Mayview Regional Service Area

Regional Olmstead Plan

The Mayview Service Area, including Allegheny, Beaver, Greene, Lawrence, and Washington Counties (the Counties), has aggressively supported the State's decision to end unnecessary institutionalization of adults who have a serious and persistent mental illness. Through ongoing, stakeholder based regional planning, the counties and the Commonwealth were able to close Mayview State Hospital in December 2008. The counties have continued their regional planning efforts to ensure services are needed to support individuals who were discharged as part of the closure and are available for those who would have used the state hospital. With their commitment to serve people in their communities, the Counties feel that it is imperative to continually develop and sustain viable community-based services to support not only those individuals who have already been discharged into the community, but also those who would have otherwise gone to the state hospital if it were still in operation.

Given their unique position as the only service area in the Commonwealth without a state hospital, the Counties have developed a Regional Olmstead Plan that focuses on the following sections:

1. An environmental scan that provides an overview of service development from the Mayview closure as well as current housing placements for those discharged. The client outcomes achieved from the closure are highlighted from an ongoing evaluation study conducted by the University of Pittsburgh. The Mayview diversion population will also be discussed along with the criteria that these counties use to determine who qualifies as a diverted individual. The significant impact of the proposed cuts in funding on the regional community-based system will also be included

2. A Comprehensive Service Area Integration Plan that focuses on sustaining the community-based system of care to support all people in their communities. An overview of the service utilization of the diversion population will be provided as a guideline for the types and levels of services that are needed at current funding levels to sustain services for those who would have otherwise gone to a state hospital. Program needs and transformation priorities will also be provided highlighting each county's plans moving forward. Challenges beyond the proposed funding cut will also be highlighted, including the need for improved discharge planning and service coordination for individuals leaving forensic state hospital commitments and interstate hospital transfers.

3. A Personal Care Home Outreach and Integration Plan that addresses those individuals throughout the region who are involved in the mental health system and are living in personal care homes that exceed 16 residents.

1. Environmental Scan

Service Development: As part of their commitment to end the state-hospital level of care in the Mayview Service Area, the Counties made substantial investments in the development and expansion of new and existing services. The funding received by the five Counties from the closure of Mayview State hospital, in conjunction with use of HealthChoices dollars and Reinvestment funds enabled the counties to enhance the community-based system of care to support those who were discharged, as well as all individuals throughout the regional system of care. These services support individuals both clinically and socially in the community to improve the overall quality of life. The attached Service Development Summary provides an overview of the county-specific services that were developed and/or expanded as a result of the Mayview closure.

Peer Supports: Peer supports were highly effective in initially engaging individuals while they were still in the hospital. Often, the relationships developed with peers while in the hospital assisted individuals in their discharge process and transition to the community. The following peer supports continue to be key components in the support network for all individuals throughout the region.

- Peer Mentors
- Warmline Services
- Peer Specialists
- County Recovery Specialists and Coordinators

Clinical Services: New and expanded community-based clinical services also support all people throughout the region, including evidence-based practices such as Community Treatment Teams (CTTs).Teams. In addition, expanded case management/service coordination, mobile medication and crisis services, outpatient, psychiatric rehabilitation and other crisis and forensic supports were all developed.

Residential Options: New community-based options were also created that provide housing for individuals throughout the spectrum of residential supports – from independent living, permanent supported living, to more clinically intensive long-term structured residences. Consistent with the State's Olmstead planning objectives, even the largest of these new residential options adhere to licensing requirements and provide community-based settings with at most 16 individuals. In addition, other housing support services, such as permanent supportive housing, housing peers, and housing support teams were also developed throughout the region to assist individuals in their recovery as they reside in housing that maximizes their level of independence.

Based on an agreed upon funding formula benefitting the entire region, this infrastructure development occurred in all of the Counties since there would no longer be a state hospital available. While extensive, these new and expanded services were developed by transferring just

59% of the annual Mayview State Hospital budget to the community ($37.4 Million of an annual budget of $63M, or on average, $91,000 per person discharged).

This system transformation resulted in a more recovery-oriented community-based system of care that offers services to individuals more cost effectively than was possible at Mayview State Hospital. The average cost/year to support a person at Mayview assuming $460/day was $144,900. In 2011, the 253 individuals who received services had a combined cost of over $13.7 million, or on average $53,000 year/per person for services (of which an estimated 40% or $5.5 million were paid by the Counties through their Base funds[1].)

