adult SMI referrals. These facilities are ill-equipped to properly address the psychiatric needs of these individuals meeting NF LOC. The process of linking with COSA for assessments and OMHSAS for Omnibus Budget Reconciliation Act (OBRA), approval are relatively smooth, however it often takes months to obtain any NF placement.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding</td>
<td>MH base funds are limited which affects the availability of housing, community employment and other recovery services.</td>
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</table>
| Dually-diagnosed       | DelCo has continuously sought to enhance and increase the supports and services for those that have both a MH and developmental disability. OBH, ODDP, and Magellan have provided trainings targeted toward both MH and ODDP staff, psychiatrists, residential staff, and case management/support coordinators.  

Services have been enhanced to include expansion of the RTF-A to include a 4-bed DD-unit and on-going reviews with the DDTT. CPS services were enhanced in early 2019 to provide specialty peer support services to those with both MH and IDD. |

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## Transition-Age Youth (TAY): (Persons 18-26 aging out of children’s services)

OBH, Magellan, providers and other stakeholders in both the children’s’ and adult behavioral health systems are working on multifaceted approaches to meet the needs and help the TAY target population transition successfully between the two systems. Increasing resources for TAY continues to be a major focus in both the child and adult systems. The Human Services website has been enhanced to include a specific page for TAY services so that those services and community-based supports are easily identified.

## Strengths

<table>
<thead>
<tr>
<th>ACT Team Expansion</th>
<th>OBH and Magellan expanded ACT services to include a second 100-member team for MA eligible persons. 25-30% of the new caseload is targeted to the TAY population. ACT has continued to accept referrals for new individuals and has served several young adults that have continued with ACT services even after aging out of the TAY category. This has provided continuity for the individuals who benefit from a high level of community treatment, while still being able to accept new TAY referrals.</th>
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<tr>
<td>Transition-Age CRR</td>
<td>The county initially identified the need for additional support to be provided to those of transitional age (18-25) living in CRRs. OBH enhanced its contract with a CRR provider to add a full-time staff who was dedicated to working with up to 4 TAY individuals within their full-care CRR programming. For over 10 years, the TAY CRR has provided expanded capacity by operating a dedicated 6-bed TAY CRR and adding a 6-bed TAY SLS subsidy program.</td>
</tr>
<tr>
<td>MY LIFE and MY FEST</td>
<td>The Magellan Youth Leaders Inspiring Future Empowerment program has grown significantly since its inception. My LIFE planning meetings have been implemented and allow for better planning of group topics and activities for the monthly meetings. Better engagement of youth has been occurring. MY FEST event and MY LIFE Leadership events are held annually to build youth leadership capacity. Youth are now being offered opportunities to give back to the community</td>
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<tr>
<td><strong>Strengths</strong></td>
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<tr>
<td><strong>High Fidelity Wraparound</strong></td>
<td>Team-based collaboration serving children including TAY up to 21 years of age and their families. The DelCo team served 34 families in FY 18-19 and we expect to serve 36 families in FY 19-20.</td>
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<tr>
<td><strong>Transition to Independence (TIP)</strong></td>
<td>TIP- Evidenced supported model for ages 16-26 that is licensed as a Blended Case Management program focusing on life skills development. In DelCo, TIP can serve up to 75 young people. TIP receives a steady flow of referrals and is presently exhausting their short waitlist. In FY 18-19, TIP DelCo served 72 young adults and expects to serve 100 young adults in FY 19-20.</td>
</tr>
<tr>
<td><strong>Youth Mental Health First Aid (YMHFA)</strong></td>
<td>YMHFA trainings are planned for various groups including human service offices and other community groups involved with children including Juvenile Detention Center, Juvenile Justice, and Community Based Providers. Family members and stakeholders are also offered an opportunity to attend these monthly trainings. Courses are offered 6 times a year as well as in coordination with Eastern University’s Undergraduate and Graduate Educational Programs.</td>
</tr>
<tr>
<td><strong>First Episode Psychosis Program</strong></td>
<td>“On My Way” is a First-Episode Psychosis Program for ages 15-30. County OBH and Magellan conduct quarterly implementation meetings with CFF to provide support, structural, and programmatic recommendations, identify any barriers and collaboratively develop solutions. “On My Way” continues to review a strict admission criterion for enrolling new members. Those that do not meet the First Episode criteria are referred to other services. On My Way First Episode Psychosis Program continues to enroll new members. Currently there are 22 young people receiving services with a projection of 25-28 young people for FY 19-20.</td>
</tr>
<tr>
<td><strong>LGBT</strong></td>
<td>PRYSM Youth Group continues to sponsor the annual LGBTQIAA training called Over the Rainbow. QI department continues to research best practices to meet the needs of this growing population in DelCo. Staff attended training for LGBTQI in aging supported living arrangements. Resources are made available for providers as appropriate. PRSYM is also a spotlight speaker at our annual Multisystem Training.</td>
</tr>
<tr>
<td><strong>Trauma Informed Initiatives</strong></td>
<td>The DelCo SOC Children’s Cabinet and Coalition continues to support the Trauma Informed Care (TIC) Initiative within Human Services, JPO, Juvenile Detention Center, Domestic Relations, and Department of Emergency Services. TIC strategic plans will continue to be assessed and modified by each department’s TIC Change. Expansion of this initiative will be offered to other County Departments but most importantly to our youth &amp; families. If we receive the SOC grant funds, increased annual trainings in Trauma 101, 102 and 103 will also be offered. Trauma 105 for Youth, and Trauma 106 for Families will also be offered to youth and parents/caretakers in the community. The development of a Certified Parent Peer Support model is being explored along with a Parent Resource Book and a support group for female juvenile offenders.</td>
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<td><strong>Question Persuade, Refer (QPR)</strong></td>
<td>QPR is a suicide prevention gatekeeper training that is available to Human Services staff, providers, stakeholders and other county systems to increase their capacity for identifying those at risk and linking them to the proper supports. This evidenced based curriculum is offered 6 times a year.</td>
</tr>
<tr>
<td><strong>TAY CPS</strong></td>
<td>Family Focus is the provider of this program that will support individuals in the community.</td>
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</tbody>
</table>
## Strengths

| Services for the TAY continue to be added as needs are identified. OBH partnered with Magellan in 2017 to identify a new Certified Peer Specialist (CPS) service for TAY. CFH was awarded the new initiative and is currently developing a team of CPS staff that will work with individuals aged 15-25. The county continues to monitor the expansion and development of TIP, FEP, and the new TAY CPS program. Continued review of outcomes and gaps in services are reviewed on an on-going basis to identify progress and need for improvement and expansion. Services to TAY individuals in an effort to support them in their recovery are vital to ensure that they are able to achieve their educational, vocational, and housing goals. |

## UNMET NEEDS

<table>
<thead>
<tr>
<th>TAY w/ ASD &amp; IDD Disorders</th>
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<tbody>
<tr>
<td>There is a need to develop housing and community-based treatment and support programs for TAY with an Autism Spectrum Disorder (ASD) diagnosis and an Intellectual and Developmental Disability. A committee has been formed to address these gaps in services.</td>
</tr>
</tbody>
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### Children: (Persons under 18)

- **Strengths**
  
  OBH, MBH, children, families, and inter-system stakeholders have moved aggressively with the adoption of a SOC model in DelCo. The grant ended June 30, 2017 but the philosophy and continued work has been managed by the DelCo SOC Children’s Cabinet & Coalition and OBH staff. May 1, 2019, the County applied for a new grant cycle with the PA Care Partnership. The goals of increasing the family driven and youth voice in all of the youth serving systems remains as a primary focus.

## Strengths

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<thead>
<tr>
<th>MY LIFE and MY FEST</th>
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<tbody>
<tr>
<td>The Magellan Youth Leaders Inspiring Future Empowerment program has grown significantly since its inception. My LIFE planning meetings have been implemented and allow for better planning of group topics and activities for the monthly meetings. Better engagement of youth has been occurring. MY FEST event and MY LIFE Leadership events are held annually to build youth leadership capacity. Youth are now being offered opportunities to give back to the community via visiting local nursing homes and interacting with the residents. Spotlight speakers at their monthly meetings offer them an opportunity to explore leadership skills and community-based resources.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>High Fidelity Wraparound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team-based collaboration serving children including TAY up to 21 years of age and their families. The DelCo team served 34 families in FY 18-19 and we expect to service 36 families in FY 19-20.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transition to Independence</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIP-Evidenced supported model for ages 16-26 that is licensed as a Blended Case Management program focusing on life skills development. In DelCo, TIP can serve up to 75 young people. TIP receives a steady flow of referrals and is presently exhausting their short waitlist. In FY 18-19, TIP DelCo served 72 young adults and expects to serve 100 young adults in FY 19-20.</td>
</tr>
</tbody>
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<tr>
<th>First Episode Psychosis Program</th>
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</table>
Question, Persuade, Refer (QPR)

QPR is a suicide prevention gatekeeper training that is available to Human Services staff, providers, stakeholders, and other county systems to increase their capacity for identifying those at risk and linking them to the proper supports. This evidenced based curriculum is offered 6 times a year.

TAY CPS

Those ages 14-18 can access peer support services that support transitional age issues and concerns. Child and Family Focus is the provider of this program that will support people in the community.

LGBT

PRYSM Youth Group continues to sponsor the annual LGBTQIAA training called Over the Rainbow when scheduled. PRYSM is also a spotlight speaking for our annual Multisystem Training.

Trauma Informed Initiatives

The DelCo SOC Children’s Cabinet and Coalition continues to support the Trauma Informed Care Initiative within Human Services, JPO, Juvenile Detention Center, Domestic Relations, and Department of Emergency Services. TIC strategic plans will continue to be assessed and modified by each department’s TIC Change. Expansion of this initiative will be offered to other County Departments but most importantly to our Youth & Families. If we receive the SOC grant funds, increased annual trainings in Trauma 101, 102 and 103 will also be offered. Trauma 105 for Youth, and Trauma 106 for Families will also be offered to youth and parents/caretakers in the community. The development of a Certified Parent Peer Support model is being explored along with a Parent Resource Book and support group for juvenile offender’s females.

UNMET NEEDS

TAY w/ASD & IDD Disorders

There is a need to develop housing and community-based treatment and support programs and treatment for TAY with an Autism Spectrum Disorder (ASD) diagnosis and an Intellectual and Developmental Disability. A committee has been formed to address these gaps in services.

Special/Underserved Populations

Individuals Transitioning Out of State Hospitals

Since the closure of Haverford State Hospital (HSH) in 1998, OBH has overseen the transfer of 215 CHIPP discharges from the state hospital to the community. As of February 12, 2018, Norristown State Hospital (NSH) stopped accepting civil/civil admissions. This resulted in all future psychiatric admissions being targeted to Wernersville State Hospital. The current DelCo civil/civil census at NSH is one, which is a 95% reduction from the 220 beds at HSH at the time of the closure.

The corresponding shift in state hospital funding to the county program has resulted in a proliferation of recovery-oriented, community-based MH services. FY 18-19, OBH successfully discharged two individuals from the state hospital to community placements; one individual from NSH and another person from Wernersville State Hospital. FY 19-20, we will continue to access the resources available within the infrastructure by successfully diverting individuals from accessing state psychiatric hospitalizations into step-downs within structured CRS placements which in turn opens appropriate discharge options for current state hospital residents.
DELAWARE COUNTY
COUNTY HUMAN SERVICES PLAN FY 2019-20

Strengths

| CHIPP Planning | OBH continues to work closely with NSH treatment teams and OMHSAS administrative personnel in discharge planning under the state’s CHIPP Plan Guidelines. |
| Community Support Plans (CSP) | CSP’s are completed for all individuals in the Civil and Forensic Units at NSH. OBH participates with NSH treatment teams and community providers in development of CSP’s and tracks post-discharge at 1, 3, 6, 9, and 12 months intervals. |
| NSH Diversion Planning | The OBH CRS Team continues to meet bi-weekly to plan for CRS target population referral and admission, as well as addressing NSH diversion and waiting list issues for both the Civil and Forensic Units. |
| Treatment Team Meetings | OBH Community Liaison and Forensic Specialist staff participate in ongoing Civil and Forensic Unit treatment team meetings and plan discharges as applicable. |
| Regional EAC Facility | The Regional Extended Acute Care Unit facility continues to provide this resource as an alternative NSH for extended inpatient service by stabilizing, assessing, treating, promoting recovery and discharging individuals successfully to the community. |

Unmet Needs

| Long-term Care Access | As CHIPP plans have been implemented and many diversionary programs developed there has been a decrease in the number of individuals currently on the waiting lists and in the amount of time accessing treatment at the Regional Psychiatric Forensic Center. |
| Housing | With the discharge of more challenging CHIPP individuals, housing providers are challenged to effectively serve these individuals as they also must meet the requirements of the diversion, justice-involved, homeless, COD, and TAY populations. |
| Funding | CRS providers continue to face year after year of static MH Base funding and are experiencing significant challenges to successfully serve various high-need target populations. There is a need for increased MH Base funding is to support these critical resources. |

Co-Occurring Disorders
OBH, Magellan, behavioral health providers, and stakeholders continue to recognize the prevalent correlation of both SMI and D&A diagnoses in many public system consumers, and emphasize an integrated approach to treatment and rehabilitation.

Strengths

<p>| Illness Management &amp; Recovery (IMR) | The county has contracted with Lindy Fox, LLC. for several years to implement the SAMHSA evidence-based IMR approach in several provider programs including Dual Dx, IOP, CRS, ACT, CRP and Halfway House serving the COD population. IMR also has a COD enhanced tool kit (Enhanced-IMR) which is being implemented in DelCo at 3 D&amp;A sites; There are 7 providers with 13 programs using the IMR practice or one of its specialized curriculums. Four of the seven are D&amp;A providers using Enhanced IMR, this curriculum, uses the core IMR program with the additional IDDT elements. One provider has implemented E-IMR in their entire practice designating 1 hour per 3-hour group as an IMR session and 1 goal IMR specific goal. This program is also working on a |</p>
<table>
<thead>
<tr>
<th><strong>Strengths</strong></th>
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<tbody>
<tr>
<td>**Pregnancy hand out to use with their individuals who are pregnancy and in</td>
<td>recovery.</td>
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<tr>
<td><strong>Integrated Dual Diagnosis (IDD) Treatment</strong></td>
<td>MBH and OBH continue efforts to increase provider competency in integrated screening,</td>
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<tr>
<td></td>
<td>assessment, and intervention for individuals with COD. Over FY 18-19, OBH’s Quality</td>
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<td></td>
<td>Department worked closely with providers to ensure that all screening include D&amp;A. In</td>
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<td></td>
<td>FY 19-20, OBH’s Quality Department will work with COD providers to utilize the evidenced</td>
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<tr>
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<td>based tool for health outcomes adopted by MH BCM units to screen for depression, anxiety,</td>
</tr>
<tr>
<td></td>
<td>insomnia, unhealthy alcohol use, and other substance use.</td>
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<tr>
<td><strong>Dual Diagnosis Treatment</strong></td>
<td>MH/IDD Services Dual Diagnosis Treatment Team. The DDTT works with individuals who have</td>
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<tr>
<td></td>
<td>an MH/IDD diagnosis. DDTT staff meet with family members and program staff both in the</td>
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<td></td>
<td>family homes and within the residential programs to assist in stabilizing members</td>
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<tr>
<td></td>
<td>situations. Several individuals have completed the anticipated 18-month treatment period</td>
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<td></td>
<td>with successful discharge back to their community programs. The Elwyn MH/IDD Natale RTF-A:</td>
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<td>This program has consistently received referrals from Magellan DelCo as well as outside</td>
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<td>county referrals. There have been several positive discharges where Natale has been</td>
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<td>able to assist in stabilizing individuals and assisting to get longer term community</td>
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<tr>
<td></td>
<td>supports in place to prevent re-admission.</td>
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<tr>
<td><strong>CIT Training</strong></td>
<td>There is a strong COD component presented by both MH and D&amp;A faculty in the semi-annual</td>
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<td>CIT certification classes for law enforcement personnel. The CIT program has trained and</td>
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<td>certified over 360 officers from the various municipal police departments, county park</td>
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<td></td>
<td>police, university police departments, state police officers, county correctional</td>
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<tr>
<td></td>
<td>facilities, and SEPTA transit systems. CIT certification classes are bi-annually and</td>
</tr>
<tr>
<td></td>
<td>faculty is comprised of consumers, families, providers, and county personnel.</td>
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<tr>
<td><strong>CRS COD Housing</strong></td>
<td>OBH maintains a 10-bed CRR and a 3-bed TPR targeted to the COD population. The CRR</td>
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<tr>
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<td>program has linkages to Dual Diagnosis IOP treatment programs.</td>
</tr>
<tr>
<td><strong>D&amp;A Certified Recovery Specialist (Peer Support)</strong></td>
<td>In FY 18-19, Magellan and DelCo OBH continued to work with MH Partnerships on the</td>
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<td></td>
<td>implementation of their Certified Recovery Specialist (CRS) program. The program</td>
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<td>employs two full-time CRSs and a CRS Supervisor. The program has a capacity to serve 50</td>
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<td>members, its current census is 11. In FY 19-20, OBH and Magellan personnel will continue</td>
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<td>to work with MHP on increasing their census through enhanced marketing efforts. Quality,</td>
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<td>program oversight and technical Support are provided through monthly implementation</td>
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<td>meetings. Magellan and DelCo D&amp;A treatment staff collaborate to identify and resolve needs.</td>
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<td>The SCA has sub-contacted the CRS program to Crozer Chester Medical Center (CCMC). This</td>
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<tr>
<td></td>
<td>program is a 24 hour “warm hand off” community-based program with the primary purpose</td>
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<td>to outreach and engage the overdose survivors who have been brought to our emergency</td>
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<td>departments. Four CRS are associated with the CCMC program. There is 1 CRS at the</td>
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<td>Harwood Halfway House and 1 encompassed in the CCMC Center of Excellence.Twenty CRS were</td>
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<td>trained through the CRS training program.</td>
</tr>
<tr>
<td><strong>Inpatient DBT program</strong></td>
<td>The county’s only D&amp;A inpatient Dialectical Behavioral Therapy (DBT) program continues</td>
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<tr>
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<td>with praises. This provider also offers outpatient substance abuse DBT programming</td>
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<tr>
<td></td>
<td>creating a seamless transition at discharge. This program has reduced persons leaving</td>
</tr>
<tr>
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<td>treatment AMA by 30%.</td>
</tr>
</tbody>
</table>
Strengths

In terms of the greatest increase in outcome rating scale scores from admission to discharge, DBT patients made more progress than the non-DBT patients. This suggests that we are screening and placing clients into DBT effectively. It also suggests that the specialized treatment is contributing to the higher change score from admission to discharge. DBT clients are entering, on aggregate (N = 219), in the clinically significant range, improving by a clinically significant margin (about 13 points, with 5 being statistically significant change), and moving from the clinically significant range (i.e. representative of people who seek clinical treatment) to the range of people whose scores are not typical of those seeking treatment. Essentially, the DBT clients’ results show that there has been both statistically and clinically significant change.

