



Mental Health Services

for Clark and Madison Counties, Inc.

A Culture of Compassion and Caring
(MHS)

**Community Health Assessment and Plan
2016 – 2019**

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MHS Vision, Mission, and Values Statements

The Vision, Mission, and Values statements were revised prior to the strategic planning endeavor in fall 2016. They are stated below.

Vision

Mental Health Services of Clark and Madison Counties will be a leading provider of quality emotional, behavioral and psychiatric care in our community.

Mission

Mental Health Services of Clark and Madison Counties will improve the safety and quality of life of those we serve through:

- Promotion of emotional and behavioral health wellness
- Accessibility to a comprehensive continuum of behavioral health services

Values

Mental Health Services of Clark and Madison Counties identifies the following Agency Values:

- Protection of patient dignity and safety
- Outcome focused behavioral health care
- Established ethical guidelines
- Collaborative partnerships
- Being vested in the community
- Responsible stewardship of available resources

Mental Health Services Community Health Assessment and Planning Process

Mental Health Services provides care for people of Clark and Madison Counties who have emotional, behavioral, or psychiatric health needs, regardless of their ability to pay.

External Influences

The operations of Mental Health Services are intertwined with the trends and factors present in the communities and other organizations in which it exists. The Mission declares safety and quality for clients and employees are foremost in consideration. Inter-relationships with the people and families served, as well as with other healthcare agencies, are addressed in the Values statements, and further elaborated in the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) set forth for the designated service area. All of these actions are performed in compliance with applicable Federal and State regulations and quality guidelines, and under accreditation of The Joint Commission.

History of the Clark County Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP)

- 2015 - Community Health Assessment (CHA) of Clark County led by the Clark County Combined Health District (CCCHD)
- Lead agencies identified topics of greatest concern based on data

- Lead agencies
 - Springfield Regional Medical Center
 - Rocking Horse Community Health Center
 - Mental Health and Recovery Board
 - McKinley Hall
- Participating agencies
 - Other healthcare agencies
 - Interested citizens
- January 29, 2016 – Report of CHA findings to all Clark County health-related agencies and other interested parties led by Clark County Health Commissioner
- CHIP Task Forces created to address topics of greatest health concern and impact
 - Charged with developing goals for health status improvement
 - Staffed by members of participating agencies
- March 29, 2016 – Task Forces presented goals in a meeting of all Clark County health-related agencies
- Community Health Improvement Plan (CHIP) created
 - Combined findings from the CHA
 - Goals and work plans of Task Forces
 - Available to the community on line
http://www.ccchd.com/ccchd/n_he/comhealthas.html
- Participating agencies charged with incorporating data from CHA and applicable interventions from CHIP Task Forces into their strategic planning processes
 - Responsible for additional drill down and assignment of responsibilities
 - Fall 2016 - Completed by Mental Health Services as part of strategic plan

MHS Representatives on CHIP Task Forces

The Mental Health Task Force relates directly to the primary focus of Mental Health Services. While all of the Task Forces interact with Mental Health Services to a greater or lesser extent, there are other entities within Clark County charged with more specifically addressing those health needs. Mental Health Services has designated internal representatives for each of the pertinent Task Forces to serve as liaisons between MHS and the larger group, to participate in the work of the Task Forces, and to serve as internal drivers for their respective assignments within MHS. The Task Forces meet regularly to continually work toward achieving their specific health objectives. Baseline data, minutes, and periodic progress reports for each Task Force can be found on line. http://www.ccchd.com/ccchd/n_he/comhealthas.html

- **Mental Health – Sue Fralick**
- Substance Abuse – Curt Gillespie
- Tobacco Cessation – Curt Gillespie
- Chronic Disease Management – Racheal Hickman
- Physical Activity – Christy Detrick
- Healthy Births & Sexuality
- Nutrition

Key Assessment Data Related to Mental Health

Data from the CHA identified the following areas of concern related to mental health:
http://www.ccchd.com/documents/contentdocuments/doc_23_5_859.pdf

- In 2015, 40.3% of Clark County adults indicated they had at least 1 day in the past month where their mental health was not good, of those 48.9% thought about death/suicide, and 16.7% attempted suicide
- 16.5% of Clark County households contain a member who is depressed or mentally ill, or had a household member attempt suicide
- In the past 5 years, there have been 88 suicides in Clark County. Of those, 80% are men between the ages of 45 and 64
- It was found that 17.7% of Clark County youth made a plan about attempting suicide in the past year. This was significantly higher than the state (11.1%) and nation (13.6%)
- In a four month period of 2013, Springfield Fire Chief noted 15.4% of EMS runs were for patients with prior or current contact with MHS, or for reasons documented as non-compliance or attention-seeking behaviors (27 people called 7 or more times (303 requests), 99 people called 4-6 times (460 requests))

