Appendix A
Fiscal Year 2016-2017
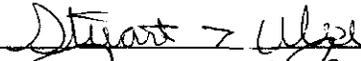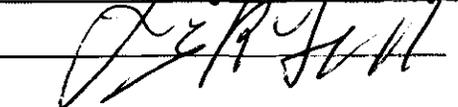
COUNTY HUMAN SERVICES PLAN

ASSURANCE OF COMPLIANCE

COUNTY OF: _____FULTON_____

A. The County assures that services will be managed and delivered in accordance with the County Human Services Plan submitted herewith,

B. The County assures, in compliance with Act 80, that the County Human Services Plan submitted herewith has been developed based upon the County officials' determination of County need, formulated after an opportunity for public comment in the County.

C. The County and/or its providers assures that it will maintain the necessary eligibility records and other records necessary to support the expenditure reports submitted to the Department of Human Services.

D. The County hereby expressly, and as a condition precedent to the receipt of state and federal funds, assures that in compliance with Title VI of the Civil Rights Act of 1964; Section 504 of the Federal Rehabilitation Act of 1973; the Age Discrimination Act of 1975; and the Pennsylvania Human Relations Act of 1955, as amended; and 16 PA Code, Chapter 49 (Contract Compliance regulations):

1. The County does not and will not discriminate against any person because of race, color, religious creed, ancestry, origin, age, sex, gender identity, sexual orientation, or handicap in providing services or employment, or in its relationship with other providers; or in providing access to services and employment for handicapped individuals.

2. The County will comply with all regulations promulgated to enforce the statutory provisions against discrimination.

COUNTY COMMISSIONERS/COUNTY EXECUTIVE

Signatures	Please Print	
(signature)	Stuart L. Ulsh	Date: 07/05/2016
(signature)	Rodney L. McCray	Date: 07/05/2016
(signature)	Larry R. Lynch	Date: 07/05/2016

Appendix B
County Human Services Plan Template

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

PART I: COUNTY PLANNING PROCESS

Describe the county planning and leadership team and the process utilized to develop the plan for the expenditure of human services funds. Counties should clearly identify:

1. Critical stakeholder groups including individuals and their families, consumer groups, providers of human services, and partners from other systems;

   The Fulton County Commissioners first formed a human services planning team in June, 2012 in order to explore opportunities that might arise from piloting the block grant. It was decided at that time that there likely would not be enough time to put together a plan in the first two years that would look a whole lot different from current plans. Also, with the state cuts in budgets, it was also felt that cutting those programs additionally would be detrimental to consumers. Therefore the initial planning team was composed largely of those persons representing agencies currently receiving funding. Through the years, it has grown to be deliberately more inclusive and team members now look more at outcomes and make decisions based more on outcomes than on specific allocations. Each year has built on the previous year and each year, additional members are added to the team. The planning team named for the 2016-17 year includes:

NAME	REPRESENTING
1. Anne Harvey	Fulton Co. Housing Authority
2. April Rouzer	Franklin/Fulton Drug & Alcohol
3. Barry Munch	Mental Health Association of Franklin/Fulton
4. Beverly Ragan	Consumer member
5. Carrie Gray	Franklin Co. Assistant Administrator
6. Connie Brode	Huntingdon/Bedford/Fulton AAA
7. Dan Miller	Fulton Co. Chief Probation Officer
8. Doug Tengler	Fulton County Chief Financial Officer
9. Elen Ott	Fulton County Family Partnership
10. Jean Snyder	Fulton County Human Services Administrator
11. Julie Dovey	Fulton County Family Partnership
12. Larry Lynch	Fulton County Commissioner (non-voting)
13. Richard Wynn	Franklin Co. Human Services Administrator
14. Rodney McCray	Fulton County Commissioner (non-voting)
15. Shalom Black	Franklin County Grants Planner
16. Sr. Margie Monahan	Fulton County Catholic Mission
17. Skip Ramsey	Consumer member
18. Steve Nevada	Franklin/Fulton MH/ID/EI
20. Stuart Ulsh	Fulton County Commissioner (non-voting)
21. Wendy Melius	Center for Community Action

It should be noted that the Fulton County Human Services administrator serves on the Franklin County planning team and the Franklin County Human Services Administrator serves on the Fulton County planning team in order to better facilitate cross-systems planning. Although the above team represents the "working" team with regard to the 2016-17 plan, other groups involved in the process include:

1) Fulton County Housing Committee – consists of 15 members including managers of local housing for the elderly, mentally ill and low-income families. This committee has provider and consumer participation. (Meets quarterly)
2) Fulton County Family Partnership – consists of more than 50 partners who represent other agencies, non-profits, churches and consumers. This is the 501©3 which provides human services planning for the county. It is composed of providers, consumer representatives, clergy, business and other community individuals who seek membership. (Meets monthly)
3) Fulton County Services for Children Advisory Board – includes 15 members including three student members. (Meets 6 times/year)
4) Family Engagement Committee – this is a sub-committee of the local Franklin/Fulton Children's Roundtable. It consists of 14 members and meets quarterly.

2. How these stakeholders were provided with an opportunity for participation in the planning process, including information on outreach and engagement;

This team is currently responsible for developing the plan for the expenditure of human services funds for the 2016-17 fiscal year. The committee is also charged with considering the various reallocation of funds throughout the year and that is done through an application process that has been developed. The planning team met on the following dates with agenda items in parentheses:

- ✓ June 2, 2015 (planning session for 15-16 plan; discussion of membership; discussion of public hearing dates for 15-16 plan; outcomes)
- ✓ October 29, 2015 (discussion of fiscal position at end of ¼ year; membership discussion; reallocation discussion)
- ✓ January 20, 2016 (discussion of fiscal position at end of ½ year; review of applications for additional funding; vote on applications; contracts; outcomes)
- ✓ April 28, 2016 (membership; fiscal position at end of ¾ year; reallocation applications and vote; outcomes; planning for 16-17 priorities; audit costs)
- ✓ May 31, 2016 (added consumer member; review of end-of-year fiscal position; 2016-17 planning – priorities).
- ✓ June 28, 2016 (committee meeting and also public hearing on 16-17 plan, outcomes)

Other boards and committees (outside of the Planning Committee) such as those outlined above are informed of block grant activities as a block grant agenda item when meetings are held. All were invited to the public hearings.

3. How the county intends to use funds to provide services to its residents in the least restrictive setting appropriate to their needs. **For those counties participating in the County Human Services Block Grant,** funding can be shifted between categorical areas

based on the determination of local need and within the parameters established for the Block Grant;

The flexibility of the block grant allows counties to serve consumers in the least restrictive setting. It is now possible to assess and address need(s) at the local level and to provide the supports that are necessary for all consumers – aging, adult, children as well as those with mental health, intellectual disability and drug and alcohol challenges to be served in the community. One of the outcomes that is measured in many of the funding streams is how many are served in their own home (as opposed to residential facilities), how many placements of children were prevented and other outcomes which are currently being identified. For the Child Welfare Special Grants, outcomes reports are submitted for the FGDM and the Alternatives to Truancy programs. Another outcome of particular value to us this year was the ability to raise the funding level for Homeless Assistance so that our waiting list could be cleared. In addition, we are often more able to provide more needed funds for Drug & Alcohol treatment.

Substantial programmatic and/or funding changes being made as a result of last year's outcomes:

This year, we are in agreement that we should focus on prevention and intervention efforts for those with opioid addictions since this has a community-wide concern due to a sharp rise in overdoses and death. We are also concentrating on an information campaign on meth labs due to an increase in those in the county. The team also has voted to use funds to expand Family Group Decision-Making from just Children & Youth to a more generic form that could include Aging, MH/ID, Fulton County Medical Center, Adult Probation and Drug & Alcohol.

4. Representation from all counties if participants of a Local Collaborative Arrangement (LCA).

Although it is not technically a local collaborative arrangement, our planning team has members from both Franklin and Fulton counties due to our collaboration with Franklin/Fulton MH/ID/EI and D&A and also has members from Bedford and Huntingdon counties due to our collaboration with Huntingdon/Bedford/Fulton AAA and Bedford/Huntingdon/Fulton Center for Community Action.

PART II: PUBLIC HEARING NOTICE

Two (2) public hearings are required for counties participating in the Human Services Block Grant. One (1) public hearing is required for counties not participating in the Human Services Block Grant.

Please provide the following:

1. Proof of publication;
    a. Actual newspaper ad – Appendix E
    b. Date of publication   - June 23, 2016
2. A summary and/or sign-in sheet of each public hearing. (This is required whether or not there is public attendance at the hearing) See Appendix F
    Public hearings were held on the following dates/times:

10

Tuesday, June 28, 2016 @10:30 a.m. Services for Children conference room
Tuesday, July 5, 2016 @10:00 a.m.   Services for Children conference room

NOTE: The public hearing notice for counties participating in local collaborative arrangements (LCA) should be made known to residents of both counties.

PART III: MINIMUM EXPENDITURE LEVEL
(Applicable only to Block Grant Counties)

For FY 2016/17, there is no minimum expenditure level requirement; however, no categorical area may be completely eliminated. Please see the Fiscal Year 2016/17 County Human Services Plan Guidelines Bulletin for additional information.

PART IV: HUMAN SERVICES NARRATIVE

MENTAL HEALTH SERVICES

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

a) Program Highlights:

Highlight the achievements and other programmatic improvements that have enhanced the behavioral health service system in FY 2015-2016.
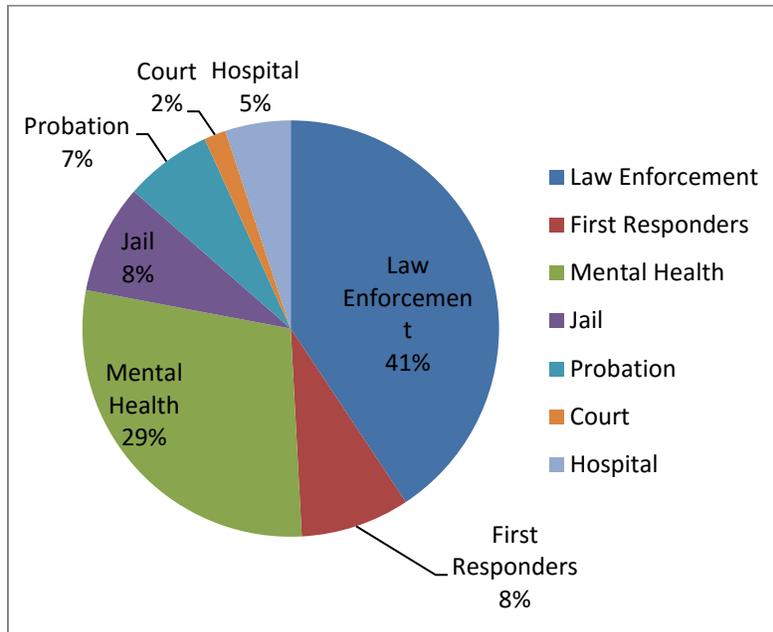
The Franklin/ Fulton County Mental Health Program provides services to Franklin/ Fulton County adults with severe and persistent mental illness and children who have a mental health diagnosis or who are at risk of developing a mental illness.
Through contracted case management, our agency provides intake, assessment, and coordination of the following services: outpatient psychotherapy, psychiatric and psychological evaluation, medication monitoring, residential programs, vocational and social rehabilitation, short-term inpatient, partial hospitalization and 24- hour emergency services.
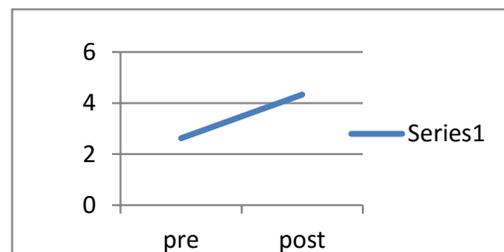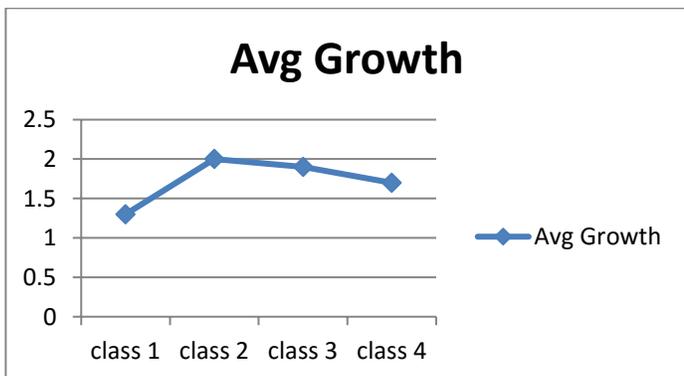Due to the budget issues faced this fiscal year, we focused on maintaining and strengthening the current services already offered in our community. The following list describes program achievements and improvements:

Crisis Intervention Team (CIT) – This initiative is in its fourth year and continuing to gain momentum. The team is now 59 strong with half of our members representing law enforcement and first responders. The remainder of the team represents crisis, jail officers/staff, probation officers, mental health professionals and advocates. We were fortunate to have hospital staff join our team this year as well.

- South Central Region CIT continues to follow the fidelity of the Memphis Model of CIT. During the 40 hours of training, we are fortunate to have a certified trainer for the Veterans module. We also offer evidence based training such as QPR (Question Persuade Refer) and Pat Madigan's hearing voices throughout the week.
- Outcomes:
  - To date we have held four (4) CIT trainings and have fifty nine (59) members with half of our team being represented by law enforcement and first responders:

- The pre/posttest show considerable growth. The training continues to show growth in learning, however, it shows a slight decline. It is possible that has we get more seasoned officers in the training they have more experience and exposure to working with individuals and professionals in the mental health system. It is also possible that they are learning from their peers who are already a CIT team member.

Mental Health First Aid
- Franklin/Fulton County is fortunate to have five (5) local trainers. Three (3) of them are Adult Mental Health First Aid instructors and two (2) are both Youth/Adult Mental Health First Aid instructors.
  - In the past five years we have trained approximately 252 participants in Adult Mental Health First Aid. Participants have come from a variety of professional backgrounds including; social work, homeless shelter staff, nursing home staff, administrative staff, corrections staff, business partners, and many others.
  - During our May celebration, there is opportunity for community members to participate in Adult Mental Health First Aid as well as Youth Mental Health First Aid.

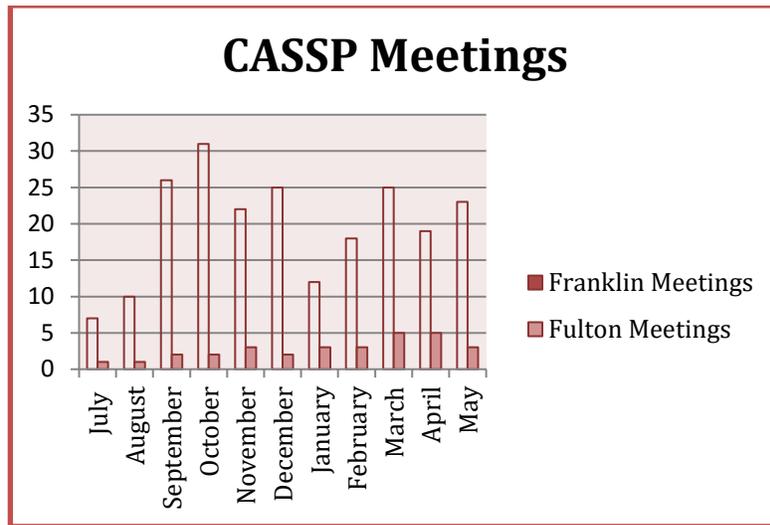We are also hosting a training in June located in Fulton County for anyone interested in taking the course.

b) Strengths and Needs:

Please identify the strengths and
needs specific to each of the following target populations served by the behavioral health system:

- **Older Adults (ages 60 and above)**
  - Strengths:
    - Continue to provide training regarding older adults and mental health to law enforcement and first responders through the CIT program. This includes multiple ways of engagement that includes utilization of several senses. Recognizing the local resources and how to access
  - Needs:
    - As the regulations are changing at the state level for the Area Agency of Aging, it will be important for the county to provide multiple education sessions.

- **Adults (ages 18 and above)**
  - Strengths:
    - Franklin/Fulton County has twenty one (21) WRAP® facilitators representing different levels of services. We are fortunate to have three (3) of our facilitators certified to do WRAP® for Developmental Disabilities. Two (2) of them even assisted in writing the workbook and were invited to present our piloted WRAP® for developmental disabilities program at WRAP® Around the World Conference in Washington DC. We were able to complete one (1) 8 week WRAP® group this year with thirteen (13) graduates. This program is one that was not able to be expanded as much as we wanted due to the budget restraint this fiscal year. Our hope is to offer a few groups throughout this new fiscal year.

The Community Support Program continues to host the leadership – Academy. The program runs one (1) day a week for eight weeks. It features class sessions on such topics as: networking, meeting coordination, dressing for success, and others. The sessions are conducted by varies professionals from our community who volunteer their time. The goal of the academy is preparation of individuals with a mental illness to serve or hold a position on local community advisory board councils and/or board of directors. To date, 64 have graduated over the past six (6) years. Currently, the class will graduate 13 students at the end of May.

- Needs:
  - Mobile service delivery for services such as outpatient and psychiatric care are not available due to the nature of the requirements for certain models like Assertive Community Treatment (ACT).

