
Adams County Children's Mental Health Partnership

System of Care Development and Implementation Manual



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serving Adams County

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Introduction

The Children’s Mental Health Initiative, Building Systems of Care, Community by Community (CMHI) projects funded by Illinois Children’s Healthcare Foundation (ILCHF) represent diverse communities and therefore reflect diverse care systems. Though the systems are different, each community has attended to a similar set of processes to develop their system to where it is today.

This manual, a requisite project element, highlights the methods this community engaged in to develop their unique care system from the initiation to the conclusion of ILCHF funding. Each of the four community manuals include descriptions of the collaborative activity among the mental health, education, medical, and other community stakeholder systems. Each area represented potential barriers and innovations in the system. These processes reflect varying levels of adherence to the Child and Adolescent Service System Principles (CASSP).

BACKGROUND

The Adams County Children’s Mental Health Partnership, (ACCMHP) is a group of concerned providers and community members organized to guide a community process of change around the delivery of children’s mental health services.

Upon release of an RFP for a CMHI planning grant, SIU Center for Family Medicine–Quincy convened a group to explore whether our community would benefit from this opportunity and if so, what kind of plan to recommend. The group represented primary care, mental health services, early intervention, crisis intervention, school, youth services and community. This group of over 30 people shaped the application to Illinois Children’s Healthcare Foundation (ILCHF).

Prior to the ACCMHP being organized, the United Way of Adams County (UW), the Adams County Health Department (ACHD), the U of I Extension, and Blessing Health Systems collaborated to provide a comprehensive community health assessment, which they used to develop their internal agency plans and to develop a community wide plan. Access to mental health services was identified in this assessment as a need in our community. The opportunity to apply for, and receive, CMHI funding allowed the community to address access issues as they relate to children. This work was done collaboratively with the larger planning groups, which will remain in place when ILCHF funding ends, thus sustaining the system of care.

The United Way led process was unfolding at the same time as the planning phase of the ACCMHP. A UW Community Health Delegation was formed to address the needs identified in the assessment. The Health Leadership Delegation mission is to guide and coordinate the activities for Community Solutions (CST) teams that are working to improve the health of our community. The CST’s that report to the delegation are Access to Medical/Oral Health, Wellness & Prevention, Maternal Infant & Child Health, Mental Health, Environmental Health, and Substance Abuse.

The Mental Health CST members were many of the same people who sat on the ACCMHP. Goal areas of this group were access to services and reduction of stigma. The team agreed that, rather than duplicate efforts, the ACCMHP would represent the needs of the 0–18 population.

The targeted geographic area for the ACCMHP includes all of Adams County, Illinois, a rural, highly agricultural community covering 856 square miles with a population of 67,000. Quincy is the county seat and the largest city, with a population of approximately 42,500. It serves as a hub for health services and retail for a 100-mile radius in three states.

Our target population is all children in Adams County ages 0–18 years, approximately 24.6% of the population, or about 16,500 children. Nineteen percent of children under the age of 19 are below the poverty level. The rate of substantiated cases of child abuse/neglect is 14 per 1,000, which is higher than the rate of 8.5 per 1,000 for the state.

An assessment to identify gaps in the current system and to recommend strategies to create a fully integrated children’s mental health system of care was conducted during the planning grant. Data reviewed included:

- assessments conducted by local community organizations
- general demographic data
- key informant interviews
- provider surveys
- physician interviews
- focus groups or interviews with school personnel
- review of Medicaid and insurance guidelines
- review of confidentiality regulations
- review of information exchange systems

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- literature related to children’s mental health systems of care
 - review of evidence-based practices

Findings of the assessment indicate:

- Early identification of children had not been accomplished in a systematic, standardized manner.
- Primary care providers enthusiastically supported an integrated SOC that would promptly, and appropriately, care for children with behavioral health problems.
- Psychiatric services for children under six years old was minimal.
- More treatment services for children under six, specialized therapies, and higher levels of expertise were required by the professionals locally to meet the needs of children and youth.
- Families had barriers for access to services, including funding, transportation, awareness, and stigma.
- Substance abuse services and supports for youth were minimal.
- Organizations within the system often did not communicate effectively, resulting in poorly coordinated services and/or duplication of services.

Early in the planning process, the community group appointed an executive team with representation from SIU (primary care), Transitions of Western Illinois (mental health), and the Adams County Special Education Committee (school).

A steering committee was created, and bylaws adopted, to formalize leadership. Representatives of key provider organizations were appointed to the committee. In addition, the bylaws provided that up to seven “at large” members would be added to assure representation of consumers, family members, and other interested community members. Realistically, consumers/family members were people in the community who wore multiple “hats,” such as a retired early childhood teacher whose son suffered from chronic mental illness, and an agency representative who has accessed many of the services for her child who has significant developmental delays.

The ACCMHP collaborated with the (All Our Kids) AOK Network to address the needs of the birth to five population. The AOK Network is a community-based collaboration (organized in 1998) that is “committed to developing a high-quality, well-coordinated, easily accessible system of care that will promote positive growth and development for pregnant women, children birth to five, and their families and to assure that they receive the services they need.”

The Substance Abuse Coalition (SA Coalition) was formed over eight years ago with federal funding from the Drug Free Communities grant and the state funded Tobacco Settlement grant. The goals of the SA Coalition are to reduce the use of substances by youth through a variety of strategies, such as social norms marketing, compliance checks, community education, and prevention strategies. While this group did not form to create more treatment options, it convenes the players in the community most likely to provide youth with substance abuse treatment. Representation from the ACCMHP participated in the SA Coalition and advocated for the additional needed treatment options, and they received support from the coalition to create changes within the local service provision network. As a result, the local DASA approved substance abuse provider, Preferred Family Healthcare, added group-based counseling for youth.

WHO CAN PARTICIPATE?

Anyone in Adams County can participate in the ACCMHP. Administrators, medical providers, behavioral health staff, volunteers, community members, and consumers are all welcome to have input into the planning, implementation, and evaluation of the system.

Any child, from birth to age 18, is eligible to receive services, including screening, referral, assessment, prevention, intervention, and treatment. It should be noted that although the funding provided for children in Adams County, the system change affects anyone who receives services in Adams County. Families and

children travel from neighboring counties/states to receive services in Adams County, so the impact of the changes are more far reaching than Adams County. For purposes of the evaluation, only Adams County children were tracked.

WHAT YOU WILL FIND IN THIS GUIDE

This manual will provide a narrative account of how our system was reorganized and enhanced to meet the goals set for the project. We will address barriers encountered and efforts to overcome those barriers, whether successful or not. Finally, we will capture the methods of sustainability that are critical to our long-term success.

1.0. Planning

1.1. Vision

The Adams County Children’s Mental Health Partnership (ACCMHP) is a voluntary network of service providers and concerned citizens interested in the social and emotional wellbeing of children in Adams County. Our vision is that all children in Adams County will possess the social and emotional health to lead productive, meaningful lives. To advance that vision, the mission of the ACCMHP is to develop and sustain an effective system of care for children’s mental health in Adams County.

1.2. Goals

The organizing document (bylaws) defines the following goals, which are the guiding principles for the approach that ACCMHP has used in its work:

- **Foster coordination** between organizations through information sharing, development of referral protocols, etc.
- **Promote early identification** of children with social–emotional concerns by encouraging adoption of a community-wide screening process.
- **Identify gaps in access to services** and developing strategies for their resolution.
- **Support integration of mental health** as a normal part of the healthcare delivery system.
- **Strengthen the workforce across systems** to increase readiness to effectively identify and intervene with children in need.

The steering committee adopted a work plan that outlined five specific goals areas. Activities were reviewed and evaluated for effectiveness, at least annually. Work plan activities were modified, discontinued or added in order to address gap areas, to improve workflow, and improve outcomes. The following are the goals of the ACCMHP:

i. Build a qualified and an adequately trained workforce with a sufficient number of professionals to serve children and their families.

Initial findings of the key informant interviews indicated that there was a sufficient number of providers, however those providers were lacking in the knowledge, skill, and comfort to serve young children. Further, they were lacking in skills and/or certification in the best practices that were identified as most impactful for children.

A strength that our project built on is the stability of the work force. While providers may change which agency they work for, there are low numbers of professionals who leave the area. At the beginning of the project, most of these professionals were generalists, providing services to both adults and youth. Very few were serving children under the age of five.

Professional development opportunities were available in the community through the Mental Health Authority Education Committee (MHA), which offered five one-day training events each year. The ACCMHP and

MHA partnered to assure topics were based on the needs identified through the key informant interviews. In addition, a modified learning collaborative model was adopted that featured a two-day learning event, with day one addressing basic overview of theory, research, and application. Day two of the event was a combination of experiential learning and case studies. Participants were then invited to attend four follow up sessions to discuss cases and implementation with the presenter, via a teleconference session (Skype). A handful of clinicians attended the follow up sessions and reported that they were implementing the new strategies within their practices.

ii. All children who have social-emotional problems are identified through a systematic community-wide screening process and are linked to services.

Throughout the planning and early implementation phases, there were multiple staff and steering committee members engaged in meetings and in ongoing conversations with the administrative personnel at the three clinics that serve Adams County. The ACCMHP requested these organizations partner to develop a screening process and to report data to the ACCMHP to fulfill the cross-site evaluation. This was a critical step, assuring the buy-in of each administration in support of the proposed changes.

Next steps included offering informational meetings and trainings to introduce the concepts to the clinic staff, to answer questions, and to assure that processes were in place for the changes to be implemented. Many of the initial meetings and trainings included a meal (breakfast or lunch) to allow clinic staff and school staff to attend, within out disrupting the workday schedules.

Quincy Public School's (QPS) screening began with a small pilot group of schools and grade levels with the purpose of learning through the process. There were unknown factors of the number of positive screens, our capabilities of providing timely follow up, parent and staff responses, and assuring that adequate supports were in place. We were also unsure of the parent response to screening. Our community has historically been conservative regarding the perception that the public schools should not teach values. There have been parents in the past who actively promoted an agenda of schools staying separate from the family social and emotional wellbeing. As a result, we purposely started small with our screening process. The result was successful. Screening has been by parent choice and the percent screened has remained high. We have had positive results with a low number of parent concerns. It was vital for us to introduce screening as part of our PBIS system and we have clearly communicated that this process allows parents to let us better understand their children. Connecting screening with social-emotional learning standards and labeling this as "social-emotional screening" may have been beneficial to the success of the process.

iii. Integrate mental health services into primary care setting

There are three unique primary care clinics in Adams County and each operates differently because of mission and financing.

Blessing Physician Services (BPS) is affiliated with Blessing Health Systems. BPS does not have a designation allowing it to bill for mental health services provided to patients covered by Medicare or Medicaid. In order to make mental health services reimbursable in family medicine and pediatrics at BPS, our community got creative. The decision was made to co-locate mental health services at the Blessing clinic. Those services were provided by Transitions of Western Illinois, a community mental health center. Attached to this manual is the contract that was used to outline the terms of the co-location. Leadership from both organizations met to outline what would be necessary to make this relationship work, including the hiring of a mental health professional, complying with HIPAA, referrals, etc.

Quincy Medical Group (QMG) was a for-profit organization and had rural health clinic designation. QMG was able to hire its own mental health professionals in order to provide on-site services to its patients. At a Rural Health Clinic, Core services are covered for Medicare and Medicaid patients. For example, states may not cover psychologists and Licensed Clinical Social Worker services in the Medicaid plan, but must

cover these services when provided by these professionals in a Rural Health Clinic because they are considered core services. The same is true for a Federally Qualified Health Center designation.

At the time of implementation, SIU Center for Family Medicine-Quincy (SIU) was designated as a Rural Health Clinic. Therefore, the same rules applied to SIU as QMG. In July 2015, SIU was designated a Federally Qualified Health Center (FQHC). As mentioned in the previous paragraph, FQHC could also bill for core services, including access to mental health services. In addition, FQHCs are eligible to participate in the 340B Drug Pricing Program (340B). This program limits the costs of drugs purchased by entities authorized to participate in the program. Participation in the 340B program means FQHCs are able to gather significant savings on the purchase of outpatient drugs for use by or sale to their patients. On average, 340B drugs cost 20 to 40 percent of the Average Wholesale Price of the same drugs if purchased on the open market. RHCs are not eligible to participate in the 340b program.

iv. Increase cross system information sharing and availability for assessment for complex children and their families.

Three primary objectives were identified during planning in 2010:

1. Create a system of case consultation with a cross-system of mental health experts to provide clinical recommendations. The Child Consultation Group (CCG) was formed with a process for referral, case presentation, and written feedback. The group comprised a pediatrician/child psychiatrist, clinical psychologist, and several cross-agency mental health professionals with expertise in trauma, attachment, cognitive therapy, and other evidence-based training. The CCG met monthly. Please refer to Appendix A1 for a description of the CCG, Appendix A2 for the referral form, Appendix A3 for the multi-agency release form, and Appendix A4 for the presentation format.

Lessons learned: Case Consultation is valuable but not necessarily when using a stand-alone group that is not connected with the client. The CCG was discontinued after one year due to low referrals. Feedback indicated that the process of gathering all documents in advance was time consuming and results weren't as helpful as one hoped. Informally, therapists expressed frustration that recommendations did not address the immediate needs for the clients. A positive result of the CCG was not necessarily that therapists accessed the CCG, but that they were seeking out consultation with cross-system experts connected directly with the client.

One gap in our system remains the inability to gather a team for consultation, due to the inability for each participant to be reimbursed for their professional time. For example, many insurance companies will not pay for this professional service. Medicaid will not reimburse more than one professional for the same client at the same meeting.

2. Create a virtual trans-disciplinary assessment team. Children and families were having to travel 100 miles to receive a comprehensive assessment. We planned to engage providers in a process where each would complete his/her part of the assessment then come together for a comprehensive report with recommendations. During discussions within Adams County, one of our primary care clinics chose to pursue building a comprehensive clinic. In consultation with NTI Upstream, QMG opened a Child Assessment Center within the first year of our project.
3. Train a cross-system network of facilitators in Wraparound, a strengths-based planning process for children and families with complex needs in multiple life domains. Cross-system trainers, in school and mental health, have provided multiple training cohorts in Wraparound. Grant funds have allowed us to engage professionals between schools and SASS providers in supporting child and family teams. This training process did not begin until year four of CMHI implementation. We assessed that professional development and implementation of lower level interventions were needed within our system before the system could adequately support the cross-system training and implementation of Wraparound.

Wraparound has been implemented within the PBIS system in the schools, and training will be sustained by multiple personnel within the system.

v. Maximize natural supports available for children and families.

An important part of the identified need for our community was to increase the supports available to children and families. While there are service providers and programs available in our community, most of them keep “regular” business hours, with the exception of a crisis intervention program SASS (Screening, Assessment, and Support Services) and the emergency room. Best practices suggest that early intervention is more effective. Families often have “extended” family, friends, neighbors, and faith communities that are available to them 24/7. Those “natural supports” in a family’s life can make the difference between whether a situation escalates or is manageable. Most of those natural supports are willing to help, but many do not understand mental health issues, nor do they feel competent to intervene. As a result of this, our community has adopted the Mental Health First Aid program. We have three staff trained to deliver the curriculums (Youth Mental Health First Aid and Mental Health First Aid). Mental Health First Aid (MHFA) provides basic understanding about mental health symptoms and teaches easy to apply steps to assess and support people who are experiencing a crisis, either until the crisis is averted or help is engaged. Identified target populations included the faith community, school personnel, and home visiting programs. All sessions were open to community members.

2.0. Governance structure: decision-making and oversight at the system level

Prior to application for a grant from the Illinois Children’s Healthcare Foundation, SIU convened a community group of key partners who work on behalf of children with mental health needs. The original group, which included primary care, behavioral health, social services, education, youth services, and court services, decided for three key partners to share the lead role in applying and implementing the grant. SIU represented primary care and behavioral health, Transitions of Western Illinois represented community mental health and The Adams County Special Education Association represented all schools in Adams County. Together, this triad led the community group in applying for and receiving the ILCHF CMHI planning grant. Three dedicated staff carry out day-to-day operations. Each of the three leadership organizations employed one staff. Transitions employed the full time Project Manager; the Adams County Special Education employed the full time Mental Health Network Coordinator; and SIU School of Medicine employed a part time Mental Health/Primary Care Coordinator. During the planning grant, these three staff identified and interviewed key informants, promoted the goals of the project within the community, and convened two work groups to create a community driven plan. Having staff dedicated to the process in the early stages assured that the systems work wouldn’t get lost in the more crisis driven service environment that tends to be associated with provision of mental health services. Staff were able to establish longer term goals and reduce the barriers that were experienced by the various agency partners who were responsible for implementation.

The Primary Care Mental Health Coordinator conducted interviews with willing physicians, nurse practitioners, physicians assistants from Family Medicine and Pediatrics practices at Quincy Medical Group, Blessing Physician Services and SIU Center for Family Medicine–Quincy. Those questions were:

- Do you currently screen for mental health issues when you see pediatric patients?
- If so, do you use a screening tool? Which one do you like best?
- Do you currently screen for development when you see pediatric patients?
- If so, do you use a screening tool? Which one do you like best?
- If a screening tool is used, at what points is it used?
- When a mental health issue is identified, what do you do next? What would drive a mental health referral?
- What is your comfort level in addressing mental health needs of children?
- How do you decide when to provide mental health interventions?

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- Do you provide anticipatory guidance/education, such as toilet training or other parenting concerns/issues?
 - What areas of education about children do you think are most important to cover with parents?
 - If you had a wish list, what two things would you want to help you better provide care to children and their parents?
 - What would you think about a mental health professional being available to you and your patients in your office setting?
 - What advice can you give me about how to/best ways to integrate primary care and mental health services for children?
 - There is money available through ILCHF for educational purposes for providers. We are trying to get the pulse from Adams County providers about their educational needs for MH and children.

Key Informant Interviews were facilitated by the Project Director and the Mental Health Network Coordinator throughout the community. Those interviewed included: clergy, public and non-public school administrators, physicians, parents, city officials, ministers, business leaders, youth development leaders, youth advocates, court personnel, early intervention specialists, and community members/families. Feedback from these interviews guided our team's planning and prioritization of needs.

The Mental Health Network Coordinator facilitated multiple key informant groups with school personnel during the grant-planning year to educate them on the CMHI project and to obtain feedback/recommendations for the mental health needs of children, as well as the professional development needs of school staff. Groups included: Administration at Quincy Public Schools, Quincy non-public schools, and county school districts, School Superintendents from all five public school districts, social workers and psychologists, guidance counselors, as well as the Regional Superintendent of ROE #1 and Regional Safe School Director. The needs summarized below were included in the prioritization and development of grant goals and objectives.

- Professional development on mental health and social-emotional needs
- Professional development for staff to learn how to provide support for kids in the classroom who have mental health issues
- Support groups during the school day
- SEL integrated into existing structure
- Getting to know other providers and community agency staff
- Having the resources to meet all the student needs
- Knowing how to better use the resources we have
- Communication loop with outside agency providers
- Having an individual person for a family to work with
- Focus on the family not just the child
- Transitioning the family and children to their next school to maintain a positive connection
- Having a family support worker in every building
- Re-word our language regarding mental health issues—"mental health" is scary to people (staff and families)
- Suggested consistent communication of social-emotional learning standards
- Training of staff on mental health red flags, teaching them ways to better communicate with families
- Psychiatric services for under age five
- Parent education/information on social-emotional developmental expectations
- Parenting classes
- Increased need for service addressing attachment issues

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- Working with AOK to figure out how to meet the needs of children impacted by budget cuts
 - What to do for kids on the waiting list for both early childhood education and mental health services

The first work group addressed Early Identification and Access to Mental Health Services. They explored expanding the role of primary care in the screening and delivery of MH services. A second area of focus was for parents and providers to have access to family-friendly services.

Minutes document that the group met three different times within a month timeframe, so the work and planning done by that group was done vigorously. The group included 26 different community members, with the majority attending all meetings. The grant team created a job description to keep the work group on task.

The purpose of convening the group was to brainstorm, strategize, and document a plan related to their topic of concern. Consideration included, but was not limited to:

- Prioritizing target population
- What gaps currently exist in service delivery?
- What tools are currently being used?
- What tools might be needed?
- Where will the services take place?
- What do we already have in place that we can enhance in year one?
- What training is needed?
- What additional information will need to be collected?

The committee reconvened, as necessary, through May to provide feedback on draft plan (one to three times between January and May).

The role of Chairperson was to convene/facilitate meetings, to assure documentation of meeting content, attendance, and progress and to assure that a draft document was completed by target date, and to communicate with Project Manager, as needed, to facilitate work group progress. The Chairperson of this group was the Early Intervention Coordinator for Child and Family Connections.

The role of Staff was to attend meetings and assist, as needed, and to carry out tasks required to keep the process moving. By the end, Work Group #One had created goals, objectives, and possible next steps.

The second work group addressed Specialty Assessment and Complex Needs. They explored ways to better coordinate services for children with complex needs using the transdisciplinary approach, ways to assure that children with very specialized needs have access to services and that staff have necessary training to deliver those services.

Meeting one began with brainstorming of “The Big Dream” for our community, resulting in four areas of focus:

FAMILY

- Family-driven care
- Every family will walk away feeling it was an unbelievable experience
- Family feels they are the same as everyone else on the team
- Entire family receives care
- Family-focused counseling
- Family mentor throughout process of services
- Families would have alternatives for temporary respite
- In-home family therapy and support—long term, therapist living in the home to be there to support situations when they naturally occur

SCHOOLS

- Mental Health workers integrated in education setting—including classroom
- Keeping kids in the classroom and the classroom having the supports needed
- Environmental adaptations are provided in the classroom—either skills on how to do this are taught to the teacher or consultation is provided
- School as home base for all care

INTERVENTIONS/THERAPEUTIC NEEDS

- Competency of all providers
- Kids get all services in our community
- One location for trans-disciplinary evaluation
- Team approach—with family provided support
- Using technology to access needed care/professional consultation/supervision

NATURAL SUPPORTS

- Natural Support (e.g. faith-based) provided with resources/consultation/training to help families through the process (before, during, and after formal services are provided)
- Skills taught to all systems (parents/teachers/natural supports)
- After school/vacation activities that are meaningful to kids

Meeting two allowed participants to “vote” in an interactive process for their top two priorities in each of the four focus areas. Using a “cafe” model, participants rotated through small groups to discuss further and expand upon the top priorities within each focus area. The prioritized items included:

FAMILY

1. Family leadership training; identify existing family advocacy systems and build upon these systems
2. Research evidence-based treatment approaches and provide training to local mental health providers around ways to improve their work with the family

INTERVENTIONS/TREATMENT NEEDS

1. Research best practices in the components of a transdisciplinary evaluation team
2. Recruit and/or train local providers to fill gaps
3. Identify prevalence of specialty areas; research evidence-based treatment approaches; provide training and appropriate clinical supervision in the identified areas.

NATURAL SUPPORTS

1. Survey existing providers of respite homes/care; research funding possibilities within current systems
2. Mental health awareness training for natural supports

SCHOOLS

1. Mental Health Consultation in the classroom; teacher training; strengths-based and family-focused training for educators

Meetings three and four continued the process of gathering input, prioritizing biggest needs, and developing goals, objectives, and possible next steps.

GOAL #1. Natural supports will be engaged in the system of care.

Objectives	Possible next steps
1. Families will be educated on accessing meaningful support systems	<ul style="list-style-type: none">• Develop parent-to-parent support systems
2. Natural supports will have the skills necessary to help manage children with complex needs	<ul style="list-style-type: none">• Training will be provided in natural gathering places for parents

GOAL #2. Children and families will have local access to a comprehensive system of mental health services and supports.

Objectives	Possible next steps
1. All kids will have access to screening, assessment and support services, regardless of payment resources	<ul style="list-style-type: none">• Develop agreements with insurance companies• Build capacity for supportive services• Expand existing services beyond 90 days, if needed
2. Specialty treatment services and support will be available locally	<ul style="list-style-type: none">• Supportive systems will be built around existing services and local providers to meet treatment gaps and develop comprehensive services necessary for treatment success (example, substance abuse treatment)• Recruit and train professionals in evidence-based methods to fill treatment gaps
3. Transdisciplinary teams are available for evaluation, consultation, and treatment planning in the child/family's natural setting	<ul style="list-style-type: none">• In-school and in-home observation, training and team treatment planning• Recruit and train individuals to fill gaps
4. Wraparound/individualized treatment planning model will be a part of this system of care, with staff hired to assure the capacity for services to support plans are in place and to assure the fidelity of the process is maintained	<ul style="list-style-type: none">• Cross-systems training will be provided in evidence-based wraparound model• Capacity-building to support identified needs within plans• Respite options will be developed as part of the needs identified in plans

GOAL #3. Mental health services will be integrated within schools and community settings.

Objectives	Possible next steps
1. Coordinated mental health services will be provided within the system that reduces "siloed" services and overlap	<ul style="list-style-type: none">• Build upon existing school-based and in-home services to develop a comprehensive, coordinated array of services• Cross-system collaboration, training, and service delivery

Shortly after the work group process, a steering committee formed from a broad array of providers and community members who had participated in the work groups, to formalize oversight of the project. During the initial phases of the project, when work was intensive, the ACCMHP met as a stand-alone group, and reported to the UW Mental Health Community Solutions team. Once the project was stable, the ACCMHP merged with the UW Mental Health Community Solutions team, thus assuring sustainable oversight of the project beyond ILCHF funding.

The steering committee adopted an organizing document outlining the vision, mission and expectations of governance. Responsibilities of the steering committee included approving the program plan, the budget, and recommending revisions, as needed. The steering committee gave priority to sustainable system changes that required little or no additional funding after the initial grant period. The rationale was that the collaborative effort should not be created in such a way that it would compete with the local and regional funding requests of the individual partners. Billing and limited local grant funds now support the integrated services within primary care and the schools. The system is operating with greater efficiency due to the adoption of process changes. Grant funding allowed for start-up of various service delivery changes, such as the co-location model between Transitions of Western Illinois and Blessing Physician Services, the multi-disciplinary team approach at Quincy Medical Group, the integrated behaviorist at SIU and QMG, and expanded community-based services in the schools.

The three project staff assumed supervision of day-to-day operations and monitoring these changes across the system.

3.0. System management: day-to-day decision-making

The ACCMHP has empowered each organization to choose implementation styles that are respectful of their organizational structure and culture. As a result, system partners have each created unique organizational processes for screening, referral, and integration.

Initially the steering committee was created to provide strong guidance and oversight of the evolving system. As the system has moved into self-sufficiency, the steering committee has been absorbed into the larger, United Way Mental Health Community Solutions team, which has the goal of assuring access to mental health services for all in need. Many of the same community partners who helped develop the children's SOC continue to be active on the United Way Solutions team.

4.0. Services

4.1. Service array (types of services allowable, for whom, and under what conditions?)

A menu of services is available within our community for any child who is identified with a need, through either screening, provider referral, or parent request.

When we initially approached physicians about screening, they indicated that they would only be willing to screen and identify potential mental health needs, if there were a robust system of services to which to refer children and families.

In order to assure that we could meet the needs of our community, we performed a Gap Analysis to identify our strengths and weaknesses.

One strength is that we are "psychiatrist rich," however, the psychiatrists that were on staff at the beginning of the project were reluctant to serve children under six. One of our partners, Blessing Behavioral Health Systems, recruited an additional Child Psychiatrist who would be available to serve the under six population. As a result of her addition to the team, additional child psychiatrists began loosening their restrictions on serving younger children, as well.

At the beginning of the project, there were no child psychologists in our community, and this was seen as a great barrier. Early on, however, a child neuropsychologist moved to Quincy. Initially, she was hired half time at Transitions of Western Illinois (ATWI) to provide testing and assessment to children identified in our system. She also worked half time with the Quincy Medical Group Child Assessment Center. Eventually, she increased her hours at QMG and quit providing services at TWI.

We have made efforts to recruit additional child psychologists, with no success. Our system will be significantly stronger when we have accomplished this goal.

Each of the three clinics has found ways to integrate behavioral health services into primary care and has created care coordination services.

A successful co-location model has been implemented between BPS and TWI. More information about this can be found in Section 11.

At QMG, in addition to the Child Assessment Center, they have expanded to a full-service behavioral health clinic, with providers who address specific specialty areas. They have located a behaviorist within the Family Practice clinic suite so that the behaviorist is available to address crisis events, assist physicians with referrals and brief interventions, and to have a “warm handoff” when the provider is referring a family for services.

At SIU the behaviorists are available to the physicians within the clinic. When a family is being referred, the physician will have a member of the behavioral health team come talk to the family. If there is a crisis, a behaviorist will be called to assist and/or to consult with the provider. Further, the physicians, and especially the residents, are encouraged to talk with behaviorists about issues that arise when they see patients. In addition, the behaviorists review tapes of the residents and give feedback on how they have handled situations that arise.

4.2. Provider network

In order to assure that the appropriate referrals were made, staff engaged the community providers in a process to develop, and update annually, a provider guide, which referenced the credentials of the staff, the areas of specialty, the ages that they served, and the sources of payment that they accept. This information was shared with the care coordinators and providers for making timely, appropriate referrals.

4.3. Meeting basic needs

To meet basic needs and coordinate the care of patients, each of the primary care sites was funded for the care coordination role. All three sites had Care Management/Care Coordination/Case Management but the models look different.

Just prior to our project beginning, Blessing Healthcare absorbed the Access Health Program. Over the life of our project, it has continued to evolve into a complex care coordination and case management program, with nursing staff and behavioral health staff. Initially designed to meet the needs of the adult uninsured and underinsured population, it has expanded to serve all BPS patients in need.

Initially, a care coordinator was hired specifically for the ACCMHP project, and this person functioned within the family practice unit and with the co-location model. By year three, the role was transferred into the Care Coordination unit, thus assuring that the role would continue beyond the grant period.

Care Management Services at QMG offer programs to help patients with chronic conditions improve the overall quality of their lives, ensure that they receive care based on the best medical practices, improve their understanding of their condition, and reduce hospital admissions and emergency department visits. The Care Managers are an extension of the primary and specialty care teams and will work with the patient, their family, nursing staff, and their primary care provider.

A NURSE CARE MANAGER WILL:

- Assess patient
- Educate patient on disease process
- Provide medication training/monitoring
- Assess for lifestyle modification
- Recommend self-care measure
- Assist in client/provider communication

-
- Refer to community and medical resources
 - Provide reminders for appointments, screenings, and tests
 - Provide regular monitoring calls
 - Provide community referrals

**PEOPLE WHO IDENTIFY WITH THE FOLLOWING STATEMENTS
CAN BENEFIT FROM CARE MANAGEMENT:**

- Ongoing complications/co morbidities
- Frequent ED visits/hospitalizations
- Lack confidence in self-care
- Lifestyle or behavioral risk factors
- Psychosocial, environmental, or healthcare access risk

SIU Center for Family Medicine—Quincy offered a voluntary and free program to patients of SIU Center for Family Medicine in which Nurse Care Managers partner with patients and their doctors to create a plan that will help improve the patient’s quality of life. Care Manager services include:

- A complete needs assessment
- Disease education and understanding
- Referrals for community services
- Coordination of health and social services
- Ongoing contact and support

4.4. Evidence-based practices

Adams County is a rural community, located 100 miles from any community with a larger population. Mental Health professionals are well trained through their higher education experiences but are typically required to provide services to all age groups, youth and adults, as well as treating a broad range of diagnoses. Training in evidence-based practices from highly skilled instructors has historically required significant travel to large cities, incurring travel and lodging expenses. After extensive research and discussion, the ACCMHP training committee developed the following training plan:

- Highly skilled instructors would be brought to Quincy to impact the highest number of mental health professionals possible within Adams County.
- Training would be provided in Partnership with the Mental Health Authority Training Committee, thereby sharing costs for the training.
- Instructors would provide a unique training model that included two days of large group instruction (Day One: Overview, Day Two: Intensive instruction), followed by a small learning cohort that met with the instructor via SKYPE/Telehealth technology once per month for four to five months (1.5 hours each) for case consultation and additional instruction.
- Training topics would be spread across multiple years to reduce the financial impact to agencies and private practitioners due to lost billable services during training.

LEARNING COLLABORATIVE TRAINING PROVIDED THROUGH CMHI

1. Effective Parenting Training	Dr. Marc Atkins
2. Cognitive Behavior Therapy-Depression/Anxiety	Dr. Mark Reinecke
3. Infant/Early Childhood Mental Health	NTI Upstream
4. Theraplay-Level 1 Certification	Theraplay Institute/Chaddock
5. Cognitive Behavior Therapy-Externalizing Disorders	Dr. Mark Reinecke
6. Infant Mental Health	Michael Trout
7. Treating Delinquent and At-Risk Youth	Dr. Jeremy Jewell
8. Cognitive Behavior Therapy	Dr. Mark Reinecke

All public schools, and some of the non-public schools, in Adams County have implemented Positive Behavior Interventions and Supports (PBIS), a research-based, multi-tiered system of support for the social-emotional needs of children and adolescents in school. Implementation of PBIS was in the early stages in 2010 when the CMHI project planning began. The three-tiered system was instrumental in supporting the successful implementation of our CMHI project, and school-based goals and objectives were integrated into the PBIS system. The Mental Health Network Coordinator, in partnership with the PBIS district coach, planned, organized, and scheduled trainings in evidence-based interventions throughout Adams County schools. Evidence-based, universal curriculum and interventions included:

TIER 1

- Second Step-Research Based, social-emotional curriculum, Pre-Kindergarten through 8th grades. Quincy Public Schools adopted this as core curriculum in 2014.

TIER 2

- Check-In, Check-Out
- Social Academic Instructional Groups (Skills for learning, Emotional Management, Problem-Solving, Empathy Building)
- SPARCS—Structured Psychotherapy for Adolescents Responding to Chronic Stress
- Sunshine Circles Supplemental to core social-emotional curriculum, implemented in special education classrooms

TIER 3

- Function Based Assessment/Behavior Intervention Planning
- Wraparound-Person-Centered Planning process that supports children and their families
- RENEW—Rehabilitation, Empowerment, Natural Supports, Education, Work
 - Person-centered planning process for high school students

4.5. System entry—intake process

Adams County has focused on the concept of a complete system of care for children with mental health needs, rather than creating a separate system, that would require formal entry/intake. 'Entry' is at the initial point of contact/screening, whether it be the school, primary care office, behavioral health office, or daycare. Our system is based on coordination of services and collaboration across different parts of the system.

Each provider retains complete responsibility for the intake of patients according to their organizational requirements. When a child is involved across various agencies, clinics, school, etc., a release of information is obtained to share information.

Early on in the project work was done with various entities to determine if there were a system that would allow more open communication on behalf of clients. A community-wide system of referral was previously in place with Access Health Adams County (AHAC), a program to assure connection of people with limited income and no insurance would be able to receive medical care on a sliding fee scale. The program consisted of three programs: Physical Led Access Network (volunteer network of providers), Care Management, and a Community Service Link (CSL). CSL was kicked-off around 2007 and was a web-based software. Agencies could become a provider on CSL. Consumers would sign a waiver to have a file set up on CSL. During this setup process, a needs assessment was conducted for each consumer to identify needs. This would allow agencies and medical providers to document the services being provided to that consumer (patient), make referrals to address needs, and close the communication gap between different providers. CSL would provide a point of entry into the System of Care for all Residents of Adams County to be plugged into needed services, such as medical care, housing, utilities assistance, food, etc. AHAC provided all of the software training to users and paid for the software. Like many other “best-laid plans,” this program never really got off the ground.

AHAC employees entered every single patient/consumer we came across to try to increase the value of the system. Other agencies/providers did not take the time to use it. Some reported concern for confidentiality, skepticism, etc. CSL dissolved by 2011.

System entry within schools is done through PBIS. Individuals can enter the tiered system at the appropriate level needed, based on the individual. Each school has data decision rules for identifying students eligible to receive secondary and tertiary evidence-based interventions. Intervention teams meet regularly to review data to identify and refer students for intervention and to monitor the progress those receiving intervention. Information/data reviewed by the teams includes: positive screens on the parent or youth completed Pediatric Symptom Checklist, behavioral referrals, teacher/parent request for support, attendance, suspension, etc. School data includes: positive screen, number of behavioral referrals, teacher/parent request, attendance, suspension, etc. Systems teams and intervention teams meet regularly to review data to determine entry into appropriate interventions and to monitor progress for effectiveness. School personnel with training in the mental health field (school social workers, school psychologists, guidance counselors) are facilitators of the intervention teams. Interventions and supports are added, as identified by the teams. Student, parent, and teacher requests for intervention can be made at any time. Referral to other services within our ACCMHP are made as assessed by the school mental health professionals and intervention teams. School integrated mental health services are initiated through the same process.

Evidence-based interventions, as outlined above, are some of the school-based services available upon entry.

One of the greatest barriers to access is stigma. The ACCMHP has partnered with the AOK Network during the first week of May to publicize Children’s Mental Health Week. Activities have varied, but included proclamations by the Mayor at City Counsel designating it “Children’s Mental Health Week,” activities in the park, a family fair where various partners distribute information, place banners in prominent areas of the community, provide educational programs targeting parents, read in classrooms to pre-school and early grade school children, make public service announcements, and distribute green ribbons.

Mental Health First Aid was selected as a strategy to address stigma and to increase the availability of “natural helpers” to support families and children with mental health needs. Natural helpers have been described as those people in the community that a family has contact with such as extended family, church members, neighbors, school staff, and volunteers.

Two populations that are often affected by stigma are the minority community and faith-based groups. We targeted both of these groups and were successful in providing the course in three of the larger congregations in our community, as well as training the parish nurses, who provide a level of outreach within their individual

churches. One church was predominantly African American, and they acknowledged the importance of challenging the myths that keep people of color and people of faith from reaching out for help.

Classes have been offered in a variety of settings and have been attended by a cross section of the community. Ratings from participants indicate that most feel an increase in knowledge about mental health symptoms, that they feel more confident in engaging with a person experiencing a mental health crisis, and that they will use the information in their daily life with family, friends, or co-workers.

An additional way that we have reduced stigma is by integration of behavioral health into the medical clinics. Parents have indicated more comfort in seeking behavioral health services for their children within the same clinic where they receive medical services. Some parents felt that just being seen walking into a mental health facility might cause their child to be labeled, but they felt that walking into the primary care office was more acceptable because no one would know if they were getting immunizations, a check-up, or a behavioral health appointment.

Transportation was identified as a barrier. Quincy has a city transportation system, and tokens are given by care coordination to increase access to services. The United Way has explored the possibility of expanding the city bus system to the county area.

4.6. Screening, assessment and evaluation

Each of the three clinics and Quincy Public Schools has developed their own system for screening, triage, referral, and evaluation. By including the screening tools in their online registration process, Quincy Public Schools has extended the screening to all students, and created a data collection system that allows them to utilize the information for student planning. In addition, it makes it available for reporting basic screening numbers.

At BPS, the screening is administered in the office, and scored by a support staff. Each physician in the practice determines what age level they prefer to screen, and whether or not to administer the ASQ 3, the ASQ SE 2 or both. The care coordinator is responsible for following up on the screening results and working with the provider to facilitate a referral, as needed.

Like BPS, QMG also administers the tool in the office. Scoring and referral is provided by the nurse and office support staff. A behavioral health tech is available to provide additional support to the office teams, as needed.

At SIU Center for Family Medicine–Quincy screening tools are mailed to the parents prior to their scheduled appointment. When they bring them in, they are scored by a nurse or office staff, and then reviewed by the physician.

SCREENING PROCESS WITHIN THE QUINCY PUBLIC SCHOOLS

Universal screening by parent/guardian

- **Tool:** Pediatric Symptom Checklist (PSC)-Parent questionnaire (public domain, research-based screener). 17 questions, domains of internalizing, externalizing, attention
- **Administered:** during school registration (see Appendix A7 and A8)
 - Initially a paper copy included with the full registration packet, turned in at registration
 - 2016 integrated into the student information system, Skyward, as one of the on-line documents parents complete for registration—all grades

Quincy Public School's screening began with a small pilot group of schools and grade levels with the purpose of learning through the process. There were unknown factors of the number of positive screens, our capabilities of providing timely follow up, parent and staff responses, and assuring that adequate supports were in place. We were also unsure of the parent response to screening. Our community has historically

been conservative regarding the perception that the public schools should not teach values. We purposely started small with our screening process. The result was successful. Screening has been by parent choice and the percent screened has remained high. We have had positive results with a low number of parent concerns. It was vital for us to introduce screening as part of our PBIS system and we have clearly communicated that this process allows parents to let us better understand their children. Connecting screening with social-emotional learning standards and labeling this as “social-emotional screening” may have been beneficial to the success of the process.

Student screening

- **Tool:** Pediatric Symptom Checklist-Youth self-report
- **Administered:** Junior high and high school students enrolled in health courses complete the screener during the mental health unit
- Parent consent for social-emotional screening is obtained during school registration consistent with consent for vision, hearing, and speech

Scoring

- Paper responses are hand-scored by school social workers and psychologists. The tool includes 17 questions and is quick to score. The format of the PSC we adopted organizes questions by domain, which allows for efficient scoring by hand.
- Skyward responses are exported to Excel with scoring formulas customized for the PSC
- Results are distributed to each school’s social worker

Review of results

- School social workers and psychologists review the screening results and follow a protocol for follow up with parents and/or students (see algorithm below).
- Results are mailed home for all positive screens along with psychoeducation materials/anticipatory guidance on social-emotional development and whom to contact at school for consultation. (see Appendix A5, A6). Two no-cost options for parent educational materials are:
 - What to Expect and When to Seek Help—Bright Futures.org
 - Snapshots of Your Child’s social-emotional Well-Being-I-KAN, Iroquois-Kankakee Regional Office of Education
- Personal contact is made by the school social worker, school psychologist, or school guidance counselor with parents/guardians of positive screens in the domain of Internalizing or other domains, as individually assessed by the school clinicians after review of existing information.
- All positive screens will be reviewed with the student assistance/intervention teams within each school to review existing information and determine if further assessment or tiered intervention is warranted.

Screening data

- Screening results remain confidential within the school setting and accessible to the student support/intervention teams that include school social workers, school psychologists, guidance counselors, administrators, and school nurses or other staff members identified by the team.
- Positive screen indicator is coded in the student information system for student tracking purposes.
- Positive screens are used as one indicator of the data decision rules for initiating tiered, social-emotional interventions.

ASSESSMENT AND TREATMENT

As indicated in the triage protocol, the decision for follow-up assessment or referral for intervention is determined by the student, parent, and mental health professional consultation in follow-up from a positive screen result. Assessment can be completed by the school mental health professionals or by choice of the parent with any provider in the ACCMHP system. Brief school interventions can be initiated; school personnel may refer a family for school-based or agency treatment; or the parent/student may choose the next steps following screening.

4.7. Decision making at the service delivery level

When the steering committee was formed, high-level decision makers for the key organizations were brought around the table to reduce administrative barriers for the work being done.

As a result, this group recognized that there was a need for clinical and programmatic staff to solve problems in how the project was implemented. A committee called the Round Table was developed. Initially, this group met monthly because many changes were being implemented within the system. After the first year, meetings were held bi-monthly then quarterly. By the end of the third year, the group agreed to meet on an as needed basis only.

Organizations appointed supervisors and key program staff to represent them. This group initially met over a lunch (provided with grant funds) to talk about the barriers that they were encountering in implementing the system of care changes. They advised ways to overcome challenges and worked through relationship issues among partners, thus improving communication, referral, and delivery of services.

An example of how this worked is that Cornerstone Agency was provided limited school-based counseling funded through the state programs and United Way. As the state began withholding payments and cutting programs, school-based counseling funding was limited to what they could provide through the United Way and private funding. In the meantime, Transitions of Western Illinois (TWI) was willing to increase their reach into school-based counseling through Medicaid. Transitions and Cornerstone worked with the school to place TWI staff in the schools with the highest Medicaid population and to place Cornerstone therapists in the schools with less opportunity to bill Medicaid. This allowed both agencies to maximize their service delivery within the schools and provided an additional number of children in school-based community services. A third provider, Chaddock, became a Medicaid provider and was included in this plan, as well. By increasing the number of provider's available, rural schools were also able to benefit from school-based community services.

4.8. Care management/coordination

Our vision was to have one dedicated staff person who would support the clinic staff, work with families, follow up on screenings, and collect all data required. Initially, the role was fully supported with grant funding and then decreased each year of the grant. The hope was that this person would become valuable to the practices by supporting screening, being accessible to the providers to assist in brief interventions and referrals, and to support families to improve follow-through with medication and appointments. This would improve the efficiency of the practice and be found to be valuable and worth keeping beyond the funding by the project.

At Blessing Physician Services (BPS), a nurse was hired and placed in the Family Practice department to fulfill this role. Her role included follow up on positive screenings, data collection, support to the providers, and coordination of the co-location model (see goal iii). Over the five years of implementation, this role changed several times, until it became a fully integrated part of the BPS Care Coordination unit.

At Quincy Medical Group (QMG), the behavioral health department was developing a model to support integrated behavioral health throughout the clinic, and to develop a Child Global Assessment center. As a result, they proposed to meet the care coordination function in a different way. The global assessment

center initially hired two techs to support the activities of the center. One tech had a portion of time dedicated to reviewing the screening results, following up with the practice staff on referrals, supporting special needs of families, entering the data, and managing the cohort.

Nurses and office technicians in each practice were responsible for the care coordination related to referral and follow up. It should be noted that, in August 2013 (two years into the project), Quincy Medical Group adopted a screening protocol to be used organization-wide in all primary care settings. This would affect clinics outside of Adams County, including locations in Illinois, Iowa, and Missouri.

At SIU, initially, a dedicated staff person was hired to complete the tasks identified by the grant. During this time, the screening rates were very high, at 90% or more. Due to concerns over sustainability of this position, when the staff person accepted a job elsewhere, the role was realigned with several staff taking on key responsibilities for the activities. While this is more sustainable, it has resulted in a slight reduction in the rate of screening.

QPS hired a full time Mental Health Network Assistant who provided the same type of activities as the care coordinators. This person was responsible for assisting with the school-based screening process and data entry.

4.9. Crisis management at the service delivery level

Student deaths by car accidents, murder, and suicide have affected our community during CMHI implementation. Adams County, a small rural community, gains strength in coming together to support one another. Relationships that existed prior to the CMHI project have been strengthened throughout our system of care development. Responding to student and family grief under these challenging circumstances has been done through an organized, yet flexible, approach that has included school mental health professionals, the faith-based community, and mental health agencies. Partnerships with mental health agencies who integrate services in the schools are valuable in times of crisis. Not only does support need to be provided to students, staff members are in need, as well. Crisis response plans include support to staff members. Some students gain crisis support and comfort through their faith. By including youth ministers from across the community to our support team, students can choose to meet with the faith-based leaders for support. The school systems have allowed this as student choice.

In response to three Adams County student suicides in six months, school and community leaders came together to develop an action plan to address the needs for mental health wellness, anti-stigma for mental health treatment, and suicide awareness/prevention. Youth representatives have been active members of the coalition. Their work has been coordinated with the Adams County Suicide Prevention Coalition, a group co-led by TWI and Blessing Behavioral Health for the purpose of community education.

4.10. Crisis management at the system level

The ACCMHP has strengthened support to the system for responding to mental health crises. Screening Assessment and Support Services (SASS) have continued to be in place and provided through Transitions of Western Illinois. Transitions also provides crisis mental health assessment to any individual who walks into the clinic, regardless of payment source. Knowledge of this was limited. Through the ACCMHP, community awareness about this resource has increased Blessing Hospital provides adult and child/adolescent in-patient and outpatient care. The Blessing Emergency Room is an option for crisis assessment. During our ACCMHP implementation, Blessing Hospital has re-designed four of their ER rooms to accommodate mental health observation and crisis intervention to stabilize and potentially deflect from hospitalization. Mental Health professionals staff the ER to provide assessment, intervention, and referral to outpatient care.

5.0. Workforce recruitment

Individual organizations within the system continue to hold complete responsibility for recruitment of staff to meet the goals of the system. During the planning year and early in the implementation phase, we identified community needs for psychiatry and other services for children under six. Those needs have been met through the partnership.

6.0. