

COUNTY OF BUCKS

HUMAN SERVICES BLOCK GRANT

FISCAL YEAR 2016 - 2017

Robert G. Loughery, Chairman, Commissioner
Charles H. Martin, Vice-Chairman, Commissioner
Diane M. Ellis-Marseglia, LCSW, Commissioner

Re-submitted
September 6, 2016

**COUNTY OF BUCKS HUMAN SERVICES BLOCK GRANT
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PART I: COUNTY PLANNING PROCESS

Critical Stakeholder Groups:

The Bucks County Executive Planning Team for the Human Services Block Grant is comprised of the following individuals: Division of Human Services Director, Division of Human Services Deputy Director, Administrator of Mental Health/Developmental Programs (MH/DP), MH/DP Fiscal Manager and Assistant Directors, Director for Behavioral Health, Deputy Director for Mental Health, Deputy Director for Intellectual Disability, Children and Youth Director, Children and Youth Quality Assurance Manager, Children and Youth fiscal staff, Bucks County Drug and Alcohol Commission (SCA) Director and Assistant Director along with fiscal staff, and community housing Provider leadership from the Bucks County Opportunity Council.

Throughout the past year, the Executive Planning team worked with critical stakeholder groups who supported the planning process through feedback and data collection. These groups included consumer and family groups such as PRO-ACT, service providers from every Department, and individual Department's (Children and Youth, MH/DP, ID, Drug/Alcohol) Board of Directors (which includes constituents from legal, education, recovery support, finance, consumers, youth, medical etc.). The Mental Health (MH) and intellectual Disabilities (ID) planning committees including the Community Family Satisfaction Team (CFST) and providers were invited to provide feedback on our performance and outcomes. Information collected by the CFST drives how the Department enhances, supplements, or eliminates programs as data indicates. The Community Support Program (CSP) also has input into the MH plan.

Additional input for Block Grant planning across systems involved participation by various Advisory Councils, Bucks County Drug/Alcohol Board of Directors, BC Department of Corrections, Juvenile Probation, Housing Providers, the Recovery community, Peer Specialists, Magellan Behavioral Health, and Bucks County Behavioral Health Services. From these groups input is not solicited in one particular meeting, but throughout the year in the form of feedback on our performance related to services provided through block grant funding.

Additionally in 2015-16, Bucks County initiated a Housing Advisory Board (HAB) strategic planning process that brought together various stakeholders from across Bucks County. Represented on the HAB were over 20 individuals from a cross section of stakeholders that included County Government, Providers, and Community representatives. This work consisted of looking at the strengths and needs of Bucks County's housing continuum, resources, and system. As part of the HAB process, over 100 other individuals participated in listening sessions, focus groups, surveys, and community meetings that contributed to that work. Although the final documentation from the HAB is not yet completed, the discussions and draft HAB recommendations have provided significant input into the housing components of the Block Grant Plan for 2016-17 as both the Human Services Director and Director of the Bucks County Opportunity Council are on the HAB.

Further, the Bucks County Commissioners and the County Chief Operating Officer were informed throughout the process and completed a final review of the allocations and recommendations from the

PART I: COUNTY PLANNING PROCESS

Executive Planning Team. The resolution for the Block Grant allocation was presented and approved publically at the Bucks County Commissioner's meeting held on July 6, 2016.

Finally, as will be detailed further in this plan, Bucks County continued to exceed minimum requirements and held three public hearings specific to 2016-17 Block Grant Planning during the development of this plan. Input from the public continues to provide insight into our systemic strengths and areas needing improvement.

How stakeholders were provided with an opportunity for participation in the planning process:

The stakeholder groups listed above were provided opportunities to participate in the planning process through various methods depending upon their role and interest in participation.

For County of Bucks staff, there are regular meetings held within the county that review service processes and outcomes that impact Block Grant planning including our: Executive Children's Steering Committee, Children's Coordination Steering Committee, Children's Roundtable, and our Transition Age Youth (TAY) Subcommittee of the Children's Coordination Committee. We also hold regular Department Head meetings where we look at our organizational goals and discuss strategic plans along with "day to day" type of updates. Internal County collaborations such as our joint Forensic Team (Behavioral Health, MH/DP, Drug/Alcohol Commission, Adult Probation, Juvenile Probation, and the Director of Corrections) occur on a regular basis.

During the 2015-16 year, the Bucks County Behavioral Health staff (inclusive of MH/DP, Behavioral Health Department, Drug and Alcohol Commission, Bucks County Division of Human Services, and Magellan Behavioral Health) participated in a strategic planning process meant to analyze systemic strengths and gaps to support service prioritization and needs assessment moving forward. While this strategic planning process continues, information gathered throughout this process has impacted programmatic planning for the coming year relative to our Behavioral Health system.

Additionally, this past year, the Division of Human Services has taken a more active role with the County's Criminal Justice Advisory Board (CJAB) starting a Human Services Subcommittee that has been looking at the intersections of human services and criminal justice and opening discussions about potential service needs for the coming year.

Beyond these internal meetings that impact planning throughout the year, efforts are made by the Director of Human Services to attend Board meetings for each of the Block Grant related Departments to accept input on the Board's observations on system performance. The Division Director also meets regularly with community providers who are the conduit of services from Block Grant funding to the community in order to hear input on services, systemic issues, and community needs and trends.

We also work closely with consumer groups as mentioned above, but most specifically we use CFST outcome data to help us identify areas needing improvement in our human services system. In addition,

PART I: COUNTY PLANNING PROCESS

our Children and Youth department sends out client surveys that provide an opportunity for family members to give feedback on the services received during the course of their involvement with the county.

During 2015, Bucks County's Division of Human Services partnered with the United Way of Bucks County to complete our "Community Conversations" project. These conversations were meant as a way to engage our local community members in an open ended conversation about community needs and services in Bucks County. While no Block Grant funds were used to support this project, it is important to note that the input received from the community is relevant and continues to aid us in our planning.

How the County intends to use funds to provide services to its residents in the least restrictive setting appropriate to their needs.

Beyond these internal committees, community connections serve as our primary way of assuring County Departmental collaboration that work to assure services are provided to residents in the least restrictive setting and in a setting most appropriate to their needs. Individual departments are also charged with this responsibility. Recently both our Children and Youth Services and our Behavioral Health Department added additional positions within their Quality Assurance (QA) units. Although not specifically part of the Block Grant funding, this point is shared to highlight our commitment to high quality services in the least restrictive environments as a value of Bucks County.

In addition, we have been moving to integrate services and function with a consumer centric approach as much as possible. One example of this is this year we began a joint effort between our child welfare and drug/alcohol agencies for a "Mobile Engagement Service", where referrals from Children and Youth will result in mobile supports and services from our Drug and Alcohol Commission that can meet clients at their location. This joint effort has been considered at great success at helping reach individuals in the community and we are looking to begin an evaluation of the program with a University partner to help document community outcomes from this effort.

Community engagement and internal collaboration helps guarantee services provided in the county maintain the value of providing services in the least restrictive setting that meets the recipient's needs. The committees and leadership staff are empowered to consider individual cases where a resident's needs may not be being met within a particular program so that the situation may be resolved through program coordination and collaboration, seeking a shift in funding if needed between programs to meet a need. We are held accountable to that standard by our community partners and stakeholders.

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

Substantial programmatic changes using Human Services Block Grant funding were implemented in 2015-16 based on the prior years' experiences and community input. The Division of Human Services is happy to report that this current year's outcomes (2015-16) have reinforced those changes as positive and will generally continue at the current level for 2016-17.

PART I: COUNTY PLANNING PROCESS

Primary among these changes was a shifting of funds towards our Drug and Alcohol services allocation. This shift was in response to the opioid epidemic that is being experienced across Pennsylvania. This shift in funding allowed Bucks County to be more financially responsive to the need in 2015-16 and as of the writing of this document it can be reported that no county residents were denied or even delayed in obtaining approved treatment based on lack of available funding. It is our plan to continue that level of funding in 2016-17 for Drug and Alcohol services.

Programmatic shifts for 2016-17 being made as a result of last year's outcomes include making changes for the use of some of our Housing funds. Whereas our overall housing funding allocations will remain the same as last year, analysis has determined that funding certain transitional housing programs is more expensive with similar outcomes as compared to rapid rehousing or other housing supports (including diversion). At this time, the Human Services Division is anticipating a series of recommendations from the Bucks County Housing Advisory Board (expected during the summer of 2016) that will support a recommendation of shifting funding away from expensive long term transitional housing toward more effective and less expensive interventions. As the Human Services Division works closely with Bucks County's Department of Housing and Community Development the Homeless Assistance Services funding will be allocated with an eye towards less expensive yet just as effective supports and services. Please see the Homeless Assistance Services section for the 2016-17 explanation of allocations.

Additionally, smaller programmatic changes are detailed throughout this document and are based on outcomes, impact, and lessons learned as detailed in the individual sections of Part IV. For example, based on minimal documented impact, we are not renewing our Credential for Strengths Based Family Workers program. We are proposing use of those funds within our Children and Youth category to expand our Healthy Families America program which has positive documented outcomes.

Finally, of note is the County's request to use some funding under the category of "Interagency Coordination" to support increased use of information technology for county planning and management activities specifically related to outcome analysis. This addition to our Block Grant plan will be further detailed in the Human Services Development Fund section.

PART II: PUBLIC HEARING NOTICE

Prior to our public hearings, a public hearing notice was posted in the Bucks County Courier Times and The Intelligencer, the two primary local newspapers as per the Sunshine Act. The notice announced that the County was holding public hearings on May 17th at 3:00 in Bensalem PA, May 18th at 1:00 in Doylestown PA and May 24th at 5:30 in Quakertown PA. Quakertown, Bensalem, and Doylestown were chosen as public hearing locations as they geographically represent the northern and southern parts of the county as well as the County seat and are easily accessible. The times were varied for the meetings in hopes of increasing community participation and allowing people to choose among mid-day, late-afternoon, and early evening meetings.

Flyers about the public hearings were distributed through our County Departments to the various service providers in the community to share with consumers. The public notice included an invitation to provide comments in writing via email to the Department of Human Services (email address provided) for anyone who preferred to communicate using this method or was unable to attend any of the public hearings.

Bucks County provided several avenues for making the public aware of the opportunity to provide input into 2016-17 Block Grant planning. Notice of the public hearings was posted on the official County website. The 2015-16 Block Grant Plan and an executive summary of services provided during the past through the block grant funding remained on our County website Human Services' page throughout the year.

The public hearing in Bensalem on June 4th was facilitated by Bucks County's Department of Human Services Director and included participation from the Deputy Director of Children and Youth, the Director of the Bucks County Drug and Alcohol Commission, The Director of Bucks County's Mental Health/Developmental Programs office, and the Director of the Bucks County Opportunity Council. The meeting was attended by 4 members of the community along with several departmental staff.

The meeting opened with introductions and each individual department presenting to attendees information related to their particular section of the Block Grant. Previous years efforts and accomplishments were reviewed and initial plans for 2016-17 were provided. Question and answer time was provided following each presentation as well as at the end of the program.

For this particular public hearing, there were no questions from attendees related to the block grant plan for Bucks County. Each question was answered and one individual had follow up appointments set with one of our provider agencies.

The public hearing in Doylestown on May 18th was facilitated by Bucks County's Department of Human Services Director and included participation from the Children and Youth Director, the Assistant Director of the Bucks County Drug and Alcohol Commission, The Director for Bucks County's Mental Health/Developmental Programs office and the Deputy Director of the Bucks County Department of

PART II: PUBLIC HEARING NOTICE

Human Services. Opportunity Council was unable to attend so the Director of Human Services presented on their behalf. The public hearing was attended by 6 members of the community along with additional County staff members.

As with the previous public hearing, attendees were given the opportunity to ask questions following department presentations and at the completion of the overall agenda. At this hearing, discussion was robust and covered a wide range of topics including how the Mental Health system responds to crisis, concerns about lack of available housing in the county, concerns for medical care for individuals in the county prison, truancy, and needle exchange programs. Input was provided around the need to increase low income housing options the need for the Mental Health system to perform complete evaluations follow crisis situations with individuals.

As mentioned earlier, Bucks County held a 3rd public hearing in Quakertown, PA on May 24th at 5:30 PM to allow the opportunity for professionals or community members who preferred an evening meeting to attend and provide input into our 2016-17 Block Grant planning process.

3 community members along with several county staff attended the hearing and heard presentations from our Children and Youth Director, the Director of Bucks County Drug and Alcohol Commission, the Director of Bucks County Mental Health/Developmental Programs, the Director of Bucks County Opportunity Council and the Deputy Director for the Division of Human Services. The Director of Human Services facilitated the discussion.

Following the presentations, there were a number of questions that focused on services to our citizens. The questions prompted discussion regarding recovery houses, the cost of placements for individuals with intellectual disabilities, residential housing for individuals with mental health concerns, transportation concerns, and questions regarding how the medical/hospital community is responding to babies who are born addicted to heroin.

The public hearings were each recorded and are available to the public should someone be interested in hearing the presentations.

In addition, Bucks County Division of Human Services did receive two comments related to Block Grant planning via email. These comments each related specifically to experiences the individual community member had with one the County's provider agencies. The comments which identified the particular individuals have been addressed with the provider agency and we are assuring the concerns raised regarding these individuals have been reviewed and addressed.

Proof of publication of the ads and sign-in sheets for each public hearing are included in this submission.

PUBLIC NOTICES

You can read these and other public notices by visiting TheIntell.com. Just click on our "PUBLIC NOTICES" link in the upper left hand side of your screen!

Classified call center 1-866-938-3010

Public Notices

The Upper Moreland School District, Montgomery County, Pennsylvania, solicits sealed bids for the following project:

Upper Moreland High School Bus Transportation Project
Sealed bids, addressed to Business Manager/Board Secretary must be clearly marked on the outside with bidder's name and name of project bid, and are due at the Upper Moreland Township School District Administration Building, 2900 Terwood Road, Willow Grove, PA 19090 by 11:00/AM (prevailing time) on June 1, 2016 at which time they will be publicly opened and read. Faxed bids will not be accepted.

Sealed bids shall be accepted by a certified check or bid bond in the amount of ten percent (10%) of the bid price. Bids must be payable to the Upper Moreland School District. Checks or bonds will be returned to unsuccessful bidders after the contract has been awarded, or the bids rejected. The successful bidder's check or bond will be returned when his contract has been properly completed. In case the successful bidder fails to enter into contract within five (5) days after notification of acceptance of bid, said check or bond shall be forfeited to the School District. All bids must be accompanied by Non-collusion Affidavit, Contractor's Qualification Statement, and bid Security in accordance with the Bid Documents. Bids must remain in force for sixty (60) days after the date of the bid opening, and may be rejected any time prior to the expiration of said date.

The successful bidder will be required to furnish a Performance Bond, Payment Bond and Maintenance bond in an amount equal to 100% of the contract price. Surety shall be satisfactory to the School District, and shall be included in the Contractor's bid amount. Specifications will be available for pick up at the Upper Moreland Administration Building, 2900 Terwood Road, Willow Grove, PA 19090. The cost of the Bid Documents is \$25.00 per set. This cost is non-refundable. Checks shall be made payable to Upper Moreland School District. Bid Documents will be available May 18, 2016, at the business Office of Upper Moreland School District.

Public Notices

ESTATE NOTICE
Township of Warminster, Bucks County PA

LETTERS TESTAMENTARY on the above Estate have been granted to the undersigned, who request all persons having claims or demands against the estate of the decedent to make known the same and all persons indebted to the decedent to make payment without delay to:

BRIAN M. BALDWIN, EXECUTOR
c/o Randall J. McDowell, Esq.
221 Noble Plaza
801 Old York Rd.,
Jenkintown, PA 19046
or his Attorney
RANDAL J. MCDOWELL
221 Noble Plaza
801 Old York Rd.,
Jenkintown, PA 19046
31 A 29, M 6, 13

ESTATE NOTICE

ESTATE OF IRVIN M. BUCKMAN, DECEASED. Late of the Borough of Doylestown, Bucks County, PA.

LETTERS TESTAMENTARY on the above Estate have been granted to the undersigned, who request all persons having claims or demands against the estate of the decedent to make known the same and all persons indebted to the decedent to make payment without delay to:

LOIS BUCKMAN DANIELS
c/o Lois A. Daniels, Esquire
104 E. Butler Ave., Chalfont, PA 18914 or to her Attorney:
BRIAN R. PRICE
SEMANOFF ORMSBY,
GREENBERG & TORCHIA, LLC
140 E. Butler Ave.,
Chalfont, PA 18914
31 A 29, M 6, 13

ESTATE NOTICE

ESTATE OF PATRICIA CALTABIANO, DECEASED. Late of the Township of Newtown, Bucks County, PA.

LETTERS OF ADMINISTRATION on the above Estate have been granted to the undersigned, who request all persons having claims or demands against the estate of the decedent to make known the same and all persons indebted to the decedent to make payment without delay to:

Public Notices

ESTATE NOTICE

Estate of ELEANORA HARM, late of Pennel, Bucks County, PA, Deceased.
LETTERS TESTAMENTARY on the above estate have been granted to the undersigned. All persons indebted to said estate are requested to make immediate payment, and those having legal claims to present the same without delay to:

Co-Executors:
William Harm, Jr.
951 Broadview
Langhorne, PA 19047 and
Jennifer Maroun
6 Morning Side Court
West Grove, PA 19380
or Attorney:
Francis Gerard Janson, Esquire
P.O. Box 667
Langhorne, PA 19047
31 M 6, 13, 20

ESTATE NOTICE

ESTATE OF ELAINE MARIE KROUT, DECEASED. Late of the Township of Warminster, Bucks County, PA.

LETTERS TESTAMENTARY on the above Estate have been granted to the undersigned, who request all persons having claims or demands against the estate of the decedent to make known the same and all persons indebted to the decedent to make payment without delay to:

CLINTON KROUT, EXECUTOR
c/o Jeffrey C. McCullough, Esq.,
16 N. Franklin St., Ste. 300
P.O. Box 853, Doylestown, PA 18001 or to the Attorney:
JEFFREY C. MCCULLOUGH
BOND & MCCULLOUGH
16 N. Franklin St., Ste. 300
Doylestown, PA 18001
31 A 29, M 6, 13

ESTATE NOTICE

ESTATE OF KENNETH T. MCCAULEY, DECEASED. Late of Warminster, Bucks County, PA.
LETTERS TESTAMENTARY on the above Estate have been granted to the undersigned, who request all persons having claims or demands against the estate of the decedent to make known the same and all persons indebted to the decedent to

Public Notices

ESTATE NOTICE

ESTATE OF PEGGY MONI, DECEASED. Late of the Township of Newtown, Bucks County, PA.
LETTERS TESTAMENTARY on the above Estate have been granted to the undersigned, who request all persons having claims or demands against the estate of the decedent to make known the same and all persons indebted to the decedent to make payment without delay to:

DEBORAH KENNEDY, EXECUTOR,
2082 Langhorne Yardley Rd.,
Langhorne, PA 19047.
OR to her Attorney:
ELIZABETH B. PLACE
SKARLATOS ZONARICH LLC
17 S. Second St., 8th Fl.
Harrisburg, PA 17101-2039
31 M 6, 13, 20

ESTATE NOTICE

ESTATE OF STEVEN Z. RAWES, DECEASED. Late of the Borough of Doylestown, Bucks County, PA.

LETTERS TESTAMENTARY on the above Estate have been granted to the undersigned, who request all persons having claims or demands against the estate of the decedent to make known the same and all persons indebted to the decedent to make payment without delay to:

MELISSA V. BOND, EXECUTRIX
16 N. Franklin St., Ste. 300,
18001 or to her Attorney
MELISSA V. BOND,
BOND & MCCULLOUGH
16 N. Franklin St., Ste. 300,
Doylestown, PA 18001
31 A 29, M 6, 13

ESTATE NOTICE

Public Notices

NOTICE OF HEARINGS
COUNTY OF BUCKS
HUMAN SERVICES
DEPARTMENT

County of Bucks Human Services Department will hold three (3) public hearings on the Human Services Block Grant Plan - FY 2016-2017.
Public input encouraged.
Tuesday, May 17, 2016
3:00 - 5:00 PM
Large Meeting Room
Bensalem Branch Library
3700 Hulmeville Road
Bensalem, PA 19020-4449

AND
Tuesday, May 24, 2016
6:30 - 7:00 PM
Meeting Rooms A-B
Quakertown Branch Library
401 West Mill Street
Quakertown, PA 18951-1248
(The Bucks County Free Library does not endorse or advocate the views of any group using our meeting or conference rooms).

AND
Wednesday, May 18, 2016
1:00 - 3:00 PM
Community Room - 1st floor
Bucks County
Administration Building
55 East Court Street
Doylestown, PA 18001
For additional information, or unable to attend please forward written comment to email: Jerubin@buckscounty.org or call: 215-348-6203 or 215-348-6201.
11 M 13

NOTICE OF PUBLIC SALE OF PERSONAL PROPERTY

Notice is hereby given that the undersigned will sell, to satisfy lien of the owner, at public sale by competitive bidding via www.storage-treasures.com on May 24th 11:30AM at the Extra Space Storage facility located at 390 North Broad Street Doylestown, PA 18001
Phone-215-345-4582
Fax -215-668-4282

Public Notices

listed below at location indicated:
Extra Space Storage
500 Jacksonville Road
Warminster, PA 18974
215-672-2168
Date of Sale:
May 24th at 12:00 PM

B375 Darryl Braxton:
Household items
D126 Doris Cain:
Household items
C218 Doris Cain:
Household items
C216 Jay Cochran:
Household items
B257 Matthew Amendola:
Household items

The auction will be held and verified at www.storage-treasures.com. Purchases must be made with cash only and paid at the above mentioned location. The successful bidder takes possession of the personal property.
21 M 13, 20

NOTICE OF PUBLIC SALE OF PERSONAL PROPERTY

Notice is hereby given that Extra Space Storage will sell at public auction, to satisfy the lien of the owner, personal property described below belonging to those individuals listed below at location indicated:
Extra Space Storage,
329 West Butler Avenue,
Chalfont, PA 18914
215-822-9172
Date of Sale:
Tuesday, May 24, 2016 at 12:30 PM
Elizabeth Curtiss
Unit #34

The personal goods stored therein include household goods.
Elizabeth Curtiss
Unit #71
The personal goods stored therein include household goods.
Elizabeth Curtiss
Unit #74
The personal goods stored therein include household goods.
Christina Sanokusky
Unit #407
The personal goods stored therein include household goods.
The auction will be listed and advertised on www.storage-treasures.com

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Bucks County, SS.

Ad Content Proof

RECEIVED
JUN 20 2016
HUMAN SERVICES

BUCKS COUNTY PURCHASING DEPT
ADMINISTRATION BLDG
DOYLESTOWN, PA 18901

3-007612006
0006961555-01

Ann Clark being duly affirmed according to law, deposes and says that he/she is the Legal Billing Co-ordinator of the COURIER TIMES INCORPORATED, Publisher of The Bucks County Courier Times, a newspaper of general circulation, published and having its place of business at Levittown, Bucks County, Pa; that said newspaper was established in 1910; that securely attached hereto is a facsimile of the printed notice which is exactly as printed and published in said newspaper on

May 13, 2016

and is a true copy thereof; and that this affiant is not interested in said subject matter of advertising; and all of the allegations in this statement as to the time, place and character of publication are true.



LEGAL BILLING CO-ORDINATOR

Affirmed and subscribed to me before me
this 16th day of June 2016 A.D.



COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
Patricia Vigneau, Notary Public
Tullytown Boro. Bucks County
My Commission Expires April 30, 2019
MEMBER PENNSYLVANIA ASSOCIATION OF NOTARIES

NOTICE OF HEARINGS

**COUNTY OF BUCKS
HUMAN SERVICES
DEPARTMENT**

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11M 13

RECEIVED
JUN 20 2016
HUMAN SERVICES

Bucks County, SS.

BUCKS COUNTY PURCHASING DEPT
ADMINISTRATION BLDG
DOYLESTOWN, PA 18901

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11 M 13

RECEIVED
MAY 16 2016
HUMAN SERVICES

3-007612006

0006961549-01

Ann Clark being duly affirmed according to law, deposes and says that he/she is the Legal Billing Co-ordinator of the CALKINS NEWSPAPER INCORPORATED, Publisher of The Intelligencer, a newspaper of general circulation, published and having its place of business at Doylestown, Bucks County, Pa. and Horsham, Montgomery County, Pa.; that said newspaper was established in 1886; that securely attached hereto is a facsimile of the printed notice which is exactly as printed and published in said newspaper on

.....
May 13, 2016
.....

and is a true copy thereof; and that this affiant is not interested in said subject matter of advertising; and all of the allegations in this statement as to the time, place and character of publication are true.



LEGAL BILLING CO-ORDINATOR

Affirmed and subscribed to me before me this 13th day of May 2016 A.D.


COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
Patricia Vigneau, Notary Public
Tullytown Boro. Bucks County
My Commission Expires April 30, 2019
MEMBER, PENNSYLVANIA ASSOCIATION OF NOTARIES

PUBLIC NOTICE

**NOTICE OF HEARINGS
COUNTY OF BUCKS
HUMAN SERVICES
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PUBLIC HEARING
**HUMAN SERVICES
BLOCK GRANT PLAN –
FY 2016-2017**

MAY 17, 2016
3:00 – 5:00 PM

BENSALEM BRANCH LIBRARY
LARGE MEETING ROOM
3700 HULMEVILLE ROAD
BENSALEM, PA 19020

IF UNABLE TO ATTEND PLEASE FORWARD WRITTEN COMMENT TO :
JERUBIN@BUCKSCOUNTY.ORG



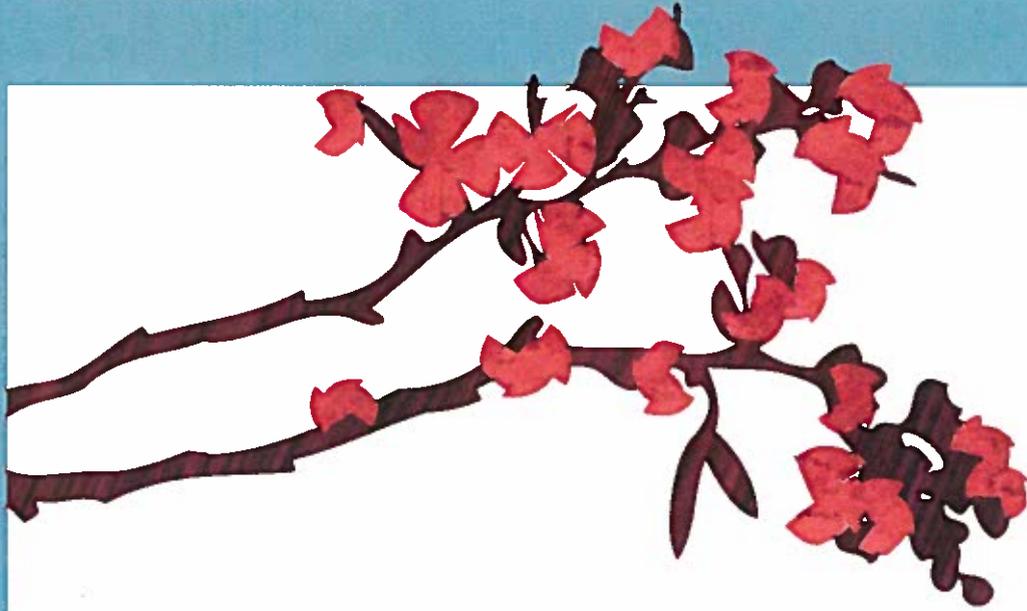
PUBLIC HEARING
**HUMAN SERVICES
BLOCK GRANT PLAN –
FY 2016-2017**

MAY 18, 2016

1:00 – 3:00 PM

BUCKS COUNTY ADMINISTRATION BUILDING
COMMUNITY ROOM – 1ST FLOOR
55 EAST COURT STREET
DOYLESTOWN, PA 18901

IF UNABLE TO ATTEND PLEASE FORWARD WRITTEN COMMENT TO:
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PUBLIC HEARING
**HUMAN SERVICES
BLOCK GRANT PLAN –
FY 2016-2017**

MAY 24, 2016
5:30 – 7:00 PM

QUAKERTOWN BRANCH LIBRARY
MEETING ROOMS A+B
401 WEST MILL STREET
QUAKERTOWN, PA 18951

IF UNABLE TO ATTEND PLEASE FORWARD WRITTEN COMMENT TO:
JERUBIN@BUCKSCOUNTY.ORG

Bucks County Human Services Block Grant Public Hearing

Bensalem Branch Library 3700 Hulmeville Road, Bensalem PA

May 17 3:00 PM

Agenda

- Introduction (Jon Rubin)
- Department Reports
 - Bucks County Drug and Alcohol Commission (Diane Rosati)
 - Bucks County Department of Mental Health/Developmental Programs (Donna Duffy Bell)
 - Bucks County Children and Youth (Marge McKeone)
 - Housing Assistance Program (Erin Lukoss)
 - Human Services Development Funds (Jon Rubin)
- Questions/comments from attendees
- Wrap up (Jon Rubin)

Next meetings

Wednesday May 18th

1:00 PM

Bucks County Administration Building Community Room

55 E. Court Street, Doylestown PA

1st floor community meeting room

Tuesday, May 24, 2016

5:30 PM

Meeting Rooms A+B

Quakertown Branch Library

401 West Mill Street

Quakertown, PA 18951

COUNTY OF BUCKS
HUMAN SERVICES BLOCK GRANT
PUBLIC HEARING - MAY 17, 2016
BENSALEM LIBRARY 3:00 - 5:00 PM

ROLE

P = Provider
A = Advocate
C = Consumer
O = Other

TELEPHONE

NUMBER

E-MAIL ADDRESS

ORGANIZATION

NAME

<u>NAME</u>	<u>ORGANIZATION</u>	<u>E-MAIL ADDRESS</u>	<u>TELEPHONE</u> <u>NUMBER</u>	<u>ROLE</u>
Margie Rivera	BCDAC, etc	merivera@ bucks county.org		
Doug Oberreit	Penndel MHC	doberreit@penndel.mhc.org		P
Dawn Sander	BC MH/DP	DISORDER@BUCKSCOUNTY.ORG		
Marge McKeene	BCCA YASSA	MEMCKEME@BUCKSCOUNTY.ORG	215-348-6936	
Luft Sander	Madisonville	MSchickling@BSMpenndel.mhc.org	215-908-8265	O
Kristen Peak	penndel MHC	kpeak@penndel.mhc.org	267-587-2300	P
Wendy Farnsworth	Bucks MH/DP	wfarnsworth@buckscounty.org		
Lisa Clanton	KA	lclanton@kabe.org	215-757-6161	P
Ann Oby	BCOC	alukoss@bcoc.org	215-345-8177	
Chris Edwards	Bucks County PFO	cedwards@buckscounty.org		O

Bucks County Human Services Block Grant Public Hearing

Bucks County Administration Building – Community Room, 1st Floor

55 East Court Street, Doylestown, PA 18901

May 18, 2016 @ 1:00 PM

Agenda

- Introduction (Jon Rubin)
- Department Reports
 - Bucks County Drug and Alcohol Commission (Margie Rivera)
 - Bucks County Department of Mental Health/Developmental Programs (Donna Duffy Bell)
 - Bucks County Children and Youth (Lynne Rainey)
 - Housing Assistance Program
 - Human Services Development Funds (Jon Rubin)
- Questions/comments from attendees
- Wrap up (Jon Rubin)

Next meetings

Tuesday, May 24, 2016

5:30 PM

Meeting Rooms A+B

Quakertown Branch Library

401 West Mill Street

Quakertown, PA 18951

Bucks County Human Services Block Grant Public Hearing

Quakertown Branch Library – Meeting Rooms A + B

401 West Mill Street, Quakertown, PA 18951

May 24, 2016 @ 5:30 PM

Agenda

- Introduction (Jon Rubin)
- Department Reports
 - Bucks County Drug and Alcohol Commission (Diane Rosati)
 - Bucks County Department of Mental Health/Developmental Programs (Donna Duffy Bell)
 - Bucks County Children and Youth (Lynne Rainey)
 - Housing Assistance Program (Erin Lukoss)
 - Human Services Development Funds (Jon Rubin)
- Questions/comments from attendees
- Wrap up (Jon Rubin)

Rubin, Jonathan E.

