Addendum



CHI Health Behavioral Health Improvement Initiative

Year 2 Community Evaluation Reports
July 2017 – June 2018

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GEOGRAPHIC LOCATIONS OF CHI HEALTH OWNED HOSPITALS

CHI Health Hospitals

Hospital	State	City	County	Metro/ Rural	2015 Population (County)
Bergan Mercy Medical Center	Nebraska	Omaha, NE	Douglas	Metro	725,756 (Douglas and Sarpy combined)
Creighton University Medical Center	Nebraska	Omaha, NE	Douglas	Metro	
Immanuel Medical Center	Nebraska	Omaha, NE	Douglas	Metro	
Lakeside Hospital	Nebraska	Omaha, NE	Douglas	Metro	
Midlands Hospital	Nebraska	Papillion, NE	Sarpy	Metro	
Mercy Hospital	Iowa	Council Bluffs, IA	Pottawattamie (Iowa)	Metro	93,671
St. Elizabeth's Regional Medical Center	Nebraska	Lincoln, NE	Lancaster	Metro	306,468
Nebraska Heart Hospital	Nebraska	Lincoln, NE	Lancaster	Metro	
Good Samaritan Hospital	Nebraska	Kearny, NE	Buffalo	Rural	47,958
Richard Young	Nebraska	Kearney, NE	Buffalo	Rural	
St. Francis Hospital	Nebraska	Grand Island, NE	Hall	Rural	60,792
St. Mary's	Nebraska	Nebraska City, NE	Otoe	Rural	15,842
Plainview Hospital	Nebraska	Plainview, NE	Pierce	Rural	7,184
Memorial Hospital	Nebraska	Schuyler, NE	Colfax	Rural	10,522
Mercy Hospital	Iowa	Corning, IA	Adams (Iowa)	Rural	3,892
			Taylor (Iowa)	Rural	6,213
Community Memorial Hospital	Iowa	MO Valley, IA	Harrison (Iowa)	Rural	14,467

Source: U.S. Census Bureau, American Community Survey, 1-year estimates for Douglas-Sarpy, Pottawattamie, and Lancaster Counties, 5-year estimates for all other counties.

Behavioral Health Initiative

2nd Annual Evaluation Report

Corning, IA – Behavioral Health Community Coalition

July 2017 – June 2018

A. COMMUNITY COALITION DEVELOPMENT AND PLANNING

Behavioral Health Coalition Vision

"To increase the preventive outreach, education efforts and resources that support the resiliency of community members who experience mental health and substance use issues".

Behavioral Health Coalition Purpose

- Increase the overall awareness of existing and potential resources among community stakeholders through an established behavioral health coalition.
- Provide community-wide trainings on mental health and substance abuse to stakeholders such as law enforcement, EMT's, pastors, school personnel, and elder care workers.
- Expand behavioral health prevention that educates and engages parents and children and youth ages 0-18.

Behavioral Health Coalition Structure

The structure of the Coalition is collaborative and anyone who has an interest in behavioral health issues are welcome to participate. A comprehensive e-mail distribution list is utilized to notify members of monthly meetings or other related information. Coalition members are encouraged to provide input and feedback regarding implementation of the grant expectations. Coalition members come together and negotiate with relative ease and compromise and utilize a consensus strategy to execute decisions.

Behavioral Health Coalition Successes

- The Coalition has sponsored adult and youth mental health first aid trainings and has surpassed the goal for numbers served.
- Two youth mental health first aid trainers have been trained and ready to provide community trainings.
- A partnership between the community college and the adult mental health first aid training has been embellished, which allows for CEU's for several professions.

- Local business/industry is showing great interest in having staff training in mental health first aid. This was an unexpected outcome.
- A website and logo have been implemented.
- Two of the three school districts have collaborated together to implement an evidenced- based program (Capturing Kids'Hearts).
- A neighboring school district has mentored with the Lenox Community School regarding Capturing Kids' Hearts and plans to implement the program.
- A community training on the Nurtured Heart Approach program was conducted.
- One Nurtured Heart Approach parent education series was conducted.
- Three people are certified trainers in Nurtured Heart Approach.
- Two people are certified facilitators for Circle of Security-Parent program.
- MOU's and policies have been drafted for various services of the grant.
- The Coalition sponsored a community education event called "Hidden in Plain Sight".
- The Coalition was successful in securing additional grant funding from Catholic Health Initiatives' Mission and Ministry to further the goals of the Coalition. This allowed for expansion of evidenced based programming.
- A news release was published in the paper.

Behavioral Health Coalition Challenges

- Gathering mental health provider data for the mental health resource guide continues to be challenging. With the development of the new website, providers will be able to update their information or a new provider can submit information. However, this presents challenges in how the data gets transferred to the website. It is a manual process to enter the information for each provider.
- Getting law enforcement committed and interested in Mental Health First Aid (MHFA) training continues to be challenging. Outreach efforts will continue to engage this sector of the community.
- Involvement from one of the school districts continues to be challenging. Creative outreach is ongoing with the school.

Collective Impact Survey Results:

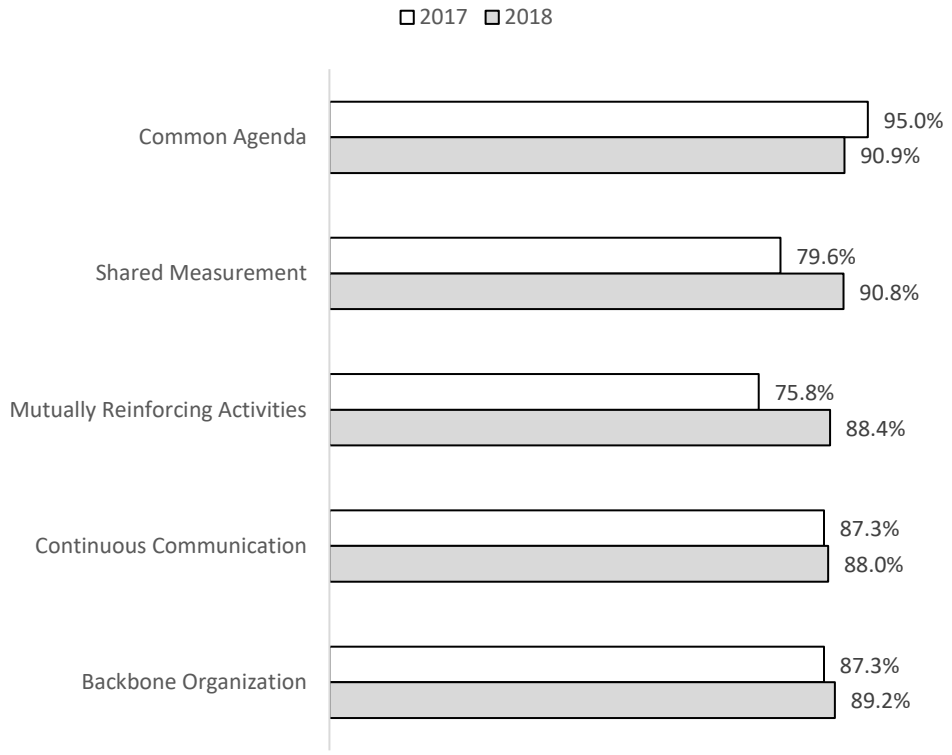
The Collective Impact survey is designed to evaluate the effectiveness of the coalitions within five domains: Common Agenda, Shared Measurement, Mutually Reinforcing Activities, Continuous Communication, and Backbone Organization. All active coalition members (i.e., those who attended at least one meeting in the past year) were invited to participate in the survey and rate their coalition on a number of survey items within each of the five domains. The survey was conducted online via SurveyMonkey.

Response Rates:
2017 - A total of 17 members of the coalition in Corning responded to the survey out of 38 invitees for a response rate of 44.7%.

2018 - A total of 13 members of the coalition in Corning responded to the survey out of 32 invitees for a response rate of 40.6%.

Each of the five domains receives an aggregate score. The aggregate score is the average of the percentage reporting “almost always” or “always” for the statements within each domain. The graph below presents the aggregates scores for each of the five domains. Ratings were high on all five domains with fairly consistent ratings for Continuous Communication and Backbone Organization but there was a decrease in ratings for Common Agenda. However, there was an increase in overall ratings for Shared Measurement, and the largest increase in Mutually Reinforcing Activities in 2018 ratings as compared to 2017. The full survey results report is located in Appendix B.

Collective Impact Survey Aggregate Scores*



*An average of the percentage reporting "almost always" or "always" for the statements within each domain.

B. BEHAVIORAL HEALTH TRAINING/EDUCATION

Trainings				
Date(s)	**Training Topic/Description**	**Description of Individuals Trained (community, school, parents, healthcare, etc.)**	**# of Participants**	**# of Organizations Participated**
July 25- 26; Sept. 25-27; Nov 8-9; Nov 29-30; Dec 13-14, Jan 12, March 9, March 23, May 17, June 21	Adult & Youth Mental Health First Aid	Community trainings were provided to Law enforcement, Schools, Fire/Rescue, Mental health providers, Faith, Citizens and other interested persons There are 3 community partners who are certified trainers, 1 for adult and 2 for youth MHFA	158	3 (certified trainers from 3 organizations)
July 2017	Youth MHFA Train the Trainer	Human service provider, community	2	2
Sept. 13 & 20 Feburary28 - March 28 June 25-26	Nurtured Heart Approach Nurtured Heart Approach - Parent Education Nurtured Heart Approach - Certified trainers	Human service providers, teachers, child care provides, parents, adoptive parents Parents identified by the school that were in need of additional support were offered parent education classes 2 school staff and 1 staff from the Area Education Agency are certified trainers	*(See Programs Implemented)*	
Aug. 21-22	Capturing Kids' Hearts	Teachers	*(See Programs Implemented)*	

Mental Health First Aid (MHFA) - Adult

MHFA educates on how to identify, understand and respond to signs of mental illness and substance abuse disorders. The trainer for adult MHFA trainings has been working collaboratively with Southwestern Community College (SWCC) to organize and market the trainings. SWCC has taken on the administrative aspects of the training and the agency the trainer works for - Imagine the Possibilities - has had the opportunity to incorporate this as part of her job duties. The evaluations are overwhelmingly positive in all aspects of the evaluations. The trainings are free to the community and everyone receives a free manual.

Here are a few quotes from the training:

- "I learned a lot in mental health and how to assist a person in need."
- "This was a great course for new employees!"
- "I enjoyed the class and wish I would have taken it 2 years ago!"
- "I learned quite a bit and opened my eyes on what I should do."
- "More people need this information, positive, excellent, was very good and informative."

Mental Health First Aid - Youth

There have been two community partners trained in MHFA for youth. Here are few quotes from the training:

- " Helped me with preparation in my plans to become a social worker."
- "Very interesting and well laid out training."
- "The trainer engaged participants in practical activities and created an environment that felt safe for everyone"

Outcomes - Mental Health First Aid – Adult and Youth

There are more than twenty-five evaluation questions that participants are requested to complete at the end of the eight-hour training course. Below are a just few of the evaluation questions that reflect the impact of the training and provide a strong overview of change.

1. Course goals and objectives were achieved. (n=139)	99.3% agreed or strongly agreed
2. As a result of this training I feel more confident that I can recognize the signs that someone may be dealing with a mental health problem or crisis. (n=138)	100% agreed or strongly agreed
3. As a result of this training I feel more confident that I can offer distressed person basic first aid level information and reassurance about mental health problems. (n=151)	82.8% agreed or strongly agreed
4. As a result of this training I feel more confident that I can recognize and correct misconceptions about mental health and mental illness as I encounter them. (n=139)	100% agreed or strongly agreed
5. Would you recommend this course to others? (n=139)	100% yes

C. SUMMARY OF PROGRAMS IMPLEMENTED

NURTURED HEART APPROACH

- **Program Planning:**
  Southwest Valley Community Schools, specifically the school At-Risk-Coordinator, took the lead in working with the Nurtured Heart Approach certified trainer, organizing the community training, engaging the community and securing child care training credit for child care providers. Due to the overwhelming positive response to the program, 3 individuals (2 form the schools and 1 from the Area Education Agency) became certified trainers in June 2018.
- **Program Description:**
  The Nurtured Heart Approach has been shown to create transformative changes in children diagnosed with ADHD, Oppositional Defiant Disorder, Reactive Attachment Disorder and other behavioral, emotional and anxiety related symptoms – almost always without the need for long-term mental health treatment. Even children experiencing social cognitive challenges, like Autism Spectrum Disorder and Asperger Syndrome greatly benefit from the Approach, reducing the need for traditional mental health and medical interventions. The training was targeted to anyone in the community, education, child care providers, parents, etc. This type of training can be utilized as a parent in their home or as a service provider in their work setting.
- **Description of Where Program was Implemented:**
  The community training was held in a handicap accessible neutral location, the Opera House located in Corning, Iowa (Adams County). The training was open to anyone in Adams and Taylor County.
  The follow-up parent education class took place in a local church.
- **Number and Description of Participants (i.e., community individuals, parents, youth, ages, etc.):**

Program Name: Nurtured Heart Approach			
Number of Individuals (or Parents) Served Directly	17	Number of Organizations Involved in Implementation	5
Number of Children/Youth Served Directly (if applicable)	NA	Number of Staff Involved in Implementation	50

Outcomes for Community Training:
Those that attended the community training reported the following:

- 76% of the participants would recommend the Nurtured Heart Approach to family or colleagues.
- 24% stated that they would recommend the Nurtured Heart Approach training if there were follow-up sessions included.
- 3 participants indicated they would like to become a certified trainer for NHA.

Comments:

The training went extremely well and there were no challenges to getting it scheduled or completed. Participants were engaged and are eager to learn more. Due to the interest, community partners are interested in having a trainer locally.

Outcomes - Parent Education: Building Resilient Kids with Nurtured Heart Approach (February 28 – March 28, 2018):

Of the five sessions of the class, 14 families (17 individuals) were present at the first session and 12 families (14 individuals) at the last session. A questionnaire with 23 questions from three different categories of the Home, Schools, Community Tool (HSC-T) (social relationships, emotional functioning, and behavioral functioning), was given to participants as a pre/post assessment for one child in their life.

The pre/post questionnaire was completed by 12 families and 14 participants present at the first and last classes of the session. Following are the pre/post aggregate results from participants:

- 57% increase in child strengths and decrease in child needs
- 64% decrease in the percentage of time yelled at child
- 86% increase in percent of time told child about positive behaviors

The Difficulties in Emotion Regulation Scale – Short Form (DERS-SF) was given to each participant as a pre/post assessment of emotion regulation. Participant averages for each sub-scale comparing first and last survey in reported in aggregate: *Difficulties in Emotion Regulation Scale – Short Form (DERS-SF).*

	Improved	
	Number of Participants	Percentage of Participants Who Improved
Strategies	11	79%
Non-Acceptance	9	64%
Impulse	8	57%
Goals	9	64%
Awareness	9	64%
Clarity	10	71%

CAPTURING KIDS' HEARTS - EVIDENCED BASED PROGRAM

Program Planning:

The Southwest Valley Community Schools and Lenox Community Schools worked collaboratively together to bring a Capturing Kids' Hearts trainer to the area in August. This was a collaborative approach in which both schools braided funding along with this grant.

Program Description:

Capturing Kids' Hearts is the beginning of a transformational, ongoing process for teachers and administrators at a school district level. The widespread impact of *Capturing Kids' Hearts* reads like a wish list for school administrators:

- Fewer tardiness.
- Higher attendance.
- Dramatically lower discipline referrals.
- Fewer dropouts.
- Increased graduation rates.
- Higher teacher satisfaction.
- Soaring student performance.

The program consists of research-based tools and processes that, when implemented, drive classrooms to a high level of performance. It is an 18-month program with ongoing support from *Capturing Kids' Hearts* and a core group of teachers from each building to lead their colleagues in this transformation. The target population was secondary school staff with, 28 from Southwest Valley Community Schools and 22 from Lenox Community Schools.

Description of Where Program was Implemented:

The program is implemented as a school-based program in Southwest Valley Community Schools located in Corning Iowa and Lenox Community Schools located in Lenox Iowa.

Participants:

Program Name: Capturing Kids' Hearts			
Number of Individuals (or Parents) Served Directly	NA	Number of Organizations Involved in Implementation	2
Number of Children/Youth Served Directly (if applicable)	NA	Number of Staff Involved in Implementation	50

Program Outcomes:

Teachers

- 100% of staff have created a social contract with their classes using a classroom behavior tool from Capturing Kids' Hearts.
- 100% of the classroom participants are greeting students at the door and doing the handshake
- 100% of teachers reported an increase in satisfaction in the classroom

Students

- 20.4% (303/381) decrease in discipline referrals/removal from classrooms from 2017 to 2018
- 20.0% (42/50) decrease in severity of discipline referrals/in school suspensions from 2017 to 2018

Program Enhancement
As a program enhancement, two teachers completed the online Teen Leadership Curriculum. Teen Leadership provides a path for the future of education and provides a system of skills and techniques that enable teachers to speak to the emotional and psychological needs of students. Teen Leadership establishes a safe and secure environment.

Students are taught emotional intelligence and leadership skills through topics such as:

- Principle based decision making
- Choices have consequences
- Public speaking
- Personal responsibility
- Goal setting
- Preparation for school to work transition
- Importance of attitude

They also learn critical skills that benefit them in social interactions, through topics such as:

- Peer mediation
- Conflict resolution
- Healthy relationships
- Resisting peer pressure

Not only do students perform at a higher level academically, they become better people socially. Teen Leadership is one step in the process of creating a high performing school environment.

Comments:
In both districts, Lora Top and Jamie Craig the administrators of the middle school and high school, respectively, have found Capturing Kids' Hearts to give their staff more confidence in the classroom when given classroom management situations to handle. The work the teachers do to build the group at the beginning of the year and continue throughout the year have developed students who are more self-monitoring and encouraging to one another. In the high school, Jamie Craig expressed that when the students are referred to him, the consistency of what the teachers have tried in the classroom helps him when following through with discipline.

The staff in each building feel that they have implemented some things very well in their classrooms but want to continue to make the idea of relationship building more impactful among the staff. This program is not only for classroom management. It also emphasizes the importance of relationships among teachers. The administration also wants to focus on this more as we continue with this process next year and change the culture in our district.

The middle/high school principal, Mr. Still, was the guiding force behind the Capturing Kids' Hearts program. He initially found the program and felt it would be a good fit for our school

district. Mr. Still has embraced the program completely, both in his work life and his home life. He has shown not only leadership over the last year for the program, but also his emotional side. *He gets "choked up" when he talks about the changes the program has made both with students and staff.* This emotional response has made Mr. Still more relatable to both students and staff.

We have had numerous teachers give testimonials regarding the changes the program have created in their classroom. Mr. Linhart, math teacher, was new to the district last year. He reported that he taught the students in his class but didn't really make many personal connections with him. He states last year, there were many kids that quietly went about their work but didn't really speak in class. With Capturing Kid's Hearts this year, Mr. Linhart began greeting these students at the door daily, and before long built personal relationships with some of these quiet students. They now feel comfortable to talk in his classroom and share personal stories with the teacher and class. *One student in the math class was extremely quiet, not many friends, and NEVER spoke in class. With Capturing Kid's Hearts, he now speaks in all of his classes and is no longer regarded as a loner. For the first time in years, this boy smiles and seems confident, even joining the bowling team this past winter!*

D. OTHER PROGRAMS IMPLEMENTED/TRAININGS OFFERED (OPTIONAL)

N/A

E. RESOURCE AWARENESS

Web Based Resource Directory

The website is live and can be accessed at https://behavioralhealthcoalition.org/. A website training was conducted with the Coalition Leader and a community partner. Two people have administrative access to add information to the website. The website went live December 2017.

Analytics for the fiscal year include:

- 280 users
- 397 Sessions
- 860 Page views
- Average time per page: 2.17 minutes

A "one pager" with behavioral health resources has been drafted with the intent to have this on the website for anyone to download in Microsoft Word. The purpose of having a "one pager" is for anyone to customize the document for their specific needs. One of the challenges that is expected is that a behavioral resource guide will be difficult to keep current.

The Behavioral Health Coalition agenda and minutes are posted on the website along with a Google calendar that has been embedded. The Calendar has the Coalition meetings, MHFA trainings and other trainings that the community can access.

F. COORDINATION AND NAVIGATION

Communication Protocols, Solutions, and Prevention Programming

A work group consisting of various mental health providers continues to meet bi-monthly. Membership includes Mental Health Advocates, Mercy Hospital Emergency Room nurses and physicians, County Magistrate, County Attorney, Adams County Board of Supervisor representative, and staff members from Pursuit of Independence, CHOICE Inc, Imagine the Possibilities and Crossroads Behavioral Health Services.

The group has been working collaboratively and have implemented an emergency room assessment that all agencies may utilize which will assist the hospital and client when the client is brought to the emergency room. This form can be accessed on the Coalition website as well. The Adams County magistrate continues to work on the protocol document and is waiting for the Chief Judge to approve it.

G. ASSESSMENTS AND PLANNING DOCUMENTS

N/A

H. ED VISITS AND COUNTY-LEVEL HEALTH DATA

To provide additional reflection on the impact of the project, baseline hospital and community wide data related to mental health is represented in the tables below. The data represents the most current year available and will be updated annually, if available. The three tables included:

- Adams County Emergency Department Mental Health Visits
- Child Well-Being Indicators
- County Health Data Indicators

Mental Health Emergency Department Visits at CHI Hospitals

	*FY 2016	*FY 2017	% change
Corning, IA (Adams County)	58	78	34.5%
Total for 10 Project Communities	**16,165**	**17,382**	**7.5%**

*Fiscal Year: July-June
Source: CHI Health Hospital Data

Child Well-Being Indicators

	Year(s)	Adams County (Corning, IA)	Taylor County (Corning, IA)
Total Population/ages 19 & under	**2015**	3,693/809	6,213/ 1,576
	2016	3,822/848	6,209/ 1,576
Percent of births to teen mothers (age 15 to 19)	**2015**	0%	unavailable
	2016	unavailable	unavailable
Number of substantiated child maltreatment victims/rate per 1,000 population	**2015**	12.3	6.2
	2016	22.0	22.6
Percent of children ages 0-17 below poverty level	**2015**	20.2%	20.3%
	2016	22.0%	18.5%

(Source: Kids Count Data Center)

County Health Data Indicators

	Year(s)	Adams (Corning, IA)	Taylor (Corning, IA)	*Iowa*	*Nebraska*
Poor Mental Health Days (ave. # unhealthy days/30 days)	**2014**	2.9	3.1	***3.1***	***2.8***
	2015	2.8	3.4	***3.3***	***3.0***
	2016	3.2	3.3	***3.3***	***3.2***
Adult Smoking	**2014**	16%	17%	***19%***	***17%***
	2015	16%	17%	***18%***	***17%***
	2016	15%	16%	***17%***	***17%***
Excessive drinking (binge/heavy drinking past 30 days)	**2014**	19%	18%	***22%***	***21%***
	2015	20%	18%	***21%***	***20%***
	2016	21%	19%	***22%***	***21%***
Alcohol-impaired driving deaths	**2010-2014**	14%	17%	***24%***	***35%***
	2011-2015	38%	25%	***25%***	***36%***
	2012-2016	17%	33%	***27%***	***37%***
Chlamydia rate per 100,000	**2013**	179	161	***356***	***393***
	2014	275	162	***382***	***401***
	2015	--	163	***389***	***423***
Premature age-adjusted mortality rate per 100,000 (under age 75)	**2011-2013**	360	292	***309***	***302***
	2013-2015	320	315	***311***	***307***
	2014-2016	313	302	***313***	***309***
Drug overdose death rate per 100,000	**2014**	--	--	--	***7***
	2013-2015	--	--	--	***7***
	2014-2016	--	--	9	***7***
Suicide Rates per 100,000	**2010-2014**	--	--	--	***11.7***
	2011-2015	--	--	--	***12.0***
	2012-2016	--	--	--	***12.4***

(Source: County Health Rankings)

I. FINANCIAL RESOURCES AND SUSTAINABILITY

Funding from CHI Health			
Source	**Program, Strategy or Coalition Support**	**Funding Period**	**Amount**
Mission and Ministry Grant	Coalition Support, Website Development, Best Practice Trainings and Programs – MHFA Nurtured Heart Approach, Capturing Kids' Heart and Circle of Security	July 1, 2017 to June 30, 2018	$105,133
CHI Health Healthy Communities	Coalition Support	July, 2017-October, 2017	$5,000
CHI Health Mercy Corning	In Kind Time - Hospital sponsor (President), VP for Patient Services and Social Services Coordinator; In Kind meeting room for Coalition Meetings and in-kind Coalition Lunches	July 1, 2017-June 30, 2018	$20,121

Also, it is important to note that $12,000 from Southwest Valley Community Schools and Lenox Community Schools were braided together with Coalition funding which allowed the Capturing Kids' Hearts program.

Education on sustainability planning was conducted at the annual summit in May of 2018. Grant administrative staff will provide a sustainability process in the fall of 2018 to the coalitions to assist them in the development of their community specific sustainability plans.

Appendix A

Corning - Adams and Taylor Counties 12-month Output Report

Report period: July 1, 2017 through June 15, 2018

Area	Metric	Input information here (only report on activities for the six months of the report period):
Community Coalition	**Number of coalition meetings:**	11
	Dates of coalition meetings:	8/1/17; 9/7/17; 10/5/17; 11/2/17; 12/7/17 1/4/18; 2/1/18; 3/1/18; 4/5/18, 5//18; 6/7/18
	Average number of coalition members attending meetings:	11
	Number of resource directories distributed (or number of hits to web-based resource directory):	Website went live 11/30/17 There have been 859-page views with 280 users The United States is the biggest user with Japan being is the second biggest user A user-friendly document with behavioral health resources is accessible on the website
School Collaboration	**Schools collaborating with agency partners to provide programming (list schools):**	Southwest Valley Community Schools Lenox Community Schools
Trainings	**Names and dates of trainings:**	*Mental Health First Aid - Adult & Youth* July 25 & 26; September 26 & 27; November 8 & 9; November 29 & 30 and December 13-14, 2017; January 12, 2018; March 9, 2018; March 23, 2018; April 8, 2018, April 9, 2018; May 17, 2018; June 21, 2018 *Nurtured Heart Approach* February 28-March 28, 2018
	Number of participants at each training:	*Mental Health First Aid - Adult & Youth* 158 trained
	Types of training participants (across all trainings):	Number of health care workers trained: 79

		Number of law enforcement trained: 1
		Number of school personnel trained: 10
		Number of other community professionals trained: 62 (consists of faith, fire/rescue, citizens, other)
Prevention Programs	**Number of prevention programs implemented:**	3
	Names of implemented prevention programs:	Capturing Kids' Hearts Circle of Security
	Number of parents and youth participating in prevention programs (across all programs):	*Nurtured Heart Approach* Parents/Community: 17 School staff: 50
		Youth: 0
Sustainability (Year 2)	**Began developing a sustainability plan? (yes/no)**	Yes
Sustainability (Year 3)	**Sustainability plan completed? (yes/no)**	In progress

Corning - Adams and Taylor Counties Outcome Checklist

Area	Outcome	Tool/Resource	Data Collection Frequency
Community Coalition	Increased awareness of resources leads to increased use of those resources	Community Service Provider Survey	Annually (every May) by Evaluator
	Members rate coalition as effective	Coalition Member Survey	Annually (every May) by Evaluator
Emergency Department Visits and Mental Health Committals	Decrease in ED visits	CHI Health Hospital Database (same as Outputs)	Annually (every May) by Evaluator
	Decrease in mental health committals		
Trainings	Increased knowledge of behavioral health in the community	Post-training Evaluations (i.e., Mental Health First Aid)	After each training
Prevention Programs	Prevention program participants experience positive changes	Post-evaluations	At the end of program period or school year
	Prevention program participants are satisfied with the program		
	Decreased truancy in participating schools	School Attendance Records	Annually by Evaluator (data submitted by schools)

Appendix B

Behavioral Health Coalition Collective Impact Survey 2017 & 2018 Results for Corning

Introduction and Methodology

Nine out of ten CHI Health Behavioral Health Coalitions have participated in the Collective Impact Survey in 2017 and 2018. One community (Omaha Metro) has not participated in this survey. The survey is designed to evaluate the effectiveness of the coalitions within five domains: common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone organization. All active coalition members (i.e., those who attended at least one meeting in the past year) were invited to participate in the survey and rate their coalition on a number of survey items within each of the five domains.

The survey was conducted online via SurveyMonkey.

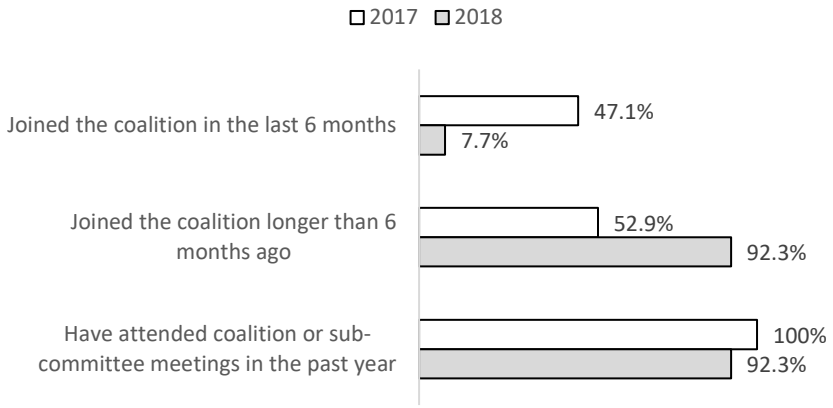
Response Rate

2017 - A total of 17 members of the coalition in Corning responded to the survey out of 38 invitees, making for a response rate of 44.7%.
2018 - A total of 13 members of the coalition in Corning responded to the survey out of 32 invitees, making for a response rate of 40.6%.

Coalition Involvement

Figure 1 shows the coalition involvement of the respondents.

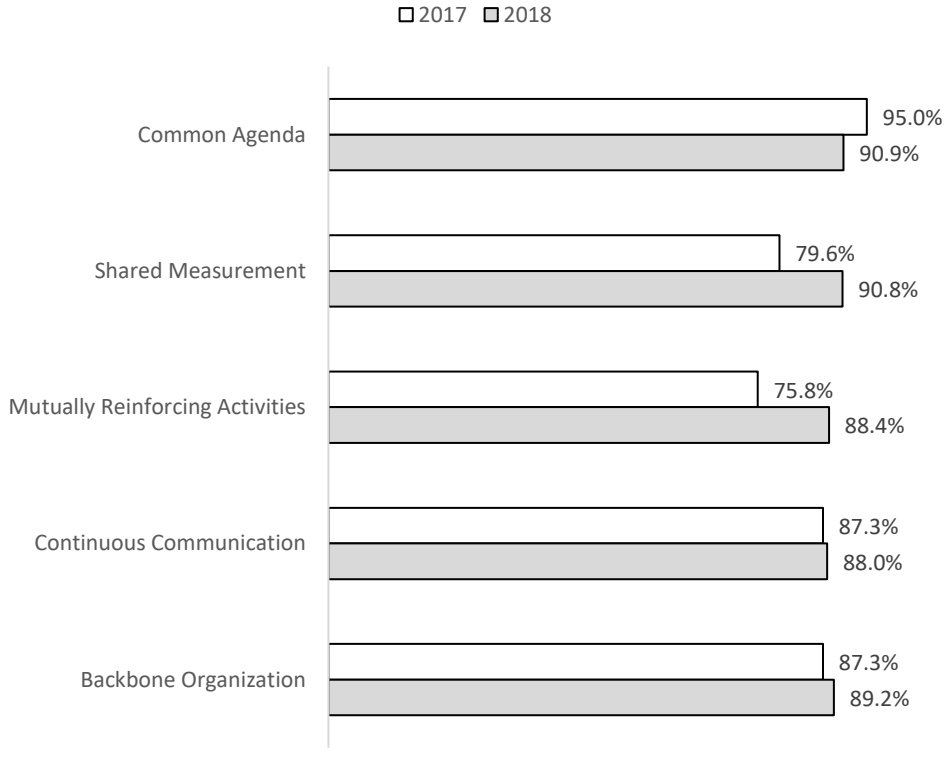
Figure 1. Coalition Involvement



AGGREGATE SCORES

Each of the five domains receives an aggregate score. The aggregate score is the average of the percentage reporting “almost always” or “always” for the statements within each domain. Figure 2 below presents the aggregates scores for each of the five domains.

Figure 2. Aggregate scores*

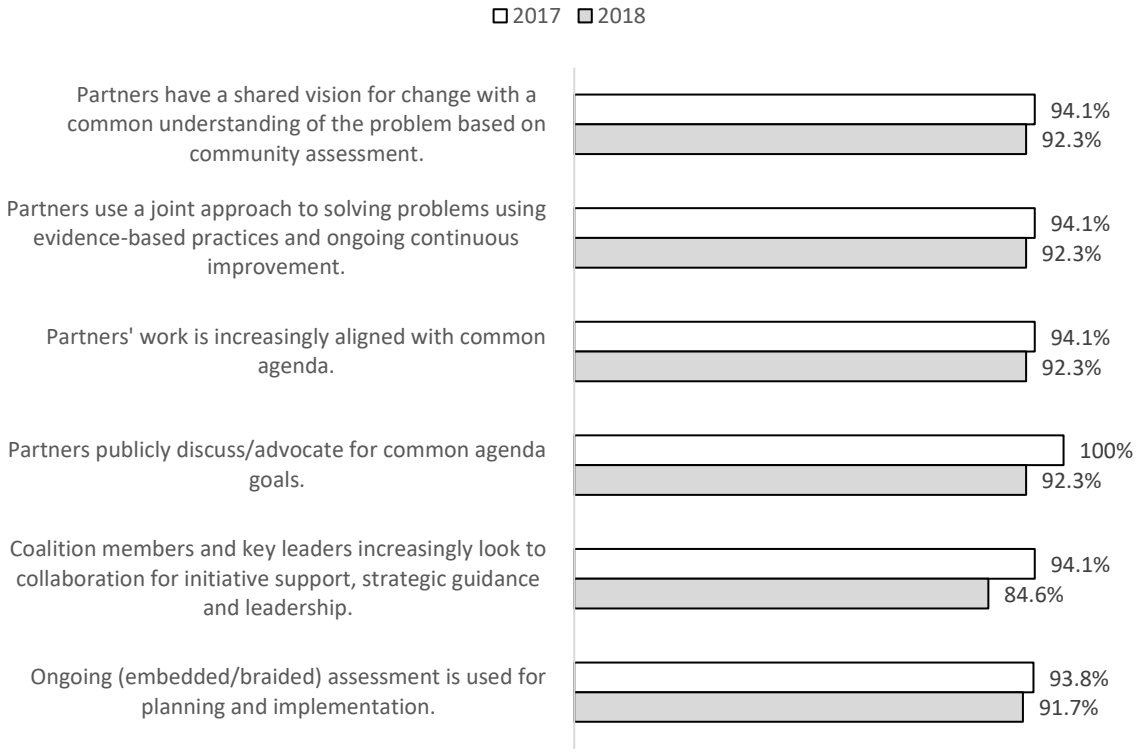


*An average of the percentage reporting "almost always" or "always" for the statements within each domain.

The remainder of this report presents the ratings for each survey item within each of the five domains of collective impact. After answering questions within each domain, respondents were given the opportunity to provide comments. Any comments that were made are included in this report.

COMMON AGENDA

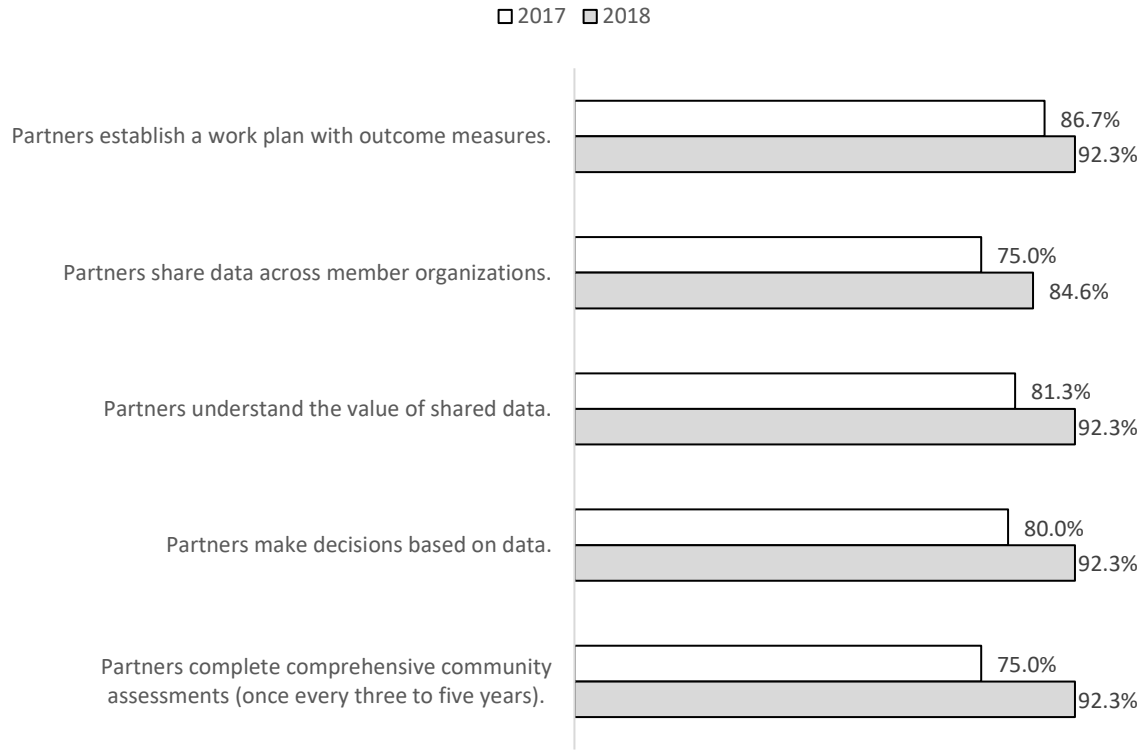
Figure 3. Common Agenda [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

SHARED MEASUREMENT

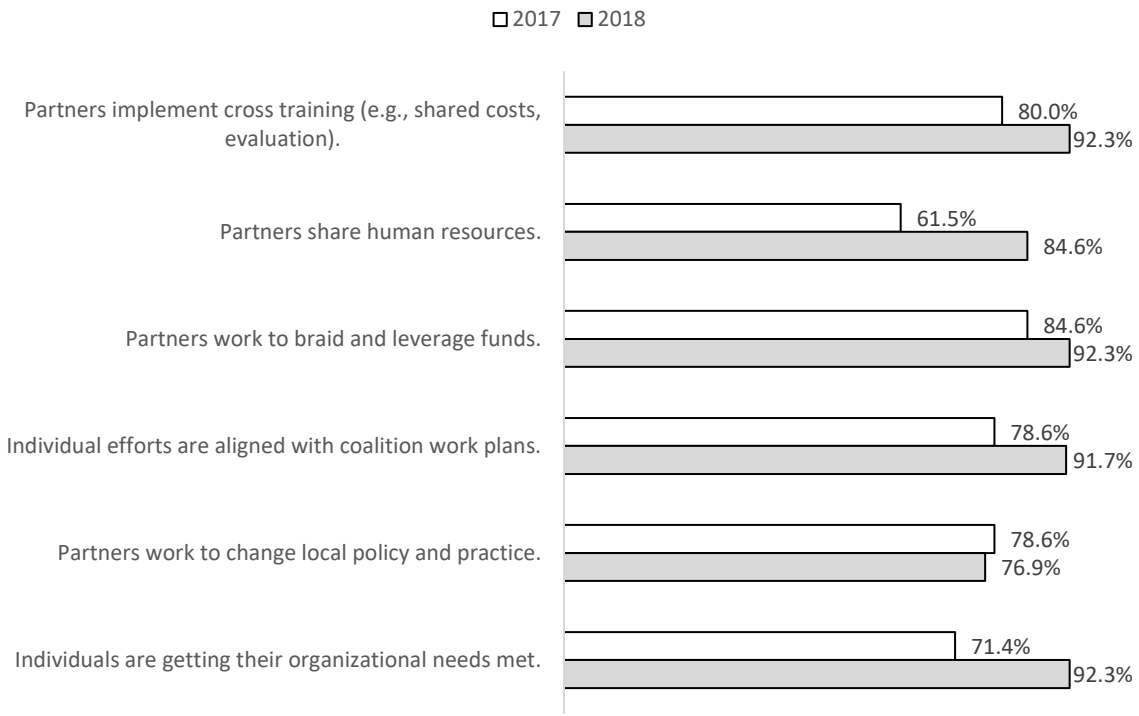
Figure 4. Shared Measurement [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

MUTUALLY REINFORCING ACTIVITIES

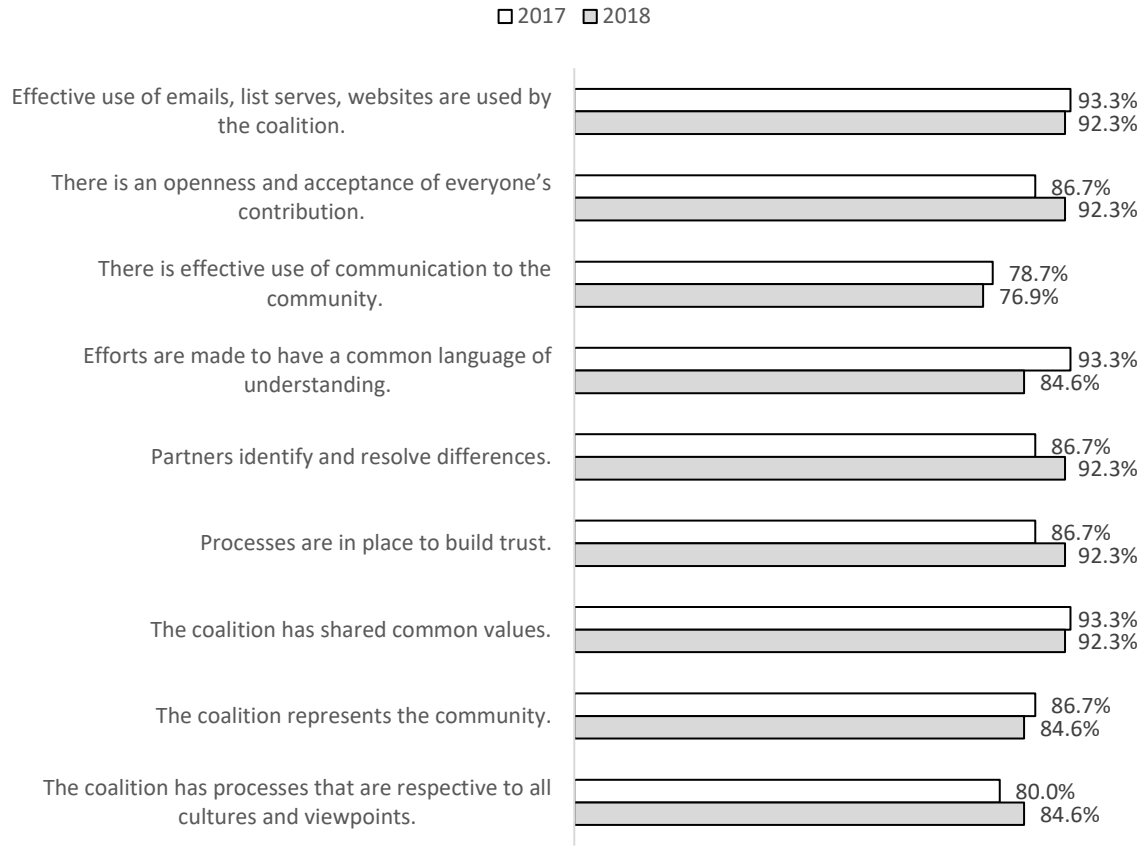
Figure 5. Mutually Reinforcing Activities [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

CONTINUOUS COMMUNICATION

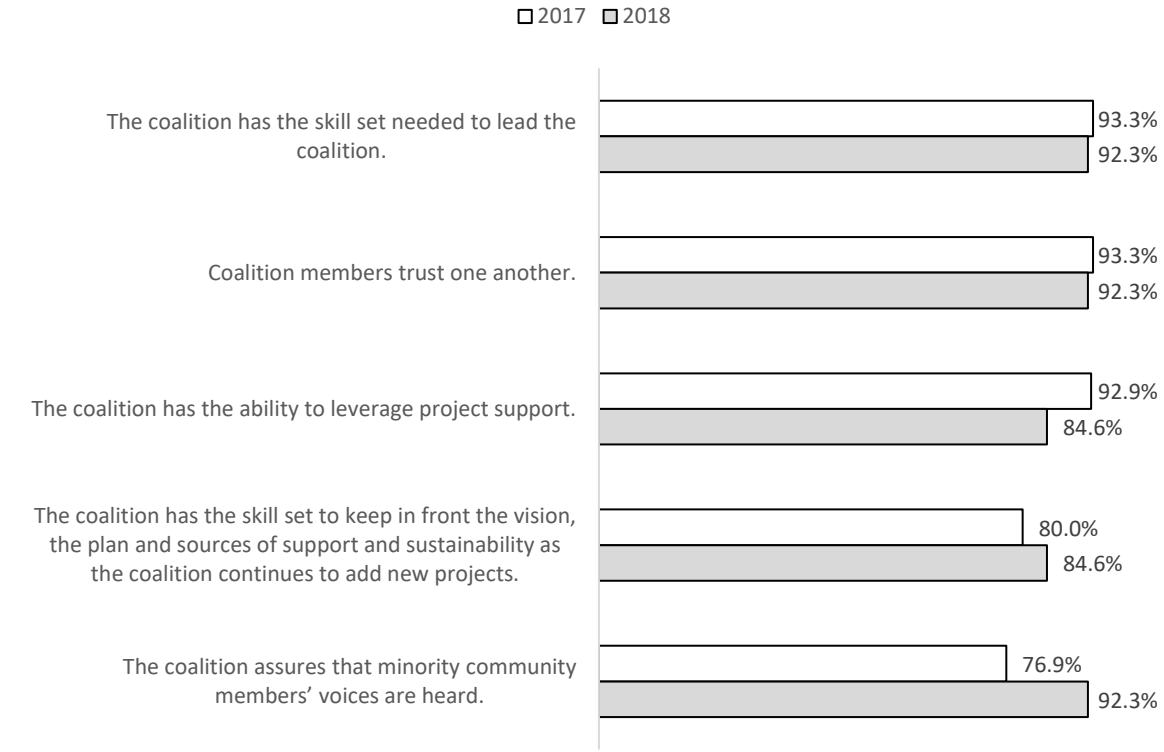
Figure 6. Continuous Communication [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

BACKBONE ORGANIZATION

Figure 7. Backbone Organization [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

CORNING - ADAMS/TAYLOR COUNTIES, IA BEHAVIORAL HEALTH IMPROVEMENT PLAN 2016-2019

Collective Vision: To increase the preventive outreach, educational efforts and resources that support the resiliency of community members who experience mental health and substance use issues.

Goals

1. Increase the overall awareness of existing and potential resources among community stakeholders through an established behavioral health community coalition.
2. Provide community-wide training on behavioral health for law enforcement, hospital staff, school personnel and other community members.
3. Implement prevention programs that educates and engages parents of children and youth 0-18.

Resources/Input

- CHI Mission and Ministry Grant Funding
- CHI Health Healthier Communities Funding
- Other Regional braided funding and MCO funding
- CHI Health Corning - Sponsor
- Community Collaborative Leaders
- Community Collaborative Partnerships
- State Bed Tracking Process

Strategies/Activities

Year 1:

- Establish a community coalition to facilitate communication and awareness of resources.
- Create a behavioral health resource guide - paper and web-based.
- Develop a collaborative communication protocol among hospital, providers, schools and law enforcement on mental health crisis and committal processes.
- Explore system solutions to address youth with chronic MH illness.
- Provide and promote Mental Health First Aid training and identify other trainings for the community to increase the skill and knowledge of behavioral health.
- Engage schools in the plan to be the conduit for connecting prevention programs with parents and youth.

Year 2:

- Promote and distribute behavioral health resource guide
- Behavioral Health training offered to stakeholders
- At least one evidence –based prevention program implemented at a minimum of two schools for parents and/or youth that may include mentoring programs, tobacco and alcohol prevention programming.
- Conduct Mental Health First Aid training with school staff in the county.
- Begin developing a sustainability plan for post grant.

Year 3:

- Community coalition continues to meet to address behavioral health issues in the community
- Other identified community needs are addressed through training and education
- Expansion of prevention programming across multiple schools and ages.
- Finalize sustainability plan and prepare to implement.

Outputs

- Number of coalition meetings and members, and number of resource directories distributed.
- Number of Emergency Department visits and committals.
- Number of schools collaborating with agency partners to provide programming.
- Number trained and type of training completed.
- Number of prevention programs implemented and the number of parents and youth participating.
- Sustainability plan established.

Outcomes

- Community Coalition shares resources formally and informally with members rate the coalition as “effective”.
- Increased awareness of community resources increases use of those resources.
- Decrease in Emergency Department visits and committals.
- Trainings increase knowledge of BH in the community.
- Teen and parents participating in programs experience positive changes and are satisfied with programming.

Behavioral Health Initiative

2nd Annual Evaluation Report

Council Bluffs – Network Mission and Ministries Subcommittee

July 2017 – June 2018

A. COMMUNITY COALITION DEVELOPMENT AND PLANNING

The Council Bluffs Behavioral Health Coalition was convened to work toward the goals of providing crisis stabilization for people seeking inpatient treatment but who do not meet inpatient criteria, improving care coordination and communication across all systems and expanding adult and adolescent detox services in the community. The coalition consists of a diverse group of stakeholders that typically meets 2 times within a 6-month period. In order to implement the strategies identified at the beginning of Year 1, the larger stakeholder group divided into workgroups that met as needed to implement specific strategies and report their progress to the larger group at coalition stakeholder meetings.

Coalition Successes

During Year 2 of the grant, from July 1, 2017 through June 30, 2018, the coalition stakeholder group met four times. Stakeholders in attendance represented a broad cross-section of the community indicating that engagement in the coalition remains strong. Organizations represented included the two local hospitals, outpatient mental health and substance use disorder treatment providers, the local federally qualified health center, homeless service agencies, the mental health disability services region, local law enforcement, and elected county officials. Average attendance at stakeholder meetings increased from the previous year from 16 to 17.5 people.

The workgroup originally involved in developing and piloting a "hybrid" Assertive Community Treatment (ACT) model demonstration project made substantial progress during Year 2. A master's-level Behavioral Health Coach was hired and the community needs assessment was completed. Efforts are currently underway to support direct care staff working in home and community-based settings (HCBS) serving clients with complex needs. In addition, ACT clients who are actively using substances have been identified. A part-time therapist was hired to assist ACT clients with substance use disorders in an effort to address gaps in services identified in the assessment. The therapist continues to collect data related to housing disruptions, incidents involving law enforcement, and hospitalizations.

Following a period of declining attendance and lack of clarity regarding next steps, the workgroup responsible for conducting a gap analysis on detox and chemical dependency issues has refocused its efforts from identifying gaps to studying the feasibility of implementing new services. Stakeholders in leadership roles within the treatment community have reengaged in the discussion and the group appears energized to move toward finding solutions to the gaps in services that exist. Progress was made by the group with regard to ruling out the existence of obstacles to licensure for establishing detox/inpatient level of care locally. At the end of Year 2, the group continues to gather data on wait time for treatment and to research cost to establish services as well as sustainability.

Coalition Challenges

Changes in the backbone organization. A challenge faced by the coalition during the reporting period involved a transition in coalition leadership from the Mental Health and Substance Abuse Network (the Network) to the Southwest Iowa Mental Health and Disability Service (SWIA MHDS) Region. The Executive Director of the Network left the organization which resulted in remaining staff, who had limited previous involvement with the coalition, assuming responsibility for continued facilitation of the project.

The time required for the new facilitator to become current on the status of each workgroup contributed to the slowing of progress experienced by the coalition overall. However, due to overlapping initiatives between the Network and the SWIA MHDS Region, the remaining staff member was absorbed by the Region and responsibility for co-leadership of the coalition has transferred to the Region. Given the long-standing working relationships that exist between Region leadership and other stakeholder organizations, improved communication and efficiency in implementation of strategies are expected.

The impact of partial funding on strategy implementation. At the beginning of Year 2 there was some confusion on the part of stakeholders with regard to the "hybrid" ACT model demonstration project. Although most are aware that the project has changed from the original scope, there remained a general lack of understanding among stakeholders of how the strategy currently being implemented differs from the original proposal.

Planning for the implementation of the "hybrid" ACT Model Demonstration Project involved a small group of stakeholder organizations. With regard to the completion of the proposal, the local hospital sponsor and Heartland Family Service worked together to draft a funding request to implement the "hybrid ACT model."

The original proposal involved assembling a team that would include a Nurse Practitioner, a Registered Nurse and a Mental Health Therapist to work specifically with habilitation and waiver home clients. In Iowa, habilitation is a service provided to people with mental illness in their own homes or shared living environments. Home and community-based services (HCBS) intellectual disabilities (ID) waiver homes typically serve individuals in their own homes or shared living environments up to 24 hours a day. Typically, 1 to 4 individuals may live together.

For purpose of this report we will refer to habilitation and HCBS ID waiver homes as group homes. Currently, clients of waiver services are not eligible to receive ACT services. The "hybrid" ACT model funded through the grant was intended to fill the gap for clients in group homes who have complex needs that go unaddressed by the habilitation or waiver services they receive.

The other gap identified by the workgroup pertained to limitations of services provided to ACT clients. Specifically, while receiving ACT services, clients are not eligible for more intensive and customized treatment services. The workgroup identified this as a major gap for clients of ACT services who also struggle with significant substance use disorders.

Ultimately, the request was only partially funded which required the workgroup to reevaluate the type of program that could be implemented. Lacking the funds to assemble the team of professionals required to implement the "hybrid ACT Model," the workgroup determined that the best use of financial resources involved hiring a Behavioral Health Coach (BHC) to serve as a resource to habilitation and waiver service providers. The shift from client-focused to staff-focused services occurred because the workgroup felt that building competencies among waiver service providers would have a more far-reaching impact than having the one grant-funded Behavioral Health Coach work one-on-one directly with clients of waiver services.

As a part of the Community Needs Assessment (CNA), the Behavioral Health Coach collected data on the number of ACT clients diagnosed with co-occurring substance use disorders recognizing that the needs of this subgroup of ACT clients are not adequately addressed by the services for which they are eligible. The workgroup also agreed to fund a part-time therapist specializing in substance use disorders to address to fill the gap.

In summary, the original planning process involved an effort to apply a modified version of the ACT model to clients of habilitation and waiver homes who have complex needs. Additionally, the workgroup identified a gap in services provided to ACT clients who struggle with substance use disorders. Having received only a portion of the funding requested the workgroup modified the strategy implementation to meet the budget while striving to have the most far-reaching impact on services provided to clients of habilitation and waiver homes and ACT services. This resulted in two separate strategies to address gaps in services. Program details of the Behavioral Health Coach and the ACT Substance Use Disorder (SUD) Treatment Enhancement will be discussed separately.

The impact of recent legislation. On March 29, 2018 Governor Reynolds signed HF2456 into law. The law expands the core services Mental Health and Disability Services Regions are required to provide calling for the establishment of twenty-two ACT teams, six "access centers," and Intensive Residential Service Homes to serve individuals across the state of Iowa. Although the administrative rules guiding implementation are not yet finalized, stakeholders are aware that the new law and subsequent rules will impact the activities of three of the coalition's workgroups: Emergency Department Alternatives, Warm Hand-off, and Detox/Treatment Feasibility.

In response, the SWIA MHDS Region and CHI Health are initiating a collaborative effort to bring together stakeholders throughout the entire Southwest Iowa Region to help develop a vision for the continuum of crisis services and services for individuals with complex needs as required by the new law. A community planning meeting is planned for late August 2018.

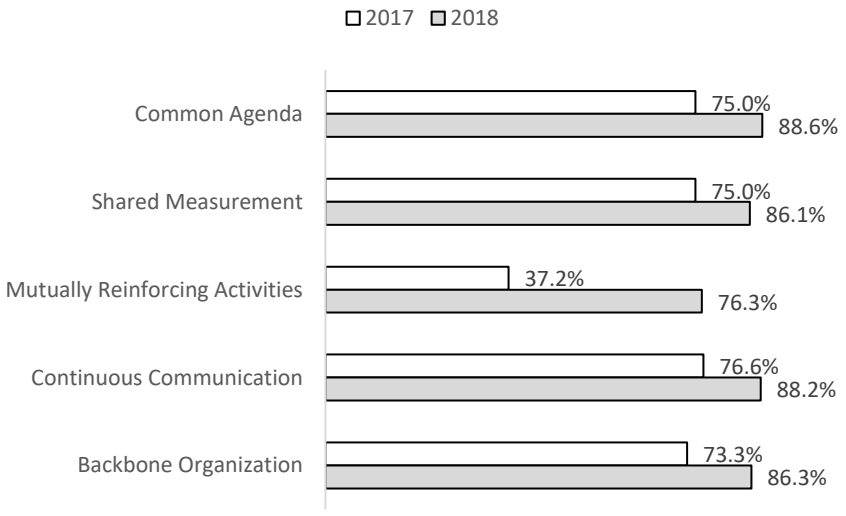
Collective Impact Survey Results:

The Collective Impact survey is designed to evaluate the effectiveness of the coalitions within five domains: Common Agenda, Shared Measurement, Mutually Reinforcing Activities, Continuous Communication, and Backbone Organization. All active coalition members (i.e., those who attended at least one meeting in the past year) were invited to participate in the survey and rate their coalition on a number of survey items within each of the five domains. The survey was conducted online via SurveyMonkey.

Response Rates:
2017 - A total of 23 members of the coalition in Council Bluffs responded to the survey out of 47 invitees, making for a response rate of 48.9%.
2018 - total of 21 members of the coalition in Council Bluffs responded to the survey out of 41 invitees, making for a response rate of 51.2%.

Each of the five domains receives an aggregate score. The aggregate score is the average of the percentage reporting "almost always" or "always" for the statements within each domain. The graph below presents the aggregates scores for each of the five domains. Ratings in all five domains increased in 2018 as compared to 2017 with the largest gain in Mutually Reinforcing Activities. The full survey results report is located in Appendix B.

Collective Impact Survey Aggregate Scores*



*An average of the percentage reporting "almost always" or "always" for the statements within each domain.

B. BEHAVIORAL HEALTH TRAINING/EDUCATION

Trainings Provided by Behavioral Health Coach to Direct Care Providers				
Date(s)	**Training Topic/Description**	**Description of Individuals Trained (community, school, parents, healthcare, etc.)**	**# of Participants**	**# of Organizations Participated**
11/14, 11/16	Understanding Mental Illness	Direct Care Staff—community-based provider (2 classes)	No staff attended the 2 trainings	0
11/29, 12/6	Compassion Fatigue	Direct Care Staff—Community-based provider (4 classes)	70	1
12/12	Understanding Mental Illness	Direct Care Staff—community-based provider (1 class)	11	1
1/29, 2/9	Compassion Fatigue	Direct Support Professionals	22	1
3/15	Understanding Bipolar Disorder	Direct Support Professionals	21	1
5/4	Professional Boundaries	Direct Support Professionals;	7	1
5/9	Body Language	Direct Support Professionals, Program Coordinators, Program Directors	7	1

11/14, 11/16, 12/12 **Understanding Mental Illness**. Trainer initially encountered difficulty getting staff to attend training. On the first two training dates, no staff attended. They are included to demonstrate the effort of the Behavioral Health Coach to provide support to the direct care staff community. After working with a Program Supervisor and the Program Coordinator, the trainer was able to develop a solution that provided staff accountability for attending training while providing coverage to the individuals in their care. After the training, attendees reported that content was relevant to their current role, was easy to understand and informative.

11/29, 12/6 **Compassion Fatigue**, attendees felt the content was relatable, the training was concise and to the point, and they enjoyed the open conversation. Open conversation led to identification of issues staff encounter which include behaviorally challenging and/or violent clients and finding ways to maintain work/life balance especially when being consistently on-call.

Compassion Fatigue 1/29, 2/5 The training for Compassion Fatigue was attended by a mixture of the residential managers and several direct support professionals (DSP). The staff found that there was a lot of good information that was shared in how to recognize the signs and symptoms of burnout and compassion fatigue. They felt that the information provided on self-care gave them a good foundation on developing a healthy self-care plan. Four trainings were scheduled over a two-week period but unfortunately two were cancelled due to low attendance and other scheduling conflicts. The trainings have attempted to be rescheduled with no success.

Understanding Bipolar Disorder 3/15 This training was requested by the Residential Coordinator as it was noticed that staff were struggling to differentiate a symptom from a behavior. The staff were appreciative of having a specific list of symptoms and being able to have open dialogue on specific examples that they've encountered. Two trainings were facilitated in the morning and afternoon in one day to accommodate both morning and afternoon staff.

Professional Boundaries 5/4 The training for Professional Boundaries was requested as the Residential Coordinators and Director were observing more lax behaviors during interactions between staff and clients. The staff were highly engaged in this training as they reported that it provided a good refresher of professional boundaries while providing several solutions for others that were unsure of what to do in an unethical situation.

Understanding Body Language 5/9 The training on Understanding Body Language was requested in response to several observations that were conducted in which the body language of the staff acted as a triggering agent to the client. This training focused on nonverbal body language that showed basic respect to the client such as eye contact and tone of voice. Body posture and being aware of their own personal triggers. Also covered topics like posture and being aware of their own triggers to help de-escalate unstable situations. Staff responded positively to the information provided and would recommend this training to others.

Outcomes:

Selected Evaluation Survey Results. The tables below present highlights from the evaluation survey results from trainings. In general, the vast majority of respondents indicated that they were positively impacted by the training in some way and would recommend the training to their peers. Overall, the staff in both trainings reported that the training was informative and the content was relatable to their current work and easy to understand.

Training participants from the **Understanding Mental Illness** and **Compassion Fatigue** trainings perceived very high improvements in their knowledge about mental illness/compassion fatigue as a result of the trainings.

My level of *knowledge* about mental illness/compassion fatigue….		
	Understanding Mental Illness	**Compassion Fatigue**
Prior to this activity was adequate. [% agree or strongly agree*]	45.5% (n=11)	35.2% (n=91)
After this activity is adequate. [% agree or strongly agree*]	100% (n=10)	82.6% (n=92)

*Response options: strongly agree, agree, neutral, disagree, disagree, strongly disagree

The evaluations from the **Understanding Mental Illness** training were positive with 100% of the participants feeling that the training was relevant to their current professional role.

Selected survey results: Understanding Mental Illness	
I would recommend this activity to my peers. [% agree or strongly agree*]	100% (n=11)
As a result of this activity, I intend to make changes to or apply new knowledge in my current practice. [% yes°]	81.2% (n=11)

*Response options: strongly agree, agree, neutral, disagree, disagree, strongly disagree
°Response options: yes, no.

The evaluation from the first **Compassion Fatigue** training was very positive with 89% of the participants agreeing to make changes to their self-care plan. They identified the barriers to identifying and addressing Compassion Fatigue in their professional lives as not having enough time, not being recognized for their work and work load. There were requests for training related to clients who have tendencies toward violence or other behavioral issues.

The evaluation from second **Compassion Fatigue** trainings was very positive with 86% of the participants agreeing to make changes to their self-care plan. They identified the barriers to identifying and addressing Compassion Fatigue in their professional lives as being exhausted, being overworked, stressed, experiencing anxiety and having clients repeat the same behavior in addition to having a high volume of work.

Selected survey results: Compassion Fatigue	
I would recommend this activity to my peers. [% agree or strongly agree*]	93.4% (n=91)
As a result of this activity, I intend to make changes to or apply new knowledge in my current practice. [% yes°]	93.1% (n=87)

*Response options: strongly agree, agree, neutral, disagree, disagree, strongly disagree
°Response options: yes, no.

The evaluations from **Professional Boundaries** were positive with 100% of the participants feeling that the content was very valuable to their current role.

Selected survey results: Professional Boundaries Training	
I would recommend this activity to my peers. [% agree or strongly agree*]	100% (n=7)
I found the content of this activity relevant to my current professional role. [% agree or strongly agree*]	100% (n=7)

*Response options: strongly agree, agree, neutral, disagree, disagree, strongly disagree

Selected survey results: Bipolar Disorder Training	
I would recommend this activity to my peers. [% agree or strongly agree*]	90.5% (n=21)
I found the content of this activity relevant to my current professional role. [% agree or strongly agree*]	100% (n=21)

*Response options: strongly agree, agree, neutral, disagree, disagree, strongly disagree

Selected survey results: Body Language Training	
I would recommend this activity to my peers. [% agree or strongly agree*]	100% (n=6)
I found the content of this activity relevant to my current professional role. [% agree or strongly agree*]	100% (n=6)

*Response options: strongly agree, agree, neutral, disagree, disagree, strongly disagree

Participants' open-ended comments about barriers to identifying and addressing the topics of the trainings in their professional role.

What are the barriers to identifying and addressing mental health symptoms/ compassion fatigue in your current professional role? (open-ended)	
Understanding Mental Illness	**Compassion Fatigue**
Working with many individuals, hearing and helping them, knowledge	Not being recognized for my work; listening; think about it; paperwork, behaviors; my way of handling stress; you feel like you're going non-stop, not as relevant in my position but sometimes it feels like there is not time to address; time; the symptoms are similar due to stress that could be related to other things outside of work; sleep, irritated, verbal abuse, take a moment to breathe; work load; watch the clients and talk to them; too close to the individual; behaviors; stress; clients and amount of hours working; understanding where your clients come from; I have lots to do; I'm always on call; lack of knowledge; myself and my negative and pessimism; not enough time; take a step back and take a break; having self-control; learn different coping skills to stay away from vicarious trauma/compassion fatigue; not able to help one person with the issues of obsessing; being too busy to slow down and look at myself, finding the time to sit and reflect; staff not helping do job duties or help care for clients; too much work (time at work, on call 24 hours, work schedule always changing), know myself, my triggers; feeling overwhelmed and taking too much on, burying feelings; too much to do with little time; I do overnights, lack of a consistent sleep schedule; Work needs; boy that's a tough one and I really need some time for self-reflection; exhaustion; more professional role; give and give; being able to say no; taking care of my needs also; always going and dealing with something; stress, anxiety; repeat of same behavior

Additional comments regarding training from the staff are as follows:

- "Good refresher…when you have been doing this kind of work for a lot of years, you tend to let things slide, or maybe not stay focused on what our roles are. I mean I can't speak for everyone just myself but it definitely was a good refresher; the discussion at the training was I think a good reminder for everyone what is wrong and what is okay when it comes to boundaries with peers. We were able to find new ideas for different

situations and were able to figure out how to handle things differently in different situations.

- "I think it was very helpful and eye opening so I think it was a very positive training that I think was good for staff to attend. Overall was a good experience; I thought it was a great meeting. We all talked and asked some questions. I did on some. It was very informative; I really enjoyed it and it was very informative. We all shared experiences with boundaries. There was a lot of feedback from everyone on different ways to handle incidents. I think every staff should go to this class."

C. SUMMARY OF PROGRAMS IMPLEMENTED

BEHAVIORAL HEALTH COACH

Behavioral Health Coach. The Behavioral Health Coach (BHC) is a master's-level therapist who was hired to conduct the Hybrid ACT Model community needs assessment (CNA), develop a plan to address gaps in service identified in the CNA, and implement strategies to address gaps. The original intent of this strategy, develop a Hybrid ACT Model to be implemented by Heartland Family Service, has changed. A Behavioral Health Coach (BHC) was hired to work with community-based providers to assess their needs and identify solutions to fill gaps in services surrounding people with complex needs. The BHC has completed the report and next steps have been identified. Additional training and professional development opportunities provided to direct care staff has been identified as a strategy to improve services.

The CNA revealed a gap between the credentials required to obtain direct care staff positions, the amount of training staff receive and the level of skill needed to work with individuals with complex needs. It was determined that efforts should focus on developing staff competencies with the belief that by increasing the level of professionalism, staff turnover would decrease and the quality of care provided to individuals in habilitation and waiver home settings would improve.

Regarding strategy implementation, the Behavioral Health Coach's primary role involves observations and consultations in group home settings and providing training opportunities to direct care staff to achieve the goals of increasing staff competency therefore decreasing client behavioral issues that have historically led to requests for inpatient hospitalization.

Description of Where Program was Implemented:

The program is currently being implemented in a community-based setting in Council Bluffs, Iowa. The four agencies originally involved in the community needs assessment have 45-50 locations throughout the local community that typically serve 3 to 4 individuals in their shared

living environment. Additional providers have requested consultations via email and/or phone as there are several clients in their care that have been identified as having complex needs

Description of Participants (i.e., community individuals, parents, youth, ages, etc.).

The Behavioral Health Coach is currently working with direct care staff from habilitation and waiver homes affiliated with Crossroads of Western Iowa, Ameriserve International, Developmental Services of Iowa and Mosaic. Approximately, 324 direct staff work for these four organizations. These organizations volunteered to participate in the community needs assessment.

Number of Participants:

Program Name: Behavioral Health Coach			
Number of Individuals Referred for Staff Consultation	9	Number of Organizations Involved in Implementation (i.e. training)	10
Number of Children/Youth Served Directly (if applicable)	N/A	Number of Staff Involved in Implementation (i.e. training)	118

Comments on Successes and Challenges:

To date, the Behavioral Health Coach continues to identify gaps in services within habilitation and waiver homes. Training to improve competencies of direct care staff working in this area has reached 57 participants within 3 organizations at the end of this reporting period (see training section)

Case Study provided by Behavioral Health Coach

Emily (name has been changed to protect identity) is a Caucasian female that is in her mid-60's. She has been residing in a wavier home for the last 8 months. She has a diagnosis of Down Syndrome, Intermittent Explosive Disorder and Schizophrenia. She has never married. Her parents are involved in her care and serve as her guardians. It was reported that she had been living in a residential facility/nursing home since before the age of 10. It is suspected that she has suffered sanctuary trauma although this has not been confirmed.

Presenting Problems

Emily was exhibiting aggression-both physical and verbal. She would use profanity and simple words to express her anger as her vocabulary is limited. She would hit staff, throw objects and make herself vomit when upset or angry. She also displayed this behavior in the Day Program and was at risk of not being able to return.

Interventions

A brief in home observation allowed me to see the layout of the home and to see how the staff and client interacted with each other. Emily was observed to be sleeping in the front room as she recently had a medication adjustment that would cause her to be drowsy. I coached staff

in understanding how adrenaline works in the brain when angry and how using large muscle movements (such as arms, legs and torso) can help bring that energy down quickly. Helping the staff problem solve places where Emily could use more large muscle movements safely such as walk indoors if need be, using an exercise ball for her to kick to staff and blowing bubbles, we were able to develop a plan that all staff would be able to implement. With staff, I discussed the possibility of her trauma and how it is affecting her behavior now in addition to assisting staff with realizing Emily's difficulty with learning in a home environment as she has always lived in institutions.

Follow up
Emily continues to do well with staff, decreasing her incidents of anger from at least daily to one or two a month over a 3-month period. Staff feel more confident when she starts to escalate and can respond quickly and positively when noticing signs of distress. Emily is attending the Day Program more and participating in more activities without incident
Staff will need to continue to practice those coping skills with Emily until it becomes a regular part of her daily routine and is committed to working memory.

ACT SUD Treatment Enhancement

ACT Substance Use Disorder Treatment Enhancement. Implementation is in the beginning stages. Baseline data have been collected from the ACT program to determine the number of individuals who have co-occurring diagnosis. Out of 76 clients receiving ACT services, 39 are actively using substances. The thirty-nine active substance users are the subgroup of ACT clients that comprise the target population.

Data are currently being collected to determine the number of housing disruptions, incidents with law enforcement, and hospitalizations experienced by ACT clients who have been identified as active substance users. The data is being compared to the general ACT population that has been identified as not having a dual diagnosis. Treatment services have not yet been offered to ACT clients.

Although the treatment model is in the planning stage, once fully implemented the substance use disorder therapist will conduct group and individual sessions with identified clients. Groups will focus on harm reduction and movement through the stages of change. Individual sessions will be held with identified clients to help them address their substance use in depth.

Description of Where Program was Implemented:
The ACT SUD Treatment Enhancement has begun implementation. The program will provide services in Council Bluffs to people in a community-based setting.

Description of Participants (i.e., community individuals, parents, youth, ages, etc.).
Once fully implemented, services will be provided to individuals receiving ACT services who have been identified as active substance users which is currently 39 individuals out of the 76 total individuals in the program.

Number of Participants:

Program Name: ACT SUD Treatment Enhancement			
Number of Individuals Served Directly	39	Number of Organizations Involved in Implementation	1
Number of Children/Youth Served Directly (if applicable)	N/A	Number of Staff Involved in Implementation	13

Comments on Successes and Challenges:

To date, more efforts have been made to identify those clients that have a dual diagnosis and provide more services to them. The substance abuse counselor has been able to contact most of those clients that are actively using substances and has begun to develop a positive working relationship with them. Several clients have been able to make small steps to address their substance use with either decreasing their use or agreeing to participate in more intensive substance use programs such as inpatient or an intensive outpatient therapy (IOP). In addition, the ACT team has had more conversations and been able to develop more specific interventions regarding client substance usage.

It has been difficult to utilize harm reduction techniques for many of the clients due to the severity of the pre-contemplation stage of change. Many clients indicate that they are complacent in the pre-contemplation stage of change and it has been difficult to find a motivator to change. The severity of their addictions makes it difficult for clients to see what abstinence from substances could be like. The substance use groups could be a practical solution to this issue but regular attendance could pose a barrier as not all clients are engaged in their treatment. Future plans include beginning open groups for those clients in the contemplation and preparation stages of change. As client's progress through the stages of change, the groups will change from open to closed to solidify their abstinence from substances.

Outcomes for ACT:

Baseline data was collected from the ACT program to determine the needs of the community in terms of serving those with a co-occurring diagnosis. Out of 76 clients participating in the ACT program as of 1/1/18, approximately 39 clients are actively using substances with the majority using alcohol, marijuana and methamphetamine. Data is being collected on how many housing disruptions those clients have had, any legal issues and subsequent hospitalizations in the past year. This is being compared to the ACT population that has not been identified as having a dual diagnosis.

Future planning for substance use includes conducting closed groups focusing specifically on harm reduction and helping clients move through the stages of change while allowing those who are in the maintenance stage of change to continue with their recovery. The ACT substance abuse therapist will also be meeting with identified clients to have 1:1 meeting with them to address their substance use more in depth.

The table below provides an average of the demographic information regarding those clients identified as actively using substances.

Gender	*Male*	29
	Female	10
Race	*Caucasian*	37
	African American	1
	Native American	1
Age (average)	*Males*	43.6 years
	Females	34.7 years
Diagnosis	*Thought disorder*	16
	Mood disorder	16
Commitments	*Mental health*	9
	Mental health/substance use	3
Legal Issues	*Males*	2
	Females	3
Average days spent with legal issues (jailed)	*Males*	23.5 days
	Females	23.6 days
Hospitalizations	*General ACT*	4
	Co-occurring	19
Average days of hospitalization	*General ACT*	5.25 days
	Co-occurring	6.79 days
Housing disruptions	*General ACT*	10
	Co-occurring	10
Stage of change (as of Feb 2018)	*Pre-contemplation*	24
	Contemplation	8
	Preparation	1
Average # of visits based on stage of change	*Pre-contemplation*	53.4 visits
	Contemplation	57.1 visits
	Preparation	33 visits
Average # of no shows based on stage of change	*Pre-contemplation*	10.8
	Contemplation	8.7
	Preparation	1.3
Treatment	Needing treatment	20
	Accepted	4
	Successfully completed	2
	Unsuccessful	2
	Currently in treatment	2

D. OTHER PROGRAMS IMPLEMENTED/TRAININGS OFFERED (OPTIONAL)

The Network operated a Community Training Opportunity program outside of this project. The program offers ongoing opportunities for behavioral health professionals to receive training related to mental health and substance use disorder related topics. During the reporting period, the Network sponsored one Community Training Opportunity titled "Hope and Trauma: The Two Sides of Sexual Abuse" presented by Sheryl Overby, MS, NCC, LIMPH from Lutheran Family Services. A total of 18 people attended the training. Overall, 94 percent of those responding to the post-training survey indicated that their skills/knowledge increased as a result of the training.

In October 2017, the Southwest Iowa Mental Health and Disability Services Region (the Region) assumed responsibility for programs and initiatives facilitated by the Network. In early 2018 the Region initiated efforts to relaunch of the Network's Community Training Opportunity (CTO) program. During May and June 2018, the Region offered two training events. The first class, titled "Borderline Personality Disorders," was presented by Dr. John Lehnhoff, Ph.D. from CHI Health Behavioral Services on May 10, 2018. A total of 42 individuals attended this training. Of those who completed the post training survey, 97 percent indicated their skills/knowledge increased as a result of the training.

On June 7th Dr. Adam Briggs, from the Munroe Meyer Institute's Center for Autism Spectrum Disorders presented "Autism Spectrum Disorders" to community providers. A total of 34 individuals attended this training. Of those who completed the post-training survey, 100 percent indicated their knowledge/skills increased as a result of the training. Both training opportunities were promoted to coalition stakeholders.

C3 De-escalation 3/28, 5/15, 5/30, 6/12, 6/15. The Region provided C3 de-escalation trainings, a total of 61 participants have taken the training with 51 completing the training in its entirety. There has been some difficulty with ensuring attendees are able to attend both sessions as it is a different format than typical trainings in that it is spaced over a 2-week period. There have been some complications with ensuring staff are able to attend both sessions as it can be difficult to get shifts covered for those 3 hours. Staff have been responding well to the training with 93.8% being satisfied with this training upon completion.

E. RESOURCE AWARENESS

Not applicable

F. COORDINATION AND NAVIGATION

Warm Handoff Process

A workgroup was convened to develop a warm handoff process. The strategy initially called for the group to explore the population health software program TAV Connect. The absence of a funding source and stakeholder buy-in has resulted in the workgroup considering other options.

During Year 2, attention shifted toward the development of a process utilizing standardized protocols and information forms with appropriate releases to improve handoffs. After much consideration, the workgroup identified two areas of communication in need of improvement: communication between community-based providers and emergency department staff on the front-end; and communication between acute psychiatric units and community-based providers upon discharge from inpatient care.

At the close of Year 2, the workgroup has completed a draft of the form that will be used to improve front-end communication. It has been suggested that given her established relationships with providers, the Behavioral Health Coach facilitate the introduction of the new process to community-based providers when the form and process are finalized.

Efforts are currently underway to improve handoffs when individuals are discharged from acute psychiatric units to their community-based providers. The workgroup has extended an invitation to all community-based providers in the local area and to representatives of the two Managed Care Organizations to attend a workgroup meeting to map the discharge communication process and identify areas for improvement. This meeting will take place shortly after the beginning of Year 3.

The efforts of this workgroup may be impacted in Year 3 by the definition of the rules associated with the implementation of services required by HF2456. Specifically, the law requires that access centers provide warm handoffs to the next service provider. The rules for implementation are currently being defined. Once complete, the workgroup will be able to determine whether it can continue on its current trajectory or whether it will need to change course to meet the requirements of the law.

G. ASSESSMENTS AND PLANNING DOCUMENTS

Emergency Department Alternatives

A workgroup was formed to study the feasibility of implementing a 23:59 observation unit. During Year 1, the workgroup members toured a similar facility at Bryan Hospital in Lincoln, Nebraska. As a result of the facility tour, identification of number of clients who would utilize this type of service locally, and lack of clear direction from Managed Care Organizations regarding funding, the members of the workgroup identified concerns were related to payer source/reimbursement for services and sustainability. Overall, the group concluded that the service is not feasible as a stand-alone unit.

Recognizing the need for a level of care between inpatient hospitalization and outpatient services, the workgroup continued throughout Year 2 to examine other options for patients not meeting admission criteria but still requiring support within the emergency department. Discussions have focused on studying the possibility of employing a psychiatric nurse practitioner and case manager to float between the two local hospitals to assess individuals

who present in the emergency department in crisis but do not require inpatient care and connect them with services within the community.

Consideration has also been given to the possibility of co-locating a crisis observation unit in a facility with other levels of care such as detox and subacute care. The progress of the workgroup may be impacted in Year 3, however, by the definition of the rules associated with HF2456. Specifically, the law requires access centers be accredited to provide crisis stabilization residential services, subacute services and substance abuse treatment simultaneously. The manner in which this is to be accomplished has not yet been defined. The SWIA MHDS Region and CHI Health are collaborating to bring together stakeholders throughout the entire Southwest Iowa Region to help develop a vision for the continuum of crisis services and services for individuals with complex needs as required by the new law. A community planning meeting is planned for late August 2018.

Detox Feasibility/Planning

A workgroup was convened to conduct a gap analyses on current detox services and chemical dependency services available in the community. The gap analysis was unable to quantify a need for specific services, however a survey of and ongoing conversations with stakeholders providing services to persons struggling with substance use issues indicate a need for detox and/or other additional services within the community.

During Year 2, the workgroup shifted from identifying gaps in existing services to studying the feasibility of implementing new services and identifying possible funding sources. To date the group has researched the possibility of obtaining licensure to establish a detox and inpatient treatment facility and has concluded that obtaining licensure will not be an obstacle.

The workgroup has been collecting data from local providers and from the Department of Public Health on treatment episodes involving local residents regardless of the location of treatment for all levels of care to establish a baseline of demand for services. Additionally, the group is in the process of obtaining data on wait time for treatment for those evaluated as needing an inpatient level of care. The purpose of the data collection is to identify the demand for detox and inpatient services originating in the local area and establish the average time individuals wait before being admitted into treatment.

Funding and sustainability represent the greatest challenge to establishing new services. While MCOs reimburse for providers for substance abuse treatment, the reimbursement rate has remained unchanged for the 20 years. Additionally, the group noted that MCOs have not been authorizing an appropriate length of treatment necessary to accomplish treatment goals.

As is the case with the other workgroups, the progress of the detox/treatment feasibility workgroup may be impacted in Year 3 by the definition of the rules associated with HF2456.

H. ED VISITS AND COUNTY-LEVEL HEALTH DATA

To provide additional reflection on the impact of the project, baseline hospital and community wide data related to mental health is represented in the tables below. The data represents the most current year available and will be updated annually, if available. The three tables included:

- Pottawattamie County Emergency Department Mental Health Visits
- Child Well-Being Indicators
- County Health Data Indicators

Mental Health Emergency Department Visits at CHI Hospitals

	*FY 2016	*FY 2017	% change
Council Bluffs, IA (Pottawattamie County)	3,307	3,562	7.7%
Total for 10 Project Communities	**16,165**	**17,382**	**7.5%**

*Fiscal Year: July-June
Source: CHI Health Hospital Data

Child Well-Being Indicators

	Year(s)	Pottawattamie (Council Bluffs, IA)
Total Population/ages 19 & under	**2015**	93,582/ 22,179
	2016	93,198/ 24,579
Percent of births to teen mothers (age 15 to 19)	**2015**	2.4%
	2016	2.5%
Number of substantiated child maltreatment victims/rate per 1,000 population	**2015**	12.9
	2016	17.4
Percent of children ages 0-17 below poverty level	**2015**	18.7%
	2016	15.1%

(Source: Kids Count Data Center)

County Health Data Indicators

	Year(s)	Pottawattamie (Council Bluffs, IA)	*Iowa*	*Nebraska*
Poor Mental Health Days (ave. # unhealthy days/30 days)	**2014**	3.1	***3.1***	***2.8***
	2015	3.4	***3.3***	***3.0***
	2016	3.4	***3.3***	***3.2***
Adult Smoking	**2014**	19%	***19%***	***17%***
	2015	19%	***18%***	***17%***
	2016	17%	***17%***	***17%***
Excessive drinking (binge/heavy drinking past 30 days)	**2014**	20%	***22%***	***21%***
	2015	21%	***21%***	***20%***
	2016	20%	***22%***	***21%***
Alcohol-impaired driving deaths	**2010-2014**	25%	***24%***	***35%***
	2011-2015	27%	***25%***	***36%***
	2012-2016	29%	***27%***	***37%***
Chlamydia rate per 100,000	**2013**	424	***356***	***393***
	2014	461	***382***	***401***
	2015	470	***389***	***423***
Premature age-adjusted mortality rate per 100,000 (under age 75)	**2011-2013**	367	***309***	***302***
	2013-2015	370	***311***	***307***
	2014-2016	381	***313***	***309***
Drug overdose death rate per 100,000	**2014**	13	--	***7***
	2013-2015	12	--	***7***
	2014-2016	12	9	***7***
Suicide Rates per 100,000	**2010-2014**	--	--	***11.7***
	2011-2015	--	--	***12.0***
	2012-2016	--	--	***12.4***

(Source: County Health Rankings)

I. FINANCIAL RESOURCES AND SUSTAINABILITY

Funding from CHI Health			
Source	**Program, Strategy or Coalition Support**	**Funding Period**	**Amount**
Mission and Ministry Grant	Coalition Leader, Behavioral Health Coach and ACT SUD Treatment Enhancement	July 1, 2017-June 30, 2018	$74,775
Healthier Communities	Coalition Leader ($5,000) and Behavioral Health Coach/ACT SUD Treatment Enhancement ($10,000)	July 1, 2017-June 30, 2018	$15,000
CHI Health Mercy	In-kind Time – Hospital Sponsor, Coalition Members and Admin Support	July 1, 2017-June 30, 2018	$9,043

Education on sustainability planning was conducted at the annual summit in May of 2018. Grant administrative staff will provide a sustainability process in the fall of 2018 to the coalitions to assist them in the development of their community specific sustainability plans.

Appendix A

Council Bluffs - Pottawattamie County 12-month Output Report

Report period: July 1, 2017 through June 15, 2018

Area	Metric	Input information here (only report on activities for the six months of the report period):
Network Subcommittee	**Number of subcommittee meetings:**	4
	Dates of subcommittee meetings:	September 13, November 8, February 14, May 9
	Average number of subcommittee members attending meetings:	17.5 subcommittee members
Crisis Stabilization	**Determine population in need of crisis stabilization (yes/no)**	Yes
	23:59 Crisis stabilization feasibility study completed? (yes/no)	Yes
	Number of patients served through new crisis stabilization services funded through grant:	N/A
Warm Hand-off	**Warm hand off process developed? (yes/no)**	In Progress
	Number of patients involved in the warm hand off care coordination process:	N/A
Expansion of Detox services	**Gap (Feasibility)analysis conducted on detox and treatment services? (yes/no)**	In Progress
	Number of individuals served through the additional detox services:	N/A
ACT SUD Treatment Enhancement	**Gap analysis/training needs assessment for ACT model completed? (yes/no)**	Yes
	Number of ACT Substance Abuse Clients:	39
Behavioral Health Coach	**Number of trainings by Behavioral Health Coach to Direct Care Providers:**	6
	Number of staff trained:	Understanding Mental Illness: 11 Compassion Fatigue: 92 Understanding Bipolar Disorder: 21

		Professional Boundaries: 7 Body Language: 7 **Total: 138 (118 individuals)**
Sustainability (Year 2)	**Began developing a sustainability plan? (yes/no)**	Yes
Sustainability (Year 3)	**Sustainability plan completed? (yes/no)**	No

Council Bluffs - Pottawattamie County Outcome Checklist

Area	Outcome	Tool/Resource	Data Collection Frequency
Crisis Stabilization	**Reduction in ED visits to CHI Health Mercy**	CHI Hospital Database	Annually (by evaluator)
	Reduction in ED visits to Jenny Edmundson Hospital	Hospital Database	
Care Coordination	**Improved behavioral health outcomes as a result of increased communication and information sharing**	TBD	TBD
ACT Model	**Increased housing stability** **Decreased incarcerations/ arrests** **Reduction of substance use** **Decrease in ED visits** **Improved daily living score**	Data tracking	Quarterly (by Heartland Services)
Behavioral Health Coach/Consultation	**Decrease in group home staff turnover** **Increase number trained staff** **Improved client outcomes (i.e., case studies)**	Data tracking	Quarterly (by Heartland Services)
Expansion of Detox services (if implemented)	**Fewer incidents of detox needed in county jails**	County Jails Database(s)	Annually (if implemented)
	Fewer incidents of detox needed in homeless shelters	Homeless Shelter Database(s)	
	Patients seeking detox services at ED decrease	Hospital Database(s)	

Appendix B

Behavioral Health Coalition Collective Impact Survey
2017 & 2018 Results for Council Bluffs

Introduction and Methodology

Nine out of ten CHI Health Behavioral Health Coalitions have participated in the Collective Impact Survey in 2017 and 2018. One community (Omaha Metro) has not participated in this survey. The survey is designed to evaluate the effectiveness of the coalitions within five domains: common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone organization. All active coalition members (i.e., those who attended at least one meeting in the past year) were invited to participate in the survey and rate their coalition on a number of survey items within each of the five domains.

The survey was conducted online via SurveyMonkey.

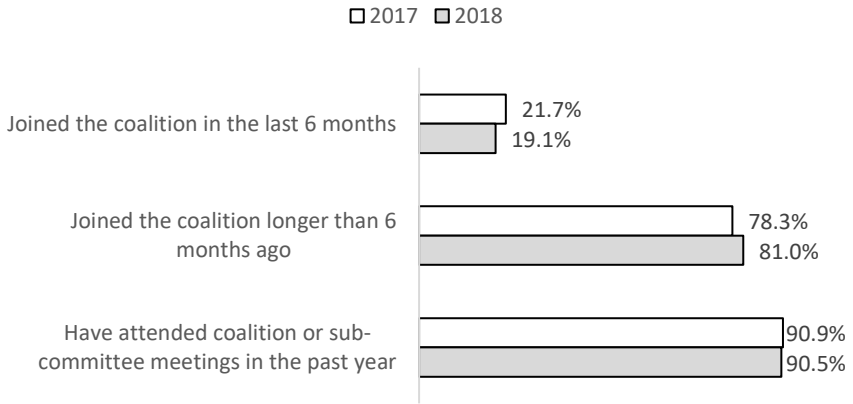
Response Rate

2017 - A total of 23 members of the coalition in Council Bluffs responded to the survey out of 47 invitees, making for a response rate of 48.9%.
2018 - total of 21 members of the coalition in Council Bluffs responded to the survey out of 41 invitees, making for a response rate of 51.2%.

Coalition Involvement

Figure 1 shows the coalition involvement of the respondents.

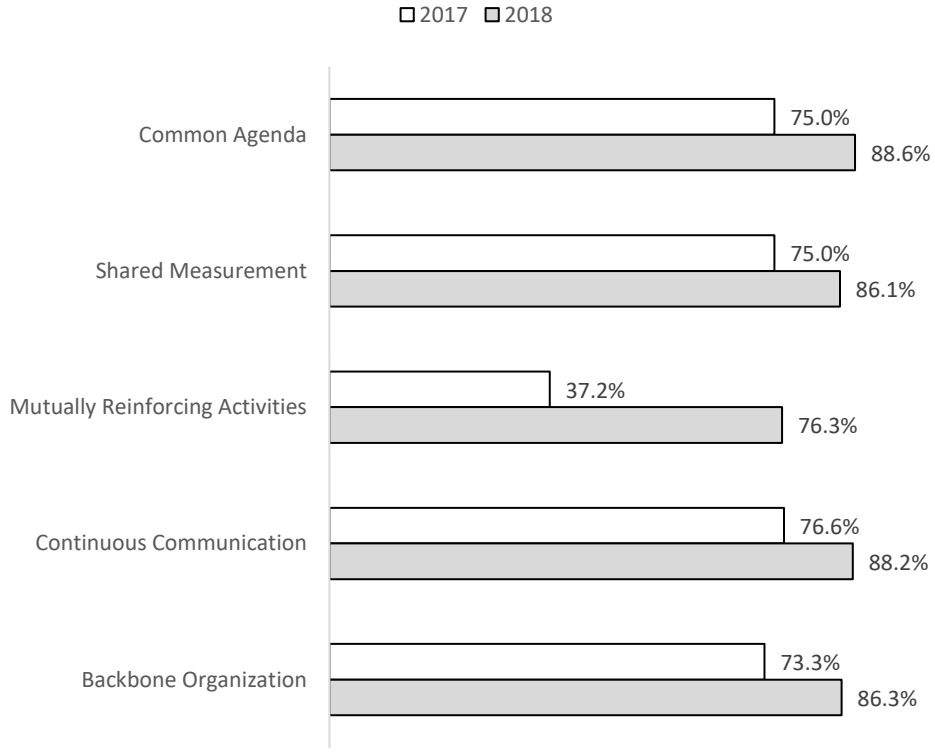
Figure 1. Coalition Involvement



AGGREGATE SCORES

Each of the five domains receives an aggregate score. The aggregate score is the average of the percentage reporting “almost always” or “always” for the statements within each domain. Figure 2 below presents the aggregates scores for each of the five domains.

Figure 2. Aggregate scores*

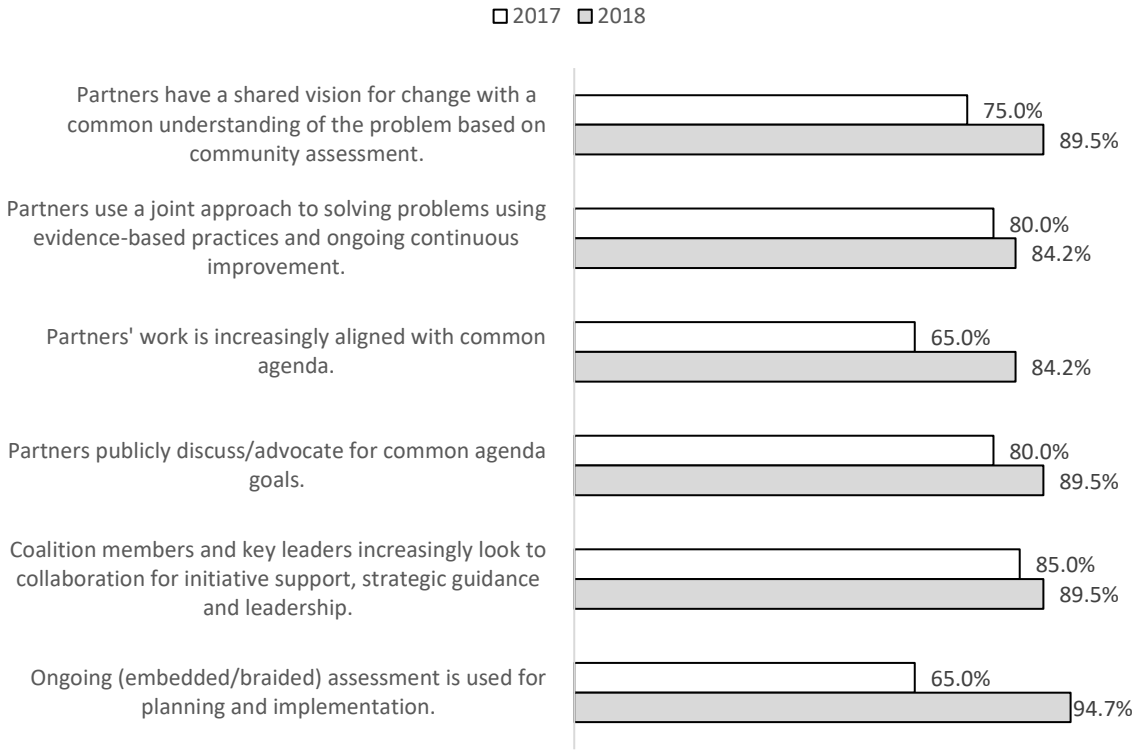


*An average of the percentage reporting "almost always" or "always" for the statements within each domain.

The remainder of this report presents the ratings for each survey item within each of the five domains of collective impact. After answering questions within each domain, respondents were given the opportunity to provide comments. Any comments that were made are included in this report.

COMMON AGENDA

Figure 3. Common Agenda [% almost always or always]*

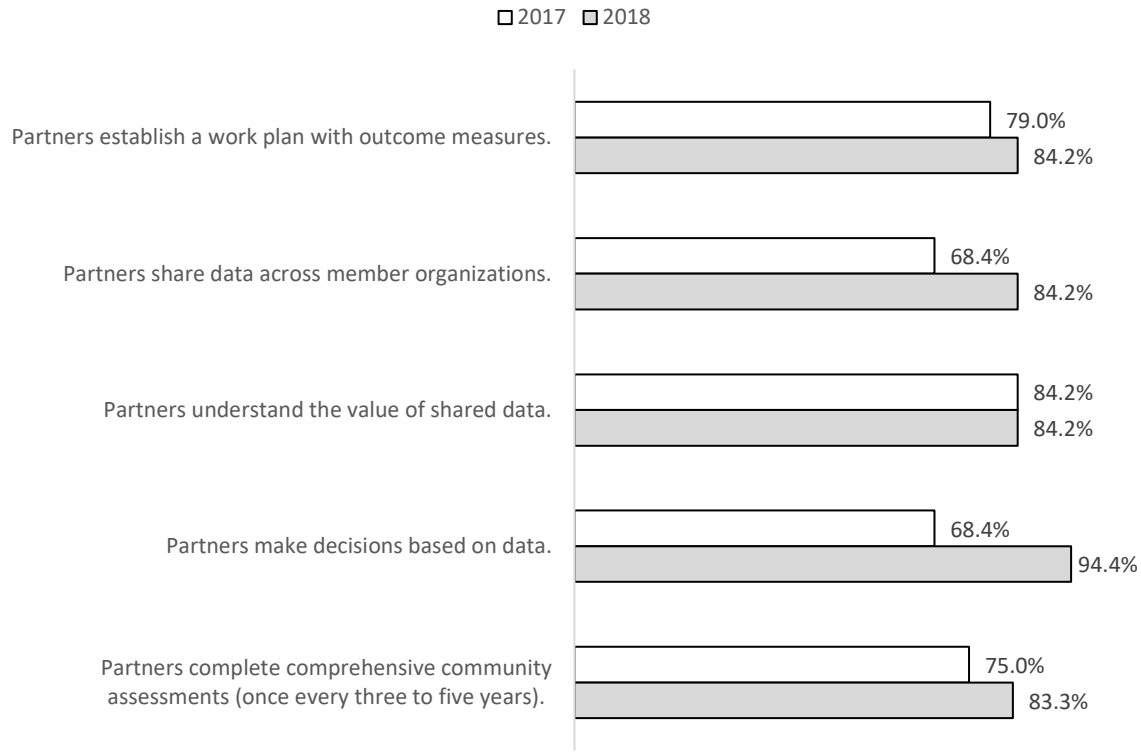


*Response options: never, almost never, sometimes, almost always, always

Comments about Common Agenda
2018
• Agendas are typically provided; however, it is disappointing that some of the individuals that are to be presenting the topic are not present. We have also reviewed the same topics regarding the 23:59, detox facility, subacute care for several months with no changes/progress to these. I often wonder if our agendas should be transitioned to another agenda/need for the community. • Moving as quickly as we can with limited funding. • There have been and continue to be huge changes in the areas of mental health and substance abuse issues and systemic changes in funding for all of these services, and it sometimes seems the planning is out of sync with the reality of dollars.

SHARED MEASUREMENT

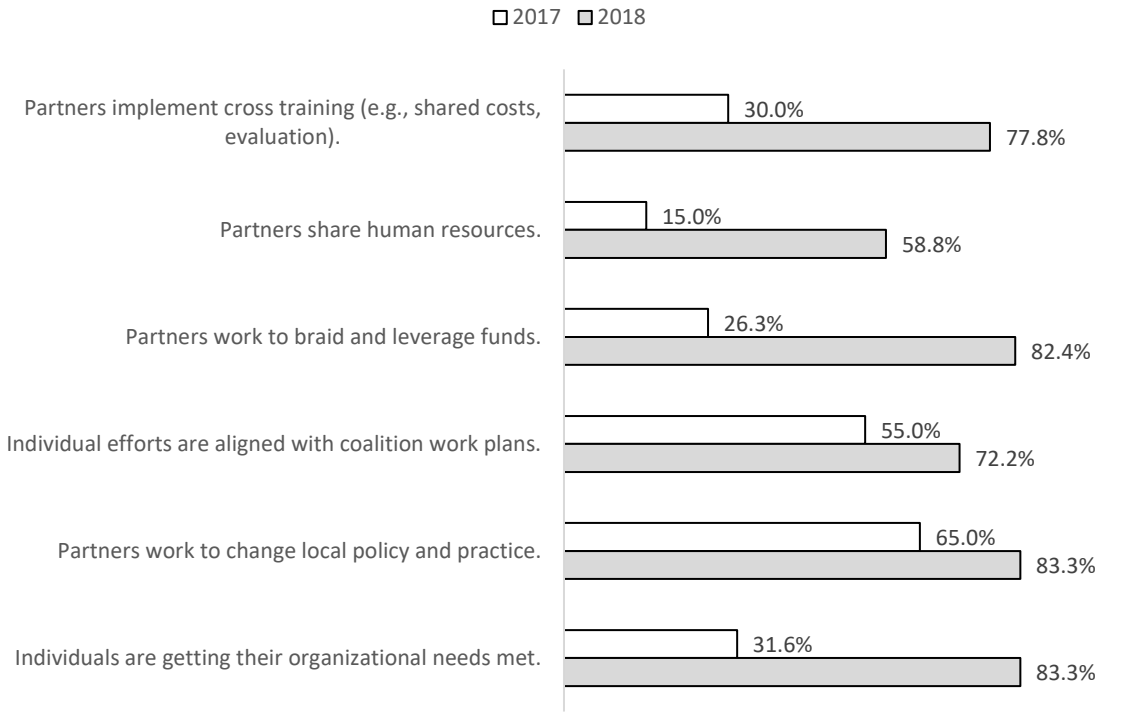
Figure 4. Shared Measurement [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

Comments about Shared Measurement
2018
• Has not yet been 3-5 years of coalition to repeat a comprehensive community assessment. • Measurements have shown that there is need for certain needs in our area but there has shown no sustainability. However, our agenda has not changed to focus on other agenda items that may be more achievable and sustainable. • Again, with all the rapid changes and political consequences of the past year, it becomes very difficult to have shared measurement systems.

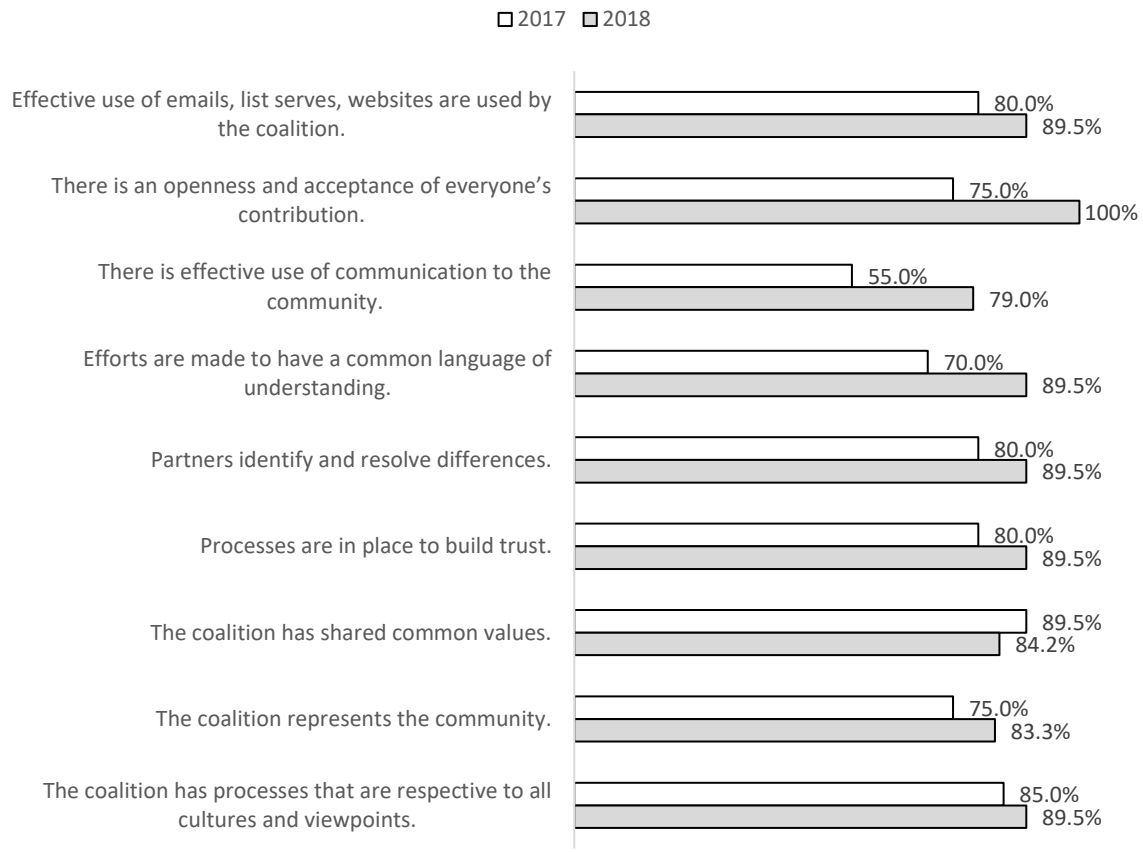
Figure 5. Mutually Reinforcing Activities [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

Comments about Mutually Reinforcing Activities
2018
• There have been positive relationships that have established from this meeting such as involvement with Heartland Family Services, Jennie Ed and CHI. However, human resources are not shared in this meeting other than networking with one another.

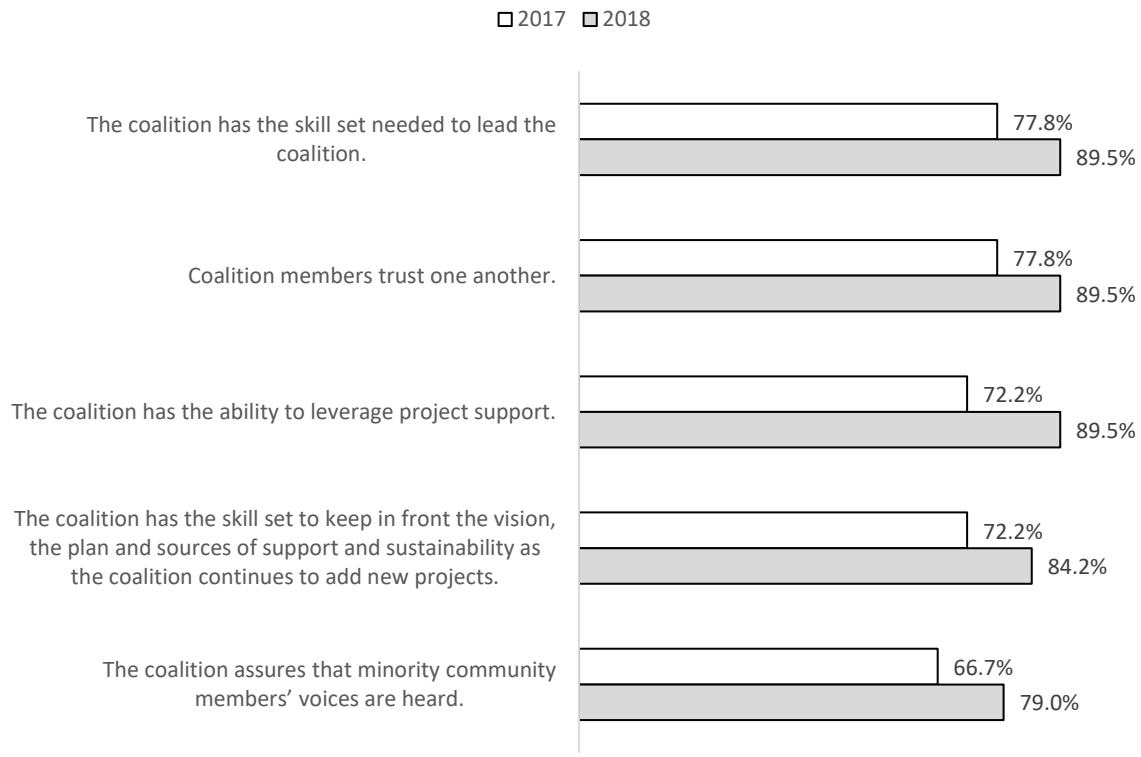
Figure 6. Continuous Communication [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

Comments about Continuous Communication
2018
• At this time, I am unsure about the communication to the community. It is not necessarily a goal of the coalition at this time to involve the general community. • The values represented within this community do not address any mental health needs for adolescents. The primary focus has been on serving adults with mental health/substance abuse related. It would be beneficial to visit with the group to see what other needs there should be met within the community.

Figure 7. Backbone Organization [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

Comments about Backbone Organization
2018
• There needs to be a project that can be determined to be sustained. At this time, there has been minimal projected deemed worthy of sustainability. • Funding, lack thereof. • The coalition attempts to have everyone's voices heard, but a lot of times agencies do not participate.

Council Bluffs/Pottawattamie County, Iowa Behavioral Health Improvement Plan 2016-2019

Collective Vision: To increase the preventive outreach, educational efforts and resources that support the resiliency of community members who experience mental health and substance use issues.

Goals

1. Provide crisis stabilization for people who seek inpatient hospitalization but do not meet inpatient admission criteria across all age groups.
2. Improve care coordination and communications across systems for all ages.
3. Expand adult and adolescent detox services in the community.

Resources/Inputs

- CHI Mission and Ministry Grant Funding
- CHI Health Healthier Community Funding
- Other braided funding through the Region and other potential resources
- CHI Health Mercy – Sponsor
- The Network and the BH Coalition - Backbone Organization
- Community Collaborative Partnerships

Strategies/Activities

Year 1:

- Determine the population in need of crisis stabilization in Council Bluffs through collected data and develop plan to address need.
- Study the feasibility of offering a 23:59 crisis stabilization service at the CHI Mercy and if feasible develop a plan for implementation.
- Develop and pilot a "hybrid" ACT model demonstration project that provides consultation to individuals in group homes and better addresses chemical dependency issues.
- Develop a "warm hand-off" process with appropriate patient releases of information for care coordination between CHI Health Mercy, Methodist Jennie Edmundson, other treatment providers, schools and other community based programs that may replicate or expand the Caring for Communities grant program process. Explore population health software program (TAV Connect).
- Do gap analysis on current detox and chemical dependency treatment services available in the community and expand as needed; explore Omaha models as part of gap analysis.

Year 2:

- Implement crisis stabilization plan(s) to increase services to identified population.
- Expand ACT demonstration model.
- Network hosts training on "warm hand-off" process and population health software program (TAV Connect).
- Implement the "warm hand-off" care coordination process.
- Determine the potential of funding for detox services with the new MCO's.
- Educate the community on the need for detox services.
- Begin developing a sustainability plan for post grant

Year 3:

- Expand crisis stabilization program(s) as needed.
- "Warm hand-off" process continues and is successful.
- Secure funding for additional detox services and implement additional services.
- Finalize sustainability plan and prepare to implement.

Outputs

- Crisis stabilization feasibility study completed.
- Number of patients served through new crisis stabilization services.
- Number of patients involved in the "warm hand off "care coordination process.
- Number of individuals served through additional detox services.
- Gap analysis/training needs assessment for "hybrid" ACT model completed.
- Number of trainings and number trained for "hybrid" ACT model implementation.
- Sustainability plan established.

Outcomes

- Reduction in ED visits to CHI Health Mercy and Methodist Jennie Edmundson.
- Improved behavioral health outcomes (to be determined in year 1) as a result of increased communication and information sharing.
- Fewer incidents of detox needed in the county jail and homeless shelters.

Behavioral Health Initiative

2nd Annual Evaluation Report

Grand Island/Hall County

H3C System of Care Subcommittee

July 2017 – June 2018

A. COMMUNITY COALITION DEVELOPMENT AND PLANNING

Purpose

Expand behavioral health prevention that educates and engages parents of children and youth 0-12 through the support of the Parent University concept and the expansion of youth and parenting programs.

Structure

Initial collaboration of this work came through the development of a subcommittee within H3C which included all partners to the CHI grant. The role of the committee was to focus on implementation of two evidence-based programs: 1) Circle of Security, a therapeutic parenting program for parents of young children; and 2) Expansion of Discovery Kids, a youth resilience program offered to elementary youth in a group setting. Circle of Security is being offered by local therapists and community agencies with funding support available for low-income parents. Discovery Kids is being offered as an after-school program to selected elementary schools in Grand Island and Hall County.

During Year 2 Hall County Community Collaborative (H3C) has an opportunity to expand behavioral health prevention work through participation in a statewide prevention System of Care. The Behavioral Health subcommittee expanded to 18, adding participants from regional behavioral health, United Way, school social workers, DHHS, CASA and Families Care, a peer organization for families with children with behavioral concerns.

A robust Behavioral Health Promotion and Prevention plan was completed in early 2018 and includes the two evidence-based programs listed above and in this grant as community-based promotion strategies. The partnership of CHI Health Saint Francis with the H3C has resulted in leveraged funds to provide participant scholarships, market programs, and ensure sustainability. The H3C Behavioral Health Subcommittee is working collectively to develop the behavioral and mental health system of care for the target population.

During this year six Circle of Security Parent classes were offered and the expansion of the Discovery Kids program was implemented fully.

