TRANSFORMING *lives*. TRANSFORMING *our community*.

2015 ANNUAL QUALITY REPORT

Instilling hope. Inspiring change. Building community.

Dear Friends:

Transformation is a word we often hear bantered about these days in healthcare discussions. The "disruptive innovation" business model that brought us the iPhone, Amazon, and Netflix are knocking at the door of behavioral health. Disruptive innovators lament that our antiquated healthcare system is adversely incentivized to focus on crisis response – hospitals profit from full beds and doctors for repeat visits.

Perhaps we can turn to the ancient Chinese proverb that declares "a crisis is an opportunity riding the dangerous wind" to guide us in these uncertain times. So how does Penn Foundation chart these proverbial rough seas to find those pearls of opportunity? We keep our compass focused on navigating individual health and well-being. That was true 60 years ago (when Dr. Loux and our founding fathers experienced "uneasy consciences" after observing the inhumane treatment of the mentally ill in state hospitals), and it remains true today.

Person- centered care cuts to the core of who we are. Our corporate desire to "innovate with integrity" is how we steer our ship. Brigette Egbert, CEO, summed up our corporate integrity philosophy perfectly:

"Character, not show. Effort, not talk. Action, not credit. Team, not self."[1]

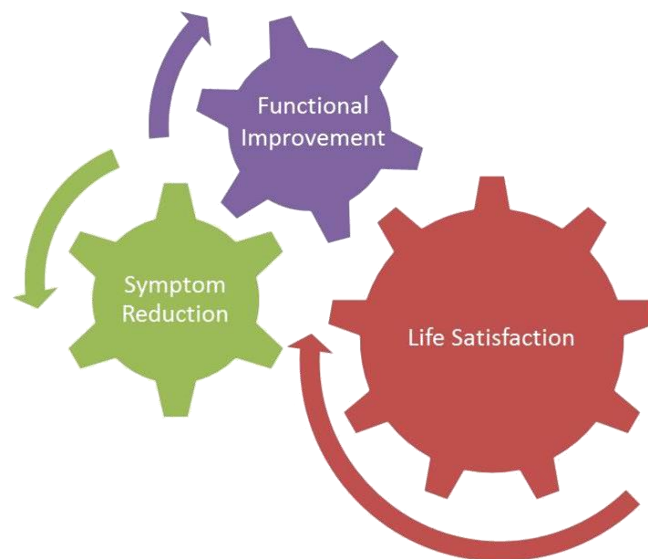
We are pleased to present the 2015 Quality Report which demonstrates our character, our effort, our actions, and our teamwork.

Wayne A. Mugrauer
President & CEO

Marianne T. Gilson
Senior Vice-President & COO

Measuring Impact

How do we measure impact? This simple question is at the forefront of healthcare transformation as we know it today. Depending on your perspective, it might be population health, HEDIS or CAHPS scores, reduced cost, improved access, or symptom reduction. So the "value equation" is really in the eyes of the beholder. From our vantage point, this opportunity can be distilled to three fundamentals: diagnosis specific reduction of symptoms, functional improvement in key life domains, and customer engagement and satisfaction in areas which are meaningful to them.



With our strategic focus clarified, the Medical Director, Christopher Squillaro, DO, and Clinical Director, Julie Williams, LPC, CCDP-D, evaluated Evidenced-Based Practice Models (EBP) which combined the best research evidence, clinical expertise, and patient values and preferences to redesign and transform our clinical models of care. The performance measurement system was re-tooled to evaluate our progress on each of these three pillars of performance.

The Evidenced Based Practice of Living in Balance (LIB), developed by Hazeldon/Dartmouth, was selected as the clinical practice guideline for our drug and alcohol continuum of care. As both a psycho-educational program and experiential treatment model, the curriculum is exquisitely comprehensive. "The major addiction-related topics include relapse prevention, drug education, and self-help education. Physical health issues

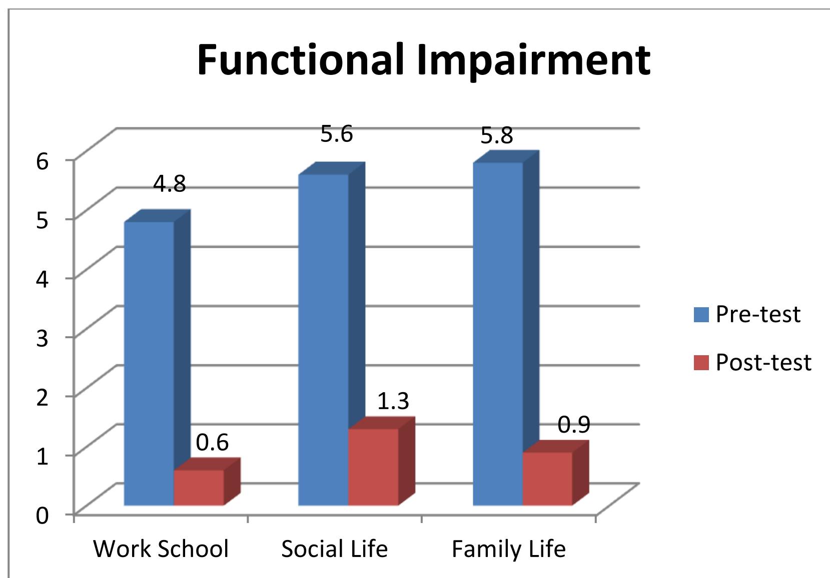
addressed include nutrition, sexually transmitted diseases (STDs), HIV/AIDS, dental hygiene and insomnia. Psychosocial topics include attitudes and beliefs, negative emotions, anger and communication, sexuality, spirituality, and the benefits of relationships. In addition, there are sessions on money management, education and vocational development, and loss and grieving…. The basic rationale of the Living in Balance model is that persons addicted to drugs develop a sense of imbalance in major areas of life functioning. Continuous drug use generally impairs a person's physical health, emotional well-being, social relationships, work performance, and other major areas of functioning. Recovery involves regaining a reasonable balance in these critical areas. Balance in the major areas of life allows clients to free themselves from their addiction to drugs and provides protection against relapse to drug use. The concept of "living in balance" is essentially a broad, holistic approach to relapse prevention."[2]

