Priority 1 Mental Wellbeing

Overview/Snapshot: Mental Wellbeing (which includes feelings of sadness, worry, and stress) was tied as the 2nd most important health issue among survey respondents. Results from focus groups of community members highlighted the pressing need for improved access to mental health services, with particular emphasis on the shortage of providers, long wait times, and challenges for Medicaid patients. Nearly half of respondents to our community health survey reported they sometimes, often, or always felt lonely, isolated, depressed, hopeless, stressed, or overwhelmed in the past year. The suicide rate among adults in Adams County was higher than the state and U.S. rates. Financial stress, stigma, language barriers, and the lack of community-based mental health support further exacerbate the mental health challenges. All four SHDHD counties are designated as Mental Health Professional Shortage Areas.

Objective MW 1: Improve access to mental health care

Strategy MW 1.1 Coordinate communication efforts to reduce public stigma.

Strategy MW 1.2 Improve access by filling prioritized (by county & by population needs) mental health provider gaps.

Strategy MW 1.3 Build/Support/Implement a community-based referral & navigation system to support screening (including SDOH), wrap around care, peer support and provider collaboration.

Strategy MW 1.4 Explore pathways for providing access to behavioral health risk assessments and screenings for all South Heartland residents.

Objective MW 2: Decrease prevalence of factors contributing to poor mental health outcomes

Strategy MW 2.1 Promote evidence-based/community-based trainings for lay community skills and interventions (Mental Health First Aid, QPR, healthy social media use).

Strategy MW 2.2 Implement "Connecting People" (evidence-based community engagement) to enhance community members' social networks and connections to improve their quality of life.

Measures/Data Sources*/Targets:

Number of SHDHD counties that are designated mental health shortage areas	HRSA	<4 Counties
Percentage of adults ever told they had depression	BRFSS	Downward trend
Percentage of adults reporting that their mental health was not good for 14 or more of the past 30 days	BRFSS	Downward trend
Percentage of HS students reporting depression in the last 12 months	NRPFSS	Downward trend

*HRSA=Health Resources and Services Administration; BRFSS=Behavioral Risk Factor Surveillance System, NRPFSS=Nebraska Risk and Protective Factor Surveillance System

Objective MW 1: Improve access to mental health care

Strategy MW 1.1 ***If We:*** Coordinate communication efforts to reduce public stigma…

Then people will …	*Resulting in …*	*And creating …*
Immediate Results	**Bigger Changes**	**End Goals**
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
Develop/Offer cultural competency training for PCP/BH healthcare professionals	Effective patient-provider communication	Reduced stigma in healthcare and behavioral health settings
Integrate measures for mental well-being along with other routine and standard primary care protocols and promote mental wellbeing as a component of chronic disease prevention/management	• Mental health care is more accessible and less intimidating	Individuals seek help when needed
Community agencies/partners collaborate on public awareness campaigns and education focusing on correcting inaccurate stereotypes about people living with mental disorders	• Availability of factual, disconfirming information about prevalence, the possibilities for recovery, etc. • More partners acknowledge and communicate about mental health	• Public understanding of mental health conditions and empathy towards affected individuals • More community members talking about mental health and recognizing concerns.
Interpersonal contact and peer support opportunities between the general public and members of a stigmatized group	Individuals who have personally experienced mental health issues provide support services to others	Reduction in self-stigma, improved self-esteem and feelings of empowerment among MH service users
With these community partners and assets…		
Extension UNL, ministerial associations, first responders, rural mental health, nursing homes, assisted living, mothers groups, CCC, parks departments Promising Practices: *Mental Health Stigma and Communication and Their Intersections with Education (https://pmc.ncbi.nlm.nih.gov/articles/PMC6660176/pdf/nihms-1507172.pdf); Understanding and Addressing Mental Health Stigma Across Cultures for Improving Psychiatric Care: A Narrative Review (DOI: 10.7759/cureus.39549)*		
Potential Performance Measures:		
How much change did we produce? How well did we do it?		*Is anyone better off?*
• # of culture competency trainings offered to providers • #/% of clinics with Integrated measures for mental well-being • # of public awareness campaigns	• % of patients reporting effective provider communication • # of individuals providing peer support services • # of interpersonal contact or peer support opportunities	• Trends in percent of patients referred for MH services who follow through. • % of MH service users with improved self-esteem.