Specialty Courts

There are several specialty courts such as D&A Treatment, MH Court and Veterans which all have high levels of COD/co-occurring among the caseload.

Unmet Needs

Trauma Competent Providers

Providers who specialize in Trauma focused treatment continue to be a challenge. Magellan/OBH contracted with Andrea Meier of Dartmouth to train 3 providers in Trauma informed treatment to improve clinical outcomes and avert the revolving door in and out of higher LOC. Unfortunately, due to staff turnover and inability of providers to meet the expectations for fidelity and data reporting, DelCo continues to have a gap in this area. OBH and Magellan will continue to plan for this area.

D&A Peer Support

Availability of billable Peer Support for persons in the D&A system, including the COD population, remains a gap when contrasted to available MH Peer Support. 1 D&A Halfway provider has a D&A Peer Specialist on staff and is included in Magellan’s bundled rate.

Housing

There are still gaps in housing for the COD population that continues to experience periodic relapse and abuse of substances that allows them to retain their housing

Justice-Involved Individuals

OBH has participated in various inter-system initiatives with criminal justice partners for many years. In 2010, a Cross-System Mapping was held for 45 county stakeholders that identified several system gaps, produced priority action steps, and resulted in many of the newest forensic initiatives being proposed and/or developed in the county. The Cross-System Strategic Planning Committee is the entity responsible for tracking intersystem program development and training initiatives. OBH also participates in the Criminal Justice Advisory Committee (CJAC), DelCo Cares initiative, MH Court Planning Team, and works with the Regional Forensic Liaison on DOC/SCI max-out planning, and with Forensic Liaisons at GW Hill Prison for inmate re-entry planning. Since there was a strong desire for cross-systems training, OBH staff provided a MH Awareness training for the Executive Board of Judges and Magisterial District Judges in January and February 2019.
## Strengths

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inter-System Administrative Forums</strong></td>
<td>The Criminal Justice Advisory Committee (CJAC), Cross-System Strategic Planning Committee (CSSPC), and DelCo Cares are the primary administrative forums for inter-system forensic planning and service development.</td>
</tr>
<tr>
<td><strong>Cross-System Mapping</strong></td>
<td>In 2010, OBH and criminal justice partners participated in a MH Justice COE led Cross-System Mapping to identify strengths and gaps and create a prioritized strategic action plan to develop and enhance forensic services in the county. More recently, adopted resolution to become involved in the Stepping Up Initiative which is a national effort which focuses in the diversion of individuals with SMI disorders from jails and into treatment.</td>
</tr>
<tr>
<td><strong>Crisis Intervention Team (CIT)</strong></td>
<td>The CIT program has trained and certified over 360 officers from the various municipal police departments, county park police, university police departments, state police officers, county correctional facilities, and SEPTA transit systems. CIT certification classes are bi-annually and faculty is comprised of consumers, families, providers, and County personnel.</td>
</tr>
<tr>
<td><strong>Transitional Housing Program (THP)</strong></td>
<td>The forensic THP, operated by GEO the provider of the County’s prison and Community Corrections Center facilities, opened in March 2014. The re-entry program established at the forensic THP is an 18-bed facility serving (all male) facility focusing on community and treatment re-engagement and other supportive services.</td>
</tr>
<tr>
<td><strong>Forensic ACT (FACT) Team</strong></td>
<td>The FACT team continues to be an integral component of the successful discharge and transition of individuals returning to the community from NSH or county and/or state correctional facility. The team will work with our criminal justice partners and community resources. The DelCo FACT team has maintained a low incarceration rate (between .01-.3%) over the first 3 quarters FY18-19.</td>
</tr>
<tr>
<td><strong>MH Court</strong></td>
<td>The MH Court continues to address the needs of the SMI/justice-involved population. There is a strong working relationship between the criminal justice and behavioral health systems.</td>
</tr>
<tr>
<td><strong>Forensic Peer Support</strong></td>
<td>Peerstar continues to implement this evidence-based model and has been an integral component in the successful recovery of individual re-entry in the community.</td>
</tr>
<tr>
<td><strong>OBH Forensic Specialist</strong></td>
<td>The Forensic Specialist helps oversee the myriad of forensic initiatives targeted to the justice-involved population.</td>
</tr>
<tr>
<td><strong>Behavioral Health Liaisons</strong></td>
<td>OBH and Adult Probation &amp; Parole jointly fund 4 behavioral health liaisons at the GW Hill prison to coordinate treatment in the prison and in the community at release.</td>
</tr>
<tr>
<td><strong>DOC Max-out Tracking</strong></td>
<td>OBH staff, in conjunction with the Regional Forensic Liaison, track and develop release plans for the C and D roster priority max-out cases returning to DelCo.</td>
</tr>
<tr>
<td><strong>RFPC Access</strong></td>
<td>Waiting lists continue to decrease for access to the Regional Forensic Psychiatric Center (RFPC) at NSH. As of May 3, 2019, there were 9 individuals on the waiting lists. The average wait time was less than 30 days.</td>
</tr>
<tr>
<td><strong>Community-Restoration of Competency Residential Treatment Facility</strong></td>
<td>Collaborative efforts of CJS and OBH systems in the development of a community-based competency restoration treatment program for individuals currently at the county prison who would otherwise be on the waiting list for the Regional Forensic Psychiatric Center.</td>
</tr>
</tbody>
</table>
Unmet Needs

<table>
<thead>
<tr>
<th>Housing</th>
<th>The CRS and mainstream housing systems continue to be impacted by those owners/property managers who mandate criminal background checks as part of their screening process and exclude most individuals with any level of justice-involvement.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding</td>
<td>Because the Housing Authority implements a criminal background check, the CRS system must provide Master Lease subsidies for persons with justice-involvement who otherwise would receive mainstream federal housing subsidy.</td>
</tr>
<tr>
<td>Youth CIT</td>
<td>A Youth CIT Training curriculum is being explored by the Department of Human Services, OBH, and Juvenile Court &amp; Probation to determine need.</td>
</tr>
<tr>
<td>Juvenile Mental Health Treatment Court</td>
<td>A Juvenile MH Treatment Court Model is being explored by the Department of Human Services, OBH, and Juvenile Court &amp; Probation to determine need.</td>
</tr>
</tbody>
</table>

**Veterans**

OBH participates in a number of forums with the county’s Office of Veteran’s Affairs, Criminal Justice System, and the Veteran’s Administration to identify issues facing Veterans returning from active combat and to get them into appropriate treatment services and housing.

**Strengths**

<table>
<thead>
<tr>
<th>Fairweather Lodge</th>
<th>The Fairweather Lodge program has been serving Veterans for several years. The capacity of this evidence-based housing program is 4-beds.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veterans’ Court</td>
<td>This is a relatively new specialty court in DelCo with a small caseload of 24. There are relationships with behavioral health providers and the Coatesville VAMC.</td>
</tr>
<tr>
<td>VAMC Forensic Linkages</td>
<td>The Coatesville VAMC Justice Outreach worker is involved with the new Veterans’ Court Program and is a member of the CIT faculty training DelCo police officers.</td>
</tr>
<tr>
<td>Veteran’s Housing</td>
<td>In 2017, DelCo was awarded the distinction of Ending Chronic Homelessness according to the standards issued by the US Interagency Council on Homelessness. The County continues to address veteran homelessness and maintain that status.</td>
</tr>
<tr>
<td>VASH Vouchers</td>
<td>The Housing Authority received an allotment of VASH Vouchers from HUD and adopted a Housing First approach to rapidly house eligible Veterans.</td>
</tr>
<tr>
<td>Support Services for Veteran’s Families</td>
<td>This program provides housing assistance to those at imminent risk of homelessness or those who are literally homeless. This program will introduce the Rapid Resolution model to service people more effectively and keep them from becoming and remain homeless.</td>
</tr>
</tbody>
</table>

**Unmet Needs**

<table>
<thead>
<tr>
<th>VA Treatment Access</th>
<th>Some Veterans report not wanting to access treatment services through the VA system which places additional demand for service on the MH Base-funded system.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>Veteran-specific housing tends to be utilized as soon as it becomes available. More VASH vouchers and access to more structured housing would be beneficial.</td>
</tr>
<tr>
<td>Funding</td>
<td>Funding for treatment is available through the VA, but many Veterans still choose not to access the VA, placing an additional burden on the MH Base-funded system.</td>
</tr>
</tbody>
</table>
Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex (LGBTQI)
Magellan, OBH and various county stakeholders jointly plan for the availability of services to the sexual minority target population that are predicated on: enhancing recovery and resiliency; building staff competencies; promoting participant satisfaction; and, achieving positive outcomes.

<table>
<thead>
<tr>
<th>Strengths</th>
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<tbody>
<tr>
<td><strong>PRYSM Program</strong></td>
</tr>
<tr>
<td><strong>LGBTGI Training</strong></td>
</tr>
<tr>
<td><strong>Parents, Families and Friends of Lesbians and Gays (PFLAG) Program</strong></td>
</tr>
<tr>
<td><strong>Center for Violence Prevention</strong></td>
</tr>
<tr>
<td><strong>In-Network Providers</strong></td>
</tr>
<tr>
<td><strong>LGBTQI Workgroup</strong></td>
</tr>
</tbody>
</table>

**Unmet Needs**
Adding new in-network providers will expand the range of services offered, enhance treatment competencies, and increase participant choice.

**System Training**
Need for ongoing trainings to increase stakeholder awareness and build staff competencies.

**Special Staffing**
Need for more staff with specialized competencies to create more capacity on specialized caseloads in more services within the county.

Racial, Ethnic, Linguistic Minorities
MBH, OBH, and various county stakeholders also jointly plan for the availability of services to Racial, Ethnic, and Linguistic minority target populations that are predicated on: enhancing recovery and resiliency; building staff competencies; promoting participant satisfaction; and achieving positive outcomes.

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<th>Strengths</th>
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<tbody>
<tr>
<td><strong>Deaf Services</strong> =</td>
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and able to individuals who need assistance navigating the MH and other systems for on-going support.

<table>
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<tr>
<th>CIT Training</th>
<th>Cultural Competency is one of the 21 core curriculum content areas of each semiannual CIT certification training that has currently been provided to over 360 DelCo police officers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network Deaf Providers</td>
<td>Magellan has several in-network providers to serve the deaf and hard of hearing population giving participants a measure of choice.</td>
</tr>
<tr>
<td>In-Network Linguistic Providers</td>
<td>Magellan has in-network provider linguistic competencies reflecting the County’s minority populations. Intercultural Family Services staff speak over 20 languages. Some providers offer Spanish speaking telephone options and staff interventions.</td>
</tr>
<tr>
<td>System Trainings</td>
<td>Cultural competency trainings have been provided to contracted agency staff for several years. Magellan has online training content available to provider staff.</td>
</tr>
<tr>
<td>Documents and Interpreter Services</td>
<td>OBH has procured a telephonic interpreter service via Language Line which allows staff to use during phone calls and/or face to face meetings coordinated by OBH staff. The use of an IPAD with immediate access to video interpreting is also available for OBH, as well as all Human Services offices. Magellan is able to provide interpreters for members who call our Member Services Line; Magellan has translated letters based on a member’s primary language; Member handbook and Newsletters are printed in Spanish.</td>
</tr>
</tbody>
</table>

**Unmet Needs**

| In-Network Providers | Adding new in-network providers will enhance service effectiveness, better meet participant demand (Spanish speaking staff), and, increase participant choice. |
| System Training      | Need for ongoing trainings to increase stakeholder awareness and build staff competencies and diversity to better serve these under-served populations. |
| Assess Staff Diversity | Need to assess diversity of staff with respect to the racial, ethnic and linguistic composition of the populations served by various county programs (like PATH). |

OBH continues to have the lead coordination role for the DelCo COC through its Adult and Family Services Division. The local Homeless Services Coalition has been operating for 23 years, and recently adopted a Governance Charter and Governing Board to comply with new HUD HEARTH Act legislation. Successful compliance with federal COC requirements results in over $4 million annually in homeless assistance funding, much of which supports the MH and COD homeless population. Additionally, OBH maintains substantial County MH base funding to support the PATH outreach and Housing First programs, in addition to providing federally required match funding through MH base and Reinvestment funds.

**Other Homeless**

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<th>Strengths</th>
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<tr>
<td><strong>Continuum Of Care (COC) Planning</strong></td>
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<tr>
<td>OBH has several staff who maintain leadership roles in the COC planning process and Homeless Services Coalition that has operated successfully for 26 years.</td>
</tr>
<tr>
<td><strong>HEARTH Act Governance</strong></td>
</tr>
<tr>
<td>In FY 13-14 a Governance Charter was drafted and a Governing Board constituted to comply with Federal HEARTH Act requirements.</td>
</tr>
<tr>
<td><strong>COC Services</strong></td>
</tr>
<tr>
<td>The county’s COC has services for homeless SMI that include: Outreach, Coordinated Entry, Emergency Shelter, Supportive Services, Transitional Housing, Rapid Rehousing and Permanent Housing.</td>
</tr>
</tbody>
</table>
Local Match Commitment

DelCo has long provided required federal match funding for homeless initiatives. Reinvestment funds have also been used when other match sources have ended.

PATH

OBH has maintained federal PATH grants through OMHSAS for many years to provide homeless street outreach and a Chronic Homeless Housing First program.

Shelter Plus Care (S+C)

OBH has also maintained 2 S+C grants for years that provide housing for the Chronic Homeless population. HUD recently consolidated these into one S+C grant.

Unmet Needs

Permanent Housing

Access to permanent housing placements is particularly difficult for persons with SMI as their needs often exceed the availability of residential staff supports.

Supportive Services

HUD’s funding formulas significantly reduced the availability of supportive services funding which in turn has made serving special needs populations very challenging.

Mainstream Housing

The DelCo Housing Authority was awarded 45 HCV to house persons who are literally homeless or at imminent risk of homelessness. All households must have a disability as defined by the federal government. Sixty percent of the households awarded HCV had a serious mental illness.

SOAR Program

The County received new funding under the Home4Good program to implement a SOAR program. Two SOAR Specialists will implement the program beginning June 1, 2019.

Other: MH/ID

OBH, OIDD, and MBH, have coordinated to enhance and increase the services and supports to the dually-diagnosed MH and intellectually disabled for several years. Trainings have been provided to cross-systems agencies and staff. The county meets internally and is dedicated to identifying at-risk individuals and plan to meet their needs. New programs have been developed to increase community-based interventions and divert from higher LOC. The Dual-Diagnosed Treatment Team (DDTT), increased bed capacity at the Natale Residential Treatment Facility for Adults (RTF-A), as well as an addition of CPS services have improved the capacity and expertise in working with this population. OBH has facilitated trainings to OIDD staff and Supports Coordinators to understand and navigate the MH system with Magellan.

Strengths

Administrative Forums

All categoricals participate in the Human Services Administrators meetings for joint planning/information sharing.

MH/ID Case Review

OBH and OIDD participate in ongoing case review forums for children and adults to identify needed services and plan joint service delivery for Dual Diagnosis clients.

Inter-system Training

OBH, OIDD, and Magellan provided a series of best practice Dual Diagnosis trainings for inter-system personnel. These trainings were targeted at Psychiatrists, Blended Case Managers & Supports Coordinators, and finally MH & IDD Residential staff.

CIT Training

A consultant from PCHC provides instruction in MH/IDD Dual Diagnosis curriculum content area to police officers attending the semi-annual certification program.
Joint programming - RTFA-DD

The current RTF-A program was approved for expansion of 4 additional beds specifically to target the BH/IDD population. The facility opened in the Spring of 2016 under reinvestment start-up and is funded on-going through HealthChoices. The RTF-A acts as a diversion to those possibly needing AIP or for those who have been discharged from AIP but may need some additional time prior to returning to the community.

Dually Diagnosed Treatment Team (DDTT)

DDTT has worked with several individuals who were deemed to be at-risk of losing their current residential placement and/or were at-risk of not being able to be cared for at home/in the community due to their MH/IDD needs. The team continues to work toward full census but has been fully HealthChoices funded after the Reinvestment start-up. Admissions and discharges are purposely done on a rolling basis over a projected 18-month period to ensure the team is able to focus on each individual’s process/progress.

Unmet Needs

ID Staff Training

Particularly on the residential side, due to impact of low salaries, there is a high need for better staff training to meet the MH needs of those in IDD placements. OBH and Magellan have funded trainings in coordination with OIDD and have met regularly with Supports Coordination staff to ensure effective planning for individuals.

Crisis/Inpatient Access

Access and competent assessment/treatment is a problem in MH crisis services and inpatient units when the MH/IDD population seeks services.

Housing

There is a lack of housing resources available to meet the primary residential and step-down needs of the MH/ID population.

Transition Age Young (TAY) Adult with ASD and IDD

There is a need to develop housing and community-based treatment and support programs for TAY with an Autism Spectrum Disorder (ASD) diagnosis and an IDD. A committee has been formed to address these gaps in services.

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

☒ Yes  ☐ No

If yes, please describe the CLC training being used. Plans to implement CLC training may also be included in the discussion. (Limit of 1 page)

Strengths

Deaf Services

The County contracts for Wrap-Around, Case Management, and BHRS in the children’s’ system. The adult system also has Case Management as well as a base-funded contract to provide information, initial assessment of needs, and referral for on-going services.

CIT Training

Cultural Competency is one of the 21 core curriculum content areas of each semiannual CIT certification training that has currently been provided to over 360 DelCo police officers.

In-Network Deaf Providers

Magellan has several in-network providers to serve the deaf and hard of hearing population giving participants a measure of choice.

In-Network Linguistic Providers

Magellan has in-network provider linguistic competencies reflecting the county’s minority populations. Intercultural Family Services staff speak over 20 languages. Some providers offer Spanish speaking telephone options and staff interventions.
Cultural competency trainings have been provided to contracted agency staff for several years. Magellan has online training content available to provider staff online.

DHS sponsor’s Lunch & Learns with our Cultural Brokers 4 times a year

DHS has an IPAD with live video interpreting services in over 200 different languages/dialects. Telephonic interpreting is also available to all departments within Human Services.

In 2016, a Cultural and Linguistic Competence (CLC) training program was developed by MBH for all HealthChoices staff and providers to be implemented in 2017. The Cultural Competency plan was inclusive of goals to address recruitment and training strategies, diversity of staff, language assistant services, bilingual staff, easily understood member related materials, and mechanisms for member involvement. All activities will be monitored quarterly and a continuous quality improvement plan will be implemented.