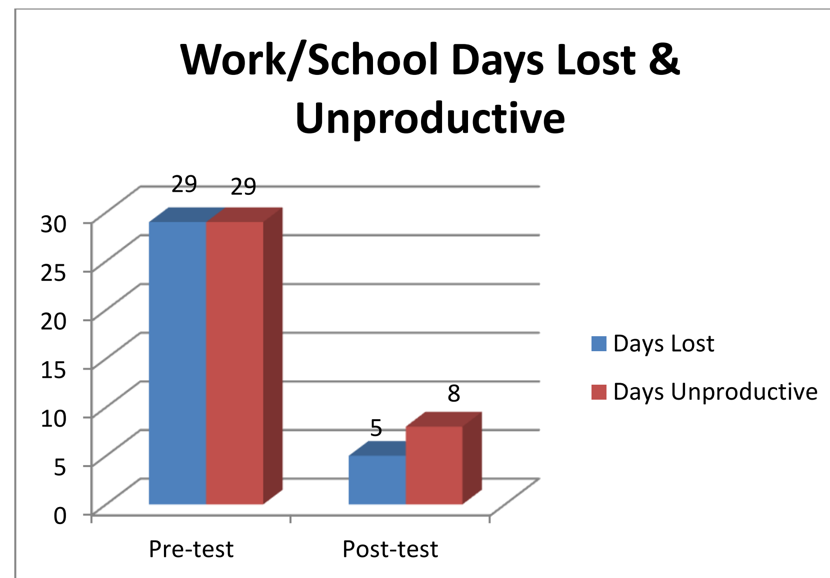
The Living in Balance curriculum was implemented in all higher levels of care in our drug and alcohol division and also in our Intensive Outpatient Program. During their inpatient detoxification or rehabilitation treatment course, persons identify situations that trigger cravings and pinpoint the decisions that lead to drug use. Individuals begin to develop immediate alternatives to drug use and implement a long-term plan for full recovery. At points-in-time post discharge, we collected data on the subset of individuals who remained within our continuum of care. In this less intensive treatment program, persons focus on life domain areas that may have been neglected or negatively impacted during addiction. Our outcome study targeted the impact of the Living in Balance interventions on the three inter-related domains of work/school, social life, and family life/home responsibilities. The psychometric measure selected was the Sheehan Disability Scale (SDS). The metric is a brief, consumer rated measure of disability and impairment. The person served rates the extent to which work/school, social life and home life and family responsibilities are impaired by his or her symptoms on a 10 point scale. This 10 point visual scale uses spatiovisual, numeric and verbal descriptive anchors simultaneously to address the various ways that individuals approach rating a continuum. Additionally, the scale poses two questions: *1) On how many days in the last week did your symptoms cause you to miss school or work or leave you unable to carry out your normal daily responsibilities? and 2) On how many days in the last week did you feel so impaired by your symptoms, that even though you went to school or work, your productivity was reduced?*

Primary clinicians assigned to the Intensive Outpatient Program (IOP) were trained on the Living in Balance curriculum in the fall of 2015. The clinicians administered the Sheehan Disability Scale to 28 persons enrolled in three IOP tracks at the Recovery Center Outpatient division between November and December. Each participant in our sample group was administered the survey upon admission to serve as baseline score and again at four weeks post intervention. Twenty four (24) persons remained in the program for 4 weeks and completed the post-test evaluation.

A score greater than 5 on any of the three scales is associated with significant impairment. Overall, 100% of study participants had elevated

Sheehan Disability Scores in all three categories at baseline. With this level of marked impairment, it was notable that 43% of individuals were unable to work or attend school in the week prior to the pre-test. After 4 weeks of Living in Balance treatment intervention, persons reported their work/school attendance was "not at all" disrupted by their symptoms (a drop of -4.2 points to essentially 0). At post-test only 16% of individuals reported that they had not worked the week prior, as contrasted with the 43% at baseline.

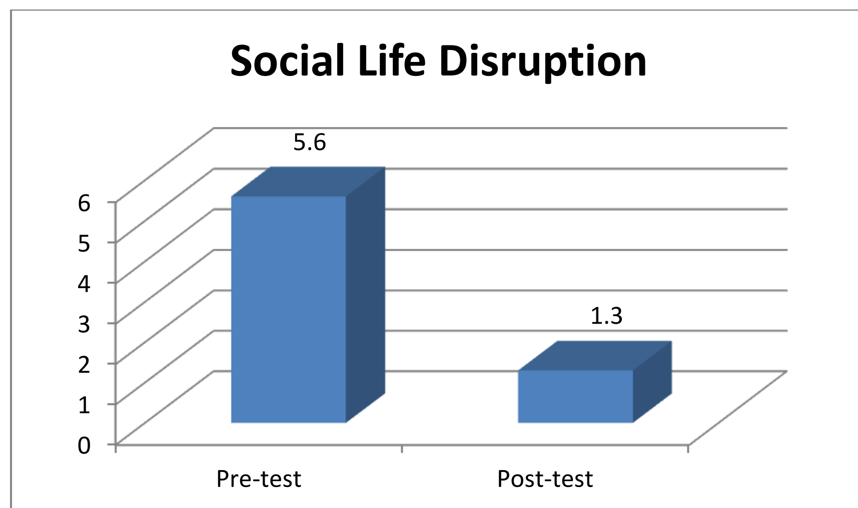


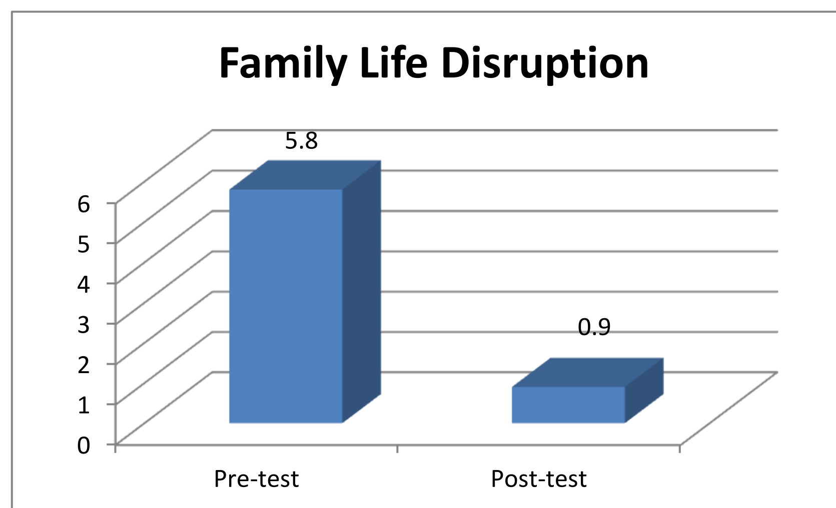


Study subjects self-reported they had missed a total of 29 work or school days at baseline due to acute symptomatology. At four weeks, the aggregate days missed were a mere 5 days. Similarly, study participants believed the week prior to entering care they had 29 unproductive days at work or at school, compared to only 8 unproductive days after four weeks of receiving Intensive Outpatient (IOP) Living in Balance treatment. Based on the average hourly wage of $25.27 for the US in December, these 21 days of employment represents $4,245.36 of earned income per individual.[3]

As having a positive recovery environment increases the prevalence of recovery, the second life domain area studied was the disruptive impact of addiction on social life and leisure activities. Upon admission to IOP, the individuals reported their addiction had moderately impaired their

social and leisure activities (5.6 average score). After four weeks of IOP Evidenced Based Treatment, persons reported minimal functional impairment (1.3 average score) in their social life.





The final life domain evaluated was the impact of addiction on family life. Addiction is a family disease that strains the entire family system. On the inpatient unit, persons are encouraged to face the impact of their addiction on their loved ones. As part of their aftercare treatment plan, they explore this subject more fully.

Upon admission to IOP, the participants reported their substance use/addiction had significant negative impact on their family and home responsibilities (average score of 5.8). After four weeks of Living in Balance treatment, the participants' average score dropped to 0.9, reflecting only mild impairment.