Objective MW 1: Improve access to mental health care

Strategy MW 1.2 ***If We***: Improve access by filling prioritized (by county & by population needs) mental health provider gaps…

Then people will …	*Resulting in …*	*And creating …*
Immediate Results	**Bigger Changes**	**End Goals**
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
Bi-annual assessments of provider knowledge, referral and specialty gaps by county and by population need	Continuing education for providers to know how to utilize resources	Providers confident in screening and referral for behavioral health needs
Healthcare/Behavioral Health/Community Collaborative Groups initiated in each county	Collaborative groups identify priority gap/s for their county and steps to address	• Priority gap/s filled • Increased access to a variety of services
Create Communication Campaigns to increase awareness of available services	People are aware the services are available	• More people obtain services • Increase in mental wellbeing for our community members
With these community partners and assets…		
Clinics/providers, BH clinics/providers, schools, churches, government offices, senior centers, libraries, Lanning Center, South Central Behavioral Services, CCBHC, Region 3, SHDHD, NE DBH		
Potential Performance Measures:		
How much change did we produce? How well did we do it?		*Is anyone better off?*
• # of Bi-annual assessments (goal =3) • # of counties with a collaborative initiated/active • # of communications campaigns	• # of continuing education opportunities offered • # of providers completing continuing education • % of providers satisfied with educational opportunities • % of county collaborative groups with steps to address identified priority gap/s • Trends in referrals from PC and BH providers • (List different screening types and how many are available.) Survey to measure increased awareness • #/% of providers utilizing resources to make referrals	• % of providers confident in screening and referral options • % decrease in ER-to-inpatient admissions for MH diagnosis • #/% Reduced depression scores • % decrease in adolescents attempted suicides • #/% decrease in completed suicides. • % of Counties with reduced gaps in mental health provider gaps (measured by assessments)

Objective MW 1: Improve access to mental health care

Strategy MW 1.3 ***If We:*** Build/Support/Implement a community-based referral & navigation system to support screening (including SDOH), wrap around care, peer support and provider collaboration…

Then people will …	*Resulting in …*	*And creating …*
Immediate Results	**Bigger Changes**	**End Goals**
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
SDOH and other intake or screening tools identified and tool use promoted with Navigators, Case Managers, Providers	SDOH and other intake or screening tools utilized to identify needs (universal – no wrong door)	Patient, Community Member needs are identified for referral
FindHelp promoted with community organizations and resources, encouraging training and participation in the single web referral platform	Expand information in FindHelp: comprehensive community resources are connected to a single web platform referral tool, functioning and accessible in all 4 counties Identify resource gaps in our counties and develop/implement a plan to fill resource gaps	Robust referral system that is sustainable and utilized universally throughout all 4 counties
Navigators, CHWs, case managers, providers, discharge staff, and others (HR Leads, EMS, Insurance SMEs, etc.), are aware of/trained/know how to use the referral tool	Navigators, case managers, providers, etc., utilize FindHelp to refer clients/patients to resources	• Improved collaboration, connection, & wrap-around care • Expanded community/mental health / health system navigation and utilization • Decreased mental health emergencies and unnecessary ER services • Increased client/patient satisfaction and access to resources
FindHelp promoted to community members and peer support system	Increased awareness of where to go (one-stop shop) to find resources/services Increased privacy/reduced stigma	Increased community awareness of area professional- and community-based services

With these community partners and assets…		
SHDHD, Schools, Clinics & providers, Clay Co Health Dept, Behavioral Clinics & providers, Churches, Government offices, Your Life Your Voice, 988, Hastings Give Day promotion for $, CIN bilingual navigator, Interpretation services, Mary Lanning, People with lived experiences, Heartland Health Center, Public Schools/ESU9, United Way, Find Help/211, Bridging Forward		
Potential Performance Measures:		
How much change did we produce?	How well did we do it?	Is anyone better off?
• Inventory of screening/intake tools (including behavioral health screeners) • # of trainings, # participants trained in FindHelp platform • Inventory of community resources by type/county • # of trainings, # participants trained in referral • # outreach/promotion activities	• #/% of agencies using intake/screening tools to identify needs • #/% of new community resources in the inventory • #/% of identified resources gaps filled for behavioral health prevention and intervention • # of FindHelp referrals; % increase in referrals over time trends in visits to FindHelp website (and to individual orgs websites) • #/% increase in utilization of services for 988 calls	• #/% clients/patients with positive behavioral health/ SDOH screening results • % of users and referral agents satisfied with FindHelp • Possible to measure referral completions? (Close the Loop) • #/% of clients referred through FindHelp satisfied with referral (referred, and received what they needed Capture/ celebrate patient stories) • Trends in use of emergency mental health care

Objective MW 1: Improve access to mental health care

Strategy MW 1.4 ***If We***: Explore pathways for providing access to behavioral health risk assessments and screenings for all South Heartland residents…

