**Healthy Yolo: Mental Health Work Group**

Minutes

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| Date & Time: | January 24, 2017 9:00 - 11:00 a.m. |
| Location: | Gonzalez Building, Community Room, 25 N. Cottonwood St, Woodland |
| Organizer: | Emily Vaden |
| Attendees: | Joan Beesley, HHSA; Amy Dyer, HHSA; Samantha Fusselman, HHSA; James Glica-Hernandez, Local Mental Health Board; Jessica Hackwell, Partnership HealthPlans of California; Kelly Lee; HHSA; Amy Leino, HHSA; Ashley Logins-Miller, HHSA; Pam Sidhu, HHSA; Anna Sutton, HHSA; Denise Tillery, CommuniCare Health Centers; Emily Vaden, HHSA;  |

1. Welcome & Introductions
* Emily welcomed the group and around the table introductions were performed.
* Emily reviewed the CHIP process to date:
	+ In 2014 the Community Health Assessment (CHA) was completed. From that, priority areas were identified.
	+ Workgroups were assembled around the priority areas, the CHIP was written with goals for each workgroup. Of partners that attended, strategies were developed to address those five year goals.
	+ Programs and partners report out data based on the strategies on a quarterly basis.
1. Data Sharing
* See Dashboard at [www.HealthyYolo.org](http://www.HealthyYolo.org) for updated data.

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| Goal & Strategy | Responsible Person | Measures | Date Range of Data |
| 1a | Samantha Fusselman | % of TAY clients reporting satisfaction with services | May 2016*Tentative data of 42% given in July* |
| 1b | Samantha Fusselman | % of hospital discharges that result in readmission within 30 days | July 2015 – June 2016 |
| 2a | Anna Sutton | # of Facebook Likes# of Facebook shares for Blue Dot Campaign# of partners who took Blue Dot Campaign photos | May 2016 |
| 3b | Samantha Fusselman | # and % of follow up appointments within 7 days | July – Sept 2016Oct – Dec 2016 |
| 3b | Samantha Fusselman | # and % of follow up appointments within 30 days | July – Sept 2016Oct – Dec 2016 |
| 3b | Samantha Fusselman | # of days for first clinical assessment | July – Sept 2016Oct – Dec 2016 |
| 3c |  | # of hits on 211 site/database for mental health services | Oct – Dec 2016 |

* % of TAY clients reporting satisfaction with services
Samantha Fusselman shared that this measure presents some challenges. This measure comes from a State required consumer perception survey. It is a lengthy survey and historically the Stat has directed counties to submit that data with the State providing the data analysis. However, that data analysis has not been communicated back to the counties timely. County staff has then been doing some of the analysis in house but the data for the October round of surveys has not been analyzed yet. In addition, the four age groups on the survey do not translate to the same age range as TAY. Amid those challenges though, Yolo County has seen an increase in the number of agencies participating in distributing the survey, as well as an increase in completed surveys. At this point, this is not a valid measure for mental health and will be removed from the Dashboard.
* % of hospital discharges that result in readmission within 30 days
Yolo County Quality Management is doing significant work to bring this number down and see the desired outcomes. Strategies implemented include:
	+ The discharge planning nurse has been moved under quality management and been provided additional supports. This is now a nurse manager position with an administrative support person to assist with communication and coordination with providers. This allows the nurse to go out to the hospitals to meet with the clients prior to discharge, increase phone contact with the facilities, provide medication coordination with the discharge facility.
	+ Trainings have been provided to the clinicians around what discharge planning is and all the components. In addition, better care coordination between the nurse manager and the clinician if the patient is already an established client.
	+ Implementation of a weekly inpatient treatment team meeting to discuss the cases that are currently hospitalized. In addition, further structure has been given regarding the case format.
	+ Focused on getting follow up appointment within 7 days of discharge. Research shows much better outcomes if a follow up appointment can happen within that time. To do so, connection with other potentially sources/services are being coordinated if the client is someone outside of Woodland, where most services are provided.
	+ All of these efforts have highlighted additional measures that the program will be tracking.
* Blue Dot Social Media Campaign
The Blue Dot Social Media campaign is based on the international symbol of postpartum depression. The current version of this campaign is focused on stakeholder engagement. In 2017, the focus to expand will be on the system of care providers. There may be different data points that would be more relevant to track.
* # & % of follow up appointments with 7 and 30 days
It was discussed that the percentage is the more meaningful data point, so the # will be removed from the Dashboard.
* # of days for first clinical assessment
With a focus on prioritizing the most vulnerable client’s need for follow up appointments within 7 days, this area has seen an increase. The team will continue looking at what is happening and was to balance the needs. Another area that has had changes documentation in the chart. An authorization committee was established to ensure all required documentation is present and that staff go back to do the clinical reassessments as per the policy. This has helped generate additional revenue, but again, has pulled some resources from the clinical assessment.
* # of hits on 211 Yolo site/database for mental health services
Due to staffing and organizational changes within 211 Yolo, this data is not currently available. Healthy Yolo staff are working to identify a new contact for data.
1. Annual Review and Report
* Emily shared that this has wrapped up the first year of data reporting for CHIP. This has been an amazing first year that included the implementation of the web based dashboard system. This Dashboard has been shared with the Board of Supervisors and in many other meetings. It is great to see both the successes and challenges in the measures.
* The team discussed the draft 2016 CHIP Annual Report that was sent out via email earlier this week. The Annual Report serves multiple purposes:
	+ Reflect on what has and has not worked for each strategy.
	+ A communication tool for the community
	The Mental Health workgroup has three really big goals that include many partners, including non-traditional ones. While there are some great strategies being employed, additional partners are needed to make this a robust workgroup.
* The following feedback was given in regards to the Annual Report
* Make sure the quotes are complete sentences.
* Some pages are really crowded with a small font. In addition, some of the visuals are hard to see.
* Additional data sources:
	+ MHSA will be adding in data around stigma, with a focus on the trainings provided.
	+ Pam shared efforts that are happening around Care Coordination, specifically around the mentally ill, who also have a chronic condition and is an older adult. It has been a very interested process. There is some great data available around what is happening.

Action Item: Emily will follow up with Jean McSorley regarding the Care Coordination.

* Brainstorming for distribution
	+ Press release
	+ Facebook
	+ Website
	+ Wave cable’s community channel – Davis has a different one than Woodland, etc, which can make it challenging to reach everyone
	+ Inpatient facilities
	+ Outpatient clinics
	+ Providers
	+ Provider Stakeholder Mtg
	+ Mailing
	+ Post a link and ask for feedback
	+ Library
	+ Health care directors (Ask Dr. Chapman) – Chief med officer, chief nursing operation, chief operating officer
	+ WIC
	+ NAMI
	+ UCD, WCC
	+ 4 main hospitals in the area – all have to do patient rights activities (Sierra Vista, Heritage Oaks, Sutter Center for Psy, Woodland Memorial, North Valley Behavioral Health)
	+ Patient rights advocate (agency – Consumer Self Help)
	+ School districts
	+ First responders/EMS
	+ UCD Integrated behavioral
	+ Graduate schools – social worker, residency training (UCD Med Center),
	+ For profit schools
1. Health Outcome Targets
* Health Outcomes are the community level indicators that the workgroups are keeping an eye on; they are the “why” of the strategies.
* When the Health Outcome measures were entered into the Dashboard system, the State data was entered as the target. At the October Joint Workgroup meeting, Emily led the group in an activity to identify more appropriate targets for the measures where Yolo County is already doing better than the State. Additional areas that we could look for targets include Healthy People 2020, or other program/community established targets.
* Emily shared that the health outcomes under “Increase Access to Services” are from the Health Care Access Survey. This survey was completed through the County and was originally planned to be repeated every two years. Due to workload and staffing capacity, it has not been feasible to repeat this survey yet and having this single data point does not add to the strength of the CHIP. For now, it was decided that those measures would be hid from the Dashboard, to be added back when the survey is able to be completed again
1. Program Updates
* None at this time
1. Questions and Next Steps
* The Annual Report will be finalized next week. Once it is finalized, an email will go out with the final report at which point, please feel free to share it.
* April will be a joint workgroup meeting, which will include more discussion on the plan for 2017.
* Please continue to invite other partners to attend and join the workgroups.

Next meeting is a Joint Work Group meeting

April 26, 2017

9:00 – 11:00 A.M.

Gonzalez Building, Community Room

25 N. Cottonwood Street, Woodland