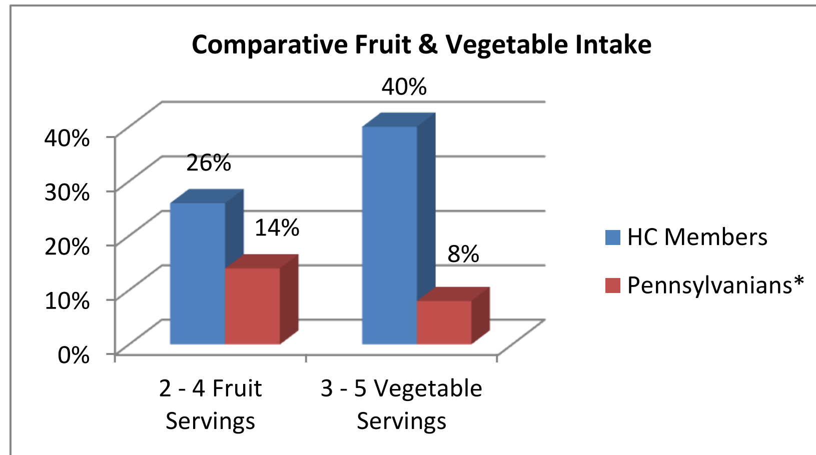
Conclusion

The results of our outcome study substantiate previous research that the Living in Balance curriculum is an effective model for promoting recovery and general sense of well-being. It is especially notable that this marked improvement in quality of life was achieved in a very short period of time – 4 weeks. The results were high impact, high efficiency, and highly satisfying.

Realigning Health with Care

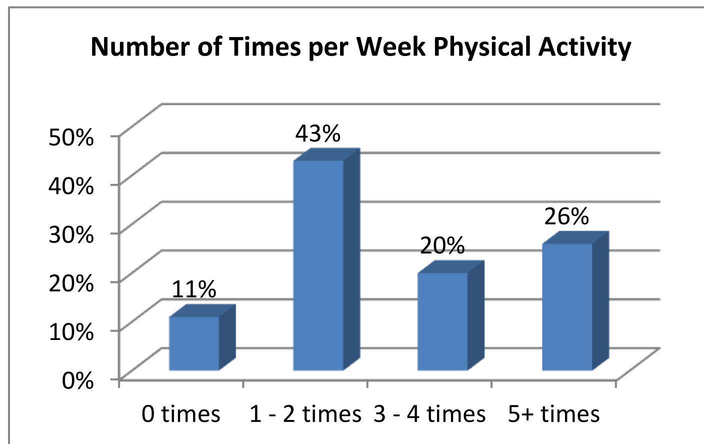
"Despite a preponderance of evidence that illnesses of the mind and body are inextricably linked, behavioral and medical health care too often run on parallel tracks."[4] Historically, behavioral health benefits were "carved out" of the medical benefit plans and managed separately. Starting in the fall of 2015, Pennsylvania has mandated an Integrated Care Program and statewide Pay-for-Performance contracting for all behavioral health MCO's. Member profiles will be developed that demonstrate information sharing and care coordination between the behavioral health (BH) and the physical health plan (PH). State outcome measures will focus for the first time on combined behavioral health/physical health inpatient utilization rates, 30 day readmission rates, and emergency department utilization rates. The program's target population is individuals with serious and persistent mental illness (SPMI) between the ages of 18 and 64. Persons identified in this SPMI target group are at risk for Antipsychotic–Induced Metabolic Syndrome: a cluster of conditions (increased blood pressure, high blood sugar levels, excess body fat around the waist and abnormal cholesterol levels) that occur together, increasing risk of heart disease, stroke and diabetes.

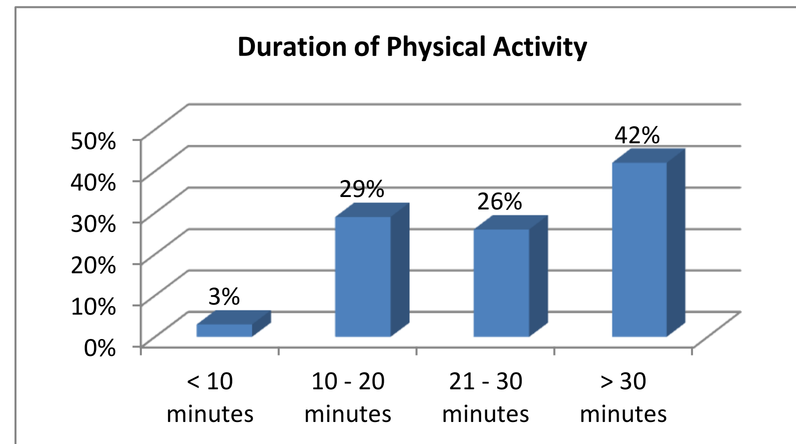
At Penn Foundation, our Health Connections Nurse Navigators make realigning health with care simple: a healthy diet, regular exercise, and routine screening and monitoring of chronic medical conditions. Is it conceivable to have higher expectations for improving the lifestyle habits of persons diagnosed with Schizophrenia or Major Depressive Disorder, when the "average American" eats fast food three times per week and when nearly 80% of Americans consume less than the recommended servings of fruits and vegetables each day?



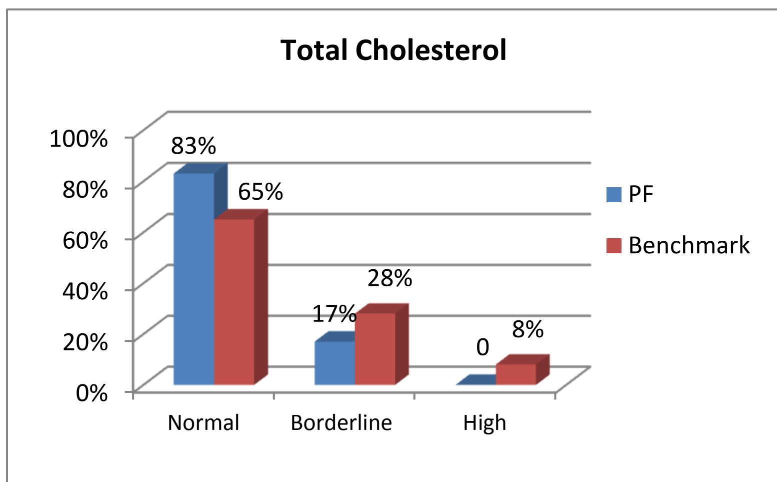
*CDC Morbidity and Mortality Weekly Report, July 10, 2015

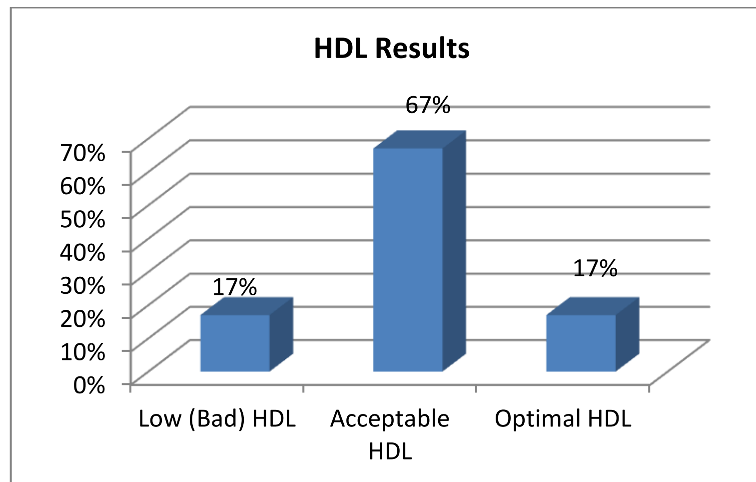
In contrast to the "average American", our 35 Health Connections members ate double the amount of recommended fruit and consumed 32% more vegetables per day. More impressive is that our "average member" is a 48 year old female with a severe and persistent mental illness and comorbid medical conditions of obesity and diabetes. Similarly, when it comes to exercise, the CDC reports that 80% of Americans don't get the recommended amounts of 2.5 hours per week of exercise. Eighty-nine (89%) of our members are exercising weekly, and 42% of those persons spend more than 30 minutes in physical activity.