From:
Sent: Tuesday, May 24, 2016 1:03 PM
To: Rubin, Jonathan E.

Hi, about the grant distribution. I would like to see some money put to a program for the dual diagnosed. Homelessness should come first, cause everyone deserves to have a roof over their head, even if they are on disability. My daughter has been going to penndel mental health for over 15 years. She is currently homeless and dual diagnosed. I called Penndel to help her with a place to stay. They are supposed to go see her where she is renting a room- that is not a safe environment for her. She has been on probation for possession. I have custody of her two children. I don't feel like anyone follows thru with her. She did have a case manager once, and she told me that didn't answer her phone or wasn't at her apartment. Don't they know that she is mentally ill and can't take care of herself! She has been hospitalized ever year. She has been in rehab twice. Nothing has helped!

Harris, Victoria L.

From: Rubin, Jonathan E.
Sent: Wednesday, June 01, 2016 4:31 PM
To: Harris, Victoria L.
Subject: FW: Follow up

Jon Rubin
Director of Human Services
Bucks County Courthouse
Administration Building
55 E. Court Street
Doylestown, PA 18901
215-348-6203 (office)
267-372-0671 (cell)
jerubin@buckscounty.org

Please note, my Bucks County Email Domain has changed to @buckscounty.org

-----Original Message-----

From:
Sent: Wednesday, June 01, 2016 11:41 AM
To: Rubin, Jonathan E. <jerubin@buckscounty.org>
Subject: Follow up

Hello John,

I spoke with you yesterday regarding my 21 year old grandson, a special needs guy due to social anxiety, and will have a more specific diagnosis when he sees a psychiatrist as required by the Office of Vocational Rehabilitation, to apply to their more aggressive program to place in a work environment.

His mentor with Access, only spends 2 hours a week with , and my grandson needs more guidance and support toward getting employment. His mother just found out that a psychiatric evaluation is required as part of the application process, so it may be some time before we have it all together to actually apply. At present, he has a psychologist evaluation, and is taking Lexapro which is helping him to be more alert and motivated.

From my perspective as grandmother, this is a weak area of support for special needs young adults who are capable of working, but lack steady guidance and support to land them a job. A Grant would certainly help to fund a stronger base of support.

Thank you.



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- [Human Services](#)
- [Row Offices](#)
- [Parks and Recreation](#)
- [Bucks County Election Information](#)
- [ADA](#)

Government Human Services

The division of Human Services is established to oversee the County administered programs delivering social services and mental wellness to residents of Bucks County. These programs include:

- [Area Agency on Aging](#)
- [Behavioral Health System](#)
- [Children & Youth](#)
- [Mental Health/Developmental Programs](#)

The Human Services Divisional Office also has administrative oversight of three quasi-county agencies, which include:

- [Bucks County Workforce Investment Board](#)
- [Drug and Alcohol Commission](#)
- and the [Opportunity Council](#)



The Human Services Divisional Office administers the Human Service Development Fund Grants (HSDF), the Homeless Assistance Program (HAP), and the Behavioral Health Services (BHS) under the Health Choices Program. It is staffed with an Administrator, Deputy Administrator, a Policy and Planning Specialist, and an Administrative Assistant.

The Divisional Office works collaboratively with public and private agencies to identify barriers and gaps in services, coordinate programming for efficient and effective service delivery and advocates with legislators and government offices for adequate funding to meet the needs of County residents.

The Bucks County Commissioners, along with the Bucks County Human Services Division, are compiling a "wish list" of needs for local Non-Profit Organizations. For more information, [click here to go to the Non-Profit Wish List Page.](#)

[PA Resources for Families](#) - Information for all stages of a healthy life for you and your family.

[Bucks County Life Program](#) - Bucks County Now is the Time Healthy Transitions Partnership. The purpose for the Healthy Transitions Partnership is to develop and coordinate services and support for youth and young adults (16 - 25 years old) with, or at risk, of serious mental illness.

The Divisional Office is generally open Monday through Friday from 8:30 AM to 5:00 PM. [Click here for a sampling of Health and Human Services Volunteer Opportunities.](#)

[Special Needs Registry](#) - Bucks, Chester and Montgomery Counties have jointly developed this registry to allow citizens with special needs and their associates an opportunity to provide information to emergency response agencies, so emergency responders can better plan to serve them in a disaster or other emergencies.

[Bucks County Crisis Intervention Team \(CIT\) Task Force](#)

[Code Blue Information](#)

[Code Blue - Commissioner Diane Marseglia on Comcast NewsChannel, November 12, 2009](#)

Division of Human Services
Jonathan E. Rubin
Director, Human Services
Phone: 215-348-8201
Fax: 215-348-8204

**NOTICE OF HEARINGS
COUNTY OF BUCKS
HUMAN SERVICES DEPARTMENT**

County of Bucks Human Services Department will hold three (3) public hearings on the Human Services Block Grant Plan - FY 2016-2017.

Public input encouraged
Tuesday, May 17, 2016
3:00 - 5:00 PM
Large Meeting Room
Bensalem Branch Library
3700 Hulmeville Road
Bensalem, PA 19020-4449

AND

Tuesday, May 24, 2016
5:30 - 7:00 PM
Meeting Rooms A+B
Quakertown Branch Library
401 West Mill Street
Quakertown, PA 18951-1248

(The Bucks County Free Library does not endorse or advocate the views of any group using our meeting or conference rooms).

AND

Wednesday, May 18, 2016
1:00 - 3:00 PM
Community Room - 1st floor
Bucks County Administration Building
55 East Court Street
Doylestown, PA 18901

For additional information or unable to attend please forward written comment to email: jsr42@buckscounty.org
Or call: 215-348-8203 or 215-348-8201

[Human Services Block Grant Final Fiscal Year 2015-2016](#)

[Human Services Block Grant Final Fiscal Year 2015-16 Appendix G-1](#)

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BUCKS COUNTY COMMISSIONERS ROBERT G. LOUGHERY, CHAIRMAN, CHARLES H. MARTIN, VICE CHAIRMAN, AND DANE M. ELLIS-MARSEGUA, L.C.S.W.

Bucks County Administration Building
55 East Court Street
Doylestown, PA 18901
Phone (Toll free within Bucks County) 1-888-942-8257
(All other callers) 215-348-8000
Email: webmaster@co.bucks.pa.us

Bucks County Justice Center
100 North Main Street
Doylestown, PA 18901
Phone (Toll free within Bucks County) 1-888-942-8250
(All other callers) 215-348-8000
Email: webmaster@co.bucks.pa.us

The Official Site of
Bucks County, Pennsylvania

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Philadelphia Web Design by [Perfection Design](#)

PART III: MINIMUM EXPENDITURE LEVEL

No categorical area has been eliminated from the Bucks County 2016-17 Human Services Block Grant Plan. Please see part IV for details.

MENTAL HEALTH SERVICES

Bucks County continues to focus on improving its service delivery of mental health (MH) supports in the most recovery-oriented and coordinated approach. Bucks County continues to elicit stakeholder involvement through the Community Support Program (CSP) committees. CSP informs multiple county initiatives and has taken a strong advocacy role this past year.

This past year, Bucks County has strengthened the commitment to its collaborative efforts with the Criminal Justice System. Multiple activities and initiatives are occurring to divert an individual with a behavioral health challenge. We continue to implement Crisis Intervention Training to all municipalities in order to support highly trained police departments that can handle challenges that present in the community. We've also developed a training curriculum for Correctional Officers that can support individuals in the Bucks County Correctional Facility. We anticipate that our training efforts will allow for the ability to divert individuals to treatment rather than incarceration and also a more timely release from incarceration.

Bucks County continues to focus on enhancing and developing its community support services and decreasing our reliance on long-term treatment options, such as Residential Treatment Facilities (RTF) and Norristown State Hospital (NSH). We anticipate some opportunity for the expansion of services through the American Civil Liberties Union Lawsuit, which the Office of Mental Health and Substance Abuse Services is currently involved. Individuals in long-term treatment have greater needs in order to transition successfully from highly structure, often locked settings to community based, voluntary treatment and supports.

Other priorities are delineated below and include the county's efforts to effect the increasing suicide rate, services that support the transition age youth (TAY) population and the need for safe, affordable housing. We have also previously focused many initiatives on training and education, especially in the areas of case management, peer support and employment. This year we are focusing our training and education activities on residential support services.

In order to ensure stakeholder input, a meeting was held with each Consumer Support Program (CSP) committee. Each priority group was discussed and feedback was provided on strengths and needs for each group. The information from those meetings has been incorporated into the mental health section of the Block Grant. After meeting with the groups, themes were identified including the need for housing, peer support, and psychosocial rehabilitation as noted in the plan. Prior to the submission of the Block Grant, CSP again had an opportunity for additional input. CSP activities and initiatives are outlined in the mental health section of the plan.

a. Program Highlights

The MH portion of the Human Services Block Grant is divided into three sections, which include areas of focus that address the Prevention for Long-Term System Involvement, areas of focus that address Engagement Opportunities throughout the system and areas to address System Transformation (although there is much over-lap within the three sections).

MENTAL HEALTH SERVICES

Prevention for Long-Term System Involvement

This past year, we've seen much by way of prevention activities and strategies. There has been a lot of work with young adults involving the Now Is The Time: Healthy Transitions Grant. Young adults have taken an active role in addressing the issue of suicide and identifying ways to affect change.

We also anticipate that in this coming year we will see increased development supporting OMHSAS' involvement in the American Civil Liberties Union Lawsuit. Bucks County may have the opportunity to expand and enhance services in order to support individuals who receive or could potentially receive state hospitalization.

Below are some of the County's efforts to prevent Long-Term System Involvement:

Children's Services – The Child and Adolescent Service System Program (CASSP) in Bucks County has utilized a System of Care (SOC) model as the organizational philosophy and framework in creating clinical and natural supports. The SOC model involves partnership across county and private agencies, providers, families, and youth for the purpose of improving access and expanding the array of coordinated community-based, culturally competent services and supports for children and youth with a serious emotional disturbance and their families. The SOC approach has served as the conceptual and philosophical framework for systemic reform in children's behavioral health. In Bucks County, this is demonstrated through the development of our Integrated Children's Service Plan and the ongoing initiatives we have implemented for children, adolescents, and young adults. The intent of CASSP and the Children's CSSC efforts in Bucks has been to build and expand upon the progress achieved in addressing the MH needs of children, youth, and families. Through collaboration and comprehensive planning with key stakeholders, we strive to utilize resources, which reduce the impact of substance abuse and mental illness in our communities.

- **Now is the Time (NITT): Healthy Transitions** – The purpose of the Pennsylvania Healthy Transitions Partnership is to develop a coordinated and comprehensive approach to the provision of supports and services to address serious MH conditions, CODs, and risks for developing serious MH conditions among youth 16-25 years old, during the five year grant.

The concern to be addressed by the Pennsylvania Healthy Transitions Partnership is that youth and young adults with, or at risk of, serious mental illness are:

- not being identified
- not being engaged
- not given a voice in what they need/want
- not supported to navigate adult systems
- not taught how to create and/or access the necessary supports and services so that they can manage their mental health challenges and live full lives

The goals of the Pennsylvania Healthy Transitions Partnership include:

- Increase awareness about early indications of signs and symptoms for serious MH concerns
- Identify action strategies to use when a serious MH concern is detected
- Enhance peer and family supports for TAY; link existing and develop effective services and

MENTAL HEALTH SERVICES

- interventions for transition age youth/young adults (TAY-YA) and their families
- Develop coordinated care models that will address key life domains such as behavioral health services and supports, housing, employment, vocational training and higher education
- Develop models of service delivery that can be replicated across the Commonwealth

As a result of these goals, the County established three subcommittee workgroups to represent each target area of the Grant, which include community education and awareness, outreach to hard-to-reach and at-risk transition age youth, and coordinating care for transition age youth identified with a serious mental health condition.

The table below outlines each area that is addressed as a part of the grant and updates on initiatives that have occurred throughout the second year.

MENTAL HEALTH SERVICES

NOW IS THE TIME: HEALTHY TRANSITIONS WORK GROUPS AND INITIATIVES		
COMMUNITY EDUCATION & AWARENESS	OUTREACH TO THE HARD-TO-REACH AT-RISK TAY-YA	COORDINATING CARE FOR TAY-YA IDENTIFIED WITH A SERIOUS MENTAL HEALTH CONDITION
<p>Initiatives:</p> <p>Develop a Train-the-Trainer model for implementing Youth Mental Health First Aid (YMHFA) training on a county-wide basis.</p> <ul style="list-style-type: none"> - 26 Instructors graduated as trainers in July 2015 and subsequently began offering aider trainings throughout Bucks County. <p>Increase public awareness through community events:</p> <ul style="list-style-type: none"> - Efforts from the Coordinating Care subcommittee will address this focus through a countywide conference for those supporting TAY in June 2016. <p>Community education opportunities, to include: the NAMI Stride for MH Awareness; Kick-off event to raise awareness of the grant's goals and activities; Workshops related to COD issues, MH psychoeducation, early intervention, and resources.</p> <p>Partner with anti-stigma educational programs that offer presenters with lived experiences, to provide hopeful presentations in the schools.</p> <ul style="list-style-type: none"> - NITT partnered with NAMI's Ending the 	<p>Initiatives:</p> <p>Develop social media campaign. Include input from TAY-YA in developing marketing materials and creating social marketing plan.</p> <ul style="list-style-type: none"> - Social marketing plan is in development with input from the newly established Young Adult Advisory Board. <p>Offer COD training opportunities to enhance understanding and identification of TAY-YA with complex needs. Enhance Student Assistance Program (SAP) services.</p> <ul style="list-style-type: none"> - TAY conference scheduled in June 2016 will include a co-occurring focus. - Student Assistance Program will include co-occurring psychoeducational groups. <p>Increase awareness of community activities and programming geared toward TAY-YA. Create other peer-to-peer community based activities for enhanced social participation.</p> <ul style="list-style-type: none"> - Organized a Bring a Friend Youthopia community event was held in August 2015. Youth and providers to facilitate connections to other peers and community supports. 	<p>Initiatives:</p> <p>Develop a centralized referral process to link the child/adolescent and adult systems.</p> <ul style="list-style-type: none"> - Centralized referral form and process is in development by the Coordinating Care subcommittee. - Memorandum of Understanding will be created to work toward bridging the adult and children serving systems. <p>Expand peer support and leadership opportunities to TAY-YA. Increase parent peer support and leadership opportunities.</p> <ul style="list-style-type: none"> - Expansion of peer support through Bucks LIFE for both at risk and already identified youth. - Addition of a Family Support position to Bucks LIFE to support parents and other grant related activities. <p>Create a respite mentoring model for youth using TAY-YA respite for Independent Living and Life Skill enhancement.</p> <ul style="list-style-type: none"> - TAY Habilitative Respite Program began development in spring 2015 and has

MENTAL HEALTH SERVICES

<p>Silence program and their annual Stride for Mental Health Awareness Event, which will be occurring on May 21, 2016.</p>	<p>Identify at-risk youth through Bucks County Housing Group's (BCHG) Housing Link referrals. Increase housing support and resources.</p> <ul style="list-style-type: none"> - Working with the Housing Link to gather data on TAY and add mental health questions to their screening tool. <p>Enhance youth and family peer support.</p> <ul style="list-style-type: none"> - Increase CPS hours through the Bucks LIFE program to reach at risk youth who may not yet be identified. 	<p>begun serving individuals.</p> <p>Increase awareness of the TIP Model and enhance ways for various TAY-YA Providers to understand and support the unique needs of young adults.</p> <ul style="list-style-type: none"> - A county-wide conference is planned for June 2016, is based on provider priority needs and the grant goal areas, including community education and awareness. <p>Design and implement "Shared Living" for TIP participants.</p> <ul style="list-style-type: none"> - The Shared Living program has been implemented. <p>Expand access to individualized planning models, including a TAY-specific High Fidelity Family Teams. Build connections to adult system/resources.</p> <ul style="list-style-type: none"> - The HiFi TAY team has begun and is supporting young adults.
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MENTAL HEALTH SERVICES

- **Youth Mental Health First Aid (Y-MHFA)** – Y-MHFA has been fully implemented and Bucks County Department of Mental Health/Developmental Programs (MH/DP) added 26 new instructors from the Commonwealth of Pennsylvania to the Mental Health First Aid™ Team, following a successful instructor training session on July 20-24, 2015. Since the instructor training occurred, 25 trainings sessions and 260 individuals have successfully completed the 8-hour training. It is anticipated another 15 trainings will be offered by July 31, 2016 and will continue to support the training outreach and opportunities for professionals, para-professionals and community members. For the instructors, quarterly collaborative meetings are held to discuss overcoming any barriers and fully support the instructors as needed.
- **Shared Living** – The Shared Living model was implemented for individuals receiving support through the Access Services Transition to Independence Progress (TIP) model. Four individuals were placed in apartment living and there are two other individuals referred for this unique residential model. The Bucks County Housing Group, Inc. provides rental assistance and assists individuals in locating affordable housing, with the goal of decreasing rental support as individuals learn the skills to maintain their housing independently.
- **Bucks County Living in Family Environments (LIFE) Program** – The Bucks County LIFE Program provides information and referral for the entire county. Activities include providing resources related to family support such as collaborations, social networking pages, training resources, newsletters, training schedules, sibling support groups, social skills groups, and socialization events. Thus far in FY 15/16, over 240 families have been served by Bucks County LIFE. A fulltime Certified Peer Specialist (CPS) is employed by the LIFE Program. The role of the CPS is designed to provide direct support to youth by assisting them and guiding them in navigating the child/youth serving systems. The CPS also focuses on empowering and educating adolescents to work with the school and agencies that support them in order to gain skills to thrive within their community. The goal is to consistently provide CPS support to 20 youth. In FY 14/15, Bucks LIFE submitted a proposal to provide an additional 40-hour CPS position. This has occurred and currently the CPS has been expanded to support up to 20 youth. In addition to direct support, the CPS position has provided assistance for the social media development and tracking for the NITT: Healthy Transitions Grant. The goal is to improve outreach for at-risk youth. Currently, the CPS is actively working with fifteen identified youth and there is a waitlist of three individuals. Bucks LIFE is in the unique position to provide Administrative Case Management (ACM) for those on the waitlist for CPS services. Additionally, the ACM works with youth receiving Residential Treatment services and assists with complex cases.
- **Respite** – The Bucks County Respite Program is a service offered through Child and Family Focus, Inc. (C&FF) that provides short-term, temporary care to families who need an interval of relief from the daily challenges of caring for a child with an emotional, behavioral, and/or developmental need. Respite services are targeted to serve children, youth, and families with a high level of behavioral health needs and risk.

The program continues to benefit from Reinvestment funds, along with braided funding from the County Block Grant. The program operates to full capacity and the County strives to meet the needs of the target population, providing a valuable support model consistent with the CASSP principles and a SOC Model.

MENTAL HEALTH SERVICES

Families are eligible for service by living in Bucks County with a child aged 3-21 with a MH diagnosis. An assessment is conducted at the time of referral to determine the level of respite support needed. Families typically receive six months of continued respite services. These services include in or out-of-home care for a child by a trained and approved respite care provider under guidance and supervision of fulltime respite staff.

The program is fully implemented and employs two full-time Respite Coordinators for Bucks County, who operate under the guidance of a part-time supervisor, to support families and providers and recruit and train new respite providers. Part-time administrative support, a part-time intern and other additional staff persons assist with program responsibilities, including billing, marketing and screening potential respite providers. Funds were provided for the recruitment of respite care providers and to compensate client-specific in-home providers and out-of-home providers.

The program is targeted to serve the MA Eligible population, including those youth and families with a high level of behavioral health needs and risk. Approximately 99% of the families served in the respite program are HealthChoices eligible.

In 2015, the Bucks County Respite Program served 127 children from 105 families. In 2015, 741.45 units of respite were delivered, including 2922.25 hours of in-home respite, 27 overnight/out-of-home respites, and 650 hours of group respite in a community setting.

Respite is utilized in many ways. Caregivers were surveyed regarding how they use respite yielding the following results:

- 60% use respite to spend time with their spouse or partner
- 60% use respite to do their 'own thing' in the community
- 40% use respite to run errands without interruption
- 20% use respite to attend school or support group meetings
- 20% use respite for other purposes such as caring for an aging parent, or another family member who is chronically or seriously ill.

Group respite is made available in a community based setting to all qualifying children including; those on the wait list, those actively receiving traditional in-home or out-of-home respite care, and those children no longer receiving ongoing, 'traditional' respite care. In addition to providing families with an interval of relief from care-giving responsibilities, community respite events also offer qualifying children with the opportunity to engage in recreation with their peers and for providers to meet some of the children who are waiting to receive ongoing care.

Community respite events at "Pump it Up" in Chalfont were held monthly during 2015, with the exception of the month of March. In total, 37 children from 30 families participated in community respite events during 2015. The facility has closed and C&FF is looking for a new facility to host community respite events.

In FY 15/16, the "Independent Living Model" was offered for specialized respite care for TAY and young adults, ages 16-25. This model will utilize the Casey Life Skills Assessment to target areas of need. The identified individuals will develop an individualized goal plan which will be implemented over the course of in-home respite. Six individuals will be identified for the pilot and evaluate outcomes as part of the NITT: Healthy Transitions Grant. Currently, two individuals have been identified and referrals are being

MENTAL HEALTH SERVICES

sought out to reach the targeted outcomes. A personalized plan of care is developed and specific activities are completed during respite events to support skills acquisition aligned with the independent living skills goals identified in the youth's plan of care. The ongoing need for TAY Habilitative Respite services is assessed every three months and additional services are authorized as needed.

American Civil Liberties Union (ACLU) Lawsuit – In October 2015, the ACLU filed a lawsuit against the Commonwealth of Pennsylvania over alleged unconstitutional delays between a court's commitment order and hospitalization for treatment. They alleged that largely due to there being too few accessible beds at Norristown and Torrance State the wait for admission into a mental health facility was excessive. Placement options are the equivalent of treatment slots. They are treatment opportunities across the spectrum of necessary care, with most placements being in the community. While no new forensic hospital beds would be developed, the state has proposed focusing on individuals who are currently in the civil section of the state hospital. Individuals are to be discharged into the community and the beds would be repurposed to provide treatment for individuals with forensic involvement. The state has partnered with the counties in the Southeast Region in the development of a time limited Mobile Clinical Assessment Team (MCAT) to complete independent, comprehensive assessments for those individuals currently at Norristown State Hospital (NSH). The assessments will evaluate the individual in a number of areas including but not limited to medical, cognitive, and behavioral health. Additionally, the MCAT will evaluate for potential risk factors and provide recommendations on how to ameliorate those risks. It is anticipated that a provider will be identified by May 2016 with assessments commencing by July 2016 and completed by December 2017.

It is the intention that these assessments will aid in determining the level of need and identify services necessary to support those Bucks County residents in the community. Once this is determined communication can occur with the state regarding the funding necessary to provide the recommended supports for discharge.

Outpatient (OP) Enhancement Initiative – In 2015, the Bucks County behavioral health system continued its efforts to enhance the quality of OP services in Bucks County. In terms of quality of outpatient services, the initiative continued to focus on several critical elements in 2015. Progress in these areas is outlined below:

Initial Access – Agencies are expected to offer initial appointments within seven days of a request. The large behavioral health organizations now offer same day access with an "open access" model, which continued to show success. Overall, providers continued to meet benchmarks for individuals accessing MH and/or substance abuse services within the seven-day timeframe. Priority access is given to individuals being discharged or released from a psychiatric hospital, drug and alcohol (D&A) treatment facility, or criminal justice setting.

Ongoing Access – In 2014, specific attention was paid to psychiatric evaluations for MH providers to occur within 10 days of the initial assessment and this continued to be a priority in 2015. Meeting this benchmark continued to be an area of opportunity for the providers. Quarterly outcomes data show positive results for the ongoing 30 day follow up appointments for the MH providers with some of the providers addressing ongoing staffing issues. The most recent follow up report has MH providers achieving follow up percentages ranging from 76% to 95%. Outpatient groups and other peer, community, self-help and natural supports are explored to enhance treatment for individuals.

Staff Competencies – All of the outpatient providers taking part in the initiative are expected to have at least one Certified Co-Occurring Disorders Professional – Diplomat (CCDP-D) supervisor and at least one

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Certified Tobacco Treatment Specialist (CTTS) on site. One provider is working on hiring a CTTS. All providers continue to hire either staff that are already licensed or have completed their course work and need supervisory hours to sit for licensure. Those hired as license eligible may require up to two years of clinical supervision hours, which is to be provided by the agency. Staff are expected to sit for their licensure exam once they have achieved their clinical supervision hours. Currently 52% to 97% of agency MH clinical staff are licensed with 100% of supervisory staff licensed.

Supervision – All providers utilize both group and individual supervision. At some of the agencies, supervision has a theme to address some of the initiative’s competency areas, such as COD and trauma focused treatment. Clinical supervision is used to give feedback to individual clinicians and to enhance their skill level and expertise in providing services.

Outcomes – Providers continued with their work to address specific outcome measures related to adult outpatient treatment. Every provider in the initiative is expected to administer a satisfaction survey to at least 25% of their adult outpatient census and if they provide children’s outpatient services. Each provider is expected to administer the Parent Satisfaction survey to at least 25% of their census. The results of the tools are to be used to develop action steps and make positive change within the agency.

Certified Peer Specialist (CPS) Program – CPS programs continued to grow at each agency and many of the CPS staff were trained in Peer Support and Whole Health and Recovery (PSWH-R) in 2015. Additional efforts around peer support are highlighted below.

Bucks County Health Connections (BCHC) Program – The MH providers continue to have success with their Nurse Navigator programs that focus on coordinating behavioral health and physical health. The Nurse Navigators perform nursing assessments with members to identify recent health concerns, gaps in care (mammogram, colonoscopy, etc.), monitor changes with vitals/weight/BMI, and to help inform goal development of integrated wellness plans. The Nurse Navigators often provide wellness education opportunities within the agencies. In 2015, there was a focus on the nurse navigators working with the rest of the team within the MH providers (outpatient therapists and case managers) to coordinate care for individuals.

In 2015, providers were surveyed regarding the current outpatient enhancement initiative and aspects that continue to be helpful and meaningful. In 2016, the County and Magellan Behavioral Health of PA (MBH) will be redesigning the initiative with more of a focus on the quality improvement process and outcome measures. The initiative will move from process measures to include a quality outcomes focus. There will be a reduction in oversight of routine activities, while maintaining or improving upon prior successes. Providers will be offered technical assistance and skills in designing and implementing quality improvement activities.

Engagement Opportunities

One of the goals of MH services should be to help individuals access needed supports when they encounter an emotional struggle, in order to transition back to more natural supports. In some instances, individuals may not feel comfortable in accessing services for various reasons. MH Services may be utilized to help develop a relationship with the individual to allow for connection to appropriate services.

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We continue to focus our efforts on meeting individual's "where they are". Our enhancement of crisis services is a priority to ensure that individuals in need of behavioral health services can access appropriate resources. We have also partnered with the criminal justice system around training and educational opportunities in order for individuals to access treatment in lieu of incarceration.

Crisis Services - In 2013, Bucks County received approval that our crisis reinvestment proposals were approved. The proposals were our attempt at enhancing the crisis services that serve adults throughout the County. Our intention is to move from a predominantly hospital-based service to one that is more mobile, in order to meet an individual's crisis needs "where they are". The first phase of our crisis enhancement involves the development of a mobile crisis team. Lenape Valley Foundation (LVF) has provided crisis services in Bucks County for over 37 years. Their experience in the behavioral health system, as well as their community partnerships, has afforded them expertise to provide mobile crisis services for the County. One of those partnerships includes their role as co-chair of the Crisis CIT Taskforce. On a daily basis, LVF staff collaborates with law enforcement to serve individuals in need of behavioral health services through mobile outreach. This partnership has diverted many individuals from the criminal justice system into more appropriate behavioral health services, and was successful in connecting individuals in need into treatment that may otherwise not have been engaged in services. LVF has also developed relationships with hospitals and provider agencies throughout the County, in order to link individuals to treatment options to avert future crisis situations. Staff remains engaged with individuals to ensure successful linkages is made.

We continue to enhance our crisis services in order to move from a predominantly hospital-based service to one that is more mobile, in order to meet an individual's crisis needs "where they are". We have partnered with LVF through approved reinvestment proposals to develop additional crisis services in order to ensure that individuals, who are experiencing a behavioral health crisis, are connected to the most appropriate treatment needed.

LVF is now in its third year of providing mobile crisis services in Bucks County. Mobile Crisis services are available Monday through Friday, 24-hours per day. The daytime service is provided by a team of two crisis workers, the overnight services are provided by an on-call crisis worker. There have been some delays, due to staffing, in expanding to weekend hours, but weekend coverage should be launched by the end of July 2016.

Mobile Crisis continues to have a very low rate of hospitalization. In the past 12 months, Mobile Crisis has hospitalized 4.03% of the individuals seen versus a 47.82% hospitalization rate for individuals seen at the site-based crisis services. The dispositions of Mobile Crisis include having 12.43% of individuals seen referred to outpatient services for the first time. An additional 26.9% are re-referred to a previous outpatient provider with whom they are familiar. We've seen an increase in our ability to intercede in a crisis situation and support individuals with accessing necessary behavioral health services.

LVF has also recently contracted with St. Mary Medical Center to provide crisis walk-in and emergency services within their Emergency Department. Crisis services began on a part-time basis April 2016. They will continue part-time through June 2016. On July 1, 2016 the service will be staffed by one LVF crisis worker 24/7. One of the goals of the service is to streamline the process of assessing patients with behavioral health needs and link them quickly to the services they need. LVF will facilitate any involuntary commitments and inpatient psychiatric hospitalizations that present in the ED. Satisfaction surveys continue to show an overwhelmingly positive response to mobile crisis including individuals receiving the service, family members and referral sources.

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The second phase to enhancing crisis services includes the addition of a Crisis Residential service, supported by Bucks County Behavioral Health Reinvestment funds. Crisis Residential is a voluntary, non-locked 10-bed program. While it will focus on stabilization and inpatient diversion, it also aims to create an opportunity for individuals to begin identifying strengths and resources that lead to recovery and resiliency. The goal is to have individuals discharged within an initial five-day authorized stay, with possible extensions of up to an additional five days, if necessary.