Housing: Another component of the environmental scan is the current housing of those discharged from the hospital. As the Residential Levels of Independence categories in the chart below indicate, most people, 38%, lived in some sort of supervised living setting, followed by 27% restrictive, 26% independent, and 9% in dependent. In addition, since the closure of the hospital, none of the individuals discharged have been homeless.

Type of Residence as of March 2012	# of People	%	Residential Level of Independence
Comprehensive Mental Health Personal Care Home (CMHPCH)	33	16%	Supervised (38%)
Specialized Supportive Housing	17	8%	
Community Residential Rehabilitation (CRR)	10	5%	
MR Residential	9	4%	
Personal Care Home	6	3%	
Enhanced Personal Care Home (EPCH)	4	2%	
Domiciliary Care	1	0.5%	
Long Term Structured Residence (LTSR)	23	11%	Restrictive (27%)
Nursing Home	10	5%	
Torrance State Mental Hospital	8	4%	
Community Inpatient – physical health admission	5	2%	
Criminal Detention	5	2%	
Community Inpatient – mental health admission	3	1%	
Extended Acute Care	2	1%	
Independent Living	47	22%	Independent (26%)
Living with Family	8	4%	
Supported Housing	17	8%	Dependent (9%)
Permanent Supported Housing	2	1%	

Outcomes: Many positive outcomes have been realized from the closure of Mayview hospital and discharge of individuals into their communities. A team of researchers from the University of Pittsburgh School Of Social Work have noted the following results in their ongoing evaluation of those who were discharged:

[1] Calculated from HealthChoices and Base claims data for Allegheny, Beaver, and Washington Counties; and HealthChoices data for Lawrence County in CY 2011.

- Psychiatric symptomatology went down steadily over time (***with*** services available and being provided to individuals)
    - 60% met criteria for remission of psychotic symptoms
    - 50% met criteria for low symptomatology for all psychiatric symptoms
- People clearly preferred living in community settings
    - They were unequivocal about preference for living in community – they are in their homes
- Social functioning improved over time
    - Standardized measures of social adjustment improved over time
    - People reported seeing friends more over time

Diversions: In addition to supporting those who were discharged from the hospital, these services support other individuals who may have otherwise needed a state hospital level of care. The Counties define these diverted individuals based on meeting any of the attached six criteria during a calendar year (see Mayview Service Area Diversion Criteria). Generally, these criteria include stays at residential treatment programs such as LTSRs, RTFAs, or EACs; multiple, or extended psychiatric inpatient stays; past admission to a state mental hospital along with a current inpatient hospitalization; or participation on a CTT

Based on this criteria, the Mayview service area provided community-based services to over 1,700 people throughout the region in 2011, with a combined cost of services of over $67M (average of approx. $39,000 year/per person), of which an estimated 21%, or $13.9M, were paid by the Counties through their Base funds[2]. Again, these are individuals who are at an increased risk for a state hospital level of care who were supported in the community.

Impact of Proposed Funding Cuts: A critical component of this environmental scan must address the proposed 20% cuts in State funding of mental health services. This reduction would impact the new funding received to maintain community services as a result of the closure by $7.5M across the five counties. The reduction to overall CHIPP funding for the region would be over $13.7M. Given the current service utilization of both the Mayview discharge population and the diversion population, clearly there will be a drastic impact on the region's ability to effectively and safely support the delivery of ongoing quality community-based services for all consumers. Potential impacts include the following:

- Recovery and stability achieved will be lost

[2] Calculated from HealthChoices and Base claims data for Allegheny, Beaver, and Washington Counties in CY 2011.

- Non MA eligible people could lose necessary CTT and case management supports
- Peer mentoring could be reduced
- Homelessness could increase
- Jail utilization could increase
- Inpatient utilization could increase
- Increase in hospital emergency room utilization

2. Comprehensive Service Area Integration Plan

Given that this region has committed to not proceeding with state hospital civil admissions with the closure of Mayview, the Olmstead Comprehensive Service Area Integration Plan focuses on the resources needed to sustain the community-based regional system of care in the absence of a state hospital.