Collective Impact Survey Results:

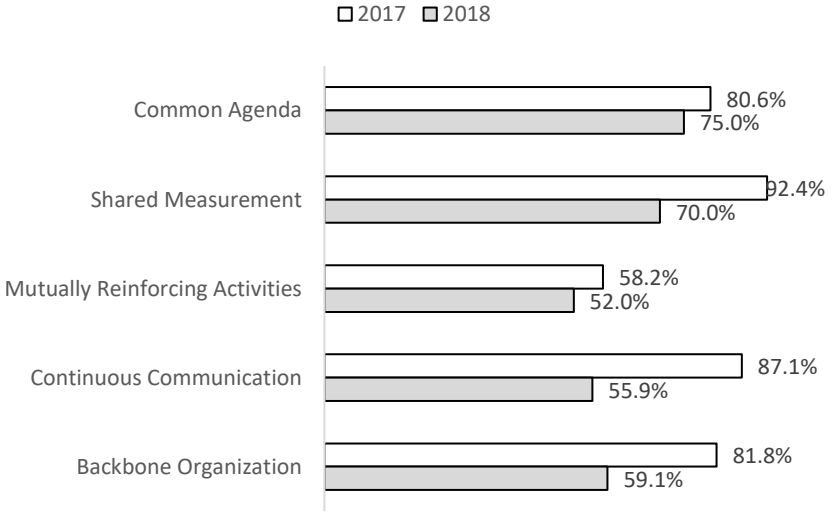
The Collective Impact survey is designed to evaluate the effectiveness of the coalitions within five domains: Common Agenda, Shared Measurement, Mutually Reinforcing Activities, Continuous Communication, and Backbone Organization. All active coalition members (i.e., those who attended at least one meeting in the past year) were invited to participate in the survey and rate their coalition on a number of survey items within each of the five domains. The survey was conducted online via SurveyMonkey.

Response Rates:

2017 - A total of 13 members of the coalition in Grand Island responded to the survey out of 25 invitees, making for a response rate of 52.0%.
2018 - A total of 15 members of the coalition in Grand Island responded to the survey out of 18 invitees, making for a response rate of 83.3%.

Each of the five domains receives an aggregate score. The aggregate score is the average of the percentage reporting “almost always” or “always” for the statements within each domain. The graph below presents the aggregates scores for each of the five domains. Ratings decreased on all five domains in 2018 as compared to 2017 and most notably within Shared Measurement, Continuous Communication and Backbone Organization. The full survey results report is located in Appendix B.

Collective Impact Survey Aggregate Scores*



*An average of the percentage reporting "almost always" or "always" for the statements within each domain.

B. BEHAVIORAL HEALTH TRAINING/EDUCATION

Trainings				
Date(s)	**Training Topic/Description**	**Description of Individuals Trained (community, school, parents, healthcare, etc.)**	**# of Participants**	**# of Organizations Participated**
4/23-4/28 2018	Circle of Security Facilitator Training - Spanish	Two Spanish speaking from Families Care, the peers support organization for children and families' behavioral health services attended.	2	1 organization added to the collaboration

The addition of two Spanish Circle of Security Parent Educators will greatly benefit the area and increase capacity.

C. SUMMARY OF PROGRAMS IMPLEMENTED

CIRCLE OF SECURITY – PARENTING

Program Description: An eight-week clinical and reflective parenting program that helps parents identify opportunities in which they are needed to support children in their moments seeking independence and to support children in their need for comfort and safety.

Description of Where Program was Implemented: Two classes of the 8-week sessions started in October and ended in December. Both were offered in Grand Island – one at the city library and one at the Early Learning Center. An additional four (4) classes occurred between January and June 2018. These classes were held in a variety of community and child care settings including Head Start, private daycare centers, and Grand Island Public Schools (GIPS). In the future, the central navigation process will be used to help register individuals and families for Circle of Security Parent classes.

In May, Circle of Security Parent Facilitators met as a group to revise the implementation policies, practices and forms, develop practices for developing an annual calendar, discuss marketing strategies, and establish a process for developing a community calendar of classes. It was determined that Grand Island-Hall County would be better served by having local marketing and website registration than the statewide system. Marketing also needs to occur in Spanish. Several members of H3C have volunteered to assist in Spanish language marketing.

Description of Participants (i.e., community individuals, parents, youth, ages, etc.).
Thirty-six (36) parents were recruited from the general community and child care centers in Hall County and other surrounding counties. Of these 18 completed classes. The completion rates improved as the year progressed. This was in part due to training held in child care centers for child care providers. Facilitators also noted that the class is too heavy for some people and so

drop out. The Facilitator team has identified a process to provide parents who are so affected by the class a referral to the Behavioral Health Prevention system for counseling if desired.

Year 2 2017-18 Circle of Security Classes

- October to November 2017: 5 began the class and 1 completed the survey
- November to December 19, 2017: 5 individuals and 4 of those completed the end survey.
- January 3 - February 21, 2018 5 individuals registered and 4 completed the end survey
- January 25-March 3, 2018 6 individuals registered and 4 completed the end survey.
- March 29-May 9, 2018 5 individuals registered and 5 completed the survey
- May - June 7, 2018 -10 Individuals registered and 8 completed the class.

Number of Participants:

Program Name: Circle of Security - Parents			
Number of Individuals (or Parents) Served Directly (completed)	18	Number of Organizations Involved in Implementation	6
Number of Children/Youth Served **In-directly** (if applicable)	67	Number of Staff Involved in Implementation	8

Comments on Successes and Challenges:

Class Implementation

→ One facilitator shared that one of the dads said he used an example from the class that week and it worked and he felt good about talking about the child's feelings instead of punishing her for not wanting to go to bed. Another success was the interaction and sharing within the group; parents talking to one another and sharing what works for them; parents wanting to be there.

→ Another facilitator noted: We had a couple in our class that was able to implement the circle at home. They noticed a big decrease in the number and intensity of behaviors. By reflecting together and having a common language to talk about parenting together, they were able to support each other, which also improved their relationship.

→ Still another facilitator noted that a mom in class had a child with self-harm behaviors such as hitting himself or banging his head. Since the class started and she began using her skills the length of her child's behavior events decreased from several hours to a few minutes.

Providing the class in a childcare center where childcare was available increased the consistent level of participation in one class.

Infrastructure Concerns:

1. Trained facilitators not providing training in community.

→ Persons being trained as COS Facilitators and other train the trainer programs are not providing the trainings in the community. One COS-PF left the area, one only train in-house.

- To address the issue of training people who then do not enhance the community system, H3C has changed the contracting process for paying for training and for providing services and will now contract with the employing organization rather than directly with staff from organizations. Contracts will include commitment by organizations to have those trained work in the community-based system a certain number of classes each year. While care and compassion will be given for family and individual circumstances, contracts will also include a clause for repayment of training fees if obligations are not met.

2. Common Practices and Use of Forms by Facilitators
   → Challenge: Submission of completed documents in a timely manner to a central source. Everyone using the same documents. Need for an improved administrative process for tracking classes.
   - The facilitator group has met and revised implementation practices.
   - A Registration Form has been devised.
   - The Scholarship application has been retired as it was seen to not be trauma informed. The needed information is now on the Registration form
   - 8 Tool Boxes have been developed (for facilitators and an extra for the office in case of loss). The file boxes have been filled with enough forms and handouts and Certificates of Completion for 3-4 classes (depending on size). Additional copies were ordered and are on file at H3C.
   - H3C has established a policy that reimbursement of facilitators for classes occurs upon receipt of specific documentation.
   - All documentation is now to be turned into a designated H3C person.

3. Class Schedule and Size
   → Challenge: Classes have been running as facilitators find students and without a central approval process. There has been no common promotion or community sign up process. Some classes are small to start. There is a high dropout rate. Parents dropping out and not completing the 8 sessions is a challenge. Noted by one facilitator, "It's a pretty intense class. Some participants didn't come back after a certain chapter."

   - The Facilitator Team will now set class schedules six months in advance.
   - Classes will be posted and advertised locally.
   - There will be online registration as well as in person registration in for classes.
   - Classes will be advertised through H3C Constant Contact. The notice will be able to be printed as a poster.
   - If a class is not full, classes will be combined.

- The H3C Central Navigator, who handles over 150 referrals a year will have the class list.

4. Common Evaluation Process:
   → Challenge: Each funding source has its' own evaluation even though all use the same forms.
   - In conversation with Sami Bradley, Nebraska Children and Families Foundation and Joyce Schmeeckle, Schmeeckle Research, CHI Health Contracted Evaluator, it was determined that until the end of the CHI grant Schmeeckle Research will do all of the Circle of Security data analysis and reporting. At the time that the CHI grant ends Nebraska Children contract evaluator, UNO Monroe Meyer Institute will assume these responsibilities.

Outcomes:
A total of 27 Circle of Security participant surveys were collected from participants upon completion of the class. Seven survey items (#3 through #9) ask participants to rate themselves and their parenting before and after the class. Participants rated each of these seven items as improving after completing the class.

Circle of Security Participant Survey Results							
		Strongly Disagree (1)	**Disagree (2)**	**Neutral (3)**	**Agree (4)**	**Strongly Agree (5)**	***Average (1-5)***
1. Meeting with a group of parents was helpful to me. (n=27)		0.0%	0.0%	7.4%	33.3%	59.3%	*4.52*
2. The leader did a good job working with my group. (n=27)		0.0%	0.0%	0.0%	14.8%	85.2%	*4.85*
3. My level of stress about parenting is high. (n=27)	BEFORE	3.7%	14.8%	18.5%	22.2%	40.7%	*3.81*
	NOW	18.5%	**51.9%**	18.5%	7.4%	3.7%	*2.26*
4. I have a positive relationship with my child(ren). (n=27)	BEFORE	7.4%	7.4%	22.2%	37.0%	25.9%	*3.67*
	NOW	0.0%	3.7%	7.4%	37.0%	**51.9%**	*4.37*
5. I recognize the behaviors that trigger my negative response to my child (i.e., my "shark music"). (n=27)	BEFORE	25.9%	22.2%	22.2%	25.9%	3.7%	*2.59*
	NOW	3.7%	0.0%	3.7%	**48.1%**	**44.1%**	*4.30*
6. I identify and respond to my child's needs for support and for comfort and contact (the top and bottom of the circle). (n=27)	BEFORE	3.7%	25.9%	51.9%	14.8%	3.7%	*2.89*
	NOW	0.0%	0.0%	3.7%	**40.7%**	**55.6%**	*4.52*
7. When I fail to respond to my child's need (I step off the	BEFORE	11.1%	29.6%	33.3%	22.2%	3.7%	*2.78*

Circle), I look for a way to repair our relationship. (n=27)	**NOW**	0.0%	7.4%	0.0%	**40.7%**	**51.9%**	*4.37*
8. I step back and think about what my child's behavior is telling me about his/her needs before I react (the Circle and Hands). (n=27)	BEFORE	33.3%	25.9%	29.6%	7.4%	3.7%	*2.22*
	NOW	0.0%	0.0%	7.4%	37.0%	**55.6%**	*4.48*
9. I feel confident that I can meet the needs of my child(ren). (n=27)	BEFORE	7.4%	22.2%	37.0%	18.5%	14.8%	*3.11*
	NOW	0.0%	0.0%	0.0%	29.6%	**70.4%**	*4.70*

Following is a selection of comments from Circle of Security participants.

Circle of Security Participant Survey Open-Ended Survey Item: Is there anything you would like to tell us about your experience with the Circle of Security parenting class? (selection of responses)
• It has helped me to notice and deal with situations and be aware of where my kids are at on the circle. • I enjoyed the class. A lot of the things I felt I was doing already but the class opened up my eyes about being with my children more. • Really enjoyed the class and learning more about child development. • It really opened my eyes about my children's needs. • Taught me that you can be a good parent 30% of the time. Meaning it's okay that I had my faults and there's a way to fix it. • It really opened my eyes in ways that I wasn't really thinking of. I react to my children differently now. • I very much enjoyed this class and it helped me improve my parenting. • Hearing other parents struggle with similar situations helps remind you you're not alone! • It was a great class. Recommend anyone with kids take it. • This program helped me to see and understand my child's needs and how I can help them and myself. • Great information to adjust thought process about why children have certain needs. • I learned that a child does not act out just to simply act out - that there is a need that he/she needs met.

Facilitator Success Story

One dad said that he has this parenting down pretty good. When we were talking about how the circle has impacted them his response was this, "I used exactly what you said about that example you gave about your daughter talking about how she was mad. So, I decide to try it with my daughter who is the same age I asked her, "You are feeling mad aren't you? Why are you mad?" He said it really worked and he was able to learn more about what was going on

with his child because he responded by "being with" instead of normally having to punish her for not wanting to go bed.

DISCOVERY KIDS

Description of Where Program was Implemented:

1. Starr Elementary School, Grand Island (20 of 20 youth completed the program)
2. Knickrehm Elementary School, Grand Island (14 of 14 youth completed the program)
3. Howard Elementary School, Grand Island (11 of 14 youth completed the program)
4. Dodge Elementary School, Grand Island (16 of 17 youth completed the program)
5. Lincoln Elementary School, Grand Island (18 of 18 youth completed the program)
6. District 1-R School, Hall County (20 of 20 youth completed the program)
7. Doniphan-Trumbull, Hall County (19 of 20 youth completed the program)

Description of Participants (i.e., community individuals, parents, youth, ages, etc.).
Discovery Kids is a seven-week educational program targeting youth in grades 2 through 5 (ages 7 – 10) in Grand Island and Hall County. The program addresses dangers of tobacco, alcohol and drug use; identifying and expressing feelings in ways that are not hurtful; variety of problem-solving, coping and self-care strategies; and development of self-esteem and self-worth. Each series of Discovery Kids ends with a family celebration that may include all family members living in the Discovery Kids participant's home.

Number of Participants:

Program Name: Discovery Kids			
Number of Individuals (or Parents) Served **Indirectly**	309	Number of Organizations Involved in Implementation	9
Number of Children/Youth Served Directly (if applicable)	123	Number of Staff Involved in Implementation	5

Comments on Successes and Challenges:
Grand Island Public Schools are a great partner in the community, especially where youth are concerned. They eagerly invite Central Nebraska Council on Alcoholism and Addictions (CNCAA) in to offer Discovery Kids. During the second half of this fiscal year, two Hall County Schools were also excited to offer Discovery Kids – this is the first time that Doniphan-Trumbull has invited CNCAA in for an after-school program.

CNCAA provides the seven-week educational series with paid staff and, for the seventh session, invites the Grand Island Police Department (for schools in Grand Island) and the Hall County Sheriff's Department (for Hall County Schools) in to talk more about gangs and drug prevention. CNCAA also invites the Community Outreach Coordinator with CHI Health St. Francis Cancer Treatment Center to the family celebration to provide education/information related to tobacco prevention to youth and their families. Quit Kits are provided free to all interested,

thanks to our partnership with Tobacco Free Hall County. CNCAA is sure to provide a bilingual interpreter at the family celebrations for all adults who speak only Spanish.

Of the 102 families, 86 attended the family celebrations. The family celebration is a great time to showcase what the youth learn in Discovery Kids and highlight additional programs/services that are available in the community for families to engage in.

Outcomes:

- 118 of 123 youth completed the Discovery Kids Program (96%)
- 86 of 102 families attended the family celebrations (309 youth and adults) (84%)
- 72 of 74 parents who completed parent survey reported that they feel more prepared to talk with their child(ren) about alcohol, tobacco and other drugs (97%)

Parent Comments:

- I liked having more ways to approach different situations than just the everyday "no"
- I liked the talks we had afterwards and the positive feedback
- My daughter is able to use what we have tried teaching her at home but more of an elaborate way and gained more skill sets in ways to approach different situations
- My child is more confident
- My child has been able to express more emotions and is more aware of existing addictions
- They are better prepared for any situation that involves better behavior and how to handle bad peer pressure
- My son is the only male at home, for me as a mom, it is difficult to talk about addictions
- This program facilitates communication, and he understands what is good and bad for his future
- My son has been able to use strategies when he gets angry to control himself better
- My child felt a sense of purpose and belonging in the group, that was nice to see
- Great conversations about topics that were covered
- Youth more vocal about adults/parents needing to quit tobacco, how bad tobacco is for your body; youth more educated about alcohol, tobacco and marijuana
- #1 thing they liked about DK is that their child loved going to the program and looked forward each week to going
- My child learned how to handle stress, how to say "no," and how to handle peer pressure
- Awesome program. I feel like this program does the hard part for a parent. Sometimes as a parent we feel embarrassed to talk to our kids about drugs, alcohol, etc. so this was extremely awesome! Keep up the good work!
- My daughter now loves to speak up for herself; she really did enjoy the "how to say no" activity
- Discovery Kids taught my child to stay away from those things (alcohol, tobacco and other drugs); she is always talking about what she learned to everybody

- My child speaks more openly about these difficult subjects; it gave her a positive space to learn hard subjects
- Seems like my child wants to talk about situations and things to stay away from and how to remove herself from a wrong situation

Discovery Kids Pre-Post Evaluation Summary Results

A total of 102 matching pre-post surveys were collected for Discovery Kids. The results indicated improvement from pre-to post on all five survey items listed in the table below that pertain to the outcomes of the grant, but substantial improvement on the first three survey items listed; knowing the dangers of substances and understanding peer pressure, with the skills to say "no".

Discovery Kids: Pre-Post Survey Results		
	Pre	**Post**
1. I know about the dangers of using alcohol, tobacco, and marijuana. [% lots*] (n=101)	63.4%	**88.1%**
2. I understand what peer pressure is. [% yes°] (n=100)	30.0%	**82.0%**
3. I have the skills I need to say "no" to peer pressure. [% yes°] (n=100)	43.0%	**90.0%**
4. I know how to set a goal and make plans to reach it. [% yes^] (n=102)	86.3%	**94.1%**
5. When I stop and think, I make better choices. [% almost always#] (n=101)	54.5%	**65.3%**

Note: only youth who completed both a pre-and a post-survey are included in the analysis in the table above.
*Response options: lots, a little bit, not at all
°Response options: yes, no, not sure
^Response options: yes, no, I don't have any goals
#Response options: almost always, sometimes, never

D. OTHER PROGRAMS IMPLEMENTED (OPTIONAL)

Not applicable

E. RESOURCE AWARENESS

Not applicable

F. COORDINATION AND NAVIGATION

Not applicable

H. ED VISITS AND COUNTY-LEVEL HEALTH DATA

To provide additional reflection on the impact of the project, baseline hospital and community wide data related to mental health is represented in the tables below. The data represents the most current year available and will be updated annually, if available. The three tables included:

- Hall County Emergency Department Mental Health Visits
- Child Well-Being Indicators
- County Health Data Indicators

Mental Health Emergency Department Visits at CHI Hospitals

	*FY 2016	*FY 2017	% change
Grand Island, NE (Hall County)	746	892	19.6%
Total of all 10 CHI Health Coalition Communities	**16,165**	**17,382**	**7.5%**

*Fiscal Year: July-June
Source: CHI Health Hospital Data

Child Well-Being Indicators

	Year(s)	Hall (Grand Island, NE)
Total Population/ages 19 & under	**2015**	61,680/ 18,089
	2016	61,705/ 18,231
Number/percent of births to teen mothers (age 17 and under)	**2015**	27/2.8%
	2016	22/2.3%
Number of juvenile arrests/rate per 1,000 population	**2015**	593/82.7
	2016	543/73.6
Number of substantiated child maltreatment victims/rate per 1,000 population	**2015**	135/8.1
	2016	106/6.3
Number in out-of-home care/ rate per 1,000 population	**2014**	193/11.6
	215	206,12.2
Percent of children ages 0-17 below poverty level	**2010-2014**	22.5%
	2011-2015	21.9%

(Source: Kids Count Data Center)

County Health Data Indicators

	Year(s)	Hall (Grand Island, NE)	*Nebraska*	*Iowa*
Poor Mental Health Days (ave. # unhealthy days/30 days)	**2014**	2.8	***2.8***	***3.1***
	2015	3.1	***3.0***	***3.3***
	2016	3.1	***3.2***	***3.3***
Adult Smoking	**2014**	17%	***17%***	***19%***
	2015	17%	***17%***	***18%***
	2016	16%	***17%***	***17%***
Excessive drinking (binge/heavy drinking past 30 days)	**2014**	18%	***21%***	***22%***
	2015	19%	***20%***	***21%***
	2016	18%	***21%***	***22%***
Alcohol-impaired driving deaths	**2010-2014**	31%	***35%***	***24%***
	2011-2015	31%	***36%***	***25%***
	2012-2016	32%	***37%***	***27%***
Chlamydia rate per 100,000	**2013**	375	***393***	***356***
	2014	385	***401***	***382***
	2015	355	***423***	***389***
Premature age-adjusted mortality rate per 100,000 (under age 75)	**2011-2013**	300	***302***	***309***
	2013-2015	303	***307***	***311***
	2014-2016	321	***309***	***313***
Drug overdose death rate per 100,000	**2014**	--	***7***	--
	2013-2015	--	***7***	--
	2014-2016	--	***7***	9
Suicide Rates per 100,000	**2010-2014**	11.7	***11.7***	--
	2011-2015	12.2	***12.0***	--
	2012-2016	12.9	***12.4***	--

(Source: County Health Rankings)

I. FINANCIAL RESOURCES AND SUSTAINABILITY

Funding from CHI Health			
Source	**Program, Strategy or Coalition Support**	**Funding Period**	**Amount**
Mission and Ministry Grant	H3C Subcommittee Facilitation, Circle of Security – Parents and Discovery Kids Program Implementation	July 1, 2017-June 30, 2018	$46,319
CHI Health St. Francis	In kind time, meeting space, lunches and refreshments for meetings.	July 1,2017-June 30, 2018	$4,859

Grants and Funding Awarded Directly to the Coalition other than from CHI Health			
Source	**Program, Strategy or Coalition Support**	**Funding Period**	**Amount**
Nebraska Children and Families Foundation /Private Funders	Infrastructure and Training	January 1, 2018 – December 31, 2019	$60,325
Nebraska Children	Direct Services (family basis) for	January 1, 2018 –	$230,000

and Families Foundation /Private Funders	Behavioral Health Prevention for families of children 0-21 with undiagnosed behavioral health concerns. (May be used for scholarships for COS)	December 31, 2019	
Rooted in Relationships		July 1, 2017 -June 30, 2018	$3,350

During this time, we have also worked on sustainability planning. As follows:

1) Included Circle of Security Parenting Classes in a new Rooted in Relationship grant for early childhood behavioral health, to enhance capacity. Included COSP scholarships in the service delivery of that process so that multiple funds are used.

2) Undertook NE System of Care for Children's Behavioral Health Prevention Planning for a multi-county area including Hall County. As part of System of Care work the decision was made to have all of the BH work be under one committee to ensure ongoing integration.

3) Participated in education on sustainability planning that was conducted at the annual summit in May of 2018. Grant administrative staff will provide a sustainability process in the fall of 2018 to the coalitions to assist them in the development of their community specific sustainability plans.

Appendix A

Grand Island - Hall County 12-month Output Report

Report period: July 2017 – June 15, 2018

Area	Metric	Input information here (only report on activities for the six months of the report period):
H3C Behavioral Health Subcommittee	Number of subcommittee meetings:	6
	Dates of subcommittee meetings:	8/3/17;10/5/17;11/16/17; 2/1/2018; 4/5/2018;6/7/2018
	Average number of members attending meetings:	15
Circle of Security	Implementation plan developed? (yes/no)	YES
	Number of individuals trained to be trainers:	2 people trained in year 2 in addition to 5 previously trained
	Number of COS classes offered:	6
	Number of parents completing the COS class:	18
Discovery Kids	Number of children participating in the expansion of Discovery Kids:	123
Sustainability (Year 2)	Began developing a sustainability plan? (yes/no)	Yes
Sustainability (Year 3)	Sustainability plan completed? (yes/no)	No

Grand Island - Hall County Outcome Checklist

Area	Outcome	Tool/Resource	Data Collection Frequency
Circle of Security	Percent of COSP Parents that indicate a more positive relationship with children, etc.	COSP Parent survey - post	At the end of each class
Discovery Kids	Percent of Discovery Kids showing improvement in knowing steps to reach goals, who make good choices, know about dangers of alcohol, tobacco, and drugs, etc.	Discovery Kids Survey	Pre-post Program Survey
Child Well-Being Indicators	Improvement in CWB indicators	Nebraska Children CWB Indicators	Annually by evaluator

Appendix B

Behavioral Health Coalition Collective Impact Survey 2017 & 2018 Results for Grand Island

Introduction and Methodology

Nine out of ten CHI Health Behavioral Health Coalitions have participated in the Collective Impact Survey in 2017 and 2018. One community (Omaha Metro) has not participated in this survey. The survey is designed to evaluate the effectiveness of the coalitions within five domains: common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone organization. All active coalition members (i.e., those who attended at least one meeting in the past year) were invited to participate in the survey and rate their coalition on a number of survey items within each of the five domains.

The survey was conducted online via SurveyMonkey.

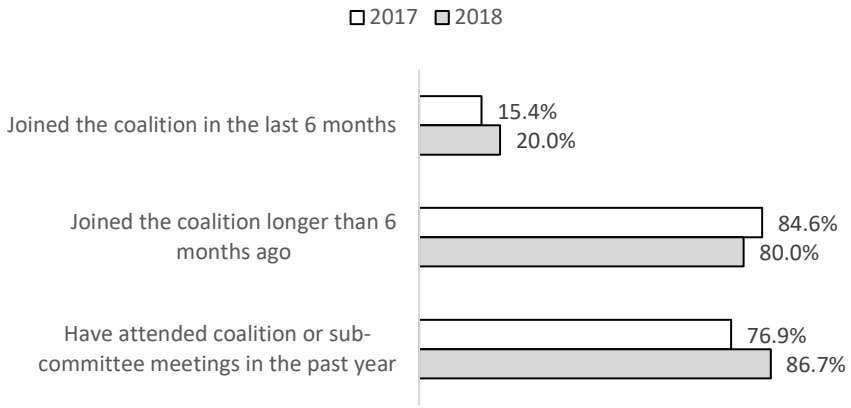
Response Rate

2017 - A total of 13 members of the coalition in Grand Island responded to the survey out of 25 invitees, making for a response rate of 52.0%.
2018 - A total of 15 members of the coalition in Grand Island responded to the survey out of 18 invitees, making for a response rate of 83.3%.

Coalition Involvement

Figure 1 shows the coalition involvement of the respondents.

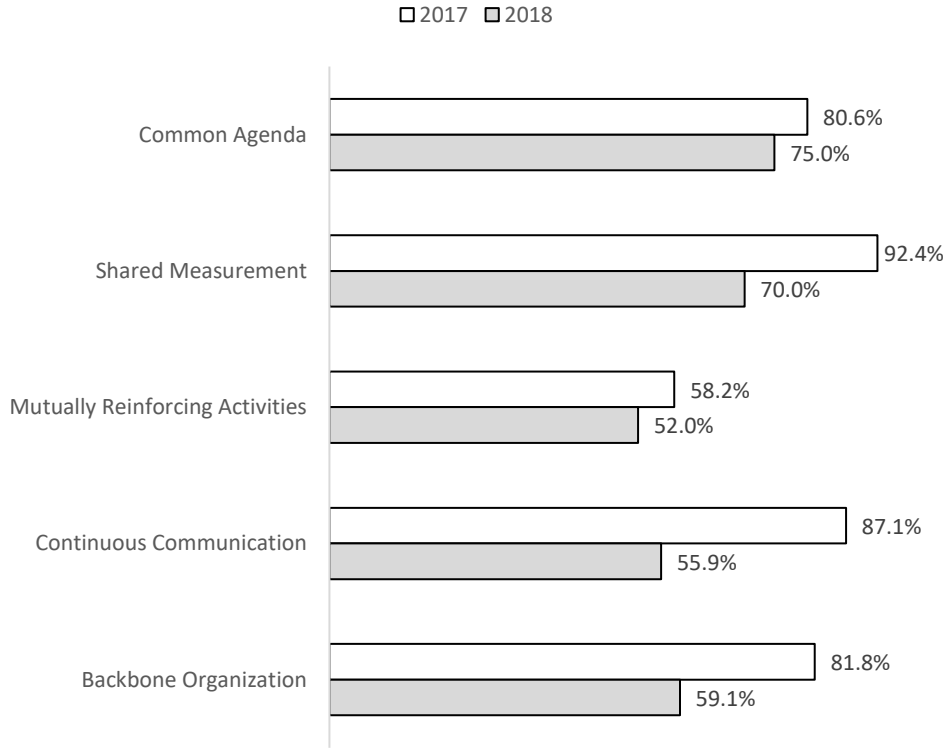
Figure 1. Coalition Involvement



AGGREGATE SCORES

Each of the five domains receives an aggregate score. The aggregate score is the average of the percentage reporting “almost always” or “always” for the statements within each domain. Figure 2 below presents the aggregates scores for each of the five domains.

Figure 2. Aggregate scores*

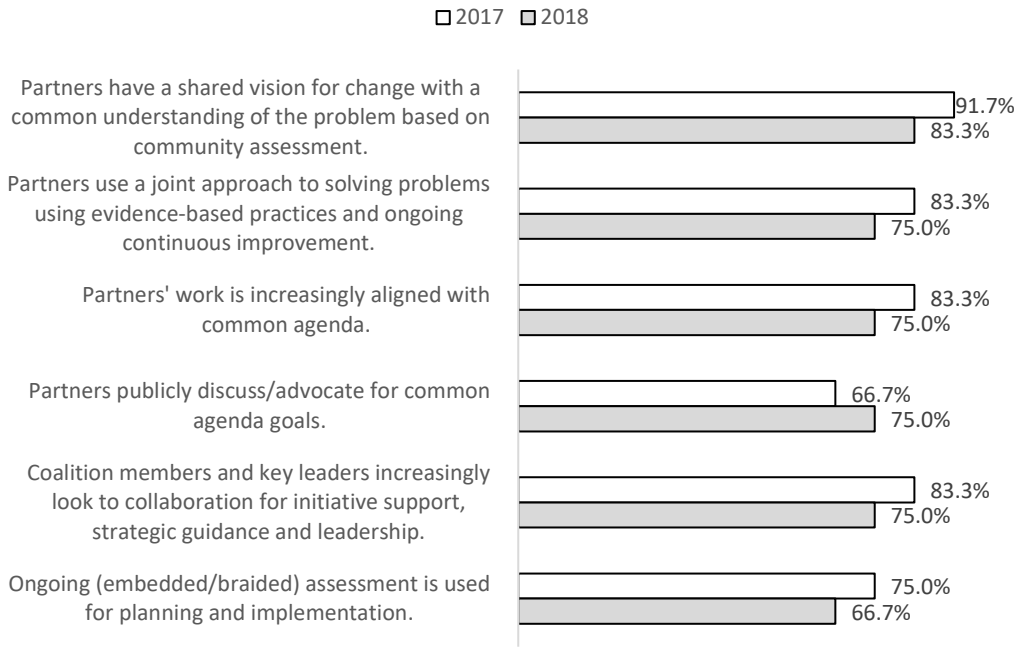


*An average of the percentage reporting "almost always" or "always" for the statements within each domain.

The remainder of this report presents the ratings for each survey item within each of the five domains of collective impact. After answering questions within each domain, respondents were given the opportunity to provide comments. Any comments that were made are included in this report.

COMMON AGENDA

Figure 3. Common Agenda [% almost always or always]*

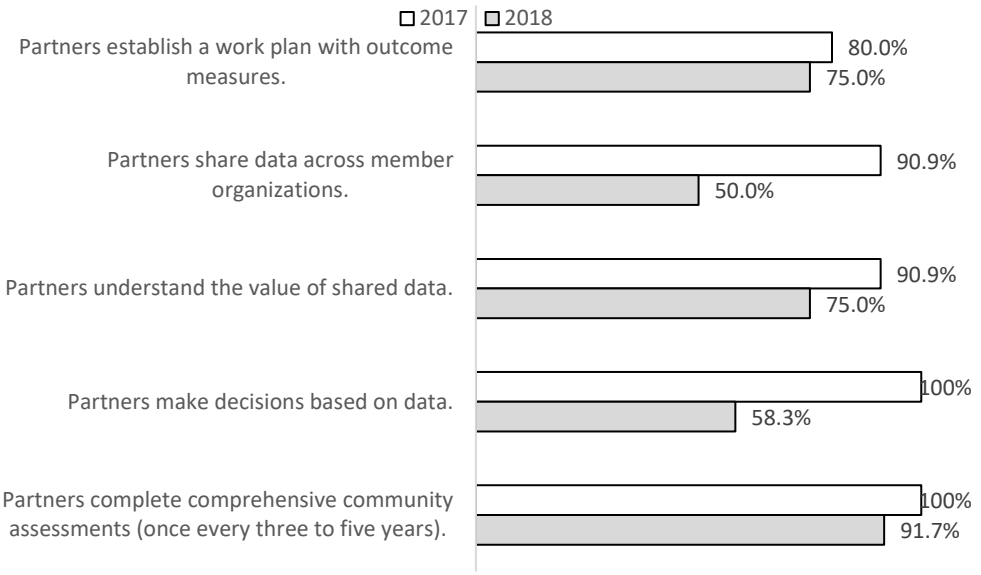


*Response options: never, almost never, sometimes, almost always, always

Comments about Common Agenda
2018
• Extensive meetings and facilitation occurred from June 2017 to date to create a comprehensive Behavioral Health Promotion and Prevention plan for use with the statewide NeSOC. As part of this work the group developed common definition for prevention and promotion and integrated the work of several sectors. • We move closer to Common Agenda all the time. I believe it is a continuum of transition and we are well on our way. • Commitment to collaboration and partnership out of the realization that this produces positive collective results that benefit both the community and the member organization. • There are a lot on concentric circles on influence that hint at one another but are not involved. CHI's Behavioral Health group should be having certain members from the COC present, but I do not believe I have seen that yet. A lot of admins and program managers are present, but there is little room yet for patients, clients, and members who are utilizing the surfaces we are attempting to improve. Having clients provide feedback, come talk, or write notes on their experience, will solidify the "best practices" we hope to implement with real-time feedback for our specific community.

SHARED MEASUREMENT

Figure 4. Shared Measurement [% almost always or always]*

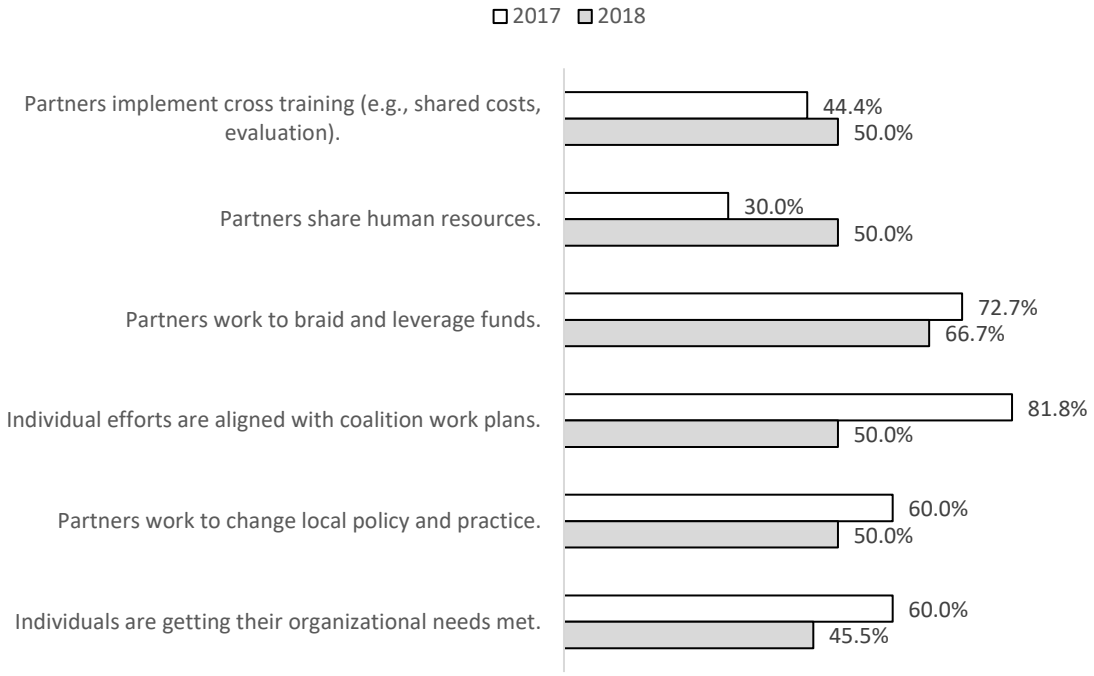


*Response options: never, almost never, sometimes, almost always, always

Comments about Shared Measurement
2018
• Extensive work has been undertaken over many years in Hall County to develop and use common data. Workplans are becoming more frequently including outcome measures. Challenges still occur in differentiating outcomes and outputs. In larger system work outcomes are long term. Almost Always responses reflect the constant work of informing new people at the table. • Again, I believe we as a collaboration are making progress in the area of data understanding and use for decision making. • CHI and the local health departments do well on their community needs assessments.

MUTUALLY REINFORCING ACTIVITIES

Figure 5. Mutually Reinforcing Activities [% almost always or always]*

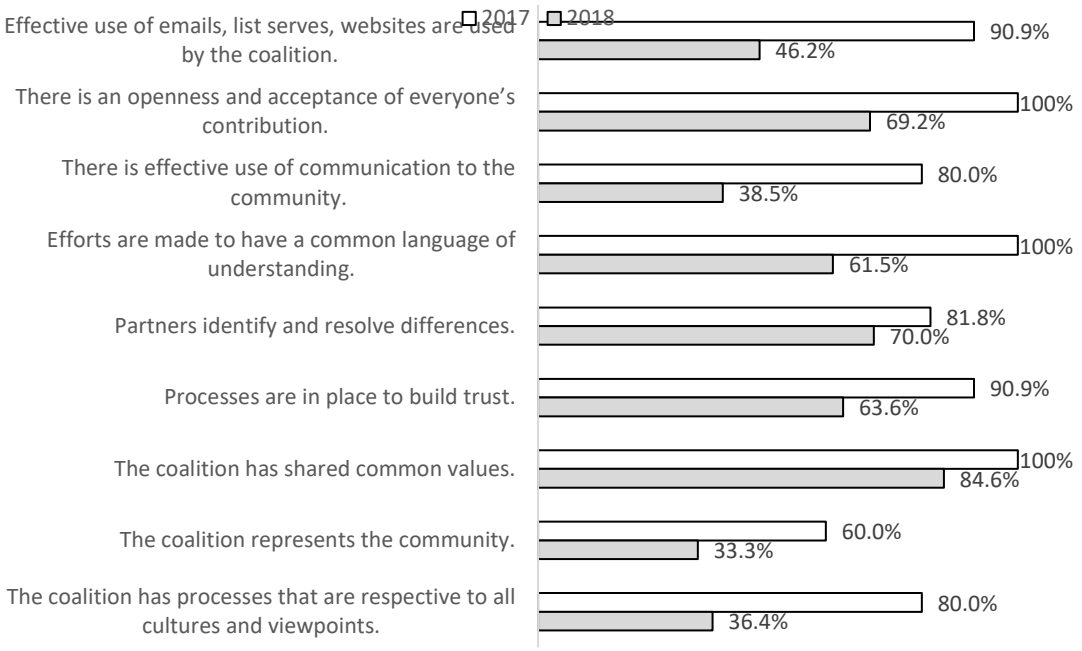


*Response options: never, almost never, sometimes, almost always, always

Comments about Mutually Reinforcing Activities
2018
• The Behavioral Health Promotion and Prevention Plan includes across system training plan. This same information was also included in the Hall County Comprehensive Youth Systems Plan. More frequently individuals are aligning work plans. There is an increase in partners sharing human resources for cross training. As a result, H3C is reviewing guidelines for contracting with agencies versus individuals from agencies. Reinforcing activities should not focus less on creating a second revenue stream for agency staff and more on agencies working together. It is a simple matter of how we define the practices of doing business.
• I believe the organizations who are putting forth the effort and faith in the collaborative are having their needs met because they understand collective impact.
• Member organizations value the relationships they've made and sustained through the Hall County Community Collaborative. Membership meetings are well attended with meaningful participation by member organizations.
• There's a lot of community events, and lunch-n-learns. But certifications, universal cross-trainings, implementing consistent education in whatever endeavors we are attempting to implement seem to be less prominent.

CONTINUOUS COMMUNICATION

Figure 6. Continuous Communication [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

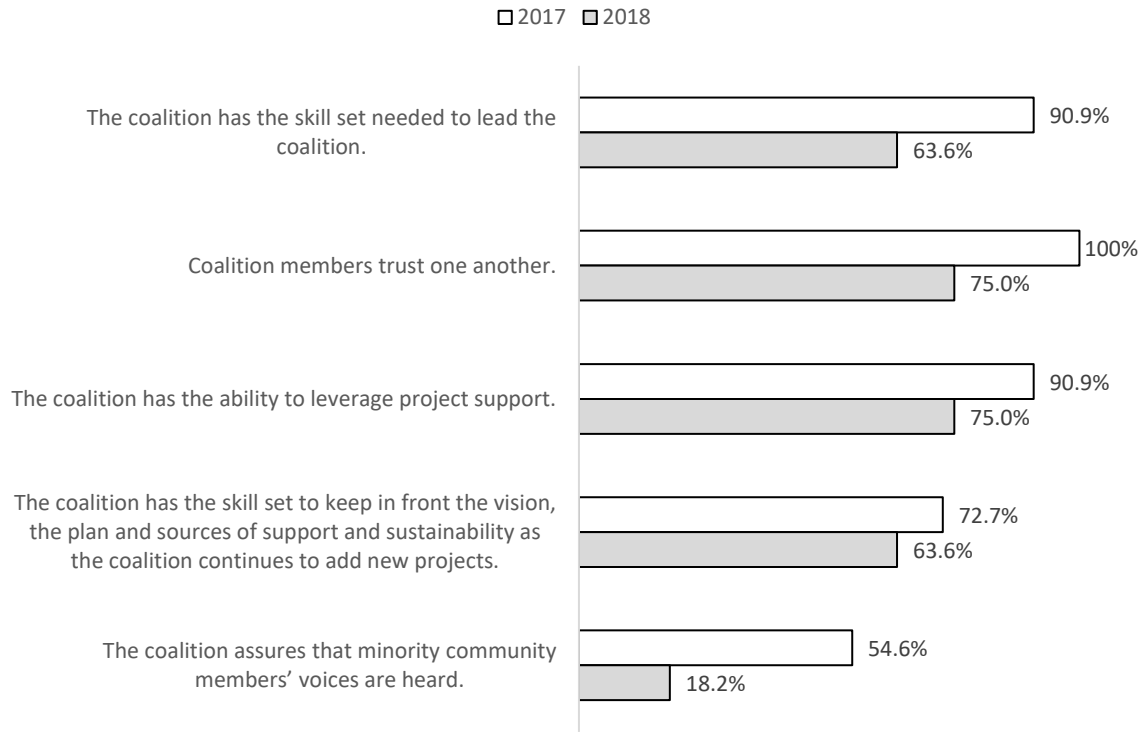
Comments about Continuous Communication

2018

- There is continuous work and growth in this area. During the last year reaching common definitions and building trust, common values in the Behavioral Health committee have been a focus. Occasionally unresolved differences surface in the larger coalition. Overall H3C has been working to upgrade the website. H3C is an inclusive organization that continues to add participants and members and to work at creating MOU's with partner organizations. During the last year the Behavioral Health work created an MOU with Region 3 Behavioral Health and added the Director of Region 3 to the Board.
- We are in a restructuring stage right now, and it has made us stronger, reinforced our shared purpose and enhanced our trust in each other and in the collaborative.
- H3C is largely composed of those in the human service field. Could be improved by making more inclusive.
- There needs to be a more concerted effort to include all segments of the population at membership meetings as well as the Board.
- If you mean that most of the people doing the work are presented, then yes - people working are consistently at these meetings. If you mean the people receiving these services, people of non-standard American heritage, whose first language is something other than English, then those people are present 1/100th of the time.
- We struggle to get complete community representation, not as a result of not trying. Grand Island has a large Hispanic population as well as other "minority" community members that don't attend. The inclusive efforts are not working.

BACKBONE ORGANIZATION

Figure 7. Backbone Organization [% almost always or always]*

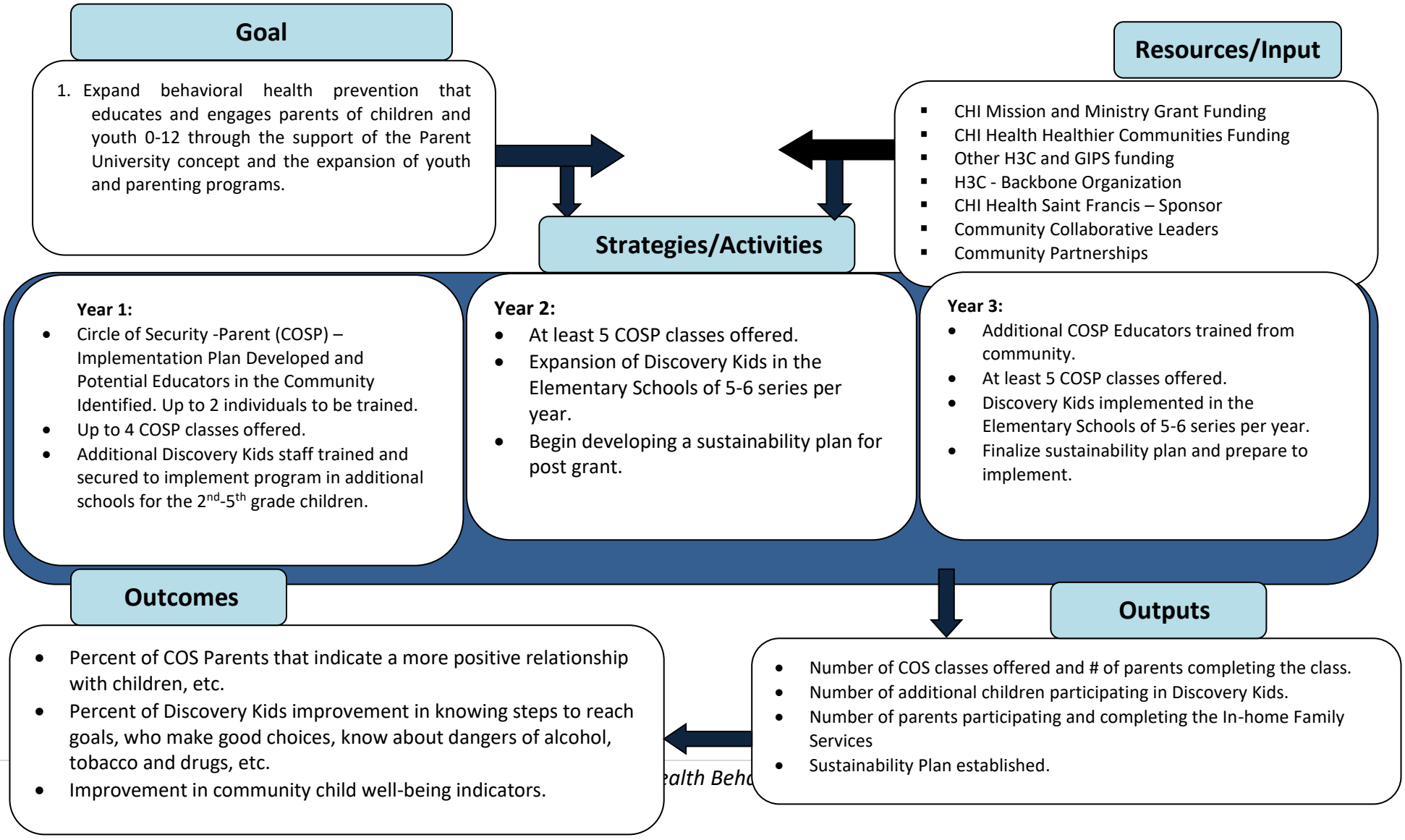


*Response options: never, almost never, sometimes, almost always, always

Comments about Backbone Organization
2018
• The backbone organization has experienced staffing challenges in the past year. Therefore, the skill sets for this complicated work have not always been evident. However, the members and the participants have strengthened their leadership to meeting the common vision. Several efforts and MOA's are in the works to strengthen the minority community capacity -not specifically in this committee or coalition but in shared determination about community direction.
• In this time of restructuring and rebuilding the collaborative we are a transition time that will lead to a stronger organization and a well-functioning backbone.
• More minority voice is needed.
• Refer to previous comment. If we want to assume that (based on research) minority populations have a higher rate of poverty, lower rates of education, more children, more dependence on public services, and are working multiple minimum wage jobs and barely making ends meet - never mind the language barriers for service, we have almost none of those people at meetings ever. Stories of previous experiences come back from people who have worked for years but don't understand "those people". We educate ourselves on shaming and cultural sensitivity, but those practices are rarely upheld. Especially when no interactions with "those people" as just "people" ever occurs.

GRAND ISLAND/HALL COUNTY, NEBRASKA BEHAVIORAL HEALTH IMPROVEMENT PLAN 2016-2019

Collective Vision: To increase the preventive outreach, educational efforts and resources that support the resiliency of community members who experience mental health and substance use issues.



Behavioral Health Initiative

2nd Annual Evaluation Report

Kearney/Buffalo County

Buffalo County Community Partners

HealthyMINDS Behavioral Health Collaborative

July 2017 – June 2018

A. COMMUNITY COALITION DEVELOPMENT AND PLANNING

Buffalo County Community Partners Board developed new initiatives for early childhood behavioral health, suicide prevention, and school mental health. The board asked key community stakeholders to join together as a Behavioral Health Advisory Board to review and report recommendations back to the board to meet the emerging community needs. The HealthyMINDS collaborative was formed.

HealthyMINDS vision is that the Buffalo County community will support our children and youths' social, emotional, and mental wellness. The mission is that children, youth and families have access to a unified behavioral health system to enhance overall wellness. The Collaborative has also been utilizing a change model to represent the work being done for children and families and encompass each system serving youth and families. Their logic model is integrated to include work being done in other coalitions that support the work of HealthyMINDS. Each piece that is funded and tracked through various grants is also captured in this community change model.

Successes and Challenges:
For the past 6 months, the HealthyMINDS Collaborative has worked on building a comprehensive plan for behavioral and mental wellness in Buffalo County through assessing strengths, barriers and gaps in current systems as well as identifying current data and funding streams available. With the help of an evaluator, the group has created an integrated logic model that includes work from early childhood, suicide prevention, and violence prevention under the HealthyMINDS umbrella to ensure that all outcomes align with the group's work.

The Collaborative has also fine-tuned their roles and responsibilities as a group, which include assessing emerging needs, identify and collaborate with groups that are already working in the area, pinpoint and share data among agencies, and sustain work through funding and

partnerships. HealthyMINDS is the holder of the cycle for behavioral and mental wellness initiatives in the community.

To ensure that systems work together across multiple sectors, HealthyMINDS collaborative has been working to first identify and understand the different systems in our community. The collaborative has been putting together a behavioral health system survey tool to begin identifying the multiple behavioral systems and the evidence-based programs they offer in the community. In addition, this tool is set up to identify strengths and gaps in systems in our community. Evidence-based programs and practices are categorized by age groups they are implemented or funded for each organization identified. This tool has been tested by the collaborative and the programs offered through the multiple braided funding for their work. The group desires to expand to additional coalitions to identify strengths and gaps in additional systems. Eventually, this tool may be communicated to the entire community to show how different systems are able to work together or be a needs assessment and a case of support.

The Collaborative has also begun discussing the need for a crisis stabilization plan for the community. Region 3 provided the group with background information on costs of similar crisis infrastructures within our region. The group plans to continue discussing what the hopes of this plan are, what data is needed, and possibly bring in a consultant to bring the entire community together.

Behavioral Health Coaches were placed in two Kearney Public schools, Emerson Elementary and Kenwood Elementary, to inform 'best practice' and effective behavioral strategies used by classroom teachers to address social emotional learning. Both coaches are licensed mental health practitioners and were hired in October 2016 and in March 2017. Last year was spent building rapport with teachers and observing classroom environments. This year many of the teachers have embraced the support and learning. The principals have highly depended on the Coaches' support.

Expansion of Behavioral Health Coaches was discussed between Ravenna School administration and Community partners as an opportunity, however there was not funding to sustain the coach salary. The school decided to forego the training and implementation until further support becomes available. While it has been a challenge to find start-up funds for this expansion, the school is always open and receptive to finding the right evidence-based practice to fit their school.

The collaborative has faced a new challenge, as one of the initial grants to support their work, CHI Violence Prevention, will no longer be a funding source beyond 2018. The group has already been discussing sustainability and next steps. The group has submitted a SAMHSA Training grant, which would support training and education, specifically for Mental Health First Aid and crisis de-escalation.

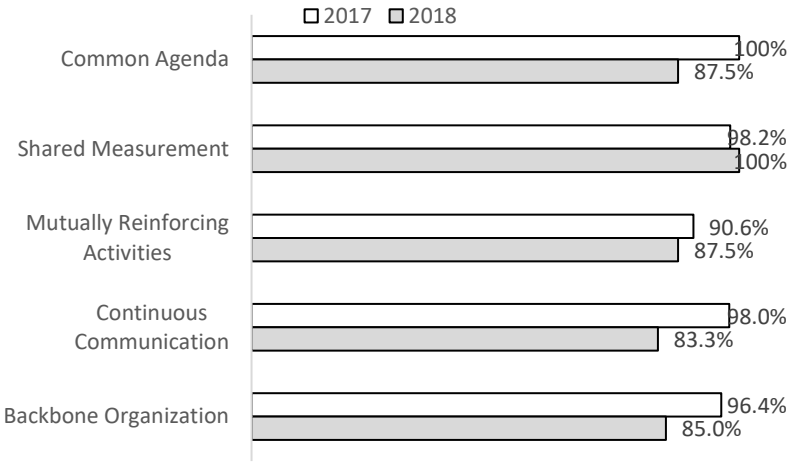
Collective Impact Survey Results:

The Collective Impact survey is designed to evaluate the effectiveness of the coalitions within five domains: Common Agenda, Shared Measurement, Mutually Reinforcing Activities, Continuous Communication, and Backbone Organization. All active coalition members (i.e., those who attended at least one meeting in the past year) were invited to participate in the survey and rate their coalition on a number of survey items within each of the five domains. The survey was conducted online via SurveyMonkey.

Response Rates:
2017 - A total of 12 members of the coalition in Kearney responded to the survey out of 16 invitees, making for a response rate of 75.0%.
2018 - A total of 8 members of the coalition in Kearney responded to the survey out of 19 invitees, making for a response rate of 42.1%.

Each of the five domains receives an aggregate score. The aggregate score is the average of the percentage reporting “almost always” or “always” for the statements within each domain. The graph below presents the aggregates scores for each of the five domains. Ratings were consistently high on all five domains but some decrease in ratings four of the five domains in 2018 as compared to 2017. The full survey results report is located in Appendix B.

Collective Impact Survey Aggregate Scores*



*An average of the percentage reporting "almost always" or "always" for the statements within each domain.

B. BEHAVIORAL HEALTH TRAINING/EDUCATION

Trainings				
Date(s)	**Training Topic/Description**	**Description of Individuals Trained (community, school, parents, healthcare, etc.)**	**# of Participants**	**# of Organizations Participated**
8/17/17	Rage to Reason	Behavioral Health Coach	2	1
1/3/18	Mental Health In-service	School teachers	600	3
2/13/18	Cyberbullying presentation	students	2685	2
2/13/18	Cyberbullying Presentation	parents	250	2
4/2/18	Behavioral Strategies In Service	School teachers	600	2
6/11/18	Youth Mental Health First Aid (YMHFA)	School teachers	14	3
6/11-12/18	TPOT	Early childhood teachers, mental health professionals, early childhood coaches	21	4
6/20-23/18	Pyramid Model	Pre-K and Kindergarten teachers	19	2

Pyramid Model:
Introductory **Pyramid Model** Implementation for Kindergarten Teachers was conducted in the spring with Independent Consultant, Patti Mahrt-Roberts. Roberts is the lead trainer for the Rooted in Relationships Pyramid Model Training for childcares in both Dawson and Buffalo County. The training was to teach kindergarten teachers different strategies and solutions from the Pyramid Model Framework.

TPOT:
HealthyMINDS Coordinator collaborated with the Nebraska Children and Families Foundation, Munro Meyer Institute, and the University of Nebraska Kearney to bring a The **Teaching Pyramid Observation Tool (TPOTTM)** training to Buffalo County. The TPOT is a reliability workshop to prepare participants in the use of the instrument to gather information on preschool teachers' implementation of Pyramid Model practices. Not only does the workshop create a collaboration across the state, but it also builds the capacity of early childhood professionals. There were 21 participants, and 13 that successfully completed and became a member of the State Evaluation team.
YMHFA:
HealthyMINDS Coordinator, Region 3 Behavioral Health and Kearney Public Schools (KPS) hosted a **Youth Mental Health First Aid** training in June 2018. The training space was provided by Education Service Unit 10 and open to teachers, staff and community in Buffalo County for a total of fourteen participants. The group was truly engaged by participating in the activities, discussion, sharing and asking questions. KPS administration truly felt that it would have been a

larger group if there was any sort of compensation for teachers interested considering the eight-hour length of the training.

Dr. Clayton Cook, Behavioral Consultant, provided guidance to KPS staff on positive behavior strategies in the classroom. This in-service supported the Multi-Tiered System of Support (MTSS) School Improvement model and strengthened staff/building capacity to provide student behavioral supports at Tier 1.