Additional data from the CHA can be found in various documents on the Clark County Combined Health District website devoted to the Community Health Assessment, Community Health Improvement Plan and Progress Reports, and Task Force Minutes.

http://www.ccchd.com/ccchd/n_he/comhealthas.html

Mental Health Task Force Objectives

Depression Screening

Impact Objective: To improve the awareness and use of a locally available on-line self-assessment tool for adolescents through adults to identify depression and risk of suicide. Use of the tool also connects the participant directly to information about local mental health services availability, location and service hours.

SMART Objective: For 2017 - increase raw participation by 20% in the Mental Health Services HANDS Depression Screening Tool through promotion and direct referral; to improve the demographic breadth and balance of participants as identified by gender, age and other pertinent demographic discriminants. To provide an immediate referral guidance tool for gatekeepers that promotes the screening tool or more direct referral as deemed necessary. To regularly identify the source of referrals as an indication of program impact and efficacy.

Mobile Integrated Healthcare

Impact Objective: To improve the efficacy of interventions available to EMS first responders for mental health related situations thereby reducing the frequency of service requests and the need for more expensive and less effective resources in those situations

SMART Objective: To better match the services provided to the needs presented. To expand non-emergency treatment protocols, including transfer of patient care, and enhance the appropriate sharing of protected health information across multiple provider agencies involved.

Physician Impact Plan

Impact Objective: To improve coordination of efforts between individual treating physicians and the community of mental health service providers

SMART Objective: By January 1, 2017 – a survey of local physicians will be conducted to identify referral practices when dealing with or prescribing medications for a mental

health condition; a survey of local mental health service providers will be conducted to identify contact information, types of services and referral requirements; a complete and regularly updated referral list of mental health service providers will be available to all physicians.

Youth Continuity of Care

Impact Objective: Create a seamless continuum of care from the school through the various medical and social service agencies when dealing with school-age children in Clark County who present with suicidal ideation or other acute mental health issues

SMART Objective: By August 2017, the MH Task Force will implement a Parental Consent to Treat and Release Information form and protocol for use by all Springfield and Clark County School districts

PAX Good Behavior Game (PAX GBG)

Impact Objective: To improve the efficacy of the elementary educational experience by implementing the validated PAX GBG curriculum programming for elementary school programs throughout Springfield and Clark County and through training and support of the elementary school teachers.

SMART Objective: 50% of all elementary school programs will support PAX GBG programming in selected classrooms by the beginning of the 2017/2018 academic year. At least one elementary school will support PAX GBG in every classroom grades 1 through 5 by the beginning of the 2017/2018 academic year. 75% of all elementary school programs will support PAX GBG by the beginning of the 2018/2019 academic year. To increase the number of PAX GBG trained teachers by at least 40 per year over the next 5 years.

Youth Suicidal Ideation

Impact Objective: Reduce the incidence of reported suicidal ideation among middle school-age children in Clark County.

SMART Objective: By March 2017, the MH Task Force will implement evidence-based programs/interventions in Springfield and Clark County School districts for middle school age students.

Mental Health Task Force Structure

Mental Health Task Force (entire group)

The entire Task Force meets bimonthly to work on overarching goals and monitor progress of two age-specific sub-groups.

MHTF – Adult sub-group

Adult sub-committee meets monthly. The focus of this group is to develop methods by which adults with depression and a risk for suicide can be identified and connected with mental health services.

Depression Screening

The HANDS Depression Tool is available for depression assessment of adolescents through adults. The HANDS Tool is a brief 10-question tool which can be accessed on-line and self-administered, or used by a Gatekeeper. Increased use of the HANDS Tool

is being promoted by the Task Force to increase awareness of, and intervention for depression before it deepens to crisis stage.

Emergency Department and Squad Transport Burden

Springfield City squad runs have increased 40% in the last 10 years, and many residents use the Emergency Department as their primary source of care. One of the major factors increasing such use is mental health issues, and repeated use of both transport and ED services by the same individuals. (*Springfield New Sun*, March 28, 2016)

The Adult Mental Health Task Force and Mental Health Services are implementing initiatives to reduce this burden. A mental health counselor has been placed in the Emergency Department during prime hours to work directly with patients in crisis, thus freeing other health professionals, who might not have the same depth of experience. Additionally, the Task Force is partnering with Springfield EMS and 211 (area help line) to develop a paramedicine program in Springfield. The purpose of this program is to increase follow-up of discharged patients, determine whether they are following their treatment plans, and if they are keeping physician appointments. The Gatekeeper initiative will also provide a secondary benefit by assisting some individuals to lower their anxiety below an emergent level.