Then people will …	*Resulting in …*	*And creating …*
Immediate Results	**Bigger Changes**	**End Goals**
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
Community awareness of importance/benefit of universal mental health screenings	Aware of screening tools/options (example: online) and trained in their use	More people are getting screened
Stake holder awareness (schools, daycares, providers, home visiting program)	Providers and other stake holders are implementing behavioral health screening tools. Example: online assessments, PHQ, etc.	Persons are referred for care or resources
Identify gaps in those receiving screening (Priority population)	Providers and other stake holders adopt policy, protocol, work flows for screening Eg: EHR triggers, or team-based implementation	Fewer adults report poor mental health days
Identify primary organizations that work with population. (Include pregnant and post partum)	Training in SBIRT for stakeholders	
With these community partners and assets…		
Lanning Center, MAAA, Health and Behavioral Health Providers, CHWs, Community Impact Network, Find Help, LTC, Home Health, Region 3, South Central Behavioral Services, ESU 9, Behavioral Health Private Practice		
Potential Performance Measures:		
How much change did we produce? How well did we do it?		*Is anyone better off?*
• # of community stakeholders aware of benefits • % of community stakeholders satisfied with training education	• # of trainings • % satisfied with the trainings • % stakeholders who adopt policy, protocol, work flows for screening (# of clinics with EHR that trigger MH screening, # of clinics utilizing a team-based approach to screening) • % Stakeholders are aware of how and where to refer.	• % of patient priority population screened for depression or substance use. • % of adults reporting poor mental health days

Objective MW 2: Decrease prevalence of factors contributing to poor mental health outcomes

Strategy MW 2.1 ***If We***: Promote evidence-based/community-based trainings for lay community skills and interventions (Mental Health First Aid, QPR, healthy social media use)…

<table>
<tr><th>Then people will …</th><th>Resulting in …</th><th>And creating …</th></tr>
<tr><th>Immediate Results</th><th>Bigger Changes</th><th>End Goals</th></tr>
<tr><td colspan="3">2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)</td></tr>
<tr><td>Diverse target audiences identified</td><td>Target audience mental wellness training needs assessed</td><td rowspan="2">Wider community prepared to identify and respond to mental wellness needs/gaps</td></tr>
<tr><td>Instructors identified; training plan created</td><td>Evidence-based trainings offered (Mental Health First Aid, QPR, healthy social media use, trauma-informed care, ACEs, Developmental Assets)</td></tr>
<tr><td colspan="3">With these community partners and assets…</td></tr>
<tr><td colspan="3">Region 3; Opioid Response Network (ORN); local trainers; Lanning Center; hospitals; BH providers, Primary Care Providers; SHDHD; schools/ESU-9; churches; Erin Walsh/Spark & Stitch Institute</td></tr>
<tr><td colspan="3">Potential Performance Measures:</td></tr>
<tr><td colspan="2">How much change did we produce? How well did we do it?</td><td>Is anyone better off?</td></tr>
<tr><td>• # Trainings offered
• # individuals trained</td><td>• % of target audiences offered/receiving training
• % participants completing trainings</td><td>• % of trained participants confident in applying skills</td></tr>
</table>

Objective MW 2: Decrease prevalence of factors contributing to poor mental health outcomes

Strategy MW 2.2 ***If We***: Implement "Connecting People" (evidence-based community engagement) to enhance community members' social networks and connections to improve their quality of life…

Then people will …	*Resulting in …*	*And creating …*
Immediate Results	**Bigger Changes**	**End Goals**
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
Curate relevant community participation opportunities	"What's your why?" portal – Assessment/Exploration Tool – created; a survey that focuses on "what do you love or want to do more of?" (e.g., sing, drama, cooking, being outside, art, volunteering, animals, knitting)	Individuals access the assessment on line or through advocates; can choose to share their info/survey results with an advocate
Identification of diverse messengers; trained and engaged community partners (advocates, could include MH/PCP) who help improve access	Community partners committed to easing and broadening access to community participation activities	Community entities adopt a more collaborative mindset (community well-being mindset)
Plan/Implement a public awareness campaign to promote "What's your why?"	Individuals participate in new opportunities, are exposed to new ideas, meet new people	Individuals build competencies, build/strengthen their social networks and circles of support and build attachment to the local community
With these community partners and assets…		
Encourage, United Way, YMCA, Prairie Loft, social service organizations, libraries, Parks & Rec, volunteer groups, breweries (community spaces), faith groups, FindHelp, CIN, PFLAG, Ag Community, Hispanic community, primary care providers (PCPs), behavioral health providers (BHPs); the "Connecting People" model - https://connectingpeople.net/home/implementation-toolkit/		
Potential Performance Measures:		
How much change did we produce? How well did we do it?		*Is anyone better off?*

Trends in survey responses: • #/% times per wk participating in a social activity • #/% people who participate in Community support system • #/% with sense of connection to community • % with >X? days depressed/poor mental health days in past 30 days	• #/% community entities w/ language access • # of community partners committed to easing/broadening access • # of people who complete survey • # of mental health referrals • # community partners trained or engaged in improving access • # of people engaged in volunteerism (trends) • Budget trends for Community Support Services (CSS)	• Anxiety/Depression score rates • Child abuse/neglect rates • Geotargeted social media "feel" • Social isolation/loneliness rates • Post-survey "how did it go"? • Engagement with MH Services