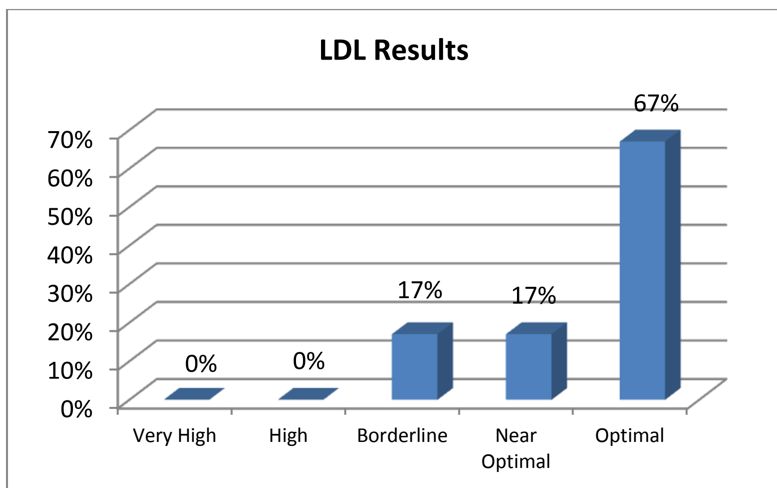


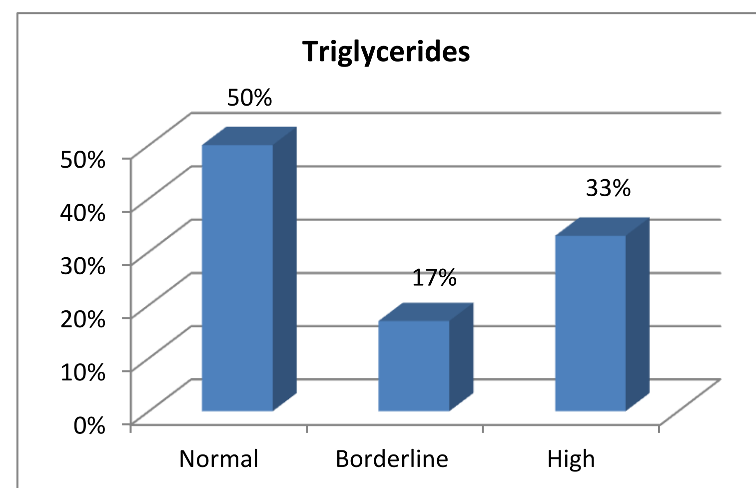


What is the impact of these lifestyle changes on our members' chronic medical conditions? The percentage of total cholesterol levels in the normal range of our enrollees (83%, n = 35) beat the county wide benchmark (65%, n = 153). Eighty-four percent (84%) of persons maintained either optimal or acceptable HDL and LDL levels.



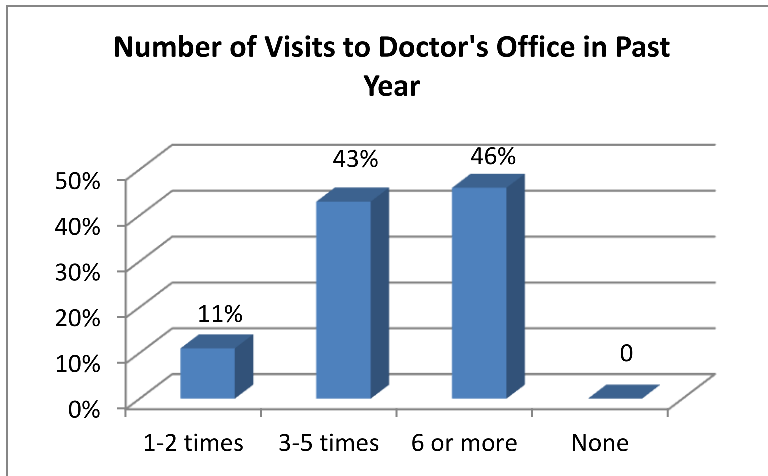


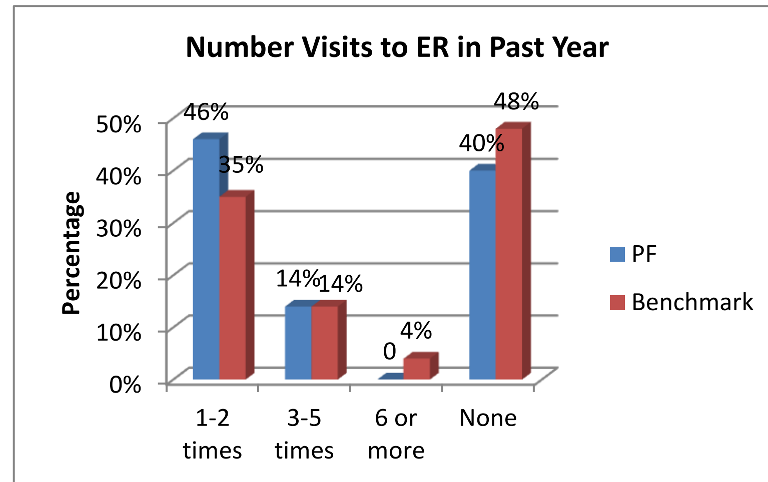


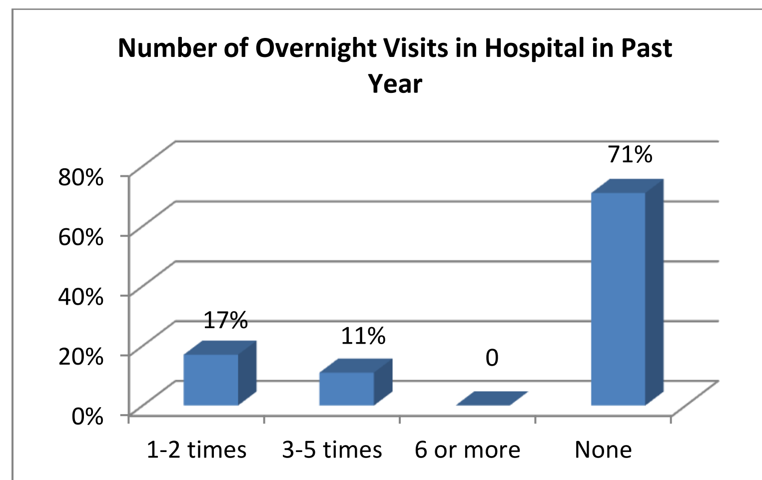


For our baseline data collection year, our Nurse Navigators assured that persons made regular visits to their medical caregivers. While the frequency of visits to the ER were above baseline for the regional group, 71% of our members spent zero days in an inpatient unit.

Good results. Pure and simple.