Gatekeepers

According to The Surgeon General's *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*, many agencies and groups within the community promote health, reduce risk factors, or otherwise touch the lives of individuals and families in crisis. <https://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full-report-rev.pdf>, (pdf pg. 42). The Task Force developed a list of these potential "Gatekeeper" agencies where additional education can be provided to prepare staff members for their role as "Gatekeeper" or first to recognize and intervene in a potential suicidal situation. QPR (Question, Persuade, and Refer) training is an established mental health methodology to identify and interrupt a suicidal crisis and direct that person to the proper care.

The first QPR training was offered in October, 2016. Additional training sessions are in process. Wallet cards listing signs of suicide and the national suicide hotline were updated for distribution, and assessment and referral resource cards are in development for the Gatekeepers to carry. MHS modified their intake procedures and their database and trained personnel to code as Gatekeeper all those who were referred through this method. This will enable identification of the number of individuals referred who sought services, and assist with validation of the effectiveness of the Gatekeeper process.

Physicians and Mental Health Service Providers

Area physicians and mental health service providers are being surveyed to develop a directory listing the following regarding treatment of patients with mental health conditions:

- Referral practices
- Referral requirements
- Treatments/services provided

- Payment forms accepted
- Private or public agency

MHTF – Adolescent sub-group

The Adolescent sub-group meets monthly. The group's primary focus is to reduce incidence of suicidal ideation among adolescents in Clark County, by working with school administrators to implement evidence-based programs in elementary and middle schools to improve behaviors and everyday decision-making.

Youth Continuity of Care

A county-wide policy and process for implementing, maintaining, and sharing information among appropriate mental health agencies for any child under treatment for mental illness or suicidal ideation is being developed. A parental *Consent to Treat and Release Information* form is being created. Parents will be asked to sign the form as part of the standard process whenever a child is referred for mental/behavioral health services, so that continuity of care can be improved across agencies.

Youth PAX Good Behavior Game (PAX GBG)

Evaluation of the PAX GBG, which was implemented on a limited basis in elementary schools during the previous CHIP, demonstrated improved self-regulation and increased classroom attention among participants. Efforts are underway to expand that program to select grades in all elementary schools, and all grades in one elementary school.

Youth Suicidal Ideation

The Task Force has sought funding to bring the evidence-based BOTVIN LIFE SKILLS training program to students in the middle schools. Under this sequential program, "Students learn how to examine their self-image and its effects on behavior; set goals and keep track of personal progress; identify everyday decisions and how they may be influenced by others; analyze problem situations, and consider the consequences of each alternative solution before making decisions; reduce stress and anxiety, and look at personal challenges in a positive light."

http://www.ccchd.com/documents/contentdocuments/doc_23_5_947.pdf (pdf pg. 13)

The program is currently being used in the school district of a neighboring county with positive results, and three Clark County school districts have committed to training and implementation.

Feedback Loops

Executive Leadership

Members of the Executive Management Team also serve as representatives on Mental Health Task Force and other related Task Forces. Because of their position within Mental Health Services, they can speak with authority within the Task Forces, and also bring information and needs from the Task Forces back to the Executive meetings for incorporation into planning and/or immediate activities. As stated earlier, the goals and objectives were also considered in the discussion and development of the MHS Strategic Plan for 2016-19.

Clients and Families

Results of Client Satisfaction Surveys are discussed and issues addressed monthly as part of the Quality Management system, or more frequently, if warranted. For this update document, results from the most recent nine months (July 1, 2016 – March 31, 2017) were aggregated across all agencies and reveal the following client responses (please see Appendix 2):

- 1.) 69% (of 101) were very satisfied or satisfied with how quickly they were offered treatment
- 2.) 81% (of 121) feel they were involved in decisions about their care, treatment and services, including treatment goals and needs
- 3.) 47% (of 49) were asked if their treatment goals and needs were met
- 4.) All of those (of 17) who expressed needs related to ethnic or cultural background during assessment felt they were met (very well to somewhat)
- 5.) 79% (of 69) are very likely or likely to recommend the services they received to others
- 6.) 92% (of 60) felt that their care was provided in a safe environment
- 7.) 72% (of 61) offered suggestions to improve safety
- 8.) 89% (of 147) were very satisfied or satisfied with overall services they received

Over 600 written comments were added to the surveys covering such topics as:

- ER / Hospital
- Timeliness of entry into system / receipt of treatment
- Availability of information
- Involvement in treatment
- Group therapy
- Medications
- Environment / Safety
- Environment / Food / Outside or Gym Opportunities
- Personnel
- Non-specific negative comments
- Ambiguous, uncertain or N/A comments
- Non-specific positive comments
- Miscellaneous comments unable to be categorized

The complete list of comments was given to MHS Leadership for further analysis and follow-up.