- **Transition-age Youth (ages 18-26)**
  - Strengths:
    - The focus is on employment opportunities and skills training for transition-age youth. Mental Health has partnered with Intellectual Disabilities to host an employment fair in May. The day will start with an informational presentation for the employers to learn the benefits available for hiring individuals with a disability. This will include a panel presentation with local employers who will share their experiences. School districts will be bringing students eighteen (18) years and older to the fair. Local providers such as the psychiatric rehab center, clubhouse, and supported employment will also be bringing individuals. Family has also been invited has there will be benefit education available on site.

  - Needs:
    - Employment and housing options are needed in our community for transition-age youth.

- **Children (under 18)**. Counties are encouraged to also include services like Student Assistance Program (SAP), Respite, and CASSP Coordinator Services and Supports in the discussion.
  - Strengths:
    - CASSP is available to all school districts and providers as well.

CASSP Meetings

Bar chart titled "CASSP Meetings" showing Franklin Meetings and Fulton Meetings by month (July through May), y-axis ranging from 0 to 35.

- o The provision of school-based mental health outpatient services is now present in all secondary schools in Fulton County.
- o The provision of the Student Assistance Program (SAP) in all of the secondary schools in Fulton County.
- o While the number of students screened is down the number of groups completed this year increased.

Fulton only				
	# students screened	% MH	% D/A	% CO
2015-2016 (through April)	39	90%	0%	10%

- ▪ Needs:
    - o Funding to provide SAP within all the elementary schools in both counties.

Identify the strengths and needs <u>specific</u> to each of the following special/underserved populations. If the county does not serve a particular population, please indicate and note any plans for developing services for that population.

- • **Individuals transitioning out of state hospitals**
  Strengths   Fulton County continues to partner with the state hospital to create a community support plan with input from the individual, their treatment team and family/friends. Prior to discharge, this plan is reviewed again by the same group and follows the person into the community.
    - o There is a committee currently working to identify needs and make recommendations to decrease the number of hospitalizations.
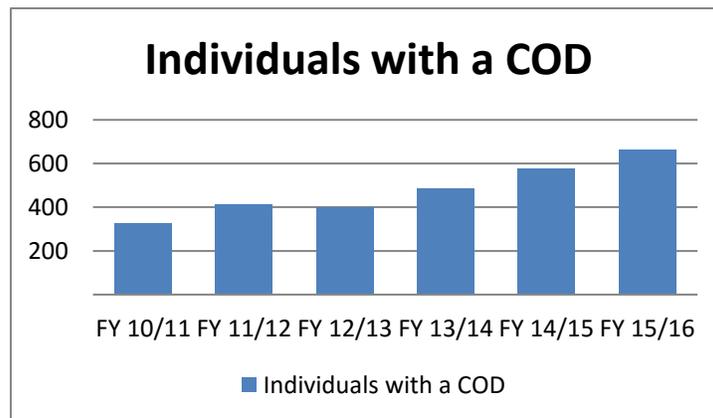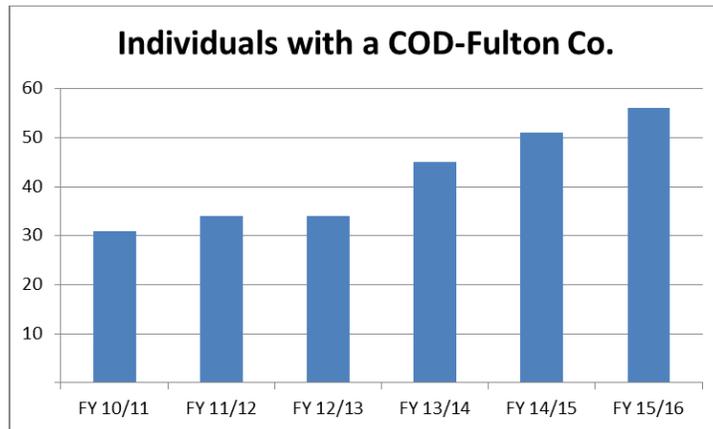
Needs:
- o There appears to be a need for more supported housing to assist in the transitions and also to provide some diversion from needing higher levels of care.

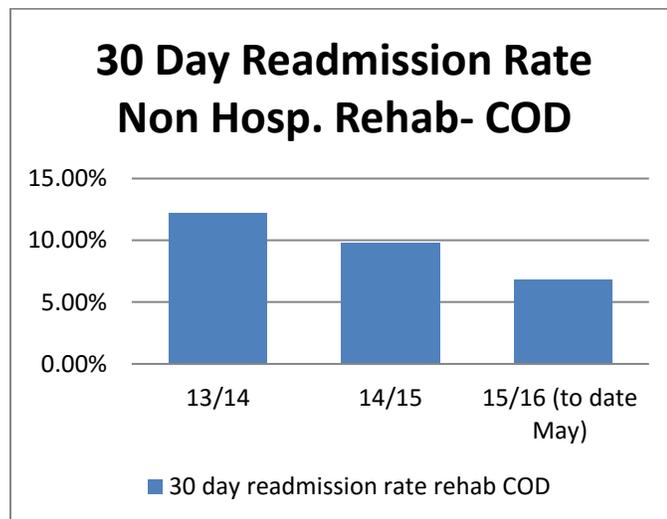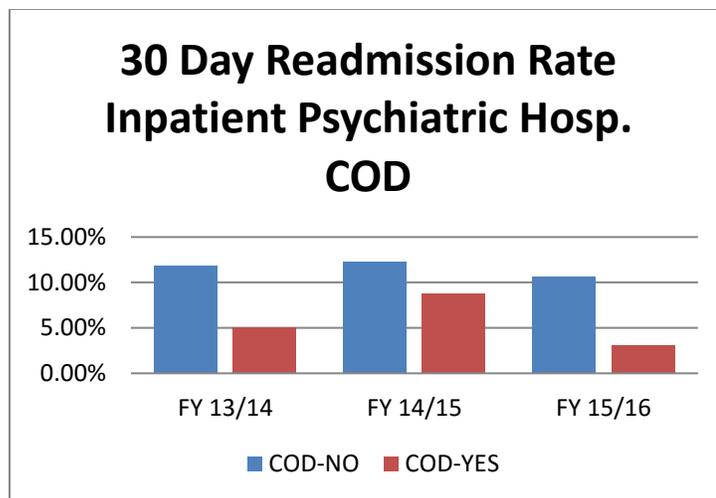- **Co-occurring Mental Health/Substance Abuse**
  Strengths:
  - o The Implementation committee created a co-occurring credentialing process for providers. It is mirrored from the OMHSAS bulletin that was created. The managed care organization and the county mental health program recognized the credentialing process and provided an enhanced rate to any provider who successfully passed. This fiscal year we had two (2) dually licensed outpatient providers pass the credentialing. As part of the credentialing the providers agreed to pilot a data collection survey. There is an increase in identified persons with co-occurring disorders that we are attributing to better diagnosis practices. Please refer to the transformation priorities for further detail.
  - o Training related to co-occurring illness continues to be offered free to our providers. We offer an on-line training series that is available for all Franklin/Fulton County providers. It features training based on the Tip-42 to include motivational interviewing.
  - o Since our initiative began we have increased the number of persons accessing services in both the mental health and drug & alcohol.
  - o A licensed drug & alcohol provider opened in Fulton County.

Individuals with a COD-Fulton Co.

o Our readmission rates are decreasing for both non hospital and inpatient hospital for individuals identified as someone with a co-occurring disorder.

30 Day Readmission Rate Inpatient Psychiatric Hosp. COD

30 Day Readmission Rate Non Hosp. Rehab- COD

Needs:
- o Financial support is needed to afford clinicians the time to prepare for and complete the Certified Co-Occurring Disorders Professional (CCDP) credential. Our data shows an decrease in services and it is concluded that clinicians having access to education and training as proven helpful in identifying and making referrals to the most beneficial services.

- **Justice-involved individuals**
  Strengths:
  - o The local outpatient provider and probation have collaborated in an effort to offer immediate or short wait times for assessments involving individuals currently on probation.

  Needs:
  - o Early identification and assessment of individuals with MH issues who become involved in the criminal justice system.
  - o Increase the CIT team members as a method of better communication between the departments/disciplines within our community.
  - o A program that would be available 24/7 to provide assessments for individuals that do not need to go to jail but need some support or diversion.

  Veterans:
  Strengths:
  - o During the week of CIT training, law enforcement is continuing to be educated about experiences of Veterans returning home after combat.

  Needs:
  - o A method of better engagement is needed. Stigma also seems to play a role in lack of access.

- **Lesbian/Gay/Bisexual/Transgender/Questioning/Intersex (LGBTQI) consumers**
  Strengths:
  - o Through CIT, Law Enforcement is being educated about experiences of persons identifying as transgendered.

  Needs:
  - o List of local MH providers trained to understand the needs of LGBTQI consumers.

- **Racial/Ethnic/Linguistic minorities**

Strengths:
- o MH/ID/EI has a contractual agreement with an agency which provides translation and interpretation services.

Needs:
- o SAP has identified a need for more services to be available in Spanish. As they complete screenings for students, they are struggling to find services to make referrals due to the language barrier. A bi-lingual therapist would prove more helpful than translation as a counseling relationship is developing.

- **Other, if any (please specify)**
  Strengths:
  Needs:
None identified

c) Recovery-Oriented Systems Transformation:

Based on the strengths and needs reported above, identify the top five priorities for recovery oriented system transformation efforts the county plans to address in FY 2016-2017.For **each** transformation priority, provide:

- A brief narrative description of the priority
- A timeline to accomplish the transformation priorities including approximate dates for progress steps and priority completion.
- Information on the fiscal and other resources needed to implement the priorities (how much the county plans to utilize from state allocations, county funds, grants, HealthChoices, reinvestment funds, etc., and any non-financial resources).
- A plan/mechanism for tracking implementation of priorities.

1. Comprehensive, Continuous, Integrated System of Care Model implementation (CCISC) to develop a service system that is co-occurring capable.
   - o Implementation team has developed a credentialing process to recognize local providers that have completed the criteria to be co-occurring capable.
     - o The certification program began the process in May 2015 with the outpatient providers interested in becoming a recognized county certified co-occurring program. The completion date target is Dec 2015. We had two (2) providers that the passed the tool and are being re-credentialed in May 2016. The process will be open to other providers that are interested in becoming certified as co-occurring capable as well.
     - o On June 16, 2016 we will hosting our second (2) annual Networking Day just for providers. The goal is to foster the relationships between community providers and increase their knowledge of each other's specialties to allow for better referrals.
     - o A two percent incentive rate has been established to encourage participation in the program. HealthChoices funds have been utilized to assist with in person

training elements of the program and County funds for an online training modules

- o This is monitored through the CCISC action plan and reviewed at implementation team meetings. In addition, this is monitored during HealthChoices monthly Quality Improvement/Utilization Management meetings.
- o CCISC will be updating the action plan this summer to address the needs identified in our local community health needs assessment. The results of the assessment will be completed and available later this summer. The target date is Dec 2016.
- o Change Agent Committee continues to meet on a quarterly basis. A review of evidence based programs that focus on the co-occurring population has just been completed and will be presented to the committee at this next meeting.
- o The targeted completion date for the committee to recommend the evidence based program is September 2016.
- o Once an assessment tool is identified, funds of $500 may be needed to provide training.
- o This is monitored through the CCISC action plan and reviewed at implementation team meetings. In addition, this is monitored during HealthChoices monthly Quality Improvement/Utilization Management meetings.

2. Data collection to increase knowledge of quality of services in order to assist in making better decisions for service delivery.
   - o Our local advocacy provider. Mental Health Association has partnered with Penn State Mont Alto to begin the development of a data warehouse. A platform has been created for a warehouse. Training to the authorized users is scheduled to begin this summer. Data entry should begin in late October 2016.
   - o Collaboration with county providers will then begin January 2017 to educate and share the benefits to having a data warehouse for our community. Actual use of the system is hoped for in 2018.
3. Suicide Prevention
   - o Objective 2.1 Develop a Zero Suicide Prevention philosophy statement and community education program emphasizing the value and importance of each individual by December 2018.
   - o Strategy 2.1.2 Identify key community influencers that share the Zero Suicide Prevention and can work on behalf of this effort.
   - o Strategy 2.2.2 Create a community awareness / education action plan for spreading this message into the community

4. Addressing health literacy in both our residents and our system
Objective 1.2 Increase the number of patients who are screened for depression within the primary care setting by December 2020.
- ● Strategy 1.2.1 Develop community consensus on a depression assessment instrument that can be used by all Primary Care Providers, Hospital Physicians, and Mental Health

Professionals. The survey instrument should include questions related to screening for and managing patients with depression and identifying resources need to assist primary care providers.

- Strategy 1.2.2 Create an action plan for educating and gaining support on the use of the depression assessment tools and compiling the assessment results at a centralized location from Primary Care Providers and Mental Health Providers.
- Strategy 1.2.3 Provide training and support for Primary Care Providers and Mental Health Professionals on the use of the assessment tools, documentation of assessment results, and making appropriate referrals for support for individuals experiencing depression.
- Strategy 1.2.4 Identify a lead organization for coordinating assessment tool training, collecting assessment results, and providing support and coaching for Primary Care Physicians and Mental Health Professionals in the assessment of patients for depression.

Objective 1.3 Improve access and quality of care by designing a model by which behavior health services are integrated with Primary Care offices by December 2018.

- Strategy 1.3.1 Develop a model for integrating behavior health services, training and resources into Primary Care offices.

Objective 1.4 Increase community awareness about depression and available resources within the community by December 2020.

- Strategy 1.4.1 develop a community awareness and education action plan for informing the community about depression and other mental illnesses.
- Strategy 1.4.2 Continue and expand existing community campaigns that educate the public about effective ways (i.e. Physical activity, nutrition) to manage depression.
5. Re-entry of individuals from our jail to our community. As a result of Coalition Planning meetings and surveys, the Reentry Coalition has established the following priorities for the next steps of reentry planning:
   o Educating employers about reentry and hiring individuals with criminal backgrounds. (January 2017)
   o Educating the community on reentry.
   o Identify inmate needs prior to release and craft individual release plan, providing the inmate with a resource directory and packet of materials. Offer guidance on how to connect with resources. (November 2016)
   o Complete a housing inventory to ensure affordable housing is available to returning citizens and craft a comprehensive housing plan for reentry. (June 2017)

SECTION BELOW ADDED PER REQUEST

Priority	Description	Target Progress Steps	Completion Dates	Resources Needed	Tracking Mechanism
1. Comprehensive, Continuous, Integrated System of Care Model implementation (CCISC) to develop a service system that is co-	a. Implementation team has developed a credentialing process to recognize local providers that have completed the criteria to be	i. The certification program began the process in May 2015 with the outpatient providers interested in becoming a recognized	Ongoing	A two percent incentive rate has been established with County and Healthchoise funds to encourage participation in the program.	This is monitored through the CCISC action plan and reviewed at implementation team meetings. In addition, this is monitored during HealthChoices

Priority	Description	Target Progress Steps	Completion Dates	Resources Needed	Tracking Mechanism
occurring capable.	co-occurring capable.	county certified co-occurring program. We had two providers that the passed the test and are being re-credentialed in May 2016. The process will be open to other providers that are interested in becoming certified as co-occurring capable as well.		HealthChoices funds have been utilized to assist with in-person training elements of the program and County funds for an online training module.	monthly Quality Improvement/ Utilization Management meetings. CCISC will be updating the action plan this summer to address the needs identified in our local community health needs assessment. The results of the assessment will be completed and available later this summer. Target date is Dec. 2016.
		ii. Program hosted our second annual Networking Day just for providers. The goal is to foster the relationships between community providers and increase their knowledge of each other's specialties to allow for better referrals.	June 16, 2016		
	b. Change Agent Committee continues to meet on a quarterly basis. A review of evidence based programs that focus on the co-occurring population has just been completed and will be presented to the committee at this next meeting.	i. Committee to recommend the evidence based program	September 2016	Once an assessment tool is identified, funds of $500 may be needed to provide training.	This is monitored through the CCISC action plan and reviewed at implementation team meetings. In addition, this is monitored during HealthChoices monthly Quality Improvement/ Utilization Management meetings.

d) Evidence Based Practices Survey:

Evidenced Based Practice	Is the service available in the County/ Joinder? (Y/N)	Number served in the County/ Joinder (Approx)	What fidelity measure is used?	Who measures fidelity? (agency, county, MCO, or state)	How often is fidelity measured ?	Is SAMHSA EBP Toolkit used as an implementation guide? (Y/N)	Is staff specifically trained to implement the EBP? (Y/N)	Comments
Assertive Community Treatment	No							
Supportive Housing	No							
Supported Employment	No							
Integrated Treatment for Co-occurring Disorders (MH/SA)	No							
Illness Management/ Recovery	No							
Medication Management (MedTEAM)	No							
Therapeutic Foster Care	No							
Multisystemic Therapy	No							
Functional Family Therapy	No							
Family Psycho-Education	No							

*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

e) <u>Recovery Oriented and Promising Practices Survey:</u>

Recovery Oriented and Promising Practices	Service Provided (Yes/No)	Number Served (Approximate)	Comments
Consumer Satisfaction Team	Yes	300	
Family Satisfaction Team	Yes	228	Includes family and youth surveys
Compeer	No	0	
Fairweather Lodge	Yes	10	
MA Funded Certified Peer Specialist	Yes	107	This number is growing
Other Funded Certified Peer Specialist	Yes	20	
Dialectical Behavioral Therapy	Yes	25	2 providers that offer DBT group
Mobile Services/In Home Meds	No	0	
Wellness Recovery Action Plan (WRAP)	Yes	27	County includes group only
Shared Decision Making	No	0	
Psychiatric Rehabilitation Services (including clubhouse)	Yes	179	
Self-Directed Care	No	0	
Supported Education	No	0	
Treatment of Depression in Older Adults	No	0	
Consumer Operated Services	Yes	500	Mental Health Association
Parent Child Interaction Therapy	Yes	13	
Sanctuary	No	0	
Trauma Focused Cognitive Behavioral Therapy	Yes	55	
Eye Movement Desensitization And Reprocessing (EMDR)	Yes	15	4 certified therapists
Other (Specify)			

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

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

INTELLECTUAL DISABILITY SERVICES

ODP in partnership with the county programs is committed to ensuring that individuals with an intellectual disability live rich and fulfilling lives in their community. It is important to also ensure that the families and other stakeholders have access to the information and support needed to help be positive members of the individuals' team.

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

Describe the continuum of services to enrolled individuals with an intellectual disability within the county. For the narrative portion, please include the strategies that will be utilized for all individuals registered with the county, regardless of the funding stream. For the chart below, regarding estimated numbers of individuals, please include only those individuals for whom base or block grant funds have or will be expended. Appendix C should reflect only base or block grant funds except for the Administration category. Administrative expenditures should be included for both base/block grant and waiver administrative funds.

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

The mission of Franklin/Fulton Mental Health/Intellectual Disabilities/ Early Intervention is Franklin/ Fulton MH/ID/EI partners with the community to develop and assure the availability of quality MH/ID/EI services and supports for individuals and families. Through the use of a person-centered planning approach and the utilization of Prioritization of Urgency of Need for Services (PUNS), the ID program assists individuals in accessing services and supports within their community regardless of the funding stream. The PUNS gathers information from the person-centered planning approach to identify current and anticipated needs. This information allows Franklin/Fulton Mental Health/Intellectual Disabilities/Early Intervention to budget and plan for the continuum of services and to develop programs to meet the needs of the community. Programs support client engagement and provide access to services for employment, training, housing and family support as appropriate. As of April 30, 2016, there were 30 people registered in the Intellectual Disabilities program in Fulton County, of which 3 are participants in the life sharing program.

	Estimated Individuals served in FY 15-16	Percent of total Individuals Served	Projected Individuals to be served in FY 16-17	Percent of total Individuals Served
Supported Employment	1	3	2	7
Pre-Vocational	0	0	0	0
Adult Training Facility	0	0	0	0
Base Funded Supports Coordination	2	7	2	7
Residential (6400)/unlicensed	0	0	0	0
Life sharing (6500)/unlicensed	0	0	0	0
PDS/AWC	0	0	0	0
PDS/VF	0	0	0	0
Family Driven Family Support Services	0	0	0	0

Franklin/ Fulton County ID Program has developed a logic model to reflect the outcomes and objectives that are being accomplished in both counties. The desired outcomes and objectives to be measured are the same as the Quality Management Plan developed for ODP. Appendix E has details that outline the desired outcomes, the objectives measured and the trends and baseline data. The narratives include more details of the outcomes.

Supported Employment: "Employment First" is the policy of all Commonwealth executive branch agencies under the jurisdiction of the Governor. Therefore, ODP is strongly committed to Community Integrated Employment for all. Please describe the services that are currently available in your county such as Discovery, customized employment, etc. Identify changes in your county practices that are proposed for the current year that will support growth in this area and ways that ODP may be of assistance to you with establishing employment growth activities. Please add specifics regarding the Employment Pilot if your County is a participant.
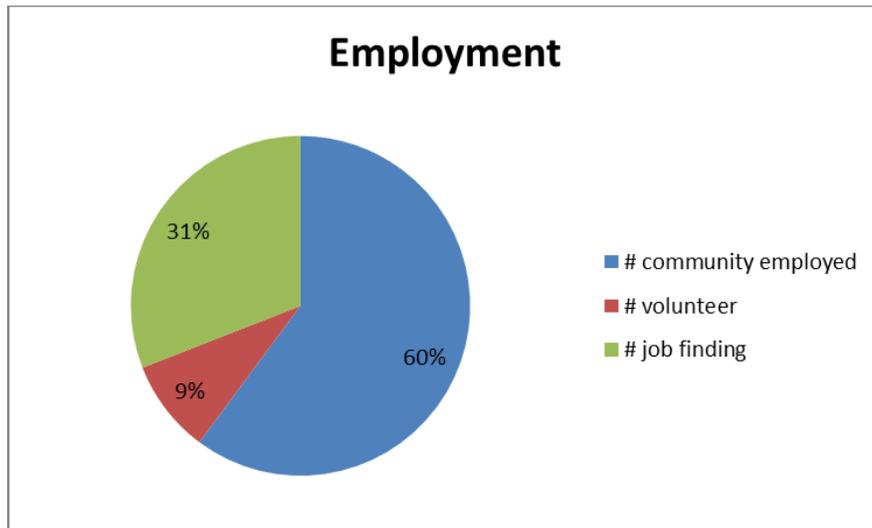
Employment First is a concept promoting community integrated employment. Franklin/ Fulton ID program is supporting this concept in a variety of ways.

The "Transition to Adult Life Success" program engages young adults with disabilities in discussions and activities pertaining to areas of self-determination and career exploration. The "Transition to Adult Life Success" program activities include presentations on employability, community resources, and post-secondary opportunities. One-to-one services include connecting with employers, job shadowing, community-based work assessments, and work incentive counseling.   There are currently 4 students in the TALS program in Fulton County. All 4 of these students are still working towards graduation and are using the TALS services to become competitively employed at graduation.

Supported Employment Services include direct and indirect services provided in a variety of community employment work sites with co-workers who do not have disabilities. Supported Employment Services provide work opportunities and support individuals in competitive jobs of their choice. Supported Employment Services enable individuals to receive paid employment at minimum wage or higher from their employer. Providers of Supported Employment Supports have outcomes of "placing individuals with intellectual disabilities in a competitive job." They were expecting to place 10 individuals in new jobs and as of March 2016, they had placed 5 individuals in jobs, not including the TALS program.

Transitional Work Services support individuals transitioning to integrated, competitive employment through work that occurs at a location other than a facility subject to 55 Pa. Code Chapter 2380 or Chapter 2390 regulations. Transitional work service options include mobile work force, work station in industry, affirmative industry, and enclave. Franklin/ Fulton ID program currently serves all individuals using Transitional Work Services in the Waiver.   There are currently 74 individuals in the Transitional Work Program in the Franklin/Fulton ID program. All these individuals are waiver funded.

The ID department is concentrating on Community Employment which includes supported employment and transitional work for the Quality Management Goal and logic model. The outcome for the Quality Management Plan/ logic model is "*people who choose to work are employed in the community*." As of April 1, 2016, there is 1 Fulton County resident in community employment. Franklin/ Fulton ID program's QM/logic model objective is to increase by 5% the number of people who want to work to achieve community employment. FY 14-15 had a baseline data of 56% of people who had an employment goal were working in the community. The percentage of individuals working in the community is currently 60% (142/236). While this is measured for both Counties, the percentage for Fulton County is 7/13 or 54%.

Employment

The Franklin/Fulton ID Program is supporting a new program which is due to begin in June 2016. The Pathways Program is a time-limited program that teaches independent living skills and/or employment skills. The outcome of this program is individuals will complete this curriculum in a 2 year period and live independently in their own apartment and/or have competitive employment at the end of the 2 years.

The Franklin/Fulton ID Program coordinated an Employment Fair on May 12, 2016. The Fair's morning program was a speaker who informs local businesses of the benefits of hiring individuals with disabilities followed by a panel discussion with businesses who hire individuals with disabilities. The afternoon was open to the public to apply for jobs at these businesses. Success will be measured by whether businesses hire someone with a disability and if individuals are hired by the businesses. The Employment Fair is in Chambersburg, PA.

The Franklin/ Fulton ID Program also partners with OVR to provide and attend Referral trainings.

The Franklin/Fulton ID Program participates in the Transition Council with OVR and the School Districts and providers to promote and support the Employment First Model.

Supports Coordination: Describe how the county will assist the supports coordination organization to engage individuals and families in a conversation to explore natural support available to anyone in the community. Describe how the county will assist supports coordinators to effectively plan for individuals on the waiting list. Describe how the county will assist the supports coordination organizations to develop ISPs that maximize community integration and Community Integrated Employment.

Base Funded Supports Coordination includes home and community based case management for individuals in nursing facilities and in community residential settings. These services are only paid for individuals who have had a denial of Medical Assistance Coverage. There are 2 people in Fulton County who have base funded Supports Coordination. Currently no one is leaving a State

Hospital system from Fulton County, so transition services are not needed at this time. We have MA denials for people who are receiving base services over $8000.

The ID Program collaborates with the Supports Coordination Organization (SCO) by holding monthly meetings with Supports Coordination Supervisors. During these meetings, individuals who are deemed high profile or have Emergency PUNS are discussed regarding natural supports and what supports are necessary for that person. Any individual can be added to this list. At these meetings, PUNS, ISPs, Physicals, Levels of Care and other items are part of the standing agenda discussed monthly. The SCO is also represented on the Transitional Council and are encouraged to participate in SELN trainings to promote community integrated employment.
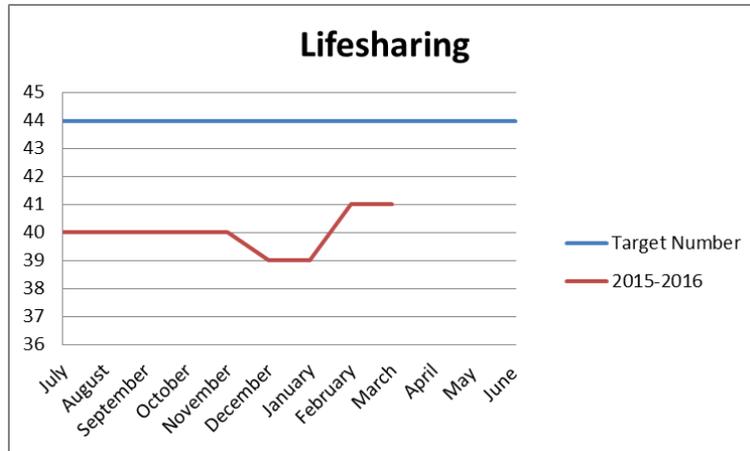
Lifesharing Options: Describe how the county will support the growth of Lifesharing as an option. What are the barriers to the growth of Lifesharing in your county? What have you found to be successful in expanding Lifesharing in your county despite the barriers? How can ODP be of assistance to you in expanding and growing Lifesharing as an option in your county?

According to 55 Pa. Code Chapter 6500: "Family Living Homes are somewhat different than other licensed homes as these settings provide for life sharing arrangements. Individuals live in a host life sharing home and are encouraged to become contributing members of the host life sharing unit. The host life sharing arrangement is chosen by the individual, his or her family and team and with the life sharing host and Family Living Provider Agency in accordance with the individual's needs. Licensed Family Living Homes are limited to homes in which one or two individuals with an intellectual disability who are not family members or relatives of the life sharing host reside." Satisfaction surveys have shown that people in life sharing living arrangements are more satisfied with their life. This along with the QM plan/ Logic Model that people choose where they wish to live have driven the objective for the 2015-2017 Life Sharing, "*to increase the number of people in life sharing.*"

The Franklin/Fulton Intellectual Disabilities Program will support the growth of life sharing in the following ways:

1. The AE and SCO will support people interested in a residential placement to meet with life sharing providers and life sharers who have openings to promote life sharing as the first option for residential placement.
2. Once per year at the annual ISP meeting, the AE will review the ISP of anyone who has a residential placement to assure the SCO has discussed moving to life sharing from other residential placements. If the person would benefit from life sharing or is interested in moving, the AE will follow up as in #1 above.
3. The AE Life Sharing Point Person will discuss with providers at least annually if they know of anyone who may benefit or want to move from a 6400 licensed home to a life sharing home.
4. Fulton County has 3 people living in life sharing Homes, representing 100% of the people in residential placement.

Life sharing is the first residential option offered to any person who needs a residential placement. This is documented in the Individual Support Plan. Currently, there are 3 people living in life sharing Homes in Fulton County (see chart below for Franklin/ Fulton QM/ logic model information). All 3 people have waiver funding to support the services they need in the life sharing home. The Intellectual Disability Program's Quality Management/ logic model Outcome is "*people live where they choose.*" The QM objective is to increase the number of people in life sharing in Franklin/ Fulton by 10% (n=44) by June 30, 2017.

Some of the barriers to growth in Life sharing in Franklin/ Fulton ID program are the lack of families willing to be lifesharers. Another barrier is the complex needs of individuals that may be interested in lifesharing. The final barrier is the caregivers that are lifesharers are aging. As they age, their own needs increase and they cannot continue to provide the care required. While there are barriers to lifesharing in Franklin/ Fulton ID program, there are also successes. Many of the people in lifesharing have lived in their lifesharing homes for 20+ years. Franklin/ Fulton has an increase in Lifesharing every year. And one provider of lifesharing actively recruits lifesharing families successfully. And finally, Franklin/Fulton has been successful in moving people from CRRs to Lifesharing when they age out of the Children's system.

Cross Systems Communications and Training: Describe how the county will use funding, whether it is block grant or base, to increase the capacity of your community providers to more fully support individuals with multiple needs.

Describe how the county will support effective communication and collaboration with local school districts in order to engage individuals and families at an early age.

Describe how the county will communicate and collaborate with local children and youth agencies, the Area Agency on Aging and the mental health system to ensure individuals and families are provided with the information they need to access needed community resources as well as formalized services and supports through ODP.

The ID program collaborates with the following agencies to increase the support for people with multiple needs. The ID program staff attends Child and Adolescent Service System Program

(CASSP) meeting to discuss the supports needed for individuals to be supported in their community and school. The ID staff also has a working relationship with Home Health Aid Providers to support people in the home and community. Lastly, the Manage Care Organization Specialized Needs Unit is available for people who meet those criteria.

The ID program also collaborates with the school districts by offering information sessions to both parents and teachers. The ID staff has attended IEPs when requested to help problem solve and/or to provide intake information. The Administrative Entity (AE) also is a member of the transition council and attends the Transition Fairs at all High Schools and County wide.

The ID program partners with Children and Youth through CASSP. There are also individual cases where C & Y and the ID Program are involved where communication between the 2 agencies resulted in the best outcome for the child while protecting the individual's rights.

The ID program participates in the Aging/ ID Meeting as well as collaborating with the PASSAR. The ID staff also attends the Building Bridges Conference.

The Mental Health and Intellectual Disabilities program have a long history of communication and Collaboration. ID collaborated with the Copeland Center for Wellness and Recovery and Mental Health to pilot WRAP® for People with Developmental Distinctions, which supports people with both a mental illness and Developmental Disability. WRAP® is a recovery oriented evidence-based model that is accepted internationally. Franklin/ Fulton County and Philadelphia are the pilot areas. The first group was held at OSI in 2013. The County is also on the committee that wrote the WRAP® for People with Developmental Distinctions curriculum in collaboration with The Copeland Center, OMHSAS, NASDDDS and ODP. This curriculum is the next step for WRAP® for People with Developmental Distinction to become evidenced-based. The County has supported WRAP® efforts to explain this new program at conferences and trainings. It was presented at the IM4Q Conference in July 2015 and the WRAP® Around the World Conference in August 2015. WRAP® groups were held throughout the year. See Mental Health Section.

The ID program also presents the module on Intellectual Disabilities in the Crisis Intervention Team Curriculum. This curriculum teaches police officers, MH professionals and first responders how to respond to someone with a disability in the course of their professions.

The ID program is also a participant in the MH/ID Coordination Meetings with Tuscarora Managed Care Alliance and Perform Care to develop policy and procedures for people who have a dual diagnosis.

The Quality Management Plan/ Logic Model also include an outcome to "*collaborate and implement promising practices to assist people in achieving outcomes.*" The objective for the 2015-2017 QM Plan/ logic model will be to identify individuals who have a dual diagnosis and/or a Behavior Support Plan, then develop a toolkit for them to assist in recovery and achieve their outcomes. In 2015, the baseline data was gathered and the toolkit started. This next year, the data will be prioritized and the toolkit finalized and distributed for use.

Emergency Supports: Describe how individuals in an emergency situation will be supported in the community (regardless of availability of county funding or waiver capacity).

Provide details on your county's emergency response plan including:

Does your county reserve any base or block grant funds to meet emergency needs?

What is your county's emergency plan in the event an individual needs emergency services, residential or otherwise, whether within or outside of normal working hours?

Please submit the county 24-hour Emergency Response Plan as required under the Mental Health and Intellectual Disabilities Act of 1966.

If waiver capacity is unavailable, individuals will be supported out of funds in the Block Grant. Base money will be provided to graduates for day programs and transportation to maintain their residence at home, and so their parents can maintain their employment status. The Fulton County ID department will increase the availability for combinations of Family Aide, Day Programs, Transportation, Adaptive Equipment, Home modifications and Respite so that individuals can continue to live at home instead of residential programs which are more costly.

The AE has a Risk Management Committee that meets quarterly to discuss incident management and any items that may arise to become a future emergency.

Franklin/Fulton ID responds to emergencies outside of normal work hours in Procedure Statement ID-2014-505 Incident Management. In this procedure statement, all Program Specialists are listed as well as the MH/ID/EI Administrator with their cell phone numbers. These contacts can be used after hours for any emergency. All providers have been trained in the policy. The Incident Management Program Specialist checks the HCSIS database on a daily basis to assure that all the incidents provide for the health and safety of the individuals served. This includes weekends and holidays. Franklin/Fulton ID program reserves base respite funds to authorize respite services as needed in an emergency and works with providers and the Supports Coordination Organization to set up these services whether during normal business hours or after. These services may become Emergency Lifesharing or Emergency Residential while the person is in respite. This provides for the safety of the person and finds a long term solution.

The MH/ID Department's mission-essential functions are those critical processes the department must maintain, during the response and recovery phases of an emergency, to continue to serve its constituents. The department's mission-essential functions must be able to be executed within 12 hours of a major emergency and be sustainable for up to 30 days during the recovery phase of the emergency.

The county 24-hour Emergency Response Plan as required under the Mental Health and Intellectual Disabilities Act of 1966, will be sent as a separate attachment along with the

Block Grant Plan.

Administrative Funding: ODP has engaged the PA Family Network to provide support and training in the community. The PA Family Network will be providing individuals who are Person Centered Thinking trainers. Describe how the county will utilize the trainers with individuals, families, providers and county staff.

Describe other strategies you will utilize at the local level to provide discovery and navigation (information, education, skill building) and connecting and networking (peer support) for individuals and families. What kinds of support do you need from ODP to accomplish those activities?

Describe how the county will engage with the HCQU to improve the quality of life for the individuals in your community. Describe how the county will use the data generated by the HCQU as part of the Quality Management Plan process.

Describe how the county will engage the local IM4Q Program to improve the quality of life for individuals in your program. Describe how the county will use the data generated by the IM4Q process as part of your Quality Management Plan. Are there ways that ODP can partner with you to utilize that data more fully?

Describe how the county will support local providers to increase their competency and capacity to support individuals who present with higher levels of need related to: aging, physical health, behavioral health, communication, etc. How can ODP assist you with your support efforts?

Describe what Risk Management approaches your county will utilize to ensure a high-quality of life for individuals. Describe how the County will interact with individuals, families, providers, advocates and the community at large in relation to risk management activities. How can ODP assist you?
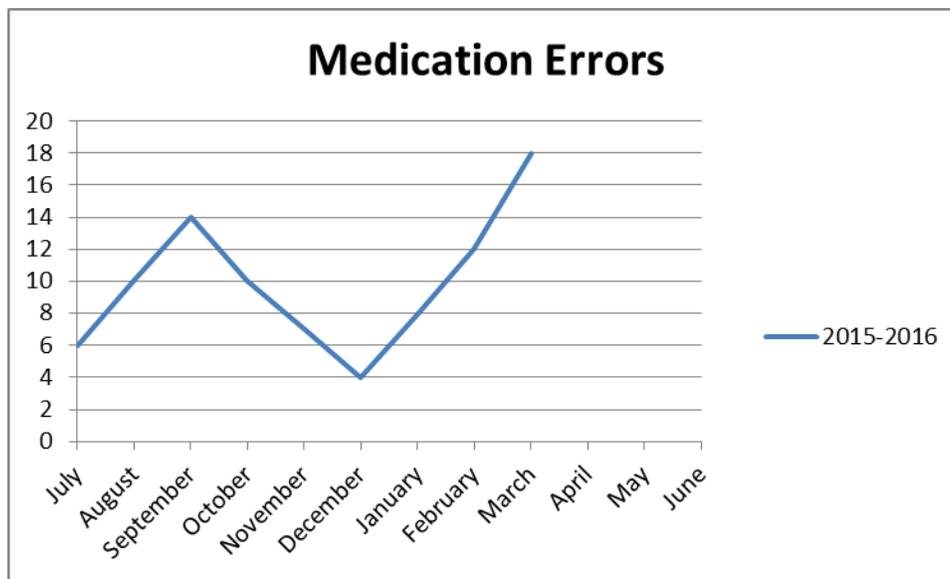
Describe how you will utilize the county housing coordinator for people with an intellectual disability.

Describe how the county will engage providers of service in the development of an Emergency Preparedness Plan.

Franklin/ Fulton ID program is planning to use the PA Family Network to provide trainings for individuals and families as well as providers and county staff. This training will be scheduled as the Communities of Practice initiative develops. The county will support and help coordinate these training and support future trainings that they can provide. The county also coordinates Information sessions for families. In the past ODP has provided technical assistance for these trainings, the AE also refers people to Advocacy Agencies and the Disability Rights Network.

The ID program uses the vast experience of the HCQU. Regular monthly trainings by the HCQU are held for families. They also provide individualized training that is requested by providers and
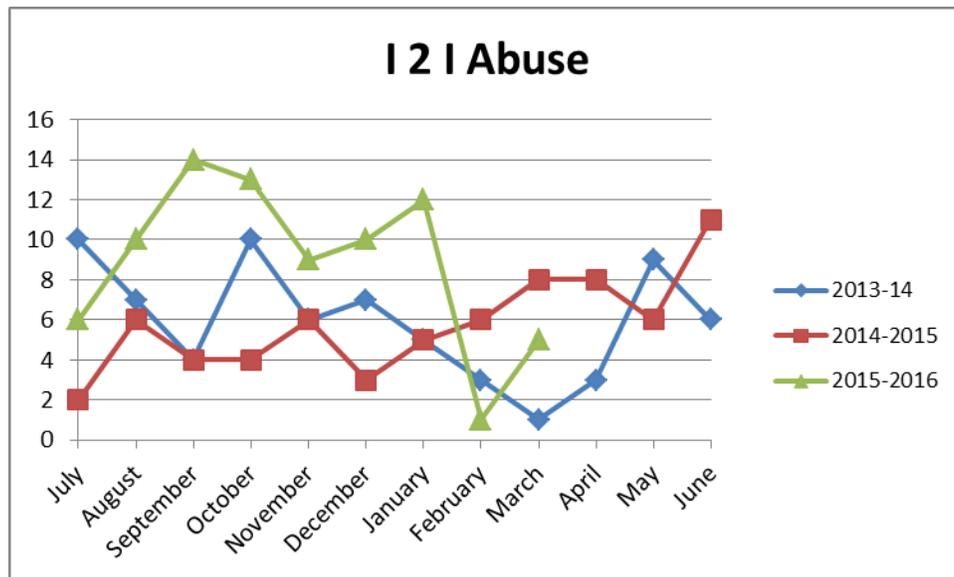
families. The AE attends the Positive Practices Committee Meetings as well as Regional HCQU meetings.   The HCQU is represented at our provider meetings and sits on both the Risk Management Committee and the QI Council. As a result of this collaboration, a Medication Error Task Force has been convened. This is an outcome and objective in both the Logic model and QM Plan.   The HCQU provides training to individuals, provider homes, staff or individuals depending on the trends found while analyzing the data. This supports the outcome t*o assure the health and safety of individuals receiving services, Franklin/ Fulton Intellectual Disabilities Program will use the objective of reducing the number of medication errors by 10% by June 30, 2017.* The baseline data is 270 medication errors from July 2013- April 2015.   As of March 31, 2016, there are 89 medication errors this fiscal year.

Medication Errors

As with the HCQU, a representative for the IM4Q local program sits on the QI Council. As a result of the IM4Q data, the local program realized that people did not know what to do in an Emergency even though they had a backup plan in their ISP. So, the QI Council recommended that a 1 page "What to do in an Emergency" for be developed. This has turned into a folder with different Emergency Preparedness information in it. This folder is given to individuals when reviewing considerations dealing with what to do in an emergency or at ISPs when questions are raised. The QI Council also reviews Employment and Lifesharing IM4Q data to determine satisfaction with services. Both of these Outcomes are included in the QM Plan and Logic Model.   The biggest barrier to reviewing IM4Q data is that the reports are not current. As a result, there is a lag in developing QM outcomes and objectives.

The ID program supports local providers by encouraging them to develop a relationship with the HCQU for trainings needed for their staff to support individuals with higher levels of need. The HCQU can also do biographical timelines, CDCs, medication/pharmacy reviews and provide training. The AE continues to support providers in developing relationships with the local hospital. As previously mentioned, the MH/ID Coordination Meetings help to support providers also.

The Risk Management Committee holds quarterly meetings to assess incidents to establish a higher quality of life for individuals. The Risk Management Committee realized that Individual to Individual (I 2 I) abuse was an issue that needed addressed.   The logic model and QM Plan both address the I 2 I abuse issue. *The outcome, "People are abuse free," is measured by the objective of reducing the number of I-2-I abuse incidents by 5%. The number of incidents of I-2-I abuse will be measured through quarterly analysis of the HCSIS Incident Data and the target trends to prevent future incidents will be analyzed by the Risk Management Team.* For 2014-2015, ODP redefined I-2-I abuse, to make sure the definition is consistent across the state. As a result, the state expects to see I-2-I abuse reports sharply increase, followed by a plateau which Franklin/Fulton will use as baseline data. The baseline data is 115 incidents of I-2-I abuse per Year. As of March 31, 2015, there were 80 incidents of I 2 I abuse. The Risk Management Committee has found several trends over this year and is working to resolve the issues.

The ID Program partners with the County Housing Program to provide an Independent Living Apartment Program. The people living in these apartments need less than 30 hours of support a week and the county helps subsidize the rent with base funds.

The County engages providers of service by ensuring that all ISPs have emergency plans included. As stated in the IM4Q paragraph, the county has developed Emergency Preparedness Folders for people who request them. This is a new procedure and the number of folders requested will be tracked over this plan year.

Participant Directed Services (PDS): Describe how your county will promote PDS services. Describe the barriers and challenges to increasing the use of Agency with Choice. Describe the barriers and challenges to increasing the use of VF/EA. Describe how the county will support the provision of training to individuals and families. Are there ways that ODP can assist you in promoting/increasing PDS services?

Franklin/ Fulton ID program has no individuals or families using VF/EA. When the VF/EA is explained to families, they choose Agency with Choice (AWC) instead. Fulton County has 4 families using AWC supports. All of them are paid with waiver funding. The county coordinates trainings for families through the Arc of Franklin/ Fulton Counties (the AWC provider) and the HCQU.

The major challenges for AWC are families have trouble finding staff especially in the rural areas of the county. This is due to the low wage, lack of transportation and/ or not near any services to name a few. Another challenge is that families have a lack of knowledge of the ID system and the service definitions. And finally, families get frustrated at the amount of documentation required of them. ODP assistance could be used to find creative ways to address these issues and to provider trainings to families.

Community for All: ODP has provided you with the data regarding the number of individuals receiving services in congregate settings. Describe how the county will enable these individuals to return to the community.

Fulton ID program has 0 people in congregate settings.   There are individuals who could be considered in a congregate setting residing in nursing homes. This is a generic support for them due to their need for a nursing home level of care.

HOMELESS ASSISTANCE SERVICES

Describe the continuum of services to individuals and families within the county who are homeless or facing eviction. An individual or family is facing eviction if they have received either written or verbal notification from the landlord that they will lose their housing unless some type of payment is received. Include achievements and improvements in services to families experiencing or at risk for homelessness, as well as unmet needs and gaps.

For each of the following categories, describe the services provided, how the county evaluates the efficacy of those services, and changes proposed for the current year, or an explanation of why this service is not provided:

- Bridge Housing – Not provided due to limited funds
- Case Management – Not provided due to limited funds
- Rental Assistance - Homeless Assistance is an area in which Fulton County has struggled to "do more with less" as homeless assistance funds have suffered continuous cuts in recent years. In the past six years, Fulton County has seen a reduction of 28% in homeless assistance funding in years prior to the Block Grant. It was hoped that the county could offset this loss with HPRP funding, but the stringent requirements on such a small amount of money were unable to be met in a county that has no housing office or staff to administer the programs. Fulton County's Section 8 housing is managed by the Huntingdon County Housing Authority. So although we are not always able to show a continuum of care locally, we have done a very good job with

case managing and finding outside resources (homeless shelters, etc.) for the homeless or near-homeless. The block grant has assisted with providing extra funding for our program through reallocation of unspent funds from other categories. In 2016-17, we again plan to supplement our allocation in order to avoid waiting lists. Money already given up for reallocation will be used as recommended by the planning team.

Fulton County has a very active Homeless Assistance Committee. It meets quarterly and meetings were held: September 23, 2015, December 23, 2015, March 23, 2016 and June 22 2016. There are twenty-five (25) committee members and they are representative of: Consumers, Human Services administration, Fulton County Catholic Mission, Area Agency on Aging, Center for Community Action, Fulton County Family Partnership, Fulton County Commissioners, Fulton County CDBG, Cardinal Glen Apartments (low-income), Mountain View apartments (elderly), Huntingdon County Housing Authority (Section 8 housing), Fulton County Housing Authority, Fulton County Planning, Food Basket, Center for Independent Living, state Dept. of Aging (Aging Specialist), local landlords, Franklin/Fulton MH/ID and Diana T. Myers & Associates.

SERVICES: The Homeless Assistance Program is state-funded on a state fiscal year (July 1-June 30) and for the FY 2009-10, 2010-11, 2011-12 and 2012-13 funding has decreased with Fulton's allocation at $17,733 for 2009-10, $17,765 for FY 10-11, $15,988 for FY 2011-12 and $14,389 for 2012-13, 2013-14, 2014-15, 2015-16 and 2016-17. The result is that as need increased due to economic conditions, funding continues to decrease. Because of the flexibility of the block grant, we were able to reallocate an additional $2,000 to the program in 2012-13. In 2013-14 and in 2014-15, we have been able to bring the funding up from $14,389 to $22,000 using reallocated funds. This has been a perfect example of the flexibility of the block grant and how it can be beneficial to counties. One example of an outcome of the grant with respect to Homeless Assistance was specifically the ability to increase per capita spending which moves the ranking of the county in terms of per capita spending from number 33 (out of 67) to number 18. In 2014-2015, we were able to serve an additional 101 children and adults to prevent homelessness. For the 2016-17, the provider has asked for $24,000 to serve an additional 60 clients to prevent homelessness.

- Emergency Shelter - Not provided – lack of sufficient funding. However these services are provided by Fulton County Catholic Mission using Salvation Army and other funding.

- Other Housing Supports - Fulton County has not used HAP funding for other housing support services due to the lack of sufficient funding. Limited housing options are available through other funding sources. Homeless outreach events and activities are held throughout the year in Fulton County. Projects for Assistance in Transition from Homelessness (PATH) collaborates with the Fulton County Catholic Mission to recognize National Hunger and Homeless Awareness week each November. Outreach materials regarding homelessness, poverty, and support services are provided to the Fulton County Catholic Mission for distribution to those individuals who visit the office for assistance. Outreach materials are also provided to Fulton County agencies that have contact with families and individuals in the community. Additionally, through the PATH program, human services representatives are able to participate in community events and provide information and educational materials on homeless resources, mental health, and drug and alcohol services. Homeless street outreach is conducted biannually during Point In Time counts. Homeless outreach is completed in partnership with housing agencies, human

service providers, formerly homeless volunteers, and PATH staff. Formerly homeless volunteers are encouraged to participate in outreach activities and street outreach. In 2015-16, the Homeless Assistance Committee participated in two trainings held in conjunction with the Fulton County Family Partnership's October meeting. There was a Housing 101 meeting designed to provide information to landlords and prospective tenants about housing in Fulton County as well as a Fair Housing Training that helped the committee to assist in updating the county's Fair Housing Plan.

In addition, Fulton County joined Bedford and Huntingdon Counties in a Housing Symposium held on January 21, 2016. The day-long symposium featured presentations from Diana T. Myers & Associates, Center for Community Action, S&A Homes and it also featured breakout sessions by county to outline each county's housing needs. In Fulton County, that session centered on the need for senior housing.

Other supports include the Center for Community Action's Emergency Solutions Grant, CoC Rapid Rehousing and Supportive Services for Veterans' Families (SSVF).

Describe the current status of the county's Homeless Management Information System implementation.

Fulton County has actively participated in HMIS for over 7 years, entering data from existing programs: Two Supporting Housing Programs and one Shelter Plus Care Program. Because Fulton County operates the Homeless Assistance Program locally, it is Franklin County and the Bedford/Huntingdon/Fulton Center for Community Action who utilizes HMIS and enters data for Fulton County. Data for the county's Homeless Assistance is not currently being entered in HMIS, but discussions are being held about beginning that practice. In Franklin County, PA-HMIS is used for three HUD funded programs which total 30 independent apartments. Of those 30 apartments, three apartments can be located in Fulton County. Currently one Fulton County apartment is occupied with the potential of adding up to two additional apartments should the need arise for someone who meets the established criteria.

CHILDREN and YOUTH SERVICES

***FOR COUNTIES NOT PARTICIPATING IN THE BLOCK GRANT, PLEASE INCLUDE THE FOLLOWING STATEMENT UNDER THE CHILDREN AND YOUTH SERVICES HEADING IN YOUR PLAN:

"Please refer to the special grants plan in the Needs Based Plan and Budget for Fiscal Year 2016-2017."

THE BELOW SECTION IS REQUIRED ONLY FOR COUNTIES PARTICIPATING IN THE BLOCK GRANT

Briefly describe the successes and challenges of the county's child welfare system and how allocated funds for child welfare in the Human Services Block Grant will be utilized in conjunction with other available funding (including those from the Needs Based Budget and

Special Grants, if applicable) to provide an array of services to improve the permanency, safety, and well-being of children and youth in the county.

Identify a minimum of three specific service outcomes from the list below that the county expects to achieve as a result of the child welfare services funded through the Human Services Block Grant with a primary focus on FY 2016-17. Explain how service outcomes will be measured and the frequency of measurement. Please choose outcomes from the following chart, and when possible, cite relevant indicators from your county data packets, Quality Service Review final report or County Improvement Plan as measurements to track progress for the outcomes chosen. When determining measurements, counties should also take into consideration any benchmarks identified in their Needs-Based Plan and Budget for the same fiscal year. If a service is expected to yield no outcomes because it is a new program, please provide the long-term outcome(s) and label it as such.

AGENCY SUCCESSES
1) The agency continues to focus on Family Engagement and this has been reflected in a decrease in both placements and in time of placement. Unfortunately, placements have begun to increase again (largely due to the opioid epidemic), but this seems to be a trend statewide. The agency has held several trainings and conferences related to Family Engagement. As mentioned in previous plans, three trainings were held in 2014 and 2015, so only FY 15-16 are described below.
- In May, 2016, the agency held a very successful conference on "Recovering Families: *Addiction, Parenting and Recovery."* This training was facilitated by Beth Bitler of Pa. Family Support Alliance and there were 90 in attendance.
- In 2015-16, agency staff was trained and certified in the use of Naloxen (Narcan) in a proactive effort to assist during possible opioid overdoses.
- In 2015-16, all staff was trained in Motivational Interviewing during a one-day training sponsored by our behavioral health provider.
- Services for Children hosted a one-day training on Adolescent Suicide" presented by the Child Welfare Resource Center.
- Family Engagement is now a subcommittee of the Children's Roundtable and monthly meetings are held to discuss Family Engagement initiatives in place and those that could be planned. The county's Juvenile Court Judges as well as the Children's Roundtable support these efforts and the committee has 14 members. During 2015-16, the committee developed written protocol for Family Group Decision Making, Family Finding and Visitation. In the next year, the agency hopes to focus the committee's efforts on Transitioning Older Youth.

2) There has been an increased focus on the schools and how the agency and schools can partner with Family Engagement and with our Truancy Initiative. Also, another subcommittee of the Children's Roundtable has been formed. The School Success/School Attendance subcommittee meets twice per year and that committee includes all three superintendents, their principals and other administrative staff, the three county Magisterial District Judges (MDJs), representatives from Fulton County Services for Children and JPO and representatives from our local Family

Engagement provider, Fulton County Family Partnership, Inc. The president Judge, who is also our juvenile court judge, attends the meetings.

3) The School Success and Check and Connect programs have now been implemented in all three school districts using a combination of HSBG and of Act 148 funds which we requested and received to expand the program to all the schools. In 2016-2017, the program will expand into elementary schools.

4) Increased focus on child abuse reporting with regard to the new Child Protective Services Laws.

5) Our Independent Living Peer Group Sessions have been very successful and the agency has gone from very little spending in IL to having a robust IL program given the size of our county. We are now holding two groups of Peer Group Session per year. Each group attends eight weekly sessions and a graduation ceremony is held on the ninth session. In 2014-15, when Juvenile Probation reported that they had 12 youths for a class, we held a special session in June which was conducted over a period of several weeks in order to accommodate those youths. During 2015-16, a new 9-week session was held in April/May/June with 16 youths (both C&Y and JPO) completing the course.

6) The agency, along with its provider agency, has been able to produce outcome reports with regard to the FGDM and the Alternatives to Truancy program. Measurements for the FGDM have included # of referrals, # of successful conferences, # of children who remained in their home vs. out of home care, and # of children in placement reunified as a result of FGDM. Outcomes for the Truancy Program are now being outlined.

7) In May, 2015, the agency voluntarily underwent a Quality Service Review (QSR). We have received the results from that we have prepared our Practice Improvement Plan which focuses on the following outcomes: Teaming/Staff Retention, Pathways to Independence and Long Term View/Stability/ Permanency.

AGENCY CHALLENGES
1) The agency continues to struggle with recruitment and retention of caseworkers. Reasons include: low salaries, unwillingness to relocate to the area due to limited recreational, shopping, etc. experiences, job stress, the additional paperwork required now vs. past years, the on-call rotation and in 2015, the increased paperwork and complexities of the new CPSL laws. We look forward to using our QSR to come up with ways to address this.
 2) Too many children in congregate care settings over long periods of time. These are children with very complex mental health problems and we are often unsuccessful with being able to access CRR Host Homes and/or RTFs. There is also an ongoing problem when children present at a hospital and need a psychiatric bed or an RTF, in more cases than not, there is not one available.
3) Due to the above, the agency has been "over-cap" with regard to Act 148 funds. Last year it was about $100,000 and this year we believe we will be very close to being within our budget. .
4) Need for more office space.

5) Need for providers to have more foster homes in Fulton County in all three school districts so that children going into care do not have to change school districts.

	Outcomes
Safety	Children are protected from abuse and neglect. Children are safely maintained in their own home whenever possible and appropriate.
Permanency	1. Children have permanency and stability in their living arrangement. 2. Continuity of family relationships and connections are preserved for children.
Child & Family Well-being	1. Families have enhanced capacity to provide for their children's needs. 2. Children receive appropriate services to meet their educational needs. 3. Children receive adequate services to meet their physical and behavioral health needs.

Outcome	Measurement and Frequency	The Specific Child Welfare Service(s) in the HSBG Contributing to Outcome
Safety – Number 2	Measured annually by using outcomes tools as described above.	FGDM
Permanency – Number 2	Measured annually using outcomes tools as described above	FGDM
Child & Family Well-Being – Number 2	Measured annually using Truancy Alternatives evaluation tool that has been in development during the past year.	Alternatives to Truancy

For each program being funded through the Human Services Block Grant, please provide the following information. The County may copy the below tables as many times as necessary.

Program Name:	Family Group Decision Making

Please indicate the status of this program:

Status	Enter X			
Funded and delivered services in 2015-2016 but not renewing in 2016-2017				
Requesting funds for 2016-2017 (new, continuing or expanding from 2015-2016)	X	**New**	**Continuing**	**Expanding**
			X	

- Description of the program, what assessment or data was used to indicate the need for the program, and description of the populations to be served by the program. If discontinuing funding for a program from the prior FY, please explain why the funding is being discontinued and how the needs of that target population will be met. If services or activities will decrease, explain why this decision was made and how it will affect child welfare and juvenile justice services in your county.
FGDM is a strength-based, family-driven evidence-based process that empowers families to develop their own plan to assure the safety and well-being of their children. If engaged in this process, the family will be more successful in eliminating circumstances that could lead to an out- of-home placement. By identifying and strengthening internal family supports, kin may be an early resource for respite and/or a temporary family plan which could avert a formal placement. No child from an ongoing case should enter placement without benefit of FGDM services. A FGDM log clearly tracks cases reviewed, the decision re: FGDM and the results if a FGDM referral is made. By helping the family to learn to utilize natural supports, they can become more self-sufficient, stronger and better able to provide for their children while assuring their safety without the need for continued child welfare involvement and/or intervention by the Juvenile Court.
A Family Engagement committee, which is part of the Children's Roundtable, consists of 16 members including agency staff, providers, GALs and parent attorneys. In 2015-16, this committee developed a formal protocol for making referrals to FGDM. Decisions regarding the FGDM program are driven by annual outcome reports submitted by providers.

- If there is additional funding being provided for this service through the Needs Based Budget and/or Special Grants, please provide information regarding the amount and how the HSBG money will be used in conjunction with those funds.
A request for additional funds was made to the Needs-Based Year for Alternatives to Truancy. The agency requested an additional $25,000 in addition to the Human Services Block Grant funds. The total for the HSBG funding for 16-17 is $29,925. However, the county's Family Engagement Committee, which is a subcommittee of our Children's Roundtable, has drafted protocol for making referrals to FGDM. This new protocol will now include more referrals made at intake which will increase our number of referrals/conferences. We estimate that, in addition to the HSBG funds, we will need an additional $25,000 to conduct 10 additional successful conferences at $2,500 each.

- If an Evidence-Based Program other than FFT, MST, FGDM, HFWA, FDC, or MTFC is selected, identify the website registry or program website used to select the model.

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Complete the following chart for each applicable year.

	FY 15-16	FY 16-17
Description of Target Population	Families on C&Y/JPO Caseload	Families on C&Y/JPO Caseload
# of Referrals	18	28
# Successfully completing program	8	18
Cost per year	$29,925	$29,925
Per Diem Cost/Program funded amount	$2,500 per successful conference	$2,500 per successful conference
Name of provider	-Fulton County Family Partnership -Professional Family Care Services	-Fulton County Family Partnership -Professional Family Care Services

*__The information provided in the above chart should reflect only funds being provided through the HSBG and the individuals/families served specifically with those funds.__

Were there instances of under spending or under-utilization of prior years' funds?
☐ Yes ☒ No

If yes, explain reason for under spending or under-utilization and describe what changes have occurred or will occur to ensure that funds for this program/service are maximized and effectively allocated and managed.

Program Name:	Alternatives to Truancy

Please indicate the status of this program:

Status	Enter X			
Funded and delivered services in 2015-2016 but not renewing in 2016-2017				
Requesting funds for 2016-2017 (new, continuing or expanding from 2015-2016)	X	**New**	**Continuing**	**Expanding**
			X	

- Description of the program, what assessment or data was used to indicate the need for the program, and description of the populations to be served by the program. If discontinuing funding for a program from the prior FY, please explain why the funding is being discontinued and how the needs of that target population will be met. If services or

activities will decrease, explain why this decision was made and how it will affect child welfare and juvenile justice services in your county.

The current protocol for the Truancy Intervention Program (TIP) is as follows: Each district has designated staff that will track student attendance and send the recommended notices to parents if unexcused absences occur. Every effort will be made by the child's home school team to identify and address issues that may contribute to the student's attendance problem by developing a Truancy Elimination Plan (TEP). Each school district will follow Section IV of the Department of Education Basic Education Circular (BEC) issued to address truancy. The FCSC Intake Supervisor will review every referral received to determine the most appropriate course of intervention. If there are no allegations of abuse or neglect and if the case is not an open case with FCSC, the new referral will be diverted to the Truancy Intervention Program (TIP) offered by the Fulton County Family Partnership (FCFP). TIP is only used for those children aged 13 or over. Referrals for children under age 13 are addressed by the agency as GPS or child neglect cases. The FCFP TIP coordinator will employ an evidence-based approach to truancy intervention. This program will be time limited and adjusted to meet the needs of each student and their families. Collaboration will continue with the referring school district, and with FCSC until the attendance problem is resolved.

FCSC provides feedback to the Magisterial District Judges. The agency's intake supervisor currently attends all MDJ truancy hearings to help build the bridge between the family, school(s), agency and the minor judiciary to try to solve the problems at that level. If there are allegations of abuse of neglect, they will be investigated by the C&Y agency and the TIP program and the agency will provide a collaborative effort to address all of the youth and family needs.

Historical data for the TIP –which is just part of the Truancy Alternatives Program, is as follows:

13-14 School Year

School Level	TIP Referrals	Investigated only by C&Y	Cases Opened by C&Y	Screened out at MDJ level
High School/ Middle School	17	0	2	0
Elementary School	19	19	1	0

14-15 School Year

School Level	TIP Referrals	Investigated only by C&Y	Cases Opened by C&Y	Screened out at MDJ level
High School/ Middle School	20 (3 repeat from 13-14)	0	3	0
Elementary School	17	11	3	6

15-16 School Year

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School Level	TIP Referrals	Investigated only by C&Y	Cases Opened by C&Y	Screened out at MDJ level
High School/ Middle School	19	4	2	2
Elementary School	12	4	4	8

If there is additional funding being provided for this service through the Needs Based Budget and/or Special Grants, please provide information regarding the amount and how the HSBG money will be used in conjunction with those funds.

A request for additional funds was made to the Needs-Based Year for Alternatives to Truancy. The agency requested an additional $76,485 in addition to the Human Services Block Grant funds. The total for the HSBG funding for 16-17 is $40,500. However, the original program did not include any referrals to the TIP provider who does the actual School Success and Check and Connect programs. Elementary school truancy referrals were only handled by the C&Y agency. We asked for the additional NBB Act 148 funds to fully implement the School Success, Check & Connect and TIP programs in all three school district's elementary schools. This will require an additional worker for our provider as well as other expenses to do such a large expansion.

If an Evidence-Based Program other than FFT, MST, FGDM, HFWA, FDC, or MTFC is selected, identify the website registry or program website used to select the model.

Complete the following chart for each applicable year.

	FY 15-16	FY 16-17
Description of Target Population	All county middle and high school students at risk of truancy, failing grades, dropping out of school Students at risk of truancy, failing grades, dropping out of school	All county students at risk of truancy, failing grades, dropping out of school Students at risk of truancy, failing grades, dropping out of school
# of Referrals	52 new referrals in addition to 39 returning from previous year or 91 total	131
# Successfully completing program	64 with 8 graduating	92
Cost per year	$40,500	$40,500
Per Diem Cost/Program funded amount		
Name of provider	-Fulton County Family Partnership -	-Fulton County Family Partnership -

	Professional Family Care Services	Professional Family Care Services

  ***The information provided in the above chart should reflect only funds being provided through the HSBG and the individuals/families served specifically with those funds.**

Were there instances of under spending or under-utilization of prior years' funds? ☐ Yes ☒ No   If yes, explain reason for under spending or under-utilization and describe what changes have occurred or will occur to ensure that funds for this program/service are maximized and effectively allocated and managed.

DRUG and ALCOHOL SERVICES

This section should describe the entire substance abuse service system available to all county residents that is provided through all funding sources, including state allocations, county funds, federal grants, HealthChoices, reinvestment funds, etc.

The Franklin/Fulton Drug and Alcohol Program (FFDA) provides funding for all levels of care for substance abuse treatment. These levels include inpatient detoxification, rehabilitation, halfway house, partial hospitalization, intensive outpatient, outpatient, and early intervention outpatient services for Franklin and Fulton county residents. FFDA also provides case management services and oversight of medication assisted treatment

This overview should provide the following information based upon data analysis and service system changes from the 15-16 plan narrative:
1. Waiting list for each level of care;
2. Barriers to accessing treatment services
3. Capacity issues
4. County limits on services;
5. Impact of opioid epidemic in the county system;
6. Any emerging substance use trends that will impact the ability of the county to provide substance use services.

This overview should not include guidelines for the utilization of ACT 152 or BHSI funding streams issued by DHS. The focus should be a comprehensive overview of the services and supports provided by the Single County Authority and challenges in providing services.
   1. Information regarding access to services:
In order to provide funding for all levels of care, there are contracts established with facilities across the Commonwealth. Currently, there are three outpatient treatment providers and one inpatient drug and alcohol treatment facility located in Franklin County. Within Fulton County, there is one outpatient treatment provider.
   2. Waiting list issues:
Treatment services are provided to any eligible resident despite age, gender, race, and ethnicity. However, we serve individuals by our priority populations. These priority populations are identified

in the following order: Pregnant Injection Drug Users, Pregnant Substance Abusers, Injection Drug Users, Overdose Survivors, Veterans and all others.

Level of care assessments are completed by contracted outpatient providers or FFDA Case Management staff. Treatment services are inclusive of detoxification, short and long-term inpatient, halfway house, partial hospitalization, intensive outpatient and outpatient services.

3. County limits on services:

It must be confirmed that an individual is a resident of Franklin or Fulton County before treatment can be authorized and funded. A photo ID is required. If one cannot be provided, the program can accept a current check stub, a current lease with their name on it, a current utility bill in their name, or other acceptable documentation that Franklin or Fulton County Assistance Office uses to determine whether an individual is eligible for Medical Assistance.

An individual who receives funding from the program must not have Medical Assistance at the time they are receiving services. A liability form is also completed for each individual to determine whether they will have a cost for the treatment. Funding restrictions do not apply to pregnant female or veterans who are in need of treatment. There are also exceptions made for adolescents where the program will fund for treatment services if they do not want their parent or guardian to know they are enrolled in services or if their parents discontinue insurance coverage for the adolescent to continue in treatment.

4. Coordination of care across the system:

Research has shown that a decrease in funding for treatment means an increase in cost for other systems (i.e. jails, prisons, hospitals, crisis centers). Our population served continues to increase as our funding continuously is stagnant or reduced. Therefore, Franklin/Fulton Drug and Alcohol Program has taken the initiative to research and identify new potential funding sources for services.

FFDA works closely with the Courts, Adult Probation, Children & Youth, and Juvenile Probation to coordinate drug and alcohol services for individuals involved in the criminal justice system. Research indicates that a reduction in prevention and intervention services increases costs to treatment as well as costs across other systems (jails, prisons, hospitals, education, vocation, employment and crisis systems). FFDA works closely with Prevention Providers to delivery evidence-based strategies, programs, practices and activities for multiple age groups. Services are delivered in the following ways: Selective, Indicated or Universal depending on the program/practice selected and target populations.