Sparking Curiosity

Penn Foundation, over its many years of providing behavioral health services, has observed that many individuals with serious mental illness have cognitive deficits which interfere with their ability to sustain independence and well-being. Previous research has shown that the combination of Cognitive Remediation Training and Cognitive Practice Activities, coupled with traditional psychiatric rehabilitation programs (such as our Wellspring Clubhouse), is more effective in improving cognition than any of these interventions alone.[5] Since the efficacy of CRT has primarily been researched with individuals diagnosed with Schizophrenia, it is conservatively estimated that the 250 individuals currently in our care would benefit from CRT intervention. As a continuous learning initiative, the Wellspring Clubhouse applied and received funding from the PEW Charitable Trust to study the efficacy of this combination approach.

Pew Grant Study Objective:

Provide *Mobile & Site-Based* Cognitive Remediation Training to adults who exhibit cognitive impairment symptoms secondary to a diagnosis of major mental illness. 70% of subject participants will report improvements in at least one of the following life domains: independent living, employment, education, social relationships and community connectedness, or overall health and well-being.

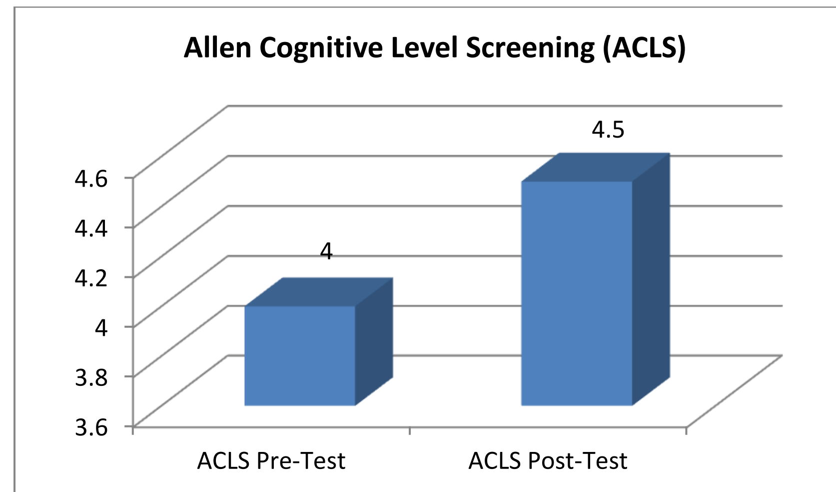
Study Design and Methods:

In year one of a three year research project funded by the PEW Charitable Trust, we explored the use of intensive Cognitive Remediation Training and Cognitive Practice Activities (CPA) to improve functioning of a small group of cognitively impaired adults. Study participants were selected using the Montreal Cognitive Assessment (MoCA) tool. Seventeen adults agreed to participate in the study. The Allen Cognitive Level Screening (ACLS) tool was administered to establish the baseline assessment of deficit and again as a post-test to evaluate effectiveness of the interventions. Cognitive goal areas were identified for each participant using the results from the MoCA and ACLS tools as well as individual preference. Over the course of three months, participants were administered Posit Science Brain HQ exercises with the assistance of staff trained to use and navigate the software. Staff supplemented the exercises with Cognitive Practice Activities created by Study Investigator, Renee Dwornitski, MA. Cognitive Remediation Training Outcome questionnaires (adapted from the measurement system currently in use by managed care organization Community Care Behavioral Health) was administered pre and post the 12 week interventions to evaluate change in independent living, employment and physical wellness.

Outcome:

The table below represents the average scores pre-CRT intervention compared with the average scores post-CRT intervention. It is noteworthy

that a score of 4.0 on the Allen Cognitive Level Screening indicates an individual requires 24-hour supervision, while a person whose cognitive ability score is 4.5 is capable of living independently in the community with a well-established routine within a safe environment.



When our 17 study subjects began Cognitive Remediation Therapy, functionally they were assessed as not capable of independent living. At the conclusion of treatment, all were potentially able to live independently within a stable and supportive environment.

The following data reflects a snapshot of the 17 participants, 16 of whom improved functioning in one or more domains:

8 Participants: 38% Success Rate in Independent Living Goal Domain

- 2 - Increased skills in cleaning, cooking, shopping, laundry, budgeting
- 1 - Moved to a more independent living environment in addition to increasing the skills mentioned above

10 Participants: 80% Success rate in Educational Goal Domain

- 7 - Began pursuing further educational development and increased skills in applying for schools or grants, studying, completing assignments and problem solving.
- 1 - Completed their goal in addition to increasing skills listed above

7 Participants: 86% Success Rate in Employment Goal Domain

- 3 - Increased skills with regard to finding employment, following instructions, following a schedule, time management and interpersonal skills.
- 3 - Began seeking and/ or found employment in addition to increasing skills mentioned above

12 Participants: 42% Success Rate in Community Connection Goal Domain

- 3 - Increased skills in listening to what others say, thinking about other people's feelings, maintaining conversation with others, keeping good boundaries, and finding social activities/events that they enjoy
- 2 - Completed their goal in addition to increasing skills listed above after completing CRT

8 Participants: 75 % Success Rate in Physical Wellness Goal Domain

- 5 - Increased skills in taking medications, personal hygiene, eating balanced meals, exercising regularly, self-managing and scheduling doctor appointments
- 1 - Completed goal in addition to increasing in the skills listed above

10 Participants: 60% Success Rate in Emotional Wellness Domain

- 6 - Increased skills in managing medications, identifying and managing emotions, problem solving, increasing self-esteem, forming and maintaining positive relationships, and self-managing

Conclusion

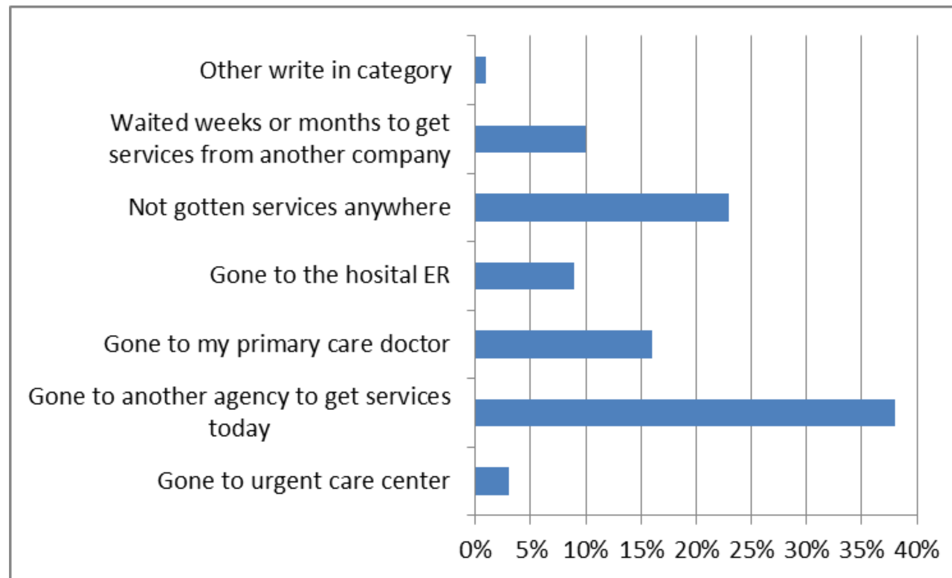
Sixteen of seventeen participants reported improvements in one or more goal areas resulting in a 94% success rate. The biggest improvements were seen in employment, education, physical and emotional wellness domains. The lowest success rates appeared in the living and social/community domains. We will continue to monitor success rates in each life domain to explore any patterns that may emerge over time as to why CRT may be having a greater/lesser impact. The goal is to improve cognitive capacity so that success can be achieved in any life domain that participants choose.