Past service utilization levels of those discharged from Mayview and of the diverted population provide an indication of the needed resources and funding commitments required to sustain the region without a state hospital. In addition, service needs continue to evolve as people's time in the community increases. Individuals with medically complex needs require increasing support and continued integration of physical and behavioral health services. Special populations such as the deaf / hard of hearing, aged, and the medically fragile require specialty care. In addition, community/social integration, employment, education, and other quality of life indicators continue to be sought and enhanced as individuals continue their recovery outside of the hospital. These challenges are compounded by issues of poverty and financial status, which limit residential, social, and transportation options for many individuals.

Summary of Needs and Transformation Priorities: In their annual mental health plans developed for the 2012-2013fiscal year[3], the Counties have identified the following system needs and recovery-oriented transformation priorities that address the clinical, physical, residential, and quality of life needs of those served throughout the region.

- Transportation providing access to services in both urban and rural areas
- Forensic / criminal justice system diversions and interventions for individuals with mental illness involved in the criminal justice system
- Crisis services / community hospital diversions
- Accountability and oversight (Single Point of Accountability and other ongoing quality improvement initiatives)
- Peer services that support recovery and resiliency

[3] County Mental Health Plans include county-specific resources, housing plans, and financial information.

- Housing, including Permanent Supportive Housing and other Housing as Home initiatives that provide safe and affordable residential options
- Supported employment
- Services/Supports for individuals who are medically complex or from special populations (blind, deaf / hard of hearing, sexual offenders, veterans, older adults, LGBTQI, dual-diagnosis and other co-occurring populations)

The table below includes each County's recovery-oriented system transformation priority areas that encompass the above areas of need.

County	Recovery-Oriented System Transformation Priorities	Priority
Allegheny	Ongoing transformation of service coordination through the Single Point of Accountability	1
	Continued development of Housing in accordance with the Housing as Home Plan	2
	Increased availability of Supported Employment services in Allegheny County	3
	Continued development of Justice Related services	4
	A focus on special populations within the County, such as persons who are deaf, Deaf-Blind, and Hard of Hearing, veterans, and/or LGBTQI	5
Washington	Apply the principals of recovery and resiliency throughout the service system	1
	Enhance system oversight and accountability	2
	Ensure quality and consistency of service development	3
	Expand and improve crisis emergency and disaster program services	4
	Develop culturally competent services and supports for special populations	5
Beaver	Prevent mental illness through outreach, screening, and early intervention and wellness promotion.	1
	Implement a framework for trauma-informed care that includes screening, assessment, and recovery support.	2
	Increase the availability of services linked to safe and affordable permanent housing for individuals, who are homeless or at risk for homelessness.	3
	Increase employment and education.	4
	Implement a Single Point of Accountability using specific case management and ACT providers.	5
Greene	Expand Greene County's peer process	1
	Implement recovery based treatment planning throughout outpatient providers.	2
	Increase family engagement.	3

	Develop an integrated health care pilot.	4
	Increase coordination of behavioral health services for the criminal justice consumers.	5
Lawrence	Transportation program in conjunction with our Fair Weather Lodge	1
	Certified Peer Specialist with Co-occurring experience	2
	Implementation of our Path Grant	3
	Continued development of our coordinated Adult Service Team	4
	Implementation of Psychiatric Rehabilitation	5

Discharges Planning for Forensic and Interstate Transfers: An additional area of need is for improved coordination and planning for individuals when they are committed to Torrance State Hospital Forensic Unit and their charges are dropped. Assessment and diversion to community-based services and supports must occur within seven days. This accelerated time requirement requires aggressive planning. If community services are not readily available, transfers to the civil unit at Torrance State Hospital are sometimes the only option.

Another area of need for improved planning and coordination is when a person with mental illness has served his/her maximum sentence in a State Correctional Institution (SCI). Depending on the extent of their illness and level of treatment while incarcerated, individuals may be in significant need of services and supports upon release. Assessment upon release may indicate the need for commitment to community inpatient services, or if longer term treatment and stabilization are required, the civil unit at Torrance State Hospital may be considered. In these situations, treatment while still incarcerated is essential along with proper discharge planning and coordination so that individuals may return to the community upon release with the needed residential and treatment services and supports in place.

Lastly, current practices around interstate transfers of individuals with mental health commitments dictate that these transfers can only occur from State Hospital to State Hospital, otherwise the commitment does not transfer. This policy needs to be revised so that Counties in the Mayview region can complete interstate transfers of individuals with commitments using community inpatient hospitals.

With the closure of Mayview State Hospital and the Counties' commitment to not use the state hospital level of care, these system needs and priority areas represent the program and resources needed to sustain the region. These programs and priority areas are essential in providing ongoing community-based support to those already discharged from the state hospital, as well as those who are at risk of needing that level of support.

3. Personal Care Home Outreach and Integration Plan

As part of its Regional Olmstead Plan, the Mayview Service Area has also prepared a Personal Care Home (PCH) Outreach and Integration Plan that addresses those individuals throughout the region who are involved in the mental health system and are living in personal care homes that exceed 16 residents. This section of the Regional Olmstead Plan identifies these individuals and the locations of their personal care homes, summarizes the services that these individuals have received over the past two years, and includes possible additional services which are needed. An outreach plan for engaging people who live in these personal care homes is also included to inform them of service, housing, and community integration options.

The Counties support individuals who receive mental health services in their choice of integrated community housing options. Many factors influence a person's choice when considering the spectrum of living options, including personal preference; availability of housing options, availability of necessary supports; availability of community-based support and treatment services that may be required to assist a person in the community; access to family, friends, and other social networks; needs for specialized services and supports; and income limitations. These factors must be taken into consideration all within the context of the least restrictive setting as possible. PCHs provide an option in the residential continuum of care. PCHs can offer an affordable residential option for certain people while providing varying degrees of residential assistance and support; however, the Counties agree that large PCHs with more than 16 beds are rarely the most integrated setting for people with mental illness, and may not provide the most conducive environment for recovery-oriented community-based care. Accordingly, the Counties have each developed their own PCH policies that provide guidelines for how referrals to PCHs are conducted; and, in particular, how exceptions are managed when referrals are submitted to PCHs that contain more than 16 beds. There are many consistencies in these policies as can be seen in the summary table below.

Summary of County Personal Care Home Policies

Condition	Allegheny	Beaver	Greene	Lawrence	Washington
Has an integrated housing options / personal care home policy in place that provides guidance in the referral of individuals receiving services in the mental health system to PCHs with >16 beds.	X	X	X	X	X
Affirms support and commitment to the development of integrated housing options rather than have individuals reside in PCHs with > 16 beds.	X	X	X	X	X

Condition	Allegheny	Beaver	Greene	Lawrence	Washington
Strongly discourages individuals who receive services in the mental health system residing in PCHs with > 16 beds.	X	X	X	X	X
Considers community-based alternatives, including support services and housing options to support individuals in the least restrictive integrated housing of their choice.	X	X	X	X	X
Establishes parameters for exception requests for referrals to PCHs larger than 16 beds. Exceptions will be considered based on individual choice and exceptional needs due to the lack of appropriate community alternatives and supports.	X	X	X	X	X
Requires that exception requests include at least two (2) alternative housing options be presented and visited, or documented as to why this was not possible.	X	X	X	X	X
Requires that exception request referrals to PCHs with > 16 beds be reviewed by County behavioral health staff to verify proper licensure status of PCH, and to verify alternative housing and support services were considered prior to approval of placement.	X	X	X	X	X
Includes a regular (most often bi-annual) outreach plan to PCHs to inform residents of available integrated housing options and support services.	X		X		X

Condition	Allegheny	Beaver	Greene	Lawrence	Washington
Includes stipulation that people receiving county funded behavioral health services have the option to receive services at an alternative site.	X		X		
Includes an education requirement to train PCH staff on behavioral health issues if the PCH has four or more behavioral health consumers as residents.		X			
Considers use of PCHs with more than 16 beds as a respite placement, which is up for review / reconsideration within 30 days.	X				
Includes a satisfaction review after 10-30 days of placement, at which time alternative integrated housing options can be pursued if needed.		X			

In addition, County staff work closely with other County Departments in conducting regular quality oversight and outreach activities to individuals living in large PCHs. This primarily includes ombudsman services through the Departments of Aging and serving on PCH Risk Management Committees. Other outreach efforts include programs such as MHA's Phoenix Center in Beaver County where peers go to PCHs and bring people back to the Center to increase community integration, mental health advocates traveling with Adult Residential Licensing (ARL) representatives in Greene County, and the use of NAMI-sponsored Consumer Action and Response Team (CART) in Allegheny County to conduct interviews of people in PCHs to assess quality of life measures. In Washington County, behavioral health and community integration training is provided for PCH administrators, through which they can receive credits for their annual education requirements.

Although these policies and practices exist to support the oversight and identification of alternative residential settings and supports for people considering large PCHs, people throughout the Mayview Service Area continue to reside in PCHs with more than 16 beds.

County	Personal Care Home Name/Address	Total # of Residents	# of Residents Known to the Mental Health System
Allegheny			

Beaver			
Greene			
Lawrence			
Washington			

Characteristics of this group – by age group; duration at current residence

Summary of Service Utilization

Outreach and Integration Plan: As part of this plan, the Counties propose a two-phase approach that will first address known individuals who are currently receiving mental health services and residing in PCHs with more than 16 beds – the group that is summarized above. Existing resources and partnerships will be leveraged to engage these PCH residents, including service coordinators/case managers, advocates, and ombudsman. PCH Risk Management Committees will also be integral for this coordination. Meeting regularly, these committees typically include County Aging and Behavioral Health Departments, along with State PCH licensing staff; and provide a forum for reviewing complaints, licensing issues and statuses, and regulation and policy changes.

Given that many individuals may be satisfied with their current residence, training materials will be provided that will which initially focus on issues of wellness and social integration. Housing alternatives will be introduced once relationships and rapport are better established in an attempt to reduce disruption and stress associated with changes in residential settings.

The next phase of the plan will be to work with large PCHs in identifying residents who are not currently involved with the mental health system but may benefit from behavioral health services, increased community integration, and/or alternative housing. This phase involves strengthening partnerships between community behavioral health services, provider networks, and PCHs so that individuals are identified during the PCH admission process, including preadmission screenings, initial assessments, and the development of support plans. Policies should be implemented that more closely link early intervention of behavioral health services when individuals are identified as needing these levels of support. Options include regular involvement of county liaisons at PCH Risk Management Committee meetings; regular case review processes with the County Departments of Aging; close coordination between Aging ombudsman and behavioral health staff; increasing awareness and use of behavioral health crisis services by PCH staff; and Mental Health First Aid training for PCH staff to enable them to better identify common signs, symptoms, and risk factors of individuals with possible mental illness. In addition, PCH administrators throughout the region must be engaged to get their insight on enhancing the connection with the behavioral health system and coordination of services, as well as engaging residents to discuss other community integrated housing options.

As an incentive to PCH staff, these system cross-trainings and outreach sessions can be offered as credits to their annual education requirements. Further, the intent is to integrate the PCH system more closely with the behavioral health system to increase skills and knowledge of support services. By assisting PCH staff in working with people with potentially challenging behavioral health needs, or by offering more integrated residential alternatives, PCH staff will be able to dedicate more of their time to other individuals within their care with complex needs.

In addition, although the Counties prefer to each perform their own PCH outreach and integration, there is the agreed need to develop a regional protocol for sharing information if a person moves from a PCH in one county to a PCH in another county. This could be similar to, or an extension of, the Western Region Reciprocal Agreement protocol if, during PCH outreach, a person is identified as needing behavioral health services and community supports in another county.

Service Needs: Many of the service needs identified in the County Mental Health Plans are needed to support both the Comprehensive Integrated Service Area Plan to sustain the region with a state hospital, as well as the PCH Outreach and Integration Plan. The housing needs identified in each County's Housing Plan will be needed to continue to provide residential options for individuals diverted from the state hospital level of care as well as integrated housing options for people wanting to leave large PCHs. Housing programs such as Permanent Support Housing and other Housing as Home initiatives can provide safe and affordable housing options. Relationships with housing authorities and housing programs will also be critical to provide adequate funding and access to residential alternatives. In-home housing support services are needed to provide support to individuals who may be medically complex or from special populations and requiring more extensive and/or specialized support. Peers can also assist people as they manage their activities of daily living that are required to maintain community-based housing. Mobile medication, treatment, and crisis services are also key components. Further, reliable transportation services in both rural and urban areas are essential for independent living and access to both treatment services and community supports. Community based respite and stabilization alternatives also serve as supports to individuals who may require acute stabilization without inpatient levels of care.

The Counties of the Mayview Service Area fully support the State's Olmstead planning and remain committed to sustaining their region without a state hospital level of care. In doing so, they also are committed to offering individuals residential options and support services in environments that are community-based and recovery-oriented - communities of their choosing to the greatest extent possible.