An area of significance, is ensuring that DelCo services are provided in a culturally competent manner. An intervention identified to ensure that this is the case includes Culturally Competent trainings available online via Magellan of PA website for free via Relias. This resource includes training modules designed to increase provider knowledge around cultural competency. For example, the training module entitled “Cultural Competence for the Direct Support Professional (DSP)” supports providers in understanding specific cultural competency strategies when working with individuals with developmental disabilities, helps providers define cultural diversity, describes how culture may influence an individual’s behavior and enhances provider understanding of the DSP’s role in responding to cultural diversity.
C. Supportive Housing

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).

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Total $ Amount for FY 17-18 (only County MH/ID dedicated funds)</th>
<th>Projected $ Amount for FY 19-20 (only County MH/ID dedicated funds)</th>
<th>Actual or Estimated Number Served in FY 17-18</th>
<th>Projected Number to be Served in FY 19-20</th>
<th>Number of Targeted BH Units</th>
<th>Term of Targeted BH Units (ex: 30 years)</th>
<th>Year Project first started</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Total $ Amount for FY 17-18</th>
<th>Projected $ Amount for FY 19-20</th>
<th>Actual or Estimated Number Served in FY 17-18</th>
<th>Projected Number to be Served in FY 19-20</th>
<th>Number of Bridge Subsidies in FY 17-18</th>
<th>Average Monthly Subsidy Amount in FY 17-18</th>
<th>Number of Individuals Transitioned to another Subsidy in FY 17-18</th>
<th>Year Project first started</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSBG</td>
<td>$904,724.</td>
<td>$939,860.</td>
<td>103</td>
<td>112</td>
<td>112</td>
<td>$550.00</td>
<td>0</td>
<td>2009</td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### 3. Master Leasing (ML) Program for Behavioral Health

<table>
<thead>
<tr>
<th><strong>Funding Source by Type (include grants, federal, state &amp; local sources)</strong></th>
<th><strong>Total $ Amount for FY 17-18</strong></th>
<th><strong>Projected $ Amount for FY 19-20</strong></th>
<th><strong>Actual or Estimated Number Served in FY 17-18</strong></th>
<th><strong>Projected Number to be Served in FY 19-20</strong></th>
<th><strong>Number of Owners/Projects Currently Leasing</strong></th>
<th><strong>Number of Units Assisted with Master Leasing in FY 17-18</strong></th>
<th><strong>Average subsidy amount in FY 17-18</strong></th>
<th><strong>Year Project first started</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>CHIPP</td>
<td>$69,379.</td>
<td>$69,380.</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>$400.00</td>
<td>0</td>
<td>2018</td>
</tr>
</tbody>
</table>

**Notes:**

* Check if available in the county and complete the section.

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

<table>
<thead>
<tr>
<th><strong>Year</strong></th>
<th><strong>Project first started</strong></th>
<th><strong>Total $ Amount for FY 17-18</strong></th>
<th><strong>Projected $ Amount for FY 19-20</strong></th>
<th><strong>Actual or Estimated Number Served in FY 17-18</strong></th>
<th><strong>Projected Number to be Served in FY 19-20</strong></th>
<th><strong>Number of Owners/Projects Currently Leasing</strong></th>
<th><strong>Number of Units Assisted with Master Leasing in FY 17-18</strong></th>
<th><strong>Average subsidy amount in FY 17-18</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>HSBG</td>
<td>2010</td>
<td>$532,148.</td>
<td>$541,167.</td>
<td>59</td>
<td>60</td>
<td>25</td>
<td>60</td>
<td>$550.00</td>
</tr>
<tr>
<td>CHIPP</td>
<td>2018</td>
<td>$35,616.</td>
<td>$89,040.</td>
<td>4</td>
<td>10</td>
<td>5</td>
<td>10</td>
<td>$700.00</td>
</tr>
</tbody>
</table>

**Notes:**

### 4. Housing Clearinghouse for Behavioral Health

<table>
<thead>
<tr>
<th><strong>Funding Source by Type (include grants, federal, state &amp; local sources)</strong></th>
<th><strong>Total $ Amount for FY 17-18</strong></th>
<th><strong>Projected $ Amount for FY 19-20</strong></th>
<th><strong>Actual or Estimated Number Served in FY 17-18</strong></th>
<th><strong>Projected Number to be Served in FY 19-20</strong></th>
<th><strong>Number of Staff FTEs in FY 17-18</strong></th>
<th><strong>Year Project first started</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>CHIPP</td>
<td>$532,148.</td>
<td>$541,167.</td>
<td>59</td>
<td>60</td>
<td>25</td>
<td>60</td>
</tr>
<tr>
<td>CHIPP</td>
<td>$35,616.</td>
<td>$89,040.</td>
<td>4</td>
<td>10</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

**Notes:**

* Check if available in the county and complete the section.

An agency that coordinates and manages permanent supportive housing opportunities.
### 5. Housing Support Services for Behavioral Health

☐ Check if available in the county and complete the section.

HSS are used to assist consumers in transitions to supportive housing and/or services needed to assist individuals in sustaining their housing after move-in.

<table>
<thead>
<tr>
<th><em>Funding Sources by Type (include grants, federal, state &amp; local sources)</em></th>
<th><em>Total $ Amount for FY 17-18</em></th>
<th><em>Projected $ Amount for FY 19-20</em></th>
<th><em>Actual or Estimated Number Served in FY 17-18</em></th>
<th><em>Projected Number to be Served in FY 19-20</em></th>
<th><em>Number of Staff FTEs in FY 18-19</em></th>
<th><em>Year Project first started</em></th>
</tr>
</thead>
</table>

### 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 etc.
### APPENDIX B 7

#### 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 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**.

<table>
<thead>
<tr>
<th>Project Name (include type of project such as PBOA, FWL, CRR Conversion, etc.)</th>
<th>*Funding Sources by Type (include grants, federal, state &amp; local sources)</th>
<th>Total $ Amount for FY 18-19</th>
<th>Projected $ Amount for FY 19-20</th>
<th>Actual or Estimated Number Served in FY 18-19</th>
<th>Projected Number to be Served in FY 19-20</th>
<th>Average Contingency Amount per person</th>
<th>Year Project first started</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Notes:**
D. Recovery-Oriented Systems Transformation

Recovery-Oriented Systems Transformation Priorities have been part of the County needs-based planning process for several years. OBH, Magellan, providers and County stakeholders are involved in the development of the Recovery-Oriented Systems Transformation Priorities and in the reporting and quantifying of data relating to the respective goals/outcome measures.

Table d. (inserted) is the list of Transformation Priorities from the FY 18-19 CHS Plan. Most, if not all of these initiatives will continue to be implemented, tracked, and monitored in FY 19-20, and are updated accordingly, along with the addition of a couple of new initiatives that will be started in FY 19-20, in shaded area.

Table d. (inserted) is the list of Transformation Priorities from the FY 18-19 CHS Plan. Most, if not all of these initiatives will continue to be implemented, tracked, and monitored in FY 19-20, and are updated accordingly, along with the addition of a couple of new initiatives that will be started in FY 19-20, in shaded area.
Recovery-Oriented Systems Transformation Priorities:

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Brief Narrative</th>
<th>Time Line</th>
<th>Funding</th>
<th>Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Older Adults: Gateway (Giving Assessment, Treatment, and Empowerment in the Aging Years)</td>
<td>GATEWAY targets and identifies isolated, at risk, older adults with behavior health (MH and/or substance abuse) issues. The program evaluates adults aged 60 and older who are experiencing behavior health difficulties and links them with the appropriate formal and informal community resources and monitors them to track their progress.</td>
<td>FY 19-20 OBH will continue to assess gaps in service, assess and plan how these gaps can be addressed and plan to address them with the larger workgroup, look at whether behavioral health providers are using evidence-based practices geared towards older adults, and if not, how they can be supported to do so. The primary objective is to ensure that adequate resources are available for the needs identified by the assessments.</td>
<td>MH base funds</td>
<td>One of the main goals for CHC was to get elderly who were diagnosed as Nursing Facility Clinically Eligible, to receive better access to behavioral health services. With this in mind, we collaborated with COSA’s GATEWAY program. In this effort, OBH shared GATEWAY statistics and outcomes with Magellan as a way help Magellan better understand the behavioral health concerns of older adults in DelCo. Focus of data was on gender, ethnicity, household composition, and the reason for referral, inclusive of MH prevalent disorders. In light of the Community HealthChoices program, outreach has been completed in partnership with Magellan, COSA, and OBH at nursing facilities, personal care agencies, legislative office, and community libraries.</td>
</tr>
</tbody>
</table>
**APPENDIX B 8**

| Older Adults: Housing | DelCo currently has an array of services available specifically to treat the needs of the aging. However, as community tenure has grown for many special populations (TAY, Forensic, ID), supportive housing opportunities have grown at a much slower rate. Specifically, for the aging, specialized housing for those with Dementia and/or other medical needs. DelCo continues to develop housing through MH base dollars utilizing the Specialized Personal Care Home Model. | FY 19-20 OBH will continue to identify housing needs as they are assessed thru these agents; GATEWAY, Older Adult Task Force, and Therapeutic Counseling. Supportive housing is identified for adults age 55 and over with severe mental illness and co-occurring disorders and has a focus on community engagement, meeting current physical health needs and future health needs as individuals age, and obtaining behavioral health supports. At the same time, individuals will work on recovery and personal goals. The program is geared to be long-term housing, so individuals can “Age in Place.” | MH base funds | Child Guidance Resource Center (CGRC) was awarded the SHAIP contract and OBH had bi-monthly meetings with them beginning August 2018 to discuss SHAIP start-up and implementation including; hiring of SHAIP staff, progress with construction, budget revisions to support added construction costs, referrals, marketing, reporting requirements (PROMISE, CCRI and CHIPPS). While there was a plan to have SHAIP housing move residents in during the Fall of 2018, residents under the former owner needed to move out and much construction needed to take place before SHAIP could accept residents. The first resident moved in on February 19, 2019 and as of April 19, 2019, there were 4 residents living at SHAIP with 1 person on the waiting list. In July 2018, OBH met with QI at CGRC to discuss possible outcomes and together developed a quarterly report focused on demographics and |
2. Justice-Involved:

**Community Forensic Interventions, LLC (R-FACT)**

<table>
<thead>
<tr>
<th>DEPARTMENT</th>
<th>OUTCOMES</th>
<th>FY 17-18 PRIMARY OBJECTIVE</th>
<th>REINVESTMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Forensic Interventions</td>
<td>The R-FACT model has helped the Mobile Assessment Stabilization &amp; Treatment (FACT) team transition to a forensic ACT model with the intent to serve a 100% forensic population. The consultants of the Community Forensic Interventions have provided training to the FACT team to enhance their skills and criminal justice expertise.</td>
<td>FY 17-18 primary objective is to provide ongoing consultation to the FACT team. Focus on harm reduction techniques, medication management, communication and maintaining fidelity. The consultants will provide trainings to the FACT team via teleconferencing, in-person trainings to improve their overall team development and its collaborative efforts with the criminal justice system.</td>
<td>Reinvestment Annually, OBH and/or Magellan participate in site visits to assess the adherence to fidelity, best practices, as well as regulatory guidelines. OBH QI is currently enhancing the current data collection to include MH Court focus.</td>
</tr>
</tbody>
</table>

**Justice-Involved:**

**Forensic Peer Support Program (FPSP)**

<table>
<thead>
<tr>
<th>DEPARTMENT</th>
<th>OUTCOMES</th>
<th>FY 17-18 PRIMARY OBJECTIVE</th>
<th>REINVESTMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forensic Peer Support Program</td>
<td>The FPSP model is being used to offer Peer Support services to the forensic population. Peerstar is providing FPSP services using the Yale citizenship model with Peers with lived forensic experience.</td>
<td>Peerstar will continue to provide community-based FPSP services.</td>
<td>Reinvestment HealthChoices County Base OBH/Magellan oversees the FPSP community team and delivery of billable CPS services. OBH will continue to track the caseload as it builds toward full capacity. In addition to caseload information (currently at 57 individuals) OBH also tracks; referrals, origination of referral, marketing strategies, waitlist, and training hours.</td>
</tr>
<tr>
<td>Justice-Involved:</td>
<td>Transitional Housing Program (THP)</td>
<td>Individuals continue to be admitted to the THP with the projected length of stay being 9-12 months. The GEO Group, Inc., continues to work with community MH providers and individuals with criminal justice involvement. The GEO Group Inc THP will continue to operate at full occupancy and work with community treatment providers to step individuals down within the continuum of services.</td>
<td>Reinvestment</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td><strong>3. Transition-Age: Assertive Community Treatment (ACT)</strong></td>
<td>THP is a forensic housing model implemented by the Geo Group, Inc. THP is sited in a Community Corrections Center (CCC) facility. Target populations include discharges from NSH, diversions from NSH RFPC, DOC/SCI max-outs and county prison releases.</td>
<td>In FY 18-19 TAY CPS has been in operation since July 2018 and has been able to utilize HealthChoices funding as of August 1, 2018. CPS program has served a total of 6 youth and has 2 active referrals. We are continuously recruiting CPS candidates. Outreach has extended throughout the region. All referrals are processed and approved by OBH. The DelCo CPS program is hoping to build their census to 24 youth. The CPS program has received referrals from HIFI, TIP, FBMHS and self-referrals. CPS staffing consist of 2 part-time CPS that were hired in December 2018. CPS program is fully staffed, full census will be 44 youth.</td>
<td>HealthChoices/base funding</td>
</tr>
</tbody>
</table>
### Transition to Independence

**TIP** - Evidenced supported model for ages 16-26 that is licensed as a Blended Case Management program focusing on life skills development in DelCo, TIP can serve up to 75 young people. TIP receives a steady flow of referrals and is presently exhausting their short waitlist. In FY 18-19, TIP DelCo served 72 young adults and expects to serve 100 young adults in FY 19-20.

HealthChoices/base funding

In FY 19-20, OBH and Magellan will continue to meet with CFF on a monthly bases to maintain oversight and monitoring of the program.

### Transitional Age Certified Peer Specialist

In the Fall of 2017, Magellan and OBH identified Child and Family Focus (CFF) to develop a CPS program for 14-26 year olds. People will be able to have the support of a CPS in the community to work with them toward their recovery goals. The team of TAY CPS will focus on working with individuals specific to their transitional age issues. CFF has submitted documentation to begin their license process and will look to hire and train up to 5 CPS staff. CFF has identified the supervisor who has already completed training. CFF has been accepting referrals since Summer of 2018.

HealthChoices/ Base funding

OBH and Magellan meet with CFF on a monthly basis to review implementation and oversight monitoring.

### First Episode Psychosis

In 2016, OMHSAS requested proposals for a grant to provide First Episode Psychosis treatment to individuals. CFF was awarded the grant and has trained and developed a team to provide community-based treatment services to individuals 15-30 years old.

In FY 18-19, OBH will continue to collaborate with CFF as a First-episode Psychosis Program for ages 15-30. OBH and Magellan conduct quarterly implementation meetings with CFF to provide support, structural, and programmatic recommendations, identify any barriers and collaboratively develop solutions. “On My Way” continues to review a

HealthChoices/ Base funding

In FY 19-20, OBH and Magellan will continue to meet with CFF regarding implementation and oversight to monitor referrals, access, and treatment. The initial treatment team has completed all trainings and has received several referrals as they work toward a census of 35 individuals.
who can benefit from these services. strict admission criterion for enrolling new members. Those that do not meet the First Episode criteria are referred to other services. Currently there are 18 individuals receiving services with a projection of 35 full census.

The treatment staff has been stable as CFF is actively looking to add an additional therapist and psychiatric time as the caseload approaches 20.

4. Children: Currently there are 3 trainers in YMHFA with 3 scheduled to go to instructor course October 2019.

YMHFA training continues as priority for stakeholder education. Human Services and various stakeholders including parents and young adults over the age of 18, are the entities that are offered these trainings 6 times a year.

County/System of Care

OBH Children’s Coordinator oversees the coordination of YMHFA training and staff
E. Existing County Mental Health Services:

Please indicate all currently available services and the funding source or sources utilized.