Karen Haase gave presentations to KPS parents and students- fifth graders, middle schoolers, and freshmen and sophomores- on social media and the legal consequences for when it is used criminally, from bullying to sharing inappropriate photos. Haase is a principal in the Lincoln law firm KSB School Law where she practices exclusively in the area of education law, and she regularly presents on social media law to audiences across the state. Haase gave parents a "Must Have Guide to Social Media" covering topics like cyberbullying and harassment, sexting, basic internet safety, and the legal consequences when kids, or adults, break the law online.

In collaboration with Region 3, Kearney Public Schools hosted a teacher in-service day to focus on students' mental health and social emotional development, providing insights and strategies to use in classroom settings. Training included: Compassion Fatigue, Wellness Recovery Action Plan (WRAP), Question, Persuade Refer (QPR), Community Resources available from system of care partners, Trauma and Youth, and Pyramid Model for Kindergarten teachers.

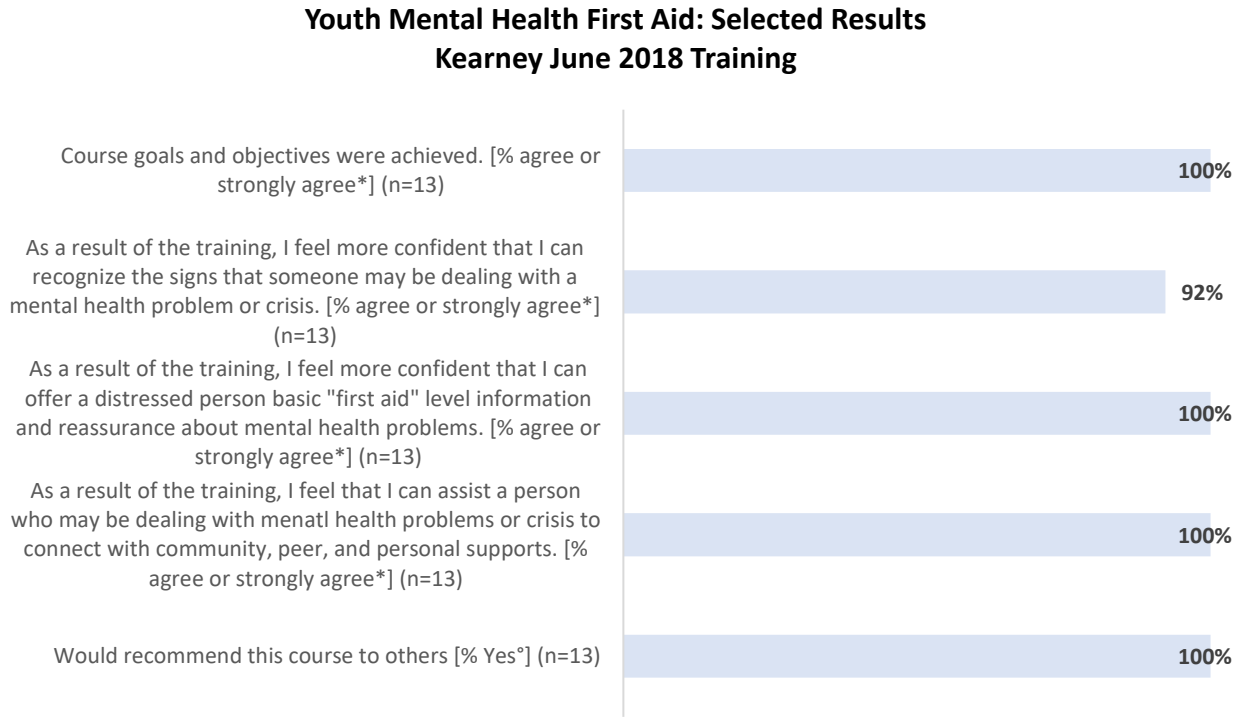
Outcomes:

A strong majority of participants in the KPS Mental Health In-Service training found the training to be beneficial or extremely beneficial.

KPS Mental Health In-Service Training Evaluation Results

	%
Usefulness of the content rated as 4 or 5 on a scale from 1 to 5, with 1 being not beneficial and 5 being extremely beneficial (n=229)	88.6%

Participant evaluations were provided for June 2018 YMHFA training. The graph below indicates high satisfaction and learning from the training.



C. SUMMARY OF PROGRAMS IMPLEMENTED

SCHOOL BEHAVIORAL HEALTH COACHES

Program Description: The school behavioral health coach provides skill training for the school personnel and parents/caregivers to work with children. The coach implements behavior intervention plans focused on increasing/reinforcing positive behaviors and decreasing disruptive/challenging behaviors that are preventing the child from experiencing success in school and/or home. Coaches also work collaboratively with the school staff, child, family, child welfare and others.

Coaches assisted in developing a Tier 1 behavior plan to be utilized by staff for all grade levels. Through positive behavior support, Tier 1 works for over 80% of all students. Coaches also helped their administration and staff develop a building wide goal utilizing their school climate survey.

- Kenwood Goal: To decrease the percentages of students and staff that feel that student misbehavior in the classroom make it difficult to learn based off the School Climate Survey (Staff--87.5% to 50% and students--60.6% to 50%)
- Emerson Goal: To utilize "Behavior Flow Chart" to document classroom interventions. The Behavior Flow Chart was created by the Emerson Behavior Coach and staff and is a tool from the Multi-Tiered System of Support (MTSS).

Coaches:

- Created a behavioral plan for the entire school staff to utilize to increase positive interactions between staff and students. In addition, the behavioral plan focused on "catching students making positive choices" and assist in creating a positive environment. Student feedback has been extremely positive and encouraging. Students enjoy the program and like getting recognition for positive acts.
- Are training paras on interaction styles and positive behavior plans (on going) and created trainings to teach paras on providing positive incentives to students throughout the school. Evaluation continues to occur on interactions styles of staff to ensure a positive environment within the classroom, hallways, and specials areas.

The Social emotional team has developed a calming room ("peace out room") and has created personalized activities for the individual students that utilize it frequently. Along with developing the calming room, coaches are collecting data to personalize activities to specific children. As a goal to develop data collection for each classroom to assist in evaluation of Tier 1 behavior plan, teachers have been asked to complete classroom quantitative data on how many incentives/positive rewards students are being provided. This data has been used to evaluate classroom climate and if individual students need a Tier 2 plan.

Coaches enhanced their knowledge, skills, and professional development by attending the following trainings: Rage to Reason training, a state-of-the art Treatment Program utilizing a Research-Based Program in Applied Behavior Analysis designed to transform and reshape the lives and futures for children with disruptive and explosive behavior due to Autism, ADHD, Anxiety, Disruptive Mood Dysregulated Disorder, Obsessive Compulsive Disorder, Reactive Attachment Disorder, Oppositional Defiant Disorder, Bipolar, and all other mental health needs; Trauma informed school web training to develop a trauma-informed approach to learning and behavior issues to school practice.

Coaches also assisted and facilitated Social Emotional Team meetings and created school wide behavioral goals and plans. They ollaborate with Social Worker, School Counselor, and Principal to promote positive environment and to encourage cohesiveness.

Description of Where Program was Implemented: Emerson, Kenwood

Description of Participants (i.e., community individuals, parents, youth, ages, etc.). Teachers and students K-5th grades.

Number of Participants: EMERSON

Program Name: School Behavioral Health Coaches			
Number of Teachers Served Directly	135	Number of classrooms involved in Implementation	12
Number of Children/Youth Served Directly (if applicable)	28	Number of Staff Involved in Implementation	1

Number of Participants: KENWOOD

Program Name: School Behavioral Health Coaches			
Number of Teachers Served Directly	80	Number of classrooms Involved in Implementation	18
Number of Children/Youth Served Directly (if applicable)	13	Number of Staff Involved in Implementation	1

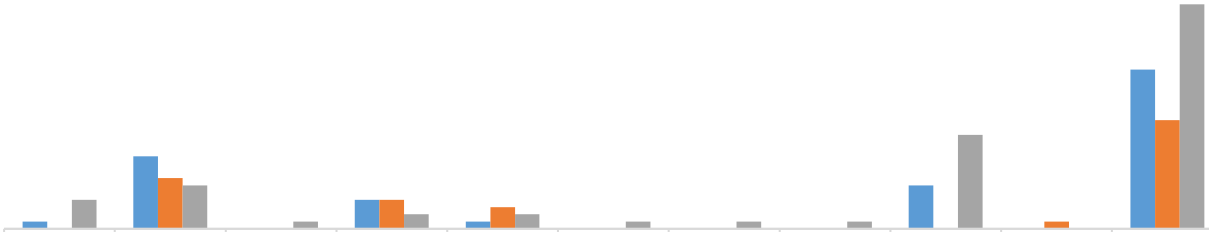
Comments on Successes and Challenges: A behavioral plan for the entire school staff to utilize to increase positive interactions between staff and students was created. In addition, the behavioral plan focused on "catching students making positive choices" and assist in creating a positive environment. Student feedback has been extremely positive and encouraging. Students enjoy the program and like getting recognition for positive acts.

The school mental health leadership team has researched evidence-based models for these coaches to utilize to ensure a fluid and consistent model between the two buildings. While there is a possibility for more training in the future, many of the models that seem the most beneficial are not financially feasible.

Outcomes: Internal coach team, including Kearney Public School administration, Buffalo County Community Partners staff, and Behavioral Health Coaches, have been meeting monthly to continue making outcome tracking consistent. Current outcomes tracked include: battery, disorderly conduct, fighting, theft, vandalism, violation of school rules, insubordination, physical altercation, threat/intimidation. The coaches are also working together with their respective administrators to create district wide cohesiveness and collaboration.

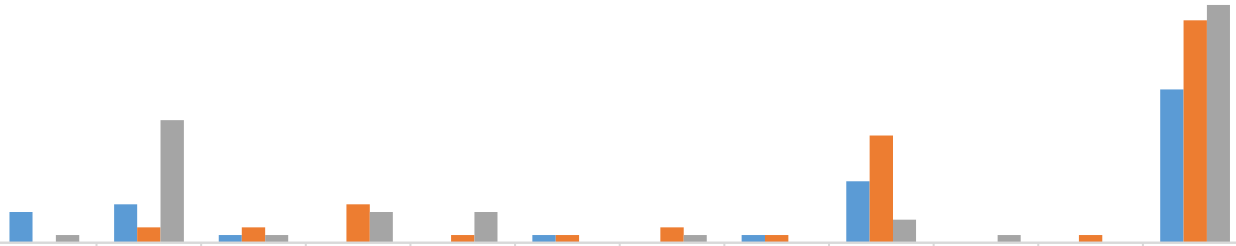
The data and graphs below reflect student behaviors in the fall of 2016, the fall of 2017 and the combined fall and spring semester of the 2017-2018 school year. Slight changes have been made with some student behaviors but more data will need to be collected. Also note that "rule breaking" was coded differently in the spring of 2018 into major and minor infractions so the comparison of data from the previous years may not be appropriate. Next year data will more accurately reflect the impact of the program.

Kenwood Elementary: Major Infractions



	Battery	Disorderly conduct	Fighting	Insubordination	Physical alter-cation (minor)	Theft	Threat/ intimi-dation	Vandalism	Violation of school rules	Tobacco	Grand total
Fall 2016	1	10	0	4	1	0	0	0	6	0	22
Fall 2017	0	7	0	4	3	0	0	0	0	1	15
2017- 2018	4	6	1	2	2	1	1	1	13	0	31

Emerson Elementary: Major Infractions



	Battery	Disorderly conduct	Fighting	Insubordination	Physical alter-cation (minor)	Theft	Threat/ intimi-dation	Vandalism	Violation of school rules	Tobacco	Suicide	Grand total
Fall 2016	4	5	1	0	0	1	0	1	8	0	0	20
Fall 2017	0	2	2	5	1	1	2	1	14	0	1	29
2017- 2018	1	16	1	4	4	0	1	0	3	1	0	31

D. OTHER PROGRAMS IMPLEMENTED (OPTIONAL)

First United Methodist Church and the **Suicide Prevention Coalition**, a work group of Buffalo County Community Partners, hosted a Faith Community Gathering to help churches become leaders in recovery, wellness and building resilience. The event opened with a keynote message by Jeremy and Bailey Koch of Cozad, who discussed their journey with depression and

suicide attempts, and the role that faith plays in their recovery. A panel discussion followed, made up of different stakeholders in the community to help connect attendees to local resources. More than 100 people filled the pews at First United Methodist Church of Kearney to hear suicide survivors, faith leaders and educators explore the issue.

The Buffalo County Youth Advisory Board (YAB) has identified issues in their community that they would like to change. One of their focal points for 2016-2018 has been mental health. In December, the YAB became trained in Youth Mental Health First Aid. After the initial board training, individual students decided to work in their individual communities to expand the training and reach more students. Pleasanton hosted a training for an additional 8 students. Kearney Catholic hosted a training with 43 students.

In March of 2018, The Buffalo County Community Partners' Youth Advisory Board joined more than 70 Buffalo County high school students for the Healthy Body, Healthy Mind summit. The event helped Kearney area students break down the stigma surrounding youth mental health. Students were provided the resources that are available for them and their peers. The premise of the summit was to encourage youth to care for their minds and bodies in similar ways. Summit attendees had the opportunity to learn from a variety of experts in mental wellness. They started the day with mindfulness and yoga, heard about the importance of having a trusted adult to turn to, listened to a panel of mental health counselors' professionals, and spent some time with therapy dogs. At the end of the summit, youths gathered with others from their schools and discussed what they could take back to start a healthy conversation about mental wellness with their classmates and peers. Many of the youths attended the summit accompanied by guidance counselors from their schools.

Second Step curriculum has been implemented district wide for all pre-k through 6th grade in Kearney Public Schools. KPS has also secured funding for Second Step in middle schools, along with School Connect (another evidence based social emotional curriculum) for high schools. Social emotional curriculum is a key element to the Pyramid Model.

Community Partners staff putting together a Second Step training presentation, recruited local champions to assist with training, and in May hosted a Second Step training for childcare providers.

E. RESOURCE AWARENESS

Not applicable.

F. COORDINATION AND NAVIGATION

- *Provide behavioral health consultation to teachers to discuss behavioral health cases and connect to resources.*
  The Behavioral Health Coaches assisted staff in developing techniques to encourage positive behavior within classrooms. Behavioral coaches assist teachers and students by modeling

techniques that may be utilized within the classroom to promote positive behavior. On several occasions, a behavioral health coach was called in to assist with a disruptive student. Students and behavioral health coach would complete relaxation and redirection techniques, then techniques and plans were discussed with teachers to be installed as preventative measures in the future.

G. ASSESSMENTS AND PLANNING DOCUMENTS

- *Conduct an educational behavioral health needs assessment with administrators, educators and staff of pre-K through college.*
  Committed to support data review and analysis for Kearney Public School.
  Providing support to the University of Nebraska at Kearney in the implementation of the evidence-based assessment, Interactive Screening Program (ISP), in the Fall of 2018. The ISP is an online program utilized by mental health services to provide a safe and confidential way for individuals to take a brief screening for stress, depression, and other mental health conditions, and receive a personalized response from a caring mental health counselor. The purpose of the Interactive Screening Program (ISP) is to identify, engage and refer to treatment students with serious depression or other conditions that put them at risk of suicide. Through an ISP website, UNK students can anonymously communicate with a mental health professional to receive recommendations, feedback, and support for connecting to available mental health services.

- *Develop a crisis stabilization plan that may include a 23:59 observation unit in a physical location, a crisis line, peer support, crisis therapy and other identified current services and resources to support increased crisis capacity.*

  Jessica Vickers facilitated the HealthyMINDS system change model. The change model has led the collaborative to an integrated, comprehensive logic model.

  Coordinator and additional HealthyMINDS members are a part of the Nebraska System of Care Leadership Council to ensure the ongoing discussion of crisis stabilization. Through this initiative, Region 3 is providing Youth Crisis Response, Therapeutic/Professional Consultation, Peer Support, and Consumer and Family Involvement. Discussions are monthly and have provided ongoing collaboration and improvements to crisis response and stabilization in our area.

  The group has been working toward a crisis stabilization plan but have not finalized a formal plan. The group strategically works through the strategic prevention framework model, to make a comprehensive plan for our community. The group has discussed the current efforts in place, such as crisis mobile response provided through Region 3, which offers 24-hour crisis response for both youth and adults. The group did discuss however that there is still need for a safe haven for individuals to be taken out of the crisis situation.

The group plans to begin year 3 inviting additional stakeholders to the next meeting to broaden the scope and the need of a crisis stabilization unit in our community.

H. ED VISITS AND COUNTY-LEVEL HEALTH DATA

To provide additional reflection on the impact of the project, baseline hospital and community wide data related to mental health is represented in the tables below. The data represents the most current year available and will be updated annually, if available. The three tables included:

- Buffalo County Emergency Department Mental Health Visits
- Child Well-Being Indicators
- County Health Data Indicators

Emergency Department Mental Health Visits at CHI Hospitals

	*FY 2016	*FY 2017	% change
Kearney, NE (Buffalo County)	320	373	16.6%
Total for 10 Project Communities	**16,165**	**17,382**	**7.5%**

*Fiscal Year: July-June
Source: CHI Health Hospital Data

Child Well-Being Indicators

	Year(s)	Buffalo County (Kearney, NE)
Total Population/ages 19 & under	**2015**	48,863/ 13,396
	2016	49,383/ 13,552
Percent of births to teen mothers (age 15 to 19)	**2015**	4/0.6%
	2016	7/1.0%
Number of substantiated child maltreatment victims/rate per 1,000 population	**2015**	442/92.0
	2016	330/67.5
Percent of children ages 0-17 below poverty level	**2015**	84/7.3
	2016	70/6.0

(Source: Kids Count Data Center)

County Health Data Indicators

	Year(s)	Buffalo County (Kearney, NE)	*Nebraska*	*Iowa*
Poor Mental Health Days (ave. # unhealthy days/30 days)	**2014**	2.7	***2.8***	***3.1***
	2015	2.8	***3.0***	***3.3***
	2016	2.9	***3.2***	***3.3***
Adult Smoking	**2014**	15%	***17%***	***19%***
	2015	15%	***17%***	***18%***
	2016	15%	***17%***	***17%***
Excessive drinking (binge/heavy drinking past 30 days)	**2014**	23%	***21%***	***22%***
	2015	20%	***20%***	***21%***
	2016	23%	***21%***	***22%***
Alcohol-impaired driving deaths	**2010-2014**	21%	***35%***	***24%***
	2011-2015	19%	***36%***	***25%***
	2012-2016	22%	***37%***	***27%***
Chlamydia rate per 100,000	**2013**	432	***393***	***356***
	2014	430	***401***	***382***
	2015	419	***423***	***389***
Premature age-adjusted mortality rate per 100,000 (under age 75)	**2011-2013**	282	***302***	***309***
	2013-2015	261	***307***	***311***
	2014-2016	253	***309***	***313***
Drug overdose death rate per 100,000	**2014**	9	***7***	--
	2013-2015	8	***7***	--
	2014-2016	--	***7***	9
Suicide Rates per 100,000	**2010-2014**	11.7	***11.7***	--
	2011-2015	13.5	***12.0***	--
	2012-2016	14.5	***12.4***	--

(Source: County Health Rankings)

I. FINANCIAL RESOURCES AND SUSTAINABILITY

Funding from CHI Health			
Source	**Program, Strategy or Coalition Support**	**Funding Period**	**Amount**
Mission and Ministry Grant	Coalition support, School Assessment, Best Practice Training and Programs – MHFA and Pyramid Model	July 1, 2017 – June 30, 2018	$89,787
Healthier Communities	Presentations and Programs – Cyberbullying, Second Step Middle School Training and TPOT	July 1, 2017 – June 30, 2018	$14,000
CHI Health Good Samaritan	In Kind staff time and meeting room space.	July 1, 2017 – June 30, 2018	$18,181

Following are additional grant funds received by the HealthyMinds Behavioral Health Coalition.

Grants and Funding Awarded Directly to the Coalition other than from CHI Health			
Source	**Program, Strategy or Coalition Support**	**Funding Period**	**Amount**
CHI Violence Prevention	Violence Prevention and Suicide Prevention	July 1, 2017 – June 30, 2018	$111,346 (funding completed)
Rooted in Relationships	Early Childhood Development	July 1, 2017 – June 30, 2018	$100,000 (beginning second year of third year implementation July 1, 2018)
Mental Health Awareness Training Grant	Mental Health Awareness and Training	September 30, 2018-August 31, 2019	$113, 645 (request for funding only, not yet awarded)

Education on sustainability planning was conducted at the annual summit in May of 2018. Grant administrative staff will provide a sustainability process in the fall of 2018 to the coalitions to assist them in the development of their community specific sustainability plans.

Appendix A

Kearney - Buffalo County 12-month Output Report

Report period: July 1, 2017 through June 15, 2018

Area	Metric	Input information here (only report on activities for the six months of the report period):
HealthyMINDS Behavioral Health Collaborative	Number of collaborative meetings:	10
	Dates of collaborative meetings:	7.11.17, 9.12.17, 10.10.17, 11.14.17, 12.12.17, 1.9.18, 2.13.18, 3.13.18, 5.8.18, 6.18
	Average number of collaborative members attending meetings:	6
Behavioral Health Coaches	Number of classrooms receiving behavioral health trainings and/or intervention plans for teachers and educational staff:	30
	Number of teachers and educational staff receiving behavioral health skill building trainings and intervention plans for students:	215
	Number of children served directly:	41
	Number of teachers attending in-service presentations:	600
Other Trainings	Number trained:	19 (Pyramid Model) 21 (TPOT) 2 (Rage to Reason)
	Attendance at prevention presentations:	Cyberbullying Students: 2,685 Parents: 250
Crisis Stabilization	Crisis stabilization plan developed? (yes/no)	NO
	Crisis stabilization plan implemented? (yes/no)	NO
	Number of patients receiving crisis stabilization services:	NOT AVAILABLE

Behavioral Health Needs Assessment	Needs assessment conducted? (yes/no)	NO
Sustainability (Year 2)	Began developing a sustainability plan? (yes/no)	YES
Sustainability (Year 3)	Sustainability plan completed? (yes/no)	YEAR 3

Buffalo County Outcome Checklist

Area	Outcome	Tool/Resource	Data Collection Frequency
Community Coalition	Reduction in ED visits to CHI Health Good Samaritan	CHI Health Hospital Database	Every six months (baseline: January - June, 2016)
	Reduction in ED visits to Richard Young	Hospital Database	
	Improvement in Child Well-Being Indicators	Nebraska Children CWB Indicators	Annually
Behavioral Health Training and Consultation with Schools	Increased teacher/staff knowledge of behavioral health signs and symptoms and awareness of community resources	Post-training Evaluations	After each training
	Increase access to services by students	Community Service Provider Survey	Annually (every May)
Crisis Stabilization	Increased access to BH crisis prevention services.	Community Service Provider Survey	Annually (every May)
	Reduction in ED visits to CHI Health Good Samaritan	CHI Hospital Database	Every six months (baseline: January - June, 2016)
	Reduction in ED visits to Richard Young	Hospital Database	

Appendix B

Behavioral Health Coalition Collective Impact Survey 2017 & 2018 Results for Kearney

Introduction and Methodology

Nine out of ten CHI Health Behavioral Health Coalitions have participated in the Collective Impact Survey in 2017 and 2018. One community (Omaha Metro) has not participated in this survey. The survey is designed to evaluate the effectiveness of the coalitions within five domains: common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone organization. All active coalition members (i.e., those who attended at least one meeting in the past year) were invited to participate in the survey and rate their coalition on a number of survey items within each of the five domains.

The survey was conducted online via SurveyMonkey.

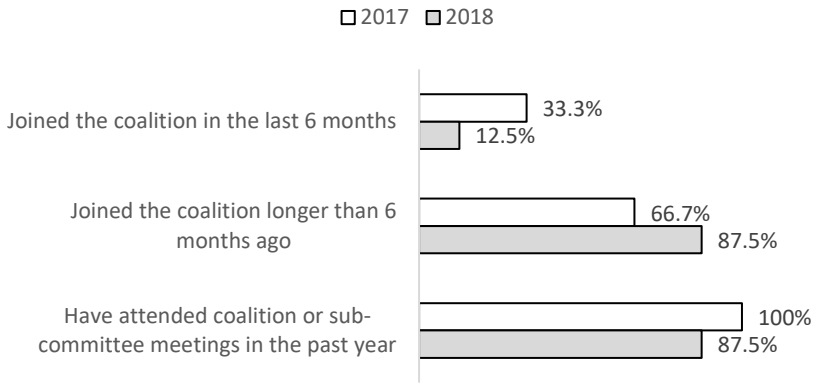
Response Rate

2017 - A total of 12 members of the coalition in Kearney responded to the survey out of 16 invitees, making for a response rate of 75.0%.
2018 - A total of 8 members of the coalition in Kearney responded to the survey out of 19 invitees, making for a response rate of 42.1%.

Coalition Involvement

Figure 1 shows the coalition involvement of the respondents.

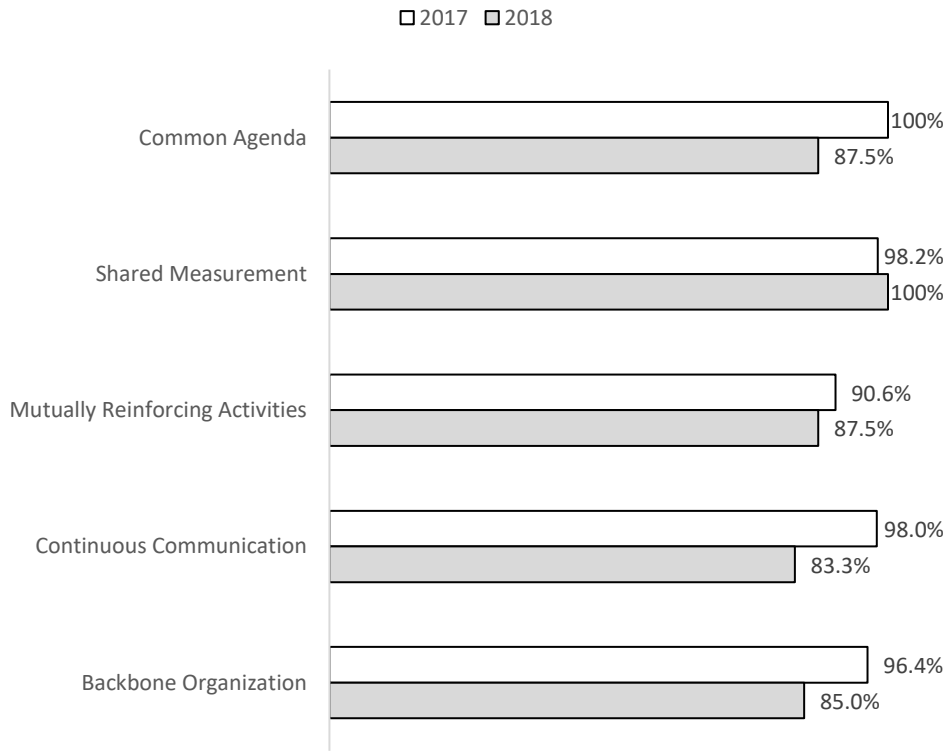
Figure 1. Coalition Involvement



AGGREGATE SCORES

Each of the five domains receives an aggregate score. The aggregate score is the average of the percentage reporting "almost always" or "always" for the statements within each domain. Figure 2 below presents the aggregates scores for each of the five domains.

Figure 2. Aggregate scores*

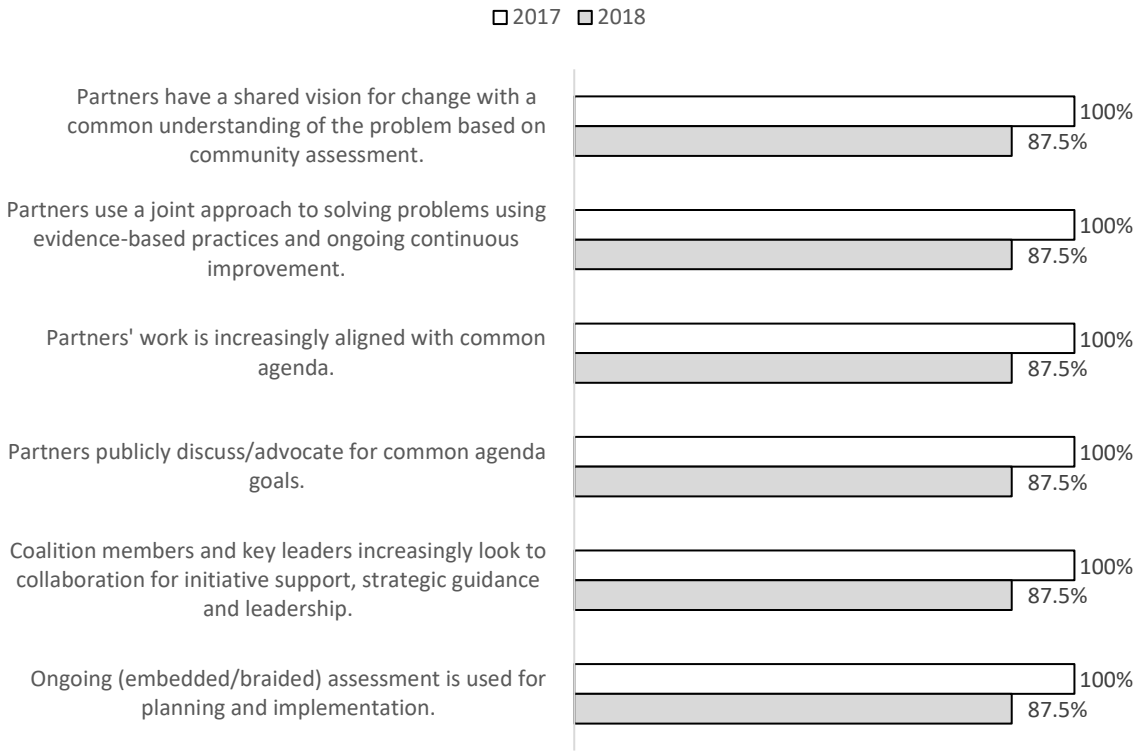


*An average of the percentage reporting "almost always" or "always" for the statements within each domain.

The remainder of this report presents the ratings for each survey item within each of the five domains of collective impact. After answering questions within each domain, respondents were given the opportunity to provide comments. Any comments that were made are included in this report.

COMMON AGENDA

Figure 3. Common Agenda [% almost always or always]*

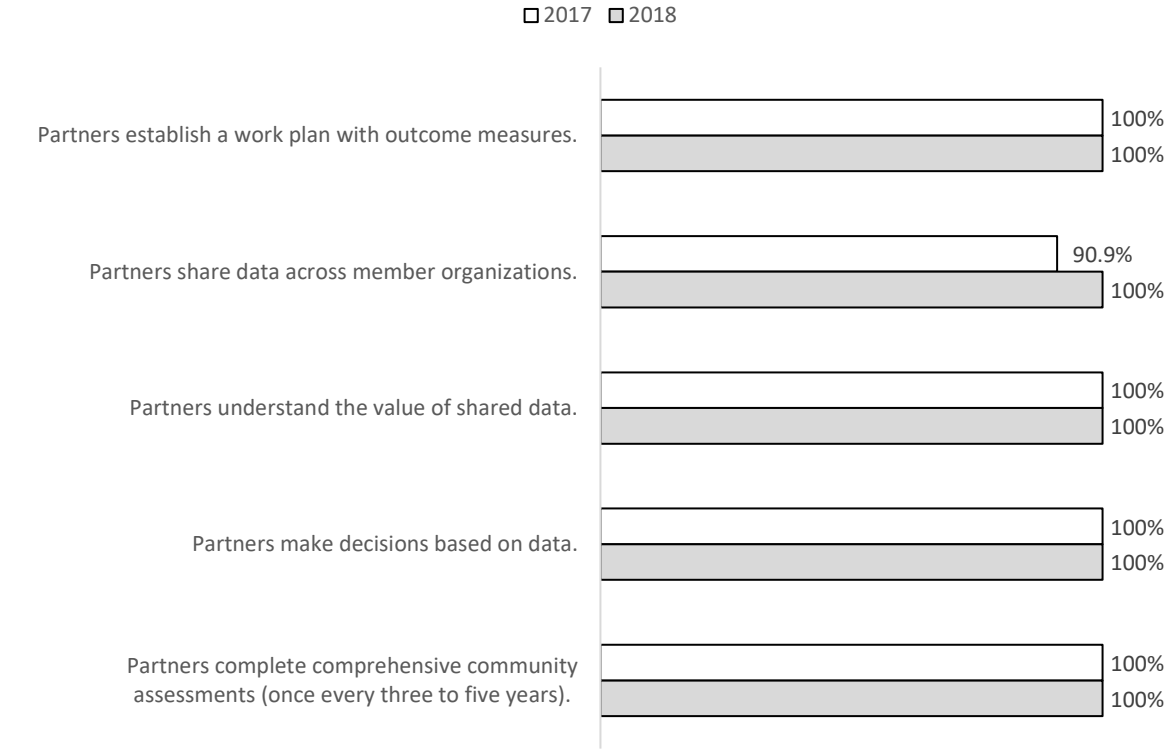


*Response options: never, almost never, sometimes, almost always, always

Comments about Common Agenda
2018
• We are in the beginning phases of coming together as a division, but we have a lot more work to do to make this happen. A lot of focus has been on the metro behavioral health but haven't tied in our local facility, but we are changing that. • The Buffalo County Community Partners has a long-standing and positive reputation of achieving positive results within the community. They are able to get things done across the entire county. • Every decision is data driven. Every effort is made to have all stakeholders involved in the process.

SHARED MEASUREMENT

Figure 4. Shared Measurement [% almost always or always]*

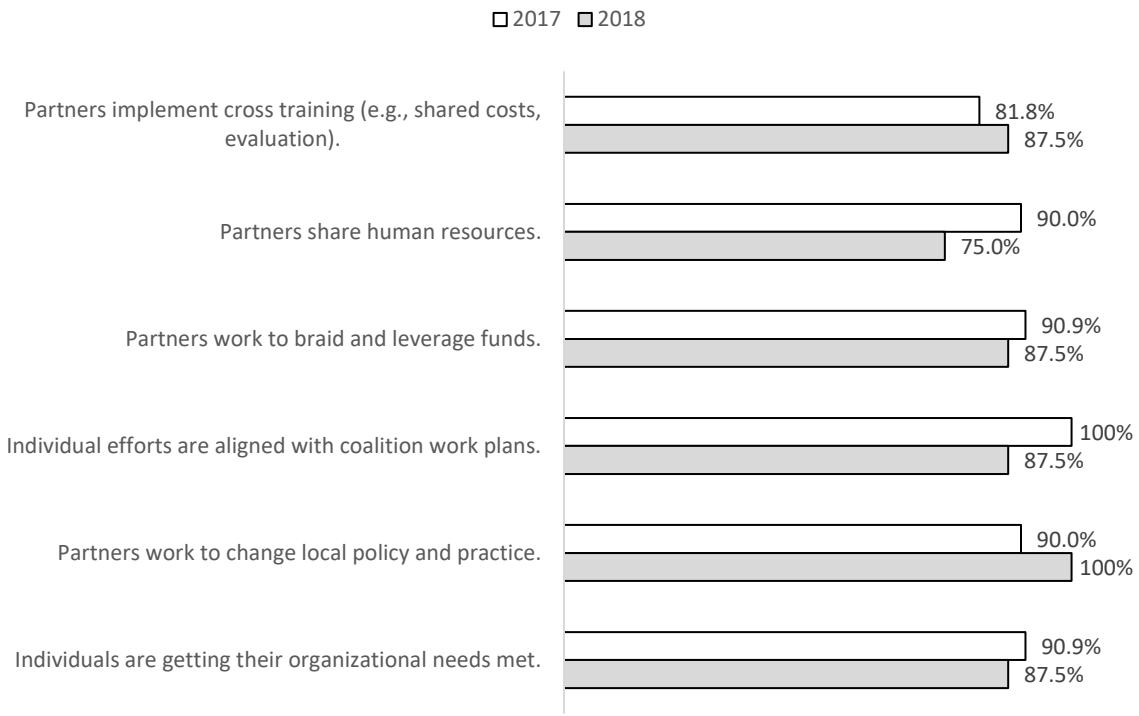


*Response options: never, almost never, sometimes, almost always, always

Comments about Shared Measurement
2018
• Data has been an essential component to the Buffalo County Community Partners. They focus resources on gathering and sharing data and making data-driven decisions. This has been a long-standing value of the Community Partners. • I'm truthfully not sure how often they do the comprehensive community assessments. I just know that we use data from those assessments to make decisions.

MUTUALLY REINFORCING ACTIVITIES

Figure 5. Mutually Reinforcing Activities [% almost always or always]*

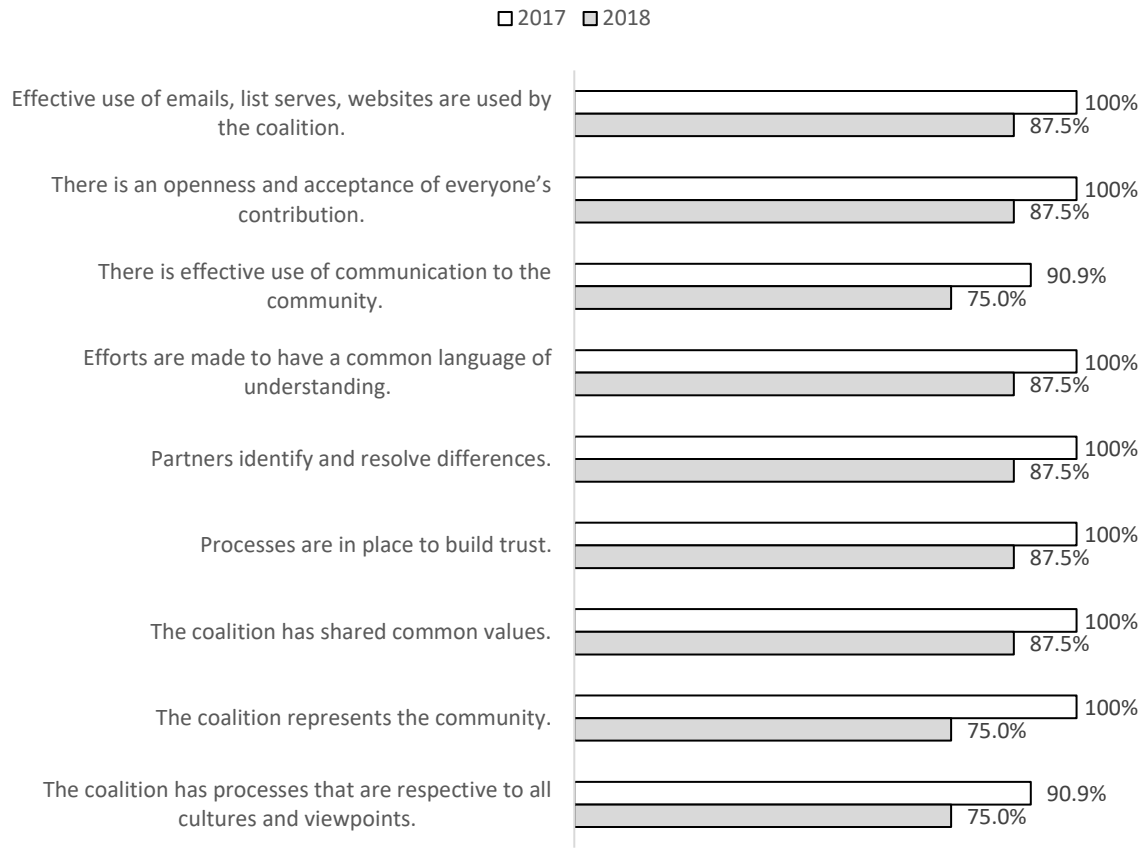


*Response options: never, almost never, sometimes, almost always, always

Comments about Mutually Reinforcing Activities
2018
• It has been an essential practice of the Community Partners to be mutually inclusive, listen to community voice to understand needs, gaps, barriers and strengths. • Sometimes it takes a while to get information from and then shared with all parties, but effort is always being made to move in that direction. Baby steps are taken to achieve goals. Quality of the efforts is more important than the quantity. This allows the coalitions and BCCP to move forward without having to redo or undo work/projects. Sustainability is always a part of the discussions.

CONTINUOUS COMMUNICATION

Figure 6. Continuous Communication [% almost always or always]*

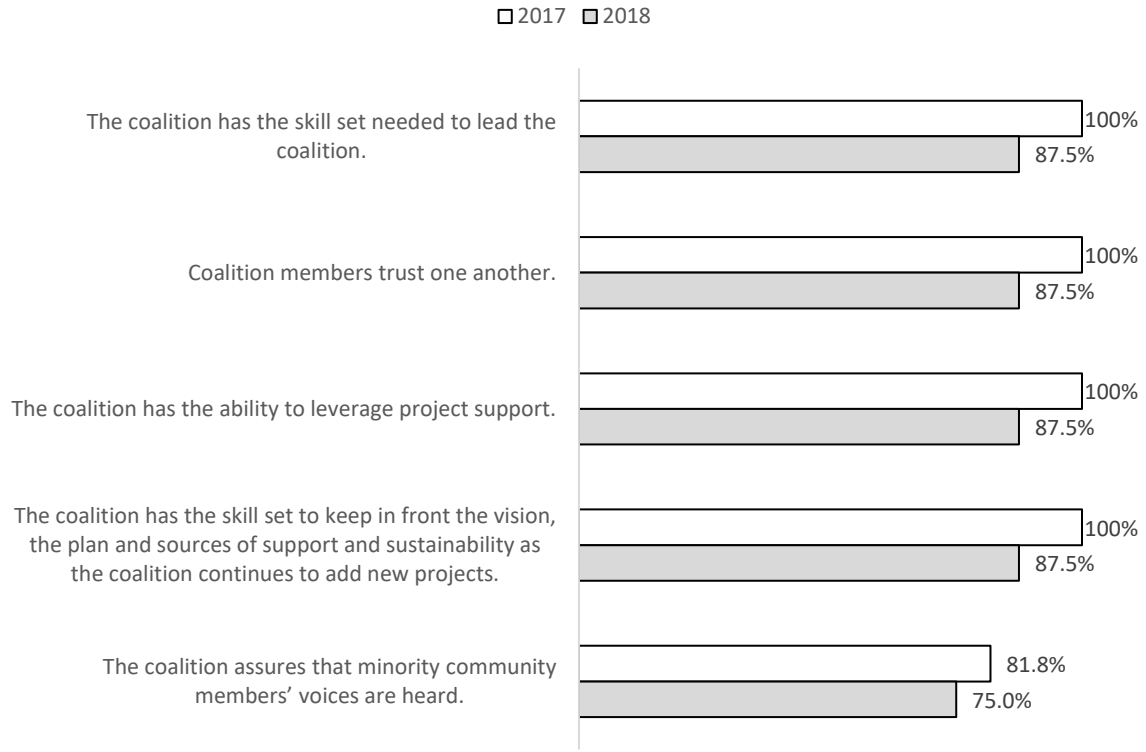


*Response options: never, almost never, sometimes, almost always, always

Comments about Continuous Communication
2018
• I hear more from community partners than the work that we are doing as an organization. • It would strengthen the Community Partners to recruit and include more minority representatives in all aspects of the coalition. • Transparency of all decisions and projects is paramount in this organization. No hidden agenda's - just want to do what will help Buffalo County communities to be healthier in all ways.

BACKBONE ORGANIZATION

Figure 7. Backbone Organization [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

Comments about Backbone Organization
2018
• There is a strong, skilled backbone organization. The Executive Director has been with the Community Partners for many years which contributes to the trust of the community, assurance of integrity, institutional knowledge of Buffalo County and the efforts of the Community Partners over the past 20+ years. The organization communicates clearly and often with partners and the community at large. Promotional materials are well done and support the community's awareness, understanding and commitment to the mission and work of the Community Partners. • The coalition works to include minority community members -- representatives from various organizations that serve those minority needs are a part of the coalition

KEARNEY/BUFFALO COUNTY BEHAVIORAL HEALTH IMPROVEMENT PLAN 2016-2019

Collective Vision: To increase the preventive outreach, educational efforts and resources that support the resiliency of community members who experience mental health and substance use issues.

Goals

1. Formation of a behavioral health (BH) community coalition through Buffalo County Community Partners (BCCP).
2. Support schools in their efforts to increase the knowledge and awareness of BH issues with students.
3. Increase mental health crisis stabilization capacity for youth and adults.

Resources/Input

- CHI Mission and Ministry Grant Funding
- CHI Health Healthier Communities Funding
- Other braided funding through Region 3 and other potential resources such as MCO's
- CHI Good Samaritan Hospital - Sponsor
- Buffalo County Community Partners - Backbone Organization
- Community Collaborative Partnerships

Strategies/Activities

Year 1:

- Establish a behavioral health coalition through BCCP to implement the BH improvement plan.
- Conduct an educational BH needs assessment with administrators, educators and staff of pre-K through college.
- Provide introductory BH education, training, and BH resource awareness to educational staff by local behavioral health experts and professionals.
- Develop a crisis stabilization plan that may include a 23:59 observation unit in a physical location, a crisis line, peer support, crisis therapy and other identified current services and resources to support increased crisis capacity.

Year 2:

- Provide comprehensive BH training to educators and staff that includes the Pyramid Model for early elementary teachers.
- Provide BH consultation to teachers to discuss BH cases and connect to resources.
- Begin implementation of the crisis stabilization plan as developed in year 1.
- Begin developing a sustainability plan for post grant.

Year 3:

- Community coalition continues to meet regularly.
- Continue strategies from years 1 and 2.
- Implement next steps from planning processes.
- Finalize sustainability plan and prepare to implement.

Outputs

- Number of coalition members and meetings.
- Number of teachers/staff attending BH training.
- Number of hours of BH consultation provided to schools.
- Number of patients receiving crisis stabilization services.
- Sustainability plan established.
- Sustainability plan established.

Outcomes

- Increased educators' knowledge of behavioral health signs and symptoms and awareness of community resources.
- Increase access to services by students.
- Increased access to BH crisis prevention services.
- Reduction in Emergency visits to CHI Health Good Samaritan and Richard Young.
- Improvement in Child-Well Being indicators and other available population indicators.

Behavioral Health Initiative

2nd Annual Evaluation Report

Lincoln/Lancaster County

July 2017 – June 2018

A. COMMUNITY COALITION DEVELOPMENT AND PLANNING

The Lincoln/Lancaster Coalition met four times as a full group as part of our quarterly meeting schedule. We have seen an increase in interest in the coalition as we have begun to gain traction and energy surrounding the grant in general. Additionally, we formed a small working group that has held three additional meetings where much of our work is being completed. Our biggest challenges have come around pulling our coalition and our community needs to fit within the grant guidelines that were written some time ago.

We are expanding our work in order to fill what our community needs which may or may not always fit the working definitions written in the past. Additionally, there is no formal tracking system in place for Wellness Recovery Action Planning (WRAP) trained professionals in Lancaster County which has required the group to think outside the box on how to achieve our needs related to WRAP. Our small group made the recommendation to the coalition that we explore Whole Health Action Management (WHAM) training for our community to reach more individuals and providers that are dealing with patients who present both mental and medical health issues.

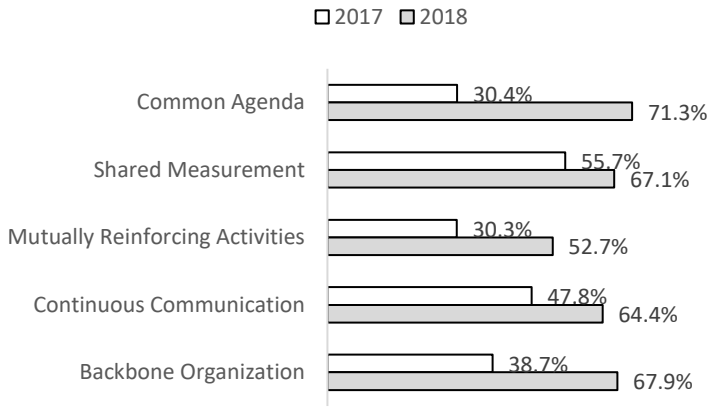
Collective Impact Survey Results:

The Collective Impact survey is designed to evaluate the effectiveness of the coalitions within five domains: Common Agenda, Shared Measurement, Mutually Reinforcing Activities, Continuous Communication, and Backbone Organization. All active coalition members (i.e., those who attended at least one meeting in the past year) were invited to participate in the survey and rate their coalition on a number of survey items within each of the five domains. The survey was conducted online via SurveyMonkey.

Response Rates:
2017 - A total of 9 members of the coalition in Lincoln responded to the survey out of 16 invitees, making for a response rate of 56.3%.
2018 - A total of 13 members of the coalition in Lincoln responded to the survey out of 18 invitees, making for a response rate of 72.2%.

Each of the five domains receives an aggregate score. The aggregate score is the average of the percentage reporting “almost always” or “always” for the statements within each domain. The graph below presents the aggregates scores for each of the five domains. Ratings increased in all five domains dramatically in 2018 as compared to 2017. The full survey results report is located in Appendix B.

Collective Impact Survey Aggregate Scores*



*An average of the percentage reporting "almost always" or "always" for the statements within each domain.

B. BEHAVIORAL HEALTH TRAINING/EDUCATION

Trainings				
Date(s)	**Training Topic/Description**	**Description of Individuals Trained (community, school, parents, healthcare, etc.)**	**# of Participants**	**# of Organizations Participated**
April 3-4, 2018	Whole Health Action Management (WHAM)	See description below	30	30
June 24-29, 2018	WRAP	See description below	7	4

Trainings were held in the second half of this grant year.

- **WRAP Training** – Doors for Wellness held a training event in June. The Lincoln/Lancaster Behavioral Health Coalition paid for seven individuals representing four coalition member organizations to attend the training (Lutheran Family Services, Mental Health Associates of Nebraska, Bryan Health and the Lincoln Regional Center). The Copeland Center facilitated this training with our coalition members receiving various levels of certification ranging from Advanced level WRAP (3), Facilitator Refresh certification (3), and Wellness Engagement (1) training. Because WRAP requires training certifications be completed in a

specific order, we have individuals at various levels. These training sessions occurred on June 24-29, 2018. No further information or data is available at this time.

- **WHAM –Whole Health Action Management (WHAM)** training was completed in Lincoln April 3-4, 2018. Nebraska Heart Hospital hosted the event. 30 individuals from our community participated. We had to turn 6 additional individuals away as we filled the class to its maximum capacity within ten days of finalizing a date and location. Participants ranged from care coordinators, to heart failure nurses, respiratory therapists, bereavement coordinators, population health coaches, diabetic educators, behavioral health education coordinators, peer outreach specialists, chronic disease nurses, religious coordinators within the prison system, recovery specialists, peer specialists and a WRAP manager. At the conclusion of the training, all participants agreed to participate in surveys on how they were implementing and utilizing their training within their respective organizations.

  Braided funding sources (St. Elizabeth Community Benefit Dollars and Nebraska Heart Hospital's in-kind) assisted the coalition and helped us to bring the WHAM opportunity to our community. There is great interest in another training as we have had additional inquiries from members outside the coalition which is helping to expand our membership and reach.

Outcomes for Trainings:

No formal evaluation data was made available for **WRAP** training.

WHAM participants received completed a training evaluation immediately after the training in April and a follow-up evaluation in June. Following are the highlighted results:

Training Evaluation (completed by 29 participants):

WHAM SKILLS – Whole Health Self-management skills were clearly presented:	**% Agree/ Strongly Agree**
1. Engagement in person centered planning to identify strengths and support.	100%
2. Writing a whole health goal based on person centered planning.	100%
3. Creation of a weekly action plan and log.	100%
4. Participation in WHAM peer support groups to create new health behavior.	100%
5. Elicitation of the Relaxation Response.	100%
6. Engagement in cognitive skills to avoid negative thinking.	100%

Comments:

- I think WHAM will really work for our patients.
- I will be using this with diabetes education, both in classes and in individual sessions.
- One of the best and useful trainings I've been too. I am really excited about facilitating WHAM.
- I look forward to seeing this practice model become one of the standards of care.

Follow-up Evaluation (completed by 13 participants):

Question	Response
1. Working with individual clients or WHAM Groups.	85% Individuals 15% WHAM Groups
2. Number of individual clients since training.	25 individuals
3. Number of WHAM groups.	2 groups

How the program is being implemented (quotes):

- We have included some components into our community transitions program questioning.
- I have begun to use it with patients one on one who have low psych scores.
- Not yet been determined. I do use bits and pieces in the RN education groups I facilitate in Outpatient psychiatry.
- I use the concepts in individual consultations with patients and have spoken with several programming personnel about implementing WHAM for staff and patients.
- I teach Outpatient Diabetes Education. The WHAM training has motivated me to improve my lifestyle as I have increased my exercise, improved my diet and lost weight. I have been able to incorporate these same principles into my diabetes education teaching with the patients I see.
- Informally using it with perinatal bereavement care and grief.
- Using it for individual patients in chronic illness self-management.

Successes (quotes):

- Patient: I have lost 15 lbs by eating healthier foods and increasing my exercise. I am also active with my church, serving as Church Chair and teaching Sunday School and Vacation Bible School. I try to sleep 7-8 hours every night. I have a positive attitude which I believe is key to overall health.
- The knowledge I gained in the training has allowed me to advocate more strongly for empowered health choices for those we serve and highlight areas where we need to asses creating more options for choice.
- Reducing blood sugars, reducing weight, eating healthier, beginning to exercise are all successes.

C. SUMMARY OF PROGRAMS IMPLEMENTED

COMMUNITY TRANSITIONS PROGRAM (CT) SINCE APRIL 2017 INITIATION

Program Planning:
The CT program started working with patients in April 2017. Our initial goal was to identify patients regularly utilizing acute mental health services within the hospital environment. Identification was based on patients who had utilized two or more visits to the mental health department in the past six months.

Program Description:
We offered our services to any patient that met the criteria and agreed to work with us. We noticed that this process did not appear to be working effectively or efficiently for the program's goals as many patients were simply agreeing to services, thinking that by agreeing the patient would be discharged quicker from the hospital. We were working with a high number of people, but the people were not actively engaging in services once discharging from the hospital.

In September 2017, we changed our approach towards patients. We began our peer support and wellness planning at our first conversation in the hospital. We continued to identify patients who have two or more visits in the previous six months. We were not just introducing the program and asking for their interest. We began having more thorough discussions with patients in the hospital about their wellness plans after discharge, how our program could help reach their wellness goals, and determining if the patient was committed to working with our program to improve their well-being. Changing the introduction process allowed us to identify patients that had motivation to change. We have signed up fewer patients since changing the introduction, but we have found patients to be more engaged in services as evidenced by them making meetings with us, completing phone contacts, and following through on trying to reach their wellness goals.

Approximately 40% of the patients we offer this program accept the services. We continue to make contact when they return to the hospital and many of them eventually become participants. Some of our participants relapse following involvement with Community Transitions, but many return for our help again. The periods between relapses when they do occur seem to be longer.

In the table below is the number of patients contacted who declined services, the total number of active participants and then we separated patients with 6 or less hospital visits prior to participation and those that had 7 or more visits. Please note that we will have to "true-up" numbers at year-end. The numbers below include three months from last grant year.

	Patients Contacted and Declined	Total Participants	Participants 1-6 Visits prior 6 months	Participants 7+ Visits in prior 6 Months
04/2017-12/2017 *(9 months)*	256	176	139	37
01/2018-06/2018 *(6 months)*	170	39	38	1

We continue to meet with patients on the units or in the Mental Health ED to provide resources as needed. Some patients decline our services as we provide them with resources to programs that fit their needs and feel that those programs will offer enough support. We see many

patients that lack hope about their future, which is a significant barrier to a patient's wellness. With our highest utilizers of the hospital, we are often seeing patients with a learned dependence on the system or patients who no longer qualify for community programs because they have used up every community resource previously. The program is a 4-6-week program.

Description of Community Transition Program Activities:

- Phone calls to support people – check-in after discharge, follow-up after therapy and med management, etc.
- Discuss wellness plans during hospitalization.
- Provide community resources to help meet needs – grief support groups, rent or utility assistance, medication assistance, domestic abuse resources, etc.
- Provide short-term transportation to provider appointments.
- Assist participants in filling out intake packets for Lutheran Family Services while participant is still hospitalized. Faxing intake packet to Lincoln Family Services while patient is hospitalized to assist in setting up services.
- Provide brief therapeutic support while participants wait for therapy services to start.
- Provide peer support to participants over phone or in-person.
- Provide bus passes as needed.
- Participate in community meetings to discuss patients and create plans to address his or her needs.
- Stay in regular contact with ED Connections at Bryan and St. Elizabeth's to coordinate efforts with mutual patients. Provide weekly update of identified patients.

Number of Participants:

Program Name: Community Transition Model (April 2017 – June 2018)			
Number of Individuals Served **Directly**	*217	Number of Organizations Involved in Implementation	1
Number of Children/Youth Served Directly (if applicable)	0	Number of Staff Involved in Implementation	2

*16 individuals are repeat clients

Weekly Participant Numbers

Week	**# of Participants**	**Week**	**# of Participants**
07/07/2017	23	01/11/2018	14
07/24/2017	31	01/18/2018	14
07/27/2017	25	01/25/2018	13
08/03/2017	21	02/02/2018	7
08/09/2017	23	02/09/2018	10
08/17/2017	26	02/16/2018	10
08/24/2017	26	02/23/2018	11
08/30/2017	28	03/16/2018	5
09/07/2017	23	03/22/2018	5
09/14/2017	24	04/06/2018	10
09/21/2017	20	04/12/2018	12

09/28/2017	20	04/19/2018	12
10/05/2017	19	04/26/2018	12
10/12/2017	17	05/03/2018	15
10/19/2017	15	05/10/2018	11
10/27/2017	13	05/17/2018	9
11/02/2017	7	05/24/2018	8
11/09/2017	8	05/31/2018	10
11/16/2017	8	06/07/2018	
11/27/2017	11	06/14/2018	
12/01/2017	12	06/21/2018	
12/07/2017	13	06/28/2018	
12/14/2017	17		
12/21/2017	19		
12/29/2017	13		
Average case load of 16 participants per week			
Phones provided: 14 Bus passes provided this year: 53			

Comments on Success and Challenges:
Bryan Mental Health department's readmission rates continue to decrease. We are seeing fewer patients meeting our 2 visits within 6 months program criteria. Some of the patients who are eligible for the program have been contacted numerous times and choose to continue their pattern of regular hospital visits. Efforts continue to try to include these individuals.

Community Transitions staff are spending additional time with patients when able while they are here in the hospital to encourage participation. Regular meetings with the clinical team assist in identifying patients who might benefit from the program who are outside our criteria if there is belief that this might prevent future hospitalizations.

The number of patients who qualify for the program has declined significantly. Our original criteria were at least *2 visits to the hospital in the past 6 months*. Efforts to avoid readmission has decreased our original numbers. As of June 1, 2018, we will *change the criteria for the program to 2 or more visits in 12 months.*

The number of recurring patients with 7 visits or more has also declined. We had 39 total patients in the grant year that fit this category. 6 between April – December, 2017 and only one in 2018 to date. Community Transitions staff are attending treatment team meetings to hear from psychiatrist and clinical team about patient's current situation. Stays can be very short term, and patients are not mentally well to have a community transitions/goal setting session. If Community Transitions staff are not able to communicate with patient who may benefit from the program at time of admission, will make one contact following discharge to see if they are wanting our support. Reasons patients are declining the program include:

- They want to think about it. Provided with information card. Are discharged without a decision and do not follow up with us.
- Patient is receiving support and services from others and do not feel they need the additional support.

- Patients appear actively delusional or psychotic while we are talking to them and are unable to focus on wellness goals.
- Patients want long term care like the Lincoln Regional Center.
- Patients not interested in working on their wellness-are not motivated to making changes at the time they are contacted. Regular visits to the hospital is their coping plan.

Greatest challenges:

- Participants wanting stable housing within a short time frame.
- Limited resources for homeless prevention – people need to be homeless to get on waiting lists for services and then have a lengthy wait.
- Participants being able to receive therapeutic services at agencies with sliding fee scales within a short time frame.
- Wait times for substance abuse treatments.
- Participant's ability to afford medications that they are prescribed at discharge.

Outcomes:

The outcomes below are based on ALL patients since the beginning of the program in April of 2017. A total of 178 patients who are not considered to be "super utilizers" (these individuals are tracked separately) have participated or are currently participating in the Care Transition Model Program. Of these patients, 129 completed the program at least six months ago. Looking at just these 129 patients, the number of inpatient visits decreased from 186 in the six months prior to participating in the program to 59 in the six months after participating in the program (a 68.3% decrease). Emergency department visits decreased from 207 in the previous six months to 135 in the post six months (a 34.8% decrease).

Care Transition Model Patient Data Summary 6-month pre-post *(non-super utilizers)**						
	Inpatient Visits			**Emergency Department Visits**		
Number of Patients	**Previous 6 months**	**Post 6 months**	**Percent change**	**Previous 6 months**	**Post 6 months**	**Percent change**
129	186	59	-68.3%	207	135	-34.8%

*This does not include the "super utilizer group of 24 patients.

A total of 39 patients who are documented as "super utilizers" (i.e. those who visited the hospital seven or more times in the previous six months) have participated or are currently participating in the Care Transition Model Program. Of these super utilizers, 36 completed the program at least six months ago. Looking at just these 36 super utilizer patients, the number of inpatient visits decreased from 91 in the six months prior to participating in the program to 43 in the six months after participating in the program (a 52.7% decrease). Emergency department visits decreased from 315 the previous six months to 129 in the post six months (a 59.0% decrease).

Care Transition Model Patient Data Summary 6-month pre-post (*super utilizers**)						
	Inpatient Visits			Emergency Department Visits		
Number of Patients	Previous 6 months	Post 6 months	Percent change	Previous 6 months	Post 6 months	Percent change
36	91	43	-52.7%	315	129	-59.0%

*Those with seven or more visits in the previous six months.

Case Studies of Seven Patients

- A – Came to the hospital with suicidal thoughts. Reported to the CT program staff that she was also in an abusive relationship. Lived with boyfriend and his mother. When discharged patient was unable to complete discharge appointments because she could not get rides to appointments. While hospitalized, A has believed her boyfriend would provide her rides. Arranged transportation for her. CT staff had provided a phone, which she used to remain in contact and discuss barriers. She reported one day that she felt like she needed to return to the hospital because she could not make her discharge appointments. CT staff went out to her home and provided her with bus passes. A used those bus passes to make it to IOP and was admitted to residential treatment for substance abuse. During treatment, she reported breaking up with her boyfriend.

- B – At his first hospitalization he had caused an injury to his hand – tendons, nerves, and skin – while experiencing a psychotic episode after using substances. The injury prevented him from being able to work, which was a major part of his identify and wellness. At his second psychiatric admission, we met with him several times in the hospital, listened to his concerns regarding his employment and ability to pay his bills. We provided him with community resources to help with one month's rent until he could work again. B made phone calls for those resources while on the unit and received help from St. Vincent de Paul. We asked for the chaplain to meet with him, since his spirituality was a major component of his wellness. We also provided him a phone since his personal phone was going to be shut off in a month and he could not afford the bill. After discharge he attend WRAP group. He recently reported that he was able to work again.

- C – Had been hospitalized 12 times prior to working with him in August – he had chronic alcohol abuse and other physical problems. He had previously agreed to services in May 2017 but did not engage in services. The social worker on Senior Mental Health asked if we could meet with him in August 2017. At this time, he had lost all of his community supports due to lack of engagement or non-compliance with programs. He was in a place where he wanted to work on goals and was re-signed up for the program. He met with us every week at the hospital – receiving peer support and brief therapeutic interventions. He began identifying how his childhood trauma impacted his mental health and substance use, and really wanted to work therapeutically on healing. We worked with him for 8 weeks until he could begin therapy at CenterPointe. Previously a barrier for him had been spending his SSDI within the first week of every month on hotels. We saw him remain at the City Mission and begin saving his money throughout

the month so that he could purchase items, such as a bicycle to transport himself. When we last met, he reported that he would soon be receiving housing through CenterPoint.

- D – Was here 79 times in 8 months prior to 10/2017. Extensive history of hospitalizations and commitment to the Regional Center. In 08/2017, he had lost his housing due to property destruction. There were community meetings with representatives from Bryan Health, Region V, LPD, TASC, MHA, People's Health Center, and Crisis Center. Initially, there was a plan for him to go to Omaha and receive community services there, but D was kicked out of his group home and hospitalized up there for several weeks. He came back to Bryan Health, and advocated for himself that he wanted to remain in Lincoln. There was another community meeting held, where the CT social worker provided Region V with information about the D's use of the hospital, allowing Region V to write up a request for individualized funding. D has remained in Lincoln since 10/2017, and has come to the hospital to check in. He has only come to the Mental Health ED for assessments 4 times.

- T - We have worked with T three times in Community Transitions. We initially worked with T in August 2017. At that time, T had 4 inpatient mental health visits and 8 emergency room visits in the previous 6 months. In May 2018, T had 4 inpatient mental health visits and 1 emergency room visit in the previous 6 months. T has significant struggles with maintaining his sobriety. He has utilized community services and failed to follow through with discharge plans, preventing him from being able to access some services to assist in detoxing and remaining sober when he wants. Between August 2017 and May 2018, T's desire to become and remain sober grew, and his biggest challenge was his confidence in himself and access to community supports. T eventually accessed substance abuse treatment services in Grand Island and remained sober for 5 months. He relapsed in May 2018, in part because his insurance would not cover his prescribed medications. T began abusing his PRN medications, and then relapsed to abuse alcohol. While hospitalized, we worked with T to support himself in advocating for his needs with the psychiatrist. We encouraged T to speak with the psychiatrist about the issues with his prescribed medications not being covered. T advocated for himself, and the psychiatrist reportedly made a call to the insurance company to assist T in having his medications covered. T has remained sober since discharge, following up with providers and attending AA to assist him.

- R - R had 2 mental health inpatient stays at Bryan West in the previous 6 months, and 5 inpatient mental health visits in the previous 12 months. She was not the most pleasant patient as she was a mother grieving the loss of her child, experiencing multiple chronic and painful medical conditions, and using substances. The peers would meet with R in the MHED, CT would check in with her on the inpatient units, and peers would check in with her during WRAP groups. We checked back in with R each time she came into the hospital, building rapport with her over time. Because of her experiences in the hospital, it inspired R to want to get well and share tools for wellness with others. R completed her own WRAP and is planning on becoming a WRAP facilitator. During WRAP she told

the peer specialists: “Thank you for all those times you guys would come into my room because it showed me that people care.” She hopes to become a peer specialist herself, as she found the hope to heal and support others through WRAP.

- K - K had 6 mental health inpatient stays at Bryan West in the previous 6 months. At the time we began working with her, she was coming to the MHED every month seeking inpatient admission. She was also identified as a high utilizer of emergency room services by ED Connections. In the previous 12 months, she had visited CHI St. Elizabeth’s 26 times. We had contacted her over the previous year, working to build rapport and encourage her to focus on improving her wellness. She has been very focused on coming to the hospital, relying on professional supports, and her medical issues. This led her to drop out of school and quit her job. When we began working with her in the CT program, we connected with her outpatient providers, using her therapist’s input to guide how staff interact with her when she does come into the hospital. We also collaborated with ED Connections at St. Elizabeth’s and had our program information included in the print out in the ER. Since she began working with us, she set a goal to not come into the hospital for as long as possible. We continue to work with her on reframing this goal on how long she can stay well, what skills she can use to remain well, and encouraged her to work in therapy on understanding when the hospital needs to be utilized. For one of the first times, she is following through with her hospital discharge plans, which include following up with her therapist, attending DBT groups, and day programming. Prior to working with us, she had 4 therapists in the previous year as she would suddenly switch. So far, she has continued working with the same therapist and is reportedly doing well. As we prepare her to discharge from our services, we have asked her to call us more and set the timeline for when she will discharge. K may continue to come to the hospital for services, but her visits have decreased.

D. OTHER PROGRAMS IMPLEMENTED (OPTIONAL)

In addition to WRAP trainings, the Lincoln/Lancaster County Behavioral Health Coalition provided Whole Health Action Management (WHAM) training to 30 participants from our coalition member organizations.

E. RESOURCE AWARENESS

N/A

F. COORDINATION AND NAVIGATION

- *Consensus with behavioral health service providers on a coordinated system to move patients into appropriate treatment and community-based programs as quickly as possible through the awareness of available openings in facilities*
- *Implement a provider coordination process*

Our coalition continues to discuss this issue and is working to find something that could realistically be adopted by the community. It has been a subject that has been under review for nearly 30-years. The last attempt was the United Way 211 program which has not been successful. We are looking at things that are more online and grassroots driven and hope to have more to report on in the future.

G. ASSESSMENTS AND PLANNING DOCUMENTS

N/A

H. ED VISITS AND COUNTY-LEVEL HEALTH DATA

To provide additional reflection on the impact of the project, baseline hospital and community wide data related to mental health is represented in the tables below. The data represents the most current year available and will be updated annually, if available. The three tables included:

- Lancaster (CHI) County Emergency Department Mental Health Visits
- Child Well-Being Indicators
- County Health Data Indicators

Mental Health Emergency Department Visits at CHI Hospitals

	*FY 2016	*FY 2017	% change
Lincoln, NE (Lancaster County)	467	577	23.6%
Total for 10 Communities	**16,165**	**17,382**	**7.5%**

*Fiscal Year: July-June
Source: CHI Health Hospital Data

Child Well-Being Indicators

	Year(s)	Lancaster County (Lincoln, NE)
Total Population/ages 19 & under	**2015**	306,468/81,922
	2016	309,637/ 82,932
Number/percent of births to teen mothers (age 17 and under)	**2015**	51/1.3%
	2016	45/1.1%
Number of juvenile arrests/rate per 1,000 population	**2015**	2,120/ 71.3
	2016	1,857/ 60.7
Number of substantiated child maltreatment victims/rate per 1,000 population	**2015**	685/9.7
	2016	804/11.3

Number in out-of-home care/ rate per 1,000 population	**2014**	762/10.8
	215	798/11.2
Percent of children ages 0-17 below poverty level	**2010-2014**	18.1%
	2011-2015	17.3%

(Source: Kids Count Data Center)

County Health Data Indicators (see Table 7 below for definitions and data sources)

	Year(s)	Lancaster County (Lincoln, NE)	*Nebraska*	*Iowa*
Poor Mental Health Days (ave. # unhealthy days/30 days)	**2014**	3.0	***2.8***	***3.1***
	2015	3.0	***3.0***	***3.3***
	2016	2.8	***3.2***	***3.3***
Adult Smoking	**2014**	16%	***17%***	***19%***
	2015	15%	***17%***	***18%***
	2016	14%	***17%***	***17%***
Excessive drinking (binge/heavy drinking past 30 days)	**2014**	23%	***21%***	***22%***
	2015	23%	***20%***	***21%***
	2016	25%	***21%***	***22%***
Alcohol-impaired driving deaths	**2010-2014**	28%	***35%***	***24%***
	2011-2015	29%	***36%***	***25%***
	2012-2016	34%	***37%***	***27%***
Chlamydia rate per 100,000	**2013**	460	***393***	***356***
	2014	495	***401***	***382***
	2015	510	***423***	***389***
Premature age-adjusted mortality rate per 100,000 (under age 75)	**2011-2013**	268	***302***	***309***
	2013-2015	269	***307***	***311***
	2014-2016	272	***309***	***313***
Drug overdose death rate per 100,000	**2014**	9	***7***	--
	2013-2015	8	***7***	--
	2014-2016	7	***7***	9
Suicide Rates per 100,000	**2010-2014**	11.3	***11.7***	--
	2011-2015	12.3	***12.0***	--
	2012-2016	13.2	***12.4***	--

(Source: County Health Rankings)

I. FINANCIAL RESOURCES AND SUSTAINABILITY

Funding from CHI Health			
Source	**Program, Strategy or Coalition Support**	**Funding Period**	**Amount**
Mission and Ministry Grant	Coalition Support – Leader Compensation and Coalition Lunches,	July 2017-June 2018	$118,426

	Best Practice Trainings and Programs – WRAP, WHAM and Community Transitions Program		
CHI Health St. Elizabeth	Whole Health Action Management Training (WHAM) WHAM	Grant Year Two – April 2018 April 2018	$11,000 In-Kind, location & food
CHI Health St. Elizabeth Foundation	In Kind Staff Support – Hospital Sponsor and Admin Support; Meeting Rooms and Refreshments for Coalition Meetings	July 2017-June 2018	$17,627

Grants and Funding Awarded Directly to the Coalition other than from CHI Health			
Source	**Program, Strategy or Coalition Support**	**Funding Period**	**Amount**
Lutheran Family Services	WRAP Training – provided through Doors to Wellbeing	Grant Year Two – June 2018	Time, travel and meals for LFS team members
Bryan Health	WRAP Training – provided through Doors to Wellbeing	Grant Year Two – June 2018	Time, travel and meals for Bryan team members
Mental Health Associates of Nebraska	WRAP Training – provided through Doors to Wellbeing	Grant Year Two – June 2018	Time, travel and meals for MHA-NE team members
Lincoln Regional Center	WRAP Training – provided through Doors to Wellbeing	Grant Year Two – June 2018	Time, travel and meals for LRC team member

Education on sustainability planning was conducted at the annual summit in May of 2018. Grant administrative staff will provide a sustainability process in the fall of 2018 to the coalitions to assist them in the development of their community specific sustainability plans.

Appendix A

Lincoln - Lancaster County 12-month Output Report

Report period: July 1, 2017 through June 15, 2018		
Area	**Metric**	**Input information here (only report on activities for the six months of the report period):**
Community Coalition	**Number of coalition meetings:**	4 full meetings/3 small group meetings
	Dates of coalition meetings:	Full – July 13 & October 12, January 25, April 12 Small Group – Aug 2, Sept 11, Nov 15
	Average number of coalition members attending meetings:	Full – 17 Small Group – 9-11
Coordination of Treatment	**Consensus among behavioral health service providers on coordinated system reached? (yes/no)**	No
	Number of providers consenting to coordination of treatment openings:	Still under discussion
	Number of clients supported through the coordination process:	None
Trainings (WRAP and other trainings)	**Names and dates of trainings:**	WHAM – April 3-4, 2018 Door to Wellbeing (WRAP) – June 24-29, 2018
	Number of participants at each training:	WHAM = 30 Door to Wellbeing = 7
	Types of training participants (across all trainings):	**Number of <u>health care workers</u> trained: 37 (several attended both trainings)**
		Number of <u>law enforcement</u> trained: 0
		Number of <u>school personnel</u> trained: 0
		Number of <u>other community professionals</u> trained: 0
	Number of train-the-trainers trained on WRAP:	3
Care Transition Model	**Pilot care transition model designed and implemented? (yes/no)**	Yes
	Number of patients participating in the Care Transition Model pilot program:	Average of 16/week 215 in past six months

Sustainability (Year 2)	**Began developing a sustainability plan? (yes/no)**	No
Sustainability (Year 3)	**Sustainability plan completed? (yes/no)**	No

Lincoln - Lancaster County Outcome Checklist

Area	Outcome	Tool/Resource	Data Collection Frequency
Community Coalition	Reduction in ED visits to CHI Health St. Elizabeth	CHI Health Hospital Database	Annually
	Reduction in ED visits to Bryan Health	Hospital Database	
Coordination of Treatment	Increased access to BH care as a result of coordination of services with increased number of clients/patients served by BH providers	Program documentation	Annually
Trainings (WRAP and other trainings)	Expansion of WRAP reduces suicide rates	Local Health Department Data	Annually
	Expansion of WRAP reduces ED visits	Hospital Database(s)	Every six months
	Increased knowledge of BH by medical staff	Post-training Evaluations	After each training
Community Transition Model	Increased well-being and successfully living at home for patients participating in the Care Transition Model	Pre/post 6-month In-patient and ED visits	Every 6 months

Appendix B

Behavioral Health Coalition Collective Impact Survey 2017 & 2018 Results for Lincoln

Introduction and Methodology

Nine out of ten CHI Health Behavioral Health Coalitions have participated in the Collective Impact Survey in 2017 and 2018. One community (Omaha Metro) has not participated in this survey. The survey is designed to evaluate the effectiveness of the coalitions within five domains: common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone organization. All active coalition members (i.e., those who attended at least one meeting in the past year) were invited to participate in the survey and rate their coalition on a number of survey items within each of the five domains.

The survey was conducted online via SurveyMonkey.

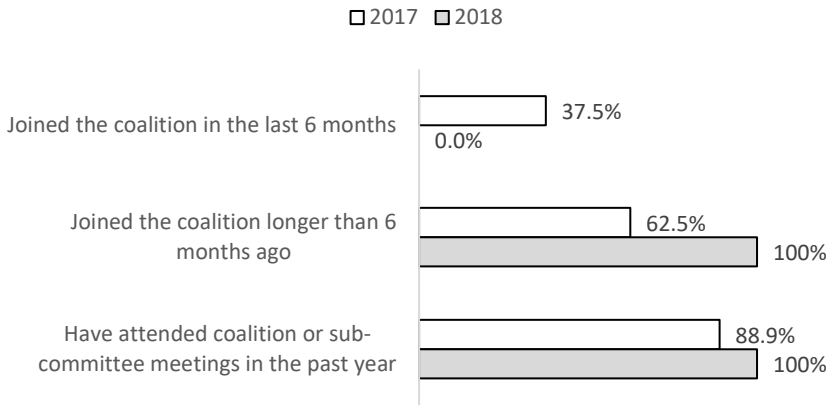
Response Rate

2017 - A total of 9 members of the coalition in Lincoln responded to the survey out of 16 invitees, making for a response rate of 56.3%.
2018 - A total of 13 members of the coalition in Lincoln responded to the survey out of 18 invitees, making for a response rate of 72.2%.

Coalition Involvement

Figure 1 shows the coalition involvement of the respondents.

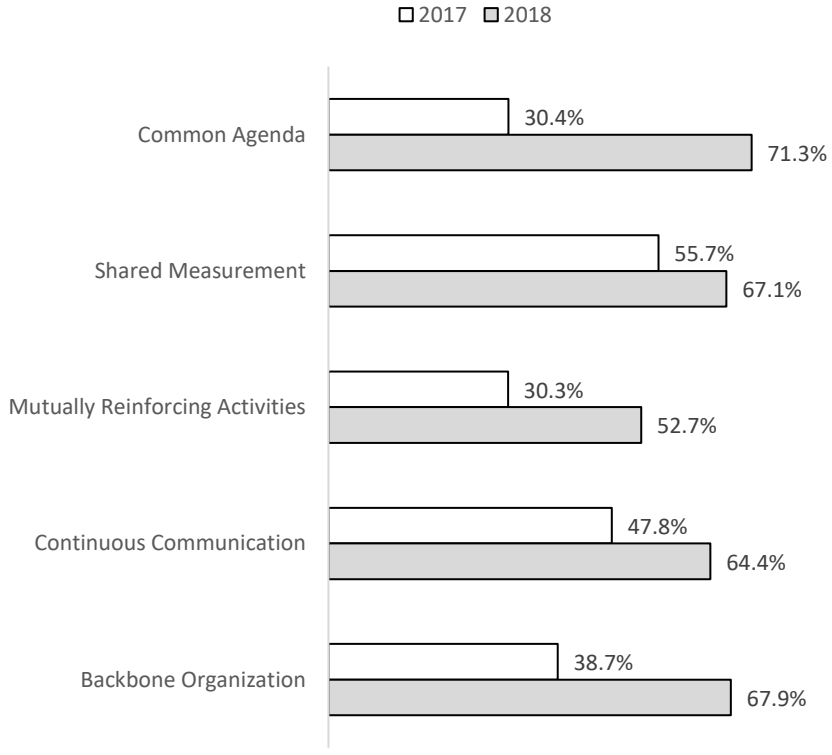
Figure 1. Coalition Involvement



AGGREGATE SCORES

Each of the five domains receives an aggregate score. The aggregate score is the average of the percentage reporting “almost always” or “always” for the statements within each domain. Figure 2 below presents the aggregates scores for each of the five domains.

Figure 2. Aggregate scores*

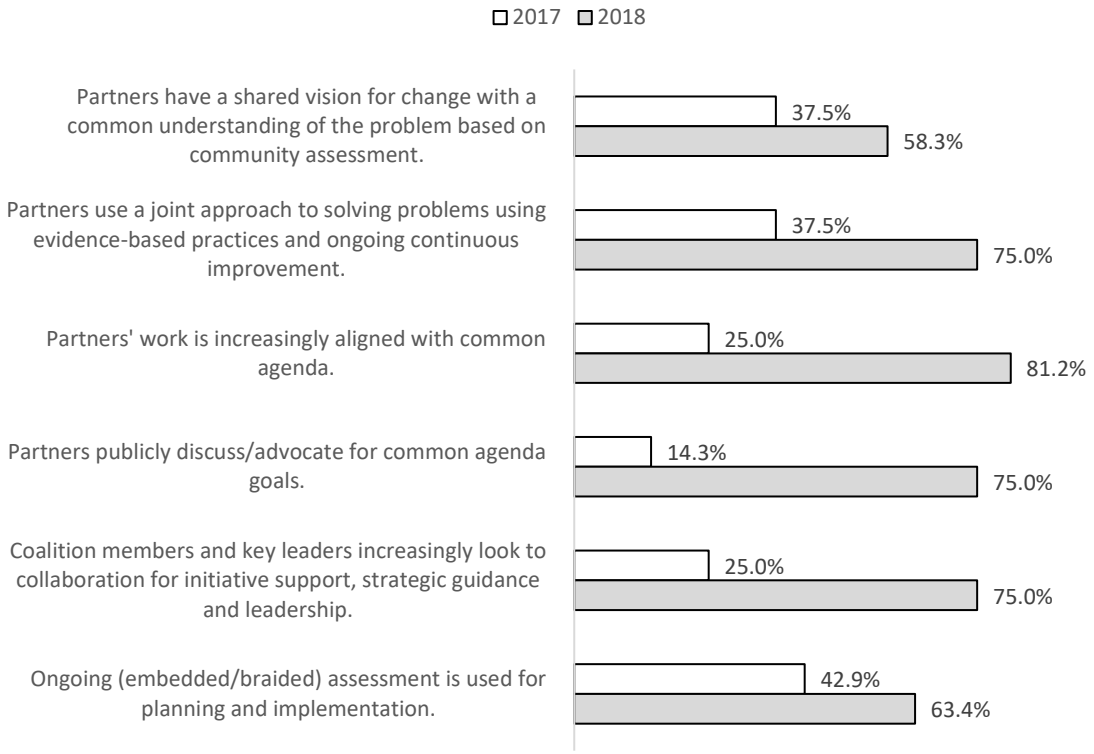


*An average of the percentage reporting "almost always" or "always" for the statements within each domain.

The remainder of this report presents the ratings for each survey item within each of the five domains of collective impact. After answering questions within each domain, respondents were given the opportunity to provide comments. Any comments that were made are included in this report.

COMMON AGENDA

Figure 3. Common Agenda [% almost always or always]*

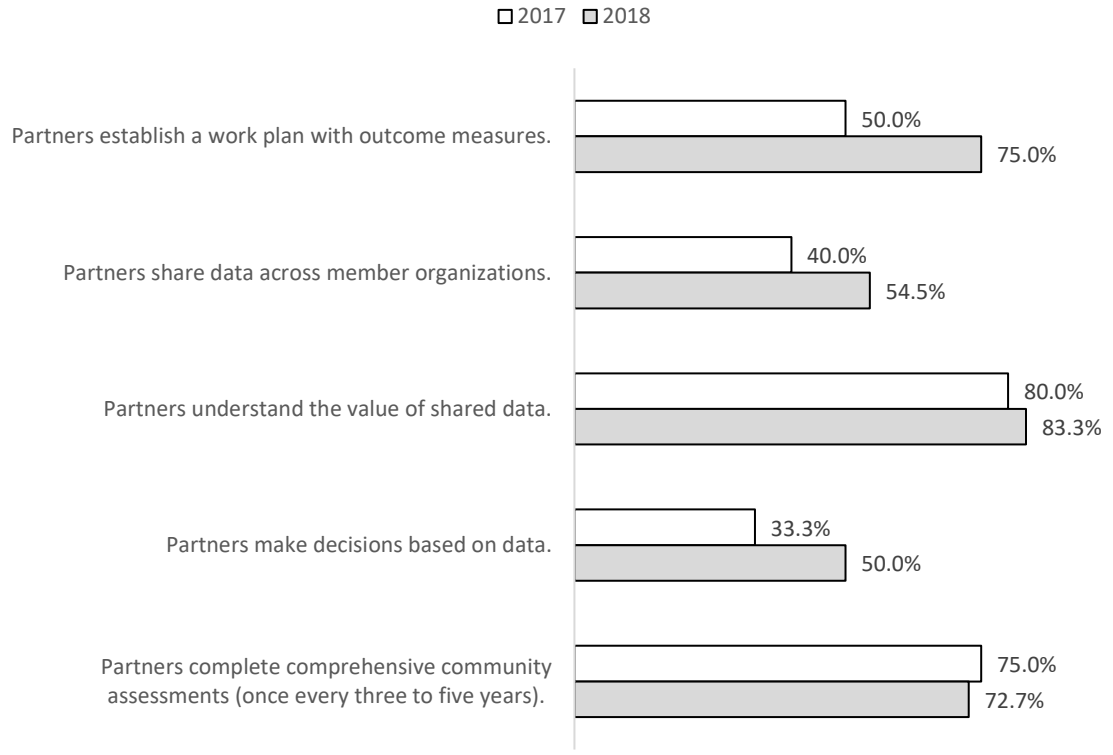


*Response options: never, almost never, sometimes, almost always, always

Comments about Common Agenda
2018
• We have come together this year and are working collaboratively in a way we did not do in the first year. It has helped to have someone coordinating things and leading the group. • Common agenda may have been clear at the outset of this process but seems to be becoming murkier lately - we probably need to revisit this so we are all on the same page heading in the same direction.

SHARED MEASUREMENT

Figure 4. Shared Measurement [% almost always or always]*

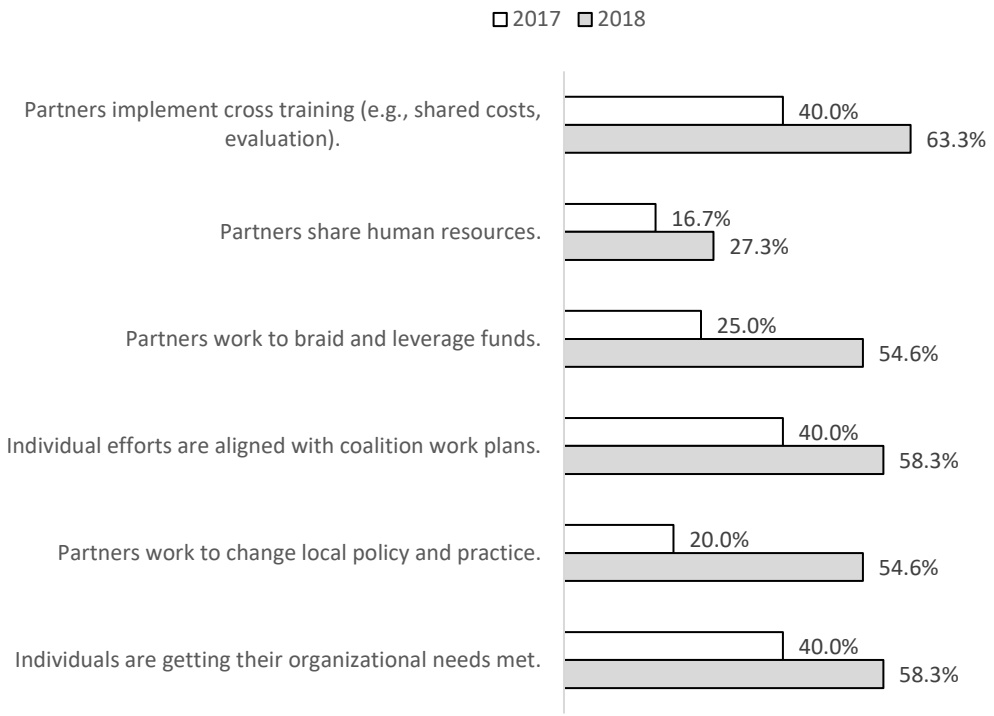


*Response options: never, almost never, sometimes, almost always, always

Comments about Shared Measurement
2018
• Many of the things we are trying such as WHAM are new and we are figuring out how to implement and ultimately measure our results. We will get there.

MUTUALLY REINFORCING ACTIVITIES

Figure 5. Mutually Reinforcing Activities [% almost always or always]*

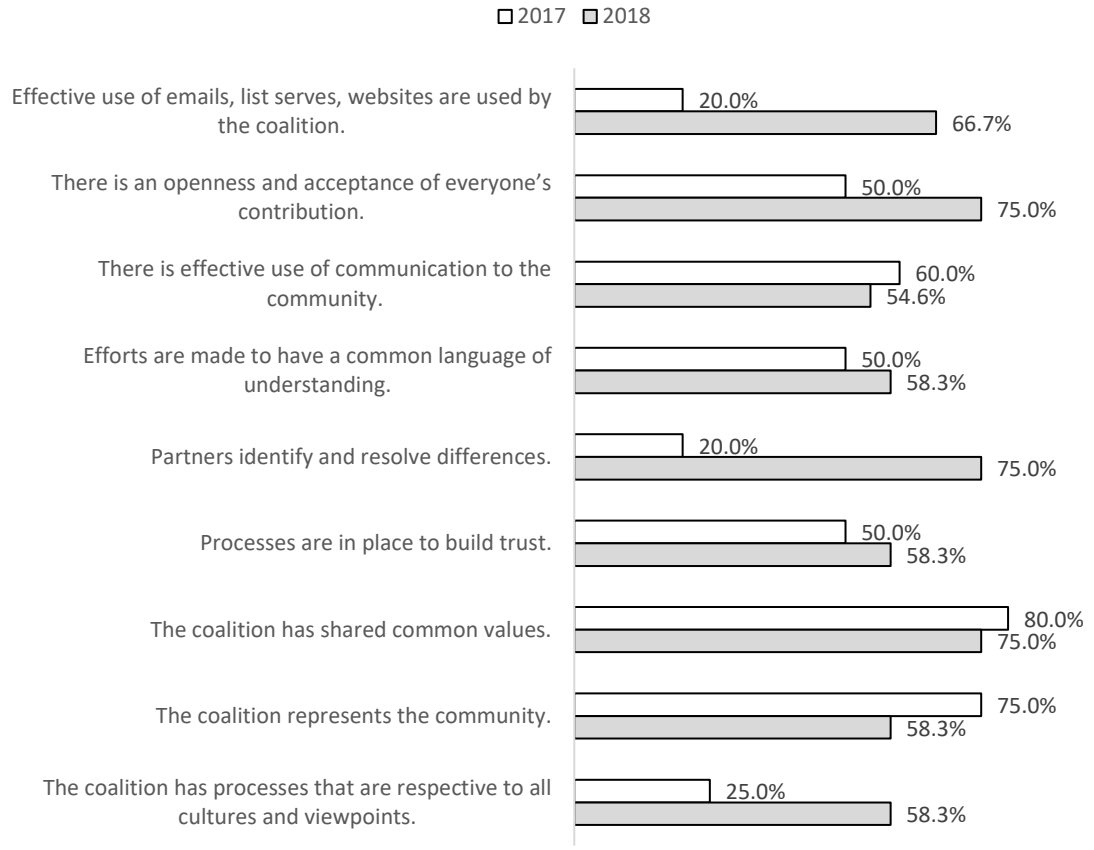


*Response options: never, almost never, sometimes, almost always, always

Comments about Mutually Reinforcing Activities
2018
• We have systems that need different things so we will not all benefit in the same way but we have a common goal to serve the great good for our community.

CONTINUOUS COMMUNICATION

Figure 6. Continuous Communication [% almost always or always]*

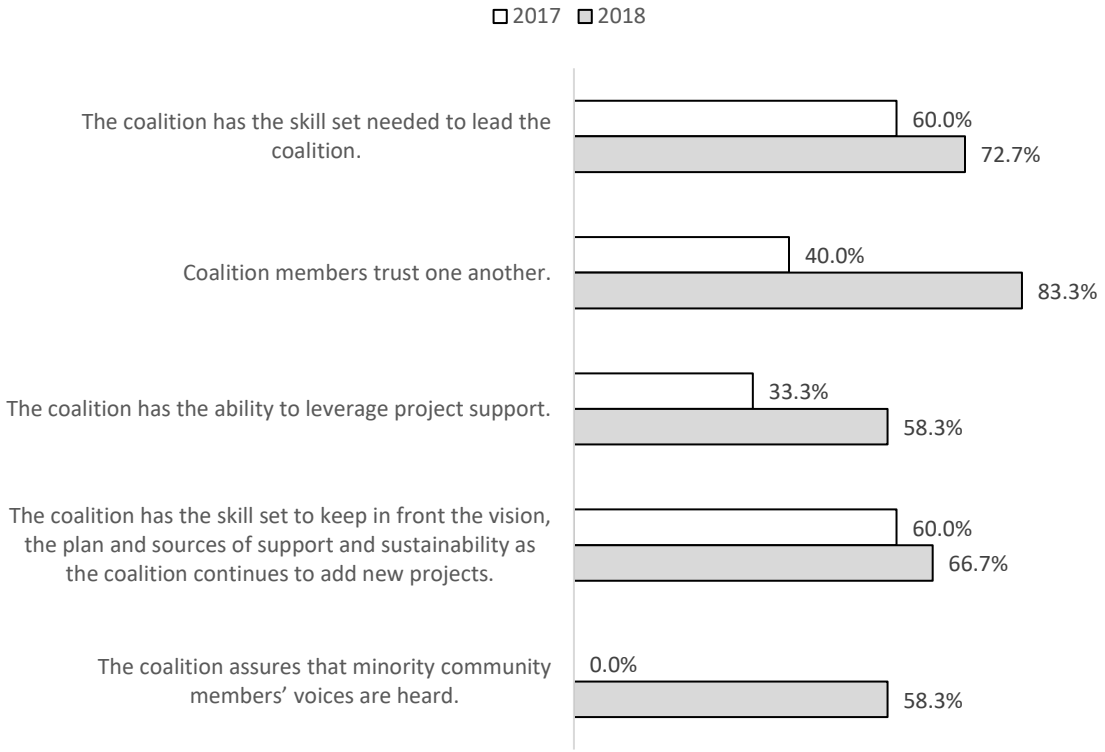


*Response options: never, almost never, sometimes, almost always, always

Comments about Continuous Communication
2018
• We are growing out coalition and have added players this year and will continue to do so. Communications have improved greatly after Laura was added to the group.

BACKBONE ORGANIZATION

Figure 7. Backbone Organization [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

Comments about Backbone Organization
2018
• CHI has given support to programs that they do not benefit from directly which we believe is what has gotten things moving. The key will be to see how we continue to work together after the grant ends. WHAM is a great opportunity for us to use to do just that in Lincoln.

LINCOLN/LANCASTER COUNTY BEHAVIORAL HEALTH IMPROVEMENT PLAN 2016-2019

Collective Vision: To increase the preventive outreach, educational efforts and resources that support the resiliency of community members who experience mental health and substance use issues.

Goals

1. Develop a community-based behavioral health coalition with hospitals, providers and other key stakeholders focused on improving behavioral health (BH) for individuals in the community.
2. Improve system flow for behavioral health patients in treatment or seeking treatment through a provider service coordination process.
3. Increase the use of BH prevention techniques with primary and integrated health clinics, schools, youth and adults in the community.
4. Expand the awareness and use of the Care Transition Model.

Resources/Inputs

- CHI Mission and Ministry Funding
- Other CHI Healthier Community Funding
- Other braided funding through Region 5 and potentially CHE and MCO's
- CHI Health St. Elizabeth Hospital - Sponsor
- Community Collaborative Leaders
- Community Collaborative Partnerships

Strategies/Activities

Year 1:

- Establish a core group of stakeholders to implement the BH improvement plan that will continue to meet over the 3-year grant and beyond.
- Gain consensus with BH service providers on a coordinated system to move patients into appropriate treatment and community-based programs as quickly as possible through the awareness of available openings in facilities.
- Expand Wellness Recovery Action Plan (WRAP) usage and training to schools, medical staff, behavioral health staff and other community-based program staff. Train additional WRAP trainers.
- Pilot the use of and expand the awareness of the Care Transition Model building upon initial study by Bryan Health.

Year 2:

- Coalition continues to meet and expanded strategies are implemented.
- Implement a provider coordination process.
- Continue to offer WRAP trainings in the community and provide other medical staff BH trainings.
- Implement the Care Transition Model pilot project.
- Begin developing a sustainability plan for post grant.

Year 3:

- Continue strategies from year 2.
- Implement next steps from planning processes.
- Finalize sustainability plan and prepare to implement.

Outputs

- Number of collaborative members and meetings.
- Number of providers consenting to coordination of treatment openings.
- Number of clients supported through the coordination process.
- Number of WRAP and other trainings offered and number participating in the training or classes.
- Number of train-the-trainers trained on WRAP.
- Number of patients participating in the Care Transition Model pilot program.
- Sustainability Plan established.

Outcomes

- Coalition efforts result in reduction in ED visits to Bryan Health and CHI Health St. Elizabeth.
- Increased access to BH care as a result of coordination of services with increased number of clients/patients served by BH providers.
- Expansion of WRAP reduces suicide rates and ED visits.
- Increased knowledge of BH by medical staff.
- Increased well-being and successfully living at home for patients participating in the Care Transition Model.

Behavioral Health Initiative

2nd Annual Evaluation Report
Missouri Valley/Harrison County, Iowa
July 2017 – June 2018

A. COMMUNITY COALITION DEVELOPMENT AND PLANNING

The Harrison County Behavioral Health Coalition was convened to work toward the goals of increasing the overall awareness of existing and potential resources among community stakeholders, breaking the generational cycle of addiction and dysfunction through prevention education of parents and youth through partnerships with schools, and improving the community's knowledge of behavioral health and the crisis response to individuals with behavioral health needs. The coalition consists of a fairly diverse group of stakeholders that typically meets 3 times within a 6-month period. At the beginning of Year 2, stakeholders decided to form two subcommittees to focus on implementing specific strategies. The subcommittees continued to meet as needed throughout Year 2 and reported their progress at coalition stakeholder meetings.

Coalition Successes

During Year 2 the coalition stakeholder group met 6 times. Stakeholders in attendance represented the local hospital, behavioral health providers, the local public health agency, the mental health and disability services region, crisis stabilization service providers, and 5 school districts located within the county. While average attendance remained fairly consistent at 14 people, the coalition experienced an increase in representation at meetings by school administrators. The increased representation was significant since implementation of prevention programs in the schools required the approval of district administration.

Following the Behavioral Health Summit sponsored by the Grant Administrator in May 2017, stakeholders made the decision to divide into subcommittees to focus on specific strategies. This approach allowed stakeholders to apply their efforts to strategies that are related to the work they do in the community. As a result, stakeholders were proactive in completing project-related tasks which helped move the coalition forward in its efforts to implement strategies. Additionally, the group became more cohesive as progress was made toward strategy implementation.

The subcommittee tasked with implementing a web-based resource directory made substantial progress during Year 2. Reallocation of grant dollars from Year 1 provided the subcommittee

with a budget to carry out the strategy and options not previously available. The subcommittee partnered with the Southwest Iowa Mental Health and Disability Services Region (SWIA MHDS Region) by providing funding for a redesign of their web-based directory *Resource Connection.* The web-based directory became operational in April 2018. Coalition dollars were used to purchase promotional materials to raise awareness of the online directory. The partnership with the SWIA MHDS Region also addressed long-term sustainability. The Region has staff to maintain and continually update the resources included in Resource Connection. The coalition will not have ongoing expenses associated with maintenance of the web-based directory.

Significant progress was also made during the reporting period by the subcommittee responsible for implementing prevention programs in schools. A School Needs Assessment conducted by the Network near the end of Year 1 revealed a need for programs targeting substance use prevention. Since the beginning of Year 2, the coalition has partnered with the substance use prevention coalition, Prevention Means Progress (PMP), located in Council Bluffs to offer Me360 to students in Harrison County. The subcommittee also collaborated with the Boys Town National Hotline to offer school-based suicide prevention education to students in coalition schools. At the conclusion of Year 2, the coalition implemented two prevention programs. As a result, students from four school districts received prevention education.

Although Mental Health First Aid (MHFA) was identified by the coalition as a separate strategy from school prevention programs, schools have expressed interest in providing Youth MHFA training to faculty, coaches, staff and community members. As a result, the coalition-sponsored MHFA trainer worked with the school prevention program subcommittee and coalition school districts to accommodate requests for training. Additionally, the coalition-sponsored MHFA trainer collaborated with the superintendent of one coalition school and Green Hills Area Education Agency to develop a protocol through which coalition schools are able to offer License Renewal Credit to faculty who attend MHFA training.

In an effort to reinforce the identity of the coalition, stakeholders voted to adopt the name Harrison County Behavioral Health Coalition. Additionally, the group developed a logo which includes the coalition name. The name and logo were used to raise awareness of the coalition's work and were included on promotional items purchased to raise awareness of *Resource Connection*.

Coalition Challenges

A challenge faced by the coalition during the reporting period involved a transition in leadership from the Mental Health and Substance Abuse Network (the Network) to the Southwest Iowa Mental Health and Disabilities Services Region (SWIA MHDS Region). The Executive Director of the Network left the organization which resulted in remaining staff, who had limited previous involvement with the coalition, assuming responsibility for continued facilitation of the project. However, due to overlapping initiatives between the Network and the SWIA MHDS Region, the remaining staff member was absorbed by the Region and responsibility for co-leadership of the coalition has transferred to the Region. A member of the Region's leadership team had pre-

existing relationships with community stakeholders, thus improved communication and efficiency in implementation of strategies has been realized.

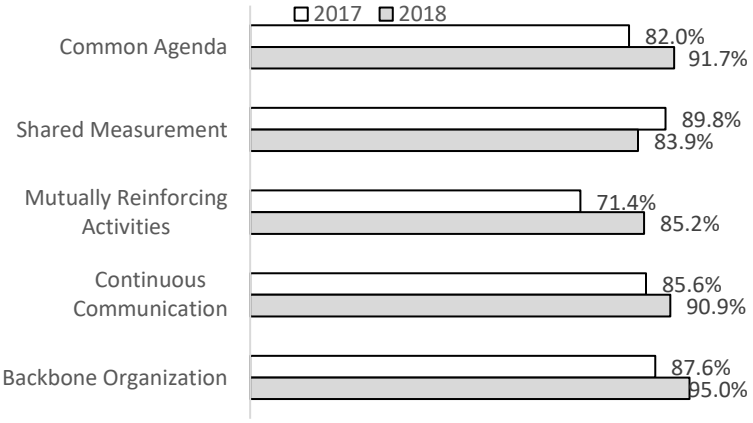
Collective Impact Survey Results:

The Collective Impact survey is designed to evaluate the effectiveness of the coalitions within five domains: Common Agenda, Shared Measurement, Mutually Reinforcing Activities, Continuous Communication, and Backbone Organization. All active coalition members (i.e., those who attended at least one meeting in the past year) were invited to participate in the survey and rate their coalition on a number of survey items within each of the five domains. The survey was conducted online via SurveyMonkey.

Response Rates:
2017 - A total of 14 members of the coalition in Missouri Valley responded to the survey out of 32 invitees, making for a response rate of 43.8%.
2018 - A total of 14 members of the coalition in Missouri Valley responded to the survey out of 35 invitees, making for a response rate of 40.0%.

Each of the five domains receives an aggregate score. The aggregate score is the average of the percentage reporting “almost always” or “always” for the statements within each domain. The graph below presents the aggregates scores for each of the five domains. Ratings were high on all five domains with an increase in ratings in four of the five domains in 2018 as compared to 2017 with the exception of Shared Measurement. The full survey results report is located in Appendix B.

Collective Impact Survey Aggregate Scores*



*An average of the percentage reporting "almost always" or "always" for the statements within each domain.

B. BEHAVIORAL HEALTH TRAINING/EDUCATION

Trainings				
Date(s)	**Training Topic/Description**	**Description of Individuals Trained (community, school, parents, healthcare, etc.)**	**# of Participants**	**# of Organizations Participated**
7/17/17	Youth MHFA Train the Trainer	Healthcare	1	1
10/26/17	Youth MHFA	School, Healthcare, Community, Church	13	5
1/18	Adult MHFA Train the Trainer	Healthcare	1	1
1/3/18	Youth MHFA	School	25	1
3/8/18	Adult MHFA	Community, Healthcare	18	6
4/18/18	Adult MFHA	Community, Healthcare	15	5
6/5/18	Adult MHFA	School	16	2
6/5/18	Youth MHFA	School	16	2

Reflection on training efforts:

Youth Mental Health First Aid (comments provided by Instructor)

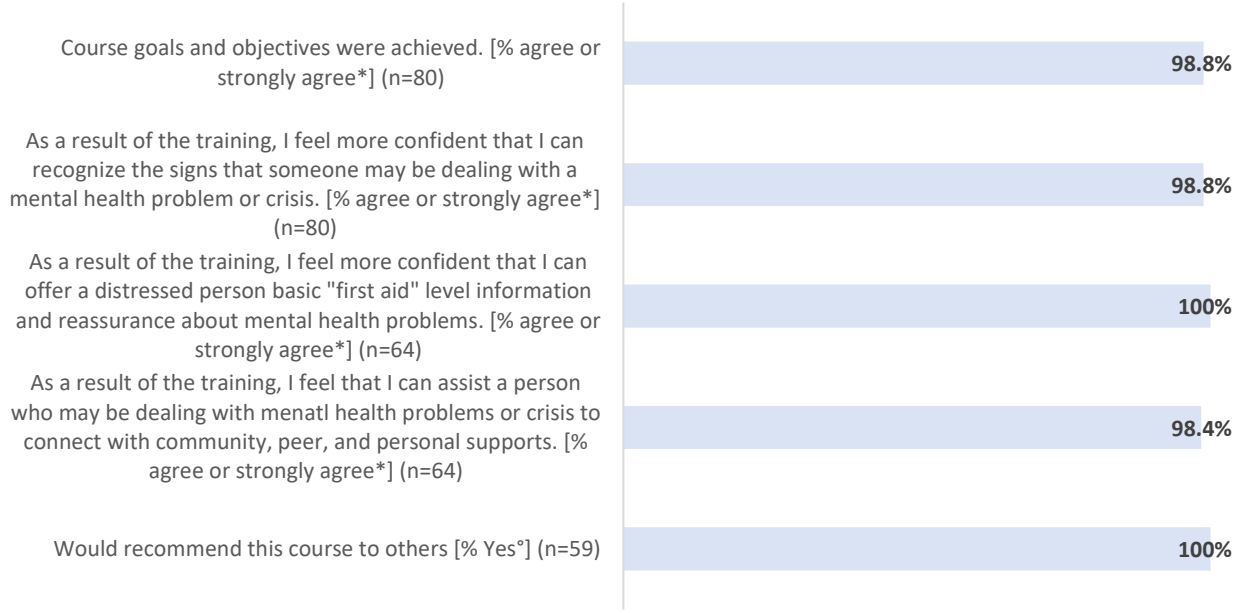
I have to say that teaching my first youth class went great. The feedback provided was all positive and the class participants were eager to get started on the Adult version. I had several people ask when the next class would be so that they could get others to come. This class consisted of a wide variety of community members who signed up simply by word of mouth. I had one participant tell me later that month that he used the information and was able to get the person in crisis to the proper help needed.

At the beginning of Year 2, the coalition sponsored one individual stakeholder in the completion of Youth MHFA. In January, the stakeholder completed the Adult MHFA trainer certification. Demand for the Youth and Adult MHFA Classes was strong during Year 2. By the end of the year, the coalition was able to meet the goal for providing 6 classes to stakeholders and community members.

Outcomes:

Participant evaluations were provided for five Mental Health First Aid Trainings. The graph below indicates high satisfaction and learning from the training.

Mental Health First Aid: Selected Results
Missouri Valley 2017-2018 Trainings



*Response options: strongly disagree, disagree, uncertain, agree, strongly agree
°Response options: yes, no
Note: Fourth item not included in the Youth MHFA Evaluations

C. SUMMARY OF PROGRAMS IMPLEMENTED

PREVENTION PROGRAMMING - ME360

Program Planning: Me360

In spring 2017, the Network conducted a School Needs Assessment to determine the behavioral health needs of school districts participating in the coalition. A survey was sent to school stakeholders of various staff positions. Twenty-one individuals responded and all six school districts were represented. Survey results indicated that staff felt they had access to mental health resources and services if and when needed. Respondents also reported having various mental health trainings and curriculums available to them either in their school or at a district level. Where substance use needs of students and families were concerned, however, staff reported a lack of resources and supports.

Having found a greater need for substance use prevention education and supports in coalition schools, the Network shared information with the stakeholder group about Me360 at the June, 2017 meeting.

Collaboration with schools to implement prevention programs with parents and youth.
At the June 2017 stakeholder meeting a subcommittee was formed to implement school-based prevention programs. The subcommittee, consisting primarily of stakeholders representing the six coalition school districts, met for the first time in August, 2017. Since the first subcommittee meeting, representation of school administrators at the collective stakeholder meetings has increased. In August, the Executive Director of Prevention Means Progress (PMP) joined the group via conference bridge to explain Me360 and discuss options for implementation. Stakeholders representing two school districts, Missouri Valley CSD and Woodbine CSD, expressed interest immediately. PMP staff worked directly with the school districts to identify time within their Family and Consumer Science (FCS) curriculum to present Me360 to students in 7th and 8th grade. In the spring, Logan-Magnolia CSD also made arrangements to have the curriculum presented to 7th and 8th grade students.

In addition to Me360, since August the subcommittee identified Coping Through the Teen Years/Suicide Prevention and Youth MHFA training as areas of focus for implementation. At the end of this reporting period, Me360 had been implemented in three school districts. Coping Through the Teen Years/Suicide Prevention was implemented in one school district in January 2018.

Program Description:
Me360 is a preventive educational strategy designed to deliver information about drugs of abuse including alcohol, marijuana, meth, prescription drugs and synthetic drugs to students 7th grade and older. The curriculum is taught by Prevention Means Progress (PMP) staff and requires 200 minutes of classroom time. The course can be tailored to fit within each school's science or health curriculum. PMP works directly with the schools to determine logistics of providing the program to students.

Description of Where Program was Implemented:
During the July-December 2017 reporting period, two coalition school districts, Missouri Valley Community School District (CSD) and Woodbine CSD, implemented Me360 with at least a portion of the target student population. Between January and June 2018, the program was provided to remaining 7th and 8th grade students in the Missouri Valley and Woodbine Community School Districts. A third school district, Logan-Magnolia CSD, also provided Me360 to all 7th and 8th grade students during the fourth quarter of the academic year.

Description of Participants (i.e., community individuals, parents, youth, ages, etc.).
During the July-December 2017 reporting period, 49 students in 7th and 8th grade completed the curriculum in the Missouri Valley CSD. Twenty-seven 8th grade students in the Woodbine CSD completed the program.

During the January-June 2018 reporting period, 54 students in 7th and 8th grade completed the curriculum in Missouri Valley CSD. In Woodbine CSD, 33 7th grade students completed the program. In April and May, 98 students in 7th and 8th grade completed the program. By the

end of grand Year 2, 261 seventh and eighth grade students in three school districts completed the program.

Number of Participants:

Program Name: Me360			
Number of Individuals (or Parents) Served Directly	36	Number of Organizations Involved in Implementation	3
Number of Children/Youth Served Directly	261	Number of Staff Involved in Implementation	8

Date(s)	Me360 Participants – Grade/School	# of Participants
Sept 6,14,20, 2017	7th Grade Students in Missouri Valley Community School District (CSD) Family and Consumer Science (FCS) class, Quarter 1	13
Sept 6,14,20,22,2017 and Oct 4, 2017	8th Grade Students in Missouri Valley FCS class, Quarter 1	11
Dec 5,7,8 2017	7th Grade Students in Missouri Valley FCS class, Quarter 2	12
Dec 5,7,8,12,14, 2017	8th Grade Students in Missouri Valley FCS class, Quarter 2	13
Oct 5,6, 2017	8th Grade Students in Woodbine Middle School FCS class, Quarter 1	12
Nov 20,21,22 2017	8th Grade Students in Woodbine Middle School FCS class, Quarter 2	15
Feb 6, 7, 9 2018	7th Grade Students in Missouri Valley FCS class, Quarter 3	13
Feb 6, 7, 9, 15, 16 2018	8th Grade Students in Missouri Valley FCS class, Quarter 3	13
April 10, 11, 13, 2018	7th Grade Students in Missouri Valley FCS class, Quarter 4	12
April 10, 11, 13, 16, 17 2018	8th Grade Students in Missouri Valley FCS class, Quarter 4	16
March 13, 15 2018	7th Grade Students in Woodbine Middle School FCS class, Quarter 3	15
May 21, 22 2018	7th Grade Students in Woodbine Middle School FCS class, Quarter 4	18
April 24, 25, 26	First ½ of 7th graders in Logan-Magnolia	27
April 24, 25, 26, 27, 30	First ½ of 8th graders in Logan-Magnolia	22
May 4, 7, 8	Second ½ of 7th graders in Logan-Magnolia	25
May 4, 7, 8, 9, 14	Second ½ of 8th graders Logan-Magnolia Schools	24
	TOTAL NUMBER OF STUDENTS SERVED	**261**

Comments on Successes and Challenges:

To date, the response to Me360 by school administrators, faculty and students has been very positive. Three school districts offered the curriculum to students during the Year 2. While all six school districts initially expressed interest in offering Me360, three school districts did not implement the program. Program staff indicated that while all schools initially expressed an interest in the program, some did not follow through with implementation. The coalition co-facilitator and program staff believe that implementation will increase in Year 3 since school administrators have time to plan ahead.

November 14th, PMP staff partnered with the Missouri Valley CSD to offer the parent component to Me360 at the Parents' Night held at the high school. The program, *Parents, You Matter* was presented to those in attendance by PMP staff. The program is designed to help parents understand why kids engage in substance use, how to start a dialogue about substance use with their child, and what steps to take if parents know or suspect their child is using. Missouri Valley CSD extended an invitation to parents and administrators from other coalition schools. In January, program staff attended Parent's Night at Tri-Center CSD to present *Parents, You Matter.* During Year 2 of the grant, a total of 36 parents attended the presentation.

One challenge encountered by program staff involved difficulty scheduling trainings with the schools that did not implement the program. Of the three schools that did not implement the program in Year 2, all indicated at mid-year an intention to implement. Upon follow up, one school suggested that substance use was not a problem with their student population and decided not to implement this year. One school was unable to overcome scheduling conflicts. A third school indicated on several occasions a desire to implement the program, but never followed up to outreach by program staff who were attempting to schedule.

Me360 (comments provided by Instructor)
July-December 2017. Me360 went very well in both school districts in both quarters. The teachers seem to be pleased with the curriculum and what we are discussing. They also have verbally expressed they are very impressed with the amount of participation and attention the students are displaying as they relate well to both the presenters and to the material we are presenting. The students are genuinely engaged in the material and interested in the topics we are discussing. They are respectful and have genuine questions about substance use, addiction, and high vs. low-risk choices. The teachers are engaged with students and seem to have a good relationship with the students as well. We are very happy to be providing Me360 and any other services we are able to provide to the Missouri Valley and Woodbine School Districts and any other schools in Harrison County.

January-June 2018. For quarters 3 & 4 we went back to Missouri Valley to present to the remaining 7th and 8th graders. In Woodbine for quarters 3 and 4 we presented to all the 7th graders in the district. Additionally, this last quarter of the year, we were able to get Me360 into the Logan-Magnolia School District and presented Me360 to all 7th and 8th graders in the district. All three schools seem pleased with Me360, the format and the information shared seem to be very favorable with teachers and students. Additionally, we have heard positive comments about the presentation in Logan-Magnolia School District from parents in the community and on the Harrison County Behavioral Health Coalition – they have reported that the students are sharing information from the presentation with their parents in a positive light.

Outcomes:

Overall, results from the pre-post Me360 were positive. Each substance was perceived as "very harmful" at a notably higher rate at pre- as compared to post.

Combined Me360 Survey Results

	Pre	Post
The presentation was excellent or good (n=224)	-	85.3%
Learned something new (n=224)	-	92.0%
Using alcohol is "very harmful" * (n=221)	22.6%	51.1%
Using marijuana is "very harmful" * (n=196)	43.4%	70.4%
Using someone else's prescriptions drugs are "very harmful" * (n=196)	45.4%	68.4%
Using synthetic marijuana is "very harmful" * (n=44)	72.7%	93.2%
Using bath salts are "very harmful" * (n=44)	75.0%	93.2%
Using meth is "very harmful" * (n=196)	76.5%	93.4%

*Response options: not at all harmful, a little harmful, harmful, very harmful
Note: not all survey items were used at each ME360 presentation due to the amount of time allowed for covering material.

COPING THROUGH THE TEEN YEARS/SUICIDE PREVENTION

Program Planning: Coping Through the Teen Years/Suicide Prevention
Following the completion of the School Needs Assessment, the formation of the school prevention program subcommittee, and the identification of Me360 to address substance use prevention needs of coalition schools, the Clinical Director of the Hope4Iowa crisis call line indicated Boys Town's interest in supporting coalition schools' efforts to prevent teen suicide. At the August 31st stakeholder meeting, Hope4Iowa staff distributed information about an upcoming Suicide Prevention Education Event at Thomas Jefferson High School in Council Bluffs for the community at large. Interest in piloting a new suicide prevention education curriculum targeting middle and high school students was indicated. Although suicide prevention was not identified directly in the School Needs Assessment, school stakeholders expressed interest in the program. One school district, Boyer Valley CSD, implemented the Coping Through the Teen Years/Suicide Prevention curriculum in January 2018.

Program Description:
Coping Through the Teen Years/Suicide Prevention is an educational program presented by Boys Town National Hotline clinical staff. This program offers separate curriculum for middle school and high school students. The course is designed to help students understand stress and depression; identify risk factors associated with suicide in themselves or others, and to respond appropriately when someone is at risk. Course materials are presented by Boys Town National Hotline clinical staff and require approximately 45 minutes of classroom time.

Description of Where Program was Implemented:
Coping Through the Teen Years/Suicide Prevention was offered to all middle and high school students in the Boyer Valley CSD on January 17 and January 25, 2018.

Description of Participants (i.e., community individuals, parents, youth, ages, etc.).
On January 17, 2018, 79 middle schools students in grades 6 through 8 completed the course. One hundred thirteen students completed the course in grades 9 through 12 on January 25, 2018.

Number of Participants:

Program Name: Coping Through the Teen Years/Suicide Prevention			
Number of Individuals (or Parents) Served Directly	0	Number of Organizations Involved in Implementation	1
Number of Children/Youth Served Directly (if applicable)	192	Number of Staff Involved in Implementation	3

Comments on Successes and Challenges:
This program was recently developed by Boys Town and offered as a prevention program resource to the Harrison County Behavioral Health Coalition. Boys Town staff indicated they had capacity to accommodate two coalition school districts during Year 2 of the grant. One school district implemented the program providing suicide prevention education to all students in grades 6 through 12. The program will continue to be available to school districts in Harrison County in Year 3.

Outcomes:

- 91% of middle school students agree/somewhat agree that they could apply the information and skills learned in the presentation to their life (n=78)
- 54% of high school students agree/somewhat agree that they could apply the information and skills learned in the presentation to their life (n=112)

D. OTHER PROGRAMS IMPLEMENTED (OPTIONAL)

The Network operates a Community Training Opportunity (CTO) program outside of this project. The program offers ongoing opportunities for behavioral health professionals to receive training on topics related to their field. During Year 2, the Network sponsored one Community Training Opportunity titled "Hope and Trauma: The Two Sides of Sexual Abuse" presented by Sheryl Overby, MS, NCC, LIMPH from Lutheran Family Services. A total of 18 people attended the training. Overall, 94 percent of those responding to the post-training survey indicated that their skills/knowledge increased as a result of the training.

In October 2017, the Southwest Iowa Mental Health and Disability Services Region (the Region) assumed responsibility for programs and initiatives facilitated by the Network. In early 2018 the Region initiated efforts to relaunch of the Network's CTO program. During May and June 2018, the Region offered two training events. The first class, titled "Borderline Personality Disorders," was presented by Dr. John Lehnhoff, Ph.D. from CHI Health Behavioral Services on May 10, 2018. A total of 42 individuals attended this training. Of those who completed the post training survey, 97 percent indicated their skills/knowledge increased as a result of the training. On June 7th Dr. Adam Briggs, from the Munroe Meyer Institute's Center for Autism Spectrum Disorders presented "Autism Spectrum Disorders" to community providers. A total of 34 individuals attended this training. Of those who completed the post-training survey, 100 percent indicated their knowledge/skills increased as a result of the training. Both training opportunities were promoted to coalition stakeholders.

E. RESOURCE AWARENESS

Community Web-Based Resource Directory

In Year 1, the Harrison County Behavioral Health Coalition was tasked with implementing a web-based community wide resource directory specific to Harrison County. This specific strategy had no budget for implementation. Additionally, stakeholders could not agree on whether to implement a web-based directory, revise the strategy to produce a print directory, or do a combination of the two. Given these challenges, the coalition facilitator at the time urged stakeholders to consider using the SWIA MHDS Region's existing web-based directory *Resource Connection*. The directory included resources from 9 counties in Southwest Iowa, including Harrison County. SWIA MHDS Region leadership agreed to allow the coalition to include additional resources from Harrison County in the directory.

At the beginning of Year 2, unused funds from the previous year were reallocated and the coalition found itself with a budget to pursue the development of a web-based directory. The coalition facilitator contacted the company hired to produce a similar website for another Mission and Ministry Grant Coalition. Based on that conversation, it was apparent that, while the coalition had the budget to set up the directory, ongoing maintenance, directory updates and sustainability would likely continue to be a challenge. Still, stakeholders had concerns about the functionality of the SWIA MHDS Region's *Resource Connection.*

The subcommittee formed to implement the resource directory carefully weighed its options and decided to use funds to partner with the SWIA MHDS Region to update *Resource Connection* to include features identified by the subcommittee as necessary. Among the features sought was a more streamlined, easier to search format with drop-down menus for category selection. The updated format would also provide the ability to print specific searches to address the desire for print directories sought by some stakeholders. Finally, the new format would allow service providers to submit contact information and program descriptions for inclusion in the directory, thus simplifying the ability to keep the resources listed in the directory updated.

The partnership with SWIA MHDS Region was viewed as desirable for several reasons. First, the cost to update the existing directory is substantially less than the creation of a stand-alone website, thus, remaining funds can be used to raise awareness in the community of *Resource Connection.* Second, the Region has staff designated to update *Resource Connection* on a regular basis which removes concerns about maintenance and updating. Finally, *Resource Connection* will continue to be maintained by the SWIA MHDS Region after Year 3 of the grant concludes, thus addressing the issue of sustainability.

The SWIA MHDS Region contracted with the University of Nebraska at Omaha's College of Information Science and Technology to update *Resource Connection* to include the features sought by the subcommittee. The revised resource directory was launched on April 6, 2018. The subcommittee purchased magnets and pens with the web address for the directory and is in the early stages of raising community awareness. Coalition staff attended the Harrison County Health Fair to demonstrate and promote *Resource Connection* to community members. Additionally, the coalition is in the process of developing informational posters to be distributed to 76 locations in Harrison County. Efforts to educate the community will continue in Year 3.

F. COORDINATION AND NAVIGATION

Counselors build relationships with schools and offer counseling in the schools.
At the completion of the School Needs Assessment conducted by the Network in April 2017, it was determined that schools had access to school psychologists, school-based interventionists through Green Hills Area Education Agency, and counselors through the school districts themselves and that the strategy, "to provide 2 dual diagnosis counselors for children and youth in the schools across the county (one in Missouri Valley and one roving") did not align with current needs.

The subcommittee formed to implement school-based prevention programs met in April 2018 to discuss program options for Year 3. A portion of the conversation focused on whether consideration should be given to this strategy again. Stakeholders who were present at the meeting indicated that, for the most part, their needs were currently being met by their guidance counselors, by school psychologists and school-based interventionists from Green

Hills Area Education Agency, or through arrangements made with private therapists. The decision was made again to not pursue this strategy.

Implement a mobile mental health crisis response team concept with support of law enforcement.
During the reporting period, modest progress was made with regard to implementation of a Mobile Crisis Response Team in Harrison County. Previously, the only law enforcement agency willing to implement mobile crisis response has been Woodbine Police Department. To date, they have been trained, but have had no incidents requiring service engagement. In March 2018 officers from the Dunlap Police Department were trained and mobile crisis response was implemented. In April 2018, law enforcement officers activated the service on two occasions.

While the other law enforcement agencies within the county originally resisted, there is some indication attitudes are beginning to change. Two agencies that were originally resistant have since indicated a willingness to meet with Mobile Crisis Response Team staff. At the close of Year 2, however, the meetings had not occurred.

G. ASSESSMENTS AND PLANNING DOCUMENTS

N/A

H. ED VISITS AND COUNTY-LEVEL HEALTH DATA

To provide additional reflection on the impact of the project, baseline hospital and community wide data related to mental health is represented in the tables below. The data represents the most current year available and will be updated annually, if available. The three tables included:

- Adams County Emergency Department Mental Health Visits
- Child Well-Being Indicators
- County Health Data Indicators

CHI Health Hospital Emergency Department Mental Health Visits

	*FY 2016	*FY 2017	% change
MO Valley, IA (Harrison County)	137	193	40.9%
Total for 10 Project Communities	**16,165**	**17,382**	**7.5%**

*Fiscal Year: July-June
Source: CHI Health Hospital Data

Child Well-Being Indicators

	Year(s)	Adams County (Corning, IA)
Total Population/ages 19 & under	**2015**	14,149/ 3,226
	2016	14,335/ 3,554
Percent of births to teen mothers (age 15 to 19)	**2015**	2.3%
	2016	1.3%
Number of substantiated child maltreatment victims/rate per 1,000 population	**2015**	12.8
	2016	10.9
Percent of children ages 0-17 below poverty level	**2015**	13.2%
	2016	15.1%

(Source: Kids Count Data Center)

County Health Data Indicators

	Year(s)	Harrison County (MO Valley, IA)	*Iowa*	*Nebraska*
Poor Mental Health Days (ave. # unhealthy days/30 days)	**2014**	2.9	***3.1***	***2.8***
	2015	3.2	***3.3***	***3.0***
	2016	3.2	***3.3***	***3.2***
Adult Smoking	**2014**	17%	***19%***	***17%***
	2015	16%	***18%***	***17%***
	2016	14%	***17%***	***17%***
Excessive drinking (binge/heavy drinking past 30 days)	**2014**	21%	***22%***	***21%***
	2015	19%	***21%***	***20%***
	2016	19%	***22%***	***21%***
Alcohol-impaired driving deaths	**2010-2014**	32%	***24%***	***35%***
	2011-2015	20%	***25%***	***36%***
	2012-2016	25%	***27%***	***37%***
Chlamydia rate per 100,000	**2013**	282	***356***	***393***
	2014	333	***382***	***401***
	2015	223	***389***	***423***
Premature age-adjusted mortality rate per 100,000 (under age 75)	**2011-2013**	384	***309***	***302***
	2013-2015	362	***311***	***307***
	2014-2016	330	***313***	***309***
Drug overdose death rate per 100,000	**2014**	--	--	***7***
	2013-2015	--	--	***7***
	2014-2016	--	9	***7***
Suicide Rates per 100,000	**2010-2014**	--	--	***7***
	2011-2015	--	--	***7***
	2012-2016	--	9	***7***

(Source: County Health Rankings)

I. FINANCIAL RESOURCES AND SUSTAINABILITY

Funding from CHI Health			
Source	**Program, Strategy or Coalition Support**	**Funding Period**	**Amount**
Mission and Ministry Grant	Coalition Support – Leader Compensation and Coalition Lunches; Best Practice Trainings and Programs – MHFA, Me360 and Coping Through the Teen Years	July 2017 – June 2018	$34,603
Healthier Communities	Coalition Support – Leader Compensation	July 2017 – June 2018	$5,000
CHI Health Missouri Valley	In Kind Staff Time – Hospital Sponsor and Others, Coalition Lunches and Meeting Rooms for Coalition Meetings	July 2017 – June 2018	$8,705

Education on sustainability planning was conducted at the annual summit in May of 2018. Grant administrative staff will provide a sustainability process in the fall of 2018 to the coalitions to assist them in the development of their community specific sustainability plans.

J. OTHER (OPTIONAL)

During Year 2, there were a number of education events and trainings offered by organizations that are members of the Harrison County Behavioral Health Coalition that were not directly sponsored by the coalition. The following events were advertised to coalition stakeholders. On September 26, the Hope4Iowa Crisis Call Line, Green Hills Area Education Agency, and Clear Mind Therapy partnered to present a Community Suicide Prevention Education Event at Thomas Jefferson High School in Council Bluffs. The panel provided material to educate attendees on risk factors, warning signs and steps to take if a student is at risk. The event was live streamed on Facebook. Promotional materials were distributed in print at the September 14th school prevention subcommittee meeting. Information was also provided to stakeholders at the stakeholder meeting on August 31.

In an effort to support families within Harrison County, Sonya Fittje from Boys Town provided information to stakeholders about Common Sense Parenting classes offered by Boys Town. The classes provided a free meal and child care to those in attendance. The first class met from September 28 through November 2 in Council Bluffs and the second class, sponsored by Tri-Center CSD was held March 3 through April 9 in Minden, Iowa. Information was shared with all schools within the coalition.

The Healthy Harrison Coalition and Harrison County Home and Public Health held Race to Resilience on December 28. The event was focused on ending the effects of Adverse Childhood Experiences (A.C.E.s) and creating strong community connections. An invitation was sent to all schools within the coalition.

Missouri Valley CSD sponsored a parents' night on January 29 at which Positive Behavior Intervention Supports (PBIS): From School to Home was presented. An invitation was extended to all schools within the Harrison County Behavioral Health Coalition.

Heartland Family Services Logan, Iowa office sponsored four sessions Circle of Security. The courses, offered in 8-weeks sessions, are designed to support and strengthen parent/child relationships. The sessions were held from November 29, 2017 to January 30, 2018; February 6 to March 27, 2018; April 3 to May 22, 2018; and May 29 to July 17, 2018. The program was advertised to coalition stakeholders.

Throughout Year 2, the coalition witnessed an increase in information sharing related to community resources available to stakeholders that were not sponsored by the coalition.

Appendix A

Missouri Valley - Harrison County 12-month Output Report

Report period: July 1, 2017 through June 15, 2018

Area	Metric	Input information here (only report on activities for the six months of the report period):
Community Coalition	Number of coalition meetings:	6
	Dates of coalition meetings:	August 31, 2017, October 17, 2017, November 29, 2017, January 18, 2018, March 15, 2018, May 8, 2018
	Average number of members attending meetings:	14.17
	Number of resource directories distributed (or number of hits to web-based resource directory):	Site Launch April 6, 2018
School Collaboration	Schools collaborating with agency partners to provide programming (list schools):	4
Prevention Programs	Number of prevention programs implemented:	2
	Names of implemented prevention programs:	Me360 Substance Use Prevention Education; Coping Through the Teen Years/Suicide Prevention
	Number of parents and youth participating in prevention programs (across all programs):	Parents: 36
		Youth: 453
Therapy at Schools	Number of children and youth participating in therapy at the schools:	n/a
Crisis Response Team	Mental health crisis team concept developed and implemented? (yes/no)	Yes, concept is fully developed; partially, implemented (2 law enforcement departments within the county).
	Crisis Response Team functioning? (yes/no)	Yes
	Number of response incidents:	2
Trainings	Names and dates of trainings:	Youth Mental Health First Aid 10/26/17; 1/3/18; 6/6/18 Adult Mental Health First Aid 3/8/18; 4/18/18; 6/5/18

	Number of participants at each training:	YMHFA: 13, 25, 16 AMHFA: 18, 15, 16
	Types of training participants (across all trainings):	Number of health care workers trained: 9 incomplete see 3/8 & 4/18 trainings
		Number of law enforcement trained: 0
		Number of school personnel trained: 58
		Number of other community professionals trained: 3 incomplete see 3/8 & 4/18 trainings
Sustainability (Year 2)	Began developing a sustainability plan? (yes/no)	Yes
Sustainability (Year 3)	Sustainability plan completed? (yes/no)	No

Missouri Valley - Harrison County Outcome Checklist

Area	Outcome	Tool/Resource	Data Collection Frequency
Community Coalition	Increased awareness of resources leads to increased use of those resources	Community Service Provider Survey	Annually (every May)
	Members rate coalition as effective	Coalition Member Survey	Annually (every May)
Prevention Programs	Prevention program participants experience positive changes Prevention program participants are satisfied with the program	Post-evaluations	At the end of each program
	Decrease in family and youth involved in the legal system	TBD	TBD
	Decrease in ED visits	Hospital Database(s)	Every six months (baseline: January - June, 2016)
	Decrease in the number of EPC's and law enforcement transports	Law enforcement data	Annually
Crisis Response Team	Decrease in law violations	Law enforcement data	Annually
	Decrease in ED visits	Hospital Database(s)	Every six months (baseline: January - June, 2016)
	Increased knowledge of BH	Post-training Evaluations (i.e., Mental Health First Aid)	After each training

Appendix B

Behavioral Health Coalition Collective Impact Survey 2017 & 2018 Results for Missouri Valley

Introduction and Methodology

Nine out of ten CHI Health Behavioral Health Coalitions have participated in the Collective Impact Survey in 2017 and 2018. One community (Omaha Metro) has not participated in this survey. The survey is designed to evaluate the effectiveness of the coalitions within five domains: common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone organization. All active coalition members (i.e., those who attended at least one meeting in the past year) were invited to participate in the survey and rate their coalition on a number of survey items within each of the five domains.
The survey was conducted online via SurveyMonkey.

Response Rate

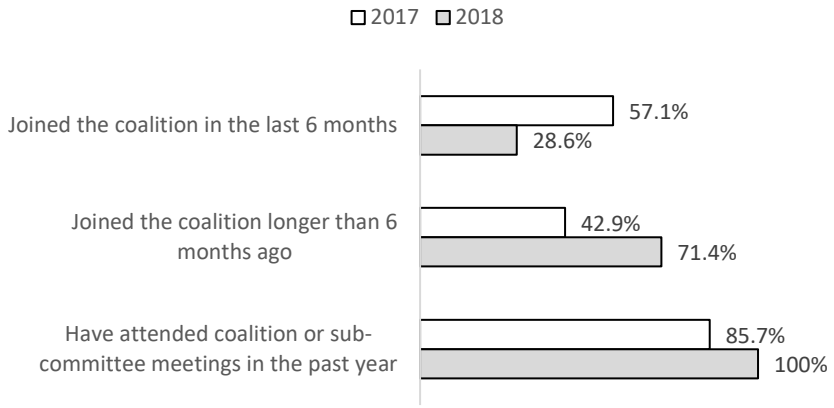
2017 - A total of 14 members of the coalition in Missouri Valley responded to the survey out of 32 invitees, making for a response rate of 43.8%.

2018 - A total of 14 members of the coalition in Missouri Valley responded to the survey out of 35 invitees, making for a response rate of 40.0%.

Coalition Involvement

Figure 1 shows the coalition involvement of the respondents.

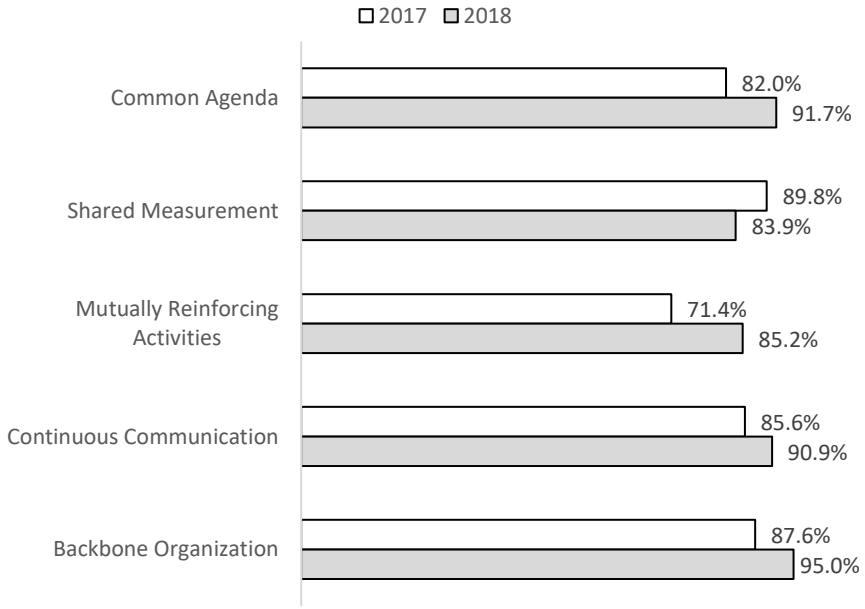
Figure 1. Coalition Involvement



AGGREGATE SCORES

Each of the five domains receives an aggregate score. The aggregate score is the average of the percentage reporting “almost always” or “always” for the statements within each domain. Figure 2 below presents the aggregates scores for each of the five domains.

Figure 2. Aggregate scores*

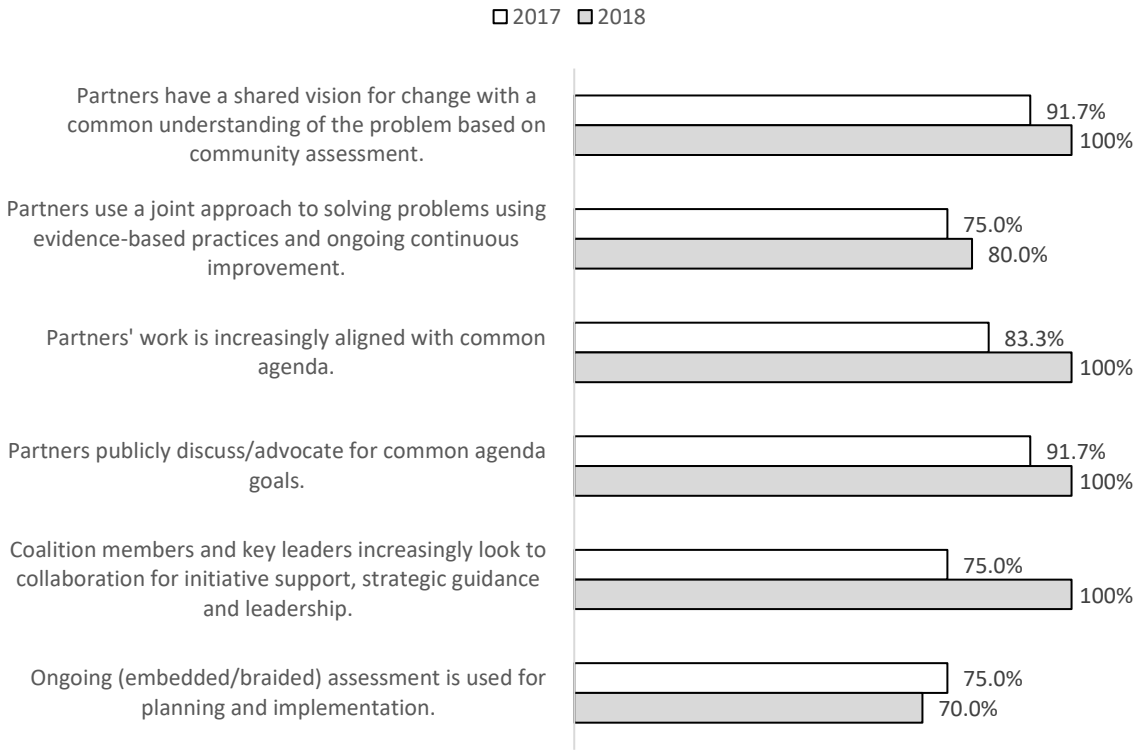


*An average of the percentage reporting "almost always" or "always" for the statements within each domain.

The remainder of this report presents the ratings for each survey item within each of the five domains of collective impact. After answering questions within each domain, respondents were given the opportunity to provide comments. Any comments that were made are included in this report.

COMMON AGENDA

Figure 3. Common Agenda [% almost always or always]*

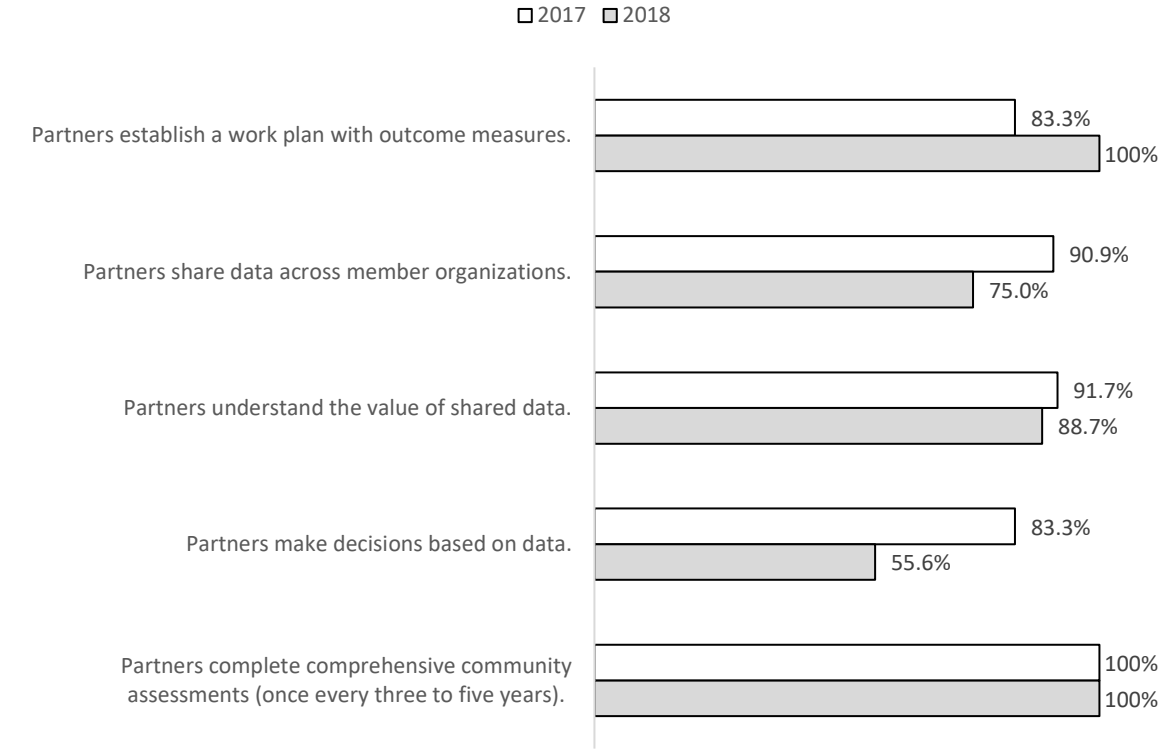


*Response options: never, almost never, sometimes, almost always, always

Comments about Common Agenda
2018
• I am very new to the Coalition and do not believe I can make an appropriate judgment on these items. From initial conversations it appears the team works collaboratively and has aligned motivations and goals. • Partners almost always have input in regards to the agenda.

SHARED MEASUREMENT

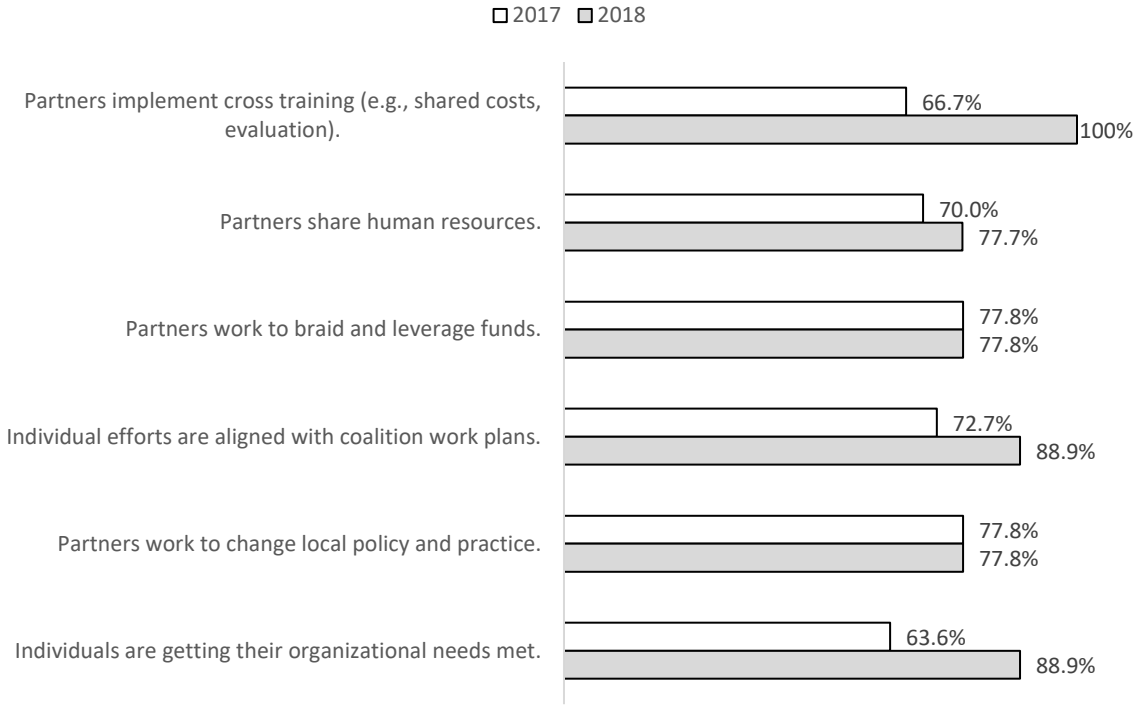
Figure 4. Shared Measurement [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

MUTUALLY REINFORCING ACTIVITIES

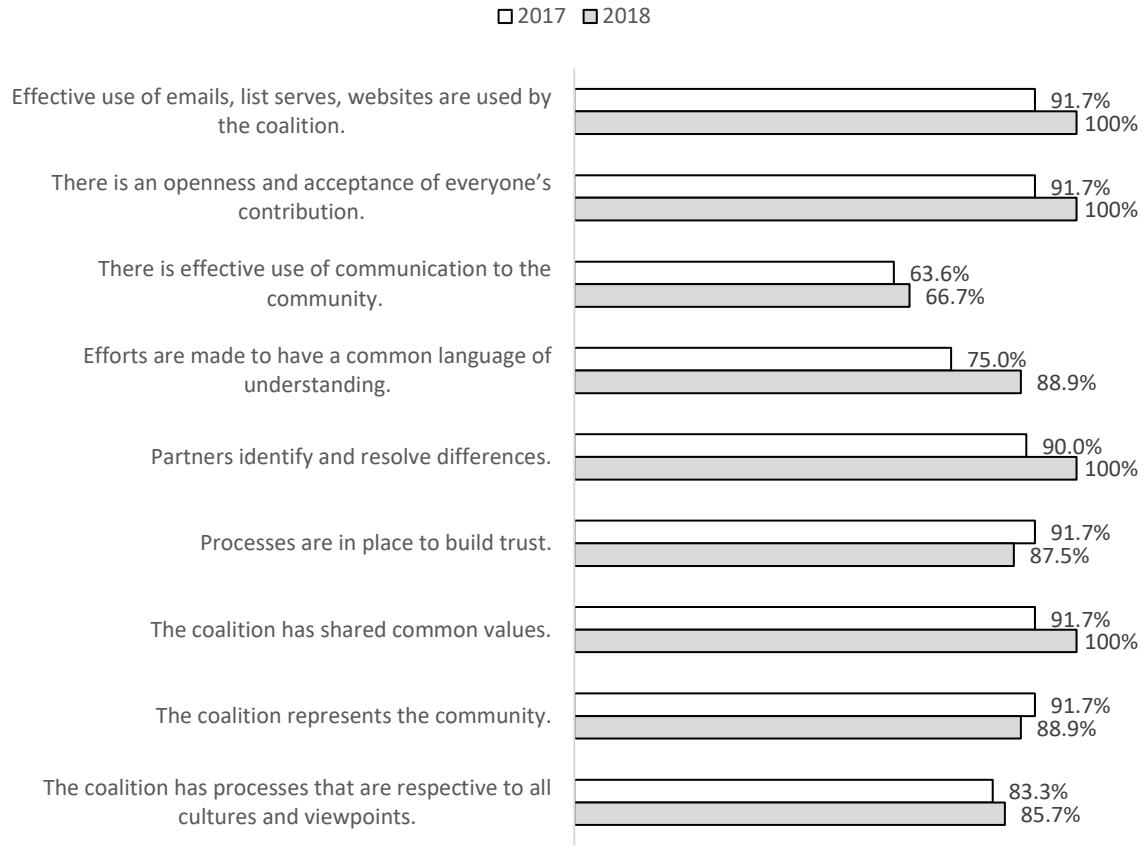
Figure 5. Mutually Reinforcing Activities [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

Comments about Mutually Reinforcing Activities
2018
• Definitely an area of strength.

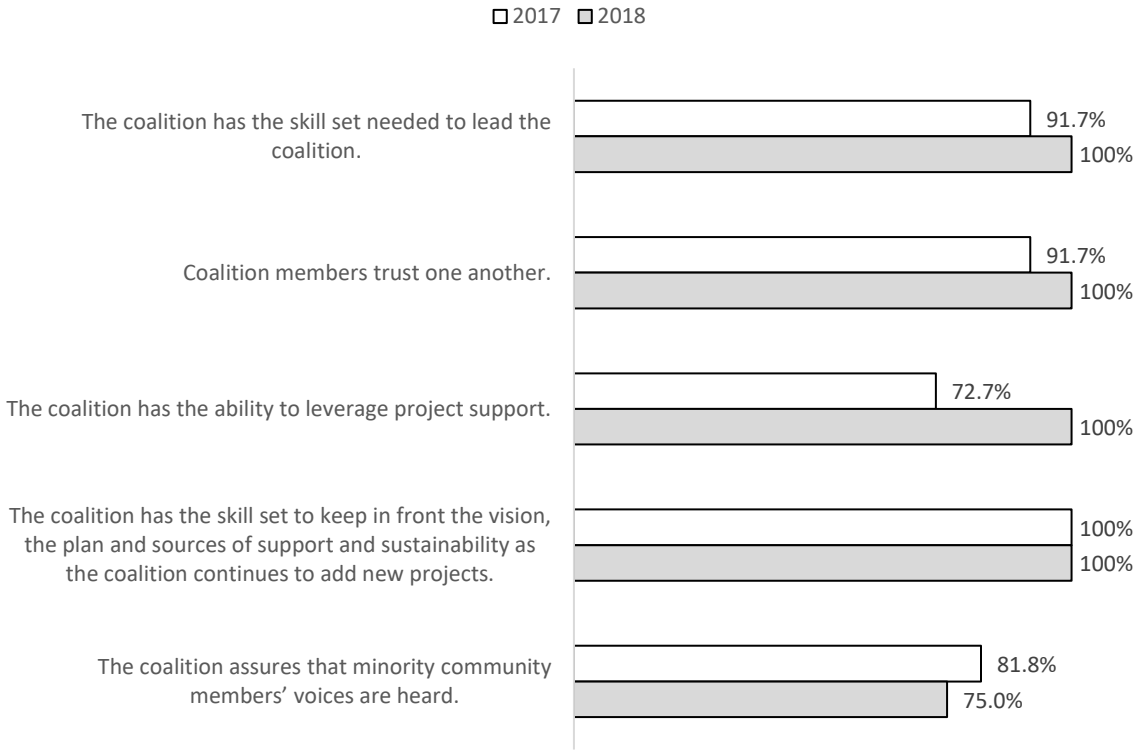
Figure 6. Continuous Communication [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

BACKBONE ORGANIZATION

Figure 7. Backbone Organization [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

MISSOURI VALLEY/HARRISON COUNTY, IOWA BEHAVIORAL HEALTH IMPROVEMENT PLAN 2016-2019

Collective Vision: To increase the preventive outreach, educational efforts and resources that support the resiliency of community members who experience mental health and substance use issues.

Goals

1. Increase the overall awareness of existing and potential resources among community stakeholders through an established behavioral health (BH) community coalition.
2. Break the generational cycle of addiction and dysfunction through prevention education of parents and youth through a partnership with the schools.
3. Improve the community's knowledge of BH and the crisis response to individuals with BH needs by supporting the work of the Network and utilization of common intake form.

Resources/Input

- CHI Mission and Ministry Grant Funding
- CHI Healthier Communities Funding
- CHI Health MO Valley - Sponsor
- Network - Backbone Organization
- Community Collaborative Leaders
- Community Collaborative Partnerships

Strategies/Activities

Year 1:

- Establish a community coalition with the support of the Network to facilitate communication and awareness of resources.
- Develop a web-based community wide resource directory specific to Harrison County.
- Subject to school administration approval, offer prevention programs and counseling in the schools.
- Counselors build relationships with schools.
- Support the work of the "Network" in developing and implementing a mobile mental health crisis response team concept with the support of law enforcement.
- Gather data to assess need for other crisis stabilization services with the hospital as a consideration for location.

Year 2:

- At least one evidence–based or best practice prevention program implemented in at least two schools for parents and youth (i.e., 40 Developmental Assets).
- Provide 2 dual-diagnosis counselors for children and youth in the schools across the county (one in MO Valley and one roving).
- The Network develops a local Crisis Response Team that includes training for local law enforcement.
- Provide Mental Health First Aid Training and other trainings offered through the Network.
- Begin developing a sustainability plan for post grant.

Year 3:

- Expansion of prevention programming across multiple schools.
- Counseling provided in all schools.
- Local Crisis Response Team active across the county.
- Trainings continue to be offered.
- Finalize sustainability plan and prepare to implement.

Outputs

- Number of coalition meetings, members and number of resource directories distributed.
- Number of schools collaborating with agency partners to provide programming.
- Number of prevention programs implemented and the number of parents and youth participating.
- Number of children and youth participating in therapy at the schools.
- Crisis Response Team functioning and number of response incidents.
- Number of trainings and number trained.
- Sustainability plan established.

Outcomes

- Community Coalition shares resources formally and informally with members rating the coalition as "effective".
- Increased awareness of community resources and increased use of those resources.
- Youth and parents participating in programs experience positive changes and are satisfied with programming.
- Decrease in Emergency Department visits
- Decrease in the number of EPC's and law enforcement transports.
- Increased knowledge of BH.

Behavioral Health Initiative

2nd Annual Evaluation Report
Nebraska City – Otoe County
July 2017 – June 2018

A. COMMUNITY COALITION DEVELOPMENT AND PLANNING

The purpose of the Otoe County BH Coalition is threefold:

1. Increase the overall awareness of and access to existing and potential resources and services among community stakeholders through an established behavioral health (BH) community coalition.
2. Outreach to the underserved populations in need of behavioral health services and connect them with peer support, mentoring and other services that meet individual needs.
3. Increase behavioral health knowledge and skills across the community.

The three purposes are being carried out through the development of a resource website; through connecting the underserved with peer support and other services; and through implementation of trainings identified to strengthen Behavioral Health knowledge and awareness to school staff, law enforcement, EMT's and other partners including community members. The Coalition is made up of various members from the community that include hospital staff, social service workers, housing directors, school staff, members of law enforcement and various other community members. The Coalition meets regularly - one time per month.

Successes experienced within the Coalition this year include

- A website has been completed and is available to the public. www.healthymindsne.com
- Billboards have been designed and placed in two locations in Otoe County that aim to destigmatize mental illness.
- Bridges Out of Poverty Training was held in January 2018. Twenty-two people participated in the training.
- WRAP I Training was held in February 2018. Eleven people participated in the training.
- WRAP II was held in April 2018. Five people participated in the training.
- Peer Support Training has been rescheduled for the Fall of 2018.

Challenges: Challenges during the past 6 months include getting stakeholders to attend monthly meetings. Other challenges involved planning, advertising, and setting up trainings that were offered throughout the past 6 months. It was also a challenge to get all of the trainings scheduled in a timely manner so that funding was not lost.

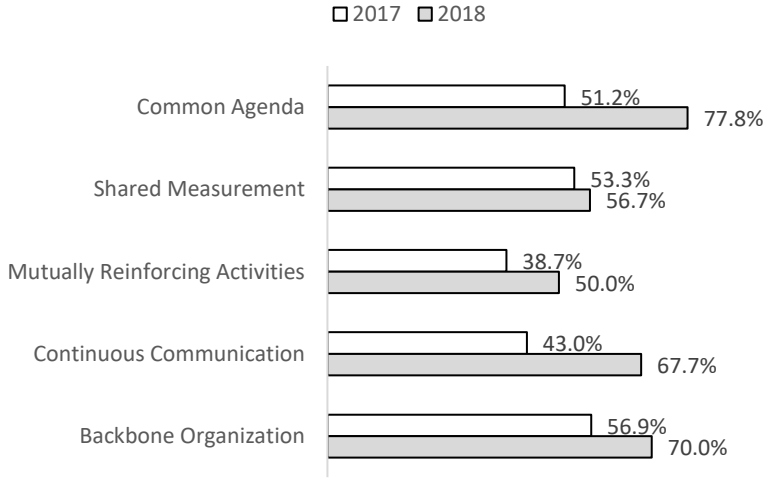
Collective Impact Survey Results:

The Collective Impact survey is designed to evaluate the effectiveness of the coalitions within five domains: Common Agenda, Shared Measurement, Mutually Reinforcing Activities, Continuous Communication, and Backbone Organization. All active coalition members (i.e., those who attended at least one meeting in the past year) were invited to participate in the survey and rate their coalition on a number of survey items within each of the five domains. The survey was conducted online via SurveyMonkey.

Response Rates:
2017 - A total of 15 members of the coalition in Nebraska City responded to the survey out of 32 invitees, making for a response rate of 46.9%.
2018 - A total of 8 members of the coalition in Nebraska City responded to the survey out of 14 invitees, making for a response rate of 57.1%.

Each of the five domains receives an aggregate score. The aggregate score is the average of the percentage reporting “almost always” or “always” for the statements within each domain. The graph below presents the aggregates scores for each of the five domains. Ratings increased in all five domains from 2018 as compared to 2017 with still more room for growth in the coming year. The full survey results report is located in Appendix B.

Collective Impact Survey Aggregate Scores*



*An average of the percentage reporting "almost always" or "always" for the statements within each domain.

B. BEHAVIORAL HEALTH TRAINING/EDUCATION

Two coalition members attended the Iowa Stepping Up Initiative Summit on October 24, 2017. Funds from the coalition were used for this for the purpose of gaining a better understanding of the Initiative, as well as what is needed to implement the Stepping Up Initiative in Otoe County, Nebraska.

Trainings				
Date(s)	**Training Topic/Description**	**Description of Individuals Trained (community, school, parents, healthcare, etc.)**	**# of Participants**	**# of Organizations Participated**
10/24/17	Stepping Up Initiative Summit	Coalition Members	2	2
1/23/18	Bridges Out of Poverty	Librarian, School Staff, Adult Protective Services, Housing Authority Directors, Volunteers, SENCA Staff	22	11
2/15-16/18	WRAP I Training	Ministerial, Volunteers, Housing Authority, Mental Health Practitioners, Domestic Violence Organization	10	4
4/16-20/18	WRAP II Training	Volunteers, Domestic Violence Organization, Mental Health Practitioner, Housing Authority	5	3

Reflection on training efforts: A better understanding of the **Stepping Up Initiative**, as well as a clearer vision of how to begin utilizing the Initiative, was gained by both attendees. Facts of poverty, along with learning about challenges of living in poverty helped to increase awareness of the impact of poverty on individuals in the **Bridges Out of Poverty** Training.

Participants in Wellness Recovery Action Plan (**WRAP**) I training learned how to write a personal wellness recovery action plan that would help keep balance and wellness in the individual's life. Participants in **WRAP II** training learned the administrative side of becoming a co-facilitator in a WRAP group.

Outcomes:

Two separate surveys were used by participants at each of the WRAP trainings. Overall, results were high, with participants indicating a hopeful attitude and reporting that the training met or exceeded their expectations.

WRAP 1 Training – Selected Post-Evaluation Survey Results

	% Agree or Strongly agree*
I have hope that I can and will feel better (n=10)	100%
I have some ideas on how to develop some new friends or to strengthen relationships I have with current friends and family members (n=10)	90%
The activities gave me an opportunity to gain a new, more hopeful attitude (n=9)	100%

*Response options: strongly disagree, disagree, neutral, agree, strongly agree

WRAP 2 Training – Daily Workshop Evaluation Form (completed each of the five days by each participant)

	% Exceeded or met expectations*
Overall learning experience (n=25)	100%
Relevance of material (n=25)	100%
Group Discussion (n=25)	100%
Presenters (n=25)	100%

*Response options: exceeded my expectations, met all my expectations, less than expected, did not meet any of my expectations

Selected comments from evaluation surveys:

- The two facilitators that taught the class were willing to help me with the problems I have.
- It will make me feel a lot better.
- [WRAP] gave me the tools to understand my needs and to manage my life. I love the idea of this program.
- I feel very special to have been blessed with this opportunity to make a difference to others.

C. SUMMARY OF PROGRAMS IMPLEMENTED

Program Planning: Planning included advertising the group, as well as speaking with school counselors in searching for referrals of junior high students for the group. Two members of the Coalition completed training to become WRAP co-facilitators. Books were ordered from the Copeland Center and supplies were purchased.

Program Description: The Wellness Action Recovery Program (WRAP) Program is designed to help individuals recognize what wellness looks like for them, and also helps them to develop wellness tools that can be used in times of crisis by the individual. One Coalition Stakeholder and one Coalition Leader were trained as co-facilitators and will implement the program. The strategy will be implemented at Arbor Psychiatric & Wellness Center in Nebraska City and will be directed toward junior high students referred by school counselors.

Program Description of Where Program was Implemented: A WRAP Program was implemented at Arbor Psychiatric & Wellness Center in Nebraska City. One stakeholder and one Coalition Leader co-facilitated this group.

Description of Participants (i.e., community individuals, parents, youth, ages, etc.): The WRAP Program is Community-based. There are 4 participants and all are junior high students in the public-school system.

Number of Participants:

Program Name: WRAP Program			
Number of Children/Youth Served Directly	4	Number of Organizations Involved in Implementation	1
Number of Individuals (or Parents) Served Indirectly	0	Number of Staff Involved in Implementation	2

Comments on Successes and Challenges: Successes would include holding an informational meeting for the public and three trainings. Each training was well attended. Another success would be the implementation of the WRAP Program in the community. School staff were involved in identifying students that might benefit from the program and referring them to the program.

Outcomes:

No outcome data on WRAP was made available.

D. OTHER PROGRAMS IMPLEMENTED (OPTIONAL)

N/A

E. RESOURCE AWARENESS

We have completed work on our website and billboards. There are currently 2 billboards placed in the county. Our website gives information on mental health and also lists providers in the area. We do not have a count of how many hits to our website. The message of our billboards is twofold – one to destigmatize mental illness, the other to create awareness of the behavioral health coalition that has been formed in our community. The billboards contain the web address of our coalition and the message "Everyone Has Mental Health – How's Yours?" "#Be Kind to Your Mind".

F. COORDINATION AND NAVIGATION

- *Identify partners (including schools and faith-based organizations) to outreach to underserved populations.*
  Talk has begun with school counselors with the goal of implementing WRAP I Program in the schools in Nebraska City.

G. ASSESSMENTS AND PLANNING DOCUMENTS

- *Develop hospital communication plan to increase awareness of providers both onsite and via tele-psychiatry.*
  As we progress with development of a website listing providers, both onsite and via tele-psychiatry, we are increasing awareness.

- *Engage Mental Health Association to provide assistance in planning a peer support program.*
  The Mental Health Association is scheduled to provide training in peer support beginning September 2018 and will also assist in planning a peer support program for Otoe County.

- *Develop plan to "outreach" to underserved populations.*
  A plan is currently being developed for outreach to underserved populations that will assist in increasing enrollment in the WRAP Program so that more individuals will be able to benefit by taking the program through the use of scholarships.

H. ED VISITS AND COUNTY-LEVEL HEALTH DATA

To provide additional reflection on the impact of the project, baseline hospital and community wide data related to mental health is represented in the tables below. The data represents the most current year available and will be updated annually, if available. The three tables included:

- Otoe County Emergency Department Mental Health Visits
- Child Well-Being Indicators
- County Health Data Indicators

Mental Health Emergency Department Visits at CHI Hospitals

	*FY 2016	*FY 2017	% change
Nebraska City, NE (Otoe County)	111	122	9.9%
Total for all 10 Project Communities	**16,165**	**17,382**	**7.5%**

*Fiscal Year: July-June
Source: CHI Health Hospital Data

Child Well-Being Indicators

	Year(s)	Otoe (Nebraska City, NE)
Total Population/ages 19 & under	**2015**	15,984/ 4,058
	2016	16,081/ 4,108
Number/percent of births to teen mothers (age 17 and under)	**2015**	3/1.4%
	2016	3/1.5%
Number of juvenile arrests/rate per 1,000 population	**2015**	48/28.3
	2016	65/38.3
Number of substantiated child maltreatment victims/rate per 1,000 population	**2015**	44/11.9
	2016	31/8.2
Number in out-of-home care/ rate per 1,000 population	**2014**	54/14.6
	215	67/17.8
Percent of children ages 0-17 below poverty level	**2010-2014**	14.3%
	2011-2015	14.7%

(Source: Kids Count Data Center)

County Health Data Indicators

	Year(s)	Otoe (Nebraska City, NE)	*Nebraska*	*Iowa*
Poor Mental Health Days (ave. # unhealthy days/30 days)	**2014**	2.7	***2.8***	***3.1***
	2015	2.8	***3.0***	***3.3***
	2016	3.0	***3.2***	***3.3***
Adult Smoking	**2014**	15%	***17%***	***19%***
	2015	16%	***17%***	***18%***
	2016	18%	***17%***	***17%***
Excessive drinking (binge/heavy drinking past 30 days)	**2014**	20%	***21%***	***22%***
	2015	20%	***20%***	***21%***
	2016	21%	***21%***	***22%***
Alcohol-impaired driving deaths	**2010-2014**	20%	***35%***	***24%***
	2011-2015	8%	***36%***	***25%***
	2012-2016	9%	***37%***	***27%***
Chlamydia rate per 100,000	**2013**	216	***393***	***356***
	2014	273	***401***	***382***
	2015	234	***423***	***389***
Premature age-adjusted mortality rate per 100,000 (under age 75)	**2011-2013**	300	***302***	***309***
	2013-2015	338	***307***	***311***
	2014-2016	310	***309***	***313***
Drug overdose death rate per 100,000	**2014**	--	***7***	--
	2013-2015	--	***7***	--
	2014-2016	--	***7***	9
Suicide Rates per 100,000	**2014**	13.2	***11.7***	--
	2013-2015	8.7	***12.0***	--
	2014-2016	15.0	***12.4***	--

(Source: County Health Rankings)

I. FINANCIAL RESOURCES AND SUSTAINABILITY

Funding from CHI Health			
Source	**Program, Strategy or Coalition Support**	**Funding Period**	**Amount**
Mission and Ministry Grant	Coalition Support – Leader Compensation, Laptop, Website and Billboard Development and Trainings – WRAP, Bridges Out of Poverty and Stepping up Initiative	July 2017 – June, 2018	$41,800
Federal FLEX Grant	Coalition Support – Leader Compensation	September 2017-August 2018	$3,750
Healthier Communities	Coalition Support – Leader Compensation	July 2017 – June, 2018	$5,000
CHI Health St. Mary's	In kind Hospital Sponsor and Co-Sponsor time and Meeting Rooms	July 2017 – June, 2018	$13,849

Education on sustainability planning was conducted at the annual summit in May of 2018. Grant administrative staff will provide a sustainability process in the fall of 2018 to the coalitions to assist them in the development of their community specific sustainability plans.

Appendix A

Nebraska City - Otoe County 12-month Output Report

Report period: July 1, 2017 through June 15, 2018

Area	Metric	Input information here (only report on activities for the six months of the report period):
Community Coalition	Number of coalition meetings:	14
	Dates of coalition meetings:	7/10/17, 8/9/17, 9/11/17, 9/27/17, 10/12/17, 11/1/17, 11/15/17, 12/6/17, 1/10/18, 2/7/18, 3/7/18, 4/4/18, 5/2/18, 6/6/18
	Average number of members attending meetings:	6
	Number of resource directories distributed:	0
Partnerships and Outreach Events	Number of partners identified:	0
	Number of outreach events:	4
	Number reached at outreach events:	58
Peer Support	MHA assists in development of peer support plan? (yes/no)	Yes
	Peer support program implemented? (yes/no)	No
	Number engaged in peer support program:	N/A
Trainings	Names and dates of trainings:	Stepping Up Initiative Summit 10/24/17 Bridges Out of Poverty 1/23/18 WRAP I Training 2/15-16/18

		WRAP II Training 4/16-20/18
	Number of participants at each training:	2 – Stepping Up 22 – Bridges out of Poverty 10 – WRAP I 5 – Wrap II
	Types of training participants **(across all trainings):**	**Number of <u>health care workers</u> trained: 1**
		Number of <u>law enforcement</u> trained: 1
		Number of <u>school personnel</u> trained: 0
		Number of <u>other community professionals</u> trained: 3
Prevention Programs	Number of prevention programs implemented:	1
	Names of implemented prevention programs:	WRAP Program
	Number of parents and youth participating in prevention programs (across all programs):	**Parents: 0**
		Youth: 4
Sustainability (Year 2)	Began developing a sustainability plan? (yes/no)	Yes
Sustainability (Year 3)	Sustainability plan completed? (yes/no)	No

Nebraska City - Otoe County Outcome Checklist

Area	Outcome	Tool/Resource	Data Collection Frequency
Community Coalition	Increased awareness of resources leads to increased use of those resources	Community Service Provider Survey	Annually (every May)
	Members rate coalition as effective	Coalition Member Survey	Annually (every May)
	Increased use of tele-psychiatry at the hospital	Hospital Records	Annually
Partnerships and Outreach Events	Outreach and peer mentoring increase utilization of services	Community Service Provider Survey	Annually (every May)
	Mental Health Association assists in the development of a peer support program	Coalition Documentation	TBD
Trainings	Community members and school staff participating in the training increase knowledge and awareness of behavioral health and are satisfied with the training	Post-training Evaluations	After each training

Appendix B

Behavioral Health Coalition Collective Impact Survey 2017 & 2018 Results for Nebraska City

Introduction and Methodology

Nine out of ten CHI Health Behavioral Health Coalitions have participated in the Collective Impact Survey in 2017 and 2018. One community (Omaha Metro) has not participated in this survey. The survey is designed to evaluate the effectiveness of the coalitions within five domains: common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone organization. All active coalition members (i.e., those who attended at least one meeting in the past year) were invited to participate in the survey and rate their coalition on a number of survey items within each of the five domains.

The survey was conducted online via SurveyMonkey.

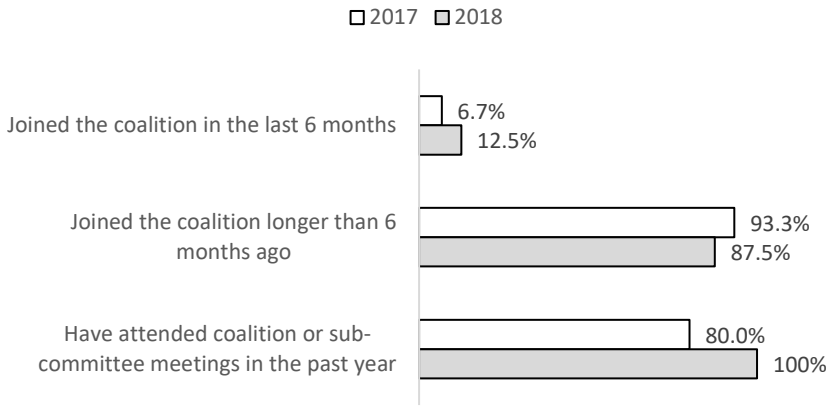
Response Rate

2017 - A total of 15 members of the coalition in Nebraska City responded to the survey out of 32 invitees, making for a response rate of 46.9%.
2018 - A total of 8 members of the coalition in Nebraska City responded to the survey out of 14 invitees, making for a response rate of 57.1%.

Coalition Involvement

Figure 1 shows the coalition involvement of the respondents.

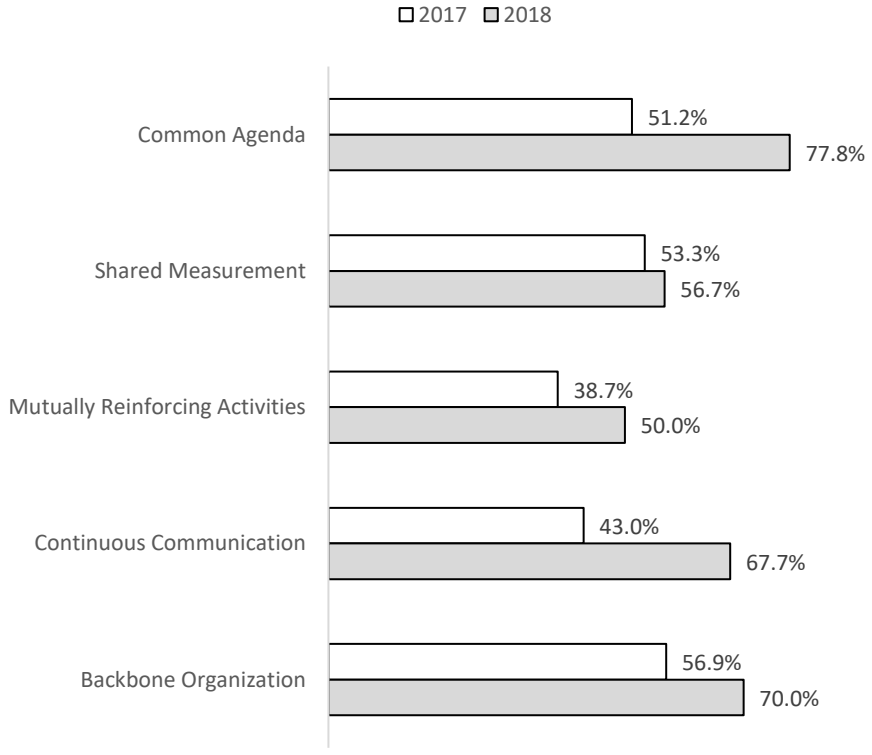
Figure 1. Coalition Involvement



AGGREGATE SCORES

Each of the five domains receives an aggregate score. The aggregate score is the average of the percentage reporting “almost always” or “always” for the statements within each domain. Figure 2 below presents the aggregates scores for each of the five domains.

Figure 2. Aggregate scores*

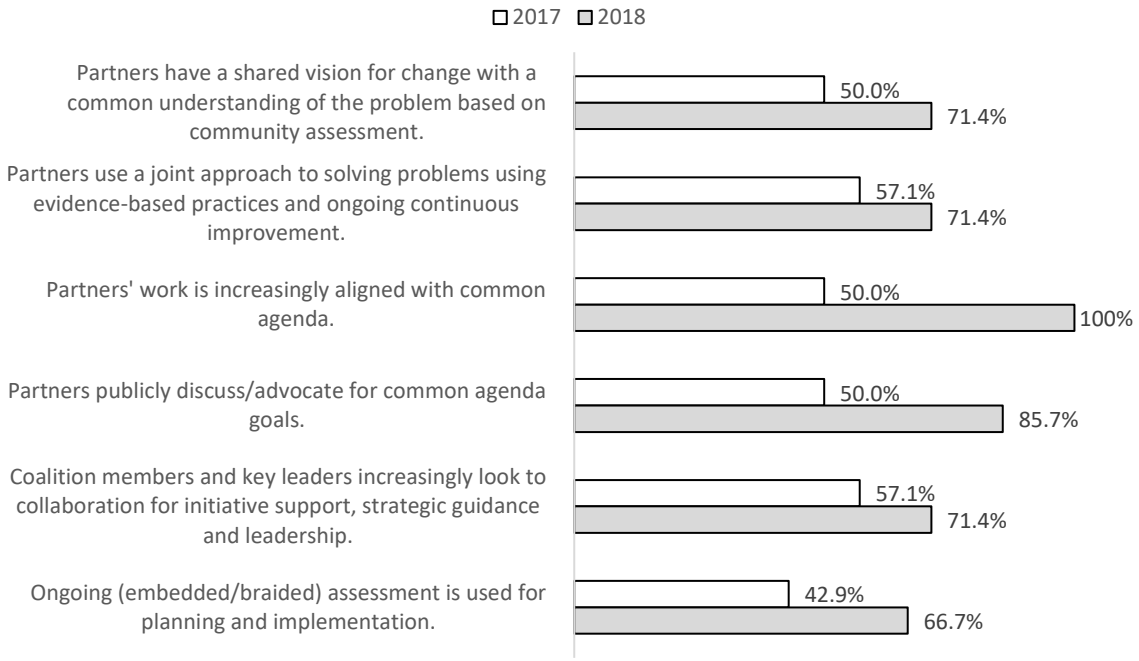


*An average of the percentage reporting "almost always" or "always" for the statements within each domain.

The remainder of this report presents the ratings for each survey item within each of the five domains of collective impact. After answering questions within each domain, respondents were given the opportunity to provide comments. Any comments that were made are included in this report.

COMMON AGENDA

Figure 3. Common Agenda [% almost always or always]*

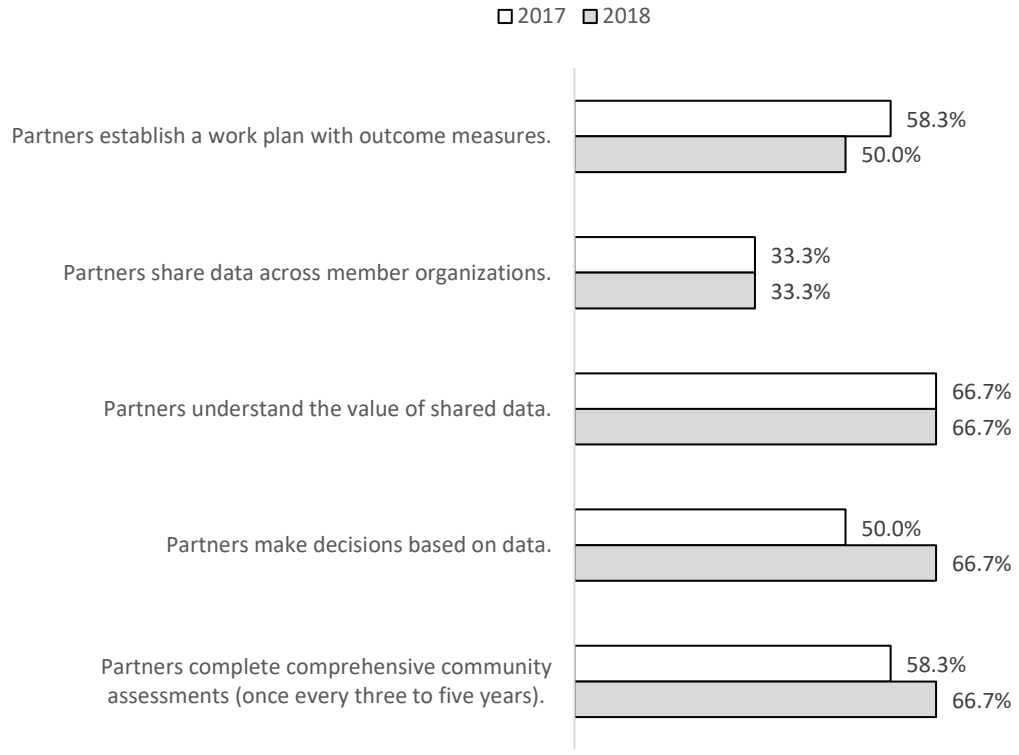


*Response options: never, almost never, sometimes, almost always, always

Comments about Common Agenda
2018
• This coalition does not implement true cross training, the rural area is very slim on trauma- informed evidence-based trainings and does not have strong support with KEY stakeholders. The committee has a few strong advocates however not everyone on the committee is bought into behavioral health and the implications. They see the social problems (jails, drugs, housing cost etc.) aspect however they are still unaware of the need for true and total community involvement as a viable option. We have just now started action items however the need here is so strong for a more rapid unified approach. More aggressive approach utilizing clusters of strong data supported low cost programs to support the clinical support they need. peer support warm line. We are doing a stigma campaign that is a brilliant team effort! But such attention will build the need.

SHARED MEASUREMENT

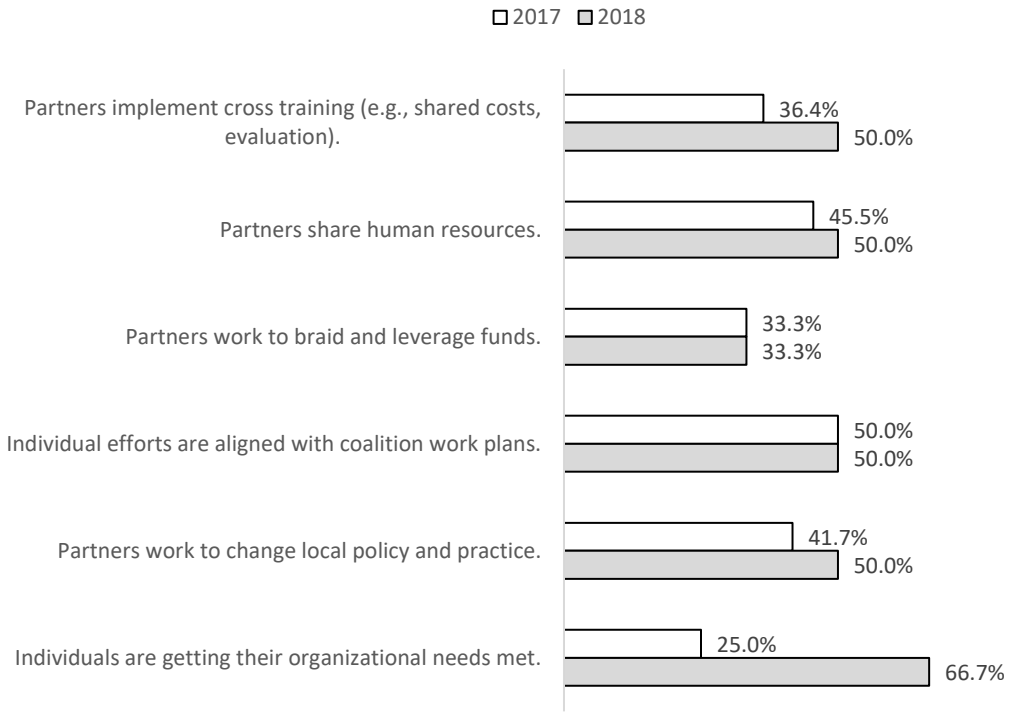
Figure 4. Shared Measurement [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

MUTUALLY REINFORCING ACTIVITIES

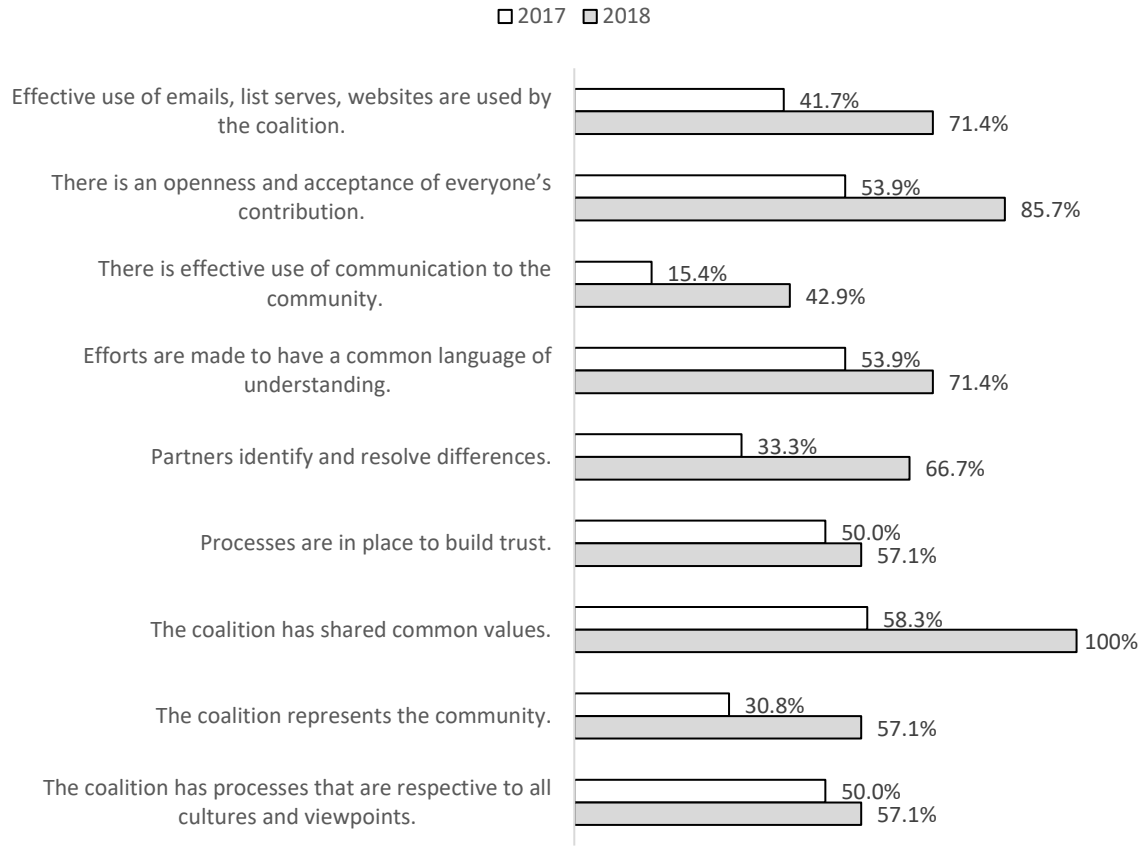
Figure 5. Mutually Reinforcing Activities [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

CONTINUOUS COMMUNICATION

Figure 6. Continuous Communication [% almost always or always]*

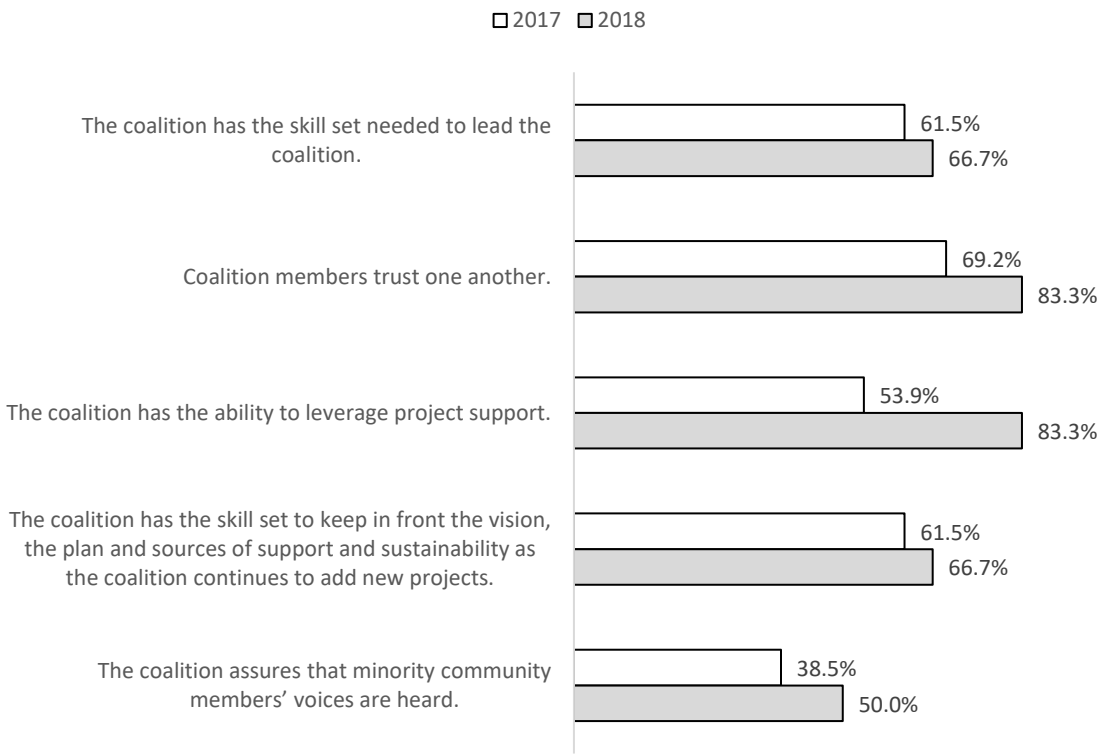


*Response options: never, almost never, sometimes, almost always, always

Comments about Continuous Communication
2018
• There are no consumers represented or parents of children with SPMI.

BACKBONE ORGANIZATION

Figure 7. Backbone Organization [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

Nebraska City/Otoe County, NE Behavioral Health Improvement Plan 2016-2019

Collective Vision: To increase the preventive outreach, educational efforts and resources that support the resiliency of community members who experience mental health and substance use issues.

Goals

1. Increase the overall awareness of and access to existing and potential resources and services among community stakeholders through an established behavioral health (BH) community coalition.
2. Outreach to the underserved populations in need of behavioral health services and connect them with peer support, mentoring and other services that meet individual needs.
3. Increase behavioral health knowledge and skills across the community.

Resources/Input

- CHI Mission and Ministry Funding
- CHI Health Healthier Community Funding
- Other braided funding through Region 5 and potentially MCO's
- CHI Health St. Mary's Fiscal Agent and Sponsor
- Community Collaborative Co-chairs
- Community Collaborative Partnerships

Strategies/Activities

Year 1:

- Establish a Behavioral Health sub-committee within Partners for Otoe County that includes consumers and youth.
- Develop a community behavioral health resource directory through a new established website and some printed materials. Begin promotion.
- Hospital develops a communication plan to increase awareness of providers both that are onsite and via tele-psychiatry.
- Identify partners (including schools and faith-based organizations) to do outreach to the underserved and plan methods to do so.
- Engage the Mental Health Association at no cost to provide assistance in establishing a peer support program.
- Create a community-wide training plan and Implement 2 community-wide trainings: WRAP and Mental Health First Aid.
- Support the Law Enforcement Educational Opportunity – Stepping-Up Initiative

Year 2:

- Update and broadly disseminate resource directory and/or design and implement mobile resource directory app.
- Implement hospital communication BH plan.
- Implement outreach plans to reach the underserved populations and begin connecting them with peer support, mentoring and other services that meet individual needs and implement peer support program.
- Implement other trainings identified to strengthen BH knowledge and awareness to school staff, law enforcement, EMT's and other partners including community members.
- Begin developing a sustainability plan for post grant.

Year 3:

- Update resource directory.
- Implement one or more new best practice prevention programs for youth and families.
- Finalize sustainability plan and prepare to implement.

Outputs

- Number of coalition meetings, members and resource directories distributed.
- Number of partners identified, outreach events and number reached.
- Number engaged in peer support program.
- Number of trainings and programs implemented.
- Number of individuals trained.
- Number of prevention programs implemented and the number of parents and youth participating.
- Sustainability plan established.

Outcomes

- Community Coalition shares resources formally and informally with members rating the coalition as "effective".
- Increased awareness of community and hospital resources and increased use of those resources.
- Outreach and peer mentoring increase the utilization of services.
- Increased use of the tele-psychiatry at the hospital.
- Community members and school staff participating in training increase knowledge and awareness of behavioral health and satisfied with training.

Behavioral Health Initiative

Annual EVALUATION REPORT

Omaha Metro –Sarpy and Cass Counties

July 2017 – June 2018

A. COMMUNITY COALITION DEVELOPMENT AND PLANNING

The planning group identified existing local community coalitions or groups and discussed the health topics the groups were focusing on and current work happening across community to ensure duplication does not take place. Based on requests from the community and schools for resources and support to address youth behavioral health needs, the planning group decided to focus on schools in Sarpy and Cass County relative to the Omaha Metro Youth Assessment instead of the entire Omaha Metro Area since Douglas County offers more behavioral health resources and services than Sarpy/Cass County.

A core group consisting of 5 Superintendents from the Sarpy and Cass County School Districts and representatives from CHI Health Midlands in Papillion NE, CHI Health Behavioral Services and Healthier Communities has formed to begin development of a joint strategic plan to address the priority issues identified in the assessment completed and described in Section G. The intent is for the core group to be expanded to include other community partners and consumers throughout plan development with the goal of plan completion in fiscal year 2019.

B. BEHAVIORAL HEALTH TRAINING/EDUCATION

Not applicable.

C. SUMMARY OF PROGRAMS IMPLEMENTED

Not applicable at this time. See assessment section below.

D. OTHER PROGRAMS IMPLEMENTED (OPTIONAL)

Not applicable.

E. RESOURCE AWARENESS

Not applicable.

F. COORDINATION AND NAVIGATION

Not applicable.

G. ASSESSMENTS AND PLANNING DOCUMENTS

The President of CHI Health Midlands agreed to be the CHI Health sponsor and he, along with the Vice President of Behavioral Services identified CHI Health staff to participate along with external partners (schools) in a Sarpy/Cass County school assessment. The Superintendent of the Papillion LaVista School District (the largest school district in Sarpy and Cass County) invited the other 4 school district superintendents in the 2 counties to participate in a joint assessment to identify assets, issues and gaps in their districts and the districts as a whole relative to mental health and substance use programming available to students experiencing mental health and substance use issues and their parents.

All agreed to participate and a Mental Health and Substance Use Assessment was conducted with all Sarpy and Cass County Schools (i.e., administrators, counseling, mental health staff and special education teachers). Results were compiled by individual school district and collectively stratified by grade level (elementary, middle school/junior high and high school) and positions in the school district (administrators, counseling staff and mental health staff).

A Day of Collaboration and Sharing was conducted in April to share results by school district and in aggregate. Results from the survey demonstrated the unmet needs related to mental health services within each school district. The results also provided illustration of the programs and services related to mental health issues available at each school district and allowed for collaboration and sharing across the 5 school districts.

H. ED VISITS AND COUNTY-LEVEL HEALTH DATA

To provide additional reflection on the impact of the project, baseline hospital and community wide data related to mental health is represented in the tables below. The data represents the most current year available and will be updated annually, if available. The three tables included:

- Douglas and Sarpy Counties Emergency Department Mental Health Visits
- Child Well-Being Indicators
- County Health Data Indicators

Mental Health Emergency Department Visits at CHI Hospitals

	*FY 2016	*FY 2017	% change
Omaha, NE (Douglas and Sarpy Counties)	10,958	11,520	5.1%
Total for 10 Project Communities	**16,165**	**17,382**	**7.5%**

*Fiscal Year: July-June
Source: CHI Health Hospital Data

Child Well-Being Indicators

	Year(s)	Douglas County (Omaha, NE)	Sarpy County (Papillion, NE)
Total Population/ages 19 & under	**2015**	550,064/ 156,696	175,692/ 53,091
	2016	554,995/ 157,715	179,023/ 53,653
Number/percent of births to teen mothers (age 17 and under)	**2015**	123/1.4%	19/0.7%
	2016	13/1.5%	12/0.5%
Number of juvenile arrests/rate per 1,000 population	**2015**	2,870/ 47.4	992/45.8
	2016	2,825/ 46.2	964/44.2
Number of substantiated child maltreatment victims/rate per 1,000 population	**2015**	1,248/8.8	273/5.5
	2016	1,252/8.7	273/5.5
Number in out-of-home care/ rate per 1,000 population	**2014**	2,213/ 15.5	317/6.4
	215	2,342/ 16.3	339/6.8
Percent of children ages 0-17 below poverty level	**2010-2014**	20.3%	10.1%
	2011-2015	20.3%	9.2%

(Source: Kids Count Data Center)

County Health Data Indicators

	Year(s)	Douglas County (Omaha, NE)	Sarpy County (Papillion, NE)	*Iowa*	*Nebraska*
Poor Mental Health Days (avg. # unhealthy days/30 days)	2014	2.9	2.5	*3.1*	*2.8*
	2015	3.2	2.7	*3.3*	*3.0*
	2016	3.3	2.7	*3.3*	*3.2*
Adult Smoking	2014	17%	15%	*19%*	*17%*
	2015	18%	12%	*18%*	*17%*
	2016	17%	15%	*17%*	*17%*
Excessive drinking (binge/heavy drinking past 30 days)	2014	23%	22%	*22%*	*21%*
	2015	22%	20%	*21%*	*20%*
	2016	22%	22%	*22%*	*21%*
Alcohol-impaired driving deaths	2010-2014	40%	54%	*24%*	*35%*
	2011-2015	37%	51%	*25%*	*36%*
	2012-2016	44%	41%	*27%*	*37%*
Chlamydia rate per 100,000	2013	604	371	*356*	*393*
	2014	734	--	*382*	*401*
	2015	646	350	*389*	*423*
Premature age-adjusted mortality rate per 100,000 (under age 75)	2011-2013	330	250	*309*	*302*
	2013-2015	328	247	*311*	*307*
	2014-2016	326	252	*313*	*309*
Drug overdose death rate per	2014	9	6	--	*7*

100,000	2013-2015	8	5	--	*7*
	2014-2016	8	6	9	*7*
Suicide Rates per 100,000	2010-2014	9.7	8.9	--	*11.7*
	2011-2015	10.0	8.7	--	*12.0*
	2012-2016	10.3	10.2	--	*12.4*

(Source: County Health Rankings)

I. FINANCIAL RESOURCES AND SUSTAINABILITY

Funding from CHI Health			
Source	**Program, Strategy or Coalition Support**	**Funding Period**	**Amount**
Mission and Ministry Grant	Facilitation	July 1, 2017-2018	$15,000
CHI Health	In-kind staff time, meeting rooms and lunch for Day of Collaboration	July 1, 2017-2018	$7,457

Education on sustainability planning was conducted at the annual summit in May of 2018. Grant administrative staff will provide a sustainability process in the fall of 2018 to the coalitions to assist them in the development of their community specific sustainability plans.

Appendix A

Omaha Metro - Sarpy and Cass Counties 6-month Output Report

July 2017 – June 2018

Area	Metric	Input information here (only report on activities for the six months of the report period):
Strategic Planning	**Number of key stakeholders attending the planning sessions:**	10
	Number of key stakeholders willing to participate in a behavioral health youth coalition	10
Evidence-based Practices	**Evidence-based practices assessment conducted? (yes/no)**	Yes
	List identified evidence-based practices:	Yes
Youth System of Care	**Behavioral health youth system of care strategic plan developed? (yes/no)**	No
Sustainability (Year 2)	**Began developing a sustainability plan? (yes/no)**	No
Sustainability (Year 3)	**Sustainability plan completed? (yes/no)**	Year 3

Omaha Metro – Sarpy and Cass Counties Outcome Checklist

Area	Outcome	Tool/Resource	Data Collection Frequency
Youth System of Care	Improvement in patient outcomes as a result of BH services provided	TBD	TBD
	Reduction in ED visits by youth	Hospital Database(s)	See report
	Improved transition of care for youth	TBD	TBD
	Positive change in community-wide behavioral health measures	Population Data	See report

Omaha Metro/Douglas and Sarpy Counties Behavioral Health Improvement Plan 2016-2019

Collective Vision: To increase the preventive outreach, educational efforts and resources that support the resiliency of community members who experience mental health and substance use issues.

Goals

1. Develop and implement a community-wide youth behavioral health system of care in the Omaha Metro area through the engagement of key community stakeholders.

Resources/Input

- CHI Mission and Ministry Grant Funding
- Other CHI Health Healthier Communities Funding
- Other braided funding through Region 6 and other potential resources
- CHI Health –Sponsor
- Backbone Organization - TBD

Strategies/Activities

Year 1:

- Investigate current community efforts to address the behavioral health needs of youth in the community and if a community coalition exists.
- Form or contribute to a behavioral health community coalition to implement the youth behavioral health system of care plan.
- Review current findings from other community behavioral health youth planning assessments including new findings from the Region 6 - 2016 child and adolescent assessment.
- Identify key community stakeholders to involve in a community-wide strategic planning process for the development of a community wide behavioral health system of care for youth.
- Engage a professional facilitator to conduct a strategic planning process for the youth behavioral health system of care.
- Conduct an assessment on the currently implemented behavioral health evidence-based practices for youth and other potential practices that may be included in the plan.

Year 2:

- Begin implementing the behavioral health system of care plan for youth in the Omaha Metro area.
- Begin developing a sustainability plan for post grant.

Year 3:

- Continue implementing the behavioral health system of care plan for youth in the Omaha Metro area.
- Finalize sustainability plan and prepare to implement.

Outputs

- Number of key stakeholders attending the planning sessions.
- Number of key stakeholders willing to participate in a behavioral health youth coalition.
- Evidence-based practices identified.
- Behavioral health youth system of care strategic plan developed.
- Sustainability Plan established.

Outcomes

- Improvement in patient outcomes as a results of BH services provided.
- Reduction in Emergency Department visits by youth.
- Improved transition of care for youth.
- Positive change in community-wide behavioral health measures that may include the Nebraska Children's Child-Well Being Indicators.

Behavioral Health Initiative

2nd Annual Evaluation Report

Plainview/Pierce County

Healthy Choices for Pierce County

July 2017 – June 2018

A. COMMUNITY COALITION DEVELOPMENT AND PLANNING

Our coalition is growing and extending invitations out to other communities in the county. Also, we have named our coalition "Healthy Choice for Pierce County" and want to make sure that the whole county is aware of this coalition so that we can brainstorm together and help one another and are working toward building relationships with surrounding communities within Pierce County.

Our Health Department and Region 4 staff are active in our coalition and are able to bring braided funding and other resources to the coalition's initiatives. In addition, the coalition has many other engaged community stakeholders who actively attend and participate in coalition meetings and initiatives.

The coalition continues to work together with Region 4, Northeast District Health Department, Plainview Police, Plainview Public School, Plainview Ministerial Society as well as CHI Health Plainview. Although, we have not gotten other member to join from elsewhere in Pierce County, we continue to bring awareness to our group as well as the community. The Police department held another Drug Takeback day in conjunction with the Plainview Pharmacy. The LOSS team spokesperson came to our group to explain what their group can do for families of suicide victims. Because of this information a lunch and learn will be scheduled in the future to include nursing and the public.

Collective Impact Survey Results:

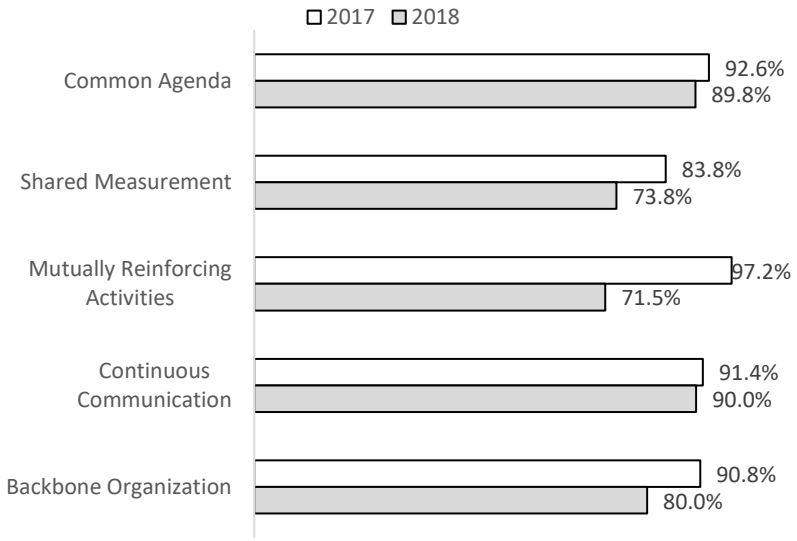
The Collective Impact survey is designed to evaluate the effectiveness of the coalitions within five domains: Common Agenda, Shared Measurement, Mutually Reinforcing Activities, Continuous Communication, and Backbone Organization. All active coalition members (i.e., those who attended at least one meeting in the past year) were invited to participate in the survey and rate their coalition on a number of survey items within each of the five domains. The survey was conducted online via SurveyMonkey.

Response Rates:

2017 - A total of 10 members of the coalition in Plainview responded to the survey out of 20 invitees, making for a response rate of 50.0%.
2018 - A total of 10 members of the coalition in Plainview responded to the survey out of 13 invitees, making for a response rate of 76.9%.

Each of the five domains receives an aggregate score. The aggregate score is the average of the percentage reporting "almost always" or "always" for the statements within each domain. The graph below presents the aggregates scores for each of the five domains. Ratings remain high on all five domains with some decrease in each from 2018 as compared to 2017. The full survey results report is located in Appendix B.

Collective Impact Aggregate Scores



*An average of the percentage reporting "almost always" or "always" for the statements within each domain.

B. BEHAVIORAL HEALTH TRAINING/EDUCATION

In July, 21 hospital staff and law enforcement attended Mental Health First Aid Training. A second Adult Mental Health First Aid training was scheduled for August 8th but no one registered for this training. We are looking for a day to hold a Youth Mental Health First Aid training in 2018 but no date is currently set.

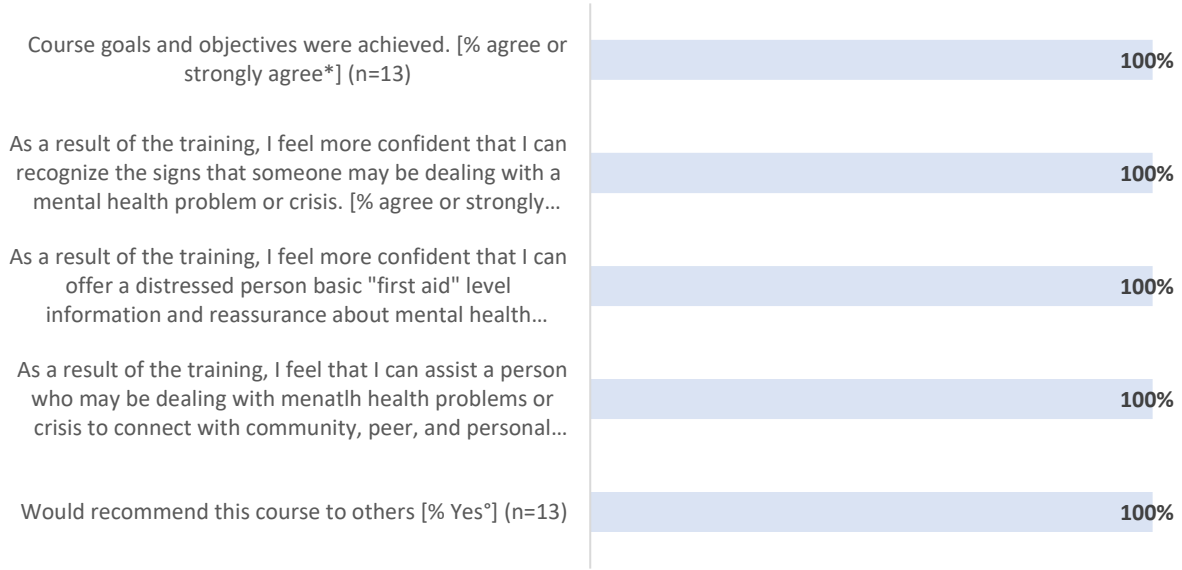
No trainings were held in the last 6 months, but there are two trainings scheduled and a possible 3rd to be held in year 3.

Trainings				
Date(s)	Training Topic/Description	Description of Individuals Trained (community, school, parents, healthcare, etc.)	# of Participants	# of Organizations Participated
July 12 and 13	Mental Health First Aid	Nursing Staff and Law enforcement	21	2

Training Outcomes:

The figure below depicts the selected results from the 13 evaluations completed from the July training. All items were rated very positively.

Mental Health First Aid: Selected Results
Plainview July 2017 Training



C. SUMMARY OF PROGRAMS IMPLEMENTED

No programs have been implemented at this time. We are working with the North Central District Health Department to start a drug and alcohol awareness program with the schools in this county. No event dates have been set. The group decided to wait until after the holidays to look at calendars to set dates and needed time to visit with the other schools in the county to get their feedback.

D. OTHER PROGRAMS IMPLEMENTED (OPTIONAL)

The coalition and Plainview Pharmacy had a Drug Take Back Day on October 28th with 7 lbs. of prescription drugs being returned. We learned by doing this event that the Plainview Pharmacy will take back drugs at any time.

Telepsych is still functioning but not being used to its full potential. There have been having equipment problems and no funds to replace them.

Coalition member Bruce Yosten, Chief of Plainview Police held another Drug Take Back Day in conjunction with the Plainview Pharmacy. They collected 2 pounds of medicine. The Plainview Ministerial Society has a program coming to our area this fall (Rick and Nick) to be held at the school and open to the public. The coalition will be hosting a Lunch and Learn with a representative of "The Loss Group" as our guest speaker.

E. RESOURCE AWARENESS

The coalition and the community have decided to use Region 4's resource guide (on-line) rather that create another directory.

A video is under development to increase community awareness of the Healthy Choice for Pierce County Coalition, its members and the mental health and substance use resources available in Pierce County. Some of the coalition members were interviewed, and when finalized, the short 4-mintue video will be included on the coalition Facebook page and website in addition to being available on other coalition websites.

F. COORDINATION AND NAVIGATION

N/A

G. ASSESSMENTS AND PLANNING DOCUMENTS

- *Develop a community plan to increase access to mental health providers including nurses*

The facility explored the option of having a counselor here in person once a week but at this time there has not been any more forward movement to our knowledge.

- *Plan for training community members on behavioral health*

We are trying to get more interest from the teaching staff at the school for the Youth Mental Health First Aid training that is planned but we have no date at this time.

- *Explore potential of implementing a Crisis Response Team concept*

The concept was explored. A decision was made to use the current Crisis Response Team that is out of Norfolk. They have the resources and training and are available for us to use.

H. ED VISITS AND COUNTY-LEVEL HEALTH DATA

To provide additional reflection on the impact of the project, baseline hospital and community wide data related to mental health is represented in the tables below. The data represents the most current year available and will be updated annually, if available. The four tables included:

- Pierce County Emergency Department Mental Health Visits
- Emergency Protective Custody Cases - Plainview
- Child Well-Being Indicators
- County Health Data Indicators

Pierce County Mental Health ED Visits at CHI Hospitals

	*FY 2016	*FY 2017	% change
Plainview, NE (Pierce County)	10	4	-60.0%
Total for 10 Communities	**16,165**	**17,382**	**7.5%**

*Fiscal Year: July-June Source: CHI Health Hospital Data

Plainview Law Enforcement: Number of Emergency Protective Custody Cases:
July 2016 – June 2017: **5** July 2017 – May 2018: **19**

Child Well-Being Indicators

	Year(s)	Pierce County
Total Population/ages 19 & under	**2015**	7,190/ 1,943
	2016	7,159/ 1,925
Number/percent of births to teen mothers (age 17 and under)	**2015**	1/1.0%
	2016	1/1.2%
Number of juvenile arrests/rate per 1,000 population	**2015**	7/8.3
	2016	2/2.4
Number of substantiated child maltreatment victims/rate per 1,000 population	**2015**	8/4.5
	2016	5/2.8
Number in out-of-home care/ rate per 1,000 population	**2014**	12/6.7
	215	8/4.5
Percent of children ages 0-17 below poverty level	**2010-2014**	4.7%
	2011-2015	5.9%

(Source: Kids Count Data Center)

County Health Data Indicators (see Table 7 below for definitions and data sources)

	Year(s)	Pierce (Plainview, NE)	*Nebraska*	*Iowa*
Poor Mental Health Days (average # unhealthy days/30 days)	**2014**	2.5	***2.8***	***3.1***
	2015	2.7	***3.0***	***3.3***
	2016	2.6	***3.2***	***3.3***
Adult Smoking	**2014**	15%	***17%***	***19%***
	2015	16%	***17%***	***18%***
	2016	16%	***17%***	***17%***
Excessive drinking (binge/heavy drinking past 30 days)	**2014**	20%	***21%***	***22%***
	2015	21%	***20%***	***21%***
	2016	20%	***21%***	***22%***
Alcohol-impaired driving deaths	**2010-2014**	29%	***35%***	***24%***
	2011-2015	25%	***36%***	***25%***
	2012-2016	19%	***37%***	***27%***
Chlamydia rate per 100,000	**2013**	84	***393***	***356***
	2014	56	***401***	***382***
	2015	208	***423***	***389***
Premature age-adjusted mortality rate per 100,000 (under age 75)	**2011-2013**	246	***302***	***309***
	2013-2015	256	***307***	***311***
	2014-2016	287	***309***	***313***
Drug overdose death rate per 100,000	**2014**	--	***7***	--
	2013-2015	--	***7***	--
	2014-2016	--	***7***	9
Suicide Rates per 100,000	**2010-2014**	6.3	***11.7***	
	2011-2015	8.1	***12.0***	
	2012-2016	11.5	***12.4***	

(Source: County Health Rankings)

I. FINANCIAL RESOURCES AND SUSTAINABILITY

Funding from CHI Health			
Source	**Program, Strategy or Coalition Support**	**Funding Period**	**Amount**
Mission and Ministry Grant	Coalition Support - Projector; Resource Awareness -SobyVISION Video	July 1, 2017 - June 2018	$1,146
Federal FLEX Grant	Coalition Support – Leader Compensation and SobyVISION Video	September 15, 2017-September 14, 2018	$3,750
CHI Health Information Technology	Coalition Support – In kind laptop	July 1, 2017 - June 2018	$702

CHI Health Plainview	In kind Support – staff time, meeting room expense and refreshments for Coalition meetings.	July 1, 2017 - June 2018	$16,791

As the group grows to include more participants, we are finding that there are other grants available through the Health Department and through Region 4. Many of the trainings are provided by Region 4 with the public Library opening their meeting room for free. The coalition may only have the cost of lunches and snacks. The Health Department has stated that they have some grants available for media campaigns and school events for alcohol and drug awareness.

Telepsych is located CHI Health Plainview and is supported by the hospital and by providers that treat the patients. We are currently looking at the option to have a counselor available in our facility. No concrete plans available at this time.

Education on sustainability planning was conducted at the annual summit in May of 2018. Grant administrative staff will provide a sustainability process in the fall of 2018 to the coalitions to assist them in the development of their community specific sustainability plans.

Appendix A

Plainview - Pierce County 12-month Output Report

Report period: July 1, 2017 through June 15, 2018

Area	Metric	Input information here (only report on activities for the six months of the report period):
Community Coalition	Number of coalition meetings:	12
	Dates of coalition meetings:	Jul 19, Aug 30, Sept 20, Oct 18, Nov 15, Dec 12, Jan 17, Feb 21, Mar 21, April 18, May 16, June 20
	Average number of members attending meetings:	9
	Number of resource directories distributed (or number of hits to web-based resource directory):	N/A
Prevention Programs	Number of prevention programs implemented through Region 4:	N/A
	Names of implemented prevention programs:	N/A
	Number of parents and youth participating in prevention programs (across all programs):	Parents: N/A
		Youth: N/A
Trainings	Community-wide training plan developed? (yes/no)	N/A
	Names and dates of trainings:	MHFA – July 2017
	Number of participants at each training:	21
	Types of training participants (across all trainings):	Number of health care workers trained: 18
		Number of law enforcement trained: 3

		Number of school personnel trained: 0
		Number of other community professionals trained: 0
Additional Funds	Additional funds obtained by the coalition from the region (amount):	None
Tele-Psych/Med. Management	Number of youth accessing tele-psych and other med. Management services:	Not Available
Sustainability (Year 2)	Began developing a sustainability plan? (yes/no)	Yes
Sustainability (Year 3)	Sustainability plan completed? (yes/no)	N/A

Plainview - Pierce County Outcome Checklist

Area	Outcome	Tool/Resource	Data Collection Frequency
Community Coalition	Increased awareness of resources leads to increased use of those resources	Community Service Provider Survey	Annually (every May)
	Members rate coalition as effective	Coalition Member Survey	Annually (every May)
Trainings	Increased knowledge of BH with healthcare providers and other community members	Post-training Evaluations	After each training
Tele-Psych/Med. Management	Number of youth accessing tele-psych and other med. management services	Hospital Records	Annually
	Decrease in law violations, EPC's, and transportations by law enforcement, and school violations	Law Enforcement Data	Annually

Appendix B

Behavioral Health Coalition Collective Impact Survey 2017 & 2018 Results for Plainview

Introduction and Methodology

Nine out of ten CHI Health Behavioral Health Coalitions have participated in the Collective Impact Survey in 2017 and 2018. One community (Omaha Metro) has not participated in this survey. The survey is designed to evaluate the effectiveness of the coalitions within five domains: common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone organization. All active coalition members (i.e., those who attended at least one meeting in the past year) were invited to participate in the survey and rate their coalition on a number of survey items within each of the five domains.

The survey was conducted online via SurveyMonkey.

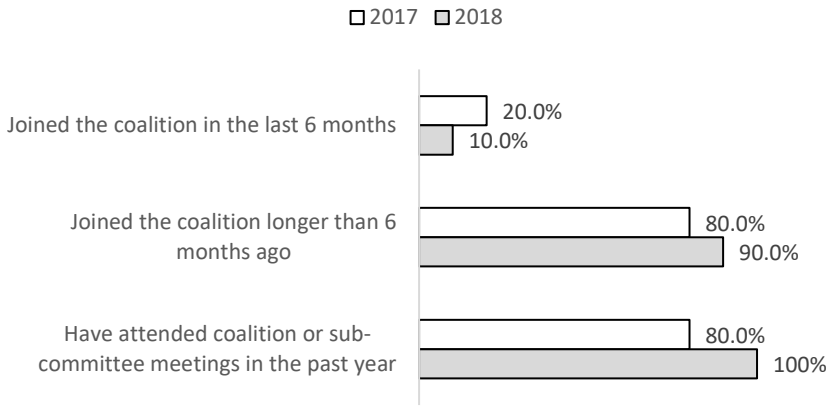
Response Rate

2017 - A total of 10 members of the coalition in Plainview responded to the survey out of 20 invitees, making for a response rate of 50.0%.
2018 - A total of 10 members of the coalition in Plainview responded to the survey out of 13 invitees, making for a response rate of 76.9%.

Coalition Involvement

Figure 1 shows the coalition involvement of the respondents.

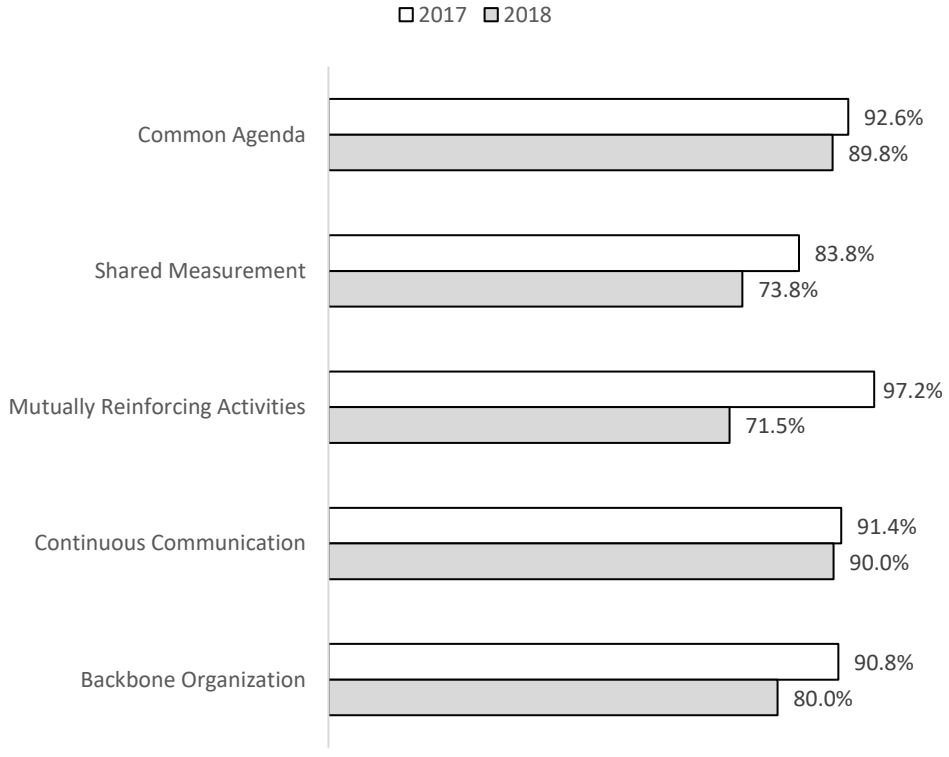
Figure 1. Coalition Involvement



AGGREGATE SCORES

Each of the five domains receives an aggregate score. The aggregate score is the average of the percentage reporting “almost always” or “always” for the statements within each domain. Figure 2 below presents the aggregates scores for each of the five domains.

Figure 2. Aggregate scores*

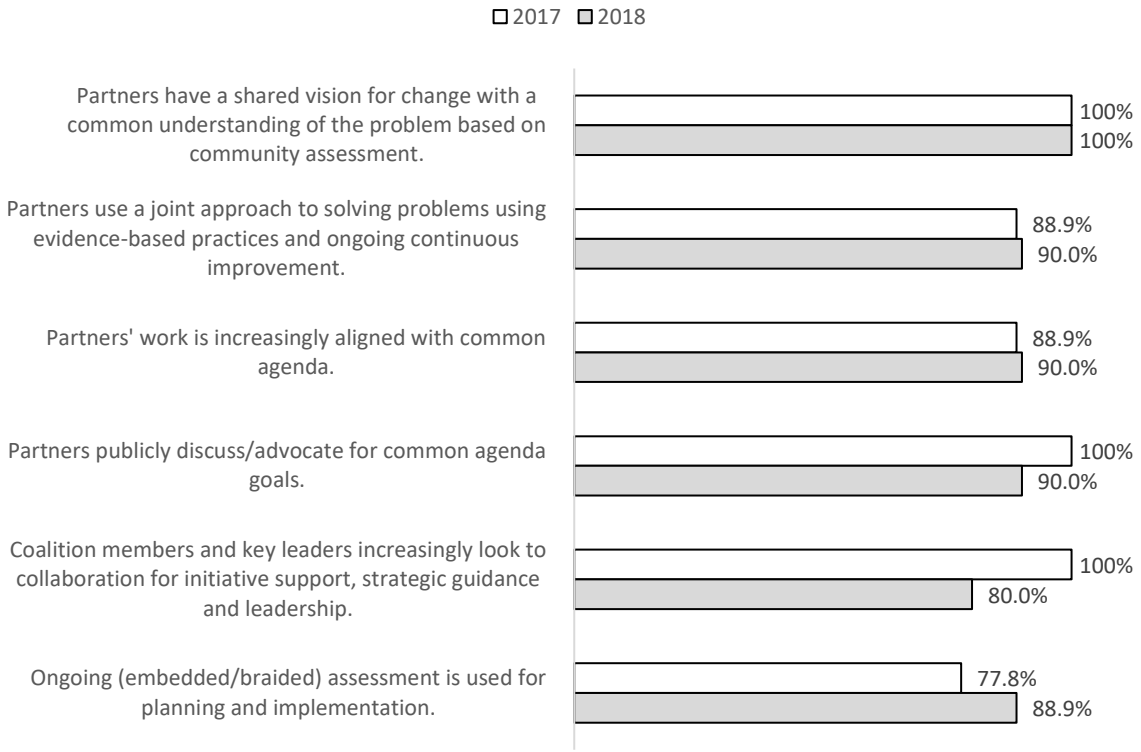


*An average of the percentage reporting "almost always" or "always" for the statements within each domain.

The remainder of this report presents the ratings for each survey item within each of the five domains of collective impact. After answering questions within each domain, respondents were given the opportunity to provide comments. Any comments that were made are included in this report.

COMMON AGENDA

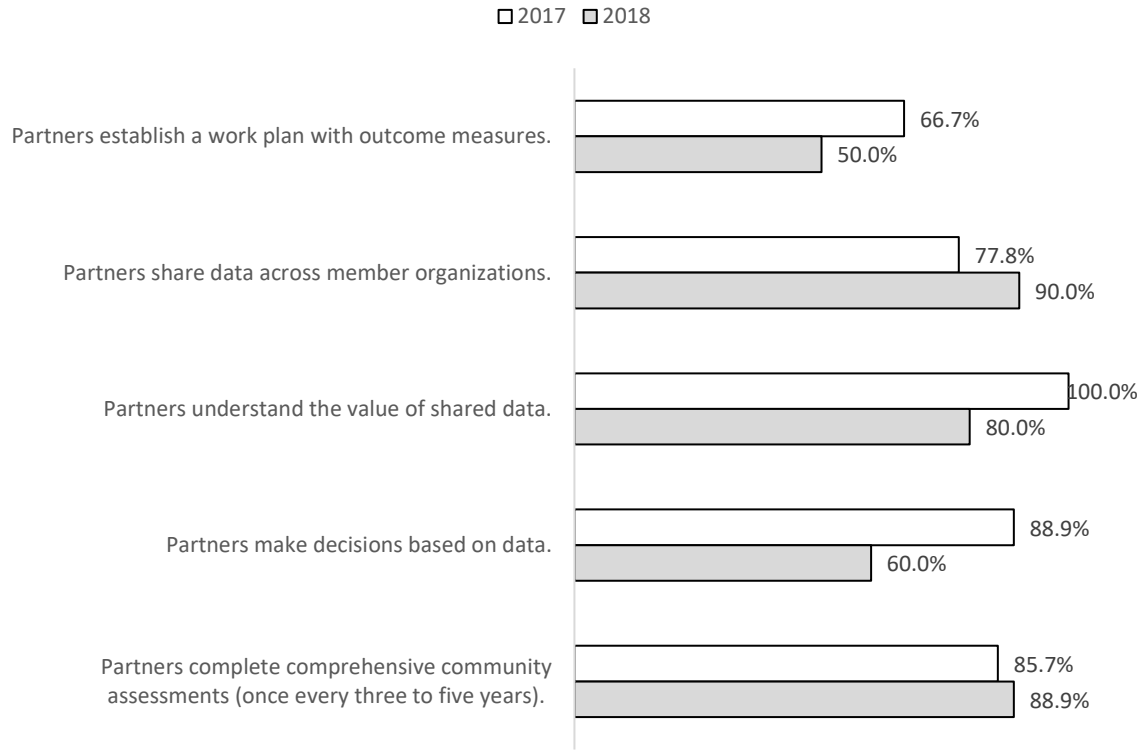
Figure 3. Common Agenda [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

Comments about Common Agenda
2018
• I feel that there is a common understanding of the problem, but nothing is really being done on the community level to address the issues yet.

