Armstrong/Indiana Behavioral and Developmental Health Program
County Plan for OLMSTEAD

I. INTRODUCTION and OLMSTEAD PLANNING PROCESS OVERVIEW

Throughout the past ten years, the Armstrong-Indiana Behavioral and Developmental Health Program (AIBDHP) and its stakeholders have been active participants in many different planning processes and groups. One endeavor where our participation was particularly strong was in the Torrance State Hospital Planning process. By working closely with staff from Torrance, various surrounding counties and their own stakeholders, we were able to move our system of care into a more recovery-oriented model. We were also able to reduce our census at Torrance State Hospital, targeting those who have been hospitalized for more than two years. The ability to further examine the possibilities of creating more regionally based community supports was also achieved. Armstrong and Indiana Counties remain committed to enhancing and possibly expanding our current recovery based system of care. We also remain committed to exploring and developing regional services that will assist us all in reducing our reliance on the state hospital system.

The following pages will present an overview of the process and resources used to complete this Olmstead Plan. The plan will reflect information, ideas and strategies presented in meetings held with the Torrance State Hospital Service Area, our local Community Support Programs, local County Planning meetings, and our Personal Care Home Resident Risk Assessment Committee. These meetings are all environments where stakeholders are free to give input and feedback into our service delivery system. Also presented will be a description of our infrastructure including residential and non-residential supports. We will outline our Personal Care Home Integration Plan as well. Finally, we will discuss all funding sources that BDHP has used in the past and what potential outside resources may be considered to help support our system in the future.

Planning Process

The process used to complete this Olmstead plan was three-fold. The main avenue to gain stakeholder participation and input was the Torrance Service Area Planning meetings. The second method was through our local Community Support Programs where stakeholders assist us in completing our annual County Plan. The final initiative was our Personal Care Home Resident Risk Assessment Committee meetings. Each of these groups contributed valuable information and direction that was used in the Olmstead Planning process. Below is a brief synopsis of each endeavor.

TSAP

The service area planning meetings included all counties who admit to Torrance State Hospital. The Armstrong-Indiana BDHP has a strong commitment to this planning process and recognizes the importance of stakeholder involvement. Stakeholders from Armstrong and Indiana counties represented a variety of interests in the behavioral health community. Below is a list of all parties who comprised our Armstrong/Indiana group:

- Community Support Programs
- NAMI
- Drop-in Centers
- Consumer/Family Satisfaction Team
- Local Providers (both residential and treatment)
- Various interested consumers and family members
- Armstrong-Indiana BDHP staff

In the beginning, the service area planning meetings concentrated on learning what resources each individual county had, as well as what gaps in service existed. What became apparent early on was that the geographic area covered by Torrance State Hospital is very large. Also, it was apparent that there are very distinct barriers that exist in service delivery between rural and urban areas. It should be noted that no matter what type or size of an area, having safe and affordable, permanent housing is a major concern.

As discussions progressed through the various meetings, a new way of assessing individuals was introduced, the Consumer Support Plan (CSP). CSPs mirrored previous CHIPP assessments, but brought continuity into the discharge planning process with each county using standard assessment tools. CSPs include assessments not only of the individual, but also their family and the treatment team. The goal first was to focus on those hospitalized at Torrance for over two years, and then gradually introduce the CSP process to each individual who was at the hospital. In the end, use of the Consumer Support Planning process has led to much more comprehensive discharges from Torrance. Results from CSPs conducted with Armstrong and Indiana county residents will be included in the next section which concentrates on the Service Area Planning.

Finally, although the Service Area Planning meetings are not held as frequently as they once were, the counties still meet at various other meetings and continue to discuss the possibilities for future, more regionalized programs. Also, all the counties still continue to participate in quarterly Continuity of Care Meeting with Torrance where we share information and issues that surround discharge planning and resources. We all realize the need for collaboration and communication in these changing times. In addition, many counties, like Armstrong/Indiana, have also tied the service area planning process in with their local County Plan processes.

County Plan/Community Support Programs

Every year, as required, each county is required to submit their annual County Plan to the Commonwealth. This plan is designed to give stakeholders input into all areas of planning and to help assist in the identification of needs. The final product is a combination of all of this plus a guideline for future program enhancement and/or growth. In Armstrong and Indiana counties, County Plan feedback is obtained mainly through our local Community Support Program meetings which are held monthly. Building on input from the 2009-2012 County Planning process, the County Plan has become a standing agenda item and updates are given to all stakeholders as they become available. All stakeholders receive copies of the monthly minutes as well. Both CSPs continue to remain active. In addition to consumers, family members, provider and BDHP staff, CSP members also include representatives from local law enforcement agencies, Community Action Programs, CYS, Value Behavioral Health, C/FST, and other human service agencies.

In conjunction with the Torrance Service Area Planning process, the county planning/CSP process also identified the need for a broader, more regional approach to supports and housing. Many times housing has been a featured topic of discussion at CSP meetings. Activities such as Fair Housing Act trainings and open discussions about housing options have been venues where all stakeholders can learn about different housing programs, individual rights, and can give input into what they think is needed in each county. We are fortunate to have many individuals who live in personal care homes attend these meetings as well. The information gathered in these discussions is also shared with our third component used to complete this plan, our Personal Care Home Risk Assessment Committee.

Personal Care Home Resident Risk Assessment Committee

The final component that was included in our Olmstead Planning Process was feedback and ideas presented through meetings held by our county Personal Care Home Resident Risk Assessment Committee. This group is comprised of many various local human service agencies and representatives from the Pennsylvania's Department of Public Welfare. This group meets to discuss licensing issues with personal care homes and acts as a reporting forum where providers can express concerns of resident care. The meetings have become a place to exchange ideas and strategies to better serve the residents of our counties through a collaborative effort. The members of this group were instrumental in the development of our personal care home integration plan as well as our personal care home policy. A more extensive description of this committee is presented in the section that defines our Personal Care Home Integration Plan.

II – VI SERVICE AREA PLANNING/IDENTIFICATION OF COMMMUNITY SERVICE NEEDS

History

Through our strong participation in and commitment to the Torrance State Hospital Services Area Planning process, we were able to begin making progress toward accomplishing the goal that no individual should be hospitalized at Torrance State Hospital for longer than two years. Armstrong and Indiana Counties were part of a 30 bed closure at Torrance in 2008-2009. With the assistance of regional collaboration, the availability of CHIPP funding, and the Consumer Support Planning process, two individuals were discharged from Torrance. One person resided at Torrance for nearly 14 years and the other for 5 years. We further reduced our bed census at Torrance by two beds in 2010 and 2011. This reduction came as a result of the "Jimmie Litigation", which focused on the dually diagnosed. By again focusing our efforts through the CSP process, the use of CHIPP funding, and relying on collaboration for specialized services with other counties, the two individuals were successfully discharged back into the community. These individuals had resided at Torrance for 3 years and 36 years respectively. With these successes behind us, we continue to actively pursue discharges for those Armstrong and Indiana County residents who have remained hospitalized for longer than 2 years, or are closing in on that targeted time frame.

Current Progress

As of June 30, 2012, there are 5 individuals from Armstrong County and 5 from Indiana County who have been treated at Torrance State Hospital for more than 2 years. Presented below is a chart that reflects how many individuals would reach the 2 year mark within the next 2 years, should no discharges occur. These numbers do not reflect admissions that may occur after the writing of this plan.

COUNTY	Current	By 6/30/2013	By 6/30/2014
Armstrong	5	6	17
Indiana	5	6	11

Consumer Support Planning (CSP) Process

The Consumer Support Planning Process consists of three distinct assessments (peer, family, and clinical) that are completed to gain a comprehensive view of the consumer's strengths, weaknesses, and needs. Each assessment provides valuable and necessary input to enhance service planning in the community. Once the assessments are complete, a multidisciplinary team begins meeting with the individual, their family, and any other persons the consumer invites to attend. It is at these meetings that the groundwork is laid for a successful discharge. To date, 5 consumers who have been hospitalized for more than two years at Torrance have started the CSP process.

One of the most challenging areas to address in the CSP process is housing. Ensuring that every consumer has safe, affordable and secure housing of their choice, is paramount to a successful discharge. For those already engaged in the CSP process, the following chart demonstrates the differences in living arrangements that were captured in the peer and clinical assessments.

COUNTY	Consumer Requests	Clinical Requests
Armstrong	1. own apartment 2. home with family	1. maximum care Community Residential Rehabilitation Program 2. enhanced personal care home
Indiana	1. own apartment 2. domestic care (domcare) 3. own home .	1. own apartment 2. enhanced personal care home 3. maximum care Community Residential Rehabilitation Program

Clearly, there are differences in opinion as to what would be the best type of community living arrangement for these individuals. Only in one case did both the peer request and the clinical request have the same response. Part of the CSP process is identifying these differences and then trying to reach an amicable solution. It is from these discussions that gaps in services are frequently identified. Work then begins to address the gaps reaching the best outcome possible... The following chart outlines the specific needs that have been

identified as a result of the Consumer Support Plans. The results are presented by levels of care.

Specific Needs Identified Via the Consumer Support Planning Process

Treatment	Residential	Recovery Oriented
ACT/CTT	Permanent independent housing	Mobile Psychiatric Rehabilitation
Mobile Medications	Enhanced Personal Care Homes with 4 beds or less	Expanded Supportive Living Services
Specialized DBT	Housing for sex offenders	Employment opportunities
Specialized Sex Offender Treatment	Emergency housing	
LTSR	Crisis residential services	

Housing

One of the biggest requests for service is to have more permanent independent housing options available. The Armstrong-Indiana Behavioral and Developmental Health Program has been committed to developing new options, and revamping existing housing options to adapt with the need. It is clear that future development will rely greatly on the collaboration between local community agencies. An example of this collaboration occurring now in each county is our local housing groups. The Indiana County Housing Consortium and the Armstrong County Housing Advisory Committee have been instrumental in securing safe and affordable housing for the residents of our two counties. The groups meet at least quarterly and consist of those individuals who are most knowledgeable about housing options and development in each county. Representatives from the local departments of Planning and Development, Community Action, Human Services, Behavioral and Developmental Health and various other stakeholders meet to, share information and to asses housing needs and identify potential funding sources. Below is a list of the housing options available in the Armstrong-Indiana catchment area:

- Maximum Care Community Residential Rehabilitation/Enhanced Personal Care Home Program
- Minimum Care Community Residential Rehabilitation Program
- BDHP Master Leasing Program
- Domestic Violence Shelters
- Homeless Shelter
- Project Light Transitional Housing Program

- Transitional Housing Program
- Low Income Apartments
- Low Income Apartments – SECTION 8
- Permanent Support Housing
- Elderly Housing
- D&A Supported Housing
- Family Housing
- Veteran's Housing

Currently, the Armstrong-Indiana Behavioral and Developmental Health Program is in the process of reassessing our housing programs. We are striving to create measurable outcomes and reduce any duplication of service which may be occurring given the numerous housing programs/options that are available in each county. Through past housing plans, AIBDHP created a Housing First Model through its Master Leasing Program. This program is the most independent housing program that we offer for individuals with mental illness. Consumers are able to live independently in a quality permanent independent housing and are free to choose if they want services from the mental health system or any other human services agency. Consumers are not required to have services, which is different from any other model of mental health housing we have traditionally provided. The program is designed to give those who have behavioral health challenges a chance at independent housing whereas they have been turned down by other housing options do to significant barriers such as poor/bad credit, a criminal history, or substance abuse. In 2011, a total of 7 individuals were served in the Master Leasing Program. Five individuals are currently being served.

Another component of AIBDHP's housing program offers outreach to those who are homeless or at risk of becoming homeless through the use of PATH funding. In 2011, outreach was provided to 76 individuals. There are 28 individuals enrolled so far in 2012. Specialized housing peer support services are available to individuals who receive PATH funding as well. The Housing Peer Specialists are able to support and guide consumers as needed to help them maintain their housing in the community and identify issues early on that might jeopardize housing.

Non-Residential Supports and Services

The Armstrong-Indiana catchment area offers a wide array of non-residential supports and services. The services can be categorized as treatment oriented, recovery oriented, and prevention/diversion. The chart below captures all of the services currently available.

Non-Residential Supports and Services

TREATMENT ORIENTED	RECOVERY ORIENTED	PREVENTION/DIVERSION
Acute Partial Hospitalization Program	Targeted Case Management	Walk-in Crisis Service
Partial Hospitalization Program	Psychiatric Rehabilitation	Telephone Crisis Service
Intensive Outpatient Services	Peer Support Program	Mobile Crisis Service
Medication Management	Justice Related Peer Support	Justice Related Case Management
Sex Offender Group	Housing Peer Support	
DBT Group	Employment Services	
	Drop-In Centers	
	Representative Payee Services	
	Consumer/Satisfaction Team	

At the present time, the Armstrong-Indiana Behavioral and Developmental Health Program is exploring the possibility of adding two services to the existing system of care. The first service is telepsychiatry. The second area that may be developed is in working with the Co-Occurring population through grants and other service providers in the area.

VII PERSONAL CARE HOME INTEGRATION PLAN

Both Armstrong and Indiana counties have a history of being home to a large number of personal care homes, many of which have a high bed count. With the recent changes in personal care home regulations, the numbers of homes has decreased significantly; however, there are still many moneys that are licensed to serve over 16 individuals. It is also widely known that many individuals with behavioral health and/or intellectual disabilities challenges reside in these homes. The chart below details the current number of homes by county, the total number of beds available, and the number of behavioral health consumers living in homes within our counties.

COUNTY	Number of Personal Care Homes	Total Number of PCH Beds	Number of mental health persons living in PCHs	Number of intellectually/ developmentally disabled persons living in PCHs	Total number of 16+ beds
Armstrong	26	562	73	26	16
Indiana	25	607	138	34	17
Totals:	51	1169	211	60	33

*Numbers as of 6/30/12

Because of the high number of homes/beds in our area, and issues that were identified within some homes, the Armstrong-Indiana Personal Care Home Resident Risk Assessment Committee was created. This long standing committee meets quarterly and is an avenue for cross system communication and collaboration. Partnering with staff from AIBDHP (ID/DD and MH) are staff members from the following agencies:

- PA Department of Public Welfare Office
- Area Agency on Aging
- Community Guidance Center (service coordination and case management)
- Family Counseling Center (service coordination and case management)
- Consumer/Family Satisfaction Team
- Indiana Arc
- Armstrong County Community Action Program
- Indiana County Community Action Program

The meetings serve as a way to identify report and potentially resolve any consumer concerns or agency concerns regarding care (or lack thereof) provided within the homes. The group provides ongoing communication and collaboration on a cross systems level by bringing together human service agency staff and the staff from the Pennsylvania Department of Public Welfare which licenses each home. The meetings have also served as a mechanism to prepare for potential closures, to provide a monitoring source after such closures, and to plan for future endeavors such as our Personal Care Home Integration Plan.

Much time is spent during the Personal Care Home Resident Risk Assessment Meetings talking about what can be done to improve the relationship between the human service agencies within each county and the personal care home owners/operators and staff. It is strongly felt that if a better relationship existed, the quality of care may improve and consumers would be afforded the opportunity to take full advantage of all the services available to them. It was from these discussions and also from input from consumers living in personal care homes that the phases of our Personal Care Home Integration Plan were

developed. Following is a detailed description of four phases/steps that make up our plan.

Phase One: Outreach

The first step of our PCH Integration Plan is to do a volume of outreach to home owners/operators, their staff, and residents. The ultimate goal is to establish a comfortable working relationship with everyone so that future education, training, support and ongoing cooperation can occur. It should be noted that some degree of rapport does exist between various agencies and the homes, but much more can be done to outreach to all homes. The plan calls for home owners/operators and their staff to be invited to attend existing Personal Care Home Resident Risk Assessment Committee meetings so that open dialogue between all agencies and the home owners can take place.

The final step of the outreach portion of this plan will be that outreach will occur directly within the personal care homes by staff from the various human services agencies within the counties. This step is planned to occur after a strong degree of rapport is achieved. It is thought that having the first phase complete will lay the groundwork for success for Phase Two.

Phase Two: Education and Training

This second step is aimed at providing education and/or training to both the personal care home owners/operators and their staff, and consumers who wish to participate as well. The first goal is to educate staff and consumers on what community services are available (including all housing options), how to access these services, and the benefits of these services. We plan to also provide information/education/training on any topics that staff and residents may request. The process is to be as open as possible in order to be as beneficial as possible. The second goal is to possibly reduce the need for emergency relocations and hospitalizations thus improving the quality of life for the residents. Having this step in place will allow for our third phase, identification/integration, to be implemented in a much more collaborative manner.

Phase Three: Identification and Integration

For the third step of our Personal Care Home Integration Plan, we propose to devise a system of early identification and complete integration. The first step will develop a system where the personal care home staff will notify the Armstrong-Indiana Behavioral and Developmental Health Program every time someone who has a known behavioral and/or intellectual/developmental disability or diagnosis. At the present time, there is no way of identifying those

individuals with behavioral health challenges who are currently residing in the various personal care homes or who may be admitted. If a person is identified, contact can be made with the consumer to see if they need or would want any type of services offered in the community. They may also require services that our counties do not provide. Early identification will allow for outreach to surrounding counties to see if those necessary services can be provided in our catchment areas.

The second component, integration, should be a natural effect of the identification process. Once we are able to accurately identify who has challenges, we will then be able to wrap support services around them and begin the process of integrating them into the community in which they live. Support services such as peer support and case management will be vital to the success of integration. These services are designed to link residents with other activities in the community and encourage residents to take part in those various community functions. The end result will be residents taking an active part in their community.

Phase Four: Monitoring

Once all the previous steps are in place, the final phase should be implemented easily. We are proposing that there be a monitoring mechanism which can assess resident and personal care home staff satisfaction. Early identification of problem areas will also be a benefit of regular monitoring efforts. This form of monitoring will be very different from the licensing monitoring provided through DPW; however, it will work in conjunction with DPW's efforts. It is our plan to work with our Armstrong-Indiana Consumer and Family Satisfaction Team to develop and conduct surveys and/or focus groups with both residents and personal care home staff. The goal is to build upon existing rapport, allowing all individuals to provide input to all involved. The process will not only focus on those things that are wrong but will focus on positive experiences as well. As the process proceeds, the results of these surveys/meetings will be complied into timely reports. These reports will then be shared with the residents, staff, and any service identified in the survey/focus group process. In addition, reports will be reviewed at the Personal Care Home Resident Risk Assessment Meetings. The ultimate goal of the monitoring will be to establish an ongoing mechanism for future outcome measurement and quality improvement.

It is anticipated that once the above outlined integration plan is fully operational, it will be come much easier to implement future policy, procedural or regulatory changes that may occur within the social service system. The forefront concern is how any change will impact the lives of those we serve. We took great care to consider how our recent development of our Personal Care Home Policy would affect consumers. This policy guides the discharge of consumers at Torrance State Hospital into homes with more than 16 beds. Our policy does not prohibit

an individual living in a home with more than 16 other residents if that is their choice. All other options, however, should be presented to the individual before they make their final decision. A fully functioning Personal Care Home Integration Plan will hopefully open the lines of communication between the homes, BDHP and Torrance with a concrete understanding that individuals do have a choice of where they wish to live. There will also be the expectation that the homes will work with all human services agencies involved with the individual to address any concerns brought forth.

Finally, the Armstrong-Indiana BDH Program looks forward to making this integration plan a reality. We look forward to continuing our working relationship with the members of the Personal Care Home Risk Assessment Committee and striving to create the best system of care possible.

VIII COMPREHENSIVE FUNDING STRATEGY

It is evident that times are changing in the human service arena. Now more than ever, agencies need to ensure that the funding they do receive is used to provide the best quality of care. That quality must be measurable and linked directly to expected outcomes as well. It is also imperative that all potential funding streams, areas for potential regional collaboration and potential cross system collaboration be identified and developed. Traditionally, the Armstrong-Indiana Behavioral and Developmental Health Program has relied on funding from the following resources:

- Mental Health Base Dollars
- Community Hospital Integration Project Program (CHIPP) funds
- HealthChoices Reinvestment Savings
- PATH
- HSDF

In moving forward, it is crucial to research all potential sources of funding. By not doing so, the collapse of some programs and the delay or ceasing of any new programming will occur. This will only result in a detriment of our stakeholders. In the mental health system directly, we will look to outside possible sources of funding through grants, future CHIP Projects and service conversions. Looking at a more system wide vision, we hope to partner with our surrounding local system partners such as Children and Youth Services, the Criminal Justice System, the Drug and Alcohol System and the Area Agency on Aging. By thinking outside the box, we will be able to be more creative in our services and hopefully find other funding resources that will sustain our services for many years to come.

VIII SUMMATION

While no one has a crystal ball, it is evident that budget reductions and poor economic times will most likely exist into the near future. We see funding that has helped build and sustain our infrastructure for years being reduced and even totally cut. With the most recent budget reduction, we have seen 4 CRRs close. These have been long standing residential services in our counties, serving many individuals over the years. Even still, the Armstrong-Indiana Behavioral and Developmental Health Program remains committed to providing the highest quality system of care as is possible. To move ahead, we must continue looking at regionalization options, cross-system opportunities, possible service conversions, and finding stable funding sources outside of the traditional mental health system. AIBDHP will remain resolved in achieving the goals and objectives outlined in this plan and containing to improve and enhance our overall system of care.