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Brief Narrative</th>
<th>Time Line</th>
<th>Funding</th>
<th>Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Adults: MHFA</td>
<td>FY 15-16, MHFA presented to targeted audiences (older adults, residential, public safety and veterans) involved in the President Judge’s DelCo Cares Initiative. These trainings have provided personnel at the County jail, direct care workers, and others with skills and resources necessary to identify and work effectively with individuals with mental illnesses. MHFA trainings have been expanded to include additional targeted groups such as faith-based and local community organizations. Existing trainers will receive supplemental training and certification in these areas. MHFA survey will be sent to these various groups and trainings will be scheduled based on their level of interest and demand.</td>
<td>MHFA trainings have been expanded to include additional targeted groups such as faith-based and local community organizations. Existing trainers will receive supplemental training and certification in these areas. MHFA survey will be sent to these various groups and trainings will be scheduled based on their level of interest and demand.</td>
<td>MH Matters Regional Grant</td>
<td>2 OBH instructors will continue to lead in planning and documenting MHFA training and staff certification per National Council requirements.</td>
</tr>
</tbody>
</table>
## Services By Category

<table>
<thead>
<tr>
<th>Services By Category</th>
<th>Currently Offered</th>
<th>Funding Source (Check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Mental Health</td>
<td>☒</td>
<td>☒ County ☒ HC ☐ Reinvestment</td>
</tr>
<tr>
<td>Psychiatric Inpatient Hospitalization</td>
<td>☒</td>
<td>☒ County ☒ HC ☐ Reinvestment</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>☒</td>
<td>☒ County ☒ HC ☐ Reinvestment</td>
</tr>
<tr>
<td>Adult</td>
<td>☒</td>
<td>☐ County ☒ HC ☐ Reinvestment</td>
</tr>
<tr>
<td>Child/Youth</td>
<td>☒</td>
<td>☒ County ☒ HC ☐ Reinvestment</td>
</tr>
<tr>
<td>Family-Based Mental Health Services</td>
<td>☒</td>
<td>☒ County ☒ HC ☐ Reinvestment</td>
</tr>
<tr>
<td>ACT or CTT</td>
<td>☒</td>
<td>☒ County ☒ HC ☐ Reinvestment</td>
</tr>
<tr>
<td>Children’s Evidence Based Practices</td>
<td>☒</td>
<td>☒ County ☒ HC ☐ Reinvestment</td>
</tr>
<tr>
<td>Crisis Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone Crisis Services</td>
<td>☒</td>
<td>☐ County ☒ HC ☐ Reinvestment</td>
</tr>
<tr>
<td>Walk-in Crisis Services</td>
<td>☒</td>
<td>☒ County ☒ HC ☐ Reinvestment</td>
</tr>
<tr>
<td>Mobile Crisis Services</td>
<td>☒</td>
<td>☐ County ☒ HC ☐ Reinvestment</td>
</tr>
<tr>
<td>Crisis Residential Services</td>
<td>☒</td>
<td>☐ County ☒ HC ☐ Reinvestment</td>
</tr>
<tr>
<td>Crisis In-Home Support Services</td>
<td>☒</td>
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</tr>
<tr>
<td>Emergency Services</td>
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<td>☐ County ☒ HC ☐ Reinvestment</td>
</tr>
<tr>
<td>Targeted Case Management</td>
<td>☒</td>
<td>☐ County ☒ HC ☐ Reinvestment</td>
</tr>
<tr>
<td>Administrative Management</td>
<td>☒</td>
<td>☐ County ☒ HC ☐ Reinvestment</td>
</tr>
<tr>
<td>Transitional and Community Integration Services</td>
<td>☒</td>
<td>☐ County ☒ HC ☐ Reinvestment</td>
</tr>
<tr>
<td>Community Employment/Employment Related Services</td>
<td>☒</td>
<td>☐ County ☒ HC ☐ Reinvestment</td>
</tr>
<tr>
<td>Community Residential Services</td>
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</tr>
<tr>
<td>Psychiatric Rehabilitation</td>
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</tr>
<tr>
<td>Children’s Psychosocial Rehabilitation</td>
<td>☒</td>
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<tr>
<td>Adult Developmental Training</td>
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</tr>
<tr>
<td>Facility Based Vocational Rehabilitation</td>
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<td>Social Rehabilitation Services</td>
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</tr>
<tr>
<td>Service Description</td>
<td>County</td>
<td>HC</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------</td>
<td>----</td>
</tr>
<tr>
<td>Administrator’s Office</td>
<td>☒</td>
<td>☒ County</td>
</tr>
<tr>
<td>Housing Support Services</td>
<td>☒</td>
<td>☒ County</td>
</tr>
<tr>
<td>Housing for the Aging population</td>
<td>☒</td>
<td>☒ County</td>
</tr>
<tr>
<td>Family Support Services for Families of Adult in MH Court</td>
<td>☐</td>
<td>☐ County</td>
</tr>
<tr>
<td>Peer Support Services</td>
<td>☒</td>
<td>☒ County</td>
</tr>
<tr>
<td>Transitional Age Peer Support</td>
<td>☒</td>
<td>☒ County</td>
</tr>
<tr>
<td>Consumer Driven Services</td>
<td>☒</td>
<td>☐ County</td>
</tr>
<tr>
<td>Community Services</td>
<td>☒</td>
<td>☐ County</td>
</tr>
<tr>
<td>Mobile Mental Health Treatment</td>
<td>☒</td>
<td>☐ County</td>
</tr>
<tr>
<td>BHRS for Children and Adolescents</td>
<td>☒</td>
<td>☐ County</td>
</tr>
<tr>
<td>Inpatient D&amp;A (Detoxification and Rehabilitation)</td>
<td>☒</td>
<td>☐ County</td>
</tr>
<tr>
<td>Outpatient D&amp;A Services</td>
<td>☒</td>
<td>☐ County</td>
</tr>
<tr>
<td>Methadone Maintenance</td>
<td>☒</td>
<td>☐ County</td>
</tr>
<tr>
<td>Clozapine Support Services</td>
<td>☒</td>
<td>☐ County</td>
</tr>
<tr>
<td>Additional Services (Specify – add rows as needed)</td>
<td>☐</td>
<td>☐ County</td>
</tr>
<tr>
<td>First Episode Psychosis</td>
<td>☒</td>
<td>☐ County</td>
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</table>

*HC= HealthChoices
### F. Evidenced Based Practices Survey

<table>
<thead>
<tr>
<th>SERVICE AVAILABILITY</th>
<th>CURRENT NUMBER SERVED IN COUNTY/JOINDER</th>
<th>WHAT FIDELITY MEASURE IS USED?</th>
<th>WHO MEASURES FIDELITY? (AGENCY, COUNTY, MCO, OR STATE)</th>
<th>HOW OFTEN IS FIDELITY MEASURED?</th>
<th>IS SAMHSA EBP TOOLKIT USED AS AN IMPLEMENTATION GUIDE? (Y/N)</th>
<th>IS STAFF SPECIFICALLY TRAINED TO IMPLEMENT THE EBP? (Y/N)</th>
<th>ADDITIONAL INFORMATION AND COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>289</td>
<td>TMACT</td>
<td>Kim Patterson of Allegheny</td>
<td>Annually</td>
<td>Yes</td>
<td>Yes</td>
<td>This includes 3 ACT programs, 2 of which are population specific (TAY &amp; Forensic). Annual TMACT, (Annually) Member Satisfaction (Annually) and outcomes (Quarterly) are collected.</td>
</tr>
<tr>
<td>Yes</td>
<td>331</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Includes full capacity</td>
</tr>
<tr>
<td>Yes</td>
<td>205</td>
<td>SE Fidelity for standalone providers</td>
<td>DelCo OBH</td>
<td>Annually</td>
<td>Yes</td>
<td>Yes</td>
<td>Members served includes standalone programs, embedded and transitional services.</td>
</tr>
<tr>
<td>Yes</td>
<td>652</td>
<td>IMR Fidelity</td>
<td>Dartmouth Lindy Fox LLC.</td>
<td>Annually</td>
<td>Yes</td>
<td>Yes</td>
<td>Currently have 7 providers of IMR, 3 D&amp;A, 4 MH Enhanced-Illness Management &amp; Recovery incorporates IDDT</td>
</tr>
</tbody>
</table>
## APPENDIX B 8

<table>
<thead>
<tr>
<th>No</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>128</td>
<td>Therapist/Supervisor/Consultant</td>
<td>Ongoing-Tams (therapist adherence measure)</td>
<td>The SAMHSA EBP toolkits have been reviewed and are referenced as a guide, along with the MST implementation guidelines to ensure effective programming and quality outcomes.</td>
<td>YES – 5-day training at hire and continuous training by supervisor and consultant including quarterly booster trainings.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes- The Incredible Years</td>
<td>12 families per year</td>
<td>TIY Self-evaluation form TIY session evaluation</td>
<td>For the 1st 2 years, the Epicenter measured fidelity. Now, CGRC (provider) measures fidelity</td>
<td>No CGRC follows the guidelines set by the TIY creator Dr. Carolyn Webster-Stratton</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Delaware County Human Services Plan 19/20
<table>
<thead>
<tr>
<th></th>
<th>Questionnaire</th>
<th>Child Group</th>
<th>Final Parent Evaluation</th>
<th>Session Protocol Checklists</th>
<th>The Incredible Years Parenting Practices Interview &amp; Eyberg Child Behavior Inventory</th>
<th>&amp; 1 time/parent 18 group module</th>
</tr>
</thead>
</table>

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

To access SAMHSA’s EBP toolkits:

http://store.samhsa.gov/list/series?name=Evidence-Based-Practices-KITs

G. Additional EBP, Recovery Oriented and Promising Practices Survey
## Recovery Oriented and Promising Practices

<table>
<thead>
<tr>
<th>Service Provided</th>
<th>Current Number Served (Approximate)</th>
<th>Additional Information and Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer/Family Satisfaction Team</td>
<td>Yes</td>
<td>657</td>
</tr>
<tr>
<td>Compeer</td>
<td>Yes</td>
<td>44</td>
</tr>
<tr>
<td>Fairweather Lodge</td>
<td>Yes</td>
<td>4</td>
</tr>
<tr>
<td>MA Funded Certified Peer Specialist- Total**</td>
<td>Yes</td>
<td>403</td>
</tr>
<tr>
<td>CPS Services for Transition Age Youth</td>
<td>Yes</td>
<td>7</td>
</tr>
<tr>
<td>CPS Services for Older Adults</td>
<td>Yes</td>
<td>0</td>
</tr>
<tr>
<td>Other Funded Certified Peer Specialist- Total**</td>
<td>Yes</td>
<td>102</td>
</tr>
<tr>
<td>CPS Services for Transition Age Youth</td>
<td>Yes</td>
<td>0</td>
</tr>
<tr>
<td>CPS Services for Older Adults</td>
<td>Yes</td>
<td>0</td>
</tr>
<tr>
<td>Dialectical Behavioral Therapy</td>
<td>Yes</td>
<td>85</td>
</tr>
<tr>
<td>Mobile Meds</td>
<td>Yes</td>
<td>15</td>
</tr>
<tr>
<td>Wellness Recovery Action Plan (WRAP)</td>
<td>Yes</td>
<td>40</td>
</tr>
<tr>
<td>High Fidelity Wrap Around</td>
<td>Yes</td>
<td>26</td>
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<tr>
<td>Shared Decision Making</td>
<td>NO</td>
<td>N/A</td>
</tr>
<tr>
<td>Psychiatric Rehabilitation Services (including clubhouse)</td>
<td>Yes</td>
<td>330</td>
</tr>
<tr>
<td>Competitive/Integrated Employment Services**</td>
<td>Yes</td>
<td>43</td>
</tr>
<tr>
<td>Self-Directed Care</td>
<td>Yes</td>
<td>48</td>
</tr>
<tr>
<td>Recovery Oriented and Promising Practices</td>
<td>Service Provided (Yes/No)</td>
<td>Current Number Served (Approximate)</td>
</tr>
<tr>
<td>------------------------------------------------------------------</td>
<td>---------------------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>Supported Education</td>
<td>Yes</td>
<td>22</td>
</tr>
<tr>
<td>Treatment of Depression in Older Adults</td>
<td>Yes</td>
<td>100</td>
</tr>
<tr>
<td>Consumer Operated Services</td>
<td>Yes</td>
<td>48</td>
</tr>
<tr>
<td>Parent Child Interaction Therapy</td>
<td>Yes</td>
<td>22</td>
</tr>
<tr>
<td>Sanctuary</td>
<td>Yes</td>
<td>HC MH residential programs for children</td>
</tr>
<tr>
<td>Trauma Focused Cognitive Behavioral Therapy</td>
<td>Yes</td>
<td>Adult OP/Community Based Services Children-Yes</td>
</tr>
<tr>
<td>Eye Movement Desensitization and Reprocessing (EMDR)</td>
<td>Yes</td>
<td>55</td>
</tr>
<tr>
<td>First Episode Psychosis Coordinated Specialty Care</td>
<td>Yes</td>
<td>20</td>
</tr>
<tr>
<td>Other (Specify) Transition to Independence</td>
<td>Yes</td>
<td>61</td>
</tr>
<tr>
<td>Other (Specify) Pivotal Response Treatment</td>
<td>Yes</td>
<td>7</td>
</tr>
<tr>
<td>Consumer Operated Services</td>
<td>Yes</td>
<td>1700</td>
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<tr>
<td>Parent Child Interaction Therapy</td>
<td>Yes</td>
<td>18</td>
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Recovery Oriented and Promising Practices

<table>
<thead>
<tr>
<th>Service Provided</th>
<th>Current Number Served (Approximate)</th>
<th>Additional Information and Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Episode Psychosis Coordinated Specialty Care</strong></td>
<td>Yes</td>
<td>22</td>
</tr>
<tr>
<td><strong>Other (Specify) Transition to Independence</strong></td>
<td>Yes</td>
<td>72</td>
</tr>
</tbody>
</table>

*Please include both County and Medicaid/HealthChoices funded services.

**Do not include numbers served counted in Supported Employment on Evidenced Based Practices Survey above [table (f)]

Reference: Please see SAMHSA’s National Registry of Evidenced Based Practice and Programs for more information on some of the practices at the link provided below.

http://www.nrepp.samhsa.gov/AllPrograms.aspx

H. Certified Peer Specialist Employment Survey:

“Certified Peer Specialist” (CPS) is defined as: An individual who has completed a 10-day Certified Peer Specialist training course provided by either the Institute for Recovery and Community Integration or Recovery Innovations/Recovery Opportunities Center.

Please include CPSs employed in any mental health service in your county/joinder including, but not limited to:

- Case management
- Inpatient settings
- Psychiatric rehabilitation centers
- Intensive outpatient programs
- Drop-in centers
- Outpatient settings
- Medicaid-funded peer support programs
- Consumer-run organizations
- Residential settings
- ACT, PACT, or FACT teams
- Long Term Structured Residence
- Mobile Crisis and Warm line

<table>
<thead>
<tr>
<th>Total Number of CPSs Employed</th>
<th>53</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number Full Time (30 hours or more)</td>
<td>31</td>
</tr>
<tr>
<td>Number Part Time (Under 30 hours)</td>
<td>22</td>
</tr>
</tbody>
</table>
INTELLECTUAL and DEVELOPMENTAL DISABILITY SERVICES

Introduction
The DelCo Office of Intellectual and Developmental Disabilities (OIDD) has embraced the Everyday Lives philosophy and is committed to ensuring that people with intellectual and developmental disabilities and those with Autism, live their lives in the community as any other citizen; with choice, responsibility, dignity, and respect. The Supports Coordination Organizations (SCO) and Administrative Entity (AE) staff assist people and families in understanding the concepts of Everyday Lives and applying this to the support planning process. In addition, we work with advocacy groups, community partners, provider agencies, and with the PA Family Network to help families and people with disabilities learn about and use the LifeCourse Tools, utilize natural community supports, and obtain useful community skills and opportunities.

Continuum of Services
Funding Streams
The County exercises flexibility in funding services from various financial sources to support people in need. Services can be funded using base/block grant funding, Waiver capacity, Medical Assistance and private insurance, as appropriate. Other necessary supports can be obtained through connection with naturally occurring programs found in the community (ex. YMCA, etc.). Primary goals in the use of any source of funding are to promote personal independence, support life in the community in the least restrictive setting to meet the person’s needs and reduce the cost of services including residential placement. During the FY 18-19, OIDD outspent its base/block grant funding allocation to support people in need. Block grant and County Overmatch funds were used once OIDD base funding was exhausted. Even though additional Waiver capacity was available during the FY 18-19 due to the allocation of 84 Community Living Waiver capacities (in two dispersals), and additional Consolidated and PFDS Waiver Capacity, the needs of people living in the community have continued to grow. This places increased demands on Block Grant funds to meet these needs. People receive priority for Waiver/Base/block grant funds if they have no supports or require a higher level of care due to an emergency, or they require services or one-time adaptations to enable them to remain in their family homes.

Continuum of Supports
OIDD provides a wide array of services ranging from those provided in the community to those provided out-of-home, including: Supports Coordination, Family Support Services (FSS), Supported Employment, day and pre-vocational services (Community Participation Supports), community and large congregate residential care, LifeSharing, Participant Driven Services (PDS), and Behavior Support, among other specialized services. Supports Coordinators work with people to maximize familial and community supports in place of, and in addition to, use of system resources. Families and people are also linked to advocates, special needs units, the local Health Care Quality Unit (Philadelphia Coordinated Health Care – PCHC), housing, and other service systems such as the OBH, Children and Youth Services and School Districts, among others. We continue to try to offer programs and information to people and their families through community and education fairs, special presentations and events. Intake for people with
Autism Spectrum Disorders continues to grow. Many providers can serve people that have Autism, such as Employment agencies and community agencies offering support groups and a range of home-based services. We also have residential provider agencies that can assist people dually diagnosed with Autism and an intellectual disability. However, supports for people with Autism need to continue to expand so that we can serve everyone appropriately.

**Strategies**

DelCo will continue to employ a multitude of strategies to ensure maximal and appropriate use of base/block grant funds and all other sources of funding, while providing the continuum of supports that are deemed necessary by the person and her/his family in conjunction with the support team. Many people have no immediate needs for services and receive SC support to identify and avail themselves of community and family resources. Others require minimal system supports and may receive services through Family Support Services (FSS) or other base/block grant funding. Still others may need more intensive levels of service and may receive or be waiting for Waiver capacity. For those with immediate needs for whom there is no Waiver capacity, the person may be supported through cross system services and/or community supports; the family may be offered Base/block grant funded Family Support Services; or in emergency situations, the person may receive more extensive services and supports utilizing unanticipated emergency Waiver capacity, Base/block grant funds and other sources of funding, up to and including short and longer-term out-of-home care.

Strategies to serve the maximum number of people and maximize all sources of funding include:

- **Everyday Lives** - DelCo continues to implement Everyday Lives principles and practices to support all people enrolled in our service system. We ensure that DelCo AE staff and the SCOs are continuously trained in Everyday Lives principles and receive Positive Approaches information. This ensures that all staff are working from the same principles, and they continually explore with families and people ways to remain ensconced in the community. Staff will continue to attend ODP Webinars and face-to-face trainings on these and related topics in the FY 19-20. We are also encouraging families to receive training in these principles through the MyODP website or through regional trainings offered through PCHC and other entities.

- **Regional Collaborative** - DelCo OIDD continues to collaborate with its SE Region suburban county partners in the Regional Collaborative. We will also continue to work with our local DelCo Collaborative Team to train and identify resources across many stakeholders. The Regional Collaborative held two meetings in 18-19 to share ideas and training resources. Additional meetings will be held to refine this vision and to share ideas in the FY 19-20.

- **DelCo Collaborative** - In DelCo, the local Collaborative which includes our PA Family Network Advisors, met seven times in FY 18-19 to discuss how to educate people and their families, providers, advocates, community partners, and others in the Community
of Practice and Everyday Lives concepts, and use of the LifeCourse Tools at every family stage. Meetings were also held to plan a community conference.
  o The DelCo Office of Early Intervention is beginning to incorporate the LifeCourse into their practices and to educate their families.
  o On April 27, 2019, the local DelCo Collaborative held a conference on “Transitions Across the Lifespan”, an event for Early Intervention families, transition-age people and their families, adults transitioning into the community, advocacy groups, and community members. The Collaborative will continue to reach out to families and community partners in FY 19-20 and will survey families to see what days and times are best for conferences.
  o Rose Tree Media School District plans to work with the Delco Collaborative on ways to include the LifeCourse in its planning with families. This connection was made through a DelCo Collaborative presentation to the Transition Council.
  o We will continue to ensure that DelCo community stakeholders, including new Supports Coordinators, are trained in Communities of Practice/LifeCourse Tools so that modes of thinking and support planning go beyond services the system has historically provided. The One-Page Profile and the Star seem to be especially effective in helping families think of their loved one as a person and not just their disability, and to include community supports and not just paid system supports. The County will work with the PA Family Network and with the DelCo Collaborative group to ensure that this is an ongoing goal.

- **Increase/Reduce Placements**
  We will continue to reduce the use of base/block grant funding for ongoing base residential placements through attrition and through conversion of some people to Waiver funding, if possible, with savings applied to serve additional people in need.