LVF has made significant progress on this project throughout the last year:

- Land Development Plans have been filed with Bristol Borough and are pending placement on an agenda of the Borough planning commission and council for review and approval.
- Meetings with the Borough engineer to discuss and review the plans include:
 1. The Borough engineer anticipates working with LVF on the access issue and move quickly to provide LVF a response letter in order to proceed with meetings with the Borough.
 2. The Borough engineer will issue a second “unofficial” and comprehensive letter to Dumack’s (LVF’s engineer) to address remaining issues.
 3. The Borough engineer has provided suggestions to expedite the sewer planning process as the service will go through Bristol Township.
 4. The Borough engineer agrees that the development approval process will be completed in 2016.
- The land lease has been fully negotiated and the document is awaiting final signature with Prime Health.
- The environmental consultant study has been completed, including habitat assessment. Report has been submitted to PA Fish and Boat Commission for approval.
- The architectural plans have been undergoing review and the final building footprint has been agreed upon.
- The LVF Board phase of the Capital Campaign is complete and has 100% participation.
- The Major Donor phase of the Capital Campaign is just beginning as is the Staff Capital Campaign
- Development of the proposals for the Foundation phase of the Capital Campaign is underway

Criminal Justice System

- **Crisis Intervention Team (CIT)** – The Bucks County CIT Task Force continues to provide the 40-hour training to law enforcement throughout Bucks County semi-annually. As of April 2016, 291 officers have graduated. Other graduates include Correction Officers, Probation Officers, County Dispatch, and Hospital Security. The Task Force continues its efforts to have 20% of each department trained in this CIT class. In June 2015, members of the Task Force were the keynote speakers at the Missouri State CIT Conference and presented on “Suicide by Cop”. They were also invited to do an encore presentation at the International CIT Conference in April 2016. The CIT Task Force continues to recognize the importance of collecting outcomes data to evaluate the efficacy of the trainings. To this end, the Task Force applied and was selected to participate in a state-wide CIT study in partnership with University of Pittsburg Medical Center. A total of 700 police reports were collected from both CIT and non-CIT officers from selected police departments throughout Bucks County. The data will be collected and reviewed by University of Pittsburg Medical Center. The CIT Task Force continues to provide course evaluations throughout the training in an effort to respond to the feedback from the evaluations. Thus far feedback received from the evaluations has been positive and police officers have recognized the importance of the CIT trainings.

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- **Crisis Response Training (CRT) for Bucks County Correction Officers** – A three day training was developed to train Correction Officers on crisis intervention techniques. Two classes were offered and a total of 54 Correction Officers were trained from both the Correctional Facility and Community Corrections. The goal of the training is to reduce crisis situations, improve safety, and promote better outcomes for individuals with a behavioral health challenge. The training provides tools, strategies and techniques that will allow Correctional Officers the ability to work collaboratively to implement comprehensive services for inmates with a mental illness.
- **Criminal Justice Advisory Board (CJAB)** - The CJAB approved the establishment of a CJAB Human Services Subcommittee in 2015. The subcommittee supports the activities and programs that enhance integration of criminal justice and human services system in Bucks County. The Subcommittee updated the Cross-Systems Mapping that was completed in 2010. The purpose of the Cross System mapping is to develop a comprehensive picture of how people with mental illness and/or substance use disorders and/or developmental disabilities move through or interface with the Bucks County criminal justice system along the five distinct intercepts.

The subcommittee has established the following priorities: intercept 2 diversion options and resources, education and training, pre-trial services early on in the continuum, a warm hand off into treatment, housing, transportation, and exploring the need for mental health court. A survey has also been developed for the Magisterial District Justices (MDJ) to complete in an effort to identify supports, and resources that are needed at Intercept 2.

A Long Range Planning Committee has been addressing the overcrowding at the jail and has asked the Subcommittee to transform our Sequential Intercept Mapping work into a series of recommendations to also address the overcrowding issue. We anticipate recommendations will be provided to the Long Range Planning Committee by mid-summer 2016.

- **Pennsylvania Commission on Crime and Delinquency (PCCD) Grant** - MH/DP was awarded a grant from PCCD known as the Forensic Support Program (FSP) Bridge Housing Subsidy. The FSP Bridge Housing Subsidy's goal is to develop a program that will provide safe, affordable, and appropriate housing to individuals with mental illness / co-occurring substance use diagnosis (MI/COD) reentering the community from incarceration or divert individuals with MI/COD from incarceration, both while maintaining public safety. This goal is to be accomplished by: 1) developing permanent supportive housing for the identified population; 2) sustaining developed programs beyond grant funding; 3) increasing the number of housing opportunities and support county MH and criminal justice collaboration; and 4) creating and continuing sustainable, affordable housing opportunities for justice involved individuals at any intercept point in the criminal justice system. Penndel Mental Health Center (PMHC), in collaboration with Bucks Co MH/DP, BCCF, Probation and Parole and the Bucks County Housing Group (BCHG) are currently serving 3 individuals who were diverted from incarceration into community based care. The program is based in an apartment complex owned by the BCHG. This project has provided for a successful transition from incarceration through engagement and supports for treatment and housing. The collaboration between all parties have allowed for successful interventions to help individuals gain skills to transition successfully to the community. All individuals have transitional plans in place to work on recovery goals to allow them to take the next step towards greater independence and give them the time they need to have resources available for finding/sustaining permanent housing in the community thus extending the operation of the grant period.

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- **Peer Support** – Efforts continue to integrate peer support into the community behavioral health system within Bucks County. Twelve behavioral health agencies are currently employing peers in the capacity of CPS, CRS and Peer Support. The majority of peer support activities are funded through HealthChoices reimbursement. Programs not HealthChoices reimbursable utilize county funding to infuse peer support through all MH supports in Bucks County. This can be exemplified by both embedded peer programs within residential programs, as well as peer-run groups within drop-in centers.

There are a number of programs and initiatives in Bucks County that utilize peer support including peer drop-in programs, crisis support, homeless outreach, forensic peer support, post-secondary education support, and peers connected with both outpatient clinical services and rehabilitative support programs. Services are delivered both in program settings and in community settings. Peers are employed in either free-standing peer programs or embedded in a program. Services are primarily delivered on a one-to-one basis, but some programs do offer groups. Below are some highlights of diverse peer programs and training opportunities provided in Bucks County:

- **Mental Health and Intellectual Disabilities (MH/ID)** – Indian Creek Foundation (IC) serves individuals with a dual diagnosis of MH/ID in their outpatient clinic. In 2012, its peer program began as a reinvestment project. In 2014, IC contracted with MBH for reimbursement through HealthChoices and hired one part-time CPS with an individual who is dually diagnosed MH/ID. Since then, staffing has increased to four part-time CPS's to further support their peer efforts. The program now has the capacity to serve 25 individuals. The CPS program provides ongoing groups for program participants, which include a computer group, women's group and a men's group. They also provide a monthly cooking class and recently hosted a "transportation training" trip to the Montgomery Mall. The program currently has one CPS who is a WRAP Certified Facilitator. At this time, IC plans to start a WRAP group for individuals with developmental distinctions.
- **Certified Recovery Specialist (CRS)** – A CRS is an individual who's lived experience, combined with drug and alcohol education, assist individuals through their recovery journey by offering peer based support services. Their lived experience can either be the individual's own experience of substance use and recovery or an individual whose experience with substance use and recovery has affected their life. In order to become credentialed as a CRS, the individual is required to receive fifty-four hours of education in the three identified domains or core areas of competence, which include recovery management, education and advocacy, and professional ethics and responsibility. As of October 2015, the Pennsylvania Certification Board (PCB) listed 70 individuals as CRSs. Out of those 70 individuals, 30 are employed as CRSs throughout Bucks County. Although a specific number is not known, many individuals working as CRSs are dually credentialed as Certified Peer Specialist (CPS), giving them a specialty of being able to support the co-occurring mental health and substance use population.

The Bucks County Drug & Alcohol Commission, Inc. (BCDAC) hosts a series of trainings that meet the PCB requirements for certification to be a CRS. In the most recent class held in Spring 2015, approximately 23 individuals participated in CRS classes. Eleven individuals completed the full curriculum and ten of those individuals were approved by the PA Certification Board (PCB) to take the test, which was administered at the BDAC, Inc. offices on June 25, 2015. In addition, BCDAC also offers a series of trainings that allow existing CRSs to complete their training requirements for recertification, which is

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required every two years. All CRS certification and recertification data is available through the PCB.

Although this service is predominantly D&A focused, CRSs serve individuals who have a co-occurring MH/D&A issue. Efforts around peer support are inclusive of MH and substance use stakeholders.

- **Wellness Recovery Action Plan (WRAP)/Peer Support Whole Health and Resiliency (PSWH-R) –** In Spring 2015, 15 employed CPSs were trained as WRAP facilitators. As a result of this training, it is expected that WRAP facilitators will provide ongoing WRAP trainings for individuals throughout the County. In October 2015, MH/DP staff collaborated with MBH in hosting a 2-day PSWH-R training for 27 employed CPS, CRS and CPS Supervisors that came from diverse county-wide peer programs. CPSs trained in PSWH-R will utilize what was learned in the training to assist with one-on-one goal planning sessions for individuals they serve and will establish ongoing PSWH-R groups. This ongoing tracking will assist MH/DP and MBH to understand how WRAP and PSWH-R is being utilized and integrated system-wide. In an effort to promote and preserve the fidelity of ongoing WRAP and PSWH-R groups, MH/DP and MBH facilitate support groups for both WRAP facilitators and PSWH-R facilitators on a quarterly basis. This also helped to ensure that the FY 15/16 Peer Support goal of ensuring that WRAP groups are consistently being offered county-wide was met. Thus far, two WRAP Facilitator support groups occurred with four more scheduled in 2016. The groups have averaged a total of five attendants. Additionally, two PSWH-R support groups have occurred, which averaged a total of six attendants per group. The Peer Coordination Committee created a goal for 2016 to “Identify barriers related to WRAP and PSWH-R groups and develop an implementation plan.” It is the intention of the Peer Coordination Committee to have ongoing WRAP and PSWH-R groups throughout the county that maintain fidelity to the original WRAP and PSWH-R models.

Over the past year, the Peer Development Network (PDN), the Peer Supervisor Group and the Peer Coordination Committee consistently met every other month to continue moving peer support forward in Bucks County. The groups are intended to help facilitate the dissemination of information between them and to ensure collaboration of County and MBH staff, CPS/CRS Supervisors and working CPS/CRS direct service staff. The PDN is accruing more consistent attendance with each meeting and is addressing issues to enhance the skills of working peers. One of the FY 15/16 goals for peer support, established by the CPS supervisor group identified a desire to track how individuals are connected to activities in the community. This survey is known as “Community Connections”. The survey was piloted with agencies who provide independent (non-embedded) CPS services and was implemented county-wide January 2016 through March 2016. The data is being analyzed by Dr. Mark Salzer of Temple University and will be presented to CPS Supervisors.

The Peer Coordination Committee is working on its goal of developing a program monitoring tool and county plan, as well as reviewing the strengths, challenges and barriers in the delivery of CPS and CRS services in Bucks County. The overall purpose of the reviews are to establish a county-wide standard of best practices to assess and assist each program. The reviews are focusing on the fee-for-service peer support programs throughout the county. The first review began in Summer 2015 and will continue through 2016 until all programs have been monitored.

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Peer Support Goals for FY 16/17:

- Review the results from the "Community Connections" CPS survey and discuss how the results will translate into potential changes at both the provider and county level.
- MH/DP and MBH staff will continue technical assistance/quality assurance monitoring meetings at all of the county's fee-for-service peer programs and completed on an annual basis.
- Identify barriers related to ongoing WRAP groups throughout the county.
- Identify barriers related to ongoing PSWH-R groups throughout the county.

Employment – MH staff and the Supported Employment (SE) providers, Goodwill Industries (GI), Employment Technologies, Inc. (ETI), and AHEDD worked together to achieve FY 15/16 goals. Identified goals for supported employment included ongoing monitoring and oversight of the SE providers, evaluation of the referral process and revision of referral documents for the SE providers.

In FY 15/16, MH staff met with the SE providers quarterly to review census numbers, new referrals, status of closures, and the progress of those individuals receiving the service. Additionally, MH/DP staff fulfilled the goal of completing comprehensive annual program reviews. Additional program reviews were conducted in 2016. The purpose of these reviews is to evaluate how extensively Evidenced Based Supported Employment principles (EBSE) from SAMHSA are integrated into the programs. Based on the findings, each agency submits an action plan based on the review. In FY 16/17, MH/DP staff will continue to meet quarterly to collaborate with each SE provider as well as monitor ongoing progress through annual reviews.

Efforts were also made to update the SE outcomes database to be more accurate and relevant. MH staff reevaluated the referral process to ensure each individual is connected with a SE provider in a timely manner. The referral process was expedited to promote the rapid attachment of individuals to supported employment by utilizing the county's contracted providers. This year MH/DP staff reworked the process of referral to the Office of Vocational Rehabilitation (OVR). This change has resulted in individuals connecting with appropriate SE resources in a more timely manner.

The MH Employment Workgroup continues to meet every other month. The workgroup continued to work on their goal to revise the SE documents including the county referral form, a readiness assessment tool to be used for all SE candidates, and resource guides for both supported employment and supported education along with creating provider ads in the referral to better inform SE candidates and promote consumer choice. MH/DP staff, with the assistance of Workgroup members, will be visiting the provider referral sources in the summer of 2016 to both explain and distribute the new forms. Goals of Employment Workgroup for FY 16/17:

- Further integrate OMHSAS's Supported Employment Evidence Based Principles into Bucks County's Supported Employment processes
- Develop a "Fact Sheet" for participants that dispels myths and offers the pros and cons of disclosing one's mental health disability to an employer,
- Develop information packets for employers that contain relevant mental health info and dispels the myths and stigma surrounding employing an individual with a mental health diagnosis.
- Coordinate a 2 day WRAP workshop with an emphasis on "Recovery at Work" for Employment Specialists, Psych Rehab staff and Clubhouse staff that support individuals who are employed. It is intended that the WRAP workshop will enable staff to assist employed individuals with their own WRAP plan to help with mental health symptomology and challenges on the job.

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Senior Empowerment for Life Fulfilment (SELF) – This program was initiated in July 2009 and is a collaboration between the county departments of MH/DP and Area Agency on Aging (AAA). It is a community based program, staffed by LVF, serving individuals 60 years of age or older who experience MH and/or D&A challenges, are not connected to traditional behavioral health supports and have not previously accessed behavioral health supports. SELF utilizes a team approach that includes medication management, clinical interventions, case management and peer support. The team works with each individual to improve their quality of life by connecting him/her to needed supports. Team members engage older adults in their home and out in community settings. Both CPS and case management play key roles in supporting individuals to achieve their goals by helping them understand their rights, explaining various community resources and completing a strengths based needs assessment to develop recovery goals. Clinical interventions are introduced when needed and the older adult is more receptive to this support. On average individuals are able to move on with their recovery without the SELF supports in less than nine months. This model allows team members to take the time necessary to build rapport and dispel the stigma many individuals have regarding behavioral health supports, thus providing them the opportunity to get connected and access supports that they otherwise may not have been open to explore. Since FY 13/14 there have been 95 people successfully discharged from the SELF program, for various reasons and all those have been able to continue on with their recovery without further SELF intervention. Quarterly, the SELF team meets with representatives from MH/DP and AAA to review statistics, discuss program objectives and review cases. A common theme addressed is assisting individuals to maintain their housing. This is accomplished by alleviating MH symptoms, working through hoarding behaviors, helping to coordinate between other agencies like the Housing Authority, or apartment management, connecting to ancillary resources, etc. In FY 15/16 SELF supported 51 older adults. Of those 51 individuals, 12 were determined to have significant housing challenges. The SELF team was able to successfully connect 11 individuals to stable housing options, which is a success rate of 91%, up from 82.5% last year. Furthermore, SELF has been reviewing the impact on high utilizers of crisis services prior to being enrolled into the SELF program. A high utilizer was defined as anyone engaging in crisis services two or more times in a six month period. Out of the 169 most recent admissions into SELF, six individuals were identified as high utilizers. Of those six, only one had a subsequent visit to crisis after enrollment into the SELF program. Lastly of the 51 individuals supported in the past year, only two (4.0 %) of the individuals required psychiatric hospitalization. This is a reduction of more than two percent from last year.

In FY 16/17 SELF will continue to track the following outcomes, which include maintaining housing, number of crisis contacts for “high utilizers” pre and post SELF enrollment, and hospitalization rate of individuals. SELF also plans to develop and administer an exit survey to help assess satisfaction with the service.

System Transformation

Housing and Residential Services continue to be a focus of System Transformation. In order to ensure that individuals most in need to support can access programs, we need to ensure that individuals can access safe, affordable housing outside of the Mental Health System. As budgets have eroded, agencies’ ability to support individuals most in need have diminished. A priority this year is to focus on enhancing our residential programs.

Housing/Residential Supports – MH/DP oversees and provides base funding for 254 residential slots including Community Residential Rehabilitation (CRR), Supportive Living Programs (SLP), Adult Acute Respite, Long Term Structured Residential (LTSR) program and housing support program. In addition to these programs receiving MH base dollars, many programs also utilize Housing and Urban Development

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(HUD) Section 811, Shelter Plus Care, Supported Housing, Pennsylvania Housing Finance Agency (PHFA) and Low Income Housing Tax Credit Exchange Funds, Project Based Section 8, Community Development Block Grant Funds and Bucks County Housing Trust Funds to support these projects. Also included in Bucks County's housing continuum are 15 residential slots within 5 different regional programs located outside of Bucks County. Each program focuses on supporting specialized populations and are a combination of CRR, SLP, and LTSR programs.

In FY 15/16, MH/DP staff continued to work collaboratively with our community partner agencies to improve accessibility to MH residential services. The Centralized Referral Database continues to allow MH/DP staff to identify individuals most in need of MH residential services. Currently, there are over 120 individuals throughout the County waiting for supported MH housing. Individuals are prioritized with the highest needs, including individuals who are in an inpatient setting, forensically involved, transitional age youth, and/or homeless. Since the start of the referral database, there has been success in transitioning individuals from inpatient hospitals, prisons and shelters into both staff supported residential programs and community apartments with behavioral health services supporting the individual in their home. The highest demand for Residential Services continues to be males who need 24-hour staff support who also have criminal histories. The need for these beds is high and the residential providers are currently unable to accommodate all of these individuals with this critical need for housing supports.

The Residential Directors from our partnering agencies continue to meet monthly with MH/DP staff to identify ways to improve access, quality, and the array of residential and housing support programs. Meetings have focused on solidifying a plan to train residential direct care and supervisory staff based on both system-wide and program needs. Residential providers have identified their program's unique training needs, and developed a plan for site-specific staff and resident training. This plan includes on-site and online training opportunities and implementation is projected for July 2016. Residential Directors completed a survey about resident utilization of community services. Service coordination has been identified as a priority to ensure individuals are linked with community supports including case management, peer support, employment, nurse navigation and treatment community teams. Increasing communication between residential providers and other service providers will create opportunities for increased service coordination and goal planning.

With the growing number of individuals being referred to the residential waiting list and the increasing number of individuals identified as either homeless or at risk of homelessness who have a SMI, the need to increase the availability and diversity of housing support programs is critical. Presently, Bucks County provides funding to a small number of creative housing supports listed below:

- **Penndel Mental Health Center PATH Program Projects for Assistance in Transition from Homelessness (PATH)** – This program assists individuals who have a SMI and/or COD who are homeless or in imminent danger of becoming homeless to obtain or maintain the housing of their choice. In August 2015 this program was monitored by the Department of Human Services (DHS). This was a one day review, which included a visit to the residence of several PATH participants in addition to an interview with two participants. The findings of this visit were positive in all areas. The only concern that was noted was what would occur if the landlord was no longer available to rent to PATH residents.

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More recently, two PATH employees recently attended a training on Critical Time Intervention, which is an empirically supported model listed on SAMHSA's National Registry of Evidence-Based Programs and Practices. This practice is used to assist individuals to advance their recovery and secure stable housing.

The Bucks County MH Housing Specialist and the PATH Director continues to report quarterly to DHS regarding utilization and expenditures in addition to preparing an annual Intended Use Plan (IUP). A CPS was hired as a full-time employee of the PATH program in the spring of 2015 and continues to be an asset to this program. The use of his lived experiences has assisted the process of engagement with individuals who are identified as the most vulnerable in Bucks County. The PATH program is challenged with data entry requirements with PMHC's electronic health record. Effective July 1, 2016, PATH will also be required to complete full data entry into the PA Health Management Information System.

- **MH Housing Reinvestment Plan** – In spring 2015 a \$1.4 million reinvestment plan received approval from the OMHSAS. This plan is intended to provide funds, which will address immediate housing needs in addition to increasing the availability of and access to long term, safe, affordable permanent housing. This plan includes goals to develop a Tenant Based Rental Subsidy Program, a Housing Clearinghouse, Contingency Funding and a Capital Development Fund (CDF).

Over the past year numerous meetings have occurred between the Bucks County Department of MH/DP administrative staff and the leadership of the Department of Housing and Community Development (HCD). The primary focus of these meetings have been in the development of an Inter-Department Agreement with regard to HCD's administration and oversight of the CDF project.

The CDF will support the development of 8-12 new units of affordable permanent supportive housing targeted to MH/DP priority consumers over a three to five year period. As the CDF Administrator, HCD will strategically use CDF resources to leverage other affordable capital development funding, including federal discretionary supportive housing programs, state and locally controlled affordable housing funding, and other funds available for affordable housing development. To meet this challenge, the HCD will develop and cultivate relationships with other affordable housing development funders (including local community development departments and public housing authorities (PHAs)), stay abreast of federal affordable housing development policies and programs and recruit and work effectively with prospective permanent supportive housing developers. Upon implementation of the Inter-Department Agreement HCD will adhere to a timetable that will include project start up, construction phase and leasing of the individual units.

With regard to the other three areas of the Housing Reinvestment Plan, MH/DP staff have partnered with the Bucks County Opportunity Council (BCOC), a nonprofit agency whose mission is to "reduce poverty and partner with our community to promote economic self sufficiency". BCOC provides a broad range of services including emergency and preventative assistance, financial literacy and asset development, food assistance, home energy conservation services, and the Economic Self-Sufficiency Program, which is the cornerstone of their service provision. We anticipate our partnership providing positive outcomes for individuals and a new way of thinking in how we provide housing supports to individuals.

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Over the past six months MH/DP and BCOC have been meeting to conceptualize our partnership and to develop an agreement of service and the MH Housing Coach job description. The Housing Coach will play an integral role in the identification of affordable housing and to assist individuals with maintaining their housing. Outcomes will include the prevention of homelessness and reduced length of stay in mental health residential programs, inpatient psychiatric hospitalization, extended acute care settings and other more restrictive settings.

We also anticipate the creation of the Housing Coach functions will allow individuals to move from MH residential housing thus increasing access for individuals who are currently in more restrictive settings.

- **Homeless Outreach Support and Transition (H.O.S.T.)** – Identifying and addressing the needs of individuals who are homeless and have a serious mental health diagnosis or co-occurring mental health and substance use disorder is critical in Bucks County. In November 2015, the Mental Health Association of Southeastern PA implemented a one year grant in Bucks County to focus on addressing this need. HOST consists of a team that provides access to housing through peer-delivered engagement, assistance and direction. The HOST team is comprised of a CPS Supervisor and peer specialists referred to in the grant as Peer AHEAD teams - Access to Housing through peer-delivered Engagement and Assistance and Direction. Additionally, there is an SSI/SSDI Outreach, Access and Recovery (SOAR) attorney, part-time nurse, and a vocational specialist

In an effort to create additional housing resources for participants of HOST, the Family Service Association of Bucks County applied for the Permanent Supportive Housing Bonus with Bucks County's Continuum of Care annual Consolidated Application. HUD will announce the Tier II funding award in spring 2016.

With regard to collaboration with other housing entities, MH/DP is an active participant on the HCoC-BC. This broad community stakeholder group focuses its efforts towards the prevention and elimination of homelessness throughout Bucks County. The MH/DP Department's collaboration with the Housing and Community Development of Bucks County and MH providers as part of the HCoC-BC has resulted in several providers receiving HUD Continuum of Care Grants. At this time, there are active grants which support both Transitional Supportive Housing and Permanent Supportive Housing including a portion of operating expenses. These grants have the capacity to serve up to thirty two individuals at any given time and are spread amongst two different programs across the county.

MH/DP staff continue to chair an HCoC-BC subcommittee known as the Local Housing Options Team (LHOT). This committee provides a forum for representatives of organizations serving individuals with behavioral health challenges as well as multiple special needs. Most recently a subcommittee of the LHOT has been working on identifying accessible housing for individuals with disabilities, including communications with the Housing Authority of Bucks County. This has resulted in discussions on simplifying the application process with rolling out one application for all units, creating online application access and better identification of how individuals are prioritized for entry into an accessible unit.

MH/DP staff has continued collaboration with the HCoC-BC Outcomes subcommittee in its effort to further coordinate Bucks County's Housing resources through the Enhanced Housing Link Workgroup. It's critical for human service agencies to coordinate efforts to increase housing stability for Bucks County residents. MH/DP is working with the Housing Link to coordinate the MH residential referral process with this larger county wide effort, with a focus on continuing to serve those most in need in

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the most efficient manner. This process will also strive to consolidate multiple waiting lists, avoid duplication on waiting lists and identify the appropriate entry point at which an individual with a serious mental illness is referred for mental health residential programs versus other housing supports.

The MH staff and behavioral health providers have continued to participate in the annual Point in Time (PIT) count for individuals who are homeless in Bucks County through community outreach prior to the count and on the PIT count date. The January 27, 2016 PIT count revealed 185 adults had a mental health or co-occurring disorder, or 59% of the adults surveyed.

In January of 2015, the Bucks County Commissioners created the Housing Advisory Board (HAB) of Bucks County. This stakeholder group of both public and private community members has continued to meet over the last year with the goal of creating a strategic plan to ensure the housing stability of Bucks County residents experiencing homelessness, most at risk of becoming homeless or who are challenged by housing affordability and options. While the HAB has continued to meet a strategic plan has not yet been released. Of considerable note however is through this department's participation in the HCoC-BC and collaboration with the HAB, greater collaboration across programs and systems has occurred allowing opportunities to avoid duplication of service towards individuals and families in addition to filling service gaps. The MH Housing Reinvestment Plan is a wonderful example of this cross system collaboration specifically between MH/DP and the Department of Housing and Community and MH/DP and the Bucks County Opportunity Council.

In regards to MH residential programs, staff continue to work towards diverting residential referrals when appropriate and decrease MH residential program vacancy rates. Over the past year the Residential Coordinator has increased her involvement with providers to assist with complex case, support in an effort to assist individuals to maintain their housing, or to plan for more appropriate housing.

As the various housing initiatives continue to unfold, we anticipate the following outcomes:

- The identification of the various needs of priority populations including TAY, individuals involved in the criminal justice system, veterans, older adults, and/or individuals with complex medical challenges.
- Strategic planning for individuals to transition from MH residential programs into safe and affordable housing of their choice.
- The identification of gaps in community based clinical and rehabilitative services that will support greater housing success and decrease higher levels of treatment.
- Continue to conduct program monitoring's of all residential service providers to review the quality of services as a tool to identify gaps in service delivery.
- The identification of available safe and affordable housing, and the development of strategies to increase coordination with housing programs and resources that support individuals in their recovery.
- The increase of service coordination and planning for individuals living in residential programs with identified behavioral health and other identified services and supports.
- The identification of all potential funding sources in order to leverage Block Grant funds.
- Increase collaboration with community partners in order to inform the housing plan.
- The provision of training/education within the MH residential programs in order to support the unique needs of individuals in order to support recovery.

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Bucks County Suicide Prevention Task Force – The Task Force continued to meet quarterly throughout FY 15/16, with subcommittees meeting regularly. The subcommittees target various populations including Adults, TAY, School Age Youth, Older Adults, Family Members, First Responders, and Professionals/Volunteers. Each subcommittee focuses on prevention/education and postvention efforts and the task force provides feedback, resources, and support to the subcommittees. Also in FY 15/16, the Task Force created and distributed its first Suicide Prevention Task Force newsletter.

With a focus on prevention/education the task force regularly provided trainings to community providers, students, and parents. A committee was also developed to collect and analyze local statistics as a way to further identify prevention needs. In an effort to address postvention needs, the Task Force established an email account, which will be used as a method to outreach to the family members of a loved one who completed suicide. The goal of outreaching to the family is to connect them with local resources for support if desired. The Task Force also continues to support LVF's annual Suicide Prevention Conference and candle light vigil. In order to continue to raise suicide prevention awareness, the Task Force is currently collaborating with four school districts to organize an "Out of Darkness" walk in Bucks County for June 2016.

Case Management Transformation Initiative (CMTI) – Since its inception in 2007, the Bucks County CMTI continues to outline quality standards and guidelines for providing case management services for individuals in Bucks County. CMTI is the collaborative effort of BCBH, MH/DP, the Drug and Alcohol Commission, Inc., and MBH, to develop expectations and work with providers to meet and exceed overarching goals that include role clarification, training, retention rates, individual empowerment, provider accountability, models of care, and agency and administrative support. Supervisors from agencies providing case management services have been critical to the success of CMTI and have played a valuable role in the refinement of objectives and movement towards furthering the initiative. This initiative is accomplished in two ways. First, representatives from MH/DP, D&A, MBH and agency supervisors meet bimonthly to discuss progress on goals identified to help continue strengthening the support during a given calendar year, upcoming trainings and resources and trends or other topics impacting the supports.

During FY 15/16 the CMTI supervisory workgroup met every other month. Meetings were co-facilitated by MH/DP, MBH and agency staff. Discussion regarding the identified 2015 and 2016 goals for calendar year 2015 and 2016 occurred regularly. There were also systemic goals identified for FY 15-16. They were to conduct an updated satisfaction survey, administered by the Bucks County CSFT, and enhance both CMTI Level I and II trainings in two ways. First by including co-presenters to discuss various supports in Bucks County, including Peer Support, Health Connections Nurse Navigators, Supported Employment, post-secondary educational resources, resources for children and TAY and D&A resources, to mention a few. Secondly, have each training include a stronger focus to educate BCMs about common physical health diagnoses that people on their caseloads may experience. The progress with these goals are documented below.

The CMTI training series is divided into two levels and each level is held twice per year. The purpose of the Level I training is to provide an introductory training to all new BCMs within six months of hire and Level II focuses on further developing skills for supporting people diagnosed with a COD.

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Level I –

CMTI Level I was offered in fall 2015 and again in spring 2016. The trainer brought her expertise in the field of social services to facilitate the basics of providing case management services: empathy, documentation, recovery and resiliency, stages of development, systems involvement, trauma, the human brain, and ethics and boundaries. To support the discussion, a CPS brought her personal experience as a recipient of case management services to provide teachable moments and emphasize the importance of developing a trauma informed understanding and deeper sense of empathy during service delivery. Over the past year the training was amended to include a focus on coordination of behavioral and physical health. This was further strengthened by providing basic medical information sheets on a number of common diagnoses individuals may experience, which include diabetes, high blood pressure, childhood obesity, benefits of smoking cessation and others. A total of thirty-six staff attended the training including one new BCM supervisor. In an effort to coordinate services there were also brief presentations regarding peer support, supported employment, post-secondary education opportunities, Bucks County Health Connections/Nurse Navigators and the children's system. The Level I training occurs semiannually and is for all new BCMs who have been hired since the previous Level I training. The next Level I training is scheduled for September 2016.

Level II –

CMTI Level II was facilitated twice throughout 2015 by an experienced trainer. The Level II training has a stronger focus on case management for individuals who are diagnosed with a COD, incorporates Stage of Change Theory and a 2-day focus on Motivational Interviewing. Level II is highly interactional and includes case reviews, role plays, and open discussion. Similar to Level I the Level II training also incorporated the importance of coordination of behavioral and physical health. In the training participants received medical information sheets, which cover diagnoses commonly experienced within the COD population such as Hepatitis A, B, and C, cellulitis, and HIV. During periods of the trainings both a CPS and CRS presented about their lived experience and impact supports had on their recovery. Additionally, guest speakers provided brief presentations on topics regarding smoking cessation groups and the availability of Certified Tobacco Treatment Specialist (CTTs), an overview of D&A services available within the county and how to access these services and information about Recovery Houses, including what they are, common house rules, how they are funded, how to access and oversight of facilities. Participants are also provided with a resource listing contact names and numbers for those Recovery Houses that participate in the board coalition the Drug and Alcohol Commission facilitates. In 2015 there were twenty-five staff trained including three case management supervisors. The next Level II trainings are scheduled for May 2016 and October 2016.