Focus Groups

In an effort to obtain the most current feedback, the author of this document met with two focus groups (NAMI [National Alliance on Mental Illness] family members of clients and PHP/Transitions [Partial Hospitalization Program] clients themselves). The discussion was guided to cover key topics of interest, but also open ended enough for participants to share whatever thoughts came to mind as the discussion unfolded.

The following information was provided to participants and they were thanked for participating:

PURPOSE: to obtain current feedback from clients or support persons of clients of Mental Health Services of Clark County (MHS).

WHY: MHS is updating their portion of the Community Health Improvement Plan that was based on the overall Community Health Assessment led by the Clark County Health Department and completed in 2015/16. Your responses will help identify current strengths and weaknesses in the provision of mental health services to residents of Clark County, and help guide MHS as future direction of care efforts is determined.

KEY POINTS:

- *No names or other identification will be used*
- *Results will be aggregated and reported in general terms as to main points, trends, etc.*
- *Responses should be as general as possible and avoid specific details related to any client's counseling or treatment plan.*
- *Questions will be open ended so participants can respond as they desire*
- *Your participation signifies your willingness for to use the information you provide in the final report.*

The following were the key topics for discussion in the focus groups:

- What do you identify as positives with Mental Health Services?
- In what ways do you think Mental Health Services might improve?
- How satisfied were you with how quickly your special person/you personally was/were offered treatment?
- What concerns do you have related to:
 - Accessibility?
 - Appointments available?
 - Times?
 - Transportation?
- If you identified any needs related to your ethnic or cultural background, were they met?
- How satisfied were you overall with the services your special person/you personally received?

The summaries of focus group comments have already been forwarded to MHS leadership. They can be found in Appendix 3 (NAMI) and Appendix 4 (PHP/Transitions).

Background Documents Following

- Appendix 1 – Mental Health Task Force Progress Report
- Appendix 2 – Patient Satisfaction Results: July 1, 2016 – March 31, 2017
- Appendix 3 – NAMI Focus Group Comment Summary
- Appendix 4 – Transitions Group Comment Summary

Appendix 1 – Mental Health Task Force Progress Report

(This section taken directly from http://www.ccchd.com/ccchd/n_he/comhealthas.html)

The following is an update on the progress the Mental Health Task Force has made toward meeting the goals and objectives created to address the mental health needs of the community as of December 31, 2016.

Mental Health Task Force: Depression Screening			
Impact Objective: To improve the awareness and use of a locally available on-line self-assessment tool for adolescents through adults to identify depression and risk of suicide. Use of the tool also connects the participant directly to information about local mental health services availability, location and service hours.			
SMART Objective: For 2017 - increase raw participation by 20% in the Mental Health Services HANDS Depression Screening Tool through promotion and direct referral; to improve the demographic breadth and balance of participants as identified by gender, age and other pertinent demographic discriminants. To provide an immediate referral guidance tool for gatekeepers that promotes the screening tool or more direct referral as deemed necessary. To regularly identify the source of referrals as an indication of program impact and efficacy.			
Process Objectives	Related Activities	Specific Dates	Performance Management
	Update the Mental Health Recovery Board Suicide Warning Signs wallet card to include more information on local mental health contact information	9/1/2016	Completed
	Develop a Gatekeeper assessment and referral resource, simple wallet size design for ease of carry and reference	7/19/2016	Completed
	Complete a retrospective evaluation of demographic and general trends from the MHS HANDS Depression Tool for past 12 months	11/1/2016	Completed
	Conduct referral program orientation to identified trainers: Gatekeepers, First Responders, Law Enforcement, and LOSS Team	Sept. 2016	Good progress/ on schedule
	Revise MHS intake procedures to include the identification of referral source	Sept. 2016	Completed
	Begin regular evaluation and reporting of MHS HANDS data and trends	Jan. 2017	Good progress/ on schedule
	Begin regular evaluation and reporting of MHS intake and referral data	Jan. 2017	Good progress/ on schedule
	Identify additional Gatekeeper agency opportunities	March 2017	Good progress/ on schedule
Mental Health Task Force: Mobile Integrated Health Care			
Impact Objective: To improve the efficacy of interventions available to EMS first responders for mental health related situations thereby reducing the frequency of service requests and the need for more expensive and less effective resources in those situations			
SMART Objective: To better match the services provided to the needs presented. To expand non-emergency treatment protocols, including transfer of patient care, and enhance the appropriate sharing of protected health information across multiple provider agencies involved.			