Trauma Informed Care Research

Penn Foundation has been involved in an on-going study of the Trauma Recovery Empowerment Model (TREM) through the University of Pennsylvania since April, 2015. Melanie Masin-Moyer, MSW, LCSW, doctoral candidate, is the principal investigator. TREM is listed in SAMHSA's registry of evidenced-based practices as an effective integrated group therapy treatment for women dealing with the effects of interpersonal trauma, as well as mental health issues and/or substance use disorders. While the research base validating TREM is generally positive, it is not vast or unequivocal. The developers have advocated for further investigation in order to clarify the findings of varying degrees of effectiveness so that the most helpful services possible can be provided. In order to strengthen the research base on TREM, the present study is comparing the effectiveness of a 16 week version of traditional TREM with an attachment-informed version of TREM (ATREM) of the same length. The ATREM curriculum closely models traditional TREM in that the majority of the topics remain the same as does the psycho-educational, cognitive-behavioral, and strengths-based format. ATREM, though, provides more education and opportunities to process the impact of past relationships on present struggles through a lens of attachment theory. Attachment-based research has become a significant focus within the field of psychotherapy as it gains substantiation from neuroscience as a critical element of healing across various life domains. The following outcomes are being assessed in the present study: mental health and PTSD symptom severity, emotional regulation, substance use, dyad and group attachment styles, and perceptions of social support. Trauma often cuts core emotional connections with others as well as within oneself, which can then impede healthy and adaptive functioning. Therefore, it is essential to understand what facilitates symptom reduction as well as changes in attachment styles. Data will be collected through the summer of 2016 and the outcomes reported in the 2016 Annual Quality Report.

Increasing Touch Points

As an organization, we understand that the longer a person has to wait for access to a behavioral health professional the more likely they are to go to another provider or not seek care at all. This was confirmed through our customer experience "point in time" satisfaction survey. Seventy-seven respondents of the 257 persons who evaluated their first contact care experience were asked where or if they would have sought service if they could not be seen on demand.



Of interest was the percentage of respondents who would have elected to go to the ER, not gotten services anywhere, or wait weeks or months to get services from another company. Forty-three percent (43%) of total respondents would not have sought necessary care or would have presented a higher level of care without the ease and convenience of our Open Access Walk-In Model. Thirty-eight percent (38%) of persons surveyed stated they would simply have sought services elsewhere. These persons are our customers, and, as customers, they have the right to choose where to go for their medical care. Persons are easier to serve if their needs are being met.
Lessons learned: 1) great customer service must be delivered on the customer's schedule, and 2) improving the customer experience is about systems as much as it is about smiles. Our goal in 2015 was to ruthlessly attack systemic delays.

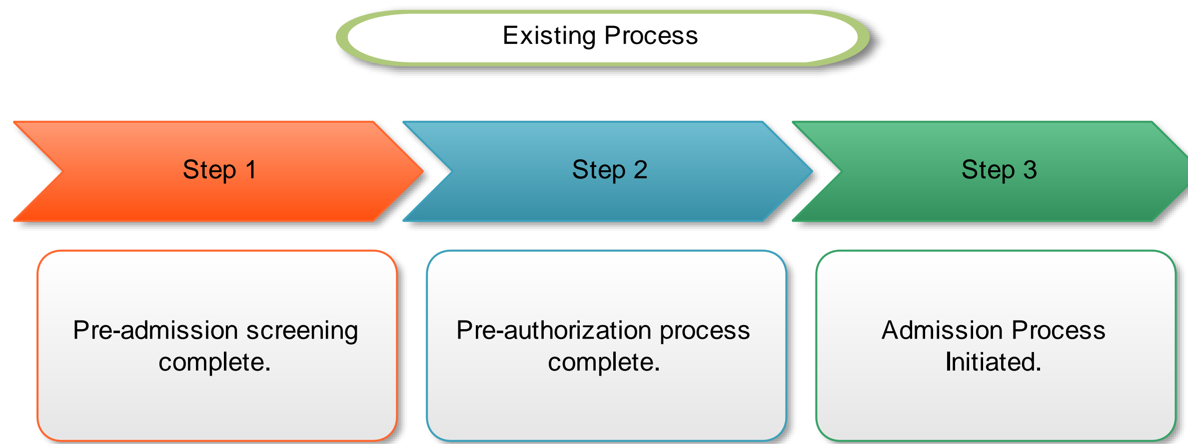
The World Health Organization has set forth a bold access strategy for global health that recognizes that mental health and well-being is a fundamental component of public health and social care systems. The mission of the "No health without mental health" strategy is to create a new social norm where persons always seek help for both mental and physical health whenever they need to. Local care providers have been challenged to translate this mission into an achievable reality.[6] For Penn Foundation, this starts with **access to care** at our customary point of first contact: the request for an initial outpatient appointment to assess need.

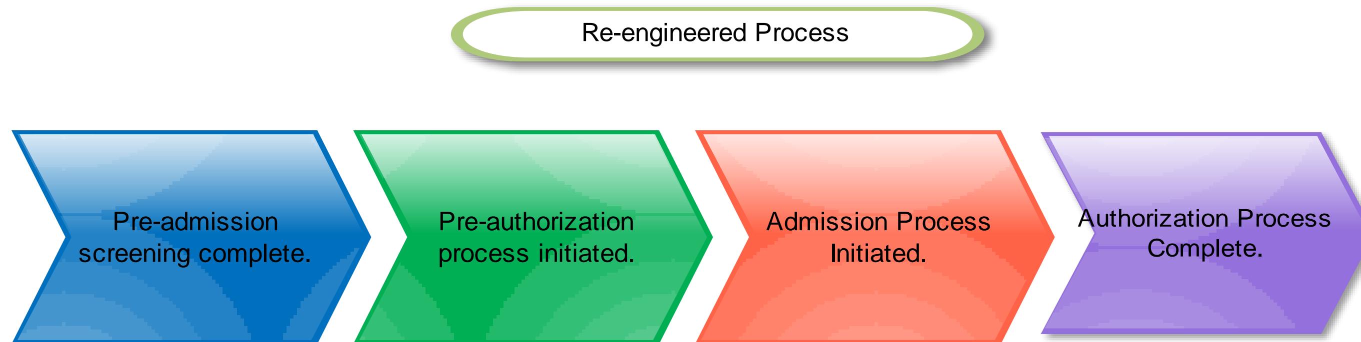
According to the National Council for Behavioral Health, a same-day outpatient appointment has a 10% chance of not being kept, but almost 25% of persons with next day appointments cancel or simply do not show up. Every person who calls to inquire about our services is offered a same day walk in appointment. For those persons who preferred a scheduled initial appointment for a routine presenting mental health problem, the agency exceeded the 7 day benchmark standard. Persons were offered an appointment within 2.2 days, with a "kept rate" of 96%.