5. Any emerging substance use trends that will impact the ability of the county to provide substance use services:

The implementation of the Commonwealth's Prescription Monitoring Program will commence in August 2016. The implementation of this program may create higher demand for treatment services within Franklin/Fulton County. With the reduction of access to prescription opioids, it's anticipated for counties to see a rise in heroin use, heroin related overdoses and heroin related overdose fatalities.

Target Populations

Provide an overview of the specific services provided and any service gaps/unmet needs for the following populations:

- Older Adults
  If indicated, older adults are eligible for all levels of care for substance use treatment. These levels include detoxification, short and long term rehabilitation, halfway house, partial hospitalization, intensive outpatient, outpatient, and early intervention outpatient services for Franklin and Fulton county residents. FFDA also provides case management services and oversight of medication assisted treatment. Older adults covered by Medicare qualify for county funding due to the lack of Medicare providers within a 50 mile radius of Franklin and Fulton Counties.

- Adults (ages 18 and above)
  If indicated, adults ages 18 to 55 are eligible for all levels of care for substance use treatment. These levels include detoxification, short and long terms rehabilitation, halfway house, partial hospitalization, intensive outpatient, outpatient, and early intervention outpatient services for Franklin and Fulton county residents. FFDA also provides case management services and oversight of medication assisted treatment. It is anticipated that many of our priority populations, including Pregnant Injection Drug Users, Pregnant Substance Users, Overdose Survivors and Veterans will fall into this age demographic.

- Transition Age Youth (ages 18 to 26)
  If indicated, transition-age youth are eligible for all levels of care for substance use treatment. These levels include detoxification, short and long term rehabilitation, halfway house, partial hospitalization, intensive outpatient, outpatient, and early intervention outpatient services for Franklin and Fulton county residents. FFDA also provides case management services and oversight of medication assisted treatment. It is anticipated that some of our priority populations, including Pregnant Injection Drug Users, Pregnant Substance Users and Overdose Survivors will fall into this age demographic.

- Adolescents (under 18)
  If indicated, adolescents are eligible for all levels of care for substance use treatment. These levels include detoxification, short and long term rehabilitation, halfway house, partial hospitalization, intensive outpatient, outpatient, and early intervention outpatient services for Franklin and Fulton county residents. FFDA also provides case management services and oversight of medication assisted treatment. Additionally, FFDA also contracts with providers of prevention and intervention programs focusing on the adolescent population.

- Individuals with Co-Occurring Psychiatric and Substance Use Disorders
  In conjunction with Franklin/Fulton Mental Health and Tuscarora Managed Care Alliance, the Franklin/Fulton Drug and Alcohol Program has implemented a co-occurring initiative in both counties. This initiative uses the Comprehensive Continuous Integrated Systems of Care Model. All local providers participate in this initiative for co-occurring competency. There are facilities that offer specialized treatment programming for individuals with co-

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occurring conditions for providers outside of the two counties. To evaluate the Comprehensive Continuous Integrated Systems of Care Model (CCISC), we track the number of in-county facilities that offer specialized treatment programming for individuals with co-occurring conditions.

- Criminal Justice Involved Individuals
  If indicated, criminal justice-involved individuals are eligible for all levels of care for substance use treatment. These levels include detoxification, short and long term rehabilitation, halfway house, partial hospitalization, intensive outpatient, outpatient, and early intervention outpatient services for Franklin and Fulton county residents. FFDA also provides case management services and oversight of medication assisted treatment. All contracted treatment providers have specialized programming for this population.
  Franklin/Fulton Drug & Alcohol, in partnership with Tuscarora Managed Care Alliance (TMCA) and PerformCare (BHMCO), participate in the Department of Drug & Alcohol Programs (DDAP) Jail Project. This specific initiative is designed to assist incarcerated individuals needing Inpatient substance use treatment to obtain medical assistance when eligible and for the medical assistance to be activated within one week of discharge from the jail/admission to the treatment facility. If medical assistance is denied, county funding is utilized to pay for the treatment services needed. This partnership will continue into FY16/17.
  Franklin County has submitted the FY16/17 application to PCCD to implement the Residential Substance Abuse Treatment grant to individuals at the Franklin County Jail. Residents from Fulton County that are eligible for this program will also receive the services provided by the grant funding. This program requires participation in utilizing Vivitrol as medicated assisted treatment to run parallel to providing substance use treatment prior to release. Franklin County will also be moving forward with planning and technical assistance to begin an Adult Drug Court in FY16/17. Franklin/Fulton Drug & Alcohol will assist with planning and development in coordination with the Courts.

- Veterans
  If indicated, veterans are eligible for all levels of care for substance use treatment. These levels include detoxification, short and long term rehabilitation, halfway house, partial hospitalization, intensive outpatient, outpatient, and early intervention outpatient services for Franklin and Fulton county residents. FFDA also provides case management services and oversight of medication assisted treatment. The County provides drug and alcohol treatment funding to a small number of veterans due to the majority of this population having insurance to cover their costs.

- Women with Children
  If indicated, women with children in need of substance use services are eligible for all levels of care for treatment. These levels include detoxification, short and long term rehabilitation, halfway house, partial hospitalization, intensive outpatient, outpatient, and early intervention outpatient services for Franklin and Fulton county residents. FFDA also provides case management services and oversight of medication assisted treatment. The county contracts with multiple providers with women with children specific services. There

will be a targeted focus placed on mothers of chemically dependent newborns entering the NICU due to their chemical dependency at birth. Services will focus on treatment as well as in-home support for non-treatment, ancillary services.

Recovery–Oriented Services

Describe the current recovery support services available in the county including any proposed recovery support services being developed to enhance the existing system. Do not include information on independently affiliated 12 step programs (AA, NA, etc.).

Franklin/Fulton Drug & Alcohol partnered with Tuscarora Managed Care Alliance to allocate reinvestment funds to support Recovery Housing and Recovery Support Specialists in both counties, starting in FY15/16 and continuing through FY16/17. Development, planning and implementation of both plans will result in county residents being able to access services to help sustain long-term recovery in their local environment. Recovery Support Specialists will be housed in local outpatient provider settings and will assist individuals from short or long-term rehabilitation to transition to a lower level of care (halfway, partial hospitalization, intensive outpatient and traditional outpatient services). These positions will also assist individuals to engage in recovery supports and long-term recovery. Recovery Housing will assist individuals to engage in housing services during their recovery. Currently neither Franklin nor Fulton Counties have available recovery housing services.

<u>*NOTE: Because Prevention Funds target large groups of people, those numbers are not included in the budget under number served.</u>

HUMAN SERVICES AND SUPPORTS/ HUMAN SERVICES DEVELOPMENT FUND

For each of these categories (Adult Services, Aging Services, Children and Youth Services, Generic Services and Specialized Services), please use the below format to describe how the county intends to utilize HSDF funds:

- The program name.
- A description of the service offered by each program.
- Service category - choose **one** of the allowable service categories that are listed under each section.
- Which client populations are served? (Generic Services only)
- Planned expenditures for each service.

Note: Please ensure that the total estimated expenditures for each categorical match the amount reported for each categorical line item in the budget.

Adult Services: Please provide the following:

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Program Name: (e.g. Meals on Wheels….)
Description of Services: ("Provides meals to...")
Service Category: (Please select one from allowable categories below.)
Planned Expenditures:

Allowable Adult Service Categories:
Adult Day Care; Adult Placement; Case Management; Chore; Counseling; Employment; **Home-Delivered Meals**;
Homemaker; Housing; Information and Referral; Life Skills Education; Protective; Transportation.

-Transportation – to be delivered by the Fulton County Family Partnership for   supplemental
transportation- not MATP-eligible.
The Family Partnership only provides supplemental transportation for those individuals (only a
small number – adult catgegory) who do not qualify for other forms of transportation available
such as MATP, Welfare to Work or Shared Ride. For example, transportation would be
provided to an individual who does not have access to a vehicle and needs to go to a medical
appointment, but does not qualify for other types of transportation services listed above. If not
funded, these transportation services would not be available.

SERVICE	AMOUNT REQUESTED	# TO BE SERVED	# UNITS	PER UNIT COST
Supplemental Transportation	$2,000	10	20	Varies

-Case Management – to be delivered by the Huntingdon/Bedford/Fulton Center for Community
Action. Case Management will be used to provide Homeless Management   Information
Services (HMIS) data input. Clients will be processed into the HMIS at entry using HMIS data
questionnaires to gather pertinent information at the time of intake.   The information is
necessary for HMIS entry and also in identifying the client's possible need for other services.
Case management services will be provided through follow-up and exit survey using HMIS
data questionnaires.   CCA can provide training to the HAP provider staff on the use of the
HMIS data questionnaires. In Fiscal Year 2014- 2015, CCA was given 37 HAP client's to
provide follow-up for. Those clients who could be reached were asked questions concerning
their current housing situation after receiving HAP assistance. CCA estimates that 37 HAP
clients will have their information entered into HMIS at entry, from HMIS approved data forms,
and during follow-up to receive exit information using HMIS approved data forms. Quarterly
reports will be provided. CCA proposes to provide Case Management services to 37 HAP
clients by providing entry data and exit data into the Homeless Management Information
System.

SERVICE	AMOUNT REQUESTED	# TO BE SERVED	# UNITS	PER UNIT COST
Homeless Case Management	$7,400	37	74	$100

Aging Services: Please provide the following: N/A

> Program Name: (e.g. Meals on Wheels….)
> Description of Services: ("Provides meals to...")
> Service Category: (Please select one from allowable categories below.)
> Planned Expenditures:

> **Allowable Aging Service Categories:**
> Adult Day Care; Assessments; Attendant Care; Care Management; Congregate Meals; Counseling; Employment; **Home-Delivered Meals**; Home Support; Information & Referral; Overnight Shelter/Supervision; Personal Assistance Service; Personal Care; Protective Services-Intake/Investigation; Socialization, Recreation, Education, Health Promotion; Transportation (Passenger); Volunteer Services.

Children and Youth Services: Please provide the following: N/A

> Program Name: (e.g. YMCA...)
> Description of Services: ("Before and after school child care services provided to …")
> Service Category: (Please select one from allowable categories below.)
> Planned Expenditures:

> **Allowable Children and Youth Service Categories:**
> Adoption Service; Counseling/Intervention; **Child Care**; Day Treatment; Emergency Placement; Foster Family Care (except Room & Board); Homemaker; Information & Referral; Life Skills Education; Protective; Service Planning.

Generic Services: Please provide the following: N/A

> Program Name: (e.g. Information and Referral...)
> Description of Services: ("A service that connects individuals...")
> Service Category: (Please select one from allowable categories below.)
> Which client populations are served?: (e.g. Adult and Aging)
> Planned Expenditures:

> **Allowable Generic Service Categories:**
> Adult Day Care; Adult Placement; Centralized **Information & Referral**; Chore; Counseling; Employment; Homemaker; Life Skills Education; Service Planning/Case Management; Transportation.

Specialized Services: Please provide the following:

> Program Name: (e.g. Big Brothers/Big Sisters)
> Description of Services: ("A youth mentoring program...")
> Planned Expenditures:

- **-Adult Literacy/GED Program** – This is a specialized program proposed by the Center and started last year for Community Action of Huntingdon, Bedford and Fulton counties and approved by the HSBG Planning Committee for Fulton County. This service was approved by DHS last year. It was determined last year that a waiver for the Adult

<u>Literacy Program was not necessary as there is no similar program in the county This
continues to be the case for this year.</u>
The agency is requesting $7,000 as follows:

SERVICE	AMOUNT REQUESTED	# TO BE SERVED	# UNITS	PER UNIT COST
Adult Literacy and GED Instruction	$7,000	15	200	$35.00

Consumers are given the TABE test to show grade level and to identify a starting point to create
lesson plans. Once the Literacy Council is fully active, individuals who are not GED Prep ready
can receive Remediation to bring them up to GED Prep level. GED instruction is given to those
individuals who test as GED Prep ready. Individuals receive grade level appropriate training to
prepare them to take and pass the GED test. GED practice tests are given to all individuals prior
to registering them for the actual test. This is an indicator of how ready for the test the individuals
may be. When individuals are deemed ready, the GED instructor will assist them with registering
to take the test. Funds will be budgeted to assist the low-income individuals with the cost of the
GED exam. The cost of the exam is $120 and can be a hardship to anyone wishing to take the
test.

-Family Group Decision Making (FGDM) – This is an evidence-based specialized service that
will be offered to families involved in categorical services that do NOT include C&Y or JPO since
other funding can be used to serve those populations. This funding will allow for expansion of
FGDM into other categorical agencies within the block grant including MH, ID, EI, Homeless
Assistance and Drug & Alcohol. FGDM is a strength-based, family-driven evidence-based process
that empowers families to develop their own plan to assure the safety and well-being of their family
members. If engaged in this process, the family will be more successful in eliminating
circumstances that could lead to an out- of-home placement for any family members such as jail,
nursing homes and institutions. By identifying and strengthening internal family supports, the
program is specifically designed to allow all family members to reside with family which is the least
restrictive placement. The provider will be Fulton County Family Partnership who is also the C&Y
FGDM provider.

SERVICE	AMOUNT REQUESTED	# TO BE SERVED	# UNITS	PER UNIT COST
Family Group Decision Making	$10,000	12	4 Conferences plus the development of brochures, public awareness.	$2,500
Family Group Decision Making	$1,000	N/A	Development of brochure and public	$1,000

			awareness campaign	

Interagency Coordination: Describe how the funding will be utilized by the county for planning and management activities designed to improve the effectiveness of categorical county human services. The narrative should explain how the funds will be spent (e.g. salaries, paying for needs assessments, etc.) and how the activities will impact and improve the human services delivery system.

Fulton County traditionally uses interagency coordination funds to support Fulton County Family Partnership, Inc. which is a non-profit 501©3 agency that coordinates human services planning for the county in close partnership with the county's Human Services Administration Department.. The funds are used to set up meetings, secure venues and coordinate planning among agencies providing human services. Funds are also used for needs assessments, resource directories, consumer satisfaction surveys, etc. The Partnership is also the administrator of the Communities That Care grant which also assists with planning for county human services. Fulton County's resource directory can be found on their website at Helpline/Human Services - www.fcpinc.org.

Beginning on July 1, 2013, the Fulton County Partnership and the Fulton County Center for Families merged to become Fulton County Family Partnership Inc. (FCFP) As such, they, in conjunction with the County's Human Services Administration office will coordinate all human services planning activities. This year funding will also be used for: a portion of the Family Partnership director's salary as it pertains to planning and coordination and a portion of the Family Partnership's Community Mobilizer salary as it pertains to planning and coordination of block grant or block grant-related activities. Block grant funds are used for 10% of the director's salary and 40% of the community mobilizer salary. NOTE: Both positions are full-time, but are funded by other funding streams to cover their activities that are not block-grant related. Job descriptions are attached as Appendix G.
One of the unique collaboration opportunities for the FCFP has been the opportunity to collaborate with the Fulton County Medical Center on their Community Health Needs Assessment (CHNA). The Partnership was able, at no cost, to add human services questions to the CHNA. The end result will be that human services will have an updated Needs Assessment which will be used to drive our planning efforts for all of our human services agencies as well as for the Block Grant.

$28,000 is requested by Fulton County Family Partnership and $3,647 will support the county's Human Services Administration office.

Other HSDF Expenditures – Non-Block Grant Counties Only

If you plan to utilize HSDF for Mental Health, Intellectual Disabilities, Homeless Assistance or Drug and Alcohol, please provide a brief description of the use and complete the chart below.

Category	Cost Center Utilized	Estimated Individuals	Planned HSDF Expenditures
Mental Health			

Intellectual Disabilities			
Homeless Assistance			
Drug and Alcohol			

Note: Please refer to Appendix C -2, Planned Expenditures for reporting instructions.

APPENDIX C-1 : BLOCK GRANT COUNTIES
HUMAN SERVICES PROPOSED BUDGET AND INDIVIDUALS TO BE SERVED

Directions:	Using this format, please provide the county plan for allocated human services expenditures and proposed numbers of individuals to be served in each of the eligible categories.
1.	**Estimated Individuals**: Please provide an estimate in each cost center of the number of individuals to be served. An estimate must be entered for each cost center with associated expenditures.
2.	**HSBG Allocation**: Please enter the county's **total** state and federal HSBG allocation for each program area (MH, ID, HAP, CWSG, D&A, and HSDF).
3.	**HSBG Planned Expenditures**: Please enter the county's planned expenditures for HSBG funds in the applicable cost centers. The Grand Totals for HSBG Planned Expenditures and HSBG Allocation must equal.
4.	**Non-Block Grant Expenditures**: Please enter the county's planned expenditures **(MH, ID, and D&A only)** that are **not** associated with HSBG funds in the applicable cost centers. *This does not include Act 148 funding or D&A funding received from the Department of Drug and Alcohol.*
5.	**County Match**: Please enter the county's planned match amount in the applicable cost centers.
6.	**Other Planned Expenditures**: Please enter in the applicable cost centers, the county's planned expenditures not included in the DHS allocation (such as grants, reinvestment, etc.). Completion of this column is optional.
7.	**County Block Grant Administration**: Please provide an estimate of the county's administrative costs for services **not included** in MH or ID Services.
	NOTE: Fields that are greyed out are to be left blank.