Due to a delay in the county being able to transition to the Avatar operating system the CMTI group unable to accomplish transitioning the previous database from a manually data entered system to one that is automated. In an effort to streamline the process the CMTI group has identified those fields that will be most helpful for assessing outcomes. These fields have been communicated to those developing the system so they can be included in the new database. Once developed it is the intent of the Department of MH/DP and the group as a whole to use the database to assess outcomes identified by the CMTI group.

In an effort to support individuals with mental health challenges in a more holistic manner, case managers are needing to understand the intersection of common health problems with behavioral

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health needs and quality of life. Case managers are also being asked to act as health navigators to assist individuals with their physical health needs. On October 8, 2015 a training entitled “Case to Care Management” was held to help case managers understand this growing expectation and realize how transforming their approach could enable them to achieve this goal. The training was sponsored by MBH and was presented by the National Council. There were 75 staff trained including BCM, BCM supervisors, and agency nurses involved with Health Connections.

We anticipate providing this training again during FY 16-17 to train new staff in this concept and strengthen the understanding in veteran staff. Additionally, we plan to provide a training specifically for BCM supervisors. The focus of this training will be to give BCM supervisors the skills they need to supervise around integrated care and wellness issues.

In early fall 2015 an updated satisfaction survey was developed with the county C/FST. Surveys were completed with recipients of case management services. The results were received by the CMTI supervisory group and reviewed in the December 2015 meeting. Based on the results from the survey new goals were identified in January 2016 to focus on for the remainder of the calendar year. The goals established include:

- Analyze the cause for “unable to locate” as a reason for discharge. Each agency will explore and identify why this is an issue and address possible engagement issues.
- Better prepare BCM staff on what they can do when someone they are supporting experiences a crisis and how to assist staff to be more confident during a crisis situation.
- BCM to assist individuals in strengthening and developing relationships with non-professional supports such as family and friends.

NAMI PA of Bucks County – NAMI PA of Bucks County’s mission is to support, educate and advocate for individuals with a mental illness and their family members. They provide a number of programs that are geared to educate individuals and their families both about mental illness, stressors and how to better understand the illness as well as how to be supportive of loved ones with a mental illness. Below are the educational opportunities that NAMI provides:

- **Peer-to-Peer** – a unique, experiential learning program for people with any serious mental illness who are interested in establishing and maintaining their wellness and recovery. Each class contains a combination of lecture and interactive exercise material and closes with Mindfulness Practice (techniques offered to develop and expand awareness).
- **Family-to-Family** – a free, 12-week course for family caregivers of individuals with severe mental illnesses. The course provides current information about various mental illnesses, medications, side effects and strategies for medication adherence. It also provides strategies for handling crises and relapse as well as how to cope with worry, stress and emotional overload.
- **In Our Own Voice** – a unique, informational outreach program developed by NAMI that offers insight into the recovery now possible for people with severe mental illness. In Our Own Voice shows how people with serious mental illnesses cope with the realities of their disorders while recovering and reclaiming productive lives with meaning and dignity. Additionally, the program provides a safe way for individuals to share the ups and downs of their recovery and learn from others.
- **NAMI Basics** – a new signature education program for parents and other caregivers of

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children and adolescents living with mental illnesses. The NAMI Basics course is taught by trained teachers who are the parent or other caregivers of individuals who developed the symptoms of mental illness prior to the age of 13 years. The course consists of six classes, each lasting for 2 ½ hours.

- **Ending The Silence** - a program especially designed for high school audiences and typically presented in the freshman/sophomore health classes during the mental health portion of the curriculum. This interactive program which provides key resource materials for students, seeks to inform them about the basic signs and symptoms of mental illnesses and reduce the stigma through personal stories.

Stakeholder Involvement

- **Consumer/Family Satisfaction Team (C/FST)** – Bucks County strives to assure a strong, independent, meaningful and effective C/FST, which empowers individuals and families to have a greater role in moving the behavioral health system forward. The goal of C/FST is to obtain feedback through surveys from individuals, families and focus groups to ensure that programs and services are effective and recovery and resiliency-focused. As the identified provider for C/FST in Bucks County, Voice and Vision (V&V) works in partnership with the County and MBH in order to adhere to the DHS HealthChoices Behavioral Health Program – Program Standards and Requirements: Appendix L. V&V and representatives from MH, D&A and MBH have collaborated to create a process, which is applied to each survey work plan and meets regularly as a workgroup to plan and coordinate all projects.

The C/FST workgroup developed a comprehensive work plan for FY 15/16 that included several projects spanning throughout the year. These projects included member surveys for BCM services, focus groups targeted at obtaining satisfaction with the Children’s Interagency Team meetings, a survey of children’s crisis services and high utilizers of adult inpatient psychiatric hospitalizations, as well as continuation of the Random Sample survey, which was retitled the Adult Health Systems Recovery Survey. Additionally, two remaining projects from the previous fiscal year were completed and recommendations were identified. Once C/FST has gathered and analyzed all of the data for each survey, a comprehensive report is compiled, which is shared with the County, MBH and providers. V&V works closely with all involved parties to identify clear outcomes and ways to utilize the results to impact the system at large. Identification of outcomes varies for each survey based on the purpose of the survey and the needs of system. The C/FST workgroup is now in the process of identifying and planning projects for FY 16/17.

In late 2015, OMHSAS distributed a draft amendment to the Program Standards and Requirements: Appendix L, requesting feedback from the Counties, HealthChoices contractors, Behavioral Health-Managed Care Organizations (BH-MCO), C/FSTs and other stakeholders. Feedback was shared between the Bucks County C/FST, the County and BH-MCO, as it was considered that a collaborative approach would yield the most effective review process. C/FSTs in the southeastern region also met and identified some common salient issues, which were shared with the County. Bucks County submitted feedback to OMHSAS as did the CFST and BH-MCO. A final version of the document is expected sometime in Summer 2016.

- **Consumer Support Program (CSP)** – The principles and values of the CSP are the cornerstone for service delivery and development within the adult MH system. These principles espouse that

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services are person-centered, empowering, offer choice, and focus on strengths. Access to service is flexible and services should be culturally competent. Services should be coordinated with other supports and meet an individual's unique needs. Services should be based in the community while maximizing the use of natural supports. Providers of MH services should be accountable to people who utilize services and include individuals and families in planning, development, implementation, monitoring and evaluating services. CSP, across Pennsylvania, has taken shape in most counties through the development of CSP committees. Since its rejuvenation in 2013, Bucks County has seen a growth of membership and involvement with each of its CSP committees. The three Base Service Units (BSU) in Bucks County host localized CSP committees in order to meet the geographical needs of the committee members. Committee and subcommittee meetings occur on a monthly basis in which individuals come together to exchange information and formulate ideas about how the larger community can coordinate resources in order to offer needed services and supports to individuals who experience MH and COD challenges and to identify opportunities where people in recovery can contribute in building a better community.

The overall goals that CSP Committees have identified are addressing housing and homelessness, transportation, advocacy, and education in order to bring awareness to MH stigma. Throughout FY 15/16, the CSP committees made tremendous progress with each of these goals.

Addressing housing and homelessness accomplishments achieved throughout the year have included the development and distribution of a Homelessness Survival Guide by the Lower Bucks CSP. This guide provides information on various resources available to individuals faced with homelessness. A 3rd Roommate matching event, spearheaded by the Central Bucks CSP, was organized in an effort to provide a safe venue for individuals in recovery to meet prospective roommates. Knowledge of the Roommate matching events has spread and one case management team at a local BSU is organizing its own and one of the other CSP committees is looking into to doing one in its area.

In terms of the advocacy goal, the Central Bucks CSP Committee has finished developing a "story telling training". The purpose of the training is to promote self-advocacy by providing education to people in recovery about how to tell their story to various audiences (i.e. legislators, other peers, youth, etc.). They are providing their first Storytelling Workshop May 2016. The CSP committees are also making strides to raise awareness about mental health stigma. In 2014, Bucks County CSP bought the rights to the documentary film, "Of Two Minds". The Upper and Central Bucks CSP committees both organized events during Mental Health Awareness Month to show this film to the public and elicit discussion about MH stigma in our community through a panel discussion with individuals in recovery. In an effort to support consumers get connected to the larger communities in which they live, the Upper Bucks CSP has begun to offer scholarships to individuals who want to attend conferences and workshops in order to develop their skills and to network. Another program that helps consumers get connected to their community is the community connections grant program that offers small grants (\$40-\$50) to help consumers to afford to participate in a leisure activity. This program is run by both Upper & Lower Bucks CSP's. Some individuals have used this grant to take educational or self-improvement classes, or to help pay for a summer pool membership. Due to the budget impasse this year the program was on hold most of the fiscal year. The program is being re-advertised and we hope to have individuals take advantage of it in May & June this year.

A major goal for Upper Bucks CSP has been to look for ways to increase transportation options for

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individuals living in the Upper Bucks area. They have brought together a diverse group of community organizations and are exploring ideas such as a bike sharing program.

Other accomplishments of Bucks County's CSP include the continued use of the CSP website, and the CSP Face Book page. CSP has also been involved in providing input into the decision of reinvestment plans. Prior to the submission of a plan, the CSP committees are afforded the opportunity to give feedback. Plans are revised based on CSP input. As CSP continues to grow, Bucks County plans to involve the CSP Committees as community stakeholders to inform the Block Grant process and obtain input into development of services, projects, and other initiatives within the Bucks County continuum of care.

b. Strengths and Needs:

There continues to be a variety of strengths that Bucks County draws upon in order to support an individual with a behavioral health challenge. We have a strong commitment to peer services, looking at creative ways to not only increase the numbers of peers who are working in the system but how peers support an individual's recovery journey. We have also collaborated with behavioral health partners to provide employment opportunities, which include hosting staff trainings for skill development. Another strength is the relationships that have been built in order to support individuals in the system, such as with the criminal justice system, county agencies including the Drug and Alcohol Commission, Area Agency on Aging (AAA), Children and Youth (C&Y), Probation and Parole, etc. and community partners. There are also a variety of unmet needs that still exist within the County. Some issues that are consistent among age groups continue to be safe, affordable housing and the ever-increasing need for county-funded support services such as Outpatient, Psychiatric Rehabilitation, Assertive Community Treatment (ACT), Case Management, and Residential Services.

Below outlines the strengths and unmet needs that are specific to the various target populations served by the behavioral health system:

Older Adults (ages 60 and above)

Strengths:

- There is a strong partnership between the county offices of AAA, MH/DP, and D&A to identify areas in which to collaborate in order to serve the older adult population.
- The Senior Empowerment for Life Fulfillment (SELF) program is an established program which serves as a model in providing behavioral health services to the aging population.
- Older adults have been trained and employed as certified peer specialists (CPS).

Needs:

- Coordination between the physical health and behavioral health systems for older adults who present with medical challenges.
- Increased risk for alcohol-related problems and accidental or intentional misuse of prescription drugs.
- Stigma that is associated with older adults accessing behavioral health services.

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- Mobility issues that make it difficult to access traditional site-based behavioral health services.
- More CPS opportunities are needed in order for older adults to feel comfortable accessing mental health resources.
- Mental health challenges can create barriers in accessing community services (i.e. senior centers, nursing homes, rehabilitation services, etc.)

Adults (ages 18 and above)

Strengths:

- The MH system has developed strong relationships and collaborations with the D&A system, the criminal justice system, the managed care organization (MCO), and provider agencies.
- The behavioral health system has established a re-commitment to peer support services and has developed a plan to continue to move peer support forward in Bucks County.
- Reorganizing the CSP of Bucks County has allowed for further stakeholder voice and has assisted in the growth of peer, provider, and county collaboration.
- MH/DP continues to improve accessibility to MH Residential Services.
- The behavioral health system has prioritized the coordination between physical health and behavioral health to address the physical health needs for individuals.

Needs:

- Limited availability of county funded resources for the increased numbers of individuals who are ineligible for Medical Assistance.
- Lack of available quality behavioral health services for individuals with multi-system involvement.
- Limited availability and diversity of affordable housing options outside of Bucks County Mental Health Residential Programs.
- Increased need for providers to move from being trauma informed to becoming trauma competent in treatment.
- There continues to be a gap in services between the child serving system and the adult system.
- Training/educational opportunities to support the development of life skills.

Transition-age Youth (ages 18 -26)

Strengths:

- Strong leadership from the TAY workgroup, which defines the direction of program development, supports monthly MY LIFE Meetings and has created an information exchange network.
- Creative system work occurring in order to address the unique needs of young adults in order to avoid becoming entrenched in the behavioral health system, including the expansion of support services.
- Expansion of the Transition to Independence Program (TIP), which is an empirically supported model to engage and support young adults in their future planning processes.
- Development of a free-standing peer support program for young adults and expansion of the role of CPS in the TIP program.

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Needs:

- Lack of the individual's own resources (financial, emotional, and social) as well as available behavioral health services that address this age group's particular needs.
- Young adults' access community services differently – more use of technology and social networking sites.
- The impact of trauma on a youth's life has an effect on his/her safety and relationships, which left unaddressed, hinder personal/emotional growth and recovery.
- There is a high rate of co-occurring (COD) substance use which frequently goes unrecognized by the young adult.
- In order for peer support to be effective, individuals need access to peers with similar lived experiences.
- Training/educational opportunities to support the development of life skills.

Children (under 18)

Strengths:

- Bucks County utilizes a System of Care (SOC) approach which has served as the conceptual and philosophical framework for systemic reform in children's behavioral health.
- The Children's Coordination Steering Committee (CCSC) has created a strong collaboration with multiple systems in addressing the mental health needs of children, youth, and families.
- The Children's Executive Steering Committee oversees the work of the CCSC and provides support, feedback, and strategic direction to the committee.
- Hi-Fidelity Family Teams is a program that has been an effective support to both parents and the youth.
- Increased collaboration and communication with Children's Crisis Support Program, which connects with families while the child is inpatient.

Needs:

- Increased need for access to targeted respite support for children being discharged from RTF.
- Lack of connection to natural supports for families when youth are transitioning home after RTF placement.
- Improved communication between the various levels of care regarding treatment and barriers to treatment, especially when a higher level of care is recommended.

Special/Underserved Populations

Individuals transitioning out of state hospitals

Strengths:

- Development of community supports that has decreased the need for state hospital usage.
- Increased community tenure for those discharged from the state hospital due to community supports.

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- The Community Support Plan process is utilized with those who transition to the community from the state hospital, which brings opportunity to connect individuals with community supports and allow for transitional visits prior to discharge.
- Current focus on discharging individuals from state hospitals, which may result in additional available resources (i.e. residential, peer support, community treatment teams, etc.)

Needs:

- Lack of more intensive treatment supports (i.e. trauma, dialectical behavioral therapy (DBT), ACT, etc.).
- Lack of housing options that provide skill building opportunities for individuals who have long stays within the state hospital.
- Due to long-term medication use and long-term institutionalization the need for coordinated care of physical health and behavioral health needs.
- Training/educational opportunities to support the development of life skills.

Co-occurring Mental Health/Substance Abuse

Strengths:

- Development of a detox/rehabilitation program which will also support coordination of care for individuals who have COD metal health/substance abuse disorders.
- The Outpatient Enhancement Initiative has created a strong collaboration among the behavioral health system in order to enhance the quality of outpatient services for individuals receiving co-occurring treatment.
- Current plans to increase the network to provide substance abuse services, which will also support individuals who have a COD.
- Mental health providers are pursuing dual licensure in order to clinically support individuals with a COD.

Needs:

- Lack of truly integrated mental health/substance abuse treatment.
- Lack of drug and alcohol detox/rehabilitation facilities that also provide personal care assistance for the older adult population.
- Limited peer/mentor supports such as Certified Recovery Specialists.

Justice-Involved Individuals

Strengths:

- Implementation of mobile crisis, which provides rapid response for individuals who may interface with law enforcement.
- Training initiative for the criminal justice system including Crisis Intervention Team (CIT) for police, security officers, 911 dispatchers, etc. Another training provides a trauma informed care

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- curriculum for correctional officers, probation officers, and law enforcement personnel.
- The Severe Mental Illness (SMI) workgroup has developed a strong collaboration between the behavioral health system, county jail, probation officers and provider agencies. The purpose is to identify resources necessary for the successful release of individuals to the community.
- The addition of Crisis Response Training (CRT) for correctional officers at Bucks County Correctional Facility, which provides education on understanding behavioral health challenges.
- Development of the Criminal Justice Advisory Board (CJAB) Human Services Subcommittee, which is focusing on the identification of gaps around the various criminal justice intercepts.

Needs:

- Lack of available resources for individuals in the behavioral health system that have criminal justice involvement.
- Lack of community reintegration supports for individuals maxing out of state sentences.
- Limited jail step-down options for treatment and residential support services.
- Training/educational opportunities to support the development of life skills.
- In order for peer support to be effective, individuals need access to peers with similar lived experiences.

Veterans:

Strengths:

- Strong collaboration between housing agencies to support veterans who are homeless.
- Vet-to-Vet peer opportunities available within Bucks County.
- Bucks County agencies can accept Veteran's insurance.

Needs:

- We continue to struggle accessing supports for which Vets are entitled through the Veteran's Administration.
- Educational opportunities are needed to reduce stigma in order for Vets to access treatment.

Lesbian/Gay/Bisexual/Transgender/Questioning/Intersex (LGBTQI) consumers

Strengths:

- Clinical treatment to support special populations currently being addressed in the Bucks County Outpatient Enhancement Initiative.

Needs:

- Training/educational opportunities for the larger community to increase awareness and reduce stigma around LGBTQI.
- In order for peer support to be effective, individuals need access to peers with similar lived experiences.

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Racial/Ethnic/Linguistic minorities

Strengths:

- Agencies within Bucks County support individuals with diverse ethnic backgrounds (i.e. Hispanic, Asian, Russian, etc.) using a translation services to assure communication is open and person centered.
- Our core Outpatient agencies employ staff that are multi-lingual.

Needs:

- Continue development of culturally competent clinicians within our treatment system.
- Training/education for behavioral health system to be more culturally competent.
- Data specific to current and emerging minority populations and current trends/demographics related to outcomes for specific populations.

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c. Recovery-Oriented Systems Transformation

Priority	Brief Narrative	Time Line	Funding	Monitoring
<p>1. Strengthen collaboration with the criminal justice system with a specific focus on diversion from incarceration and more timely release</p> <p>a. Continue to train law enforcement in the Crisis Intervention Team (CIT) model</p>	<p>To date, 291 officers have been trained. The current goal is to ensure 20% of the County police workforce is CIT-trained.</p>	<p>Two 40-hour trainings were provided FY 15/16 – 53 additional officers were trained. The next CIT training is scheduled for October 2016.</p>	<p>HS Block Grant</p>	<p>The CIT Task Force meets monthly to identify areas for improvement in the continued roll-out of CIT. Pre and post tests are provided to participants to ascertain specific improvements and enhancements to training modules.</p> <p>Bucks County has been chosen to participate in the University of Pittsburgh’s grant for CIT outcomes.</p>
<p>b. Continue to train Bucks County Correctional Facility Officers in the Crisis Response Training (CRT)</p>	<p>CRT is a CIT-like training provided to correctional officers in order to enhance their knowledge of behavioral health challenges and effective intervention strategies.</p>	<p>Two classes have been held in FY 15/16. 54 officers have been trained. The next CRT class is scheduled for September 2016. FY 16/17 plan to adapt this training for high school students in Bucks County’s Vo-Tech schools who are involved in first responder curriculums.</p>	<p>HS Block Grant</p>	<p>Representatives from MH/DP and the county prison meet regularly to identify areas for improvement and training opportunities.</p>

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<p>c. Continue implementation of a 2 year PCCD Grant</p>	<p>MH/DP, Bucks county Correctional Facility, and Penn del Mental Health Center (PMHC) collaborated to apply for a PCCD Grant. The proposed project supports the County's MH and forensic partnership to address the gap in housing available to individuals with a co-occurring mental illness and substance use disorder, who are justice involved. The program provides safe and affordable transitional housing for six individuals.</p>	<p>Bucks County was awarded the PCCD Grant June 2015. Currently 3 individuals are being served with housing and behavioral health treatment supports.</p>	<p>PCCD Grant</p>	<p>Quarterly monitoring meetings have been established between MH/DP staff and PMHC. Outcome measures include:</p> <ul style="list-style-type: none"> • Community tenure • Reduced recidivism • Engagement in treatment services
<p>d. Continue participation in the Criminal Justice Advisory Board Human Services Subcommittee to address overcrowding in the County Correctional Facility</p>	<p>MH/DP has participated in FY 15/16 in the development of an Intercepts Framework to identify system strengths and gaps for the forensic population. The workgroup has been specifically tasked to develop recommendations to address the overcrowding in the County Correctional Facility.</p>	<p>Recommendations will be submitted Summer 2016.</p>	<p>HC Reinvestment HS Block Grant Other grants as identified</p>	<p>The County Criminal Justice Advisory Board meets on a quarterly basis and provides oversight of the work of the Human Services Subcommittee.</p>
<p>2. Strengthen our support of community-based housing for individuals with mental illness</p>				
<p>a. Continue implementation of a 5 year Housing Reinvestment Plan</p>	<p>This multi-year Reinvestment plan is aimed at the development of increased permanent housing capacity, tenant-based rental subsidies,</p>	<p>Reinvestment Plan approved April 2015.</p>	<p>HC Reinvestment HS Block Grant</p>	<p>Outcomes have been developed and monitored by MH/DP and the Bucks County Dept. of Behavioral Health.</p>

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<p>b. Coordinate with MH providers to enhance access to and the quality of supported residential housing programs</p>	<p>contingency funding for associated moving/renter costs, and a clearinghouse to provide a centralized and integrated housing referral system.</p> <p>MH/DP funds are being utilized to support the provision of additional supported housing capacity for individuals with mental illness and complex social needs. Residential staff workforce development is also a focus to improve the quality and efficacy of interventions to support individuals in moving to or sustaining permanent housing.</p>	<p>Meetings occur routinely with stakeholders to develop the Tenant-Based Rental Subsidies anticipated July 2016.</p> <p>Contingency Funding anticipated July 2016.</p> <p>Clearing House anticipated July 2016.</p> <p>Capital Development anticipated 2020.</p> <p>A training plan has been developed to enhance competency and support residents' unique needs.</p> <p>Training will be offered to housing provider groups, on-site at provider agencies, and through the web. Training to commence July 2016.</p>	<p>HS Block Grant</p>	<p>Housing access and utilization are being tracked on a monthly basis by MH/DP.</p> <p>Training participation outcomes will be tracked by residential providers and MH/DP. Provider training sustainability plans will be required in FY 16/17.</p>
<p>3. Enhance prevention and early intervention efforts</p> <p>a. Increase suicide prevention activities</p>	<p>Suicide prevention is a priority of Bucks County with the ultimate goal of eliminating completed suicides.</p>	<p>Task Force re-established December 2013.</p> <p>Suicide Awareness Signs erected at train stations February 2015. E-mail account established in order to outreach to families of completed suicide Summer 2015. Power Point</p>	<p>Block Grant</p> <p>In-kind Services – staffing from provider agencies, schools and other County agencies.</p>	<p>The Suicide Prevention Task Force meets quarterly. The Steering Committee and various sub-committees meet more regularly. Goals are established by each sub-committee and efforts are supported by the Steering Committee.</p>

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<p>b. Continue implementation of the 5 year SAMHSA grant, "Now is the Time" Healthy Transitions (NITT-HT): Improving Life Trajectories for Youth and Young Adults with, or at Risk for, Serious Mental Illness</p>	<p>NITT-HT is a federal initiative which the SAMHSA has embraced. The purpose of this program is to improve access to treatment and support services for youth and young adults ages 16-25 that either have, or are at risk of developing, a serious mental illness or substance use disorder, and are at high risk for suicide. SAMHSA has selected Bucks as one of three counties in PA to partner in this grant opportunity.</p>	<p>presentation and brochure developed for resources and training purposes Summer 2015. For FY 16/17: Out-Of-Darkness Walk scheduled for June 2016. Death Review Committee will continue to refine data elements for trending purposes. A Question Persuade Refer (QPR) initiative to train all Bucks County employees is targeted to be initiated by January 2017. A Transition Age Youth education/resource flyer has been developed with distribution expected by September 2016.</p>	<p>SAMHSA Grant</p>	<p>Outcomes are monitored by MH/DP and BHS in collaboration with the University of Pittsburgh and SAMHSA. Outcomes data is provided to OMHSAS on a quarterly basis.</p>
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<p>c. Enhance the County Crisis Service Continuum</p>	<p>Continue development of a 10-bed Crisis Residential facility which will focus on stabilization and inpatient diversion. Delays have occurred which have pushed back the anticipated start date.</p> <p>Increase Crisis Service coverage to one community hospital which initiated purchase of Crisis Services in FY 15/16 to support individuals having behavioral challenges that present in the emergency department.</p> <p>Continue to evaluate mobile crisis service utilization and identify fiscally sustainable</p>	<p>media and marketing plan around mental health education and resources.</p> <p>Work will continue with the countywide Housing Link to utilize data to identify at-risk youth and gather data on this transition age population.</p> <p>The TAY Rehabilitative Respite Program which was developed in Spring 2015 will continue to serve identified individuals/families in need.</p> <p>Reinvestment plan submitted Plan approved – February 2013</p> <ul style="list-style-type: none"> - Architectural plans developed - Capital campaign initiated in 15/16 - Implementation anticipated 2017 <p>April – June 2016 – implementation of a part-time staffing complement.</p> <p>July 2016 – implement 24/7 staffing</p>	<p>Reinvestment HealthChoices HS Block Grant Provider Agency Capital Campaign</p> <p>Funded through the community hospital</p> <p>Health Choices HS Block Grant</p>	<p>Outcomes have been identified and will be monitored by MH/DP and MBH when service is operational.</p> <p>Outcome data will be included in the Crisis service agency submission to the County.</p>
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<p>4. Ensure access to trained peer support opportunities across the behavioral health service continuum</p> <p>a. Review The "Community Connections" survey results and identify provider/County change recommendations</p> <p>b. Continue to provide technical assistance to provider-based CPS programs</p> <p>c. Explore barriers to providing WRAP training and Peer Support Whole Health groups</p>	<p>strategies to expand adult crisis coverage to weekends.</p> <p>In FY 15/16, an additional free-standing Certified Peer Specialist (CPS) program was added to the continuum. As of July 2015, there are 101 trained CPSs throughout Bucks County.</p> <p>In collaboration with Dr. Mark Salzar of Temple University, this survey was developed to evaluate how individuals are being connected to activities in the community.</p> <p>This is individualized, site-specific assistance.</p> <p>Attendance at offered trainings has been trending lower.</p>	<p>Survey results to be reviewed and recommendations made by Jan 2017</p> <p>This is provided on an as needed, ongoing basis.</p> <p>Barriers to be identified by October 2016</p>	<p>Reinvestment HealthChoices Block Grant</p>	<p>For items a –c, MH/DP and Magellan Behavioral Health staff review records and provide recommendations to organizations providing CPS. Oversight process also includes three committees – County Coordination Committee, the Peer Development Network Committee and the Supervisors' Committee</p>
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<p>5. Improve transitions of care</p>	<p>Effective system/community navigation, integrated person-centered planning, skill development, and sufficient step-down resources in the transition from institutions and from the child-to-adult service systems have been identified as critical needs for successful community-based living.</p>	<p>FY 16/17 will focus on the initiation of a two year plan to restructure the Outpatient Enhancement Initiative from a more process-focused model to a Value-Based Purchasing model. The roll-out of this two phase project will be presented to community service providers in June 2016.</p>	<p>HealthChoices HC Reinvestment HS Block Grant</p>	<p>Agency liaisons meet semi-annually with providers to gauge improvements and address challenges. Bi-annual meetings with all participating providers are held to share experiences and identify challenges. Data is provided to agencies on a monthly basis to ensure they are meeting the benchmarks that have been established.</p> <p>Performance/Value-Based Outcomes will be developed and monitored in conjunction with service providers by MH/DP, Bucks County Department of Behavioral Health, and Magellan Behavioral Health.</p>
<p>a. Implement revised Outpatient Enhancement Initiative</p>	<p>The behavioral health system made a commitment to improve the access to and quality of OP services in both MH and D&A providers. Rate increases were provided with the understanding that specific areas would be addressed in order to provide timely access and enhancing clinical services. See MH Narrative for benchmarks achieved FY 12/13 – FY 15/16.</p>			

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<p>b. Improve psychiatric evaluation/treatment and care coordination workforce competencies in meeting the needs of individuals with co-occurring MH/ID challenges</p>	<p>The goal continues to be enhancement of existing outpatient services to deliver quality evaluations, treatment planning, medication management, and behavioral health supports for individuals with intellectual disabilities and co-occurring mental health diagnoses.</p> <p>Benchmarks met to date include:</p> <p>October 2013 – Kick-off January 2014 – Implementation of expert consultation for 2 provider agencies to refine data collection, expand numbers of individuals served and refine outcomes. FY 15/16 – utilizing lessons learned in FY 14/15, expansion of consultation to two additional provider agencies</p>	<p>FY 16/17 will continue with the expert psychiatric and care coordination consultation with the two additional agencies who began project implementation in FY 15/16.</p>	<p>HC Reinvestment HealthChoices HS Block Grant</p>	<p>Outcomes have been identified and are monitored by MH/DP, BHS and MBH.</p> <ul style="list-style-type: none"> • Increase psychiatric competency • Decrease hospitalization and crisis contact rates • Decrease physical health hospitalizations
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<p>c. Continue and enhance the Case Management Transformation Initiative (CMTI)</p>	<p>CMTI is a collaborative effort of MH/DP, the Bucks County Department of Behavioral Health, the Bucks County Drug and Alcohol Commission, Inc., and Magellan Behavioral Health to outline quality standards and guidelines for providing case management throughout Bucks County.</p>	<p>The two levels of CM training have been redesigned to incorporate behavioral health/physical health coordination.</p> <p>On October 8, 2015, a training entitled "Case to Care Management" was held to help CM understand the growing expectation to support individuals in a more holistic manner. The training was presented by the National Council. 75 staff were trained.</p> <p>We anticipate providing this training again FY 16/17.</p>	<p>HealthChoices Block Grant</p>	<p>Bucks County's C/FST completed satisfaction surveys to ensure goals are met and redefined as needed.</p> <p>A follow-up survey was provided to CM providers around physical health/behavioral health coordination to determine the effects of the training provided. Positive results were seen and have identified additional areas for training.</p>
<p>d. Work in collaboration with other funding sources to develop a coordinated navigation and person-centered planning capacity across the County behavioral health system</p>	<p>In FY 15/16, these same entities identified above initiated a strategic planning collaborative to create a behavioral health system of care which improves the integrated care experience of individuals seeking/receiving services and promotes coordinated system/community navigation and person-centered vs silo'd program planning. A Navigation/Person-Centered Planning Subcommittee was established which developed and distributed a provider</p>	<p>FY 16/17 will focus on the review of provider surveys, the conducting of provider focus groups, the identification of recommendations for a navigation pilot project, and the implementation of a pilot. A January 2017 pilot initiation is targeted.</p>	<p>HealthChoices HC Reinvestment HS Block Grant</p>	<p>Outcomes for the pilot project will be identified by the Behavioral Health Strategic Planning Collaborative.</p>

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navigation and integrated planning capacity and feedback survey.			
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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	Y	158	TMACT	AHCI	Annually	Y	Y	
Supportive Housing	Y	238 See Comments	NONE	N/A	N/A	N	N	Includes Supported Living and CRR Program capacity; programs do not follow Supportive Housing EBP as defined by SAMHSA
Supported Employment	Y	19	SE EBP	MH/DP Staff	Annually	Y	Y	
Integrated Treatment for Co-occurring Disorders (MH/SA)	Y	94	TMACT	AHCI	Annually	Y	Y	
Illness Management/ Recovery	N							
Medication Management (MedTEAM)	N							
Therapeutic Foster Care	N See Comments							Provided in Bucks County through Dept. of Children and Youth

Multisystemic Therapy	Y	115	PIDR	Penn State Epicenter; Adelphoi Village	Annually	N	Y	
Functional Family Therapy	N							
Family Psycho-Education	N							

*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) Recovery Oriented and Promising Practices Survey:

Recovery Oriented and Promising Practices	Service Provided (Yes/No)	Number Served (Approximate)	Comments
Consumer Satisfaction Team	Y	437	
Family Satisfaction Team	Y	22	
Compeer	N		
Fairweather Lodge	N		
MA Funded Certified Peer Specialist	Y	343	
Other Funded Certified Peer Specialist	Y	33	
Dialectical Behavioral Therapy	Y	24	
Mobile Services/In Home Meds	Y	201	
Wellness Recovery Action Plan (WRAP)	Y	64	
Shared Decision Making	N		
Psychiatric Rehabilitation Services (including clubhouse)	Y	133	
Self-Directed Care	N		
Supported Education	Y	31	
Treatment of Depression in Older Adults	Y	58	
Consumer Operated Services	Y	3506	
Parent Child Interaction Therapy	Y	12	Will be expanding with another provider
Sanctuary	N		
Trauma Focused Cognitive Behavioral Therapy	Y	54	
Eye Movement Desensitization And Reprocessing (EMDR)	Y	33	
Other (Specify) HiFi	Y	93	Includes TAY population

*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

Bucks County has long provided an array of supports and services for its citizens with Intellectual Disabilities (ID).¹ Recognizing that many individuals with an ID diagnosis are identified early in their lives and that the diagnosis is life long, Bucks County was at the forefront of developing and delivering supports to individuals in their family's home. By so doing, we have been able to prevent the need for more costly out-of-home placements. We believe it is imperative that we continue to ensure delivery of services and supports in the least restrictive manner, which helps to ensure an individual's health and safety while enabling a family to maintain their loved one in their home for as long as possible.

When in-home services and supports are delivered in the family home personal relationships are established between individuals, their families and service providers. These relationships have resulted in an increased interest by individuals and their families in Lifesharing (formerly known as Family Living). Lifesharing is a supportive service model in which one or two individuals with ID reside in a family's home in the community. The 'family' unit may be a single man or woman, a traditional family, a single parent family, etc. Regardless of the configuration, the model is predicated on the idea that those living in the home are part of an interdependent and reciprocal relationship built on respect and understanding.

In addition to forming lasting relationships, in-home supports have also provided individuals and their family, Supports Coordinators (SC's) and caregivers, an opportunity to truly know one another while working together to determine an individual's need and how best to support him/her in the least restrictive setting when out of home placement becomes necessary.

A life of citizenship and contributing to the community at large is also strongly encouraged. To be a part of the community, individuals need to be engaged, thus we promote employment, volunteerism and the use of generic community resources.

County Planning Process

In an effort to prevent gaps in service between the time an individual finishes school (at age 21), we have been working with SC's to better support the educational system in collaboratively engaging students in meaningful transition planning at age 14. We have provided transition-related training and materials to school-aged youth, families, and Supports Coordinators to use as resources during the school transition years. We have collaborated with the Early Reach Coordinator (a licensed Social Worker whose role is to work with transition age youth interested in employment) from the Office of Vocational Rehabilitation (OVR) in an effort to bridge the gap between school and work. In addition, we will continue to work with schools in an effort to enhance their knowledge of ID supported employment services, as there is often a disconnect between school and the adult-serving system. The ID system relies on natural workplace support to promote the full inclusion of individuals with ID in the workplace with access to job coaches for training or retraining needs – not the intensive, daily hands-on support that many individuals have while in school.

¹ ID is defined as significantly sub-average general intellectual functioning (an IQ of approximately 70 or below) that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety. The onset must occur before the individual's twenty-second (22) birthday.

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Since Fiscal Year (FY) 2009-2010, capacity management became the management tool for the two Federal Medicaid Waivers for individuals with ID - the Person Family Directed Supports (P/FDS) Waiver and the Consolidated Waiver. Capacity management replaced the traditional model of funding allocations tied to a total number of people to be served. Within the traditional model, if we were fiscally prudent (and we most often were), we could present the Office of Developmental Programs (ODP) with documentation that we could support more people within the amount of money that they had allocated and acquire additional capacity to serve more individuals. The traditional model also allowed the County to set rates for each service a provider offered to individuals. Given our historical knowledge of providers, the individuals they served and the costs associated with providing services to individuals, we were able to maintain providers' solvency and ensure quality care in a cost effective manner.

The current method of capacity management requires us to manage a certified capacity in each of the waivers. We no longer receive waiver allocations to manage. In FY 15-16 we were given additional waiver capacity which increases our capacity to five hundred twenty-two (522) people in the P/FDS waiver and to six hundred fifty-eight (658) people in the Consolidated waiver. The capacity management model has also heralded the start of state set rates for services. In many cases, rates have significantly increased while others have been reduced to the point where many providers, most especially residential providers, are increasingly reluctant to serve individuals with an ID diagnosis and co-occurring behavioral health challenges. In addition, of late, the Bureau of Human Services Licensing (BHSL) has started to issue providers with physical site citations during inspections. Providers have been extremely challenged to keep up with site repairs and upkeep due to low reimbursement rates which have resulted since the move to capacity management.

Capacity management requires strong stakeholder input which is the result of collaboration, communication and cooperation between County ID Department [aka the Administrative Entity (AE)] staff and the Directors from the Supports Coordination Organizations (SCO's). Department staff meet with SCO's to review the waiting list [known as Prioritization of Urgency of Need for Services – (PUNS)], discuss individual circumstances and prioritize needs to ensure expeditious management of any capacity vacancy. To be identified for enrollment in a specific waiver, an individual's needs must be able to be met within the specific waiver, and they must be on PUNS in the Emergency category of *needing* services within six months.

At the beginning of FY 15-16 we had fifty-three (53) individuals identified to graduate in June 2016. We anticipate full utilization of the graduate capacity that we received from the ODP, by the end of this fiscal year. We are projecting that through both the increased capacity and attrition in the P/FDS waiver that we will meet the needs of all 53 individuals.

Among those being served, as a result of our rigorous weekly internal waiver capacity management process, are all of our 2016 graduates who are aging out of Early Periodic Screening, Diagnosis, and Treatment (EPSDT), Residential Treatment Facilities (RTFs), Approved Private School residential placements, and Children & Youth (C&Y) custody. It should be noted that there are three (3) individuals in the intake process who may be eligible for ID services and will graduate in June 2016 who are not included in our counts.

In addition, we continue to experience the challenge of successfully transitioning individuals out of RTFs, which are highly structured/highly regimented to the less structured/less regimented community-based

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residential supports that are available through the ID system. We see a need for reform of the RTF model, so individual's level of supports can be stepped down in preparation for their transition into ID community-based residential supports. We also see some of the current policy regarding settings where waiver services can be delivered, as a barrier to successful transition. We would encourage changes, on the state and federal level that would encourage the use of waiver services, while an individual is in the RTF setting. This would allow for more seamless transitions from RTFs into community life.

We are currently aware of fifty-two (52) individuals who will graduate in June 2017 who will be in need of services upon graduation. In addition, there are seven (7) individuals in the intake process who may be eligible for ID services and will graduate in June 2017. Of the 52, forty-three (43) individuals will need supports through the P/FDS Waiver and, at this time, up to nine (9) will need the Consolidated Waiver. Of the 9 possibly in need of the Consolidated Waiver, 3 are individuals who currently receive support through the EPSDT program. In addition, one (1) individual is in C&Y custody in an out of home placement and cannot return home. Two (2) are in Approved Private Schools and cannot return home. Finally, 1 is in a RTF due to intense behavioral health support needs. The remaining 2 individuals live at home and their needs are too great to be met within the P/FDS Waiver and thus, they are in need of the Consolidated Waiver.

Managing the needs of graduates is compounded by managing the needs of individuals who reside at home with their caregivers and receive, in some cases, no support. Often times, these are individuals whose families have managed without the system for many, many years. Thus, as the parents tend to be quite elderly when a need arises the situation frequently becomes the primary priority for the capacity management team. As of May 3, 2016 we have eighty-three (83) individuals who were born prior to 1975 on PUNS. At any time one of these individuals could become an immediate emergency priority for Consolidated Waiver should something happen to their primary caregiver(s).

During FY 15-16, we saw a significant number of intakes of individuals over the age of 40 whose families have never requested services or supports some have parents who are quite elderly and in some cases their parents have passed away and their siblings are assisting them in the intake process. In many of these cases, the families are looking for some support in their homes to maintain their son/daughter/sibling in their current living arrangement. In other cases, the families are in need of residential services for their loved one. There are currently 3 people in the intake process, who are over the age of 40.

SCO's are responsible to oversee Family Support Services (FSS) funds, which are used to address the short-term needs of individuals not enrolled in a waiver. While overseen by the SCO, the funds are ultimately authorized by the AE. All other available base funds have been allocated to 150 unique individuals in a variety of supports and services. Base funded supports and services include employment, sheltered workshops, transportation, adult training facilities, supported living, home-based supports, and residential services. Some of the individuals supported through the base allocation have been enrolled in the ID system for many years. However, they are not eligible for service through the Federal Medicaid Waiver due to lack of documentation of an ID diagnosis prior to age 22.

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Base Intellectual Disability Services

	Estimated/Actual Individuals served in FY 15-16	Percent of total Individuals Served	Projected Number of total Individuals Served FY 16-17	Percent of total Individuals Served
Supported Employment	56	33%	48	29%
Pre-Vocational	22	5%	21	4%
Adult Training Facility	9	3%	8	3%
Base Funded Supports Coordination	114	6%	114	6%
Residential (6400)	14	3%	14	3%
Life sharing (6500)	1	2%	1	2%
PDS/AWC	0	0%	0	0%
PDS/VF	0	0%	0	0%
Family Driven Family Support Services	120	100%	120	100%

In addition, it should be noted that forty-nine (49) adults are served with base funding in a variety of services that fall outside of the categories listed above.

Supported Employment:

Supported Employment services include job finding and job support. Job finding includes assisting an individual with searching for a job, preparing a resume, reaching out to potential employers, preparing for an interview and any additional tasks which may assist the individual in obtaining community employment. Job support includes assisting the individual with learning job tasks, and support to help maintain community employment.

We are dedicated to supporting individuals in their desire to become competitively employed in their own communities. We are committed to Pennsylvania's Employment First policy and ODP's philosophy of Community Integrated Employment for all. We have promoted employment as the goal upon graduation since the 1980's. We continue to support the growth of supported employment services for individuals in various venues throughout the year. We strive to ensure that employment is at the forefront of planning with individuals, families, SC's, school systems and providers working with transition age youth (TAY). In addition, as part of the Individual Support Plan process, we continuously promote and encourage teams to explore employment options with individuals who receive traditional day supports on at least an annual basis.

The ID Coordinator of Individualized Support Services has been identified as the AE Employment Point Person. The Coordinator is an active member of the local Transition Coordination Council (TCC), Right to Education Task Force, and participates in multiple cross system events, which include various school district expos, Employment Fairs (in which students and potential employers partner together), the Bucks County Intermediate Unit (BCIU) Post-Secondary Expo, Parent/Family Forums and various training

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sessions. The Employment First initiative is a focus of discussion at meetings with provider agency directors, during routine meetings with employment providers, and at SCO Director Meetings. The Coordinator stays current with state initiatives and developments regarding employment by attending the PA Transition Conference and PA Disability Employment Summit (PADES) annually. The AE staff collaborates with Mental Health Program staff on a number of employment and transition related activities.

AE staff continue to be actively involved in the development of initiatives set forth by the Supported Employment Leadership Network (SELN), a nationwide network of states dedicated to better supported employment outcomes for all individuals with ID. The Coordinator is also involved in the PA Association of People Supporting Employment First (APSE), which is dedicated to ensuring integrated employment for people with disabilities. The Coordinator continues to be involved in Work Incentives Planning and Assistance Program (WIPA) advisory meetings to ensure that Social Security and Supplemental Security Income (SSI) recipients are educated on the benefits they may continue to receive while working.

Currently, we have one individual participating in the Discovery Process. This is a non-traditional process aimed at developing customized employment supports for individuals based on a rigorous assessment of an individual's interests and strengths. While the individual's family has expressed optimism about the process and the potential for their loved one it is a long, slow process. The AE would appreciate being able to offer this unique service to individuals BEFORE they age out of school. We so often find individuals on PUNS who are indicating employment as their service choice only to opt out of it as there are mitigating pressures on the individual/family for 'care' during a family's work day hours. We believe that if this option was available earlier we would be more successful in a school to employment transition. Access to more Discovery trained staff would be greatly appreciated.

We work collaboratively with the OVR and have developed processes to help ensure employment is an option for all individuals. We have provided trainings for individuals, families, SCO's, School Transition Coordinators, school Social Workers, teachers and providers, both in concert with and independent of OVR. We are committed to working directly with students, their families, SC's and their school teams, to ensure an understanding of adult employment services and ensure transition activities in schools are focused on real jobs, not simply job rotations. In addition, we are striving to foster an enhanced understanding of the role SC's need to play in the development of the goals of a TAY's Individualized Education Plan (IEP) to ensure readiness for employment upon graduation. OVR's Early Reach Initiative provides information and consultation to youth, their families, school personnel and community agencies. Department staff are committed to working with OVR to reach students as early as age 14 to better prepare for their transition to community employment once they leave school. The AE will continue to reinforce with individuals, families and stakeholders on the benefits to be gained from integrated community day supports, with an emphasis on employment as the first and preferred service outcome.

On March 10, 2016 Governor Wolf directed Pennsylvania by way of Executive Order that "*Employment First*" is the first consideration and preferred outcome of publicly-funded education, training, employment and related services, and long-term supports and services for working-age Pennsylvanians with disability." We are exploring a part-time per diem position in the Department for an individual with an intellectual disability to assist with some critical clerical functions for both waiver and program staff.

In the Fall of 2015 the AE hosted Family Forums at three SCOs which targeted TAY and their families to

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begin planning for life after school with a focus on the employment and life skills needed to navigate the world of work. From these Family Forums, we invited TAY to participate an Employment Project. Six (6) students are currently participating in the Project, each working with a Supported Employment provider to explore careers, enhance independent living skills necessary on the job, build vocational skills, enhance their networks of natural supports, and participate in small group learning experiences. Two of the six have obtained employment in the community!

Supports Coordination:

The purpose of Supports Coordination service is to promote an individual's right to an *Everyday Life*. SC's accomplish this through their representation and advocacy for individuals by way of their functions of locating, coordinating and monitoring needed services and supports. These functions include assisting the individual in gaining access to needed medical, social, educational, communication tools/devices and other services through natural supports, generic community resources, and monitoring those services along with the services and supports delivered through the ID system. The AE currently has eight SCO's supporting Bucks County citizens with ID. The AE's ID Director of Supports Coordination works with each SCO to ensure they are meeting the requirements and responsibilities to the individuals we support, as defined by ODP, federal and state regulations.

The AE has maintained its expectation for SCO's to apply the same standard of service and oversight to all individuals regardless of funding source. This principle has successfully allowed the Department and the SCO's to best support each individual while taking into account the supports and services from all available funding and natural resources. Starting with the ID Intake, Registration and Referral the AE uses assessment tools to explore the supports and services used by and available to individuals and their families. The information collected during registration is passed on to the selected SCO and incorporated into the ISP. Following enrollment the AE continues to inform and engage SC's along with individuals and their families in the discovery and use of natural supports through the ISP review, sponsored trainings, distributing community announcements, and collaboration with community partners in creating and sustaining resources. The AE also works to educate SCs, individuals and their families on the transitional life stages and incorporating those changes into an individual's ISP.

PUNS is used to gather information to categorize the urgency of the future needs of individuals with ID. The information allows the AE to plan for future services. The AE routinely reviews the information on individuals who have a PUNS and meets individually with SCO's throughout the year to review and discuss the individuals on the PUNS emergency and critical status. This practice provides for more efficient planning for individuals on the PUNS and for a more accurate reporting to ODP on the AE's future needs. In addition, annually AE staff meet with SC's to review the PUNS protocol. In addition each month the AE provides each SCO with a list of upcoming PUNS due for annual review.

The AE reviews and approves all ISPs by applying the same ODP requirements and AE expectations, regardless of fund type. In reviewing and approving each ISP we evaluate the use of community integration and employment and when appropriate instruct SC's on their efforts to identify the appropriateness and availability of needed services and supports and enhance information captured for a successful transition process. Our ISP reviewers participate in ODP sponsored trainings and webinars to ensure thoroughness in the development and review of ISPs. We apply the same guidelines, as outlined in the ISP Manual and our own ISP guide to safeguard the consistency of all ISPs.

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Several AE staff recently participated in the ODP Community of Practice: Supporting Families throughout the Lifespan training. As the project gets underway we will familiarize our staff with Community of Practice strategies for supporting families and look at how the Life Course framework and tools can be used to improve the lives of individuals with ID. It is our hope that this project will assist individuals and their teams to better connect with natural community supports and services through enhanced person-centered planning and thinking.

Significant changes have occurred in the technology to support individuals in the workplace. The AE will focus on continued education of our staff and SCO's to enhance and expand the use of devices and tools that can assist individuals in achieving greater independence across all environments: work, home and recreation. We are committed to assisting SC's to feel confident in their ability to help guide individuals and their families through transitional life stages by enhancing the SC's skill set and tools to use for meaningful and mindful person-centered planning.

Through innovation, coordination, and a commitment to service, the AE and SCO's can and will provide individualized, person-centered support and training to help individuals with disabilities attain their goals to achieve an Everyday Life. In FY 16-17 the AE will be reaching out to Nancy Richey from ODP to conduct a local training for SC's to enhance their understanding of the Life Course framework and tools to support individuals and families.

Lifesharing Options:

Lifesharing is a residential model that supports individuals with ID to live with qualified unrelated adults (known as Lifesharers) who provide support to individuals usually in the Lifesharer's home. Lifesharing is about living and sharing life experiences with supportive people who form a caring household. Lifesharing is recognized as both a close personal relationship and a place to live. Lifesharers offer individuals the opportunity to be part of a caring household, and to participate in community life. Lifesharers and individuals are carefully matched, and supported by qualified professionals who help individuals to achieve their desired outcomes. Birth families are strongly encouraged to be part of the matching process, and actively involved in the lives of their children who choose a Lifesharing option.

The ID Consumer Services Coordinator has been identified as the Bucks AE Lifesharing Point Person and is actively involved in both the Statewide and the Southeast Regional Lifesharing Coalitions. In addition, to weekly capacity management meetings, staff meet bi-weekly to discuss individuals who are on PUNS for residential services, including Lifesharing.

The Coalitions are actively involved in providing input to the Commonwealth regarding potential changes to Lifesharing regulations, as well as feedback related to the implementation of Centers for Medicare and Medicaid Services (CMS) Home and Community-Based Services Final Rule, in Lifesharing settings. Recent changes to the United States Department of Labor's Wage and Hour rules have proved challenging for Lifesharing providers. Providers are faced with the potential for increased costs of complying with the ruling. The overall number of individuals receiving Lifesharing services in Pennsylvania has been on the decline. From FY 14-15 to FY 15-16 we increased the number of people served through Lifesharing by 3.

Lifesharing continues to be discussed regularly at both our SCO Director and provider meetings.

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Updates are given, based on information obtained at Lifesharing regional and statewide meetings. We encourage provider Residential Directors and other agency personnel to attend the regional and statewide meetings.

The ID Consumer Services Coordinator will be attending SCO staff meetings to discuss with SC's how to inform individuals/families about Lifesharing and the benefits to be derived from the service model.

ISP's are reviewed for compliance with Chapter 51 requirements, to ensure that Lifesharing is always considered first as a residential option. It is discussed with everyone in need of residential services including individuals graduating, as well as with those who are aging out of other child serving systems and are in need of residential supports.

We are proud of our commitment to and the continued expansion of Lifesharing as an option for individuals. The enduring relationships that can result change the lives of all involved.

Cross Systems Communications and Training:

Department staff participates on three committees targeted at coordinating children's services. The first is the Bucks County Children's Executive Steering Committee consisting of Department Heads from C&Y, the Juvenile Probation Office (JPO), the Bucks County Drug and Alcohol Commission, Bucks County Behavioral Health, MH/DP, and Magellan Behavioral Health (MBH). The charge of this group is to oversee all children's services to ensure seamless service delivery to children and their families. The Committee is further charged with ensuring that identified service gaps for children are remediated.

The second committee is the Children's Coordination Steering Committee (CCSC), which is the County's cross systems planning team. This committee is comprised of staff from the aforementioned agencies. The committee works to develop strategies and recommendations to advance systems improvement. The committee's purpose is defined, *"...to support the healthy development of families and communities through a child serving system that is integrated, efficient, effective, holistic and inclusive of parents, youth and providers."* An overall goal of the committee is to reduce the placement of youth in RTF's through the development of community-based alternatives and individualized planning process. In addition, the committee members are working to strengthen a person-centered planning culture which includes peer support, community and natural support and promoting youth leadership opportunities. The committee's focus in 2016 continues to be Interagency Team Meeting (ITM) process. It is a multi-system initiative, partnering with MBH, to enhance the team meeting process.

A series of family focus groups was held in early 2016 for the purpose of gathering feedback from families regarding their experience with the content and structure interagency team meetings. We are also planning to hold trainings in the coming year for cross systems partners on the ITM process and how to effectively facilitate these meetings.

The Integrated Children's Case Planning Committee (ICCP) has undergone a transformation this year, in an effort to make the meeting more productive and relevant. This forum has become the Bucks County Children's Leadership meeting. The goal is for it to be a forum for: better communication, coordination, and discussion; exploration of systems barriers; strategizing and problem solving; data sharing and project updates. The first meeting was held in March, and subsequent meetings will be held quarterly.

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The ID Children's Services Coordinator (CSC), works specifically with children who are diagnosed with both mental health and intellectual disabilities, and receive behavioral health services. She works collaboratively with ID service provider agencies, non-ID service providers, families and care managers to ensure the child with multi-systems needs is supported holistically. As children with disabilities are entitled to Medical Assistance (MA) it is imperative that children and TAY (up to 21) access all services they are entitled to receive through EPSDT, most especially as the waiver is the payer of last resort.

In addition, she is the ID point person for Bucks County children with an ID diagnosis who reside in RTF's, those whose parents/treatment teams are recommending RTF level of care, and for youth who are transitioning back to the community from a RTF. To assist in more successful transitions from RTF's to waiver-funded residential services; our office has developed a TAY assessment tool. The administration of the tool will begin by age 18 to help ensure the team fully understands the structures and supports necessary for a successful transition from the RTF to the ID adult serving system. We have noted a disjointedness and lack of understanding by the RTFs of what is and is not possible in the ID adult serving system. Our goal is to help RTF's develop strategies that can be successfully utilized in the adult serving system to ensure a seamless transition for the TAY.

One of our greater challenges, relative to children aging out of RTF's, is the disjointedness between the structured, restrictive environment of the RTF, and the person centered, strengths-based community setting. With the RTF's high staffing ratio (often 1:1) more rigid scheduling, and treatment based more on needs, stabilization and maintenance; the RTF model is not reflective of and does little to prepare an individual for the transition to home. Systems barriers often preclude a smooth overlap of services that would allow for strong collaboration. Also, the difference in licensing regulations, restrictive procedures, etc., can add an additional burden to transition planning. The use of restraints in the RTF settings has been particularly challenging. The need to reduce the use of restraints in the RTF setting is something that has been and continues to be discussed in meetings across all systems.

The ODP/OMHSAS have received a grant. As we understand it, this grant is to improve collaboration between the two departments and to hire a state transition coordinator. The role of the transition coordinator will be to work on issues surrounding TAY moving from RTFs to the adult ID system.

The CSC is also the primary contact for SC's who are working with families and their children who are receiving Behavioral Health Rehabilitation Services (BHRS) within the family home, or are identified as needing those services. There is a particular focus on TAY, working with teams to identify the strengths and needs of the youth. This is essential to understanding and planning for the supports and services an individual will need to ensure a successful transition into the adult ID system.

The CSC interacts closely with the Behavioral Health (BH) and Mental Health (MH) Children's Services staff. They meet regularly as the "Children's Team" to discuss trends, issues, meeting agendas, MBH policies and other items. She also participates in many of the multi-systems meetings, workgroups and committees with the aforementioned agencies. This collaboration may also include SCOs, the local Independent Monitoring for Quality (IM4Q) organization, school districts, the BCIU, community behavioral health provider agencies and non-clinical service provider agencies.

In addition to children, we remain steadfastly committed to improving the lives of adults with an ID diagnosis who have co-occurring mental health challenges. To that end, the ID Unit has forged a solid working relationship with Bucks County Behavioral Health and MBH.

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Staff work collaboratively with the aforementioned entities to find creative approaches to addressing some of the challenges inherent when multiple systems are involved. We work diligently to collaborate, resolve and stabilize situations before adult inpatient treatment becomes necessary. We have found that many of the local psychiatric inpatient hospitals are reluctant to accept patients with an ID diagnosis, due to their lack of expertise in working with individuals with an ID diagnosis. To that end, through our collaborative working relationship, when an inpatient commitment has been necessary, MBH has been willing to authorize inpatient treatment at non-network hospitals that have better expertise working with adults with ID who need inpatient MH treatment to ensure the best possible outcomes.

To help prevent the need for inpatient MH treatment, the AE has been at the forefront of collaborative efforts with community based mental health treatment providers, to ensure care is available locally for individuals with ID.

Individuals who are dually diagnosed with MH/ID have more trouble accessing mental health services than individuals without an ID diagnosis. In addition, individuals with ID may have significant challenges such as issues with group home living, lack of control over their life, employment barriers and social challenges. These challenges can lead to feelings of isolation. Individuals with a dual diagnosis need assistance and support to communicate their mental health symptoms and understand the side effects of their medication.

MBH has worked to increase the network of psychiatrists available to treat individuals with a dual diagnosis. Psychiatrists are beginning to use psycho-social evaluations. Efforts to improve the coordination of physical health with psychiatric care is ongoing.

We have also worked to increase individual and group therapy options including non-traditional modalities of therapy such as art, music, exercise and role-playing in the clinical setting. In addition, more clinicians are being trained in Trauma Informed Care.

In addition, we have worked to ensure that there are Certified Peer Specialists (CPS) with the skills necessary to successfully engage with individuals with a dual diagnosis. One individual with a dual diagnosis who has become a Certified Peer Specialist (CPS). She provides specialized CPS services focused on activities to promote independence, relationship building and has sponsored monthly peer support groups and educational activities.

The ID Residential Coordinator (RC) co-chairs the MH/DP Behavioral Health Workgroup. This cross-systems workgroup has been in existence for over ten years and is charged to improve the behavioral health services and outcomes for individuals with a dual diagnosis.

In 2013, Bucks County MH/ID received Reinvestment funds to develop a service model for outpatient psychiatric care that would meet the needs of individuals with a dual diagnosis. The goal is to enhance existing outpatient psychiatric services to deliver quality evaluations, medication management, treatment planning, and behavioral health supports for individuals with a dual diagnosis. This project has been extended into FY 15-16.

The project involves a well-regarded psychiatrist with extensive expertise in treating individuals with a dual diagnosis by assisting community-based psychiatrists to enhance their skills it help ensure an improved level of clinical care services for individuals with a dual diagnosis. Each individual involved in

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the project receives multiple collaborative psychiatric consultations between the expert psychiatrist, the community-based psychiatrist and his/her team which minimally consists of the individual, his/her supports coordinator, and the care coordinator. Additional support team members may include any service provider (MH or ID) involved with the individual, his/her family, and anyone else the individual deems as important in his/her life.

The role of the Care Coordinator is to:

- Coordinate psychiatric evaluations and other behavioral assessments as needed.
- Ensure that all records/materials are available for evaluations/medications checks.
- Ensure that information is shared between the expert psychiatrist, community-based psychiatrist, and the support team.
- Coordinate follow up activities.
- Collect outcome data.
- Ensure data collection related to target symptoms occurs.

At the end of this project it is proposed that there will be at least:

- Four sites with a psychiatrist who has been mentored by the expert psychiatrist on the unique needs of individuals with a dual diagnoses.
- Enhanced individual choice between four local community behavioral health centers with the expertise to perform a thorough evaluation and provide ongoing treatment for an individual with a dual diagnosis.
- A reduction in the number of psychiatric and physical health hospitalization of the target pilot members by 10%.
- A reduction in the number of physical health emergency room visits and behavioral health crisis visits, by the target pilot members by 10%.

The following is a list of a few of the accomplishments over the last several years:

- Increased capacity of the MH system to serve individuals with a dual diagnosis.
- Standardization of the Social Emotional Environmental (SEE) Plan Criteria and training on it to Bucks County SC's and providers.
- Revision of the SEE Plan to meet the new criteria as mandated by the ODP to include information about recovery and trauma informed care.
- Collaboration with a well-regarded psychiatrist with expertise in working with individuals with a dual diagnosis.
- Training for community-based psychiatrists and MH professionals to better treat individuals with a dual diagnosis.

Through our collaborative cross system efforts we continue to work to reduce risk while working to ensure individuals receive the quality care and supports they need to maintain their physical and mental health.

The AE collaborates and communicates regularly when individuals with an ID diagnosis enter/come into contact with the Bucks County Area Agency on Aging (AAA) system. Sometimes it is because an

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individual is in need of a short-term stay in a nursing facility for rehabilitation purposes. Sometimes it is related to a previously unknown individual who the AAA Case Worker believes may have an ID diagnosis and their primary caregiver has fallen ill and is now under the auspices of AAA. This can lead to the initiation of an intake for the individual into the ID system. Both systems work in concert to ensure the needs of the individual are met.

Emergency Supports:

As previously stated, our reliance on the Federal Medicaid Waiver programs to address the needs of Bucks County citizens with an ID diagnosis cannot be understated. With only 150 individuals receiving regular and consistent base funded services/supports, it is essential that we receive increased waiver capacity to meet the needs of the individuals on the PUNS waiting list.

Without increased capacity, we will not be able to address the needs of our 2017 graduates. In addition, there are currently ninety-eight (98) individuals in the P/FDS waiver that are within \$2,000 of the \$30,000 cap. *Many* of these individuals are in need of additional supports. As previously mentioned there are currently 83 individuals who are living at home with elderly caregivers, many of whom are quite frail. Should something happen to the primary caretaker the individual will very likely present as in immediate need of the Consolidated waiver.

Administration of the waivers demands adherence to the Administrative Entity Operating Agreement (AEOA). Our rigorous approach to capacity management helps to ensure we are aware of individuals and their needs in a timely manner. This ensures we are managing any available waiver capacity both effectively and efficiently. Maintenance of our base allocation is essential to ensure the continuation of the services/supports to individuals for whom we cannot establish waiver eligibility, for SC services to those not eligible for Medical Assistances and for the provision of FSS.

Recognizing emergencies can occur anytime day or night, our Department's on-call line is available to citizens in need. If the emergency involves an individual with an ID diagnosis, a call to a DP staff person is made to coordinate a response to the situation. Coordination of the emergency response will be made in concert with the individual's identified SCO. The use of available Family Support Services (FSS) funds to cover temporary respite will be utilized. Long-term planning will involve collaboration/communication with the ODP.

Administrative Funding:

In collaboration with our regional Health Care Quality Unit (HCQU), Philadelphia Coordinated Health Care (PCHC), the AE will assist providers in increasing their competency and capacity related to serving individuals with aging-related, physical health, behavioral health and communication needs through trainings. Provider meetings will also be a forum for dialogue amongst providers and AE staff regarding these issues.

PCHC staff participate in the AE provider meetings, AE Provider Risk Management meetings, have assisted with risk mitigation, and are available to providers, individuals and families to address specific training or health care access needs. In the coming FY we expect the Bucks County Quality Council will be reinvigorated and we will seek to include PCHC as an active participating member.

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When an individual is moving into residential services, PCHC reviews an individual's record, family history, and other supportive documentation to identify health care needs and potential areas of health risk. The AE has a process to help ensure that any recommendations made through the review process are followed by the individual's team.

AE program staff together with individuals, families, SC's and service providers identify individuals who are experiencing complex or unresolved medical and/or psychiatric issues through ISP review and/or review of data in the Enterprise Incident Management (EIM) system. Once identified teams may make a referral to PCHC for a Community Health Review (CHR). Upon completion of the CHR the AE collaborates with providers and SC's to ensure necessary follow up care is completed based on the recommendations contained in the CHR.

If, following the CHR, an individual whose outstanding medical issues have been resolved continues to present with challenging behaviors or his/her behavioral health concerns are of such frequency and intensity a Behavioral Health Clinical Review (BHCR) will be sought. The BHCR team includes the individual, the family, service providers, psychiatrist, behavioral consultant, nurse, and other professionals as deemed necessary. This process focuses on all aspects of an individual's life in order to help ameliorate the challenges to an individual's life. Once a BHCR is completed the team reviews the recommendations with the individual's PCP and treating psychiatrist to determine a course of treatment. A PCHC nurse in concert with AE staff follow-up to ensure the loop is closed on all recommendations.

Independent Monitoring for Quality (IM4Q)

The AE is actively engaged with the local IM4Q program to continuously enhance the quality of services and supports provided to individuals. The IM4Q interview process affords an opportunity for individuals to voice their thoughts on issues such as, choice, control, community inclusion and relationships.

Annually ODP provides the AE with a random sample of individuals who are receiving services from different funding streams. The IM4Q team interviews the individuals, their families and/or staff and as a result develops what are known as 'considerations' for the individual's team to review and take action on. These considerations may be opportunities or things that an individual would like to have access to or made available to enrich their daily life. The AE ensures the consideration is seen through to fulfillment. If, for some reason, the local IM4Q team does not feel that a consideration was fulfilled or seriously reflected upon they may ask the team to take a deeper look. Through enhanced oversight of the consideration process and interaction with our IM4Q team the value of considerations and teams responsiveness to them has been heightened. This has resulted in a much more cohesive, collaborative and meaningful outcome for the individual.

The data collected during the IM4Q interviews is collated and presented in 3 formats. One is the National Core Indicators, another is aggregated state data and finally the data is presented to reflect each AE. Bucks AE data reflects that individuals are equal to or exceed State/National levels of satisfaction in most every area explored. For example, data from the 2014-2015 report show: 90% of individuals from Bucks County report they go out for fun; state data reflects an 87% response rate. 85% of Bucks County individuals report being able to see friends whenever they want; state response rate is 80%. 62% of the individuals surveyed from Bucks County report choosing where they live versus a statewide response rate of 47%. While some of the percentages displayed are high the data also exposes areas where continued growth and improvement is necessary, for instance in choice of living

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arrangements. This information helps to focus the AE on areas for continuous quality improvement.

Indicators of Quality are shared with the AE when the IM4Q team observes exemplary service/supports for an individual. For instance, an individual chose his staff 18 years ago and this staff continues to support him or individuals who have decorated their home in a manner of their choosing or the individual who is employed full time with his own apartment. These examples offer illustrations of situations where an individual is living an Everyday Life.

Risk Management

Internally the AE's Risk Management Team (RMT) meets on a weekly basis to discuss individuals who are 'at-risk' or have active incident reports in EIM. The team brainstorms ways to better support people living at home who are at-risk but do not equate to 'imminent risk' by Adult Protective Services (APS). This small group of individuals is particularly challenging as they are often our most impoverished and there are often mitigating family dynamics that create barriers to an easy resolution. SC's are very active in trying to creatively assist these families to better ensure the health and safety of their family member with ID.

In addition, the RMT examines current incident reports, follows up on emergency situations and discusses any reported information that may lead to a risk/incident situation for an individual. Resources for risk mitigation are also discussed.

The RMT also reviews relevant SC issue sheets, service notes and ISP's to crosscheck information for any risk concerns. The Risk Team may request information be updated and/or recommend corrective actions be taken.

Some members of the RMT are also as Certified Investigators (CI's). The CI investigates incident reports regarding neglect, abuse and death. They may co-investigate with other organizations; Providers, C&Y, AAA and APS. The RMT ensures that the appropriate protective agencies are notified about an incident, if necessary.

Our Risk Management Specialist (RMS) is actively involved in the Southeast Regional Risk Management meeting. The group hosts annual Meet and Greet Forums for providers and community partners to better understand risk management procedures. The AE hosts a local provider Risk Management meeting to provide updates, discuss best practices and have discussions to promote safe and healthy environments.

Housing

The ID Residential Coordinator (RC) advocates for housing opportunities for individuals with ID in a number of ways. The RC works closely with the MH Housing Coordinator.

The RC participates in the Local Housing Option Team. (LHOT) The LHOT is a multi-system collaboration team that includes representatives from Bucks County MH/DP, AAA, Bucks County Adult Probation and Parole, Department of Housing and Community Development, Bucks County Housing Authority (BCHA), Center for Independent Living (CIL), Behavioral Health and other providers. The prime focus of the LHOT is to advocate and support the development of affordable housing options. Most recently, the LHOT

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worked on promoting accessible housing for individuals and identifying private landlords as well as landlords connected to BCHA.

Emergency Preparedness

The AE has representation on the Regional Task Force Functional Needs Subcommittee. This committee focuses on the preparedness issues for any individual who may need additional assistance in the event of a large scale emergency or disaster. The committee is charged to make recommendations to support the needs of individuals with disabilities in emergency planning activities. Information from these meetings is shared with ID providers at the provider meeting.

During provider monitoring the AE reviews records to ensure that each provider has an Emergency Disaster Response Plan. This plan must include how the safety of individuals will be ensured as well as communication and operational procedures. The monitoring also confirms that all staff have received training on these procedures before working with individuals and annually thereafter.

Participant Directed Supports

Our AE has seen a steady increase in the number of individuals choosing participant directed supports (PDS). We promote PDS by providing individuals/families with information regarding participant directed service-options, during the ID intake process. Additionally, we are considering how best to provide information on PDS to individuals/families upon the identification of an individual for enrollment into one of the ID waivers. The AE promotes PDS through our participation in the readiness review process. As part of the readiness review, individuals/families are educated regarding the benefits and responsibilities related to participant directed services.

We have found certain barriers to the further expansion of PDS. At times, families may not fully consider the implications of being a managing employer or common law employer. Another barrier to the model is the recruitment and retention of qualified staff. In addition, we have found that in the FMS service model, common law employers can have issues managing their employees' time, resulting in the excessive use of overtime. We would appreciate ODP developing their response to overtime as relying on SC's and letters from the AE have not successfully ameliorated the on-going issue of overtime being paid to the staff of individuals receiving PDS.

Community for All

Data received from the ODP shows that Bucks County currently has one hundred eight (108) individuals residing in community ICF/ID's, nursing homes and large community ICF/ID's (16 or more individuals/site). It is important to note that of the 108, fifty-six (56) reside in small community-based ICF's and thus, are afforded the opportunity for a life in the community to the extent that the ICF regulations allow. Four of the 56 individuals will be converting to waiver funding on July 1, 2016. Twelve of the individuals reside in nursing facilities with an average age of 60. Based upon information received from their SC's all have medical needs and require 24 hour care and many require 2-persons to assist with all of their personal care and transfers. Some have medical needs that would require 24-hour care in the community.

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As an AE we are committed to the full citizenship of individuals with ID in their communities and to an Everyday Life for each individual we help to support.

Over the years, most of the families of the individuals who reside in the large ICF's have been approached about having their son/daughter relocate to their home communities. We have not been successful in convincing them to relocate their loved one. It is quite discouraging and in many cases the parents of the individuals are deceased, but their children promised their parents they would never move them and to date none of them have been willing to, as they see it, "go back on their word". We will encourage SC's, once again, to discuss community living with the individuals and their families during FY 16-17 and to ensure said discussion is included in service notes.

HOMELESS ASSISTANCE SERVICES

Homeless Assistance General Overview

Bucks County offers a range of homeless assistance services to meet the needs of individuals and families experiencing a housing crisis.

Currently, all housing services provided by the County of Bucks are initiated through our centralized intake platform we call Housing Link. Housing Link serves as our initial intake and screening process for those who are homeless or facing homelessness. Following the Housing Link intake process, individuals who are not diverted out through supportive phone consultation are assigned to a provider agency who will complete a more thorough assessment using a standardized assessment tool that helps the county determine eligibility for our range of services.

Services provided range from diversion coaching to permanent housing placement. Diversion coaching assists the family or individual in identifying personal resources to resolve their own crisis with little to no financial assistance. This type of work has been practiced for several years but only formalized through training in the last 2 years. Other services available to individuals and families facing a housing crisis include rental assistance to prevent a homeless episode, emergency shelter to temporarily shelter a homeless family or individual, rental assistance to secure permanent housing thus ending a homeless episode, and bridge housing to assist a homeless family build skills, increase income, and maintain permanent housing.

In 2015-16, Bucks County embarked on a collaborative effort to address the challenges of homelessness in our county through the creation of the Bucks County Housing Advisory Board (HAB). The HAB is responsible for the creation of a strategic plan to ensure the housing stability of Bucks County residents experiencing homelessness, at most risk of becoming homeless, or who are challenged by housing affordability options. In May, 2016, the HAB completed the final set of recommendations to the county commissioners called, A Home for All: Bucks County's Vision and Action Framework to Prevent and End Homelessness. This document includes community-wide impact goals for 2017-2021:

1. Exit more families, youth and single adults experiencing homelessness in Bucks County directly to permanent housing with stability.
2. Reduce the number of families, youth and single adults who become homeless or return to homelessness in Bucks County.
3. Improve system performance and outcomes while reducing the cost of ending and preventing homelessness in Bucks County.

These goals are obtainable and require collaboration among county agencies and nonprofit organizations to achieve desired outcomes. As these recommendations move forward into more advanced and concrete planning efforts the ability to use these funds from the Human Services Block Grant to meet identified needs through collaborative strategies will be important. The efforts outlined in this section reflect work completed during the past year, but it is our collective hope and expectation that in the coming year Homeless Assistance Services will be enhanced and measurable outcome improvements will take place.

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BRIDGE HOUSING PROGRAM

Services Provided

The Bridge Program is a subsidized housing program for homeless families and Youths aging out of the Foster Care System, who reside in Bucks County. The purpose of the program is to provide housing and case management for families who are transitioning from homelessness and dependency to permanent housing.

This ultimate goal of independence is attained through participation in education and training programs with a career emphasis, while being employed on a part time or full time basis; depending upon the circumstances.

The Bridge Program is administered by Bucks County Children and Youth Social Services Agency. Case Management for client families is provided by Children and Youth, Bucks County Housing Group and Bucks County Opportunity Council with the goal of strengthening families. A maximum of fifteen (15) families at any one time can be accommodated by the program. The length of time in the program is usually 12 – 15 months.

The Bridge Housing Program is a result of a collaborative effort by various public and private social services agencies with the mutual goals of moving families from homelessness and dependence on the social services system to permanent housing.

Program Objectives:

1. Family unit is maintained or appropriate family members are reunited
2. Achieve safe affordable housing
3. Secure full-time employment is achieved by all appropriate family members, a balanced budget is achieved utilizing housing and/or child care subsidy; or a balanced budget is achieved except for a childcare subsidy
4. Secure full-time livable wage employment with a balanced budget without subsidies. Family achieves full self-sufficiency and permanently leaves human services systems

Evaluation of efficacy for Bridge Program Outcomes to date for 2015-2016

2015-2016

- 7 HH, 19 people, participated in the Bridge program from July 1, 2015 to May 15, 2016
- Average length of service is eleven (11) months
- Projected- 8 Families in Program through June 30, 2016

Results as of May 15, 2016:

- 2 families were exited from BCOC's Bridge Program
 - 1 was employed full or part time at the time of exit
 - 1 remained enrolled in the Economic Self-Sufficiency program
 - 2 maintained the same permanent residence upon exit

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- 5 families enrolled as of May 15, 2016
 - 1 is enrolled in an education program
 - 3 have maintained employment or gained new employment
 - 3 are dually enrolled in the Economic Self-Sufficiency program

Changes proposed

No changes have been proposed from our 2015-16 plans at this time, however the Housing Advisory Board has established a set of recommendations to improve homeless services in the coming year including integration of all systems providing housing supports and movement away from traditional transitional housing to a rapid rehousing model to assist the most people gain stable, permanent housing as quickly as possible.

As we are awaiting this coordinated county planning based on the HAB recommendations we look forward to utilizing these funds in the most effective way possible, in alignment with best practices and the county's strategy.

CASE MANAGEMENT

Services Provided

Residents who face homeless situations or who are currently homeless and desire housing are provided case management and depending on their situation and eligibility, may receive financial assistance to resolve their problem.

Residents in need of assistance to resolve or prevent a homeless situation may be eligible for one or more of the following which is paired with Case Management:

- Rental Assistance
 - To prevent homelessness or move out of homelessness
- Security Deposit
 - To move out of homelessness
- Mortgage
 - To prevent homelessness

Case Management services may be offered to any subsidized housing resident in resolving an emergency, and increasing and maintaining level of independence that would prevent recidivism.

Specific services provided include development of a monthly budget with each client applying for HAP assistance. An assessment of the monthly budget assists the Self-Sufficiency Coach in assessing the client's ability to have sustainable income sufficient to pay rent in the future or have no income but have reasonable expectations for sufficient income in the next 90 days.

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Clients who have received HAP assistance will be offered follow-up services in an effort to prevent recidivism. The Self-Sufficiency Coach will make a personal follow-up contact to the client three times 30, 60 and 90 days after the final HAP payment. During these calls the Coach will perform a needs assessment, offer supportive services and assure stabilization of the crisis. Dependent on assessment, the Self-Sufficiency Coach may encourage additional follow-up services and establish a face-to-face interview with the client.

When services are provided to clients with no income, the narrative in the client file will reflect the reason for providing assistance. Clients who are escaping domestic violence will be reviewed on an individual case basis. Income eligibility screening will be completed but waived whenever determined to be in the best interest of the individual/family to secure safe and/or permanent housing. Intensive follow-up services are enacted to provide an effective delivery of services to clients at risk of homelessness and to prevent recidivism. When a client exhausts their available HAP financial assistance within the 24-month period, a letter will be sent to them notifying them of this situation. Copies will remain in the client file for documentation. Clients who have not previously benefited from enhanced follow-up and supportive case management services and repeat their request for HAP financial assistance will be reviewed on a case-by-case basis.

Evaluation of efficacy for 2015-16

The Opportunity Council will use Clients to Success (CTS) to measure all HAP Program Results. These measures will be used to continue our work in developing an effective homeless prevention program. Among the results that will be measured are:

- Demographics of participants
- Total Payments
- Average Assistance Payment
- Sustained results 30, 60 and 90 days follow-up
- Total assistance from non-HAP fund sources including total private assistance to resolve housing crises

Outcomes for HAP Case Management programs from 7/1/15 thru 5/15/16

Counseling to resolve Potential Eviction

- 1303 people in 605 households received counseling services to prevent homelessness
-Forecast for YE is 1,564 people

Received Budgeting Tutorial and Developed Budget

- 424 people received Budgeting Tutorial and developed household Budget
-Forecast for YE is 488 people

Changes Proposed

No changes have been proposed from 2015-16 plans, however, as was noted previously, The Housing Advisory Board has established a set of recommendations to improve homeless services in the coming year.

HOMELESS ASSISTANCE SERVICES

RENTAL ASSISTANCE

Services Provided

A resident who is homeless or near homeless and requests financial assistance will receive and intake interview and assessment on the same day they complete an application for Homeless Assistance. Applicants who are unable to meet for their intake and assessment interview when they complete their application; negotiate an alternative time. HAP applicants are required to provide the necessary documentation within a reasonable time frame.

Clients are instructed to bring in all necessary income, identification, proof of eviction, and supporting documentation in order to fully determine eligibility for assistance. If a resident does not submit necessary documentation, particularly income documentation, they will be considered ineligible for HAP assistance pending submission of requested documentation. The client will be allocated a maximum of seven (7) calendar days, from the time of first meeting, to present needed information and complete the application process. When applications have not been completed within this time frame, clients will disqualify themselves from assistance and/or encouraged to restart the entire application process.

Income documentation that confirms the client is at or below 200% of the federal poverty level will be used to determine their eligibility to receive HAP assistance. Clients may receive a maximum of \$1,000 for adult-only families or households or \$1,500 for families or households with children during a consecutive 24 month period. HAP services provided to clients with no income will have documentation in the file as to the reason a decision was made to assist the client. No client will be assisted who is not income eligible within the 30-day period.

The Self-Sufficiency Coach will make HAP resources available to the client through a comprehensive voucher process. The voucher requires appropriate original documents or copy (verified by the Self-Sufficiency Coach) who witnessed the original document). Written eviction notices from landlords must be on original letterhead, outlining monies owed and a statement that payment of the identified monies will prevent eviction. The Self-Sufficiency Coach will follow up verbal confirmations of eviction from landlords in writing, outlining monies owed and a statement that payment of the identified monies will prevent eviction. The same procedure will be followed regarding move-in notices. An original lease and/or witnessed copy must be present in the file. All BCOC clients will be asked to make a contribution toward the financial assistance received by the agency. Confirmed copies of the client co-pay receipt will be attached to each voucher.

Shelter payments for clients in hotels/motels may be paid up to a maximum of 60 days and require prior approval of the Executive Director. Any meals paid for on behalf of the client in the motel must be included as part of the total overnight bill. HAP assistance for homeless emergencies should be viewed as a last resort after all Bucks County "continuum of care" services for the Homeless or Near-Homeless have been exhausted. They will be used to bridge the client's connection with permanent housing solutions.

Residents applying for HAP assistance that currently participate in some other subsidized housing program are assessed on a case-by-case basis. Only in exceptional circumstances will financial assistance be provided to a Section 8/ Housing Choice Voucher Program or other subsidized housing resident.

HOMELESS ASSISTANCE SERVICES

Move-in assistance for Section-8 recipients will usually be limited to once (life-time limit). Final decisions to determine financial assistance will be the responsibility of the Executive Director upon recommendation from the Director of Client Services.

If a household is requesting assistance and the adult member in the household has received a rental assistance payment within the past 24 months as a member of another household, the payment will be divided as equally as possible among each adult in the household. However, the maximum amount available to the household will be reduced by the amount that was received by the person who in the past 24 months received a rental assistance payment as a member of another household.

Evaluation of efficacy

Prevent eviction or move out of homelessness

- 424 people in 160 households received financial assistance and counseling services to prevent eviction or move out of homelessness. (51 households out of homelessness and 109 households avoided eviction
-Forecast for YE is 488 people

Changes Proposed

No changes have been proposed from our 2015-16 plans, however, as was noted previously, the Housing Advisory Board has established a set of recommendations to improve homeless services in the coming years.

EMERGENCY SHELTER

Services Provided

Bucks County does maintain Emergency Shelter Services through our Family Services shelter. This program is funded through other funding streams and is not currently within the Block Grant plan. The shelter is accessed through the Centralized Intake (Housing Link) process and is part of the overall county strategy related to homeless services.

During 2015-16, Bucks County did utilize retained earnings from 14-15 to support case management and emergency shelter during periods of Code Blue. At this time we are not requesting additional funding for that service and it was a "one-time" expenditure utilizing the previous year's retained earnings.

Evaluation of Efficacy

Bucks County has recently completed a year-long evaluation and planning for homeless services. We continue to evaluate and define outcome measures for all components of our system as part of the process. Block Grant funds are not directed towards these emergency shelter services other than the rental assistance services described above.

Changes Proposed for the Coming Year

The Bucks County Housing Continuum of Care has made a concerted effort to coordinate services for Emergency Shelter clients. We have leveraged the HAP funding to provide rapid response and move families and individuals out of emergency shelter and into permanent housing. As we implement our plan in the year ahead, we will continue to prioritize households in emergency shelter for services. It is not expected that block grant funds would be utilized specifically for emergency shelter (although it should be noted again the county does provide these services utilizing other funding streams).

HOMELESS ASSISTANCE SERVICES

Why this service is not provided

As stated above, the county does provide Emergency Shelter services, however the HAP funds provided through the Block Grant are leveraged to secure other homeless rental assistance funds to move people out of shelter and into permanent housing, thus ending a homeless episode for a family.

OTHER HOUSING SUPPORTS

Services Provided

Bucks County residents who are facing a housing crisis are directed to contact the centralized intake and coordinated assessment, Bucks County Housing Link. The Housing Link call center triages new callers, makes a brief assessment of need, and refers eligible callers to an assessment center nearest them. Clients seeking prevention services or move in assistance are seen quickly to determine need and appropriate intervention to prevent homelessness or end homeless episode. Bucks County's largest provider of these services (BCOC) continues to experience an increase in requests for homeless prevention assistance. The need far exceeds the resources. Because of this continued increase, we work collaboratively with multiple organizations, landlords, and community supports to provide the best intervention services possible.

Other housing supports are also detailed in the Children and Youth Services section of the Block Grant plan. Those individuals are not listed here to avoid duplication of reporting.

Evaluation of Efficacy

Bucks County continues to work on developing outcome goals and measures of success for our overall housing system in collaboration with the HAB. For the purposes of the Block Grant report evaluation measures are listed relative to specific services in the sections above. We look forward to reporting extensively on our outcomes evaluation efforts in the coming year.

Changes Proposed

As the HAB moves forward with recommendations and the Bucks County Human Services Department working with other county departments and service providers This year, the Housing Link Assessment services will be funded through the Block Grant funds. Funding for the Housing Link is a collaboration of Block Grant, Housing and Community Development, other grants, and private funding. The Enhanced Housing Link Taskforce has been working on improved collaboration and integration of other housing supports in the county to provide true continuum of services.

Why Services not provided

Housing Link services will continue to be provided and enhanced in the current year.

HOMELESS ASSISTANCE SERVICES

Homeless Management Information System Implementation

Bucks County adopted its HMIS system in 2007 and has incorporated 13 service providers and 35 housing programs to date. Participating HMIS programs represent an overall bed coverage rate of 88% of all beds designated for homeless persons in the County. The HCoC-BC continuously pursues expansion of the system to include Non-HMIS participating beds.

The Executive Committee of the Housing Continuum of Care of Bucks County (HCoC-BC) is the oversight body for the HMIS and provides final approval for all governance policies; data quality and security plans; Point in Time Count (PIT), Housing Inventory Count (HIC), and Annual Homeless Assessment Report (AHAR) reports before submission. The HCoC-BC Data Management/Outcomes Committee is responsible for drafting all governance documents in accordance with federal regulation and community need, as well as interpreting and providing comment on federal regulations regarding HMIS implementation, tracking system-wide outcomes measurements and developing new initiatives for using HMIS data more effectively within HCoC-BC planning.

The Data Management/Outcomes Committee, in conjunction with the HMIS Lead Agency, provide analytical support to the Bucks County Housing Advisory Board (HAB), a Commissioner appointed board that is tasked with recommending housing-related system changes and funding priorities to be included in the strategic planning process.

There is a governance charter in place between the HCoC-BC and the HMIS Lead Agency, the County of Bucks Department of Housing and Community Development (HCD). Department staff carries out the day-to-day operations and administration of the HMIS implementation. A department staff member chairs the Data Management/Outcomes Committee and will represent the HCoC-BC on the newly forming PA HMIS Collaborative Board that will oversee HMIS Governance.

The HCoC-BC is a participant of the semi-statewide PA HMIS Collaborative, a multi-continuum HMIS collaborative that joins 54 counties in one single HMIS database. The vendor for this HMIS has been the PA Department of Community and Economic Development (DCED), which developed and operates the PA HMIS. In 2014 DCED began the process of purchasing a new software product on behalf of PA HMIS Collaborative. Client Track successfully merged client data from the previous software and was formally launched on December 15, 2014 as the new PA HMIS Collaborative software.

The HCoC-BC's pilot centralized intake and coordinated assessment project, the Bucks County Housing Link, screened 3,680 households in calendar year 2015 and completed 1,472 eligibility assessments. Quarterly and Annual Housing Link Community Impact Reports were monitored by the HCoC-BC to closely track outcomes and success of the project. The successful pilot project has led to the formation of the Enhanced Housing Link that was launched in late 2015. The Enhanced Housing Link moves to improve operating efficiencies, develop better system metrics to monitor qualitative and quantitative results, and most importantly, drive future change and improve service for all Bucks County residents. The County's HMIS will play an important part in the evolution to better system metrics.

CHILDREN and YOUTH SERVICES

HSBG funding provided to Bucks County Children and Youth Social Services Agency enables the Agency to implement and sustain programming which supports its mission to strengthen families and protect children by ensuring their safety and well-being.

The agency continues to respond to the challenge of increased referrals from the community and subsequent service demands. The in-home service population has significantly grown in the past 5 years culminating in the provision of service delivery to 10,238 children in 2015. The new mandates enacted by the Child Protective Services Legislation, which increased the pool of mandated reporters and extended the definition of child abuse, became effective January 2015 and has escalated referrals demonstratively from the community to the Agency. In the year 2015, referrals increased 88% over referrals in 2014. Comparing the first quarter of 2016 to the first quarter of 2014, the agency has seen a 107% increase in referrals.

To assist in service delivery to the expanding client population, Block Grant funds enable Children and Youth to provide an array of evidence based programs including Multi-Systemic Therapy for ungovernable youth who are not MA eligible and otherwise would not qualify for the intensive in home treatment services as well as to cover the "gap time" allowing services to begin immediately while the family completes the Medicaid application; Family Group Decision Making, which empowers families by allowing them to convene with their natural supports and create their own plan for child safety; High Fidelity Wrap Around which offers families in home professional support to address challenging child behaviors resulting from mental illness. The 2015-2016 saw a strong increase in the referrals for Truancy with over 100 children requiring agency services. Alternatives to Truancy is a diversionary service, which provides counseling, advocacy and skill building to assist youth at risk of truancy, has been very successful in preventing the need for agency services with this population. Due to the current economic climate, high unemployment and personal crisis, families are struggling to pay escalating utility bills, rent and perform necessary maintenance to secure existing housing. Housing Assistance has proven essential in responding to this need by providing funds to ensure housing stability and mitigate the need to place children into the foster care system due to homelessness in the county.

Block Grant funded programs and services have proven effective in promoting cross systems collaboration between Child Welfare, Mental Health, Drug and Alcohol, education, and contracted providers. Program outcomes are impressive and the achievement of program goals has had a significant impact on increased family strengthening as well as improved child safety and wellbeing.

Outcomes	
Safety	<ol style="list-style-type: none">1. Children are protected from abuse and neglect.2. Children are safely maintained in their own home whenever possible and appropriate.

CHILDREN and YOUTH SERVICES

Permanency	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 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	All Child Welfare Services in HSBG Contributing to Outcome
<p>SAFETY 2: Children are safely maintained in their own home whenever possible and appropriate.</p>	<p>Outcomes are gathered by weekly clinical supervision weekly MST consultation and collaboration with systems partners.</p> <p>Outcomes are measured as the percentage of children safely maintained in their home.</p> <p>HiFi outcomes are measured using the WFI-EZ data collection tool. Data is collected at 90 days and again at transition. Bucks County HiFi is also participating in the Youth and Family Training Institute pilot.</p> <p>CSF program outcomes are measured by the number of successful referrals and</p>	<p>Multi-Systemic Therapy</p> <p>High Fidelity Wrap Around</p> <p>Family Group Decision Making</p>

CHILDREN and YOUTH SERVICES

<p>PERMANENCY 2:</p> <p>Continuity of family relationships and connections are preserved for children.</p>	<p>CSF program outcomes are measured by the number of successful referrals and conference as defined later in this section.</p> <p>Outcomes are gathered by weekly clinical supervision weekly MST consultation and collaboration with systems partners. Outcomes are measured as the percentage of primary caregivers demonstrating improved parenting skills; percentage of Children involved in pro-social peers/activities; percentage of families demonstrating improved family relations; percentage of families showing an improved network of supports.</p> <p>HiFi outcomes are measured using the WFI-EZ data collection tool. Data is collected at 90 days and again at transition. Bucks County HiFi is also participating in the YFTI pilot.</p>	<p>Family Group Decision Making</p> <p>Multi-Systemic Therapy</p> <p>High Fidelity Wrap Around</p>

CHILDREN and YOUTH SERVICES

	<p>performance of students completing the program.</p>	
<p>CHILD AND FAMILY WELL-BEING 1: Families have enhanced capacity to provide for their children's needs.</p>	<p>Outcomes are gathered by weekly clinical supervision weekly MST consultation and collaboration with systems partners. Outcomes will be measured as the percentage of children safely maintained in their home.</p> <p>HiFi outcomes are measured using the WFI-EZ data collection tool. Data is collected at 90 days and again at transition. Bucks County HiFi is also participating in the YFTI pilot.</p> <p>CSF program outcomes are measured by the number of successful referrals and conference as defined later in this section.</p> <p>HFA is a new program in its first year of implementation with the agency: outcomes will be measured by the amount of enrolled children that receive necessary medical care, numbers of Mother-baby pairs that screen positive for</p>	<p>Multi-Systemic Therapy</p> <p>High Fidelity Wrap Around</p> <p>Family Group Decision Making</p> <p>Healthy Families America</p>

CHILDREN and YOUTH SERVICES

	<p>healthy bonding and that have no reports of child abuse or neglect or out of home placement.</p> <p>Outcomes for C&Y housing assistance are measured by tracking families receiving direct assistance resulting in the prevention of imminent child placement due to homelessness or unsafe housing.</p> <p>VYH measures program outcomes by tracking location of youth upon discharge.</p> <p>BCHG measures outcomes by tracking the location of families, income level and educational progress upon program completion.</p>	<p>Housing Assistance</p>
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EVIDENCE BASED PRACTICES

Program Name:	Credential for Strengths Based Family Workers
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Status	Enter X		
Funded and delivered services in 2015-2016 but not renewing in 2016-2017	X		
Requesting funds for 2016-2017 (new, continuing or expanding from 2015-2016)		New	Continuing
			Expanding

CHILDREN and YOUTH SERVICES

Oversight for the Credential for Strengths Based Family Workers, formerly known as Family Development Credentialing, was transferred from the Community Action Association of Pennsylvania (CAAP) to Temple University Harrisburg (TUH) effective 9/1/13. The program mission remains the same, to enhance the individual professional development of front line paraprofessionals in the human service field by teaching them engagement skills from strengths based perspective. Eleven human service agencies in Bucks County have participated in the SFW program by enrolling staff in the course. Twenty-Four students have completed the curriculum, passed the exam and submitted a detailed portfolio thereby meeting all requirements for achieving their credential.

Program outcomes involve individual professional development which reorients practice to a strengths based, empowerment model using enhanced family engagement skills resulting in improved quality of service delivery. Outcomes are measured by the number of students who complete program requirements and receive the SFW credential.

Expected outcomes include: Enhancement of community support services, increased strengths based support skills and positive family focused attitude including transfer of learning to peers. Organizations within the county have offered positive feedback and are repeatedly represented by staff in classes offered. The addition of potential foster parents of adolescents to the Target population is expected to decrease the number of adolescents living in congregate care by providing foster parents the additional skills to be able to maintain them in a safe environment and provide for engagement with the family of origin.

	FY15-16	FY 16-17
Description of Target Population	Front line paraprofessionals in human service organizations	
# of Referrals	0	
# Successfully completing program	0	
Cost per year	0	
Per Diem Cost/Program funded amount	\$50/hour Instruction \$35/hour Advising	
Name of provider	Two Instructors Four Advisors	

Were there instances of under spending or under-utilization of prior years' funds?

Yes No

Under spending can be attributed to the need to retrain the instructors and Advisors as to a change in curriculum by Temple University Harrisburg (TUH). The need for retraining and

CHILDREN and YOUTH SERVICES

changes to program decreased the interest in the credentialing for instructors and potential candidates. While the need and expected outcome are still considered important, the viability of the program does not exist. Due to the flexibility of the Block Grant, those funds will be able to be utilized by other programs funded within the block Grant such as FGDM, Truancy services and Healthy Families America to strengthen families and keep children in their families of origin.

Program Name:	Multi-Systemic Therapy
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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)	New	Continuing	Expanding
		X	

MST services are provided in Bucks County through a contract with K/S Consultants, Inc. The targeted population includes ungovernable adolescents involved with Children & Youth who are not MA approved and therefore unable to access MST services through the county Health Care Management Organization (Magellan). The treatment program is designed to maintain youth in their home via improved adaptive functioning of both parents and child.

Therapists operate in teams of no fewer than 2 and no more than 4 therapists (plus the Clinical Supervisor). The MST Clinical Supervisor conducts weekly team clinical supervision, facilitates the weekly MST phone consultation and is available for individual clinical supervision for crisis cases. Overall, the average duration of treatment is 3-5 months. Each MST therapist tracks progress and outcomes on each case by completing MST case paperwork, participating in clinical supervision and weekly MST consultation. With the buy-in of other organizations, MST is able to take the lead for clinical decision making on each case. Stakeholders in the overall MST program have responsibility for initiating these collaborative relationships with other organizations while MST staff sustains them through ongoing, case specific collaboration.

Expected target outcomes of the program include a reduction of adolescents in out-of-home placement, improved child wellbeing through improved academic performance and family strengthening by increased supports and improved relationships.

MST outcomes for reporting period 7/1/15 - 5/1/16:

Referrals to the program	37
Referral withdrawn	0
Ongoing services	9
Successful Discharges	28

CHILDREN and YOUTH SERVICES

The successful referrals were evidenced by program completion and all of the following:

- Primary caregiver improved parenting skills 93%
- Involved in pro-social peers/activities 82%
- Improved family relations 96%
- Improved network of supports 96%
- Success in educational/vocational setting 89%
- Attending school /working 92%
- No new arrests 96%

	FY 15-16	FY 16-17
Target Population	Ungovernable adolescents ineligible to access services through Medical Assistance	Ungovernable adolescents ineligible to access services through Medical Assistance
# of Referrals	37	35
# Successfully completing program	28	26
Cost per year	\$ 18,000	15,000
Per Diem Cost/Program funded amount	\$45/unit	\$45/unit
Name of provider	K/S Consultants	K/S Consultants

Were there instances of under spending or under-utilization of prior years' funds?

Yes No

The under-spending indicated for the MST program does not represent an underutilization of the program is indicative of the programs provider, K/S Services, being able to increase the efficiency and speed with which they were able to get eligible clients approved for medical assistance for this service. The flexibility of the Block Grant allowed the agency the ability to use these funds in the area of Truancy, Housing, and FGDM to provide services to strengthen and maintain children in their homes and communities.

Program Name:	Family Group Decision Making
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Status	Enter X		
	New	Continuing	Expanding
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	

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Family Group Decision Making is evidence based practice embraced by the Agency to enhance family engagement, promote family empowerment and to prevent placement.

The Agency maintains a contract with Community Service Foundation to provide coordination and facilitation of family conferences. Families, through the FGDM process, are given a voice and encouraged to create their own plan to ensure child safety and provision of family based supports resulting in the overall strengthening of the family unit. The Agency offers this voluntary service to all clients. It has proven particularly effective in identifying kinship resource homes, long term connections for aging out youth and ongoing natural supports for families at risk of child placement.

The agency has experienced a significant increase in referrals due to parental substance abuse. In response to this increasing trend, FGDM services were expanded to include a contract with Community Service Foundation. CSF services were engaged to provide FGDM to families of parents receiving substance abuse treatment at four treatment centers in the county; Aldie Counseling Center, Today Inc., Penn Foundation and Pyramid. This initiative began with CSF staff meeting with D&A provider staff to explain the program and work out logistics. The FGDM outreach to the Drug & Alcohol community is expected to raise family awareness, increase natural supports for addicted parents, including safe child care and prevent the need for child welfare system involvement. Outreach to this community continues to now include the Mobile Engagement Specialists assigned to the treatment providers. There has been little response from the Drug and Alcohol Community to date but continued efforts at collaboration are expected to begin to yield referrals.

Program outcomes are measured in terms of successful and unsuccessful referrals and successful conferences. Successful referrals are defined as new family engagement actions/activities occurring after a referral to FGDM that directly correlate to the FGDM referral, but do not lead to a successful FGDM conference. Unsuccessful referrals are defined as the referral of a family to FGDM that does not result in an FGDM conference or any new engagement activities due to lack of engagement of nuclear and /or extended kin. Successful conferences are defined as a conference that is held with a facilitator, nuclear family, extended friends and/or family.

During the reporting period 7/1/15 – 5/23/16:

Community Service Foundation Outcomes:

51 conferences (31 initial, 20 follow ups)

7 successful referrals

10 unsuccessful referrals

As we look to 2016-17, we project a very slight decrease of the utilization of FGDM from 15-16 based on the significant jump this year over the previous year (from 49 to 68) which is not likely to be fully sustained. In addition, funding for FGDM was very slightly lowered to allocate resources to other programs being expanded within the Grant. It was felt that this was the best utilization of the funds allotted based on current Agency needs and anticipated FGDM referrals.

CHILDREN and YOUTH SERVICES

	FY 15-16	FY 16-17
Target Population	Families involved with or at risk of involvement with the child welfare system	Families involved with or at risk of involvement with the child welfare system
# of Referrals	68	65
# Successfully completing program	51	46
Cost per year	\$80,000	75,000
Per Diem Cost/Program funded amount	\$74.91/hour capped by outcome* (includes expenses)	\$74.91/hour capped by outcome* (includes expenses)
Name of provider	Community Service Foundation	Community Service Foundation

*NOT TO EXCEED:

UNSUCCESSFUL REFERRAL \$ 250.00

SUCCESSFUL REFERRAL \$1000.00

SUCCESSFUL CONFERENCE \$3000.00

Were there instances of under spending or under-utilization of prior years' funds?

Yes No

Program Name:	High Fidelity Wrap Around
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Status	Enter X		
	New	Continuing	Expanding
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	

Bucks County Children and Youth, through a contract with Child and Family Focus, offer High Fidelity Wrap Around services in the county. HFWA utilizes a national model to bring change to the lives of families with children with complex needs. It is a family-driven planning process that puts families and youth in charge of their own plans, by partnering with them to use their voice, strengths, and supports to build teams that keep children in their homes with fewer professionals and more community supports.

The program serves youth up to age 21 who have complex needs, are multi-system involved, with a risk of out-of-home placement or are in placement for mental health or child welfare reasons. The mission is to promote collaboration among all team members, including natural supports, service providers and system partners, to create an integrated planning team. Service

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duration is contingent on when the family has learned the process and is comfortable leading their team meetings.

The HFWA 3 member team is composed of a bachelor's or master's level Facilitator who initially manages the process and facilitates the meetings, a Family Support Partner who has lived experience as a caregiver of a youth with complex needs, and a Youth Support Partner who has their own mental health lived experience and can relate to youth from personal experience.

The program is fully staffed with 4 facilitators, 2 Family Support Partners and 3 Youth Support Partners (the equivalent of 4 teams). Strategies utilized to reduce the length of stay in RTF include supporting the family throughout residential treatment to keep them involved and active in family therapy and treatment planning; assisting the family and youth to transfer gains in treatment to the natural living environment; focusing on discharge planning at the time of admission; and identifying and engaging the youth and family in community activities and natural supports to prepare for a smooth reintegration.

- HiFi Teams have worked with 9 youth who are in or have transitioned out of RTF.
- The implementation of chart forms continues and is a very useful tool in generating data for CQI. All newly enrolled youth into the HiFi program will be tracked using the data gathering forms, known as Chart Forms, which are an initiative of the Youth and Family Training Institute (YFTI) in partnership with CFF. Enhanced data will be tracked, measured and reported using this vital tool, which will be made available quarterly to CFF and county stakeholders.
- We are proud and excited that expansion of HiFi was accomplished under the Now is the Time Transition Age Youth Grant in Bucks County. Fifteen new transition aged youth aged 16-25 are being served under this grant, managed by Bucks County Behavioral Health. The first youth entered this program in June 2015.
- The HiFi program continues using the WFI-EZ, a fidelity measurement tool. Reports will be generated by YFTI twice annually. A report is due out in August 2016.
- Magellan's annual report that tracks and reports service utilization pre-during-post HiFi is still pending from Magellan as of this date.
- There have been 4 families who were able to close with CYS while being supported with HiFi.

CHILDREN and YOUTH SERVICES

High Fidelity Census FY 2015/16:

- The program has a capacity of 50, with new admissions replacing monthly discharges. Referrals are reviewed and prioritized through the monthly referral meeting process, with priority given to CYS identified youth at risk of out of home placement and Behavioral Health youth at risk of out of home placement.
- Total referrals received 7/1/15-3/31/16: 26 total ; avg. 3.4 per month
- Total families/youth served: 23 (closed) + 43 (active) = 66
 - of the families/youth served were also involved with BCCYSSA: 10 active + 7 closed
 - of the families/youth served were also involved with JPO: 0 active + 0 closed
 - of the families/youth served were only involved with MH: 33 active + 16 closed
- Total Number of families/youth who discharged: 23
- Total Number of families/youth who graduated/successfully transitioned: 15
- Total number of families/youth who moved to TAY HiFi: 1
- Total Number of families/youth who moved out of county: 1
- Total Number of families/youth who withdrew from the service: 6 (left process without allowing HiFi to finish the planning process)
- Total Number of families/youth who declined the service: 3 (from referral list). Some families choose not to participate after deciding they process is not what they want.

	FY15-16	FY16-17
Target Population	Youth up to age 21 with complex needs due to mental health & child welfare issues at risk of placement	Youth up to age 21 with complex needs due to mental health & child welfare issues at risk of placement
# of Referrals	66	60
# Successfully completing program	15	10

CHILDREN and YOUTH SERVICES

Cost per year	\$290,496	\$230,000
Per Diem Cost/Program funded amount	\$40.40 per diem	\$40.40 per diem
Name of provider	Child and Family Focus	Child and Family Focus

Were there instances of under spending or under-utilization of prior years' funds?

Yes No

Program Name:	Healthy Families America
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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)	New	Continuing	Expanding
			X

Healthy Families America (HFA) is a nationally recognized evidence-based home visiting model specifically developed for families who are at-risk for child abuse and neglect. The model engages families with histories of trauma, intimate partner violence, mental health concerns and/or substance abuse issues. It is proven to work with both first-time mothers and those with multiple children. Beginning during pregnancy and serving families until the child is age three, HFA staff visit families in their home. Services emphasize parent engagement, parent-child interaction, parental knowledge of child development, health education, and connection to community-based health and social services. Interactions with parents and other caregivers are strengths-based, family centered and culturally sensitive.

Despite the fact that MCC's HFA program includes many of the highest risk families, MCC's HFA program has nationally achieved the same depression outcomes as did other MCC sites. HFA achieved a 64% reduction in positive depression screens over the course of participation. In addition, 75% of HFA clients initiated breastfeeding (versus 49% in comparable communities). The program had the following additional outcomes:

- 100% of children enrolled have a medical home
- 97.6% mother-baby pairs screen positive for healthy bonding.
- There have been no reports of child abuse or neglect among MCC's HFA participants.

Due to the delay in the implementation of this program during the fiscal year, it is too early for us to determine outcomes specific to this partnership. It is however expected that they should be comparable to the national outcomes.

CHILDREN and YOUTH SERVICES

The Website where this program can be found is Home Visiting Evidence of Effectiveness: <http://homvee.acf.hhs.gov/Implementation/3/Healthy-Families-America--HFA--sup---sup-/10/1>.

	FY15-16	FY 16-17
Description of Target Population	At Risk Families with Children Birth to age 3	At Risk Families with Children Birth to age 3
# of Referrals	25	25
# Successfully completing program	6 active and engaged families	15* anticipated active and engaged families at the end of a year
Cost per year	\$38,208	\$85,000
Per Diem Cost/Program funded amount	\$7,642	\$11.64 per diem
Name of provider	Maternal care Coalition	Maternal care Coalition

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

This program is in its first year of implementation with the Agency. Due to budget impasse, the full implementation was delayed until a contract could be approved in January 2016 with a February 1, 2016 start date. This service was program funded from February 2016 through June 2016, to assist with setting it up and getting active within Bucks County. Beginning on July 1, 2016, it will be paid on a per diem contract. This partnership shows great potential in its beginning with us. We have currently have 6 active families with more anticipated to be opening imminently. We have a current wait list of 19 families, with more being referred daily. The agency has identified this service as one of the hallmark programs for assistance to CAPTA baby referrals. These referrals have increased substantially this fiscal year. We are averaging 91% more referrals of this type on a monthly basis over this time 2015. We are confident that the funds will be utilized in its entirety this fiscal year and are looking to increase the program to account for the increased need.

CHILDREN and YOUTH SERVICES

TRUANCY

Program Name:	Alternatives to Truancy
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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)	New	Continuing	Expanding
			X

The Alternatives to Truancy Program targets truant youth or those at risk of truancy in grades 3 through 10. Referrals are generated by the County's thirteen school districts. The program, which is a collaborative effort between BCCYSSA, Bucks County School Districts and District Justices, is designed to provide prevention treatment in the home and school for a period of 3-5 months to overcome barriers to educational success. Services encompass diagnostic screening, educational program development, facilitation of parental communication with the school, in home family therapy, parent education, individual skill building, counseling and advocacy for the child, case management, collaboration with key stakeholders, linkage to community services and 24 hour emergency consultation. A team comprised of an intake coordinator, child advocate/educational liaison and family therapist are responsible for service delivery. Performance measures include improved academic performance, increased school attendance and reduction of truancy referrals to Children & Youth. In the current 15-16 school year, K/S received at least one referral from each of the 13 Bucks County School Districts.

Identified outcomes are measured by the tracking of truancy referrals to the Agency, contacts with schools and monitoring of attendance and performance. Monthly case reviews are facilitated by the Children & Youth Manager responsible for program oversight including the participation of Agency staff, vendor staff and school personnel. The majority of youth referred to the program were chronic and severe with respect to truancy. There has been a significant increase in the number of younger students referred to the program frequently identified with mental health issues including school specific anxiety, separation anxiety and PTSD-like symptoms and behaviors.

The K/S Truancy Program is able to serve sibling groups in families that have chronic truancy issues with more than one family member. Thus, multiple students are served (not just the identified student), by the program at essentially no cost.

K/S was instrumental in facilitating educational plans and appropriate school placements for approximately 25% of cases this school year, in which students had no identified school plan at the start of services.

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Exclusion criteria for the program are students that have either Children and Youth or Juvenile Probation involvement. Linkage to other mental health services was successful. Referrals to MST, Family Based, Drug & Alcohol and Wrap Around Services helped families with sustainability in regard to acceptable attendance. Diversion and prevention remain proven facets of the program.

Various levels of services were provided, with all cases having a K/S advocate and a majority of cases having Family Service Coordinators (FSC) during service provision. Some cases received only Advocate or FSC as determined at the time of referral or as step-down levels of service. The average length of service was 4.5 months.

Outcomes are reported on the 53 cases closed from 7/1/15 to 5/01/16.

- 80% Increased school attendance
- 100% demonstrated an increase in attendance or a sustained attendance
- 75% Improved academic performance
- 68% Improved school behavior
- 30% Behavior remained the same
- 75% Improved or maintained their overall family adaptation
- 100% Improved or maintained school relationship
- 100% Increase in parental supervision & monitoring of their children
- 100% Prevented Placement

	FY15-16	FY 16-17
Target Population	School age youth in grades 3-10 at risk of truancy	School age youth in grades 3-10 at risk of truancy
# of Referrals	104	130
# Successfully completing program	53 (38 still open and engaged)	116
Cost per year	280,000	\$300,000
Per Diem Cost/Program funded amount	Level I (intensive) \$1,000 per child/family per month Level II (intensive) \$750 per child/family per month Level III (step down) \$750 per child/family per month Level IV (step down) \$500 per child/family per month	Same rates
Name of provider	K/S Consultants, Inc.	K/S Consultants, Inc.

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

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Alternatives to Truancy is a diversionary program that has effectively addressed one of Children and Youth's largest problems of truancy. The issue of truancy has historically lead to out of home care in high cost placements. Alternatives to Truancy has demonstrated a 100% effectiveness at avoiding out of home placement. This year we are requesting an increase of \$20,000 to the allotment last year of \$280,000 to increase the amount of children served. In this past fiscal year, we utilized the entire amount allotted. Children and Youth has had an unprecedented referral of over 100 truancy cases for the 2015-2016 school year. There were approximately 80 last school year.

Increasing the case load of Alternatives to Truancy is anticipated to reduce the amount of truancy referrals and need for agency service and/or placement.

Program Name:	Summer T.R.A.C.K. Programs
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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)		New	Continuing	Expanding
			X	

Neighborhood First:

In the **Bristol Township School District**, Neighborhood First Program, Inc. structured a four week TRACK Camp for 15 middle and high school students. The main component of Camp Pride was the importance of education and attendance. The acronym **PRIDE: Power, Restore, Initiative, Develop, Education** laid the foundation of what Camp Pride represented. Camp Pride represented the true value of education and commitment to education with a school-like atmosphere. Camp Pride stood on the core values of enrichment, accountability, fitness, teambuilding, diversity, and community service.

A Pre/posttest was administered every day to evaluate the overall learning experience for each activity. Also there was a daily progress note on each participant at the end of each day to evaluate, behavior, attendance, and participation. Arriving on time was theme of camp, and the youth showed true accountability by arriving on time and being attentive. Discussions of truancy issues, conflict resolution, and decision making led the youths' empowerment to share their stories and the changes they have made.

The youth participated in many life skills and team building exercises, this included, storyboards, outdoor water games, and self-affirmations. The participants also participated in many educational activities including an overnight camping trip, Belmar Beach, Viking Yacht Company, Penn's Landing, Clementon Park, Bristol Pike Lanes, and presentation by the Bristol

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Township K-9 unit and Bristol Township Fire Department. The importance of health and wellness was implemented before every activity, as youth were asked to fully participate and challenge each other.

Of the students tracked in the 2014-2015 school year, after the 2015 Summer Program:

4 students withdrew from the school district,

1 student's attendance rate was not available for comparison

6 student's grades from the previous year were not available for comparison,

4 student's grades from this year were not available for comparison

Of those still in the district and with grades and academics for comparison:

- 70% (7) improved in attendance (comparison data available for 10 students)
- 20% (1) improved academically (comparison grades available for 5 students)

Neshaminy School District:

Neshaminy School District's PASS program (Planned Action Stimulates Success) has been in place since 1994. On a yearly basis the PASS program services approximately 100-150 at-risk students within Neshaminy School District. A significant component of PASS is our early intervention summer program, which provides services to a total of 60 students. The summer program is a professionally supervised educational, career exploration and recreational program that is specifically structured for middle school students. Students are selected based upon their behavioral and emotional needs and/or issues surrounding grades, attendance, poor socialization skills, or a combination of the aforementioned. The program is planned to help students improve and develop social, physical and intellectual skills all while participating in academic, career and recreational activities.

Daily bus transportation is provided to and from the program. Students are also provided with a free breakfast and lunch each day. All of the students' progress is tracked during the school year by means of attendance, grades and feedback from guidance counselors.

The summer programs objective is to provide a positive learning experience that will teach teamwork, build creative learning skills, and develop positive relationships within the school environment. A positive learning environment will decrease negative behavior, strengthen emotional stability, increase attendance, improve grades, improve socialization skills, and develop intellectual and physical skills.

The academic curriculum included each student developing, discussing and presenting projects on all of the career exploration field trips. Additionally, support groups were offered throughout the four weeks on topics such as healthy relationships, anger management, conflict resolution, and substance abuse. A recreational component headed by two of our districts most accomplished physical education teachers included rock climbing, hiking, fishing,

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canoeing, Frisbee golf, and many other team sports. The students visited Temple University where they learned about the many different educational programs and majors the university has to offer. The students also got a chance to see what college life is all about through the examples of current Temple students who gave the tour.

Of the 51 students tracked in the 14/15 & 15/16 school year after attending the 2015 Summer PASS Program:

- 59 percent (30 students) improved in attendance
- 51 percent (26 students) improved academically.

Pennsbury School District:

The Pennsbury School District Summer School Track Program operates with 15 middle school students. Each of the students attends the first three hours of their day in a summer school academic class. At the conclusion of the academic program at 10:30am, these 15 students move into the Summer School Track Program for the remainder of the day.

Students recommended for the track program have been identified due to poor attendance, academic and behavioral issues. During the time spent in the Summer Track Program, the staff will work with each student to improve the student's self-worth and address anger management problems. Many students act out due to academic failures or problems at home. Our staff will attempt to show students they can be successful if they attend school on a regular basis and that there are ways to channel aggressive behaviors. Activities will be used to work on team building and how to prepare themselves for their working years. Our goal is to prepare these students for a successful start to the coming school year.

The Summer track program 2015, included 12 middle school students in 7th through 9th grade. Of the 12 students that started in the program, the outcomes are as follows;

- 41.6% (5) Improved their attendance in the 2015-2016 school year
- .08% (1) withdrew from school
- 83.3% (10) improved their grades in the 2015-2016 school year

	FY14-15	FY15-16
Target Population	Youth in middle and high school at risk of truancy	Youth in middle and high school at risk of truancy
# of Referrals	90	90
# Successfully completing program	Varies by program	Varies by program
Cost per year	\$30,000	\$30,000
Per Diem Cost/Program funded amount	\$10,000 per program	\$10,000 per program
Name of providers	Neighborhood First	Neighborhood First

CHILDREN and YOUTH SERVICES

	Neshaminy School District Pennsbury School District	Neshaminy School District Pennsbury School District
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Were there instances of under spending or under-utilization of prior years' funds?

Yes No

HOUSING

Program Name:	Housing Assistance
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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)		New	Continuing	Expanding
			X	

Block Grant funds are utilized to assist families in maintaining their current home or provide funds necessary for them to secure housing in the community in an effort to mitigate homelessness, promote self-sufficiency and decrease child placements due to lack of safe and stable housing . Bucks County Children & Youth disperses Housing Assistance funds directly to county residents and indirectly through contracts with Valley Youth House (Supportive Housing Program) and Bucks County Housing Group.

Bucks County Children and Youth

Bucks County Children and Youth, with funds provided through Housing Assistance, Rapid Rehousing and First Housing directly aids families with rent, utility bills, and essential housing repairs which threaten housing and family stability.

Outcomes for the reporting period 7/1/15-6/1/16:

- Families received assistance for hotel stays 10
- Families received rental assistance 18
- Families received assistance with utility bills 5
- Families received assistance with essential home maintenance 1

	FY15-16	FY16-17
Target Population	Families of children ages birth -18 years	Families of children ages birth-18 years
# of Referrals	34	
#Successfully completing program	N/A	N/A

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Cost per year	\$20,000	\$21,704
Per Diem Cost/Program funded amount	Assistance Varies	Assistance Varies
Name of provider	Bucks County Children & Youth	Bucks County Children & Youth

Were there instances of under spending or under-utilization of prior years' funds?

Yes No

Valley Youth House

Valley Youth House, through its Supportive Housing Program, provides residential stability and support services for young adults transitioning from homelessness to independence. In the current fiscal year, 26 Bucks county youth 18 -22 years of age and 21 Babies/Children received program services and were discharged.

The following represents the outcomes for those discharged during the reporting period 7/1/15-6/15/16

- 11 were discharged from the program
- 9 of the 11 (81%) were discharged to stable housing
 - 9 were renting their own or shared apartment
 - 1 to a family member's home
 - 1 to a friend's house/ apartment
- 9 advanced their education
 - 4 completed high school or received a GED
 - 8 were attending college,
 - 1 completed a vocational program as a Medical Assistant.
- 7 were employed
 - 6 full time
 - 1 part time while attending school
- 8 increased their monthly income from entry to exit.
- 10 had a savings account upon discharge; 3 saved greater than \$500 and 7 saved less than \$500.

The program will have served 26 youth and 21 Babies/ Children during the 2015/16 fiscal year.

	FY15-16	FY16-17
Target Population	Families of children ages birth -18 years	Families of children ages birth -18 years
# of Referrals	26	26
# Successfully completing program	11	11

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Cost per year	\$61,855	\$61,855
Per Diem Cost/Program funded amount	Various rates apply	Various rates apply
Name of provider	Valley Youth House	Valley Youth House

Were there instances of under spending or under-utilization of prior years' funds?

Yes No

Bucks County Housing Group

The Bucks County Housing Group provides case management to families residing in their four supportive housing programs located in Penn-del, Morrisville, Doylestown and Milford Square. Case management services include conflict management, life skills development, linkage to community resources, budgeting and other functions required to maintain permanent housing.

Between 7/1/15 through 6/30/16 intensive case management was provided to approximately 40 families.

	FY 15-16	FY 16-17
Target Population	Families of children ages birth -18 years	Families of children ages birth -18 years
# of Referrals	40 families	40-50 families
# Successfully completing program	87-90% Success Rate	87-90% Success Rate
Cost per year	\$50,000	\$50,000
Per Diem Cost/Program funded amount	\$4,166.67/month	\$4,166.67/month
Name of provider	Bucks County Housing Group	Bucks County Housing Group

Were there instances of under spending or under-utilization of prior years' funds?

Yes No

DRUG and ALCOHOL SERVICES

The Bucks County Drug & Alcohol Commission, Inc. (BCDAC), is the state and locally designated Single County Authority (SCA) for alcohol, tobacco and other drugs. BCDAC, Inc. is charged with ensuring the provision of a comprehensive and balanced continuum of quality prevention, intervention, treatment and recovery support services for Bucks County residents. As noted in the County Human Services Plan Guidelines, BCDAC, Inc. oversees the entire substance abuse service system available to all county residents. Funding sources include the Human Service Block Grant, the PA Department of Drug and Alcohol Programs, Driving Under the Influence Fees, County Match, Human Service Development, Donations, etc. BCDAC, Inc. serves on the Behavioral Health Coordination Committee, where Reinvestment Plan concepts are presented and fulfilled, based on systemic gaps and community need. BCDAC, Inc. carries out services through the following:

Approval of Care Services are provided by BCDAC, Inc. to ensure that individuals seeking treatment receive a quality assessment and are referred to the appropriate level of care, in a timely manner. We utilize the Department of Drug and Alcohol Programs mandated Pennsylvania Client Placement Criteria Version 3 as a basis for treatment approval. Our services include responding to consumer, family and community inquiries, offering provider training on how to access services, conducting continuing care reviews and other utilization management and quality assurance functions designed to facilitate the movement of individuals from one level of care to another. The essential element is a philosophy that acknowledges all pathways to recovery and to encourage each individual to complete a full episode of care and to commit to involvement in long term community recovery supports.

Treatment services financed by BCDAC, Inc. include outpatient, intensive outpatient, medication assisted therapies, partial hospitalization and residential alternatives. Specialty services for pregnant and parenting women, adolescents, injection drug users, clients with co-occurring disorders and incarcerated individuals are also available. Services for special populations and special needs are addressed on a case by case basis. As funding is available, BCDAC, Inc. subsidizes a portion of the treatment costs for residents who do not have insurance or another source of funding, and who meet our funding criteria. Because the demand for treatment had outpaced the available funding, BCDAC, Inc. had historically been forced to limit treatment admissions for residents. The 2015-2016 Plan Narrative noted over 100 residents who could not be admitted to detox or residential treatment due to financial constraints. During 2015-2016, however, a direct result of the Human Service Block Grant, as well as funds freed up due to Medicaid Expansion, BCDAC, Inc. did not have a wait list for treatment. We were able to approve treatment for individuals who qualified, without a financial wait for treatment. Any wait for treatment was due to a residential bed capacity issue, an item that affects not only Bucks County, but most PA Counties. We are working diligently to address the capacity issues, including:

- Reinvestment Plan (approved) for ten bed halfway house for men who are enrolled in Medication Assisted Treatment and/or have Co-Occurring Disorders;
- Reinvestment Plan (approved) for 24 detox and rehab beds in Lower Bucks County;
- Women's Facility building an outpatient office on their current campus, with anticipated 30 slot outpatient capacity;

DRUG and ALCOHOL SERVICES

- New MAT Outpatient provider to open in Lower Bucks County, with capacity of 200 for Methadone Maintenance Treatment

County limits on services were lifted during 2015-2016. We were able to lift our former one episode of treatment per month, limitation, for our residents. In addition, we were able to extend lengths of stay in treatment. Individuals enrolled in Medical Assistance can access care through the county's HealthChoices Behavioral Health managed care program – Magellan Behavioral Health of PA, Inc. Clients who may potentially be eligible for Medical Assistance covered care are required to complete the Medical Assistance application process.

Intensive Case Management Services (ICM) are provided through a subcontract. ICM uses a strength-based model to ensure that eligible or targeted clients receive the services needed to support long term recovery from their substance use disorder and self-sufficiency in the community. This includes linking individuals to needed ancillary services such as transportation, child care, housing, food and clothing. Additionally, these services are provided to clients whose treatment is financed through Magellan Behavioral Health of PA, Inc., our Medicaid behavioral health managed care program. Specialty services, including Mobile Engagement Services (MES) are offered to individuals who might traditionally not follow through with a lower level of care following detox, or individuals who are not yet treatment ready, but are willing to pursue recovery options. A specific MES is offered to adolescents, as well as to women who are pregnant, as they can encounter significant obstacles and are high risk and priority populations. During 2015-2016, a specialty MES was initiated, with the focus on families referred to the county's child welfare system. Since its launch in the Fall of 2015, the program has been at capacity and is undergoing an approved expansion.

Recovery Support Services are available to assist individuals in their recovery journey. These include volunteer recruitment and coordination, advocacy and mentoring services, peer and volunteer led life skills programming, recovery community centers, peer recovery specialists and recovery coaches – all designed to acknowledge the many pathways to recovery and to support long term recovery from addiction.

Well beyond a trend, the current prescription medication and opiate abuse, have challenged our system. For the past four years, heroin has surpassed alcohol as the primary drug of use reported by individuals entering treatment funded through BCDAC, Inc. Bucks County has a multi-pronged approach to the heroin epidemic which is affecting our communities. The District Attorney's Tip Line has resulted in prosecution of drug dealers in our region. We expanded Medication Assisted Treatment, whereby our main outpatient agency has over 500 individuals enrolled in Methadone Maintenance Treatment. Bucks County has developed vital systems collaborations to provide education and rescue medication (Narcan) to our residents. During 2015-2016, BCDAC, Inc. focused on overdose reduction, beginning with local Police Departments. In the past year, over 120 lives have been saved by police departments, with the use of Narcan. All thirteen Bucks County school districts have agreed to develop policies on the use of Narcan, and we provided free doses for each district. We have provided community forums on Overdose Prevention, providing over 200 doses of Narcan to participants. In addition, we have provided specialty training to Recovery House Association owners, along with doses of Narcan, once they have policies in

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place. Bucks County's Upper Bucks Heroin Prevention Task Force has held community Town Hall meetings. In the prevention field, Bucks County leads PA in the amount of medications collected via our twice annual Medication Give Back events, as well as our 33 permanent Drop Boxes located throughout the County. At the April, 2016 Bucks County Medication Give Back event, roughly 10,000 pounds of medications were collected, far surpassing other counties. Our recently acquired Strategic Prevention Framework – Partnerships for Success, grant, is focused on underage drinking prevention, as well as medication misuse prevention, among youth.

Drug and alcohol services for Bucks County residents without insurance coverage are funded through BCADC, Inc., when funds are available. We follow the DDAP guidelines regarding admission of priority populations, which provides preferential treatment to pregnant women, people who use injecting drugs, and individuals who have overdosed. During this year, DDAP has also added Veterans to the listing of priority populations. It is also important to note that BCDAC, Inc. supports the DDAP philosophy of reducing barriers to treatment, so it is anticipated there may be a blurring of county line funding, especially for top priority populations. SCAs are working together to ensure that individuals receive the treatment they are seeking, and the reduction of barriers to access is a key factor.

Target Populations

Older Adults - The prevalence of Older Adults, noted within the Plan Guidelines as those ages 60 and above), are a high priority population for the drug and alcohol system. The number of referrals had remained steady over the last decades, though this past few years has seen a roughly 10% increase this past fiscal year. Trends include an increase in medication misuse/abuse, alcoholism and opiate addiction, for this age group. Bucks County developed Project MEDS (Medication Education Designed for Seniors) over 25 years ago. This peer presentation model of prevention seeks to provide presentations to older adults on the topic of medication misuse and alcohol use among older adults. The project, which has been replicated in many counties in PA and nationally, provides a pre-test and post-test, and is provided in senior centers, caregiver groups, etc.

Adults - The majority of those seeking drug and alcohol treatment, who are not privately or publicly insured, are Adults. We offer specialized treatment programs for Adults, including the Matrix Model of Intensive Outpatient Treatment, Seeking Safety, TREM, Medication Assisted Recovery, the full continuum of care including Outpatient, Intensive Outpatient, Partial Hospitalization, Detoxification, Rehab, Halfway House and Mobile Engagement Services. We support Medication Assisted Treatment, which may include Methadone, Suboxone, or Vivitrol.

Transition Age Youth (ages 18 to 26) – Any transition age youth resident who is seeking drug and alcohol treatment is prioritized. The current Opiate Epidemic is further evidenced by an increase in TAY individuals seeking treatment, most often with heroin or medication abuse issues. We continue to note a trend regarding parents of Transition Age Youth, who are seeking support. Bucks County's recovery oriented systems of care providers offer family education and support for such families. Our collaborations with the Children's Coordination Committee, Child Death Review, Near Fatality Review,

DRUG and ALCOHOL SERVICES

Adult and Juvenile Probation and Parole, Safe and Drug Free Schools, Bucks Promise for Youth and Communities, to name a few, are essential in ensuring this safety net. We support an in-county residential providers, whose focus is on adolescents.

Adolescents (under 18) – BCDAC, Inc. offers prevention, intervention and treatment options for Adolescents. From prevention programs such as school based educational support groups , to intervention programs such as Student Assistance Programs, to treatment options including assessment and the full continuum of care, we ensure that Adolescents have access to drug and alcohol services. We do find that most youth are insured through their family’s private insurance plan or are eligible for Medical Assistance, but we prioritize each Adolescent who is referred to BCDAC, Inc. for services. We serve on the Bucks County Behavioral Health System Children’s Coordination Committee, with a goal of ensuring that drug and alcohol resources are effectively utilized and drug and alcohol issues identified in youth. During 2016-2017, we will offer a streamlined Act 53 (Involuntary Commitment of Minors) procedure.

Individuals with Co-Occurring Psychiatric and Substance Use Disorders – Bucks County has been a leader in training providers in co-occurring identification and treatment. Several providers are considered Co-Occurring competent. We review provider charts on an annual basis to ensure that the appropriate assessment questions regarding co-occurring issues are pursued. One provider, for example, is moving toward a No Wrong Door practices, whereby staff will be cross-trained in assessment of substance use disorders as well as mental health concerns.

Criminal Justice Involved Individuals – One of our strongest partnerships is with the criminal justice system. We serve on the Criminal Justice Advisory Board (CJAB), as well as employ two staff of the Pre-Trial Program which is located in the Department of Corrections. Non-violent criminal offenders may qualify for the Treatment Accountability for Safer Communities (TASC) Program, funded by BCDAC, Inc. The Clinical Director of the BCDAC, Inc. also serves in the capacity of the Clinical Director of the Bucks County Drug Court. The Bucks County MA Jail Pilot program has increased access for people with substance use disorders to enter residential treatment on the date of release from jail. The success of this project rests on the collaborative efforts of the criminal justice system, drug and alcohol providers, the County Assistance Office and Magellan Behavioral Health. Like most counties, our Bucks County Correctional Facility (BCCF) is over capacity and the vast majority of inmates are incarcerated for a drug and alcohol related offense, with an estimated 70% having a substance use disorder. During 2016-2017, we will launch a Pilot Recovery Program Unit at the BCCF. This free standing unit, located on the BCCF grounds, will provide drug and alcohol workbook/curriculum based education and intervention programming.

Veterans – The majority of those seeking treatment with a history of military service are eligible for Veteran’s benefits. However, we are aware that Veteran’s services have been difficult to access, and are sporadically offered. The PA DDAP has mandated that SCA’s prioritize Veterans, regardless of any Veteran’s benefits they may have. BCDAC, Inc. is committed to providing funding to Veterans, and at

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the end of 2015-2016, providers were so notified. We have notified our stakeholders that priority will be given to anyone who is a Veteran.

Women with Children - There are significant challenges surrounding substance use disorders for women with children. BCDAC, Inc. is addressing these factors through the full continuum of care, spanning prevention through recovery support services. The highest priority is given to pregnant women who are seeking services. Bucks County is most fortunate to host a women's halfway house, as well another facility located on the same campus, which is a residential program specifically for Women with Children. While in treatment, women and their children participate in evidence based prevention/education programming. The same provider has just undergone a capital project and will begin outpatient substance use disorder treatment for women and their children, during g 2016-2017. In addition, a women's recovery house is located on the same property and is undergoing renovation, expected to open during 2017. In recognition of the high percentage of women/families connected with the Child Welfare system who have substance use involvement, a special outreach program has been implemented.

Recovery-Oriented Services

Bucks County maintains a wide array of recovery support services. There are three Recovery Centers in Bucks County, each of which offers some level of peer support or recovery coaching. Several providers employ individuals who are in recovery from substance use disorders, who have specialized training that allows them to offer their lived experience to others. One Recovery Center houses Certified Recovery Specialists, who are funded through HealthChoices as well as BCDAC, Inc. An outpatient provider, in addition, maintains Certified Recovery Specialists who provide Mobile Engagement Services. BCDAC, Inc. supports the Bucks County Recovery House Association, and we maintain contracts with five Recovery Houses to offer two to four weeks of initial rent, to allow individuals time to gain employment, develop peer support, etc. Several residential providers also maintain a recovery house on their property. The concept of funding solely a treatment experience has not proven the most effective for our residents, so the movement toward a Recovery Oriented System of Care is essential. During 2015-2016, BCDAC, Inc. expanded CRS funding for providers who will partner with local hospitals. This is an effort to address the issue of overdose, and overall substance use, for hospital admissions. Three providers who have hired CRS staff will be working with Bucks County hospitals to develop a plan for hospital staff training, on-site consultation and screening of individuals who are admitted post overdose. Finally, an item that is of concern is the payment methodology for Certified Recover Specialists. Since the inception of Certified Peer Specialists, there has been available reimbursement for the CRS services through Medicaid. The CRS services are still tied to the CPS original Policy Bulletin and accompanying requirements. BCDAC, Inc. respectfully requests a revisit of this policy, as it is a barrier for expansion of CRS services, if they cannot be reimbursed through HealthChoices. Peer services are considered a cornerstone of long term recovery, and we are committed to expanding CRS services during 2016-2017.

HUMAN SERVICES and SUPPORTS/HUMAN SERVICES DEVELOPMENT FUND

HSDF was created “for the purpose of encouraging county government to provide locally identified services that will meet the human services needs of citizens in their counties.” These funds are to be used by the county solely to provide and administer county based social services and service coordination within the county. Persons 18 years of age and under the age of 60, resident of the county and meet the financial eligibility criteria.

Our plan for 2016-2017 lessens funds from 2015-16 programs that did not demonstrate the ability to meet identified outcomes or community impact. Those funds have been redistributed as described in the categorical services as outlined below.

Adult Services

Program Name: A Woman’s Place

Description of Services: A Woman’s place provides empowerment options counseling to victims of domestic abuse and violence. Counseling includes direct counseling on the dynamics of abuse, as well as information on protection orders, civil legal matters, jobs, finance, welfare, healthcare, relationships and housing issues.

Service Category: Counseling, Information and Referral, Protective

Planned Expenditures: \$5,050.00

Program Name: Advocates for the Homeless and Those in Need

Description of Services: AHTN is a Bucks County interfaith nonprofit providing temporary help to the homeless by providing intervention in a crisis situation and includes services necessary to remove an eligible individual from a dangerous situation. AHTN helps those in need by offering with dignity and compassion emergency shelter, food, clothing and other related services.

Service Category: Protective, Transportation

Planned Expenditures: 5,000.00

Program Name: Bucks County Drug and Alcohol Commission, Inc. (BCDAC)

Description of Services: BCDAC Inc. assists with the continuation of counseling services targeted for eligible individuals living in high risk communities. It allows the consumers to continue to work while addressing their recovery from addiction. The first priority for funding of counseling services continues to be those narcotic dependent individuals living with a co-occurring mental illness or serious medical condition(s), pregnant women, parenting women and men and other intravenous drug users.

Individuals with co-occurring mental illness would receive services from a single provider (not multiple providers) who is able to provide support for that population.

Service Category: Counseling, Information and Referral

Planned Expenditures: \$33,000.00

Program Name: Bucks County Opportunity Council, Inc. (BCOC)

Description of Services: BCOC uses funds for case management salaries to administer their CPSI (Crisis Prevention for Self-Sufficiency and Independence) program that helps low-income individuals and families achieve the highest level of self-sufficiency they can through a combination of assessment, short-term case management. The goal of the short term intervention is to stabilize situations and limit or eliminate future need for assistance. Additionally BCOC uses HSDF to support coordinated assessment and case management services as referred by the Bucks County Housing Link, our centralized intake for housing supports.

HUMAN SERVICES and SUPPORTS/HUMAN SERVICES DEVELOPMENT FUND

Service Category: Case Management, Counseling, Information and Referral

Planned Expenditures: 57,972.00

Program Name: Catholic Social Services

Description of Services: Utilizing the HSDF funding, CSS will provide case management services.

Individuals and families will initially be given a needs assessment session to determine the level of need and will speak with a case manager for services and referrals. Follow up services will be determined and mutually agreed upon by the staff and the client.

Service Category: Case Management, Information and Referral

Planned Expenditures: \$10,000.00

Program Name: Family Service Association of Bucks County

Description of Services: Funding for this program targets those needing professional behavioral healthcare to maintain stability or achieve self-sufficiency. The majority of clients are single parents which are female headed households; couples with children, most commonly in blended, re-married or unmarried families; and single adults who are under age 30 and have not been able to establish independent households or who are over age 50 and suffering from depression and may have a co-occurring physical illness. Each group has distinct needs and obstacles to overcome.

Additionally this funding support Family Service Association's work with Information and Referral services in our community, proving information about social and other human services to all persons requesting it. This work includes referrals to other community resources by staff dedicated for this purpose.

Service Category: Counseling, Information and Referral

Planned Expenditures: \$41,000.00

Program Name: St. Mary Medical Center

Description of Services: Saint Mary's has the Family Resource Center Program which provides intensive case management for homeless pregnant women and their families. Case management focuses on working collaboratively with families to develop a plan of action for housing, employment and/or training. Case managers assist clients in establishing goals and appropriate housing plans early in their stay in the apartments. Case management services include conflict resolution, life skills development, appropriate resources and referrals to other social services and/or treatment, time management, maintenance and sanitation issues, emotional support, budgeting, mental and physical health issues, follow-up of assigned tasks, and any issues determined by the family or case manager.

Service Category: Case Management, Housing

Planned Expenditures: 6,500.00

Program Name: Senior Care Centers of America, Inc.

Description of Services: Senior Care provides a daily program of health services in an enjoyable, safe, home-like environment for clients under the age of 60. Services are provided to assist in performing the basic tasks of everyday living and include medication administration (not prescribing or medical services), therapeutic recreational activities, social services, and assistance arranging transportation for occupational, speech and physical therapy.

Service Category: Adult Day Care

Planned Expenditures: 10,200.00

HUMAN SERVICES and SUPPORTS/HUMAN SERVICES DEVELOPMENT FUND

Program Name: The Salvation Army

Description of Services: Case management services include emotional support and assessment/service planning for individuals and families. Referral to other community supports based on assessment is also part of the services provided.

Service Category: Case Management

Planned Expenditures: 5,500.00

Program Name: Volunteers for the Homeless, Inc.

Description of Services: Provide case management and referral services for food, clothing, and shelter in the community.

Service Category: Case Management

Planned Expenditures: \$2,750.00

Program Name: Worthwhile Wear/The Well

Description of Services: The Well is a long-term protective services shelter for sexually exploited and trafficked women in Bucks County. It has a comprehensive program for helping women coming out of the sex slave trade and transitioning back to self-sufficiency. Funds are not to be used for payment of housing or rental services, but for case management, and non-medical supports.

Service Category: Counseling, Life Skills Education, case management

Planned Expenditures: \$10,000.00

Aging Services

Program Name: Bucks County Area Agency on Aging

Description of Services: BCAA is a department in the Human Services Division that receives this allocation. BCAA contracts with several providers to provide Day Care and Personal Care Services from which their senior clients can choose. Day Care programs meet the needs of seniors and their families for a safe and stimulating environment. A variety of carefully planned programs and activities are available, provided by a caring and competent staff. Personal Care services are provided by a professional healthcare individual to ensure quality personal care to ease the burden for the client and their family. Assistance with bathing and dressing, medication management, meal planning and preparation, assistance with doctor appointment are some of the services available. Each client is evaluated and chooses the services they personally need.

Service Category: Adult Day Care, Personal Care

Planned Expenditures: \$96,872.00

Specialized Services

Program Name: Libertae, Inc.

Description of Services: Libertae has a Drug & Alcohol Program Inpatient, non-hospital Halfway House, and Residential Women and Children Services. Specific services provided are life skills and case management; comprehensive case management planning (long/short term); comprehensive economic planning (GED tutor, Career Link, resume building, budgeting, communication, job search, credit counseling); housing planning, applications for programs, transitional and permanent, along with coordination of services for medical needs (making appointments, support with storing and dispensing

HUMAN SERVICES and SUPPORTS/HUMAN SERVICES DEVELOPMENT FUND

prescriptions, transportation to appointments). Children also receive comprehensive services to include: kids group and play therapy, child care center with a curriculum unique to Libertae population. Libertae services include staff, volunteers and community resources.

Service Category: Case Management, Counseling, Life Skills Education

Planned Expenditures: \$26,000.00

Interagency Coordination: (planned expenditure \$60,000).

In addition to the Policy and Planning Specialist who supports interagency coordination, Bucks County is including in the 2016-17 plan an additional \$10,000.00 designated for the Human Services Information Technology Manager to work to develop and design effective and reliable coordination and utilization of data related to the outcomes of the block grant plan. It is expected that the work of the IT Manager will include data collection, cleaning and analysis, creating of dashboards and data visualizations of outcomes. This work will support cross system coordination and interagency evaluation of outcomes.

In addition to the Human Services IT Manager, \$50,000.00 is allocated towards the employment of our Policy and Planning Specialist.

The Bucks County Human Services Office, and particularly through the work of the Policy and Planning Specialist, maintains a relationship with the local United Way in an effort to leverage HSDF effectiveness with the broader services funded by the agency.

Additional coordination for the planning, management, and delivery of social services is effected by the Policy and Planning Specialist's membership with numerous boards and coalitions. These include but are not limited to:

1. Citizens Advisory Committee, a coalition of public and private human services agencies that meets monthly to network and problem-solve case and system issues.
2. HUBBUB (Helping Upper Bucks Be Universally Better), a community-driven group of residents and professionals dedicated to network, educate and coordinate family support services as well as improve the overall quality of life in the Upper Bucks area.
3. Bridge/Home Stabilization Program, a program administered by Bucks County Children & Youth Social Services Agency in conjunction with direct service delivery by Bucks County Opportunity Council and Bucks County Housing Group which affords homeless families an opportunity to receive rent assistance and social service support while they improve their educational and training skills
4. Bucks County Homeless Coalition, an association of public, private social service providers seeking to coordinate services for the homeless population in Bucks County; this also includes submission of an annual HUD Supportive Housing Application for project funding for emergency, transitional and permanent housing resources and development of a 10-Year Plan to end Homelessness. The Policy and Planning Specialist is a member of the Training, Outcomes and HMIS Data Management subcommittees.

HUMAN SERVICES and SUPPORTS/HUMAN SERVICES DEVELOPMENT FUND

5. Mid-Atlantic Region Homeless Management Information System (MARHMIS) Committee, a group dedicated to offering support, networking and technical assistance to peers to insure compliance with federal mandates to capture homeless population data.
6. Bucks Promise, a coalition of community mobilizers, service providers, law enforcement personnel, and key leaders working to improve community life in each of the county's school catchment areas. The Policy and Planning Specialist is a member of the Writing Committee which submits op-ed articles to two local Bucks County newspapers approximately every six-eight weeks. These informative commentaries cover topics of interest to the Bucks County community such as e-cigarette misuse, powdered alcohol concerns, truancy and gambling issues.
7. Bucks County Hunger Nutrition Coalition, a group of individuals representing public and private non-profit agencies that works to ensure that people in Bucks County low-income households have access to resources for food security and basic nutritional needs. The Policy and Planning Specialist helps organize a bi-annual Hunger Forum and collates data from approximately 1,400 surveys from pantry users for use at the Forums and for local officials, legislators and the public to understand the extent of food insecurity in Bucks County.
8. Bucks-Chester-Montgomery Link, a Pennsylvania Link to Aging and Disability Resources Center, part of a nationwide effort to provide a seamless approach to the way the social service community assists seniors and adults with a disability who need help with activities of daily living. *It connects individuals and families to local services and supports to ensure a secure plan for independence, and additionally, helps consumers remain or return to their community because of a disability, an illness or accident, or to transition from an institution back to the community.* Aging and Disability Resource Centers are funded through a partnership between the Administration for Community Living (formerly AOA) and the Centers for Medicare and Medicaid Services.
9. Bucks County Transport, Inc. Persons with Disabilities Local Advisory Committee Work Group, a public-private partnership engaged in planning and evaluating the shared ride program for residents of Bucks County with physical, and/or mental health disabilities.
10. United Way Collaborative Impact, a new initiative of Bucks County United Way, which seeks to reorganize its fund distributions by employing a collective approach and convening Solutions Teams charged with addressing six areas whose goals are to: Bring more resources to bear on affordable housing and homelessness. Develop greater systems coordination and infrastructure to address hunger and food insecurity. Strengthen and standardize information and referral county-wide. Deepen and consolidate our commitment to early child care and education. Explore the creation of an emergency assistance fund for basic needs. Reduce barriers and increase access to public benefits for older residents. The Policy and Planning Specialist is a member of Solution Teams which address hunger, information and referral, emergency assistance, and public benefits for older residents.

HUMAN SERVICES and SUPPORTS/HUMAN SERVICES DEVELOPMENT FUND

Information obtained from the Specialist's interactions with social service providers, local business and government representatives, and recipients of service is utilized by the Specialist and the Director and Deputy Director of Health & Human Services to increase access to service, minimize duplication of service, improve resource allocation, and provide the Board of Bucks County Commissioners the information they need to approve HSDF Funded allocations to the agencies providing the services.

Block Grant Administration – ten (10) percent of HSDF funding (*planned expenditure \$41,093*) is allocated for administrative costs that include salary and fringe and supplies and services. The Human Services office currently has a full time staff of four (4); that include the Director, Deputy, Policy & Planning Specialist and Administrative Assistant. FY 2016-2017 Plan includes Human Services IT Manager for a full time staff of five (5).

TOTAL PLANNED HSS/HSDF EXPENDITURES \$410,937

HUMAN SERVICES and SUPPORTS/HUMAN SERVICES DEVELOPMENT FUND

Interagency Coordination:

Allocation for salary and benefits for the Policy and Planning Specialist is \$50,000.00.

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HUMAN SERVICES and SUPPORTS/HUMAN SERVICES DEVELOPMENT FUND

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HUMAN SERVICES POLICY AND PLANNING SPECIALIST

County of Bucks

EXEMPT: Yes

JOB CODE: 094

DEPARTMENT: Human Services

UNION: 00

UPDATE: 05/23/2001

SUMMARY: Position functions as the program assistant to the Human Services Director in overseeing the operation of the County Human Services System. Includes public and quasi-public agencies in the division. In conjunction with the Director, will be responsible for collaborating and coordinating activities with the private sector to improve the Human Services network in the County. Requires ongoing contact with state, federal and local governments to evaluate the impact on service delivery.

ESSENTIAL DUTIES AND RESPONSIBILITIES include the following:

- Analyzes laws and regulations that impact upon programs.
- Reviews and analyzes programmatic plans and projects to assure compliance with regulations.
- Reviews agencies' planning processes to insure maximum collaboration and minimize duplication.
- Analyzes agency program structures and if necessary, recommends change.
- Interprets impact of policy decisions to Director and other government officials.
- Evaluates ongoing relationship between public and private sectors and makes recommendations for improvement.
- Meets with public and private agency officials on collaboration and coordination issues
- Collects data on pertinent matters and compiles and organizes data into written reports.
- Researches economic, social and demographic phenomena and interprets their significance to impact upon the County's planning and policy strategies.
- Prepares correspondence to answer inquiries regarding human services.
- Presents oral information in meetings or conferences.
- Collaborates with Human Services Director as well as Finance Director on proposals to generate funds.
- Monitors recipients of grants to insure compliance with grant requirements.
- As required, participates in meetings.
- Attends Human Services Advisory Council meetings and as requested, provides information.
- Performs any other related duties that may be assigned.

QUALIFICATION REQUIREMENTS: To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

- Master of Social Work Degree plus six years of progressive responsibility in a public or private organization. Minimum of three years of experience must be in a supervisory/management capacity.

PHYSICAL DEMANDS: The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is regularly required to sit. The employee frequently is required to use hands to finger, handle or feel objects, tools or controls; and talk and hear. The employee is occasionally required to stand; walk; and reach with hands and arms. The employee must frequently lift and/or move up to 10 pounds and occasionally lift and/or move up to 50 pounds. Specific vision abilities required by this job include close vision, color vision and the ability to adjust focus.

WORK ENVIRONMENT: The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

The noise level in the work environment is usually moderate.

HUMAN SERVICES INFORMATION TECHNOLOGY MANAGER

County of Bucks

EXEMPT: Yes

JOB CODE: 095

DEPARTMENT: Human Services

UNION: 00

UPDATE: 06/10/2016

SUMMARY: Reporting directly to the Director of the Division of Human Services, this position is responsible for overall management of activities related to the design, development and implementation of information systems and software applications for Bucks County's Division of Human Services.

This includes working with the Division leadership on system improvements for data collection, quality and outcome analysis, coordination of data sharing among Human Services Departments, and data visualization.

This position requires coordination with the Bucks County IT Department, communication and planning with County Department Heads, and supervision of the day to day work of IT Technical Specialists assigned within Human Services Departments at various locations.

- **ESSENTIAL DUTIES AND RESPONSIBILITIES** include the following:
- Identify and plan for technology needs for Human Services Division and advise the Human Services Director on all aspects of technology needs. Performs needs assessments with the assistance of Department IT staff preparing for business requirements and future technology adjustments. Recommend technical solutions for complex business needs.
- Serve as liaison to Bucks County IT Department business analyst on behalf of Human Services in coordination with the Director of Human Services. Works collaboratively with the IT Department's standards, reviews, and approval architecture. This includes working with the Division leadership on system improvements for data collection, quality and outcome analysis, coordination of data sharing among Human Services Departments, and data visualization. Able to conceptualize and present the "What if" scenario to Division Leader and CIO.
- Assist in the ongoing design, development, and enhancement of Division information systems.
- Provide project management over all Human Services IT projects including monitoring consulting contracts. Work with software and hardware vendors in support of assuring high quality products that meet departmental needs. Develop project plans and ensure deadlines are met.
- Provide direct supervisory oversight of primary IT staff assigned to Human Service Departments
- Ensure the consistency and maintainability of existing IT applications by creating, maintaining, and enforcing standards/procedures for implementing technical solutions in collaboration with County IT
- Develop and design effective and reliable coordination of cross system utilization of data. This may include data collection, cleaning and analysis, finding and obtaining secondary data sources, and gathering input from contracted providers. Transform raw data collected into actionable information
- Create dashboards and data visualizations

- Support the development and implementation of quality improvement strategies
- Work with Bucks County IT to assure appropriate levels of information security
- Assists in the development and implementation of the Division's research and analysis strategies including advising on technical needs and providing guidance on optimal data structure, system requirements, and operational needs. Interpret data collection results using a variety of techniques ranging from simple data aggregation to complex data mining and visual representation
- Participate in Continuous Quality Improvement meetings and activities

Supervisory Responsibilities: This position provides supervisory oversight of IT staff assigned within the Human Services Division.

Additional Responsibilities: From time to time the employee will be required to perform additional tasks and duties as required by the employer.

Qualifications/Experience Requirements:

- Bachelor's degree from an accredited college or university related to performance of this position. This includes information technology, computer science, statistics, mathematics, human services, social work or other related field. Master's degree preferred
- Five years of job related experience
- Knowledge of Project Management methodology

Preferred Knowledge and Skills:

- Demonstrated interest in public service and research that support improvement in health and well-being of the community.
- Proficient in the Microsoft productivity and other analytic tools. Skills in database development, website development, and data visualization (use of Tableau software) and data mining methods are considered a plus.
- Knowledge and experience working with large data in rapid development including:
 - SQL
 - Java
 - .Net
 - XML
 - Web Services
- Ability to be self-directed and take initiative while maintaining a team orientation and collaborative approach to work
- Innovative, demonstrating creativity in problem solving. Strong analytic and critical thinking skills

- Experience working with a variety of information systems and data files, including large and complex files, transforming raw data into finished products
- Strong interpersonal skills; ability to clearly communicate (written/verbal) with diverse audiences and to work in teams; sensitive to a cultural diversity in the workplace and towards consumers
- Excellent time management and organizational skills; can set priorities and accomplish a wide variety of tasks
- Attention to detail and quality
- Ability to interact professionally with County leadership, system partners, community service providers, and consumers
- Ability to thrive in an environment that requires flexibility and multi-tasking

PHYSICAL DEMANDS: The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

- While performing the duties of this job, the employee is regularly required to sit; use hands to finger, handle or feel objects, tools or controls; and reach with hands and arms. The employee is frequently required to hear and talk.
- The employee is occasionally required to stand and walk. The employee must occasionally lift and/or move up to
- 10 pounds. Specific vision abilities required by this job include close vision and the ability to adjust focus.
- Local travel required. Occasional regional travel required.

WORK ENVIRONMENT: The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

The noise level in the work environment is usually moderate.

**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, CWSSG, 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 <u>not</u> associated with HSBG funds in the applicable cost centers. <i>This does not include Act 148 funding or D&A funding received from the Department of Drug and Alcohol.</i>
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 <u>not</u> included in MH or ID Services.
	NOTE: Fields that are greyed out are to be left blank.
	<ul style="list-style-type: none"> ■ 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).

**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
BUCKS						
MENTAL HEALTH SERVICES						
ACT and CTT	70		493,685	0	20,337	0
Administrative Management	3,050		1,843,935	0	75,959	126,000
Administrator's Office			1,789,666	0	73,723	0
Adult Developmental Training	0		0	0	0	0
Children's Evidence-Based Practices	0		0	0	0	0
Children's Psychosocial Rehabilitation	0		0	0	0	0
Community Employment	175		341,631	0	17,853	0
Community Residential Services	300		7,353,613	0	87,505	0
Community Services	250		71,336	0	2,939	230,000
Consumer-Driven Services	0		0	0	0	0
Emergency Services	2,000		838,490	0	34,541	0
Facility Based Vocational Rehabilitation	15		91,749	0	0	0
Facility Based Mental Health Services	5		10,000	0	0	0
Family Support Services	95		486,777	0	20,464	0
Housing Support Services	60		425,000	46,874	205,582	70,960
Mental Health Crisis Intervention	2,200		1,135,557	0	46,778	0
Other	0		0	0	0	0
Outpatient	625		247,849	0	10,210	0
Partial Hospitalization	85		153,819	0	6,366	0
Peer Support Services	100		287,984	0	11,863	0
Psychiatric Inpatient Hospitalization	65		374,570	0	15,430	0
Psychiatric Rehabilitation	0		0	0	0	0
Social Rehabilitation Services	85		153,670	0	6,330	0
Target Case Management	480		780,866	0	32,167	0
Transitional and Community Integration	0		0	0	0	0
TOTAL MENTAL HEALTH SERVICES	9,660	16,880,197	16,880,197	46,874	668,047	426,960

**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
BUCKS						
INTELLECTUAL DISABILITIES SERVICES						
Administrator's Office			2,816,208	0	98,724	20,000
Case Management	320		571,428	0	23,200	0
Community-Based Services	111		764,391	0	31,034	0
Community Residential Services	210		3,523,419	0	127,436	0
Other	0		0	0	0	0
TOTAL INTELLECTUAL DISABILITIES SERVICES	641	7,675,446	7,675,446	0	280,394	20,000
HOMELESS ASSISTANCE SERVICES						
Bridge Housing	30		154,054		6,255	0
Case Management	1,564		48,300		1,961	0
Rental Assistance	488		198,842		8,073	0
Emergency Shelter	0		0		0	0
Other Housing Supports	0		0		0	0
Administration	0		0		0	0
TOTAL HOMELESS ASSISTANCE SERVICES	2,082	401,196	401,196		16,289	0
CHILD WELFARE SPECIAL GRANTS SERVICES						
Evidence-Based Services	185		405,000		16,442	0
Promising Practice	0		0		0	0
Alternatives to Truancy	220		330,000		13,398	0
Housing	110		133,559		5,423	0
TOTAL CWSG SERVICES	515	868,559	868,559		35,263	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
BUCKS						
DRUG AND ALCOHOL SERVICES						
Case/Care Management	0		0		0	0
Inpatient Hospital	5		15,000		0	0
Inpatient Non-Hospital	575		966,532		30,821	0
Medication Assisted Therapy	205		253,200		29,500	0
Other Intervention	500		105,000		0	0
Outpatient/Intensive Outpatient	230		92,000		0	0
Partial Hospitalization	20		14,000		0	0
Prevention	0		0		0	0
Recovery Support Services	480		40,000		0	0
TOTAL DRUG AND ALCOHOL SERVICES	2,015	1,485,732	1,485,732	0	60,321	0

HUMAN SERVICES DEVELOPMENT FUND

Adult Services	920		186,972		7,591	0
Aging Services	24		96,872		3,933	0
Children and Youth Services	0		0		0	0
Generic Services	0		0		0	0
Specialized Services	120		26,000		1,055	0
Interagency Coordination			60,000		2,436	0
TOTAL HUMAN SERVICES DEVELOPMENT FUND	1,064	410,937	369,844		15,015	0

7. COUNTY BLOCK GRANT ADMINISTRATION			41,093		1,668	
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GRAND TOTAL	15,977	27,722,067	27,722,067	46,874	1,076,997	446,960
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