Process Objectives	Related Activities	Specific Dates	Performance Management
	Research and evaluation of frequent users of EMS with mental health concerns for trends and conditions. Combined effort to involve EMS, hospital and Mental Health Services for data and analysis	7/1/2016	Completed
	Develop protocols essential to meet identified trends. Personal care plans vs. situational need plans	Sept. 2017	Good progress/ on schedule
	Establish approved documentation procedures and information sharing platforms. Managing Medical Professional contact information	1/24/2017	No progress/ intervention needed
	Identify approved communication procedures with the various treatment providers	1/24/2017	No progress/ intervention needed
	Establish a medical direction quality control plan to include feedback from referral service providers	1/24/2017	No progress/ intervention needed

Mental Health Task Force: Physician Impact Plan

Impact Objective: To improve coordination of efforts between individual treating physicians and the community of mental health service providers

SMART Objective: By January 1, 2017 – a survey of local physicians will be conducted to identify referral practices when dealing with or prescribing medications for a mental health condition; a survey of local mental health service providers will be conducted to identify contact information, types of services and referral requirements; a complete and regularly updated referral list of mental health service providers will be available to all physicians.

Process Objectives	Related Activities	Specific Dates	Performance Management
a. Develop general physician survey tool for distribution b. Provide the survey to the CCCHD (Clark County Combined Health District) for distribution to known physician contacts c. Evaluate and report survey results		1/24/2017	No progress/ intervention needed
a. Develop a mental health service provider survey tool for distribution b. Establish a distribution list c. Evaluate and compile survey results d. Print the resulting referral guide e. Distribute the guide to all local physicians and referring agencies		1/24/2017	No progress/ intervention needed

Mental Health Task Force: Youth Continuity of Care

Impact Objective: Create a seamless continuum of care from the school through the various medical and social service agencies when dealing with school-age children in Clark County who present with suicidal ideation or other acute mental health issues

SMART Objective: By August 2017, the MH Task Force will implement a Parental Consent to Treat and Release Information form and protocol for use by all Springfield and Clark County School districts

Process Objectives	Related Activities	Specific Dates	Performance Management
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Develop a county-wide policy for information sharing among Clark County schools, hospitals, physician offices, and any agency providing mental health services for school-aged children a. Obtain approval for a policy from all pertinent agencies and offices b. Create Consent for Release information form agreeable to all parties c. Create a tool for information sharing to be used among all agencies and offices	Oct. 2016	Completed
Prepare schools for implementation a. Obtain a Memorandum of Understanding with schools, agencies and offices county-wide	Oct. 2016	Good progress/ on schedule
Implement program a. Implement programming b. Document process	Sept. 2016 - Feb. 2017	Slow progress
Implement policy a. Educate schools, agencies and parents to expect this as part of the process when a child is referred for mental/behavioral health services	Feb. 2017	Slow progress
Evaluate utilization	Jan. & June	Slow progress

Mental Health Task Force: Youth PAX Good Behavior Game (PAX GBG)

Impact Objective: To improve the efficacy of the elementary educational experience by implementing the validated PAX GBG curriculum programming for elementary school programs throughout Springfield and Clark County and through training and support of the elementary school teachers.

SMART Objective: 50% of all elementary school programs will support PAX GBG programming in selected classrooms by the beginning of the 2017/2018 academic year. At least one elementary school will support PAX GBG in every classroom grades 1 through 5 by the beginning of the 2017/2018 academic year. 75% of all elementary school programs will support PAX GBG by the beginning of the 2018/2019 academic year. To increase the number of PAX GBG trained teachers by at least 40 per year over the next 5 years.