- **One-Time Funding**
  We provide base/block grant funds for adaptations or other one-time services that allow the person to remain home and avoid out-of-home care. DelCo served at least four people in this category in the FY 19-20. We have also paid for three specialized assessments to ensure that services and supports would be appropriate designed to meet the specialized needs of people with extreme behaviors (Ex, fire and sexuality risk assessments). Finally, one person needed extermination services so she could safely remain at home. These kinds of thoughtful and creative efforts will continue in the FY 19-20.

- **Emergency Funding**
  Our office provides base/block grant “bridge” funding to pay for emergency residential placements, day supports or extensive in-home services until Waiver capacity is available. DelCo served at least 12 people in this category in FY 18-19. That said, if the person needs placement and it is an “unanticipated emergency”, DelCo has been successful in securing capacity for some people in the 18-19 FY. We received Waiver funding for three people for unanticipated emergencies.
Supplemental Base/Block Grant Funding
DelCo has used base/block grant funds to supplement services for people in the P/FDS Waiver program that have reached the financial cap, but who do not require significant funding to warrant conversion to Consolidated Waiver. The Community Living Waiver has helped tremendously in reducing the number of people requiring additional funds. However, people continue to present with needs that exceed the PFDS funding cap. We will continue to provide supplemental funds, as needed and appropriate, in FY 19-20. We will not do so, however, without first having the team review needs, not wants, and by ensuring that utilization of services is appropriate.

- Increase LifeSharing/Supported Living
  We plan to increase promotional and educational strategies, and collaborate with ODP, providers and advocates, to increase the number of people served in LifeSharing/Supported Living. The number of people in LifeSharing has steadily decreased and currently stands at 27. This number clearly needs to increase to take advantage of this excellent and cost-effective service.

- Improve Transition
  We will assist people, their families and their teams to understand the value of employment in the community and the necessity to explore these options from high school age through adulthood. DelCo has and will continue to participate in community transition fairs and hold Provider Information Fairs. These efforts will continue in FY 19-20.

- Increase Employment
  We continue to work with Supported Employment providers, businesses, OVR and others to ensure employment opportunities are available for people we serve. We will continue to support people utilizing base/block grant funds who are no longer eligible for OVR services but require continued Supported Employment, and excessive Waiver funds are not needed. One strategy for maximizing use of Waiver capacity is to use base/block grant funding for services and supports that do not rise to the level of PFDS or other Waivers.

- Cross Systems Collaboration
  We continue to collaborate across the various human service and community service systems, and to access natural community supports to ensure maximum use of resources and reduce use of base/block grant or other sources of OIDD/county funding.

- Continue FSS Program
  DelCo OIDD works to increase the number of people served under the FSS program who warrant services, but do not need significant funding that would require P/FDS, Community Living or Consolidated Waiver funding. FSS is a source of supports for people who are on the waiting list, do not have other sources of funding and live at home with their families. FSS funding is vital to keeping families together in their own homes and communities. While the program did not meet its goal for total persons served in FY 18-19 (projected to serve 215, will serve approximately 180), we project
to match last year’s total number served, and the grants awarded were typically larger than in previous years. In the FY 18-19, the program projects to serve at least 180 people and their families. We find that families are extremely grateful for any funding and assistance they receive. As is our past practice, when people in the FSS program convert to Waiver funding, new people will be added for identified supports.

- **Use PUNS and Waiver Capacity** – OIDD will utilize the PUNS and Waiver capacity to serve people in all types of settings as truly needed and agreed to by the person’s team. Supports could include in-home staff services (many self-directing their services), home and vehicle adaptations, transportation funding, supported employment, LifeSharing, and group homes, among other potential sources of support.

### People Served

<table>
<thead>
<tr>
<th></th>
<th>Estimated People served in FY 18-19</th>
<th>Percent of total People Served</th>
<th>Projected People to be served in FY 19-20</th>
<th>Percent of total People Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supported Employment</td>
<td>13</td>
<td>8.3%</td>
<td>15</td>
<td>9.4%</td>
</tr>
<tr>
<td>Pre-Vocational</td>
<td>14</td>
<td>3%</td>
<td>15</td>
<td>3.3%</td>
</tr>
<tr>
<td>Community participation</td>
<td>6</td>
<td>4%</td>
<td>7</td>
<td>4.8%</td>
</tr>
<tr>
<td>Base/block grant Funded Supports Coordination</td>
<td>312</td>
<td>13.5%</td>
<td>310</td>
<td>13.4%</td>
</tr>
<tr>
<td>Residential (6400)/unlicensed</td>
<td>53</td>
<td>9.7%</td>
<td>50</td>
<td>9.2%</td>
</tr>
<tr>
<td>LifeSharing (6500)/unlicensed</td>
<td>0</td>
<td>0%</td>
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**Supported Employment**

With Pennsylvania being an Employment First State, we continue to work with individuals with disabilities to successfully gain competitive employment in an inclusive work environment.
• The DelCo Employment Forum, which consists of administrators, advocates, and Supported Employment Providers, meets on a quarterly basis to brainstorm the best way to get individuals employed in an appropriate job.
• With the new FY approaching, we plan on working as a team on how to facilitate with businesses in the community where consumers could become possible employees.
• We are looking to branch out to new employers we have not worked with in the past.
• The different Supported Employment Providers agreed to work together on getting all folks employed and referring them to each other if they are unable to meet someone’s needs in the workforce.
• Lastly, the forum has been working diligently on highlighting successful employment stories for consumers and different places of businesses. The team plans to continue to distribute the Newsletter for a bigger audience in hopes that it will help or encourage an individual with a disability to land a competitive employed job.

DelCo is working diligently to increase competitive employment for all individuals.
• There is a plethora of supported employment agencies with whom the county partners with to work on this goal. The services provided by the supported employment agencies are the following: career assessment, job finding, job development, and job support. Some are using the small group employment service where they work with others who have an intellectual disability as a team in preparation for a competitive job in the community in an inclusive environment.
• The DelCo Employment Forum, who meets on a quarterly basis, consists of advocates, administrators, vocational programs, and supported employment agencies have been collaborating to make sure that no one goes unserved.
• The forum communicates amongst themselves if they receive a referral from a support coordinator or OVR for an individual they cannot currently serve.
• The number of attendees for the forum during the FY 18-19 has risen significantly which increases the ideas and communication.

Employment Growth Activities
• Efforts to increase supported employment is a popular topic during the Employment Forum meetings.
• Currently, all those working with someone with an end goal of employment are to attend the ACRE course. This training is offered by educators to teach the employment professionals competence in all areas of the employment process. Well educated employment professionals will increase the success of getting and maintaining a job.
• Those from the employment forum also attended a state-wide Association of People Supporting Employment First training where the focus was on facilitating with businesses in the community to hire individuals with disabilities. Success stories were shared at this training and the focus of the process was successful actions to place someone in a job.
• Supports Coordinators make referrals to OVR and other supported employment agencies, as appropriate, and utilize the “Pathway to Employment, Guidance for Conversations” when speaking with people and their families about possible employment.
• All SCOs that work with people from DelCo maintain training through mandatory webinars and trainings on the MyODP website to ensure that they are up to date on ways to increase opportunities and the dialogue around employment.

• A change for FY 19-20 is that supportive employment progress reports are sent to the DelCo Employment Point Person and reviewed in its entirety. The point person reviews the progress reports provided by the different agencies and notes what has been successful or unsuccessful and increase or decrease in hours worked.

• The employment forum is working on having all folks receiving supported employment services have their supports decrease and utilize natural supports within the workplace to be successful. The forum has been discussing in detail and reviewing who may be appropriate, with a team discussion, for a fading plan of supportive employment.

• We feel supported by Regional and State ODP in these efforts and will continue our collaborative work and request technical assistance as needed. The Regional representative shares information and ideas with the Employment Forum and attends meetings regularly.

Employment Pilot.
Although DelCo is not an Employment Pilot County, the Employment Forum was developed and continues to carry out efforts to increase employment for the people we serve.

Supports Coordination
• The AE ensures that each SCO has information on the LifeCourse and that all SCs have taken the ODP training on the LifeCourse.

• Through discussion with the Deputy Administrator of the DelCo SCO, the SCO made changes to accommodate use of the LifeCourse Tools into its ongoing practices.

• The DelCo SCO ensures that the LifeCourse is discussed with each individual at the annual meeting. The LifeCourse Tools are also addressed as appropriate throughout the year and are not relegated to the annual ISP.

• In the ISP letter, families are invited to participate in Life Course training sessions with their SC, as provided by PA Family Network/Vision for Equality.

• Along with the ISP invitation letter, the SC attaches information on Charting the LifeCourse and encourages people and their families to begin completing the LifeCourse Portfolio. The LifeCourse website in also referenced in the letter.

• SCs are directed to enter information about Charting the LifeCourse that was reviewed with families in the “desired Acts” section of the ISP. Information about the LifeCourse is included as part of the ISP “tip sheet” that was developed by the DelCo SCO for its staff.

• The DelCo AE Quality Management Coordinator encourages all SCOs to incorporate LifeCourse practices into their ongoing SC Activities.

• In addition, the PA Family Network Advisors have made presentations to the DelCo SCO and have worked with people from other SCOs and their SCs to work on the LifeCourse tools.
• The AE is piloting a change in its intake process for people with Autism ages 16 to 24 and their families. Information will be written into the intake report that will be shared with the receiving SCO.

• Another option being enacted at some SCOs is to have the LifeCourse presented to families as part of SCO intake. This ensures that new people are aware of the LifeCourse as soon as they enter the door, and readies families for the discussions they will have with their selected SC.

• People First is considering covering the LifeCourse as part of their SCO intake process. Thus, People First, like the DelCo SCO and others, is working to embed the LifeCourse as part of its ongoing SCO process.

Waiting List.
• The AE Deputy Administrator conducts a monthly review of the PUNS list and asks the SCOs for regular updates for people who continue to remain in ER PUNS status.

• The AE is also in support of the SCOs utilizing the LifeCourse Tools so that families and SCs can have better discussions about what constitutes a good life and do not automatically begin offering paid services as a first option. Discussion of the use of the LifeCourse Tools is held at each meeting between the AE and the SCO providers.

• The AE will also require that all people on the ER PUNS list, and those a year away from any planned transition (ex. graduating from high school), have a full ISP. The full ISP will accomplish two purposes.
  o First, it will challenge SCs, families and teams to discuss what natural resources and supports may be available.
  o Second, it will provide a full and accurate “picture” of the person so that any necessary service referrals will be appropriately received by providers.

Self-Direction
As of May 1, 2019, DelCo served 327 people in the two PDS programs.

• The AE point person for PDS provides training at least four times a year to new SCs as well as to those SCs needing a refresher training. Topics include the philosophy that drives the Person-Directed model focusing on the benefits to the people and to their families and supporters and explaining the differences between the agency with Choice Model and the model in which a family member/relative is the Common-Law Employer (VF/EA). The AE point person talks about how to start the process and what information will be requested, hiring and training staff, keeping Progress Notes and how employees are paid. The AE point person attempts to educate SCs on the responsibilities associated with each model so that the SC can help the family/person decide on the model that best meets their own situation.

• The AE point person offers a training each year (the FY 18-19 training was held on April 25, 2019) for Common Law Employers, Co-Managing Employers, Participants, SCs, and anyone who has expressed an interest in PDS services. The training is conducted by a panel that includes representatives from Public Partnership, The ARC of Chester County (AWC), the Office of Developmental Programs (ODP), a Supports Coordination Organization, family members, and participants. Topics covered include changes in Service Definitions or any ODP changes that may affect PDS services, reminders about the process for completion of timesheets, requirements for expenses
associated with Home Adaptations or Home Modifications, Transportation Reimbursement, and completion of Progress Notes by staff. Best practice procedures are shared by family representatives and the SCO representative offers tips about the SC role in PDS services. The agency representatives are available to answer a variety of questions associated with the roles and responsibilities of being a Common-Law Employer or Co-Managing Employer.

- The AE PDS point person and the Supports Coordinators work together to resolve outstanding issues. For example, as soon as any discrepancy is found, whether it be a service that is incorrectly authorized, a situation where overtime is being utilized or situations where services are under-utilized, the AE Point person immediately notifies the SC to work on a resolution.
- The DelCo AE will continue to promote this opportunity by providing ongoing training to Supports Coordination staff who will be the first point of contact with families and people, and by supporting people and families when they choose these options.

LifeSharing and Supported Living:
- DelCo supports the growth of LifeSharing and Supported Living by encouraging SCOs to always consider LifeSharing/Supported Living first when a person needs a residential placement.
- SCs discuss and explain LifeSharing/Supported Living to people and families at the annual ISP meeting, and at other appropriate times as warranted.
- DelCo conducts a LifeSharing Information session for people, families, and SCs. The session consists of a panel of representatives which includes the ODP LifeSharing point person, agencies who offer LifeSharing and families who have people who are living in their homes. The participants are encouraged to ask questions and are given the opportunity to meet with provider agencies after the presentation. Provider agencies are also given the opportunity to have a table at the meeting where they can display their brochures and information.
- DelCo hosts a yearly Provider Fair where agencies can have tables and meet with families who are interested in learning more about their LifeSharing services.
- The AE LifeSharing/Supported Living point person continues to attend both the regional and state LifeSharing meetings throughout the year. The AE point person attended the annual state LifeSharing conference which was held on October 15 and 16, 2018 in Mt. Pocono.
- DelCo also maintains a referral list of provider agencies who offer LifeSharing/Supported Living.

Barriers to the Growth of LifeSharing/Supported Living
- Barriers include families’ unwillingness to have their people reside with other families. Birth families often feel like they may be replaced or have the mindset that if my loved one cannot live with his current family how can they succeed with a LifeSharing family.
- Families in DelCo many times prefer a community living home as that is what they are most familiar with due to the many group homes and campus settings in our area.
- An additional barrier for provider agencies is the lack of start-up funds from ODP. It would be beneficial for agencies to have funds to prep homes and support people through the matching process. These efforts are currently not reimbursed.
Some of the providers seem to have lost focus on LifeSharing, while others continue to provide this service. In FY 19-20, OIDD plans to convene a brainstorming session with the local providers to generate ways to increase service offerings. The increased service offerings will be shared with all SCOs so referrals can be made.

Additional LifeSharing sessions will be held for the SCOs and new SCs to remind them why this is such a valuable and cost-effective service.

Expanding Services Despite the Barriers?
So far, DelCo has been stymied in trying to increase this service. We have not found anything to be successful to date.

The newer interpretation of the LifeSharing service definition allows birth families (parent, child, stepparent, grandparent, grandchild, brother, sister, half-brother, half-sister, aunt, uncle, niece, or nephew) to provide unlicensed LifeSharing in their home. We do have a few families doing this.

DelCo is represented on the state coalition to promote the growth of birth families doing LifeSharing. This approach may be helpful in encouraging some families, or relatives of the people we serve, to engage in LifeSharing.

ODP Assistance in Expanding and Growing Lifesharing/Supported Living
ODP can assist counties in growing LifeSharing/Supported Living by continuing to participate in both the Regional and State LifeSharing meetings. ODP can also help by continuing to meet and communicate regularly with the State ODP point person and sharing with us the information from those meetings.

Cross Systems Communications and Training:
Base/Block Grant Funding to Increase the Capacity of your Community Providers.
Providers in DelCo and the Southeast Region of Pennsylvania have been extremely reluctant to expand services or to accept individuals with complex needs. Due to funding limitations, supervisory and administrative staff at provider agencies have been spread very thin. Low rates of pay and the risks of working with challenging people for direct service professionals has resulted in excessive turnover at provider agencies. Even if additional supports are offered, providers often continue to refuse to accept new or challenging individuals for services. The revised state set rates have resulted in rate cuts for some agencies and has have resulted in many agencies no longer employing nurses or having to cut back severely in this area. This makes it difficult for agencies to feel confident serving people with medical needs. Direct service professionals do not have the skill levels for intervention in many medical situations, nor do agencies feel they can accept the liability of serving people with complex medical needs. Unfortunately, new providers are becoming qualified at a high rate and offer to serve people with complex needs. However, they clearly do not understand the steps that must be taken to properly support these people.

DelCo works with individual agencies when a need arises and assists them in planning to receive training and gather the supports necessary to properly care for the person being referred for placement.
• PCHC, the local Health Care Quality Unit, has conducted nursing reviews for many people with complex medical needs and has made recommendations that are helpful to the team and to the prospective provider.
• PCHC also provides training for direct care staff in many areas related to medical issues.
• However, in many cases, we have had great difficulty finding agencies willing to provide care for people with complex medical needs. Often these people must then be referred to ICF/ID programs. DelCo has also used base/block grant funding to temporarily fund people in this category.
• The implementation of the Health Risk Screening Tool (HRST) is a big step in ensuring that people living in residential settings have their medical needs identified and addressed. DelCo OIDD assisted in this effort by providing sessions for providers to develop policies and procedures related to the Fatal Four. These policies and procedures should dovetail nicely with implementation of the HRST.
• DelCo’s insistence that providers use behavior support services has been helpful in maintaining placements. However, it has not necessarily resulted in more people being accepted for services. Base funds have been utilized in a few cases for behavior support services for those people that do not have Waiver. We plan to continue this use of base/block grant funds for Behavior Supports and to continue to engage the above strategies in FY 18-19.
• DelCo has now initiated a proposal format for any new provider or existing provider that may appear to lack skill in serving people with complex needs. Proposals must be thorough and reviewed by the County before placement can proceed.
• HealthChoices Reinvestment dollars has enabled the county to provide the Dual Diagnosis Treatment Team (DDTT), under the auspices of Merakey. DDTT, has been instrumental in helping people to remain at home in their communities, remain in their current placement, or transition into new placements as appropriate. A total of 13 unduplicated people from DelCo were served in the DDTT program in FY 18-19. This is a critically important service that will continue in FY 19-20. Base/block grant funds can be used to support people in this service if they do not meet managed care insurance criteria, but no such funds have needed to date.

Communication and Collaboration with Local School Districts
• County staff have attended information fairs at the local Intermediate Unit to spread information about OIDD services and have attended school district transition fairs to emphasize the importance of individual engagement with the OIDD system at any age. The SCO and AE will attend additional transition fairs in the FY 19-20.
• A DelCo representative continues to attend the DelCo Transition Council and Right to Education Task Force meetings and activities. Agenda items include presentations from provider agencies and state services.

School Districts and Employment
One school district regularly attends the Employment Forum meetings to increase the number of district youth involved in career planning and skill development. We will encourage them to continue their involvement with the Employment Forum and with the
Regional Collaborative working on the Community of Practice and learning about the LifeCourse tools.

**SCO Attendance at IEP Meetings**
Each SC that has school-age students attends IEP meetings to discuss employment planning and prepare for the person’s needs as they approach adulthood. LifeCourse information is shared at these meetings. The DelCo AE has a representative on the local Right to Education Task Force and the Transition Council to share and gather information on what school districts and OIDD are doing to support youth. Information gathered is shared with the SCO administrators.