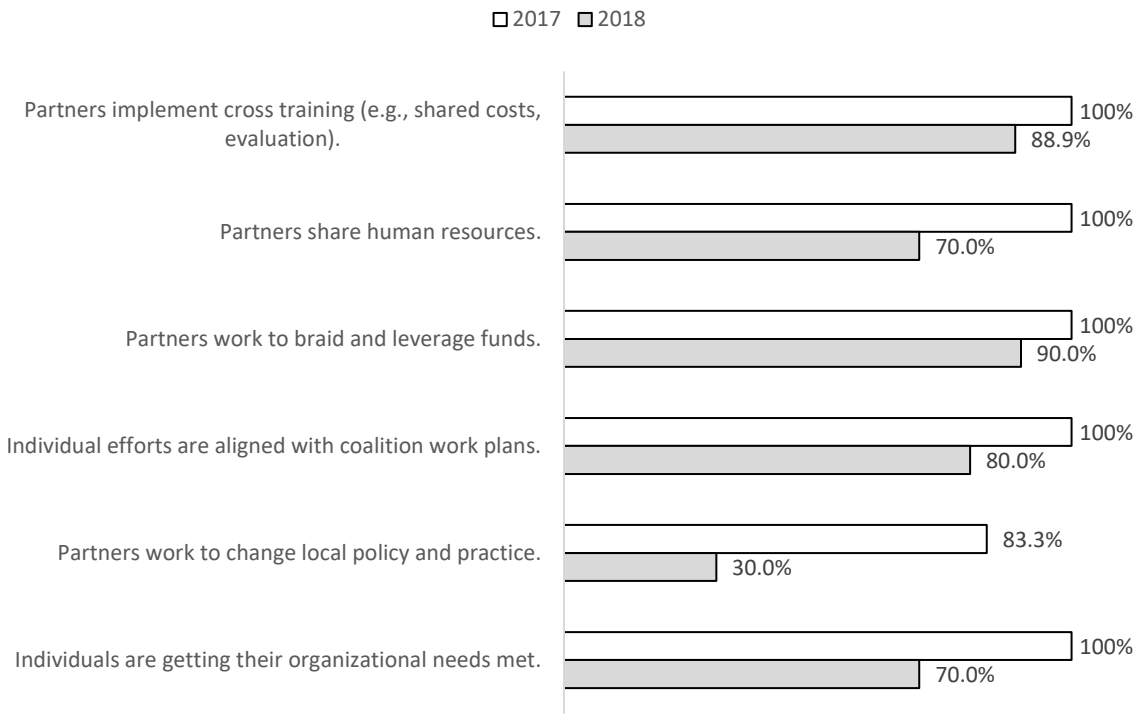
Figure 4. Shared Measurement [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

MUTUALLY REINFORCING ACTIVITIES

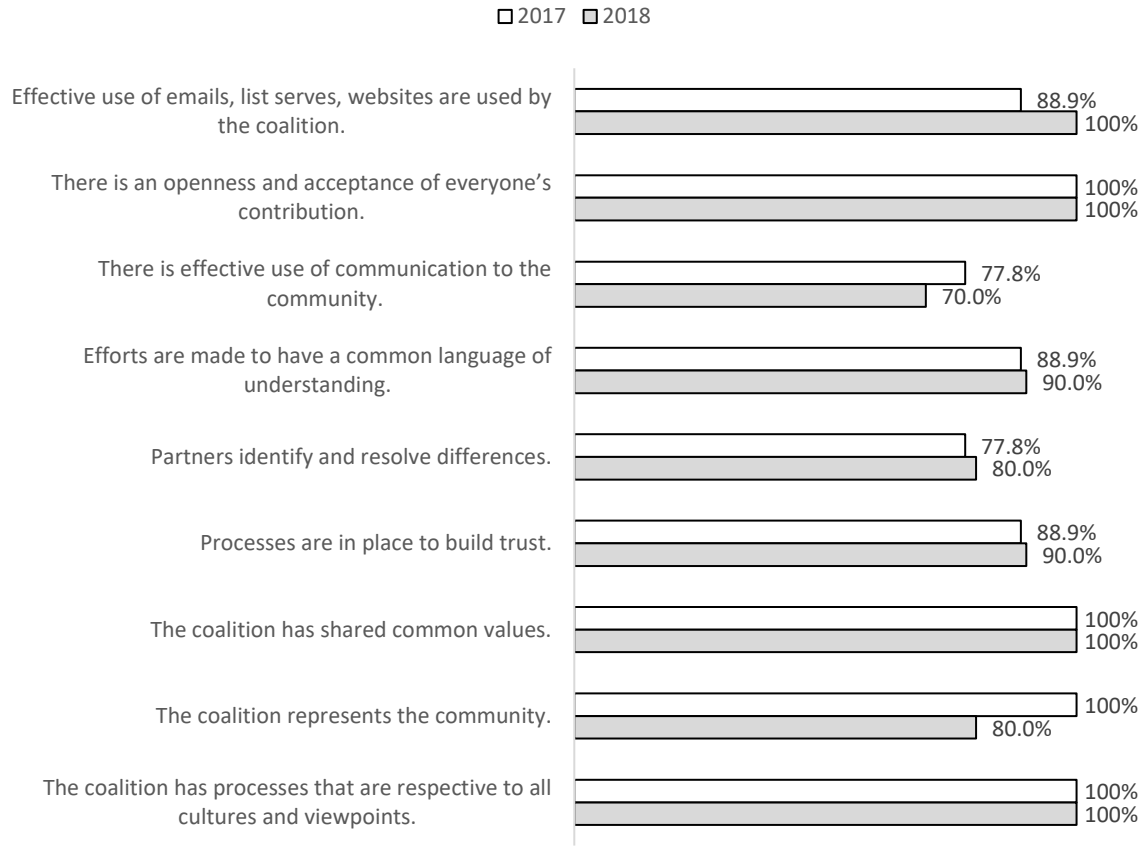
Figure 5. Mutually Reinforcing Activities [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

Comments about Mutually Reinforcing Activities
2018
• I feel that there are times when we have a meeting, but nothing is actually being done and it is a waste of time

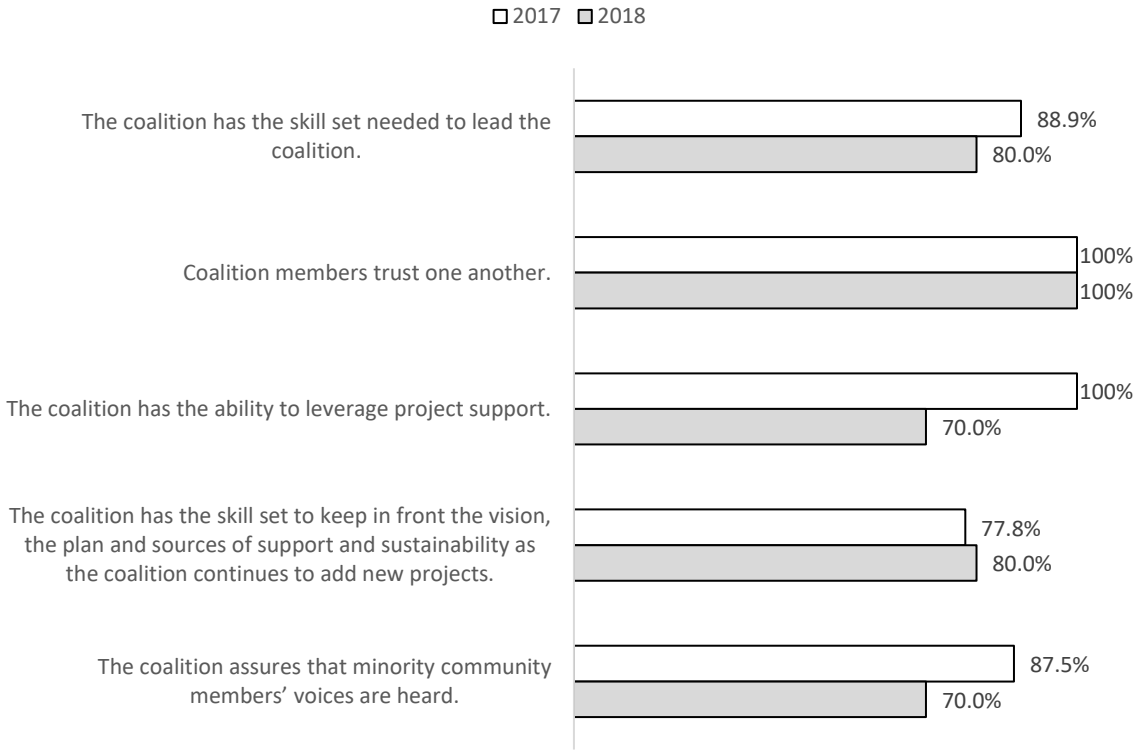
Figure 6. Continuous Communication [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

BACKBONE ORGANIZATION

Figure 7. Backbone Organization [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

Plainview/Pierce County, Nebraska Behavioral Health Improvement Plan 2016-2019

Collective Vision: To increase the preventive outreach, educational efforts and resources that support the resiliency of community members who experience mental health and substance use issues.

Goals

1. Increase the overall awareness of existing and potential resources among community stakeholders through an established behavioral health community coalition.
2. Provide community-wide training on mental health and substance use to stakeholders such as healthcare workers (i.e., nurses) law enforcement, EMTs, pastors, school personnel, and elder care workers.
3. Increase access to mental health providers in the community that may include support of medication management services and increased use of tele-psych and educate community healthcare providers on behavioral health (BH).

Resources/Input

- CHI Mission and Ministry Grant Funding
- Other CHI Health Healthier Communities Funding
- Other braided funding through Region 4
- CHI Health Plainview –Sponsor
- Backbone Organization - TBD
- Community Collaborative Partnerships

Strategies/Activities

Year 1:

- Establish a community coalition to facilitate communication and awareness of resources.
- Create a behavioral health resource guide with links to providers and programs.
- Offer MANDT (i.e., restraint) Training to law enforcement and other community stakeholders.
- Offer 2 Mental Health First Aid Trainings (youth and adult) in the community.
- Develop a community plan to increase access to mental health providers, including nurses, and for training community healthcare providers on BH.

Year 2:

- Promote and distribute behavioral health resource guide.
- Offer 2 Mental Health First Aid Trainings (youth and adult) in the community.
- Coalition explores Crisis Response Team concept.
- Implement the plan to increase access to mental health providers in the schools and the community, i.e., tele-psych in the schools.
- Train hospital staff to become trainers of Trauma-Informed Care.
- Begin developing a sustainability plan

Year 3:

- Community coalition continues to meet to address behavioral health issues in the community.
- Trauma-Informed Care Training offered to other community members and medical staff.
- Crisis Response Team concept may be implemented.
- Finalize sustainability plan and prepare to implement.

Outputs

- Number of coalition meetings, members and resource directories distributed.
- Sustainability Plan completed.
- Number of prevention programs implemented through Region 4.
- Number of trainings offered and number participating in the trainings.
- Additional funds obtained by the coalition from the Region.
- Number of community members trained and type of training completed
- Number of trainings held and number trained.
- Number of youth accessing tele-pysch and other med management services.
- Sustainability Plan established.

Outcomes

- Community Coalition shares resources formally and informally with members rate the coalition as “effective”.
- Increased awareness of community resources increases use of those resources.
- Schools have increased access to mental health providers.
- Increased knowledge of BH with community healthcare providers and other community members.
- Decrease in law violations, EPC’s and transportations by law enforcement and school violations.

Behavioral Health Initiative

2nd Annual Evaluation Report

Schuyler – Colfax County

July 2017 – June 2018

A. COMMUNITY COALITION DEVELOPMENT AND PLANNING

This period we had three major success stories:

a) Schuyler-Colfax County Behavioral Health Coalition braided funds with Schuyler Community Schools to bring the full implementation of the Capturing Kids' Hearts program to K-8 teachers and students. The braided funding helped develop long-term support for the emotional well-being of the staff and students through the success of the program. The program was implemented to all staff at the Schuyler Middle School, Fischer's School, and Richland Elementary, as well as to new staff members at Schuyler Elementary, who had not participated in the initial implementation of the program in 2016.

b) Schuyler-Colfax County Behavioral Health Coalition was able to fund the Building Healthy Relationships (BHR) program in the 2017-2018 school year. This program had previously been in existence for more than ten years at Schuyler Central High School, but due to grant stipulations, had been lost. The teen advocates from the BHR program assist greatly outside of group time – their assistance to school counselors is vast. The benefits of this program are incalculable for students and families.

c) The in-school therapy has continued for the 2017-2018 school year. The therapist held 60-minute sessions for 10-12 weeks per student, one time a week at each school (Middle School, and Central High School). During this new school year, there has been more coordination in getting questionnaires and forms filled out, however this is sometimes still hard to get lined up.

One set back is that Medicaid is now requiring first a diagnostic evaluation by a psychiatrist. This has been cumbersome for some families, in coordinating their visit. Some of the challenges that were identified were the parental follow through, follow through with the referral process, understanding how to follow through with the referral process. It was found that there was also a lack of understanding of the role of the counselor as an outside agency providing an outpatient therapy service within the school system, as well as the financial process tied to this.

There were also elementary school referrals that either had lack of transportation or lack of parental follow through to the middle or high school. Elementary school referrals most likely also need family therapy – so a non-English speaking parent and/or student might increase this challenge. It was also identified that if the referral was identified as having a main issue in the home in a Spanish-speaking household, these families were then referred to an agency that provides that service.

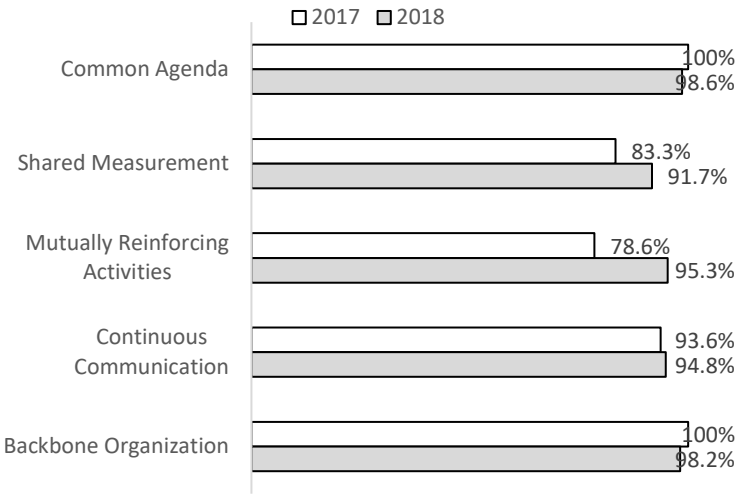
Collective Impact Survey Results:

The Collective Impact survey is designed to evaluate the effectiveness of the coalitions within five domains: Common Agenda, Shared Measurement, Mutually Reinforcing Activities, Continuous Communication, and Backbone Organization. All active coalition members (i.e., those who attended at least one meeting in the past year) were invited to participate in the survey and rate their coalition on a number of survey items within each of the five domains. The survey was conducted online via SurveyMonkey.

Response Rates:
2017 - A total of 10 members of the coalition in Schuyler responded to the survey out of 38 invitees, making for a response rate of 26.3%.
2018 - A total of 12 members of the coalition in Schuyler responded to the survey out of 24 invitees, making for a response rate of 50.0%.

Each of the five domains receives an aggregate score. The aggregate score is the average of the percentage reporting “almost always” or “always” for the statements within each domain. The graph below presents the aggregates scores for each of the five domains. Ratings primarily maintained high ratings in 2018 with a notable increase in Mutually Reinforcing Activities and Shared Measurement in 2018 as compared to 2017. The full survey results report is located in Appendix B.

Collective Impact Survey Aggregate Scores*



*An average of the percentage reporting "almost always" or "always" for the statements within each domain.

B. BEHAVIORAL HEALTH TRAINING/EDUCATION

Trainings				
Date(s)	**Training Topic/Description**	**Description of Individuals Trained (community, school, parents, healthcare, etc.)**	**# of Participants**	**# of Organizations Participated**
Summer 2017	Capturing Kids' Hearts	K-8 administrators, faculty, and staff members	*(See Programs Implemented)*	

The Capturing Kids' Hearts program was implemented to administrators, faculty, and staff members K-8 that had not previously received the training. This is an ongoing evidence-based program.

This period, there were three Mental Health First Aid (MHFA) training sessions offered, however there were not enough enrollees to actually hold the session. For the first one, there were no enrollees, for the second only two participants that signed up, and for the third one there was only one. The third session was to be held in Spanish, to reach our Spanish-speaking population. This was lined up by our MHFA trainer. We had an additional person trained as a trainer for MHFA in April.

C. SUMMARY OF PROGRAMS IMPLEMENTED

IN-SCHOOL THERAPY PROGRAM

Program Planning: There was a concern that youth needing to attend counseling services were not compliant in their care mainly due to lack of transportation and non-compliance from their parents not taking them to their sessions. East Central District Health Department (ECDHD) and Schuyler Community Schools identified this problem and worked towards a collaboration of how they could provide the counseling services within the schools.

Program Description of Where Program was Implemented: This program is a collaboration between Schuyler Community Schools and East Central District Health Department. It was implemented at Schuyler Middle School and Schuyler Central High School to provide counseling services to youth during school hours, so that their compliance is not jeopardized due to transportation issues or non-compliance from their parents not taking them to their sessions.

Description of Participants (i.e., community individuals, parents, youth, ages, etc.): Middle and High School – age youth and their parents.

Number of Participants:

Program Name: In- School Therapy Program			
Number of Children/Youth Served Directly (if applicable)	10	Number of Organizations Involved in Implementation	2
Number of Individuals (or Parents) Served Indirectly	4	Number of Staff Involved in Implementation	5

Comments on Successes and Challenges: There have been a total of 10 students, with a total of 108 visits from July to June 2018 (331 visits since implementation of Program, from July 2016 to June 2018). The sessions went back to being 60 minutes, given the availability and lower demand of sessions. Over the summer months the program did not run, because school was not in session, therefore it did not start back up again until late August. Students with Medicaid as a payer source found obstacles in the delivery of the program, due to there being a requirement for them to first see a psychiatrist in person before beginning the counselling sessions. The coordination of care that this implied burdened some students due to availability and coordination of schedules.

There is more of a streamline in regards to how the program is currently working. There has been more coordination to help students and their parents navigate the system and understand what is required for their insurance to pay for the services. Also, teachers were more open to therapy since instead of missing an entire morning of classes the student only missed 1-2 classes.

There have also been challenges: participation from primary care givers and attaining the needed paperwork for consent and finances were major issues throughout implementation. We overcame the barriers by being flexible, and through assistance from the school secretaries and school counselors, in working with the parents to come in around schedules - possibly separate from the students - to get needed information and paperwork signed. There continued to be a lack of understanding that this was not a service provided by the school system, but rather an outside agency (ECDHD) providing outpatient service in the school system using the same financial process they use in their agency.

One additional key learning is that the key to making the implementation work was understanding that each school (even within the same school district) is a little different in culture and processes and all parties have to be open to helping each other. It couldn't have been done as well if there wasn't help from all school personnel. Learning to be flexible and adapting as a provider to understand that there are differences between schools and to be able to adapt processes and schedules to make it work was also important. There was also recognizing that some referrals were sent on to more appropriate providers – an example, if the main issue is in the home and they are Spanish-speaking, then the therapist would refer them to an agency who provides that service.

CAPTURING KIDS' HEARTS (CKH)

Program Planning: Schuyler Community Schools proposed braided funding to CHI Health in hopes of obtaining a full implementation of Capturing Kids 'Hearts training for K-8 teachers and students in the Schuyler Community School District. In December of 2015 Schuyler Community School District had sent a scout team to research the program. In May of 2016, the district covered the cost of 30 school and community leaders to develop their individual skills by participating in the Leadership Blueprint Training. In October of 2016, the full teaching staff at Schuyler Elementary School also completed the Capturing Kids 'Heart training. Given the success that was seen by this, the Schuyler Community Schools wanted to implement this long-term.

Program Description: A research-based process that improves the five key indicators of school performance: fewer discipline referrals, improved attendance, higher student achievement, lower dropout rates, and higher teacher satisfaction.

Description of Where Program was Implemented: This is being introduced to new staff at the Schuyler Elementary, as well as all staff at Schuyler Middle School, Fischer's and Richland Schools.

Number and Description of Participants (i.e., community individuals, parents, youth, ages, etc.): On August 7th and 8th 2017, staff from six buildings within the Schuyler Community Schools district participated in a Capturing Kids Hearts Training through the Flippen Group. All staff from the following buildings participated: Schuyler Middle School, Fischer's, and Richland.

Staff that were new to Schuyler Elementary School and Schuyler Preschool for the 2017-18 school year participated in the training, as well as a focus group from Schuyler Central High School. Schuyler Elementary School and Schuyler Preschool had the training the previous fall.

In total, 50 staff members and one community member participated. Of the fifty plus staff members, five were administrators, 48 were teachers, and two were guidance counselors. (Please note, there were a total of 50 people who were trained previously by means of the Behavioral Health Coalition Grant Money – 5 of the participants had already been trained, and just attended as a "refresher"). Once the training was completed, all PK-8 teachers, guidance counselors, and administrators for Schuyler Community Schools were officially trained.

Number of Participants:

Program Name: Capturing Kids Heart			
Number of Individuals (or Parents) Served Directly	n/a	Number of Organizations Involved in Implementation	1
Number of Children/Youth Served Directly (if applicable)	n/a	Number of Staff Involved in Implementation	50

Future Plans for Capturing Kids Hearts:
The 2018 Schuyler Community Schools Strategic Plan includes the implementation of Process Champions, which is the next step to Capturing Kids Hearts. K-8 administrators, guidance counselors, and classroom leaders will take part in this program in order to take the next steps to stabilizing a positive and productive climate throughout the school community.

Outcomes (Schuyler Middle School):

Attendance Summary
There was a drop in excused absences. More medical days were taken. Unexcused absences dropped, despite the fact that school enrollment rose. There was a heavy increase in the number of students that took vacation from their families, primarily during the holiday season.

Attendance Summary	2016-2017	2017-2018
Excused	623.10	548.33
Medical	1638.25	1896.52
Out of School Suspension	16.95	21.77
Unexcused	262.66	250.47
Vacation	293.13	347.74

Behavior Summary
Due to the increase of monitoring behavior, the number of in-school suspensions rose. Of the sixty-five days for ISS, fourteen days were repeat attempts. There were no students that dropped out of Schuyler Middle School.

Behavior Summary	2016-2017	2017-2018
Expulsions	1	2
Out of School Suspensions	13	8
In-School Suspensions	28	65

Academic Achievement Summary

The total SMS students with a 3.0 out of 4.0 decreased by fifteen from Fall 2016 to Fall 2017. The number of total SMS students earning a perfect 4.0 rose from 13 to 19 from Fall 2016 to Fall 2017.

Academic Achievement Summary	Fall 2016	Fall 2017
Total Honor Roll	244	229
Total Gold Honor Roll	13	19

Comments from SMS Staff Members:

- "Social contracts give us all an expectation of what is to be expected in the classroom."
- "Capturing Kids Hearts has helped me realize that there is a difference between loving kids and loving to serve them. The four questions also help me process with students in a more rational way that encourages both the student and myself to de-escalate stress in order to solve problems with one another."
- "I am looking forward to taking the training from The Flippen Group. Coming from a building with the PBiS Model, this will help me understand how the building operates and how kids learn."
- "Teachers that have highly implemented Capturing Kids Hearts can see a raise in academic achievement, a drop-in behavior issues, and a higher professional rating. This program gives staff members the fundamental opportunities to lead students in successful daily behaviors to become successful in and out of the classroom."

BUILDING HEALTHY RELATIONSHIPS (BHR)

Program Planning: Schuyler Community Schools proposed re-implementation of this program, as it had been lost due to grant stipulations. It had previously been existing for more than ten years.

Program Description: An evidence-based practice that addresses sexual assault, domestic violence, dating violence and stalking among adolescents and young adults that brings incalculable benefits to youth in our community.

Description of Where Program was Implemented: To students at Schuyler Central High School and Schuyler Middle School by Center for Survivors.

Number and Description of Participants (i.e., community individuals, parents, youth, ages, etc.): There was a total of 7 groups. 4 girls and 3 boys group. (of these groups 1 boy group and 1 girl group were at the Schuyler Middle School; the remaining being held at Schuyler Central

High School). There was a total of 44 participants at Schuyler Central High School and 20 at Schuyler Middle School.

School	Groups – Boys	Groups – Girls	Total Groups	Total Number of Participants
Schuyler Central High School (Fall 2017 and Spring 2018)	2	3	5	44
Schuyler Middle School (Fall 2017)	1	1	2	20

Number of Participants:

Program Name: Building Health Relationships			
Number of Individuals (or Parents) Served Directly	0	Number of Organizations Involved in Implementation	2
Number of Children/Youth Served Directly	64	Number of Staff Involved in Implementation	4

Comments on Successes and Challenges: The program is offered by the Center for Survivors. Of the 64 students who participated in the program, following were contacts with students by counselors from the Center for Survivors and referrals for therapy.

	N = 29 Fall High School (2017)	N = 20 Fall Middle School (2017)	N = 15 Spring High School (2018)
Number of crisis counseling calls by students	7	1	15
Number of duplicated follow-up with students	32	0	62
Number of students referred to therapy	2	0	5

Outcomes:

A 15-item pre-posttest was administered to participants of Building Healthy Relationships. A total of 42 pre-tests and 32 post-tests were collected. The average score increased from 72% at pre to 95.3% at post.

Building Healthy Relationships Pre-Post Test Scores

	Pre (n=42)	Post (n=32)
Number correct out of 15	10.8	14.3
Percent correct	72.0%	95.3%

In addition, three survey items were included on the post-survey. All participants who completed a post-survey indicated that they are better able to identify dating violence and are now more likely to get help from a friend who is in an unhealthy relationship.

Building Healthy Relationships Pre-Survey Items

	% Yes
1. Are you better able to identify dating violence and sexual assault? (n=32)	100%
2. Would you know where to get help should you or a friend be the victim of dating violence of sexual assault? (n-32)	93.8%
3. After completing BHR, are you more likely to get help for yourself or a friend who is in an unhealthy relationship? (n=32)	100%

D. OTHER PROGRAMS IMPLEMENTED (OPTIONAL)

Discussion was held regarding expansion of Second Step (bullying awareness program) that is currently being used at the Elementary School. There is a request to push out bullying awareness and prevention to 6-12th grades at Schuyler Community Schools. There will be some motivational speakers lined up during the 2018-2019 school year. Currently, there has been confirmation of Fabian Ramirez coming to Schuyler and presenting two sessions. Fabian is a renowned anti-bullying speaker and drug prevention specialist. The morning session will be aimed towards Colfax County Middle School students. The afternoon session is open to the entire community. This is scheduled to take place on August 16, 2018.

Columbus United Way offered a session of "Bridges out of Poverty" in Schuyler and had multiple agencies participate.

Tele-Psychiatric consults between June 2017 and June 2018:

- There was a total of 30 encounters of tele-psychiatric consults, one of which was a middle school student, during the time period of June 2017 - June 2018.

E. RESOURCE AWARENESS

- **Resource information translated into other languages.**
  The resource book is in the final stage of being developed**.** It will include not only mental health resources, but also basic need resources, and hotlines. The resource guide will be available in Spanish as well as English. It was decided that there will be some printed, as well as a pdf version, which will be distributed to the different coalition members for their availability to post on their own websites. There will also be ads referencing the availability of the resource guides, that will be in the local chamber newsletter, as well as in the local newspaper. Posters will be put up throughout the county saying where resource guide is available both in print and in electronic formats.

F. COORDINATION AND NAVIGATION

- **Community Response Team**. From July 2017 to June 2018 there was an increase in self-referrals due to the necessity to meet basic needs, as well as living conditions. Families in Colfax County are facing hardship due to external factors, such as immigration, which

reflect on various aspects of their lives. The goal for families referred to this program is to find stability in their situation in a term of 90 days. If it goes over the 90 days, referrals are made for additional assessments and could involve higher end systems of care. When the Family Coach encounters situations that are out of their scope of practice, they also refer out. Assistance is provided, and an education component is also included to avoid this situation from being recurring. There is sometimes concern with follow through and contact on behalf of the Coaches. Many times, it is found that the families are still presenting with needs at the end of the 90-day period, while others receive just short-term assistance.

- **Case Review** monthly meetings hosted by County Attorney continue to take place. They are held at the Hospital but do not currently involve any hospital staff.

- **Provider collaboration** (i.e., schools, law enforcement, probation, hospital, Region 4 services) – Law enforcement has seen an increase in the number of incidents compared to the same time period in 2016 (2393) to 2017 (2998) (information reflective to 12/28/17).

G. ASSESSMENTS AND PLANNING DOCUMENTS

- *Exploration of the development of a group home for unaccompanied youth.*
  This has not been explored. It has been determined that this is not a priority at this time.

- *Explore feasibility of a once-a-month weekend in-person psychiatrist.*
  This was discussed, but no concrete actions have taken place yet.

H. ED VISITS AND COUNTY-LEVEL HEALTH DATA

To provide additional reflection on the impact of the project, baseline hospital and community wide data related to mental health is represented in the tables below. The data represents the most current year available and will be updated annually, if available. The three tables included:

- Colfax County Emergency Department Mental Health Visits
- Child Well-Being Indicators
- County Health Data Indicators

Mental Health Emergency Department Visits at CHI Hospitals

	*FY 2016	*FY 2017	% change
Schuyler, NE (Colfax County)	51	61	19.6%
Total for 10 Communities	**16,165**	**17,382**	**7.5%**

*Fiscal Year: July-June
Source: CHI Health Hospital Data

Child Well-Being Indicators

	Year(s)	Colfax County (Schuyler, NE)
Total Population/ages 19 & under	**2015**	10,520/ 3,382
	2016	10,414/ 3,439
Number/percent of births to teen mothers (age 17 and under)	**2015**	3/1.5%
	2016	3/1.4%
Number of juvenile arrests/rate per 1,000 population	**2015**	3/2.3
	2016	18/13.4
Number of substantiated child maltreatment victims/rate per 1,000 population	**2015**	26/8.3
	2016	24/7.5
Number in out-of-home care/ rate per 1,000 population	**2014**	38/12.1
	215	32/10.0
Percent of children ages 0-17 below poverty level	**2010-2014**	18.0%
	2011-2015	18.4%

(Source: Kids Count Data Center)

County Health Data Indicators

	Year(s)	Colfax County (Schuyler, NE)	*Nebraska*	*Iowa*
Poor Mental Health Days	**2014**	2.7	***2.8***	***3.1***
	2015	2.7	***3.0***	***3.3***
	2016	3.0	***3.2***	***3.3***
Adult Smoking	**2014**	15%	***17%***	***19%***
	2015	15%	***17%***	***18%***
	2016	14%	***17%***	***17%***
Excessive drinking	**2014**	19%	***21%***	***22%***
	2015	17%	***20%***	***21%***
	2016	20%	***21%***	***22%***
Alcohol-impaired driving deaths	**2010-2014**	14%	***35%***	***24%***
	2011-2015	17%	***36%***	***25%***
	2012-2016	33%	***37%***	***27%***
Chlamydia rate per 100,000	**2013**	178	***393***	***356***
	2014	269	***401***	***382***
	2015	400	***423***	***389***
Premature age-adjusted mortality rate per 100,000	**2011-2013**	263	***302***	***309***
	2013-2015	283	***307***	***311***
	2014-2016	282	***309***	***313***
Drug overdose death rate per	**2014**	--	***7***	--

100,000	**2013-2015**	--	***7***	--
	2014-2016	--	***7***	9
Suicide Rates per 100,000	**2010-2014**	12.3	***11.7***	
	2011-2015	16.1	***12.0***	
	2012-2016	16.3	***12.4***	

(Source: County Health Rankings)

I. FINANCIAL RESOURCES AND SUSTAINABILITY

Funding from CHI Health			
Source	**Program, Strategy or Coalition Support**	**Funding Period**	**Amount**
Mission and Ministry Grant	Coalition Support, Resource Guide, Best Practice Trainings and Programs – Capturing Kids' Hearts and Healthy Relationships	July 1, 2017-June 30, 2018	$31.028
Federal FLEX Grant	Coalition Support	September, 2017through August, 2018	$3,750
Healthier Communities	MHFA Trainer	July 1, 2017-June 30, 2018	$2,250
Community Benefit	Anti-bullying Campaign (Fabian Ramirez – speaker)	July 1, 2017-June 30, 2018FY2018	$4,500
CHI Health Schuyler	In kind Support – Coalition Leadership and Meeting Participation, Lunches and Meeting Rooms	July 1, 2017-June 30, 2018	$14,287

Education on sustainability planning was conducted at the annual summit in May of 2018. Grant administrative staff will provide a sustainability process in the fall of 2018 to the coalitions to assist them in the development of their community specific sustainability plans.

Appendix A

Schuyler - Colfax County 12-month Output Report

Report period: July 1, 2017 through June 15, 2018

Area	Metric	Input information here (only report on activities for the six months of the report period):
Community Coalition	Number of coalition meetings:	5
	Dates of coalition meetings:	8/28/17, 10/24/17, 12/14/17, 2/28/2018, 4/25/2018
	Average number of members attending meetings:	14
	Number of resource directories distributed (or number of hits to web-based resource directory):	-
	Number of resource directories translated into other languages (list languages):	-
Tele-Psychiatry	Number of patients using tele-psychiatry at the hospital:	30
	Number of students referred to tele-psychiatry in the hospital:	1
Trainings	Number of coalition members trained to conduct trainings:	2 MHFA (one is no longer a coalition member, and one more was trained)
	Names and dates of trainings:	MHFA - None during this time period (3 were scheduled 4/21/18; 5/23/18; 6/16/18) but not held due to no or low registrations.
	Number of participants at each training:	n/a
	Types of training participants (across all trainings)	Number of health care workers trained:

		Number of law enforcement trained:
		Number of school personnel trained:50
		Number of other community professionals trained:
Building Healthy Relationships	Number of students completing the Building Healthy Relationships program:	64
Best Practice Program – Capturing Kids Hearts	Number of school staff members trained	50
Community Partner Collaboration	Number of community partners collaborating on case reviews:	2
Unaccompanied youth	Explored the development of a group home? (yes/no)	No
	Number of unaccompanied youth identified in need of a group home:	0
Counseling	Number of counseling sessions at the school:	108
Sustainability (Year 2)	Began developing a sustainability plan? (yes/no)	No
Sustainability (Year 3)	Sustainability plan completed? (yes/no)	No

Schuyler - Colfax County Outcome Checklist

Area	Outcome	Tool/Resource	Data Collection Frequency
Community Coalition	Increased awareness of resources leads to increased use of those resources	Community Service Provider Survey	Annually (every May)
	Members rate coalition as effective	Coalition Member Survey	Annually (every May)
	Increased use of tele-psychiatry at the hospital	Hospital Records	Annually
Trainings	Community members and students participating in training increase knowledge and awareness of behavioral health and are satisfied with the training	Post-training Evaluations	After each training
Prevention and Intervention Strategies	Decrease in law violations, committals, and transportations by law enforcement with teens and adults	Law Enforcement Data	Annually
	Number of unaccompanied youth identified in need of a group home	None identified	None identified

Appendix B

Behavioral Health Coalition Collective Impact Survey
2017 & 2018 Results for Schuyler

Introduction and Methodology

Nine out of ten CHI Health Behavioral Health Coalitions have participated in the Collective Impact Survey in 2017 and 2018. One community (Omaha Metro) has not participated in this survey. The survey is designed to evaluate the effectiveness of the coalitions within five domains: common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone organization. All active coalition members (i.e., those who attended at least one meeting in the past year) were invited to participate in the survey and rate their coalition on a number of survey items within each of the five domains.

The survey was conducted online via SurveyMonkey.

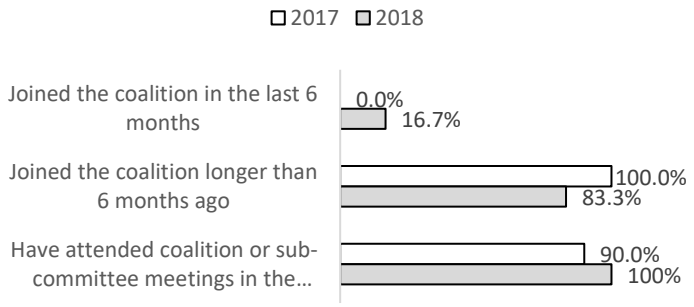
Response Rate

2017 - A total of 10 members of the coalition in Schuyler responded to the survey out of 38 invitees, making for a response rate of 26.3%.
2018 - A total of 12 members of the coalition in Schuyler responded to the survey out of 24 invitees, making for a response rate of 50.0%.

Coalition Involvement

Figure 1 shows the coalition involvement of the respondents.

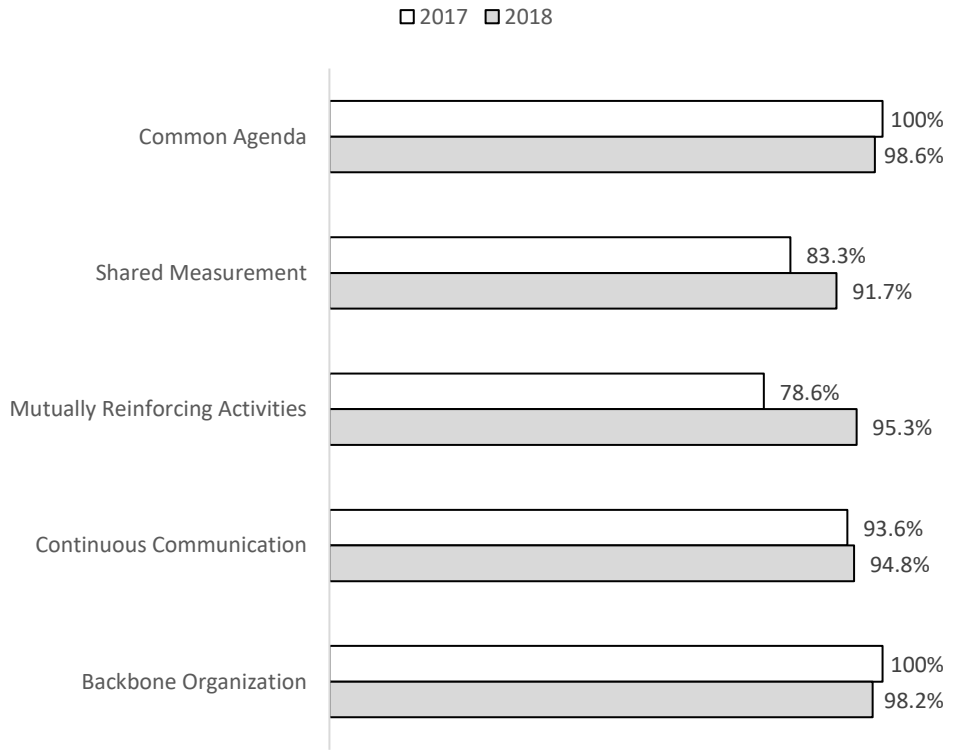
Figure 1. Coalition Involvement



AGGREGATE SCORES

Each of the five domains receives an aggregate score. The aggregate score is the average of the percentage reporting “almost always” or “always” for the statements within each domain. Figure 2 below presents the aggregates scores for each of the five domains.

Figure 2. Aggregate scores*

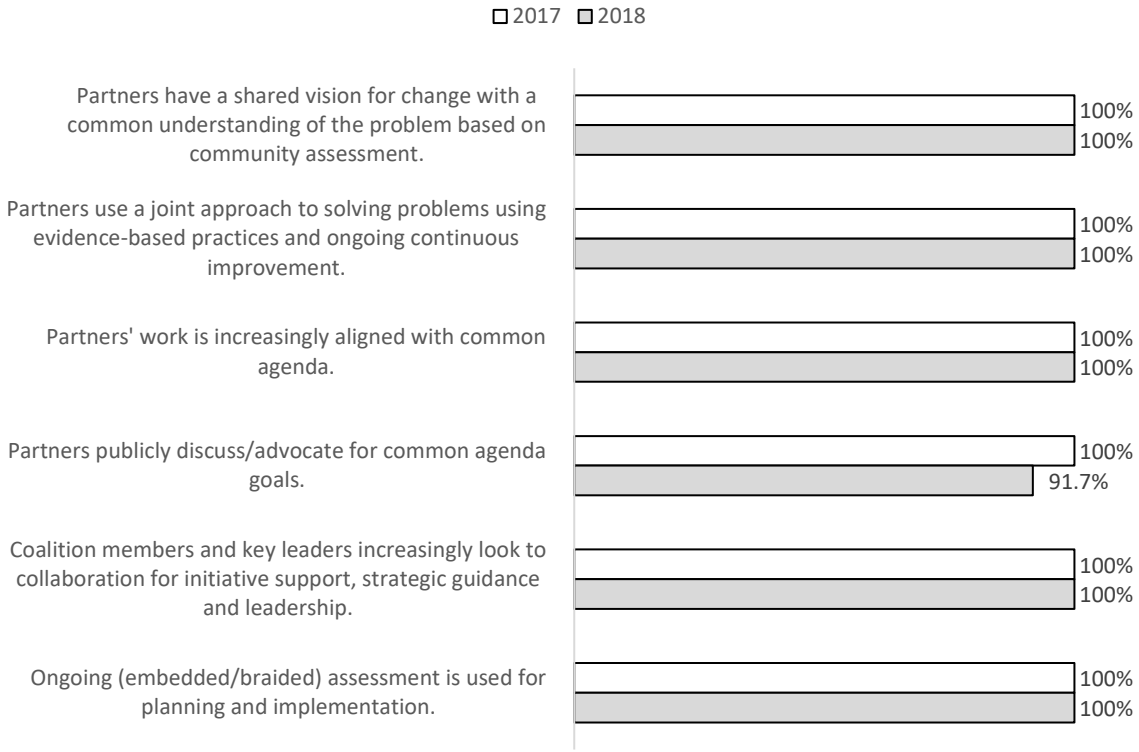


*An average of the percentage reporting "almost always" or "always" for the statements within each domain.

The remainder of this report presents the ratings for each survey item within each of the five domains of collective impact. After answering questions within each domain, respondents were given the opportunity to provide comments. Any comments that were made are included in this report.

COMMON AGENDA

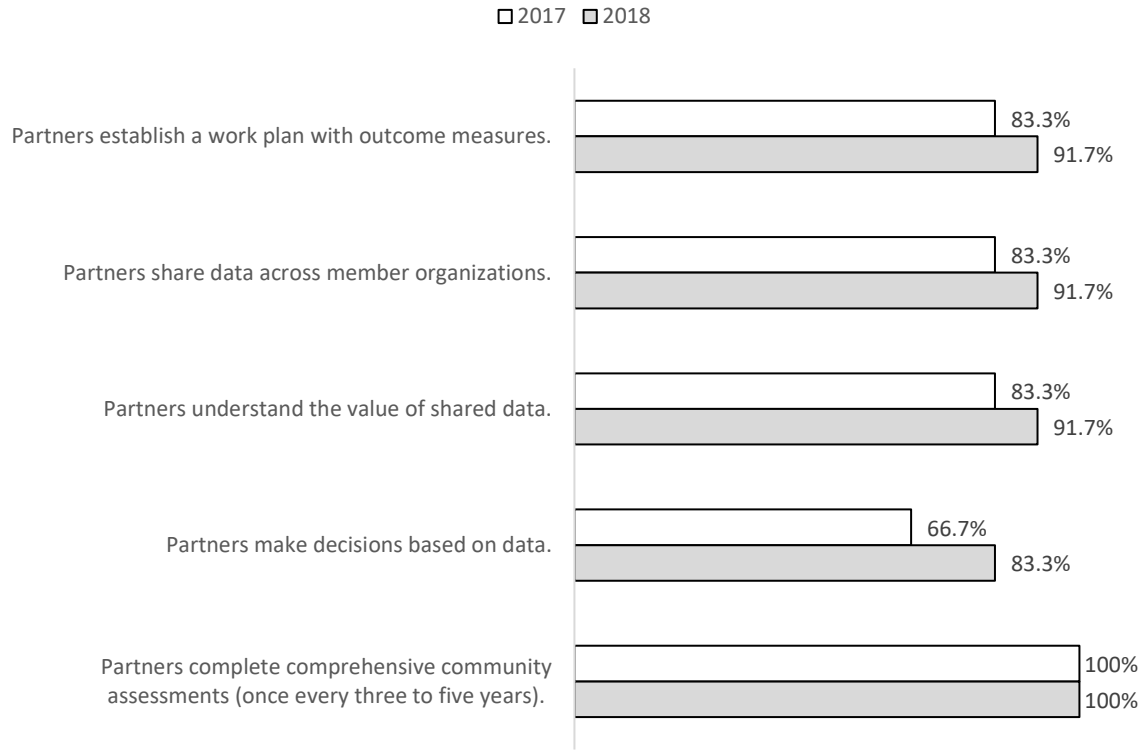
Figure 3. Common Agenda [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

SHARED MEASUREMENT

Figure 4. Shared Measurement [% almost always or always]*

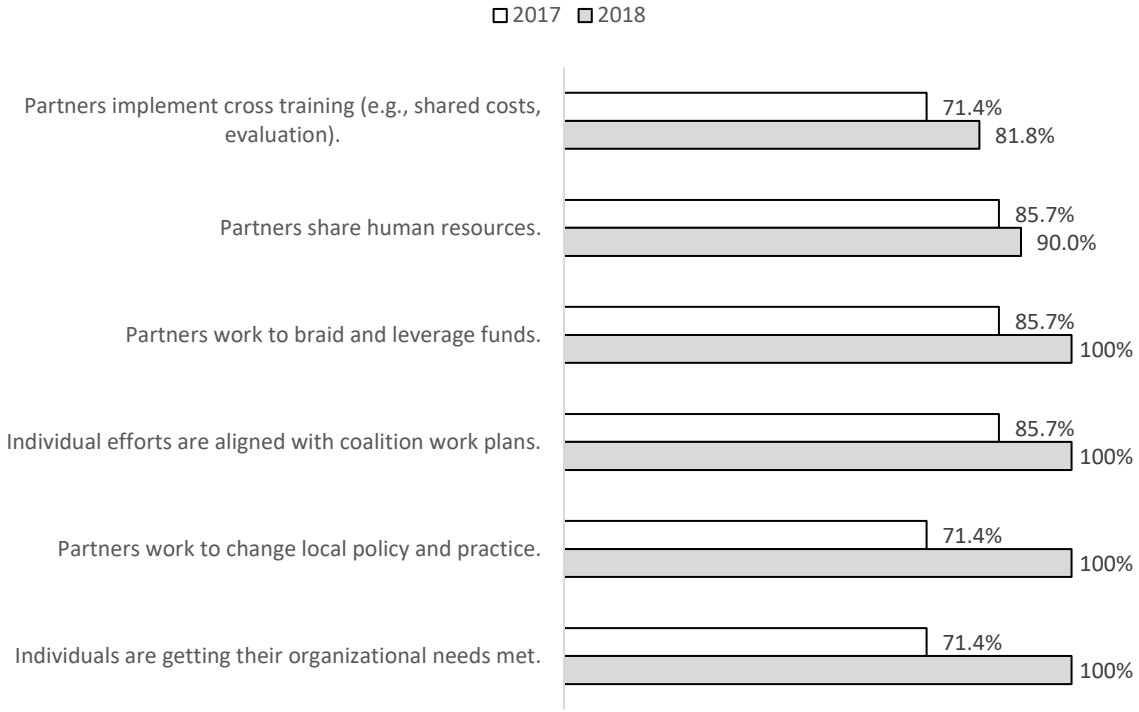


*Response options: never, almost never, sometimes, almost always, always

Comments about Shared Measurement
2018
• I realize that what we are supposed to be doing is data driven but sometimes you also have to rely on the people who are working in these communities every day to know what is or is not best for the community. Our team does a great job of discussing issues and goals and coming up with creative solutions. I am very proud to be associated with this team.

MUTUALLY REINFORCING ACTIVITIES

Figure 5. Mutually Reinforcing Activities [% almost always or always]*

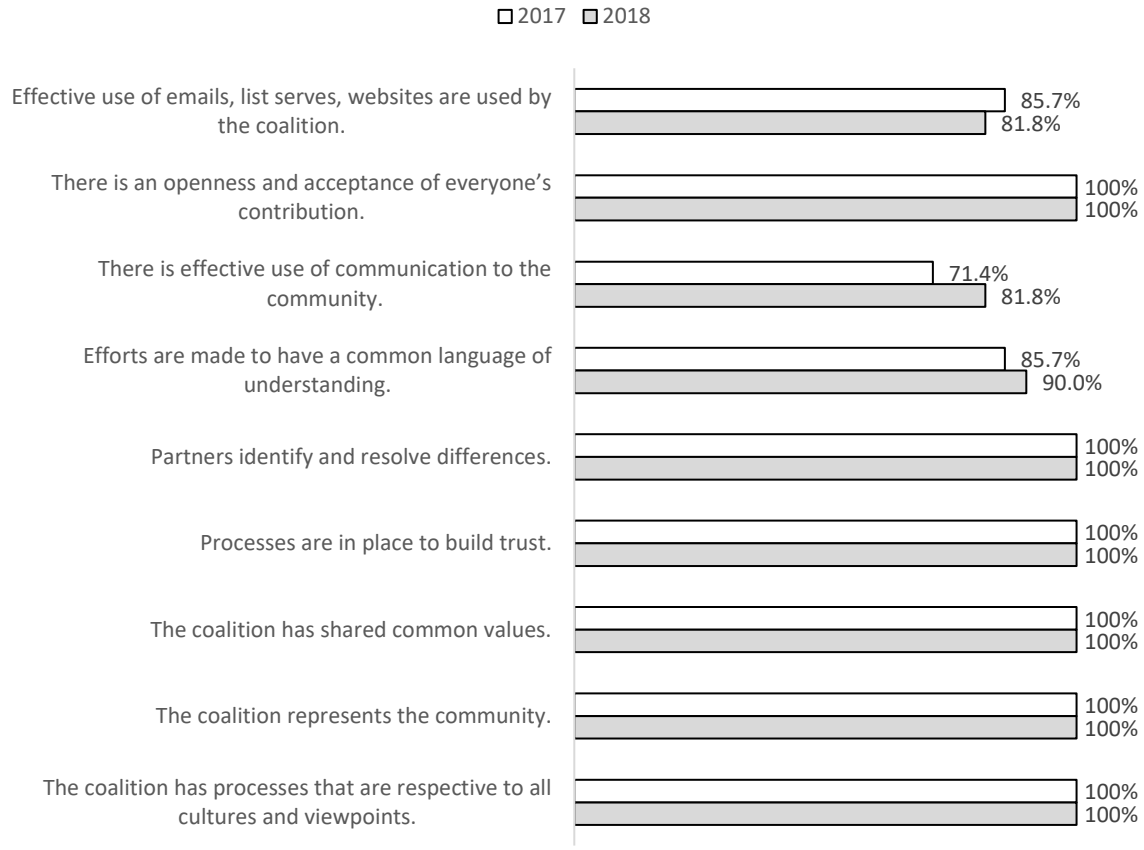


*Response options: never, almost never, sometimes, almost always, always

Comments about Mutually Reinforcing Activities
2018
• This group does a great job working together and collaborating.

CONTINUOUS COMMUNICATION

Figure 6. Continuous Communication [% almost always or always]*

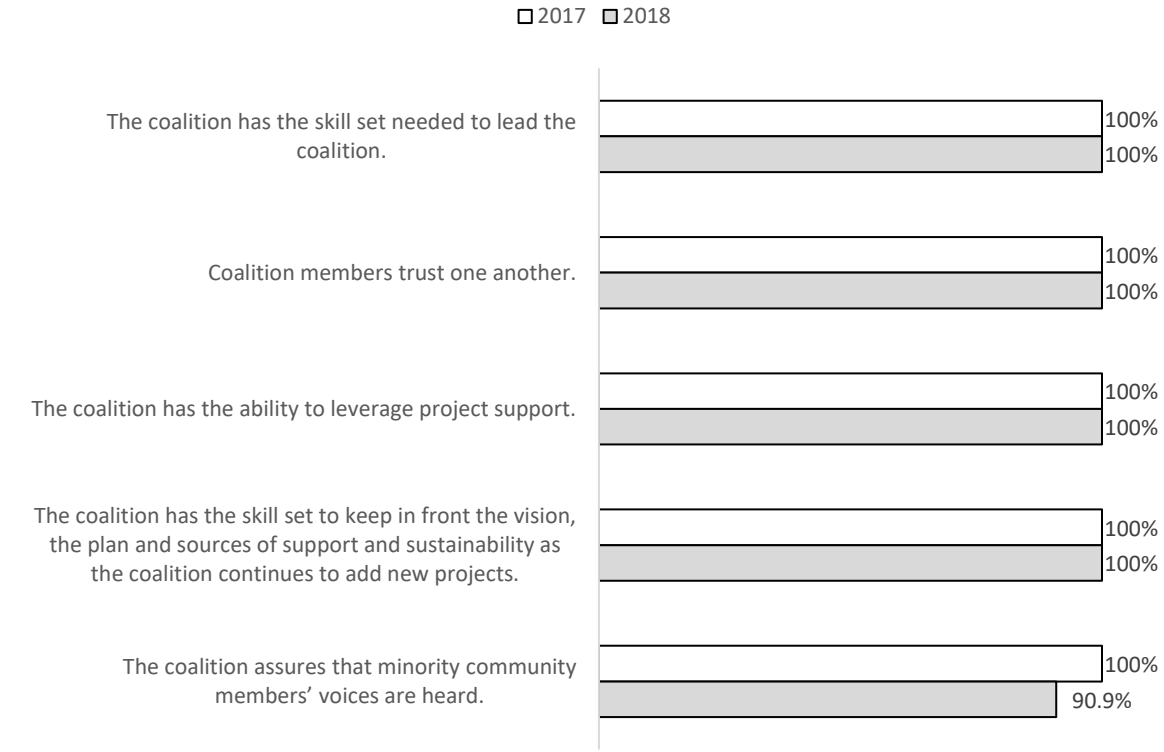


*Response options: never, almost never, sometimes, almost always, always

Comments about Continuous Communication
2018
• We are always working and open to making our group more diverse but at the last meeting we just added a new component - folks who work with the Somali population. We try very hard to include everyone.

BACKBONE ORGANIZATION

Figure 7. Backbone Organization [% almost always or always]*



*Response options: never, almost never, sometimes, almost always, always

Comments about Backbone Organization
2018
• I am glad to be part of the minority and would like to keep being part of the coalition as it moves forward to assist the needs of the community • This group is great about working together and being open to new ideas!

SCHUYLER/COLFAX COUNTY, NE BEHAVIORAL HEALTH IMPROVEMENT PLAN 2016-2019

Collective Vision: To increase the preventive outreach, educational efforts and resources that support the resiliency of community members who experience mental health and substance use issues.

Goals

1. Increase the overall awareness of existing and potential resources among community stakeholders through an established behavioral health community coalition.
2. Increase the knowledge and skills of local community members through behavioral trainings provided by Region 4.
3. Develop a collaborative process among regional providers, law enforcement, schools, probation and the hospital to address families in crisis that include prevention and intervention strategies that considers the diversity of community members.

Resources/Input

- CHI Mission and Ministry Grant Funding
- Other CHI Health Healthier Communities Funding
- Other braided funding through Region 4
- CHI Health Schuyler –Sponsor
- Backbone Organization - TBD
- Community Collaborative Partnerships

Strategies/Activities

Year 1:

- Establish a coalition with support staff and an identified backbone organization.
- Develop a community behavioral health resource directory (paper or online) with the assistance of Region 4. Distribute and promote the guide throughout the community.
- Increase community awareness of the crisis response team and of available tele - psychiatry mental health services through the hospital
- Two community members attend Trauma 101 and Mental Health First Aid train-the trainer training offered through Region 4.
- Continue the prevention program at the middle and high school “Step Up and Speak Out - Building Healthy Relationships”.
- Provide in-person counseling in the school for youth.
- Case review monthly meetings hosted by the County Attorney to discuss services for youth and families in crisis includes the hospital and other healthcare providers.
- Explore the feasibility of a once-a-month weekend in-person

Year 2:

- Provide Trauma 101 and Mental Health First Aid training to the community and offer cultural diversity training and resources for translation services.
- Utilize the resources available through Region 4.
- Expand the collaboration between schools, law enforcement, probation and the hospital and Region 4 services.
- Explore development of group home for unaccompanied youth in community.
- Begin developing a sustainability plan for post grant.

Year 3:

- Continue strategies from years 1 and 2.
- Provide resource information in other languages where feasible.
- Coalition and collaborations continue to meet and expanded strategies are implemented.
- Finalize sustainability plan and prepare to implement.

Outputs

- Number of coalition meetings and members, and number of resource directories distributed and translated into other languages.
- Number of patients using tele-psychiatry at the hospital and from the school.
- Number of coalition members trained to conduct trainings, number of trainings held; and number trained.
- Number of students completing the Building Healthy Relationships program.
- Number of community partners collaborating.
- Number of unaccompanied youth identified in need of a group home.
- Number of counseling sessions at the school.
- Sustainability plan established.

Outcomes

- Community Coalition shares resources formally and informally with members rating the coalition as “effective”
- Increased awareness of community resources increases use of those resources.
- Increased use of the tele-psychiatry at the hospital and with the school.
- Community members and students participating in training increase knowledge and awareness of behavioral health and are satisfied with training.
- Decrease in law violations, committals and transportations by law enforcement with teens and adults.