■ Please use FY 15-16 primary allocation less the one-time Community Mental Health Services Block Grant funding for the Housing Initiative for completion of the budget.

■ The department will request your county to submit a revised budget if, based on the budget enacted by the General Assembly, the allocations for FY 16-17 are significantly different than FY 15-16. In addition, the county should notify the Department via email when funds of 20% or more are moved between program categoricals, (i.e., moving funds from MH Inpatient into ID Community Services).

County:	1. ESTIMATED INDIVIDUALS SERVED	2. HSBG ALLOCATION (STATE & FEDERAL)	3. HSBG PLANNED EXPENDITURES (STATE & FEDERAL)	4. NON-BLOCK GRANT EXPENDITURES	5. COUNTY MATCH	6. OTHER PLANNED EXPENDITURES
MENTAL HEALTH SERVICES						
ACT and CTT						
Administrative Management	43		18,071		468	
Administrator's Office			58,470		1,567	
Adult Developmental Training						
Children's Evidence-Based Practices						
Children's Psychosocial Rehabilitation						
Community Employment	1		3,243		87	
Community Residential Services	1		44,453		1,191	
Community Services	245		54,085		1,449	
Consumer-Driven Services						
Emergency Services	4		1,191		32	
Facility Based Vocational Rehabilitation						
Facility Based Mental Health Services						
Family Support Services	1		403		11	
Housing Support Services						
Mental Health Crisis Intervention	124		59,715		1,600	
Other						
Outpatient	42		139,873		3,522	
Partial Hospitalization						
Peer Support Services	3		5,331		143	
Psychiatric Inpatient Hospitalization						
Psychiatric Rehabilitation						
Social Rehabilitation Services	12		29,549		792	
Target Case Management	21		14,231		381	
Transitional and Community Integration						
TOTAL MENTAL HEALTH SERVICES	497	436632	428615	0	11243	0

APPENDIX C-1 : BLOCK GRANT COUNTIES
HUMAN SERVICES PROPOSED BUDGET AND INDIVIDUALS TO BE SERVED

County:	1. ESTIMATED INDIVIDUALS SERVED	2. HSBG ALLOCATION (STATE & FEDERAL)	3. HSBG PLANNED EXPENDITURES (STATE & FEDERAL)	4. NON-BLOCK GRANT EXPENDITURES	5. COUNTY MATCH	6. OTHER PLANNED EXPENDITURES
INTELLECTUAL DISABILITIES SERVICES						
Administrator's Office			55,669		318	
Case Management	3		1,541		41	
Community-Based Services	18		16,106		432	
Community Residential Services	0		0			
Other	0		0			
TOTAL INTELLECTUAL DISABILITIES SERVICES	21	95707	73316	0	791	0
HOMELESS ASSISTANCE SERVICES						
Bridge Housing						
Case Management						
Rental Assistance	285		24,000			
Emergency Shelter						
Other Housing Supports						
Administration						
TOTAL HOMELESS ASSISTANCE SERVICES	285	14389	24000		0	0
CHILD WELFARE SPECIAL GRANTS SERVICES						
Evidence-Based Services	28		29,925		1,496	
Promising Practice						
Alternatives to Truancy	131		40,500		4,050	
Housing						
TOTAL CWSG SERVICES	159	70425	70425		5546	0

APPENDIX C-1 : BLOCK GRANT COUNTIES
HUMAN SERVICES PROPOSED BUDGET AND INDIVIDUALS TO BE SERVED

County:	1. ESTIMATED INDIVIDUALS SERVED	2. HSBG ALLOCATION (STATE & FEDERAL)	3. HSBG PLANNED EXPENDITURES (STATE & FEDERAL)	4. NON-BLOCK GRANT EXPENDITURES	5. COUNTY MATCH	6. OTHER PLANNED EXPENDITURES
DRUG AND ALCOHOL SERVICES						
Case/Care Management						
Inpatient Hospital						
Inpatient Non-Hospital	4		8,628			
Medication Assisted Therapy						
Other Intervention	265		7,000			
Outpatient/Intensive Outpatient	12		9,886			
Partial Hospitalization						
Prevention			4,750			
Recovery Support Services						
TOTAL DRUG AND ALCOHOL SERVICES	281	28514	30264	0	0	0
HUMAN SERVICES DEVELOPMENT FUND						
Adult Services	47		9,400			
Aging Services						
Children and Youth Services						
Generic Services						
Specialized Services	55		18,000			
Interagency Coordination			31,647			
TOTAL HUMAN SERVICES DEVELOPMENT FUND	102	50000	59,047		0	0
7. COUNTY BLOCK GRANT ADMINISTRATION			10000			
GRAND TOTAL	1345	695667	695667	0	17580	0

**Appendix D
Eligible Human Services Cost Centers**

Mental Health

For further detail refer to Cost Centers for County Based Mental Health Services Bulletin (OMHSAS-12-02), effective July 1, 2012.

Administrative Management

Activities and administrative functions undertaken by staff in order to ensure intake into the county mental health system and the appropriate and timely use of available resources and specialized services to best address the needs of individuals seeking assistance.

Administrator's Office

Activities and services provided by the Administrator's Office of the County MH Program.

Adult Development Training (ADT) – Adult Day Care

Community-based programs designed to facilitate the acquisition of prevocational, behavioral activities of daily living, and independent living skills.

Assertive Community Treatment (ACT) Teams and Community Treatment Teams (CTT)

SAMHSA-recognized Evidence Based Practice (EBP) delivered to individuals with serious mental illness (SMI) who have a Global Assessment of Functioning (GAF) score of 40 or below and meet at least one other eligibility criteria (psychiatric hospitalizations, co-occurring mental health and substance abuse disorders, being at risk for or having a history of criminal justice involvement, and a risk for or history of homelessness).

Children's Evidence Based Practices

Practices for children and adolescents that by virtue of strong scientific proof are known to produce favorable outcomes. A hallmark of these practices is that there is sufficient evidence that supports their effectiveness.

Children's Psychosocial Rehabilitation Services

Activities designed to assist a child or adolescent (e.g., a person aged birth through 17, or through age 21 if enrolled in a special education service) to develop stability and improve capacity to function in family, school and community settings. Services may be delivered to the child or adolescent in the home, school, community or a residential care setting.

Community Employment and Employment Related Services

Employment in a community setting or employment-related programs, which may combine vocational evaluation, vocational training and employment in a non-specialized setting such as a business or industry.

Community Residential Services

8

Care, treatment, rehabilitation, habilitation, and social and personal development services provided to persons in a community based residential program which is a DHS-licensed or approved community residential agency or home.

Community Services

Programs and activities made available to community human service agencies, professional personnel, and the general public concerning the mental health service delivery system and mental health disorders, in order to increase general awareness or knowledge of same.

Consumer-Driven Services

Services that do not meet the licensure requirements for psychiatric rehabilitation programs, but which are consumer-driven and extend beyond social rehabilitation services.

Emergency Services

Emergency related activities and administrative functions undertaken to proceed after a petition for voluntary or involuntary commitment has been completed, including any involvement by staff of the County Administrator's Office in this process.

Facility Based Vocational Rehabilitation Services

Programs designed to provide paid development and vocational training within a community-based, specialized facility (sheltered workshop) using work as the primary modality.

Family-Based Mental Health Services

Comprehensive services designed to assist families in caring for their children or adolescents with emotional disturbances at home.

Family Support Services

Services designed to enable persons with serious mental illness (SMI), children and adolescents with or at risk of serious emotional disturbance (SED), and their families, to be maintained at home with minimal disruption to the family unit.

Housing Support Services

Services provided to mental health consumers which enable the recipient to access and retain permanent, decent, affordable housing, acceptable to them.

Mental Health Crisis Intervention Services

Crisis-oriented services designed to ameliorate or resolve precipitating stress, which are provided to adults or children and their families who exhibit an acute problem of disturbed thought, behavior, mood or social relationships.

Other Services

Activities or miscellaneous programs which could not be appropriately included in any of the cited cost centers.

Outpatient

Treatment-oriented services provided to a consumer who is not admitted to a hospital, institution, or community mental health facility for twenty-four hour a day service.

Partial Hospitalization

Non-residential treatment services licensed by the Office of Mental Health & Substance Abuse Services (OMHSAS) for persons with moderate to severe mental illness and children and adolescents with serious emotional disturbance (SED) who require less than twenty-four hour continuous care but require more intensive and comprehensive services than are offered in outpatient treatment.

Peer Support Services

Refers specifically to the Peer Support Services which meet the qualifications for peer support services as set forth in the Peer Support Services Bulletin (OMHSAS 08-07-09), effective November 1, 2006.

Psychiatric Inpatient Hospitalization

Treatment or services provided an individual in need of twenty-four hours of continuous psychiatric hospitalization.

Psychiatric Rehabilitation

Services that assist persons with long-term psychiatric disabilities in developing, enhancing, and/or retaining: psychiatric stability, social competencies, personal and emotional adjustment and/or independent living competencies so that they may experience more success and satisfaction in the environment of their choice, and can function as independently as possible.

Social Rehabilitation Services

Programs or activities designed to teach or improve self-care, personal behavior and social adjustment for adults with mental illness.

Targeted Case Management

Services that provide assistance to persons with serious mental illness (SMI) and children diagnosed with or at risk of serious emotional disturbance (SED) in gaining access to needed medical, social, educational, and other services through natural supports, generic community resources and specialized mental health treatment, rehabilitation and support services.

Transitional and Community Integration Services

Services that are provided to individuals who are residing in a facility or institution as well as individuals who are incarcerated, diversion programs for consumers at risk of incarceration or institutionalization, adult outreach services, and homeless outreach services.

Intellectual Disability

Administrator's Office
Activities and services provided by the Administrator's Office of the County ID Program. The Administrator's Office cost center includes the services provided relative to the Administrative Entity Agreement, Health Care Quality Units (HCQU) and Independent Monitoring for Quality (IM4Q).

Case Management
Coordinated activities to determine with the individual what services are needed and to coordinate their timely provision by the provider and other resources.

Community Residential Services
Residential habilitation programs in community settings for individuals with intellectual disabilities.

Community Based Services
Community-based services are provided to individuals who need assistance in the acquisition, retention, or improvement of skills related to living and working in the community and to prevent institutionalization.

Other
Activities or miscellaneous programs which could not be appropriately included in any of the cited cost centers.

Homeless Assistance

Bridge Housing
Transitional services that allow individuals who are in temporary housing to move to supportive long-term living arrangements while preparing to live independently.

Case Management
Case management is designed to provide a series of coordinated activities to determine, with each individual, what services are needed to prevent the reoccurrence of homelessness and to coordinate their timely provision by administering agency and community resources.

Rental Assistance
Provides payments for rent, mortgage arrearage for home and trailer owners, rental costs for trailers and trailer lots, security deposits, and utilities to prevent and/or end homelessness or possible eviction by maintaining individuals and families in their own residences.

Emergency Shelter
Refuge and care services to persons who are in immediate need and are homeless; e.g., have no permanent legal residence of their own.

Other Housing Supports

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Other supportive housing services outside the scope of existing Homeless Assistance Program components for individuals and families who are homeless or facing eviction. An individual or family is facing eviction if they have received either written or verbal notification from the landlord that they will lose their housing unless some type of payment is received.

Child Welfare Special Grants (Services relevant to HSBG only)

Promising Practice

Dependency and delinquency outcome-based programs must include the number of children expected to be served, the expected reduction in placement, the relation to a benchmark selected by a county or a direct correlation to the county's Continuous Quality Improvement Plan.

Housing

Activity or program designed to prevent children and youth from entering out of home placement, facilitate the reunification of children and youth with their families, or facilitate the successful transition of youth aging out or those who have aged out of placement to living on their own.

Alternatives to Truancy

Activity or service designed to reduce the number of children referred for truancy, increase school attendance or improve educational outcome of student participants, increase appropriate advancement to the next higher grade level, decrease child/caretaker conflict, or reduce percentage of children entering out of home care because of truancy.

Evidence Based Programs

Evidence-based programs use a defined curriculum or set of services that, when implemented with fidelity as a whole, has been validated by some form of scientific evidence. Evidence-based practices and programs may be described as "supported" or "well-supported," depending on the strength of the research design. For FY 2016-17, the CCYA may select any EBP (including, but not limited to Multi-Systemic Therapy (MST), Functional Family Therapy (FFT), Multidimensional Treatment Foster Care (MTFC), Family Group Decision Making (FGDM), Family Development Credentialing (FDC), or High-Fidelity Wrap Around (HFWA)) that is designed to meet an identified need of the population they serve that is not currently available within their communities. A list of EBP registries, which can be used to select an appropriate EBP, can be found at the Child Information Gateway online at:
https://www.childwelfare.gov/topics/.

Drug and Alcohol

Care/Case Management

A collaborative process, targeted to individuals diagnosed with substance use disorders or co-occurring psychiatric disorders, which assesses, plans, implements, coordinates, monitors, and evaluates the options and services to meet an individual's health needs to promote self-sufficiency and recovery.

Inpatient Non-Hospital

Inpatient Non-Hospital Treatment and Rehabilitation
A licensed residential facility that provides 24 hour professionally directed evaluation, care, and treatment for addicted individuals in acute distress, whose addiction symptomatology is demonstrated by moderate impairment of social, occupation, and/or school functioning. Rehabilitation is a key treatment goal.

Inpatient Non-Hospital Detoxification
A licensed residential facility that provides a 24-hour professionally directed evaluation and detoxification of an addicted individual.

Inpatient Non-Hospital Halfway House
A licensed community based residential treatment and rehabilitation facility that provides services for individuals to increase self-sufficiency through counseling, employment and other services. This is a live in/work out environment.

Inpatient Hospital

Inpatient Hospital Detoxification
A licensed inpatient health care facility that provides 24 hour medically directed evaluation and detoxification of individuals diagnosed with substance use disorders in an acute care setting.

Inpatient Hospital Treatment and Rehabilitation
A licensed inpatient health care facility that provides 24 hour medically directed evaluation, care and treatment for addicted individuals with co-existing biomedical, psychiatric and/or behavioral conditions which require immediate and consistent medical care.

Outpatient/ Intensive Outpatient

Outpatient
A licensed organized, non-residential treatment service providing psychotherapy and substance use/abuse education. Services are usually provided in regularly scheduled treatment sessions for a maximum of 5 hours per week.

Intensive Outpatient
An organized non-residential treatment service providing structured psychotherapy and stability through increased periods of staff intervention. Services are provided in regularly scheduled sessions at least 3 days per week for at least 5 hours (but less than 10)

Partial Hospitalization
Services designed for those individuals who would benefit from more intensive services than are offered in outpatient treatment projects, but do not require 24 -hour inpatient care. Treatment consists of the provision of psychiatric, psychological and other types of therapies on

a planned and regularly scheduled basis at least 3 days per week with a minimum of 10 hours per week.

Prevention

The use of social, economic, legal, medical and/or psychological measures aimed at minimizing the use of potentially addictive substances, lowering the dependence risk in susceptible individuals, or minimizing other adverse consequences of psychoactive substance use.

Medication Assisted Therapy (MAT)

Any treatment for opioid addiction that includes a medication approved by the U.S. Food and Drug Administration for opioid addiction detoxification or maintenance treatment. This may include methadone, buprenorphine, naltrexone, or vivitrol.

Recovery Support Services

Services designed and delivered by individuals who have lived experience with substance-related disorders and recovery to help others initiate, stabilize, and sustain recovery from substance abuse. These services are forms of social support not clinical interventions. This does not include traditional 12 step programs.

Recovery Specialist
An individual in recovery from a substance-related disorder that assists individuals gain access to needed community resources to support their recovery on a peer to peer basis.

Recovery Centers
A location where a full range of Recovery Support Services are available and delivered on a peer to peer basis.

Recovery Housing
A democratically run, self-sustaining and drug-free group home for individuals in recovery from substance related disorders.

Human Services Development Fund / Human Services and Supports

Administration

Activities and services provided by the Administrator's Office of the Human Services Department.

Interagency Coordination

Planning and management activities designed to improve the effectiveness of county human services.

Adult Services

Services for adults (a person who is at least 18 years of age and under the age of 60, or a person under 18 years of age who is head of an independent household) include: adult day care, adult placement, chore, counseling, employment, home delivered meals, homemaker, housing, information and referral, life skills education, protective, service planning/case management, transportation, or other service approved by DHS.

Aging

Services for older adults (a person who is 60 years of age or older) include: adult day care, assessments, attendant care, care management, congregate meals, counseling, employment, home delivered meals, home support, information and referral, overnight shelter/supervision, personal assistance service, personal care, protective services- intake investigation, socialization/recreation/ education/health promotion, transportation (passenger), volunteer services or other service approved by DHS.

Children and Youth

Services for individuals under the age of 18 years; under the age of 21 years who committed an act of delinquency before reaching the age of 18 years or under the age of 21 years who was adjudicated dependent before reaching the age of 18 years and while engaged in a course of instruction or treatment requests the court to retain jurisdiction until the course has been completed and their families include: adoption service, counseling/intervention, day care, day treatment, emergency placement, foster family care (except room & board), homemaker, information & referral, life skills education, protective and service planning.

Generic Services

Services for individuals that meet the needs of two or more populations include: adult day care, adult placement, centralized information and referral, chore, counseling, employment, homemaker, life skills education, service planning/case management, and transportation services.