**Communities of Practice**
Because school is such a vital part of young children’s lives, it is critical to get school districts involved in the Community of Practice efforts. At a recent presentation by members of the DelCo Collaborative on the LifeCourse, Rose Tree Media school district expressed interest in meeting with the DelCo Collaborative to discuss how to incorporate use of the LifeCourse with their students in FY 19-20.

**Communication and Collaboration with local Children and Youth Agencies, Area Agency on Aging (AAA), and the Mental Health System**
OIDD coordinates with a variety of entities in the service system including County Children & Youth Services (CYS), the Children’s Cabinet, MBH, the OBH, the County Office of Services for the Aging (COSA), and many other private and public agencies. By meeting collateral service needs, these efforts decrease the likelihood that people will require costlier services and/or placement in the OIDD system.

**CYS**
OIDD staff regularly interact with CYS around people and families involved in both systems. This may entail sharing information and coordinating services and supports for youth and/or for their parents through the team process. The SC and the CYS case manager work together for the benefit of everyone involved.

- At times, OIDD may have a person that lives at home and has come to the attention of Adult Protective Services or Incident Management. If the allegation involves one or more parents, and there are children under age 18 in the home, OIDD will make an additional report to CYS.
- OIDD staff attend Complex Case Review Meetings with CYS and OBH if there is a youth with ID involved in all three systems.
- OIDD accepts referrals for intake from CYS if there is suspicion that a youth may have IDD or Autism.
- Training on Communities of Practice as well as LifeCourse tools has been held for some members of the other human services departments in DelCo so they can see how they can play a part in supporting families to dream for their children and plan for increased use of natural and paid supports.

This holistic effort will help to combat the system silos that have existed as barriers for decades in the human service system. Unfortunately, some children age out of CYS and need to come fully under the auspices of OIDD, often bringing a large price tag for services.
OBH
Communication between OIDD and the OBH occurs on a regular and frequent basis.

- As cases are identified and involve both systems, or should involve both systems, OIDD contacts OBH, or vice versa.
- Regular meetings are held between the departments. Dual Diagnosis Adult Collaboration meetings between OIDD and OBH each occur at least quarterly. These meetings are designed to coordinate services and supports for dually diagnosed people and avoid duplication or gaps in services.
- Use of mental health resources in combination with OIDD base funding have enabled the systems to thus far avoid any State Center/State Hospital admissions, and often to avoid costly out-of-home placement (but not always).
- The OIDD Administrator also attends OMHSAS quarterly meetings with regional OMHSAS representatives, OBH staff, Magellan representatives, CYS staff, OBH fiscal staff, and advocates. The discussion for OIDD centers around initiation of new services (DDTT and RTF-A) and areas that still need to be addressed.
- DelCo OIDD is also a member of the Children’s Cabinet, a cross system group facilitated by OBH that addresses issues and services for children in the systems.
- A training about Communities of Practice and the Life Course Tools was presented by the PA Family Network to the Children’s Cabinet/System of Care in the fall of 2017. Another training should be scheduled for FY 19-20.
- OIDD also participates in the cross systems training given on a regular basis for staff new to the systems so staff from other systems understand OIDD eligibility, processes and supports; and OIDD staff understand the functioning of the other systems. These collaborative efforts will continue in FY 19-20.

AAA
OIDD staff and COSA regularly communicate around the needs of families and people we serve.

- Two OIDD staff attend the OIDD/COSA collaboration meetings to discuss individual cases.
- At times, COSA may become involved with a family and discover that there may be an adult who appears to have an ID. COSA refers these people to OIDD for possible intake and subsequent supports.
- There have been cases in which OIDD has identified a parent or a person with ID that may be in need to COSA services and these referrals are made by SCO staff.
- Trainings have been held to share information with stakeholders in the area of aging. Continued training efforts and cooperation between our two agencies will continue in FY 19-20.

Emergency Supports
Despite the variability of Waiver capacity to meet the need, OIDD manages base/block grant funding and other available resources to assist people in emergency circumstances. Whenever possible, supports are provided to maintain people in their community homes and to avoid residential placement.
If a person is in emergency need of supports, a special base funding request process must be followed, and approval obtained before base funding can be used. Base funds can be used for in-home or other community supports or for temporary residential placement. Most people requiring emergency supports are provided with community-based supports, as opposed to residential care.

The goal is to convert to Waiver funding as soon as possible, if appropriate.

In FY 18-19, OIDD spent in excess of its base allocation for emergency support services and temporary placements, which necessitated requests for block grant funds to support these people. This effort to support individuals in emergencies using base/block grant funds remains a critical initiative.

In FY 18-19, OIDD was able to secure “unanticipated emergency” funding for three people and avoid using Base/Block Grant funding.

It is important to note that no needs for out-of-home care were identified after hours in FY 18-19. In-home and other community supports were arranged to support people in need after hours. Typically, those persons were already receiving community supports, and those services were increased over the weekend to cover the needs.

Emergency Response Plan
While funds are not specifically reserved for emergency needs, emergencies are considered a priority in our county and requests are done via a base funding request process. Block grant funds are requested if base funds have been exhausted.

Emergency Plan for Individuals
If the emergency need occurs outside of normal work hours, OIDD has arranged an on-call system in which an SCO professional works with the family, individual and/or provider to secure needed supports.

If natural supports are unavailable or inadequate to address the situation, approval is sought from the AE Deputy Administrator, the AE QM Coordinator, or from the OIDD Deputy Administrator for expenditure of funds as noted above.

DelCo ensures that its base allocation for OIDD is available for OIDD use first and foremost. This allows us to ensure that enough funds are available to provide the services people need, even if no Waiver capacity is available.

When an emergency occurs and a person requires emergency residential or other services, the SCO discusses the need internally and first ensures that natural resources have been appropriately explored to deal with the situation.

If paid supports are required, the SCO Administrator brings the need to the attention of the AE Deputy Administrator, the AE QM Coordinator, and/or the OIDD Deputy Administrator for base funding approval as noted above. This approval can be made within a day (typically within hours) regardless of whether it is within normal work hours or after normal work hours. While awaiting approval, the SCO works quickly to secure a residential placement or another/additional service(s) to ensure the health and safety of the individual. For example, if a residential placement is not immediately available, approval may be given for staffing to be sent into a family home to provide extra support. The case is then reviewed on the next business day if approval was given after hours, to ensure follow up of the approved emergency plan.
Mobile Crisis Services
DelCo has a county-wide 24/7 mobile crisis unit called DelCo Crisis Connections Team (DCCCT).

Mobile Crisis Team Knowledge To Work with Individuals with ID and/or Autism diagnosis
- Elwyn was selected to provide mobile crisis services in part because of their experience working with people with ID and Autism.
- Initial training for staff includes meeting the unique needs of people with ID and/or Autism.
- Elwyn provides its own training for these staff members as a requirement of its contract. There is a 90-minute Elwyn online training on ID. A 45-minute module on Autism is also required to be taken yearly.
- There is also a 60-minute module on child development, a module on APS, and a module on verbal de-escalation.
- There have also been case consultations on specific problematic cases as needed.

Mobile Crisis Team and Background in ID and/or Autism?
Several of the staff on the mobile crisis team have background experience with people with ID and/or Autism. Others may not have direct experience, but receive training.

Mobile Crisis Team Training
In addition to the training provided by Elwyn as part of its contract, DelCo OIDD has informed DCCCT of the valuable information available on the MyODP website, as well as the PCHC website, among others. DelCo OIDD is available for consultation around training needs as appropriate.

If your county does not have a mobile crisis team, what is your plan to create one within your county’s infrastructure?
N/A.

County 24-hour Emergency Crisis Plan
See attached.

Administrative Funding
County’s Interaction with Individuals, Families, Providers, and County Staff.
- When the PA Family Network Advisors made training arrangements for families, the county has distributed these training announcements through its SCO agencies to share with families. Unfortunately, this strategy did not result in the desired turnout. The county has met on several occasions with the PA Family Network Advisors, Lisa Tessler, and the Regional Collaborative co-facilitator to discuss possible ways to increase family involvement in the LifeCourse Training and in the Regional Collaborative.
The PA Family Advisors have found success in arranging meetings with families and individual SCOs in which they plan an evening and each interested SC brings a family with them to learn about the LifeCourse.

The PA Family Advisors have provided face-to-face trainings for SCO staff. OIDD recently had the ODP Regional Representative for the Regional Collaborative present to new SCs about the LifeCourse. SCs were very interested and engaged. Trainings for SCO staff and providers will be repeated in the FY 19-20.

The PA Family Network Advisors have also been able to achieve better family turnout to sessions scheduled with the local advocacy agency and its membership.

As we work with individuals and families around high school graduation, we have asked the PA Family Network to connect with them to assist them to plan for a full life in the community as much as possible. A letter has been sent to all graduates sharing the PA Family Network Advisors’ information and some of the LifeCourse materials. We have asked SCs to follow up with these individuals and families to ensure follow through with the LifeCourse. This will be repeated as graduates are identified for FY 19-20.

The LifeCourse is now part of the AE intake process for Autistic people ages 18 to 24 and their families. The Star will be completed during intake and shared with the SCs who receive the case. The names and contact information of the PA Family Advisors will be shared with these individuals and their families.

Discovery and Navigation and Connecting and Networking for Individuals and Families.

The DelCo Regional Collaborative has embarked on a campaign of information and education for families, people we serve, providers, SCOs, school districts and other interested stakeholders. On April 27th, there was an event titled, “Transitions Throughout the Lifespan”. About 39 people attended the day-long session. Topics included the Everyday Lives, the LifeCourse, and ODP Waiver changes. Information was shared and participants were mentored to use the LifeCourse tools.

We plan to follow up with a survey of stakeholders to determine what days, times, and topics families would like to have presented at future trainings/workshops.

We will also continue to support the PA Family Network Advisors to partner with individual SCs and families.

Magellan has engaged a peer support network, Peerstar, to provide peer support for people with dual diagnoses of IDD and MH. The agency is open for referrals now in FY 18-19.

Presentations were held for providers, the SCOs, and for the System of Care partners on the Community Collaborative and the LifeCourse.

DelCo will be paying for three people to attend the State Regional Collaborative Conference on June 12, 2019 to share and gain new ideas for implementation in the FY 19-20.

Further efforts to reach our system partners, provider agencies, community stakeholders, and people and their families will continue in FY 19-20.
Support From ODP
The DelCo Regional Collaborative will continue to require the support from the SE Regional ODP representative and from the State level PA Family Network to ensure that the LifeCourse tools and Everyday Lives concepts are spread throughout the County at every level of stakeholder. Learning what other regional collaboratives are doing helps our collaborative with new ideas on ways we can implement our project. Handouts and links to websites are also invaluable, as well as suggestions on effective ways to engage families.

Engagement with Health Care Quality Units (HCQU)
- The HCQU for DelCo is PCHC and the nurse assigned to DelCo attends the quarterly DelCo AE QM meetings.
- The nurse also attends the quarterly DelCo All Provider meetings and shares training information with all service providers.
- She has participated in the DelCo Fatal Four Policy meetings with providers and has supplied resources critical to effective policy and procedure development. The nurse will also participate in the Fatal Four sessions for families.
- PCHC continues to provide Community Health Reviews for people with a variety of medical issues, and the Integrated Health Clinical Review when teams are supporting people with both physical and mental health issues. This fiscal year, the clinicians at PCHC have completed community health reviews for two people in DelCo and attended a team meeting for a third person.
- PCHC is one of our main resources for training providers and SCOs when IM4Q, PIER, or SCO monitorings indicate a training need.
- In addition, the new Behavioral Coordinator from PCHC participates in the DelCo Human Rights Committee.
- The Director of PCHC also visited a local provider, CADES, with the Deputy Administrator to learn more about their use of the Health Risk Screening Tool (HRST). We will be monitoring the rollout of the provider use of this tool very carefully in FY 19-20.
- We plan to continue to use the HCQU in FY 19-20 as we plan for the discharge of several people from RTF and congregate care settings into the community. We will need nursing and behavioral assessments to help the teams to best prepare for the person’s life in the community.

HCQU Generated Data as Part of the Quality Management Plan
- Feedback has been provided to individual providers when we have seen cases in which excessive medication have been prescribed or lack of follow through on PCHC recommendations.
- We also use the data to see which providers are availing themselves of the various PCHC online and face-to-face trainings. Those that are not utilizing PCHC trainings for their staff are strongly encouraged to do so.
- DelCo will look at other ways it may use PCHC data in FY 19-20 and additional trainings will be developed as topics are identified.
Independent Monitoring for Quality (IM4Q) Program

As of May 1, 2019, the IM4Q team completed 212 of the required 247 monitoring visits. Results of the monitorings are entered into the HCSIS system and reviewed by the AE and SCO. The SC is then responsible for addressing any issues in the report within 21 days. To date, there have been 385 considerations reported and most have been addressed.

- If the IMT reports indicate a trend or common issue that needs to be addressed on a larger scale, then the issue will be presented to the QM team. The QM team then reviews the concerns and decides what follow up action is needed. If the QM team decides that the concern needs ongoing follow up, then an action plan is developed and added to the Quality Management Plan.
  - An example is the communication issue that is currently part of the QM plan. IMT reports indicated that once people age out of the education system, their needs for communication assessments and assistive devices are not easily addressed by the adult service system. To address this issue, the county now presents annual training on communication assessments and assistive technology. The Pennsylvania Initiative on Assistive Technology, part of the Institute on Disabilities at Temple University, presents this information to our SCOs.

- IM4Q reports also recognized that many people were asking for basic computer training. To meet this need, the DelCo Advocacy and Resource Center developed a Computer Literacy Course for DelCo people. These sessions are ongoing.

- The IM4Q Coordinator presents data on the previous FY each fall at the BH/IDD Board meeting, at the AE QM meeting and at the all provider meeting. Printed reports are shared with the SCOs. This process will occur in the fall of FY 19-20. Results for specific Provider agencies are shared with them individually.

Provider Competency and Capacity

- AE representatives attend case collaboration meetings with COSA, CYS and OBH. As appropriate, information from these meetings is shared with relevant providers.

- PCHC offers online and face-to-face trainings related to many issues facing the aging population (ex. dementia), those with health needs (ex. diabetes, dysphagia, etc.), and people with dual diagnoses of ID or Autism and MH disorders. A presentation on the Fatal Four was held in the FY 18-19 and will need to be repeated in future.

- A representative from PCHC attends the quarterly OIDD all provider meetings to share announcements regarding training and to answer questions. DelCo OIDD encourages providers who serve people with these issues to engage in these trainings.

- DelCo OIDD also receives training announcements from DelCo OBH which it passes on to both providers and families.

- During the FY 18-19, DelCo OIDD provided sessions for providers on developing policies related to the Fatal Four. The goal was to ensure that each agency identified people with issues and developed global and specific plans and policies on how they would support people with medical needs.

- Two training sessions will be held for families on the Fatal Four as well so they can be better educated and understand what agencies are doing when they interact with them about their loved ones.
If needed, a referral to PCHC for a clinical evaluation is recommended to the team by the AE or the SCO.

The county also recommends behavioral assessment and support in cases in which behavioral health needs are threatening placement or the ability of the person to remain in the community, or if the person has 1:1 or 2:1 staffing as a result of behavioral needs. When OIDD has a person requiring services, we make every attempt to refer to the most appropriate providers with the expertise to meet that person’s needs.

OIDD also shares LEAP results with providers and SCOs.

New providers wanting to accept people with behavioral and/or psychiatric issues must now complete a program description that details how their agency will appropriately support the person. This description includes what they know about the person, what training will be provided for staff, staff ratios, their Behavior Support Plan, how the agency will engage with psychiatric supports, and how they will handle behavioral crises.

ODP Assistance to County

DelCo OIDD would like to engage in a dialogue with ODP regarding ways to better support providers. Examples of ways that other counties or states are successfully supporting providers would be helpful.

However, it must be noted that DelCo OIDD has experienced tremendous support from ODP in every area, especially regarding people with dual diagnoses. The support from the DD Clinical Director, Dr. Amy Nemirow, has been unwavering and she has gone out of her way to assist in complex cases. In addition, the Regional Program Manager, Shelley Zaslow, has been very supportive from a programmatic standpoint and in our request for additional supports for specific people/providers as needed. The entire SE Regional Team has been outstanding in their support of our efforts to support agencies by moving people out of institutions, discussing interpretation of regulations, resolving risk management issues, promoting the Community Collaborative, and problem solving in many areas related to provider supports.

Risk Management Approaches

The DelCo OIDD QM Coordinator, Benita DiLucido-Saff, and the IM Coordinator, David Kaiser, regularly attend the Regional Risk Management meetings. They return with ideas on ways to improve our QM processes and procedures.

DelCo OIDD contracts with PIER-CFST which continues to monitor the 74 Pennhurst class people receiving services in DelCo. They visit each class member every year and report any issues with service delivery. Two class members declined to be interviewed this year. Health and safety concerns are immediately reported to the AE and addressed with the SCOs and providers. AE staff investigate serious issues directly as needed and assist in training provider staff as necessary.

All other issues are part of the PIER-CFST monitoring report which is sent to the SC and the service provider, with a request for follow up. The reports are reviewed by the AE, and any trends noted are discussed with providers on an individual basis, or at the quarterly DelCo All Provider meetings.
As of May 1, 2019, PIER has conducted 122 monitoring visits (people are seen at residential and day settings) for FY 18-19, however, only 25 written reports have been received thus far. An additional meeting will be held with PIER-CFST to discuss ways to ensure that the monitorings are completed in a timelier way.

These Pennhurst monitorings will continue in FY 19-20 and reports will be required to be submitted within 10 working days of each monitoring visit.

In addition, AE QM monitors restraints, individual to individual abuse, considerations for communication concerns, Fatal Four-related incident reports and concerns and resolutions reported by the SCOs related to health and safety. The AE works with providers to correct and ameliorate these issues.

Risk Management Activities
- DelCo OIDD shares all information it receives from the Human Services Disaster Coordinator with provider agencies, and with families as appropriate. A family-friendly disaster preparedness training was offered in the FY 17-18 and the announcement was shared with DelCo families. This training needs to be repeated in FY 19-20.
- Any announcements about risk management-related issues are shared with the Delaware County Advocacy and Resource Organization (formerly The ARC of Delaware County) to share with its membership.
- When significant events are pending (ex. serious snowfall or flooding) DelCo OIDD sends an email to identified contacts at each provider agency, and to families, reminding them to enact their preparedness plans and ensure they have the necessary supplies.
- If providers need assistance with developing plans, the AE provides the necessary resources.
- The AE QM will also hold four trainings for families and individuals in FY 19-20 related to risk management. Topics will be identified through the processes above and by surveying families.