Process Objectives	Related Activities	Specific Dates	Performance Management
Train teachers 1. 25 currently in 2016 2. 20 potential in 2016/2017 3. 40 potential in 2017/2018 4. 40 potential in 2018/2019 5. 40 potential in 2019/2020 6. 40 potential in 2020/2021		Annualized	Slow progress
Move classrooms to fidelity standard		2019/2020 academic yr	
Focus on Simon Kenton Elem. For full integration		June 2017	Good progress/ on schedule
Integrate Lincoln Elem. Into Clark County program		Jan. 2017	Completed
Optimize use of SWISS Data System			Slow progress
Create ongoing trained teacher support and infrastructure			Slow progress
Legislative advocacy			Slow progress

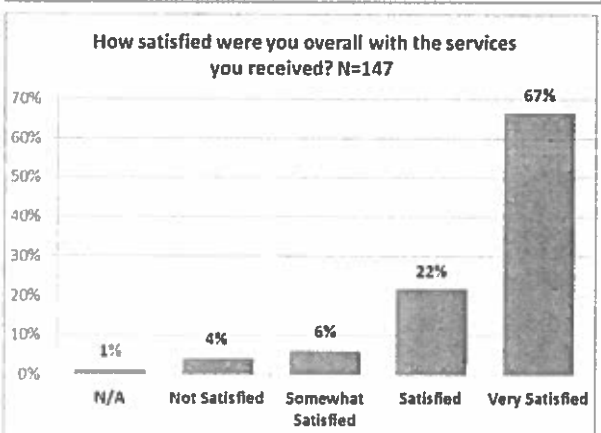
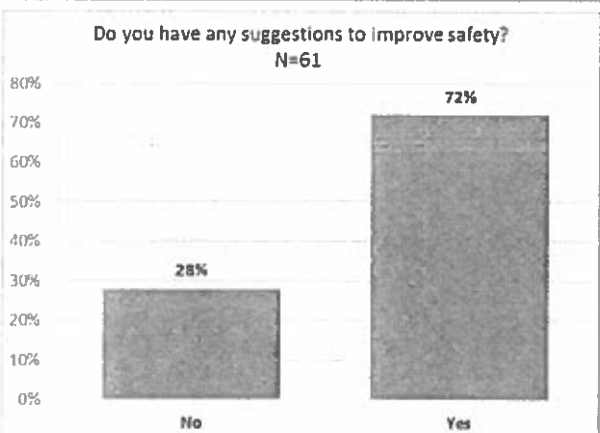
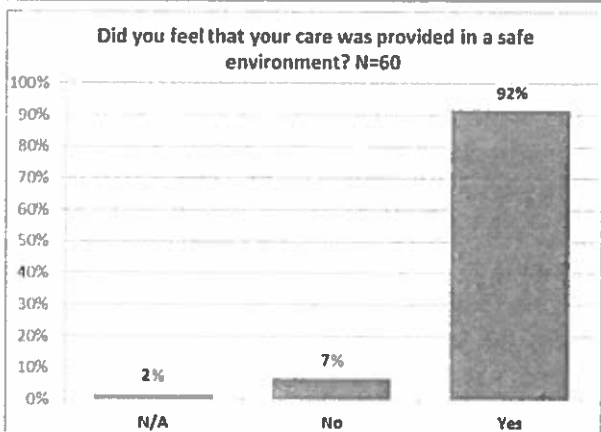
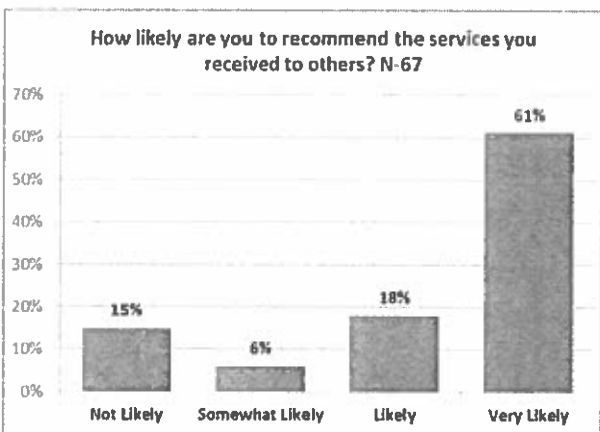
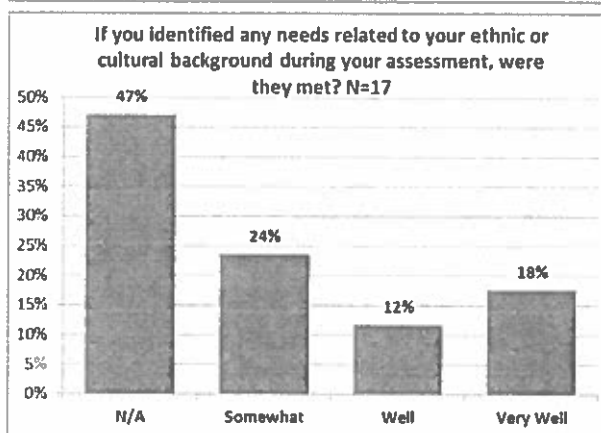
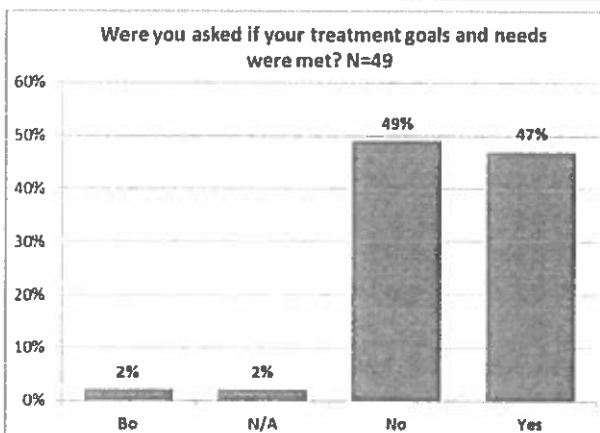
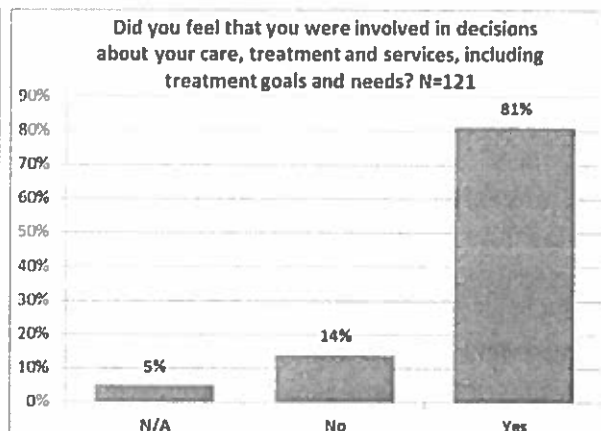
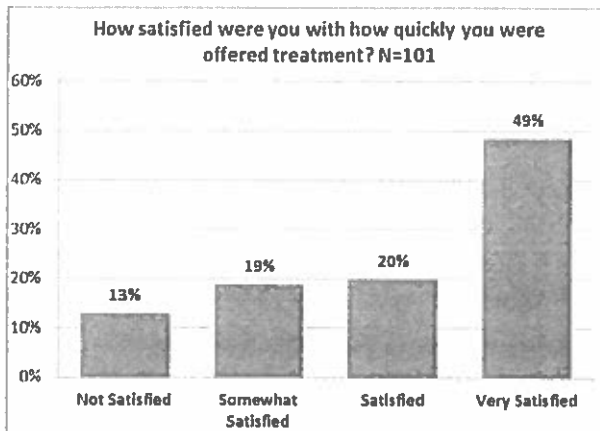
Mental Health Task Force: Youth Suicidal Ideation