Specialized Services

New services or a combination of services designed to meet the unique needs of a specific population that are difficult to meet with the current categorical programs.

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PROOF OF PUBLICATION

STATE OF PENNSYLVANIA, COUNTY OF FULTON, ss:

_____Jamie Greathead_____, being duly sworn, deposes and says: that The Fulton County News was established in 1899, that it is a weekly newspaper of general circulation, published weekly, as defined by the Act of Assembly approved May 16, 1929, P.L. 1929, page 784, and that its place of business is McConnellsburg Borough, Fulton County, Pennsylvania, and that the attached printed notice is a copy of the legal advertisement, exactly as printed in the said publication in its issue of_____6-23-16_____.

That the affiant is not interested in the subject matter of the advertisement or advertising and that I, _____Jamie Greathead_____, am the publisher of The Fulton County News and that all allegations of the statement as to the time, place and character of publication are true.

Sworn to and subscribed before me this _23_

day of ___June___, A.D., 20 _16_

My commission expires _____MY COMMISSION EXPIRES FIRST MONDAY IN JANUARY 2018

PUBLIC HEARING NOTICE

The Fulton County Commissioners will hold two public hearings on the planned use of 2016-17 Human Services Block Grant funds in Fulton County. The first hearing will be held on Tuesday, June 28, 2016, at 10:30 a.m. in the conference room of the Fulton County Services for Children offices at 219 N. Second St., Suite #201, McConnellsburg, Pa. The second hearing will be held on Tuesday, July 5, 2016 at 10:00 a.m. in the conference room of the Fulton County Services for Children offices. The block grant consists of seven funding streams and allows counties the flexibility to decide where the money is needed most. Those funding streams are: Mental Health Community Programs, Intellectual Disabilities, Community Base, County Child Welfare Special Grants, Homeless Assistance Program, Act 152, Behavioral Health Services Initiative and Human Services Development Fund. Questions and comments, both written and/or oral, are invited and welcomed. Also, if you are unable to attend either hearing or wish to make oral comments or questions, you may make special arrangements by calling 717-485-3553.

County of Fulton
Board of Commissioners
Stuart L. Ulsh, Chair
Rodney L. McCray
Larry R. Lynch

Run 1t as legal notice in the June 23 edition

Please provide proof of publication and tearsheet and bill to Fulton County Human Services Administration, 219 N. Second St., Suite #201, McConnellsburg, PA 17233
Please do <u>not</u> include on the county's bill, but bill the above separately.

Summary of Public Hearing Comments:

FIRST PUBLIC HEARING

Tuesday, June 28, 2016 @10:30 a.m. in the Fulton County Services for Children conference room

15 in attendance (Attendance sheet attached)

This public hearing was held just prior to a Fulton County Human Services Block Grant Planning Committee meeting and was attended by 15 members of the Planning Committee and the public.

An overview presentation on the Block Grant was given by Jean Snyder and those in attendance were given the opportunity to ask questions and/or give comments. A copy of the draft 2016-17 HSBG plan was distributed to planning team members several days prior to the hearing and a draft copy was also available at the public hearing.

Although there were no questions or comments on requested changes/amendments, a discussion was held on the presentation which included:

- o How the Block Grant began and Fulton County as a pilot joinder county;
- o Funding streams included in the Block Grant;
- o Flexibility of the Block Grant;
- o Members of the Block Grant Planning Team;
- o Reasons to become a Block Grant county;
- o Block grant allocations for Fulton County by funding stream;
- o Summary of how funds have been spent in past years;
- o Which programs benefit most by the Block Grant;
- o How funding decisions are made:
- o Review of the FY 16-17 Block Grant Plan and allocations.

Fulton County
Human Services Block Grant

FIRST PUBLIC HEARING
TUESDAY, JUNE 28, 2016
10:30 AM
FULTON COUNTY SERVICES FOR CHILDREN
CONFERENCE ROOM
ATTENDANCE

NAME	REPRESENTING
James Snyder	Human Services Administrator
Deborah Dresser Perdew	citizen /public
Paula Steele	Center for Community Action
Dan Miller	Probation
Deb Hulland	Fulton Area Agency on Aging
Mary Mencher	Fulton Catholic Mission
Julie Dorey	FC Family P-ship
Pete Lynch	Commr. Dorey
Doug Temple	Business office
Stud Lensch	FF MHIDEI
Elen Ott	FCFP
Stuart Ulsh	Commissioner
Rodney McCray	Commissioner
Beverly Ragan	family Rep.
Barry Munch	MHA

Summary of Public Hearing Comments:

SECOND PUBLIC HEARING

Tuesday, July 5, 2016 @10:00 a.m. in the Fulton County Services for Children conference room

9 in attendance (Attendance sheet attached)

This public hearing was held just prior to a Fulton County Human Services Block Grant Planning Committee meeting and was attended by 9 members of the Planning Committee, the County Commissioners and the Human Services Administrator.

An overview presentation on the Block Grant was given by Jean Snyder and those in attendance were given the opportunity to ask questions and/or give comments. A copy of the draft 2016-17 HSBG plan was distributed to planning team members several days prior to the hearing and a draft copy was also available at the public hearing.

Although there were no questions or comments on requested changes/amendments, a discussion was held on the presentation which included:

- o Funding streams included in the Block Grant;
- o Flexibility of the Block Grant;
- o Members of the Block Grant Planning Team;
- o Block grant allocations for Fulton County by funding stream;
- o Summary of requests for Block Grant funding for 2016-17
- o Which programs benefit most by the Block Grant;
- o How funding decisions are made:
- o Review of the FY 16-17 Block Grant Plan and allocations.

Fulton County
Human Services Block Grant

SECOND PUBLIC HEARING
TUESDAY, JULY 5, 2016
10:00 AM
FULTON COUNTY SERVICES FOR CHILDREN
CONFERENCE ROOM
ATTENDANCE

NAME	REPRESENTING
1. Jean E. Snyder	Fulton Co. Human Svcs. Admin.
2. Shalom Black	Franklin Co. Grants
3. Steve Nevada	FF MH IDEI
4. Rick Wynn	FC. HS
5. Dan Miller	Probation
6. April Brown	FIF Drug & Alcohol
7. Stuart Ulsh	Commissioner
8. Rodney Mcbay	''
9. Pete Lynch	''
10.	
11.	
12.	
13.	
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15.	
16.	
17.	

Fulton County Family Partnership

TITLE: Executive Development Director

SUPERVISION: BOARD OF DIRECTORS

Position Classification: Full-Time - Exempt Employee - Salary

JOB SUMMARY:
The Executive Development Director shares responsibility as Administrators of the Fulton County Family Partnership with Executive Program Director. Together, the Board, Executive Development Director and the Executive Program Director assure Fulton County Family Partnership's relevance to the community, the accomplishment of the organization's mission and vision, and the accountability of Fulton County Family Partnership to its diverse constituents.

The Board delegates responsibility for the management and day-to day operations of the organization to the Executive Development Director and Executive Program Director who have authority to carry out these responsibilities, in accordance with the direction and policies established by the Board.

The Executive Development Director and Executive Program Director provide direction and assist the Board as it carries out its governance functions.

Duties performed include but are not limited to the following:
1. **Planning and Setting Objectives**
    * Oversee and manage the financial performance and human resource functions of the organization to ensure sustainability of operations.
    * Oversee and manage the community collaborative portion of the agency which is responsible for planning and management activities designed to improve the effectiveness of county human services. Including oversight of the Community Mobilizer position responsible for human services planning.
    * Implement fiscal management and control systems to assure that the Board has appropriate and adequate information to meet its fiduciary responsibilities.
    * Direct the development of program financial plans and budgets including all operating costs, in-kind, capital and extraordinary expenditures.
    * Submit or cause to be submitted to Board of Directors an annual budget showing in detail anticipated revenues and expenditures.
    * Pursue additional grant and funding opportunities consistent with the mission and in order to expand capacity to meet the needs of the community and to increase the financial sustainability of organization.
    * Facilitate the development and implementation of an overall strategic plan. Ensure that the goals and objectives presented in grant proposals and business plan are consistent with the aims of the long-term strategic plan. Develop organizational policies and direct activities to ensure objectives are met.
    * Prepare information to be considered by Board on the determination of policy and ensure compliance with federal and state regulations.
    * Maintain strict confidentiality as legally defined and in accordance with policy.

2. Organizing, Evaluating and Monitoring
    * Provide monthly comparisons of actual results of operations to the budget and recommend any changes as required.
    * Monitor budget expenditures and prepare as needed budget revisions.
    * Prepare and assist in annual audit. Work to resolve audit exceptions and implement management recommendations.
    * Maintain inventory and property records.
    * Serve as the primary liaison with funding agency regarding fiscal issues. Ensure that all required fiscal reporting requirements are met in full.

- Establish administrative policies and procedures that assure efficient program operations and compliance with all contractual terms, conditions and obligations.

3. Motivating and Communicating

- Serve as liaison between the organization, grantee programs, and community agenda.
- Create an atmosphere where upward communication is valued and encouraged.
- Promote good public relations by serving on boards and committees, participating in community activities, and speaking to church or civic groups about organization as requested.
- Serve as advocate for organization.

4. Personnel Management

- Administer personnel policies, benefits, and procedures as established by Board.
- Keep personnel informed of pertinent policies and procedures affecting the department and/or their jobs.
- Ensure compliance with all federal and state laws concerning hiring and promotion.
- Coordinate staff recruitment and retention.
- Review and make recommendations on personnel actions such as employment, salary review, retention, promotion, suspension, discipline, and termination.
- Be responsible and accountable to the Board of Directors, keeping them informed of pertinent matters relating to operations.

Qualifications/Specific Requirements:

The Executive Program Director will be thoroughly committed to Fulton County Family Partnership's mission. All candidates should have proven leadership, coaching and relationship management experience. Concrete demonstrable experience and other qualifications include:

- Bachelor's degree in related field and/or at least 10 years of senior management experience
- Track record of effectively leading an outcomes-based organization and staff
- Unwavering commitment to quality programs and data-driven program evaluation
- Excellence in organizational management with the ability to coach staff, manage, and develop high-performance teams, set and achieve strategic objectives, and manage a budget.
- Past success working with a board of directors with the ability to cultivate board member relationships
- Strong marketing, public relations, and fundraising experience with the ability to engage a wide range of stakeholders and cultures
- Strong written and verbal communication skills
- Action-oriented, entrepreneurial, adaptable, and innovative approach to business planning.
- Passion, idealism, integrity, positive attitude, mission-driven, and self-directed
- Able to read, write and speak English in an understandable manner.
- Must possess management, supervisory and leadership ability to work with professional and nonprofessional staff.
- Ability to plan, organize, develop and interpret component goals, objectives, policies and procedures necessary to provide quality services.
- Must function independently and with flexibility, personal integrity, and the ability to work effectively with families, personnel and support agencies.
- Must be able to relate to and work with a variety of people with differing abilities and perspectives.
- Employment contingent on clear Child Abuse and Criminal Record Clearances (PA and FBI) reports.
- Must have an initial physical exam and TB test and repeat physical bi-annually.
- Must have a valid driver's license and personal vehicle available for use.
- Must maintain current CPR and First Aid.

Working Conditions

- Works in FCFP Administrative office and in community settings.
- Sits, stands, bends, lifts and moves intermittently during working hours.
- Works flexible hours as needed to meet needs of organization.
- Must possess sight/hearing senses or use prosthetics that will enable these senses to function adequately so that the requirements for this position can be fully met.
- Must be able to lift, push, pull and move a minimum of twenty five pounds.

FCFP reserves the right to modify, interpret or apply this job description in any way the company desires. This job description in no way implies that these are the only duties to be performed by the employee occupying this position. This job description is not an employment contract, implied or otherwise. The company remains and "At-Will" employer. Qualified employees who require reasonable accommodations to perform the essential function of the position should notify the Board of Directors

Job Description

Job Title: Community Mobilizer/Prevention Coordinator

Classification: Permanent Full Time Salaried – Non-exempt

Education: Bachelor's degree related to Human Development, Juvenile Justice, Social Work or other related field and/or equivalent experience. Preference for previous grant management and/or supervisory experience.

Reports to: Executive Director and Family Partnership Board

Overview: Position is responsible for initiating, implementing and evaluating county-wide human services planning. The position will be responsible for facilitating the local collaboration of health and human service agencies (Partners) to provide an integrated seamless, comprehensive and easily accessed network of services   They will be responsible for linking school, public and private agencies, churches, businesses, civic organizations and individuals in an effort to reduce community risk factors and enhance protective factors to provide optimal environment for children, youth and families. Additionally, they are expected to lead the collaborative in identifying, instituting and promoting new practices and procedures that improve service outcomes.

Specific responsibilities:
1. Oversee the development and implementation of Human Service Collaborative (Partners) in Fulton County
2. Assist Key Leaders to achieve the outcomes as designated by the Human Service Collaborative (Partners)
3. Coordinate data collection including PAYS
4. Participate in professional development activities related to Human Service Collaborative (Partners) and prevention practices
5. Participate in and actively contribute to community groups to advocate and champion the Collaborative process
6. Research, develop and/or write grant applications to assist with securing sustainable funding sources for collaborative goals and prevention programs.
7. Provide direct prevention programming including outcomes data collection
8. Assist with needs assessment and outcome tracking for the Human Services Block Grant
9. Assist with Community Health Needs Assessment (CHNA).   Maintain and monitor goals and objectives related to county human services as established by the CHNA plan.
10. Other duties as directed by Executive Director

Required Knowledge, Skills and Abilities:
1. Skills in management, including effective communication both oral and written
2. Organizational skills in developing successful community relations and network with county leaders (county government, community leaders, families, health care professionals and educators)
3. Strong leadership ability, supervisory and organizational skills.
4. Ability to work independently, make decisions and recommendations and organize work load with minimal supervision
5. Willingness to travel, give presentations and attend meetings at various hours including evening and weekends as required
6. Ability to utilize technology for program management and presentations to include work processing, database and spreadsheets.

This is not a comprehensive list of responsibilities, but rather an indication of some of the key concepts that must be achieved.

In compliance with ADA, the employer will provide reasonable accommodations to qualified individuals with disabilities and encourages both prospective employees and incumbents to discuss potential accommodations with the Employer.

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This is not intended to be a complete list of every duty, rather an example of how the responsibilities are shared by the three identified staff persons. Separation of Job Responsibilities as related to the County Human Services Collaborative (Partners):

Executive Development Director	Executive Program Director	Community Mobilizer/Prevention Coordinator
Oversee and manage the financial performance and human resource functions of the organization to ensure sustainability of operations.	Initiate prevention planning discussion with community providers	Assist with coordination and monitor effectiveness of evidence-based prevention programs being delivered by various providers in Fulton County. Provide summary reports to coalition to assist in evaluation of effectiveness of efforts and progress towards achieving community goals/priorities.
Pursue additional grant and funding opportunities consistent with the mission and in order to expand capacity to meet the needs of the community and to increase the financial sustainability of organization.	Assist community providers in the development of outcomes collection & analysis plans for evidence-based programs in Fulton.	Maintain an awareness of new developments in programming and evaluate their appropriateness for integration into the services. Serve as resource to coalition providing suggestions of programs specifically designed to target community priorities
Monitor budget expenditures and prepare as needed budget revisions.	Ensure communication between prevention providers and coalition to assist in the analysis of effective programming practices	Assist in the preparation of grant applications as requested to aid in achieving coalition goals.
Lead the community conversation around prevention planning at monthly Partner meetings and ensure compliances with grant funders.	Make recommendations to coalition about effective programs and funding priorities	Regularly provide coalition with updated listing of community resources related to prevention to include activities: Promising Practices, Polices and Good Work.
Facilitate the development and implementation of an overall community prevention plan. Ensure that the goals and objectives presented in grant proposals are consistent with the aims of the long-term plan.	Guide coalition discussions to focus on identification of the of the most effective delivery of prevention programs	Develop, implement, and maintain an ongoing evaluation system to ensure quality control of all programs. Provide coalition with feedback summary of programs and progress towards reaching community outcomes.
Serve as the primary liaison with funding agency regarding fiscal and program issues. Ensure that all required fiscal and program reporting requirements are met in full.	Chair PA Youth Survey Resource Committee – schedule, plan, facilitate and summarize committee work and provide info back to full coalition	Attend and participate in CCC Committee meetings and special committees to obtain guidance, provide leadership and coordinate the activities of these groups.
Communicate with collaborative group progress, action steps and needs of community	Guide and supervise Community Mobilizer to ensure effective coalition efforts	Prepare monthly report to be distributed to FC Partnership (Coalition) with program outcomes and progress on goals.
Coordinate vision of Key Leaders with work of FC Partnership Collaborative members	Oversee completion of necessary program reports to PCCD and/or other funders to ensure compliance with funding requirements.	Coordinate administration of PAYS in county schools to provide coalition with ongoing data about community needs and monitor progress towards the identified outcomes.
Attend and participate in monthly collaborative meetings – guide and assist efforts to achieve goals in community plan	Attend and participate in monthly collaborative meetings – guide and assist efforts to achieve goals in community plan	Assist in monthly update to Community Action Plan and provide to coalition.
		Attend Regional meetings and trainings as available
		Communicate to collaborative members and general public the work and successes of the collaborative
		Attend and participate in monthly collaborative meetings – guide and assist efforts to achieve goals in community plan