While we have successfully closed this gap for mental health access, we have not similarly transformed our access for drug and alcohol initial assessments, a critical gateway to same day admission to our Recovery Center Inpatient Detoxification and Rehabilitation. Benchmarked to the National Council standards, the average length of time from initial request for service to initial assessment was 3.8 days. The kept rate was only 50%. Seeking help is one of the most difficult decisions an addict can make. Any hesitation is a lost opportunity for recovery.

After fully implementing our open access model for all alcohol and other drug service requests, the initial appointment kept rate skyrocketed to 97%.

We then turned our attention to the visit cycle time. Once the individual had been screened using ASAM & PCPC criteria and met medical necessity criteria for inpatient level of care, the next obstacle to patient flow was the pre-authorization process. Wait time ranged from 2 hours to 6 hours in our facility, until such time as the primary insurer authorized the inpatient stay. This resulted in a bottleneck of unit admissions on second shift between the hours of 3 pm and 6 pm. The Recovery Center management team analyzed data of the percentage of pre-authorization denials from our primary funding stream (managed Medicaid plans). Armed with the knowledge that the denial rate was essentially zero, the patient flow model was immediately re-designed.



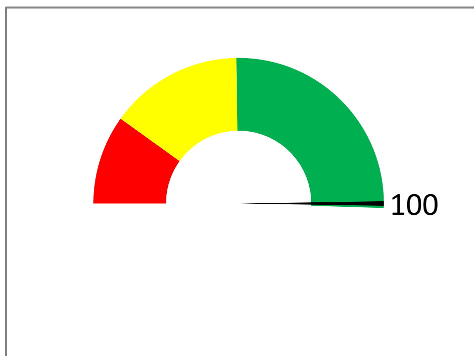


The re-engineered process resulted in decreased wait times and improved satisfaction on the part of persons served and their families.

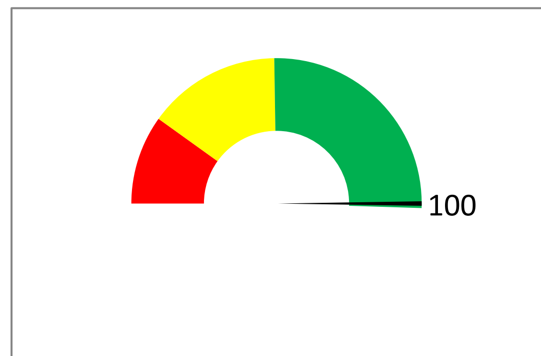
Ongoing Access

For ongoing access, regional benchmarks vary depending upon the type of service and the credentials of the professional. Persons with an identified primary substance use disorder typically had access to a psychiatric evaluation within 4 to 7 days, which was within the standard of less than 10 days. The average wait time for an individual with a mental health diagnosis was 27 days from initial assessment to psychiatric evaluation, which exceeded the standard by 17 days. The agency continues to be impacted by the shortage of qualified psychiatrists and certified psychiatric nurse practitioners. Recruitment efforts have been conducted in earnest throughout the year by the Human Resources Department in collaboration with recruitment agencies that specialize in medical professional recruitment.

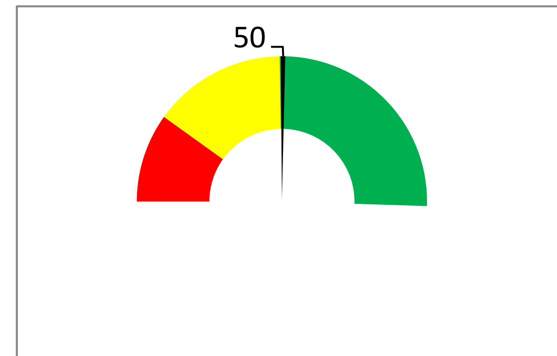
100% of persons completed follow up MH appointment within 30 day standard



100% of persons completed follow up D&A appointment within 7 day standard



50% of persons had access to a Psychiatrist within 10 days of initial appointment



Improving Internal Access and Collaborative Care

In late 2014, our Director of Crisis Services, Wendy Shapiro, MA, identified an opportunity for improvement between the Crisis Service, located at the Department of Emergency Medicine at Grand View Health, and our Inpatient Drug and Alcohol Programs. Internal communication barriers had led to diminished referrals to our own Recovery Center. “Lost opportunity” admissions were determined to be 39 of the total 97 persons who needed inpatient drug and alcohol treatment that presented in the ER over a 9 month period in 2014. In January of 2015, we instituted a rapid cycle change process pilot to embed and cross train a crisis worker to conduct admissions screenings in our Recovery Center. The crisis worker was trained to conduct PCPC assessments and learned the admission criteria and admission workflow of the unit. The goal was to develop a knowledge base and collaborative teamwork approach to facilitate a future “warm hand off” from the ER to the Recovery Center inpatient unit. At the completion of the 90 day pilot, a total of 11 warm hand offs to successful admission had been made. This three month total exceeded that of all referrals to the unit for the previous 12 months. With the success of the pilot, an additional crisis worker was similarly cross-trained. Cumulatively in 2015, the enhanced collaboration and communication between departments led to 47 referrals and subsequent admissions.

Rising to Meet the Need of Complexity

Penn Foundation was awarded a “learn by doing” pilot grant from the HealthSpark Foundation. This grant supports the extra cost that an organization incurs to launch a small scale project to test new ways of delivering services in conjunction with new partners. Penn Foundation is partnering with Grand View Health to pilot an integrated team of physical and behavioral medicine specialists to create a care transitions program for dual-eligible elderly adults with behavioral health conditions and chronic physical health conditions (such as Congestive Heart Failure or COPD). The joint venture aims to increase patient health IQs through education that supports disease self-management, optimally uses outpatient services to reduce the continued need for higher levels of care, and prevents hospital readmissions within 30 days. Based on care transition best practices guidelines, the integrated team will provide hospital patients with a behavioral health needs assessment, medication reconciliation, care coordination with PCP and pharmacy, community resource linkage, and health education coaching (including diet, exercise, smoking cessation, and stress management). The two year grant will continue through January of 2018.

Seizing Opportunity

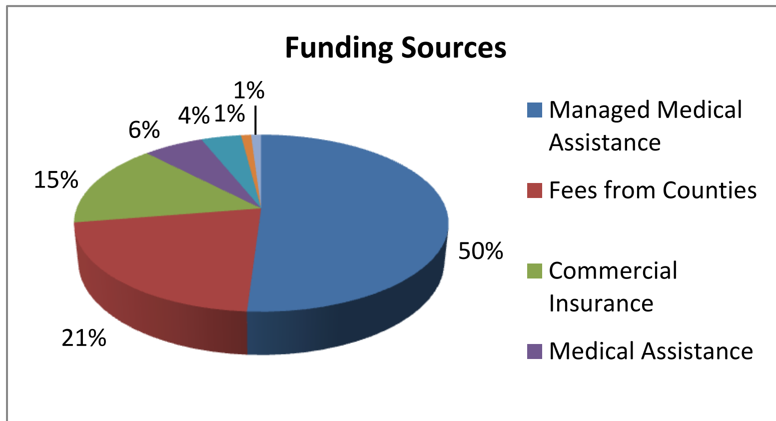
“Because many patients with depression are treated in primary care settings, development of effective strategies in these settings is essential. Current research is examining a range of innovative strategies for collaborative care using mental health specialists in primary-care based disease management strategies. These strategies involve two basic approaches. First is the approach that adds routine, systematic screening to identify primary care patients who are depressed, followed by a collaborative care approach that enhances the usual primary care treatment for depression. Often such patients otherwise go undiagnosed and untreated. Instead, a mental health specialist works collaboratively with the primary care team to provide evidenced-based depression treatment. A second approach adds collaborative, evidence-based mental healthcare to the primary care setting for patients already diagnosed with depression.”[7]

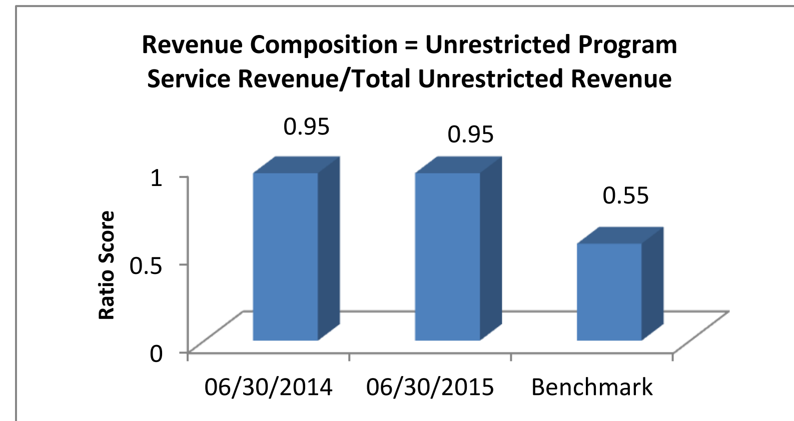
Penn Foundation’s Integrative Health Services Department had the opportunity to partner with Tandigm Health in 2015. Tandigm Health is a ground breaking joint venture by Independence Blue Cross and Health Care Partners, LLC, working in tandem with primary care physicians to create a new paradigm of high-quality, affordable health care in the Philadelphia region. Penn Foundation’s rich 60 year history of service to community is a good fit with Tandigm Health’s mission to empower physicians to build out the community-based health delivery system: the people, programs, and places in the empty space between doctor’s offices and the emergency room.[7] Medical Director, Christopher Squillaro, DO, and Integrative Services Director, Angela Hackman, MSW, LCSW, developed a collaborative care algorithm presently being used by Tandigm Health’s network of primary care physicians to screen their patients for depression. Beginning in 2016, two local medical practices are piloting a preferred access model with Penn Foundation for the treatment of depression as a co-morbid disease of the primary medical condition being monitored by the PCP. This initiative is in line with Penn Foundation’s strategic planning goal of implementing disease specific care by January of 2016.

“No margin. No mission”

Sister Irene Krause, credited with the infamous phrase, intuitively understood that strong fiscal management, not just charity, is what an organization needs to be sustainable. Corporate social responsibility includes achieving a healthy operating margin. If there is a mission there must be a margin.[9] We believe in the triple bottom line - a socially responsible business model leads to better individual, societal and financial outcomes.[10] As a community behavioral health center, Penn Foundation is largely dependent upon fee-for-service public and private insurance and out-of-pocket patient payments as its primary funding streams. Compared to general medicine, specialty psychiatric and addiction practices across the country typically receive a higher proportion of funds from public insurance. The holds true for Penn Foundation, as 77% of our FFS

income was reimbursed by Managed Medical Assistance, Medical Assistance and Fees from Counties in 2015. With the full implementation of the Affordable Care Act, spending on behavioral health is likely to increase under both commercial insurance and Medicaid. From our various funding sources, our annual accounting audit confirmed that we show $0.95 cents in program revenue for each dollar of revenue generated. In contrast, the industry benchmark for Community Mental Health Centers generating between $10 and $50 million dollars of revenue annually was only $0.55 for each dollar.





Rooted in Tradition and Reaching Toward the Future

SAMHSA Drug and Alcohol Prevention Grant

With the state of Pennsylvania leading the nation in drug overdose deaths among young adult males, there is a renewed sense of urgency around drug prevention. Bucks County has the dubious distinction of having the highest rate of overdose fatalities associated with the heroin epidemic in the state. The DEA attributes this high incidence to the availability of some of the purest and cheapest heroin in the nation passing through Philadelphia. It is clear from demographic patterns of use that the opportunity lies with reaching teens ages 12 – 18, whose overdose fatality rates are one-tenth those of young adults.[11] Penn Foundation is currently in year two of a three year SAMHSA /Bucks County sponsored Strategic Prevention Framework Partnerships for Success Grant. The SAMHSA grant is designed to address two of the nation's top substance

abuse prevention priorities: underage drinking among persons aged 12 – 20, and prescription drug misuse and abuse among persons aged 12 to 25 years.

As part of this grant, Gordon Hornig, LSW, Director of Mobile Engagement Services, and Deb Ryan, AA, Director of Community Outreach, presented "Protecting Our Children" seminars to parents and grandparents of students enrolled at Pennridge High School, Palisades High School, Quakertown Christian School, and Nativity of Our Lord Catholic School. The presentation focused on having caregivers evaluate their attitudes around alcohol and prescription drug use for teenagers versus young adults in their families, followed by coaching/education on how to talk with kids around the dangers of substance use. We have also established a Youth Advisory Committee to engage young people in the process of planning prevention activities for their peer group. Simultaneous with our prevention efforts with parents, our Medical Director, Christopher Squillaro, DO, presented a colloquium on "How to Manage Drug-Seeking Behavior" to thirteen local physicians. All the physicians indicated they talked to their patients about the dangers or problems associated with the use of tobacco, alcohol, or other drugs at least once per week during the past 30 days. The majority of physicians (82%) talk with their patients more than once a week and 18% of physicians talk to their patients 3 – 5 times daily. All attendees requested further substance abuse training on this important topic. Six additional physician trainings have been scheduled for 2016.

Leadership Institute

Penn Foundation has established a Leadership Institute in our desire to mentor future leaders' ability to embrace and inspire innovation, adapt to the changing healthcare environment, and remain connected to the needs of our community. The Institute is the fulfillment of our strategic plan to "create a mentoring program which maximizes the potential for professional success." The experience is designed to give future leaders ways of thinking and practicing that are congruent with our corporate values and vision. "Our program has been more than a year in planning with Nancy Aronson, Ph.D., a gifted teacher, mentor and faculty member of the Philadelphia College of Osteopathic Medicine" says Karen Kern, LCSW, Vice-President, who is spear heading this effort. Institute participants will experience various models and frameworks for leadership and understand the theory that underpins them. They will expand their leadership capacities as they look at their own management abilities with fresh eyes and more deeply understand the larger context in which they operate. They will make connections between their values and strengths and the mission of Penn Foundation. Congratulations to the 2016 inaugural class: Ginny Afman, MH Outpatient Supervisor, Jen Brent, Recovery Center Administrative Assistant, Heather Davis, ID Supports Coordinator Supervisor, Jessica Farkas, Penn Villa Assistant Director, Jill Horan, Clubhouse Director, Bill Roth, MH Outpatient Supervisor, Ryan Schweiger, Peer Support Team Leader, Debra Springer, Wrap Around Director, Pete Stolz, IT Assistant Administrator, Amanda Ward, Billing Coordinator, and Tim Zwilling, Crisis Service Supervisor.

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