ODP Assistance with Stakeholders
DelCo OIDD would be very happy to brainstorm with ODP and other system stakeholders regarding how to better interact with stakeholders around risk management-related activities. We have long had problems getting stakeholders to attend meetings and events, especially families. If there are more effective ways to get information out to stakeholders, we are open to hearing them.

County Housing Coordinator Assistance for People with Autism and Intellectual Disability
- OIDD has been working closely with the DHOT (Disability Housing Options Team) to attempt to secure subsidized housing for people who are capable of living in their own apartments with supports. So far, we have secured a housing voucher for one person, and there are three additional applications in process. This is a new process that is much welcomed by our SCs, individuals and families.
- We can access the Coordinator of Adult and Family Services (AFS) or the shelters in emergency situations. The Coordinator of AFS has been helpful in training AE and SCO staff in what the system has to offer regarding housing services.
If we have an individual in a shelter, we have been able to move them to stable housing by returning them to their home in the community or working with the system to acquire permanent subsidized housing.

The overall goal is to avoid homelessness for individuals with ID and/or Autism by providing supportive services in their home community.

If warranted, DelCo OIDD is willing to use base/block grant funds to provide staffing supports to people with ID/Autism in temporary or permanent housing situations. We have done this in the past and will do so in future if needed to ensure the person’s health and safety. However, we are typically able to P/FDS funds to support these people in their own apartments.

Providers Development of an Emergency Preparedness Plan

Several years ago, DelCo made a coordinated effort to work with providers to develop Emergency Preparedness Plans for their entire agencies, including group homes, and homes in which they provide support.

ODP requires that each agency have an emergency disaster plan and a health and behavioral emergency plan. These plans are reviewed by AE provider relations staff during QA/I reviews if ODP includes this as a question. However, the AE ensures that all new providers have these plans in place.

Providers have also been informed that they can sign up for the County’s emergency alert system. It is available on the homepage of the county’s website.

DelCo also ensures that the SCOs help families to complete the Premise Alert information so local first responders have the necessary information in an emergency.

Participant Directed Services (PDS):

PDS (AWC VF/EA)

DelCo OIDD is proud to be in the forefront with the number of people registered with our office who use Participant Directed Services (PDS). It makes sense in the communities we serve because many neighborhoods are close knit with families living there for generations.

Families have connections in the community and very often the person with the disability participates in community events, so he/she too is known in the community. The benefits to the person of having staff who know him or her and are familiar with the support needs are tremendous. Families are very comfortable hiring relatives and friends because they are familiar and families know that they are reliable and trustworthy.

As of the third quarter of the FY 18-19, 189 people with Waiver funding have chosen the Agency with Choice Model (The ARC of Chester County), one person with base/block grant funding have chosen the Agency with Choice Model and 138 people with Waiver funding have chosen to work with Public Partnerships LLC (PPL)/now PALCO where a family member or friend is a Common-Law Employer.

DelCo OIDD is not experiencing difficulties engaging families in utilizing PDS. However, we have found that Supports Broker services are extremely valuable. Increasing numbers of people and families have chosen to engage the services of a Supports Broker to better understand the requirements and the many responsibilities associated with being a Common-Law Employer or Co-Managing Employer. The
Supports Brokers provide training on developing a good system to manage paperwork, hiring and scheduling of staff, how to manage staff, and arranging for appropriate training to ensure that the needs of their loved ones are being met. The ongoing challenge continues to be finding adequate staff to address the needs identified in the ISP.

- Common Law Employers and Co-Managing Employers struggle to be able to provide a good backup plan so that services can be provided when they are needed. Natural supports are often very limited or in many cases not available at all.
- During FY 19-20 Supports Coordination staff will continue to offer people and families the choice of a Supports Broker.

Training for SCO’s, People, and Families on Self-Direction

- The AE Point person for PDS provides training at least four times a year to new SCs as well as to those SCs needing a refresher training.
  - Topics include the philosophy that drives the Person-Directed model focusing on the benefits to the people and to their families and supporters and explaining the differences between the Agency with Choice Model and the model where a family member/relative is the Common-Law Employer.
  - The AE point person talks about how to start the process and what information will be requested, hiring and training staff, keeping Progress Notes, and how employees are paid.
  - The AE Point person attempts to educate SCs on the responsibilities associated with each model so that the SC can help the family/person decide on the model that best meets their own situation.

- The AE point person offers a training each year and in FY 18-19 the training was held on April 25, 2019 for Common Law Employers, Co-Managing Employers, Participants, SCs, and anyone who has expressed an interest in PDS services. The training is conducted by a panel that includes representatives from PALCO, The ARC of Chester County (AWC), the Office of Developmental Programs (ODP), a manager from Supports Coordination Organizations, family members, and participants.
  - Topics covered include changes in Service Definitions or any ODP changes that may affect PDS services, reminders about the process for completion of timesheets, requirements for expenses associated with Home Adaptations or Home Modifications and Transportation Reimbursement and completion of Progress Notes by Staff.
  - Best Practice procedures are shared by family representatives and the SC Unit Manager offers tips about the SC role in PDS services.
  - The Agency Representatives are available to answer a variety of questions associated with the roles and responsibilities of being a Common-Law Employer or Co-Managing Employer.

ODP Assistance in Promoting/Increasing Self-Direction

- The Representative from ODP in the Southeast Region has been very instrumental in providing a variety of information to County staff which enables them to work effectively with PDS participants and Common-Law employers. The Representative notifies the AE point person as soon as any discrepancy is found whether it be a service that is incorrectly authorized, a situation where overtime is being utilized or
situations where services are under-utilized. The AE PDS point person and the SCs work together to resolve outstanding issues. We have found ODP staff to be extremely helpful.

- DelCo AE will continue to promote this opportunity by providing ongoing training to SC staff who are the first point of contact with families and people and by supporting people and families when they choose these options.

- It is essential that ODP continue to provide the technical assistance that is needed to address issues and concerns as they arise. Participant-Directed Services cannot work without the “behind the scenes” oversight by ODP as the both the AE Point person and the SCs become actively involved when the Common-Law Employer has a problem and they have no place to turn as PPL is a Fiscal Agent that is not like our traditional Providers.

Community for All: ODP has provided you with the data regarding the number of people receiving services in congregate settings.

Enable People to Return to the Community.

DelCo has a commitment to moving individuals from large congregate care settings and nursing homes, as appropriate, into the community.

- If it is appropriate to step someone down from a nursing home, RTF or ICF into a community-based based placement and Waiver capacity is not immediately available, DelCo utilizes base/block grant funding to support the person in a Waiver-eligible placement until Waiver capacity is available.

- DelCo currently has 277 people in private ICFs (large and small), base funded large congregate care, and nursing homes.

- We support the downsizing of ICF facilities in our home county and have participated in the planning and movement of individuals to the community.

- During the 18-19 FY, one person moved from Woods Services back to a community group home setting, while another person moved from a congregate care setting back to his family. There are four additional persons in congregate care settings identified to move at this time, and their teams are convening to discuss how, when and where these transitions can take place. One person is planned to move from Selinsgrove back to the community, but a pressing medical issue must be addressed first. A community provider has already been identified for her.

- There are barriers to rapidly moving many people back to the community.
  - A major barrier is the lack of funding/capacity to support them in the community.
  - Another barrier is some people and families are choosing not to move to the community from the relative “safety” of a larger congregate care setting where everything is provided and controlled. Older people often have the most reluctance to move, especially if they have medical issues or major issues related to the aging process.
  - In addition to these challenges, many providers are financially over-stretched and refuse to expand to serve new people. The lack of start-up funding from ODP is identified by Providers as a barrier.
  - We also find that some people have very complex skilled nursing needs and smaller Waiver providers do not feel equipped to safely care for them.
o Sometimes people were placed from their original living arrangement due to behavior problems, or the family had difficulty caring for the person in the community. These families are very reluctant to move their loved ones back into the community. However, we have had some cases in which families have opted to move their loved ones back home from a congregate care facility and not into another Provider.

- Since current waiting lists for services are long, additional capacity is desperately needed to make these community moves a reality. Most of the people in congregate care have few resources in the community. They often have aging parents or siblings who are not equipped to care for them, even if in-home supports are offered. Additional capacity is needed even if many of these people were to choose LifeSharing as an option.

- DelCo utilized all its base allocation for the FY 18-19 plus additional block grant dollars to support people in need. In order to make more community options a reality, additional Consolidated and Community Living Waiver resources are needed for this population.
HOMELESS ASSISTANCE SERVICES

Continuum of Care (CoC) for Homeless and near Homeless Individuals and Families

The DelCo CoC is the community planning system that addresses the needs of persons who are homeless or experiencing a housing crisis. The purpose of the CoC is to coordinate our response to homelessness, and promote a community-wide commitment to the goal of ending homelessness. This is accomplished via the work of the Homeless Services Coalition (HSC), one of the longest standing coalitions in the country, which has been coordinating homeless services in the County since 1991. The HSC has a 25-member Governing Board (GB) with five standing committees, a governance charter, a CoC Advisory Team (CoCAT) and over 100 persons representing the full membership consisting of many service sectors, providers, and key stakeholders. The CoC has the following system components: Homeless Prevention, Street Outreach, Coordinated Entry, Emergency Shelter, Transitional Housing, Rapid Rehousing, Permanent Supportive Housing, and Services.

The HSC is the center of our CoC structure and has a shared mission of public and private organizations who invest their time and efforts for the purpose of collaborating, identifying, and addressing system gaps. Dedication and volunteerism are the driving forces in the HSC as quarterly meetings, sub-committee participation, and partnerships in new programs contribute to the 27-year success. Consumer voice is also at our table and is encouraged via GB representation, consumer focus groups, annual consumer achievement recognition, and meeting attendance.

The CoC operates under a Housing First philosophy and is committed to these three guiding principles: 1) prevent homelessness whenever possible, 2) re-house people quickly when homelessness cannot be diverted and; 3) provide wrap-around services that promote housing and income stability.

**The CoC Mission**
To have an integrated community-based system of care which prevents homelessness and provides the necessary support and opportunities to ensure that homelessness is rare, brief and non-recurring.

**Guiding Principles**
In our effort to provide individualized self-sufficiency solutions to persons that are experiencing housing crises, the HSC follows the following guiding principles:

- Prevent homelessness whenever possible;
- Rapidly re-house people when homelessness cannot be prevented;
- Provide wraparound services that promote housing stability and self-sufficiency.

**The CoC adopts the following federal population-specific goals**
- To end homelessness among veterans
- To end chronic homelessness among people with disabilities
To end homelessness among families with children
To end homelessness among unaccompanied youth
To end homelessness among all other individuals

The CoC Strategic Initiatives include
- Aggressive outreach initiatives designed to identify, engage, and rehouse unsheltered individuals and families as quickly as possible.
- A community-wide coordinated approach to addressing housing crises through a comprehensive Coordinated Entry System
- Transitioning homeless households to appropriate housing and effective individualized services that promote self sufficiency
- Ensuring access to and availability of affordable stable housing
- Promoting leadership, collaboration, and system improvement by allocating resources effectively, growing the resource base and making data informed decisions.

The CoC continually focuses on
- Increasing affordable housing opportunities
- Strengthening prevention and diversion practices
- Creating solutions for unsheltered homeless persons
- Helping people exit from homelessness to find employment success.

Using Data to Evaluate Performance and Determine Unmet Needs and Gaps –
The Annual Countywide meeting provides CoC stakeholders the opportunity to discuss CoC priorities, identified needs and gaps, and our progress on reducing the number of people who become homeless. When systemic CoC needs are identified, they are brought to the GB and CoCAT table for discussion, planning, and decision-making purposes. Responsibilities under the HSCGB and CoCAT include management of the CoC via a governance charter, implementing the CoC strategic plan and implementing coordinated intake and assessment countywide.

Each year, the CoC is required to update our unmet needs for Emergency Shelter, Transitional Housing, and Permanent Housing Beds. Based on data collected in our HMIS, Point-in-Time (PIT) counts of sheltered and unsheltered people, our current bed capacity and utilization rate from the Housing Inventory Chart (HIC), and the newly added CoC System Performance Measures, outcomes are analyzed along with program and provider performance. This is conducted across the CoC and HSBG programs and data collected via the HMIS system in place. The following are other reports used to analyze performance and identify needs and gaps:
- Annual Homeless Assessment Report (AHAR)
- Annual Performance Report (APR)
- Homeless Management Information System (HMIS) reports.
- Employment and Income status of persons at entrance and exit
- PIT Counts twice annually.
- Data Quality Reports distributed monthly to providers
In addition, the CoC analyzes the following HUD System Performances Measures:

<table>
<thead>
<tr>
<th>Reduce the number of people who become homeless</th>
<th>Reduce the length of stay for those who become homeless</th>
<th>Reduce Homeless Recidivism</th>
<th>Promote financial security</th>
</tr>
</thead>
</table>

Evaluating Through Monitoring
The County Planning Team monitors each program annually using several methods: desk side file reviews via HMIS, site visits, hard copy file review, staff interviews and regularly scheduled, ongoing program management meetings.

The following measures to ensure programs operate efficiently and are cost effective.
- Discharge destinations for clients upon exit or verified connection to permanent housing;
- Increased participation by homeless individuals in mainstream programs
- Length of Stay in Shelter and Transitional programs
- Homeless Recidivism
- Reduction on first time homelessness.

2019 System Changes
The Coordinated Entry System (CES)
The CoC CES, completed the implementation of an easily accessible process that allocates CoC resources as effectively as possible no matter how or where people present. This system ensures that homeless persons move out of homelessness more quickly and prioritizes assistance based on vulnerability and severity of service needs.

The DelCo CES was designed using a crisis response model that allows for a triage assessment that directs households along the path that best meets their needs and situations. There are three paths that are possible;
- shelter diversion (with housing counseling and/or financial rental assistance)
- emergency shelter placement; and
- housing assistance/homeless prevention

The CoC is in the process of conducting a provider and user evaluation of the CE System.

Permanent Housing Clearinghouse (PHC)
The CoC has fully implanted the PHC, a web-based platform that manages the “by name” lists of prioritized households who require Rapid Rehousing or Permanent Supportive Housing as part of their housing crisis resolution. The PHC is a “warehouse” of all units/beds of RRH and PSH and assigns vacant units to prioritized households.

Program Update - One CoC program was converted from a facility-based transitional housing facility to a short-term transitional setting called Joint TH-RRH. This program targets unsheltered homeless men, temporarily houses them and transitions them to Rapid Rehousing. The program has shown great success.
2018 CoC and Homeless Service Achievements
- A SOAR program was funded and will begin in June 2019
- Completed the Coordinated Entry Manual
- Home-at-Last program implemented
- Implemented the Permanent Housing Clearinghouse
- Transformed Ralph Moses House program into “A New Day”
- Applied for and received 45 Mainstream Housing Choice Vouchers (HCV)
- Twenty-seven people graduated from DCHA grant funded programs to the HCV program
- Organized four trainings (Housing Quality Standards, Critical Time Intervention, Prepared Renters Education Program and Housing Choice Voucher
- Improved Data culture
- Applied for Home4Good Funding and received
- Developed an HSC training calendar
- Evaluated racial disparity
- Revision of LHOT into DHOT and met twice
- Maintained veteran housing initiative
- Applied for DV Bonus in CoC application
- Made new connections with Youth and LGBTQ

HSBG Funding Priorities for Homeless Services
- Maintain the operations of seven shelter programs and two-day center programs
- Fund additional Homeless Prevention Assistance
- Fund additional RRH units
- Target unsheltered homeless persons and transition them into services, shelter, and housing.
- Explore methods to improve the economic stability of all CoC participants.

Bridge Housing
Bridge Housing is no longer offered under the HSBG. The program was eliminated as a result of State budget cuts.

Case Management
Case Management services are provided by the following providers and programs:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Service Area</th>
<th>Description</th>
<th>Program Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Action Agency</td>
<td>Coordinated Entry, intake for shelter, prevention services and Case Mgmt. for RRH and housing locator. Shelter Diversion</td>
<td>Provides centralized screening, intake and assessment for emergency shelter for families with children, financial rent and utility assistance and funds case management for 3 transitional housing programs and homeless prevention services.</td>
<td>Number of households where homelessness was prevented or diverted.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of households re-housed and how quickly they were rehoused.</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix B

#### Delaware County Human Services Plan FY 2019-20

##### Domestic Abuse Project

<table>
<thead>
<tr>
<th>Provider</th>
<th>Service Area</th>
<th>Description</th>
<th>Program Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Abuse Project</td>
<td>Shelter Services</td>
<td>Provides case management at the Safe House Shelter.</td>
<td></td>
</tr>
</tbody>
</table>

##### Mental Health Association

<table>
<thead>
<tr>
<th>Provider</th>
<th>Service Area</th>
<th>Description</th>
<th>Program Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Association</td>
<td>Connect</td>
<td>Centralized intake, outreach and case management for single adults in eastern portion of county.</td>
<td>Reduction in homeless recidivism.</td>
</tr>
</tbody>
</table>

##### Salvation Army

<table>
<thead>
<tr>
<th>Provider</th>
<th>Service Area</th>
<th>Description</th>
<th>Program Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salvation Army</td>
<td>Stepping Stone – Coordinated Entry</td>
<td>Centralized intake, outreach and case management for single adults in southern portion of county.</td>
<td>Length of time homeless</td>
</tr>
</tbody>
</table>

##### Interfaith Housing Network

<table>
<thead>
<tr>
<th>Provider</th>
<th>Service Area</th>
<th>Description</th>
<th>Program Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interfaith Housing Network</td>
<td>Family Promise</td>
<td>Provides case management and a Day Shelter with services.</td>
<td></td>
</tr>
</tbody>
</table>

- There are no changes to Case Management services for FY 19-20.

#### Rental Assistance:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Service Area</th>
<th>Description</th>
<th>Program Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Action Agency</td>
<td>Rent Assistance</td>
<td>Homeless prevention financial assistance for rental arrears to prevent evictions and utility assistance.</td>
<td>Increase the number of households where homelessness was prevented or diverted. Increase in number of households re-housed. Average payments per household.</td>
</tr>
</tbody>
</table>

- There were no changes to Rental Assistance services in FY 19-20.

#### Emergency Shelter

<table>
<thead>
<tr>
<th>Provider</th>
<th>Service Area</th>
<th>Description</th>
<th>Program Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Action Agency</td>
<td>Temporary Emergency Shelter</td>
<td>Voucher based motel placement for primarily vulnerable single adults and families with children.</td>
<td>Length of stay in shelter.</td>
</tr>
<tr>
<td>Cobbs Creek Housing</td>
<td>Life Center of Eastern Del. County</td>
<td>Supports operations at this facility-based shelter for single men and women.</td>
<td>Shelter exits to permanent situations.</td>
</tr>
<tr>
<td>Mental Health Association</td>
<td>Connect-By-Night</td>
<td>Supports operations and staffing at this overnight church-based shelter for single adults.</td>
<td>Increase in income.</td>
</tr>
<tr>
<td>Salvation Army</td>
<td>Warming Center</td>
<td>Supports operations and staffing at this overnight shelter for single adults.</td>
<td>Increase access to mainstream benefits.</td>
</tr>
<tr>
<td>Wesley House</td>
<td>Wesley House</td>
<td>Supports shelter operation and staffing costs for families with children and single adult women at this facility-based shelter.</td>
<td></td>
</tr>
</tbody>
</table>

- There are no changes to Emergency Shelter services for FY 19-20.
Other Housing Supports:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Service Area</th>
<th>Description</th>
<th>Program Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Action Agency</td>
<td>Tokens</td>
<td>Purchase of public transportation tokens for homeless persons to get to housing, medical, treatment, school and employment appts</td>
<td>Shelter exits to permanent situations. Increase in income. Increase access to mainstream benefits</td>
</tr>
<tr>
<td>Community Action Agency</td>
<td>Innovative Outreach and Engagement</td>
<td>Program will provide extended stay at a voucher-based facility to bring unsheltered, vulnerable adults off the street and into a safe setting where services can be wrapped. Targeting single adults. Allows for 40 days of voucher-based shelter</td>
<td>Numbers engaged from street to services/shelter</td>
</tr>
<tr>
<td>Community Action Agency</td>
<td>Innovative Re-housing, Prevention and Diversion</td>
<td>We will expand the rental assistance component to fund special housing crisis situations that require specific funding to resolve the housing crisis and cannot be obtained elsewhere. ($30,000 MH)</td>
<td>Number of households diverted from homelessness.</td>
</tr>
</tbody>
</table>

Homeless Management Information Systems:
DelCo implemented the CARES Homeless Management Information System (HMIS) in 2007. The system is web-based and has 59 programs and 125 users from 15 organizations. Our HMIS has the following functions: intake, case management, assessment, service planning, outreach module, online referral, daily bed register, and inter-agency data sharing. In 2017, we implemented and continued to use the Permanent Housing Clearinghouse with scanning and uploading documents to keep electronic filing of homeless verification documents. In 2019, we plan to add a landlord/rental unit data base that can be used for rent reasonableness and as a resource for Housing Navigators.
SUBSTANCE USE DISORDER SERVICES

1. Waiting List Information

<table>
<thead>
<tr>
<th>Service</th>
<th># of Individuals</th>
<th>Wait Time (days)**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Withdrawal Management</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Medically-Managed Intensive Inpatient Services</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Opioid Treatment Services (OTS)</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Clinically-Managed, High-Intensity Residential Services</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Partial Hospitalization Program (PHP) Services</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Use average weekly wait time

The SCA polled several in county provider agencies and requested current statistical data regarding their admission and wait list process. The information requested was to identify the number of DelCo individuals in a specific Level of Care (LOC) and the average wait time.

All individuals who have received a LOC assessment must be admitted to the most appropriate LOC available within 14 days of the assessment. Individuals in need of withdrawal management must be admitted to treatment within 24 hours. If these time frames cannot be met, the reason will be documented in the individual’s file.

The SCA has increased the availability of extended after-hours assessment resources which has decreased wait times for individuals needing treatment services. Being on a waiting list is frequently mentioned as a barrier, leading some people to give up on treatment and to continue using, while prompting others to view sobriety during the waiting period as proof they do not need treatment. Providers base their waitlist on the number of discharges scheduled for the day and try to predict upcoming discharges as well, at least 10 days out.

Many substance users in DelCo reported that they experience multiple barriers that produce significant challenges to linking with treatment services. The methadone maintenance numbers reflected above that indicate a delay in accessing opioid treatment services, are primarily due to scheduling arrangements with agency physicians. It is important to note that while an individual has been assessed for methadone maintenance treatment and are waiting, they are receiving outpatient treatment for continuity of care.

2. Overdose Survivors’ Data

To track the number of individuals who have recently survived an overdose, as much as possible, the SCA is using the CRS model, which aims also to provide screening, and/or referral of overdose survivors to a professional provider who will assess and
refer to treatment options, as well as sometimes referring directly into treatment. Chester Crozer Medical Center administers the 24/7 Warm Hand-Off service, utilizing a 24/7 hotline and a team of CRS’s under clinical supervision. The staff are PCB trained commensurate with the service.

<table>
<thead>
<tr>
<th># of Overdose Survivors</th>
<th># Referred to Treatment</th>
<th># Refused Treatment</th>
<th># of Deaths from Overdoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>227 (2018 Year)</td>
<td>55</td>
<td>172</td>
<td>219</td>
</tr>
</tbody>
</table>

3. Levels of Care (LOC)

<table>
<thead>
<tr>
<th>LOC ASAM Criteria</th>
<th># of Providers Located In-County</th>
<th># of Providers Located In-County</th>
<th># of Co-Occurring/Enhanced Programs</th>
<th># of Co-Occurring/Enhanced Programs In-County</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 WM</td>
<td>4</td>
<td>1</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3.7 WM</td>
<td>19</td>
<td>2</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>3.7</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>3.5</td>
<td>33</td>
<td>1</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>3.1</td>
<td>12</td>
<td>1</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>2.5</td>
<td>0</td>
<td>0</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>2.1</td>
<td>4</td>
<td>4</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>1</td>
<td>4</td>
<td>4</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

4. Treatment Services Needed in County

There continues to be several barriers to accessing treatment related services within DelCo. One of the most pressing needs at the current time is the availability of evening/weekend assessment services. In addition, the SCA is still lacking adolescent treatment provider contracts for inpatient/residential treatment. This is due to the decline of adolescent residential treatment providers.

DelCo substance users also report a need for expanded medication assisted treatment (MAT) service providers (Suboxone). There seems to be a lack of D&A Outpatient agencies who start Medication Assisted Treatment inductions. Many residents enter residential treatment to address this demand; the SCA has encouraged several providers to expand their services.

It would also benefit the SCA and DelCo residents to increase transportation access for individuals seeking outpatient services. There is limited public transportation options in the western side of the county, as well as extensive travel times for individuals using public transportation.

Crozer Keystone Health Systems is currently pursuing opening a second residential detox and rehab facility at another hospital in our community. A reinvestment plan will be submitted for approval for expansion of these services.
Crozer Keystone’s Access Center has moved to the main hospital and has extended assessment hours to 11pm, Monday-Friday. DelCo is very supportive of this move and is looking forward to expanding access hours to a 24/7 delivery system. The Access Center provides screening and assessments to our D&A population.

Medicaid expansion has brought more residents into the substance use treatment system. This has created an influx of individuals seeking services who are in need of withdrawal management. SCA’s continue to strategize ways to expand services. DelCo has a valued partnership with Magellan, our BH-MCO and together we collaborate on ways to address the opiate epidemic that plagues our county.

There is also a need to have additional housing resources for those individuals who have an Opiate Use Disorder (OUD). The SCA has increased the availability of Recovery Housing, specifically for individuals who are on MAT services. Most of the Recovery Housing providers in DelCo are drug free and only accept residents who are on Vivitrol or Sublocade.

The county is prepared to conduct a bed capacity analysis of the current provider network to ensure all services are available and accessible within DelCo.

5. Access to and Use of Narcan in County

Narcan is currently carried by all 41 police departments and the Pennsylvania State Police. DelCo Adult Probation and Parole and Treatment Court staff are also equipped with Narcan. All of these agencies have been provided kits through funds from the DelCo District Attorney’s Office.

DelCo SCA has also provided funds for five providers to have Narcan on site at their organizations. Crozer Chester Medical Center, Community Campus, offers monthly community naloxone trainings and all attendees receive a Narcan kit upon completion of the training. Key Recovery also offers community naloxone trainings every other month and all attendees receive a Narcan kit upon completion of the training as well. The trainings offered by Crozer-Keystone Recovery Center and Key Recovery provide information on addiction and how to properly use the lifesaving medication in an event of an overdose; over 200 individuals have been trained in Community Narcan this year.

6. County Warm Handoff Process

It is the policy of DelCo SCA to provide priority access to assessment, referral, and treatment services to overdose survivors. In 2016, DelCo’s Certified Recovery Specialist (CRS) program was implemented. The purpose and mission of the program is to provide 24/7 warm hand off engagement to all seven emergency rooms in the county for a person who has experienced an overdose from substances. If engaged, the CRS staff will work to assist the individual in accessing D&A treatment services. Since inception, the CRSs have engaged 2654 individuals, and have helped 815 individuals gain access to treatment and initiate that process.
DelCo currently contracts with Crozer Chester Medical Center (CCMC) to provide Recovery Support Services to individuals who have experienced an overdose as part of the warm handoff initiative. These seven CRS’ will engage any individual who experiences an overdose, with prioritized focus on individuals with an OUD, as well as aid individuals and families who call the 24-hour hotline for assistance in accessing treatment. The CRSs are able to offer inpatient screening and referral, connection to CCMC Access Center, a warm hand off to the D&A ICM agencies, and follow up to ensure connections are made or reengagement offered if necessary. The ER CRS will continue to work with the client until a warm hand off is made.

1st Shift - 7:00am-3:30pm  
Swing Shift - 10:00am-6:30pm  
2nd Shift - 3:00pm-11:30pm  
3rd Shift - 11:00pm-7:30am  
PRN 1st Shift - 7:00am-3:30pm (Saturday and Sunday)  
Part Time 2nd Shift - 3:00pm-11:30pm (Saturday and Sunday)  
PRN 3rd Shift - 11:00pm-7:30am (Saturday and Sunday)

Logs of connections, engagements, referrals, and any client/consumer contact will follow the log and reporting specified in the contract. ER CRS staff will be networking with the Center of Excellence manager and staff creating a Hub and Spoke Networking system with providers in the County that include the Emergency Departments of CCMC, Springfield DCMH, Taylor, Fitz, Riddle and Bryn Mawr. The ER CRS staff and manager continues to build relationships with the police (presenting at the CIT In October and April), EMT’s, treatment providers, and other referral sources to be available to the community and providers for referrals, for victims of overdose, their families and first responders. Weekend coverage will be maintained by flexible work schedules and PRN staff. The part time manager will provide on call availability for CRS staff off hours.

Considering that many individuals with SUD related to the opioid crisis are seen at the physical health Emergency Rooms, the confidentiality laws and data sharing barriers hinder improved coordination. Hospitals, D&A providers, Managed Care Organizations and Mental Health providers are unable to share data because of these barriers. Updated regulations from a Federal and State level to increase access to data by improving confidentiality limitations to improve coordination, data sharing integration, and electronic data network would be beneficial to address these barriers.

**Warm Handoff Data: (Inception to present day)**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number Served</strong></td>
<td>2654</td>
</tr>
<tr>
<td><strong>Number Entering Treatment</strong></td>
<td>815</td>
</tr>
<tr>
<td><strong>Number Completing Treatment</strong></td>
<td>600(Estimate)</td>
</tr>
</tbody>
</table>
HUMAN SERVICES AND SUPPORTS / HUMAN SERVICES DEVELOPMENT FUND

- Adult
- [ ] Aging
- [ ] CYS
- [ ] SUD
- [ ] MH
- [ ] ID
- HAP

Adult Services – three programs are funded

1. **Program Name** - Family and Community Services – Adult Counseling  
   **Description of Services** - Sliding fee scale one-on-one counseling for adults who do not have resources to obtain this much needed service.

   **Service Category** -  
   Counseling - Nonmedical, supportive or therapeutic activities, based upon a service plan developed to assist in problem solving and coping skills, intra- or inter-personal relationships, development and functioning.

2. **Program Name**: Mercy Home Health  
   **Description of Services**: Homemaker staff assists eligible clients with activities of daily living such as light cleaning, laundry and grocery shopping.

   **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.

3. **Program Name**: Catholic Social Services - HRCP  
   **Description of Services**: Housing Resource Coordination is an educational resource on topics such as home maintenance, housing stability, homeless prevention tools and other supports. This is offered to participants in permanent housing programs to ensure housing stability. Money Management Workshop is a workshop for adults that covers the 3 R’s of Budgeting: Responsibility, Resources and Reality

   **Service Category**: Life Skills Education - Provides to persons the practical education and training in skills needed to perform safely the activities of daily living. The term does not include job readiness training, instruction in a language, or remedial education.

Specialized Services

1. **Program Name**: DelCo Intermediate Unit – Family Center Program  
   **Description of Services**: Services include Parents As Teachers, parent education classes, teen support groups, preventive health services, crisis intervention, Project Elect, and information and referral. In addition, the Family Centers have formal Memoranda of Understanding with Chester Youth Build and Head Start to provide service components to benefit the common populations of each.
2. **Program Name: HIV AIDS – Counseling, case management and education**  
**Description of Services:** Non-medical HIV/AIDS related services, assessment, service plan development and accessing all services and resources appropriate to their needs, including HIV case management, medical care, services and entitlements. Education includes outreach to schools, churches and community groups and a peer-led consumer group, where selected consumers and the peer-facilitator are also participating in outreach and education activities.

3. **Program Name: Cobbs Creek Housing; Mental Health Clinician**  
**Description of Services:** Cobbs Creek Housing is a 50-bed emergency shelter for homeless men and women. Approximately 55% of the resident’s self-report serious mental illness. The Mental Health Clinician provides on-site counseling and daily support to ensure that people with serious mental illness receive intensive support and linkages to treatment.

4. **Program Name: Family and Community Services – Food Program Coordination**  
**Description of Service:** Family and Community Services (FCS) is contracted to oversee and coordination the State Food Purchase Program (SFPP) and the Temporary Emergency Food Assistance Program (TEFAP). FCS coordinates the Delaware County Interfaith Food Assistance Network (DIFAN), hosts and convenes the DIFAN monthly meetings, and works to ensure that all DIFAN participating food pantries are compliant in all aspects of food storage and food distribution.

**Division of Adult and Family Services**

Human Service and Support allocation will be utilized to support the salary of the Adult and Family Services Deputy Administrator under the following two areas:

- Coordination of local planning and coordinating bodies in multiple service fields.  
  Coordinator for the DelCo Women’s Commission whose goal is to assist the County in:  
  1) assessing the needs of women and girls;  
  2) identifying existing resources to meet those needs;  
  3) promoting the utilization of identified resources;  
  4) identifying service gaps, and  
  5) making recommendations to the DHS and County Council for improvements to services.

- Coordination of County Continuum of Care for Homeless Services: Complete oversight of CoC for the County and Co-Chair of County Advisory Team for homeless and homeless prevention activities that includes but is not limited to: fostering the development and implementation of the county’s CoC system; maintaining the Homeless Crisis Response System; developing and implementing various service strategies like Housing First Strategy and Rapid-RE-housing; conducting annual evaluations of system needs and gaps, and develop strategic plans to meet the needs of the systems.
V. SUMMARY

DelCo has been operating under a Human Services model for several years and the natural progression to a block grant model was easily achieved. We believe we have been able to maximize the benefits of being a block grant county to the betterment of DCHS, our providers, and the individuals we serve. Although each categorical department always involved multiple stakeholder groups in decision making, planning, and development of initiatives, as a block grant county we have coordinated stakeholder involvement so that input is generated for and across all departments. We are all in agreement that it is essential to collaborate and share the goal of holistic approaches to services. We continue to move beyond the point of identifying what we cannot do to thinking about what we can do to meet the identified needs of the residents we serve. The one area that will continue to defy resolution is the ever-increasing need for housing. We will not be requesting a waiver for FY 18-19 as all funds have been categorically allocated and we predict, will be used. We look forward to another productive year of serving the residents of Delaware County in the most appropriate, cost effective, and least restrictive LOC, and support.
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Human Services Proposed Budget and Individuals to be Served
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Human Services Proposed Budget and Individuals to be Served
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Human Services Proposed Budget and Individuals to be Served
SUBJECT: 24-Hour Response System
DATE: Revised April 25, 2018
DEPUTY ADMINISTRATOR SIGNATURE: Susan Proulx

POLICY

It is the policy of the DelCo Office of Intellectual and Developmental Disabilities (OIDD) to respond to consumers, families, and the public within 24 hours whenever possible. This is completed through a system in which the SCO is the first line of response. The SCOs then contact OIDD if authorization for additional supports, or technical advice is needed. The AE also has delegates on duty on weekends and after hours to monitor incident reports.

PROCEDURE

Supports Coordinators, AE staff and managers are expected to return calls/emails within 24 hours. When a staff person is away from the office, the voice mail/automatic reply must inform the caller/emailer that the staff person will return the call/email upon his/her return. The voice mail/automatic reply must also instruct the caller to dial the main Supports Coordination Organization phone number if it is an emergency and the call cannot wait.

24 HOUR EMERGENCY ON CALL SYSTEM

It is the policy of the DelCo OIDD and the Supports Coordination Organization to maintain a 24 hour/7 days week emergency contact system.

1. If the emergency need occurs within normal or outside of work hours, OIDD has a delegate system. First, the SCO professional works with the family, individual and/or provider to secure needed supports.

2. If natural supports are unavailable or inadequate to address the situation, contact is made with the AE Deputy Administrator or with the AE QM Coordinator for technical assistance or approval of expenditure of funds. DelCo ensures that its base allocation for OIDD is available for OIDD use first and foremost. This allows for the ability to ensure that sufficient funds are available to provide the services people need, even when no Waiver capacity is available.
3. The SCO Administrator brings the funding need to the attention of the AE Deputy Administrator or the AE QM Coordinator for Base funding approval as noted above. This approval can be made typically within a day regardless of whether it is normal work hours or outside of normal work hours.

4. While awaiting approval the SCO works quickly to secure a residential placement or another service to ensure the health and safety of the individual. For example, if a residential placement is not immediately available, approval may be given for staffing to be sent into a family home to provide extra support.

5. The case is then reviewed on the next business day if approval was given after hours, to ensure follow up of the approved emergency plan.

6. In cases in which the AE Deputy Administrator and the AE QM Coordinator are not available, SCOs are instructed to call 610-713-2400 and ask to be connected to the OIDD Deputy Administrator.

7. If the AE delegate identifies an incident after hours or on the weekend that requires attention by the SCO or by AE management, those parties are contacted for further action.

**OFFICE EMERGENCY CLOSURE**

In the event that the office is dismissed early due to an unforeseen situation or due to a holiday, there will be a delegate on call or present in the office, functioning as the skeleton crew.

If the office is closed due to an emergency or building closure, the voicemail message on the office line will be changed to say, "The office is closed today due to …. (state reason). If this is an emergency, call the on-call number (the number for that particular SCO is given)."

After regular business hours, including weekends, the main Supports Coordination Organization phone number is programmed with a voice message alerting all callers to the on-call number in the event of an emergency situation.

**PROCEDURE**

The Supports Coordination Organizations maintain a yearly schedule of on-call rotation.