Impact Objective: Reduce the incidence of reported suicidal ideation among middle school-age children in Clark County.

SMART Objective: By March 2017, the MH Task Force will implement evidence-based programs/interventions in Springfield and Clark County School districts for middle school age students.

Process Objectives	Related Activities	Specific Dates	Performance Management
Invite key personnel from city and county school districts, RHC and SRMC. a. Contact school-based personnel who work with children in crisis b. Contact personnel for RHC (Rocking Horse Center) who work with children in crisis c. Contact the ED manager of SRMC (Springfield Regional Medical Center)		May 2016	Completed
Research evidence-based programs. a. Utilize the CCCHD evidence-based practices repository for resources b. Research Botvin Life Skills program currently in use in Urbana and Miami County schools c. Determine appropriate program based on student needs and level of success d. Determine cost of program e. Once chosen, acquire all documents/tools necessary to implement program		Aug. 2016	Completed
Prepare schools for implementation a. If necessary, develop and complete Memorandum of Understanding with schools b. Determine school personnel needed for implementation c. Discuss implementation process with school administration d. Select dates and times to begin implementation e. Implement training of personnel		Aug. 2017 - July 2018	Good progress/ on schedule
Implement program b. Develop and document process steps c. Implement programming		Aug. 2017 - Sept. 2017	Good progress/ on schedule
Evaluate program a. Obtain documentation from participating schools b. Analyze data c. Compile results and share with schools		Dec. 2017 - March 2018	Good progress/ on schedule
Share results with community and CHIP Group a. Summarize results of program b. Present results to community via press release, social media, etc. c. Share results with CHIP Group at next meeting		March 2018	Slow progress

Appendix 2 –Patient Satisfaction Responses: 7/1/2016 – 3/31/2017



Appendix 3 – NAMI Focus Group Comment Summary

Services are not there that are needed

- Social inclusion group for late teens/early 20's who need "just one friend"
- Need more places like Mulberry Terrace
- Some help for clients who "fall through the cracks"
- Told too high functioning for Vernon Center (BHR)
- Too low functioning to get a job
- No peer group for higher functioning clients
- Would like counseling for the family unit
- Is there a transition plan for seniors who have mental health issues (that is neither dementia nor Alzheimer's)?
- Is there transportation for those who live outside the city? Need to come in weekly to get drug box filled – what happens if parent is not able/available to drive the client?
- Is there some kind of job training/mentoring/internship to help client get and keep a job, like there is for developmentally disabled?
- Would like to see something like the ACT Team (psychiatrist, case manager, therapist, peer support) that work as a team to help mentally ill young people for 3 months after they've been released from jail? (It can be reimbursable if fidelity established with criteria; Lynn West Director at TCM; researched at Case Western)

More case managers and therapists needed

- Took 4 months and many requests to get a case manager, and then only after threatening to go to Dayton and have them bill Clark Co., then got one in a week
- Only see case manager once to help with Social Security, etc.; no social or sustained support
- "Hard to get in – almost have to prove you're one minute from suicide"
- Case managers "missing"
- "Feel very alone" – a case manager would help to navigate the system – need a family/parent advocate

Communication

- "No one told me about NAMI"
- Found out about NAMI from "outside" therapist
- NAMI is beginning to build bridges since the new director took over
- A newsletter or other means of telling about services available would be helpful, especially first time into the system
- Great interest and enthusiasm about CHIP and Mental Health Task force. "It's encouraging that all those things are being worked on." Only one person was aware of CHIP. Told others how to access all the documents.

Personnel

- Crisis intervention training for police is a positive, so they can approach an agitated client and not escalate the tension
- Not enough case managers and therapists

- When person calls in to MHS for help/guidance about the system, the response is sometimes “less than friendly”
- Doctor is wonderful – he always takes time to answer questions
- Doctor – reaction mixed – one person stated that he was sitting at the desk and not doing anything, but would not talk to her even though she requested it through the nurse, and all the paperwork was signed. Other response was more positive, “like him”

Appendix 4 – PHP/Transitions Group Comment Summary

Positive Comments

- Provide outpatient treatment so don't have to do inpatient
- New building
- Rooms are clean
- Nice to have own space on inpatient unit (did not have roommate)
- Group meetings on inpatient unit
- Crisis intervention available in ER (but sometimes it takes a long time to get to counselor)
- Able to get help even if no insurance
- 7.9 (on 10 scale) avg. rating for Transitions (more 1:1 counseling would make it a 10)
- 6.25 (on 10 scale) avg. rating for inpatient (more RN's and counselors would make it a 10)

Areas for Improvement

- Community / Outpatient
 - More community information on mental illness to help remove the stigma
 - Wait time to see crisis counselor in ER too long (very positive when finally get to see someone)
 - No counselor in ER at night – need to wait over-night for MHS
 - Cost to transfer from ER to MHS is a “rip-off!!!!” Cost \$400 – could have walked over with an escort for a lot less. Provide cheaper option. Major agreement on this point.
 - Several clients didn't know there is an “ER” available directly at MHS in the daytime (If I had known, I could have avoided the cost of transport).
 - If you live outside city limits, bus won't pick up for Transitions Group – “you can come if you provide your own transportation.”
 - Client came to MHS “ER” and said she was “going to kill myself” if not admitted. Not admitted; sent home and told to call her doctor to get her meds changed.
- Inpatient Unit Personnel
 - Not enough counselors – no (or not enough) 1:1 except at discharge and that's not enough
 - If have 24x7 watch on one client, it takes away help from other clients
 - More 1:1 meetings on inpatient unit
 - Client felt intimidated to speak up
- Inpatient Unit Timeliness
 - Didn't get meds on time
 - Have to wait for everything
 - Post a schedule but don't stick to it; difficult to plan personal phone calls around schedule when it isn't followed
- Inpatient Unit Safety
 - When a patient gets something that is restricted or potentially dangerous, staff doesn't follow up to make sure it is used in a public place and returned to staff.
 - One client hurt self while upstairs (not enough 1:1)
- Inpatient Unit Food
 - Food is “terrible” (consensus) – no flavor, need to warm it up
 - An Indian patient was allowed to get food from home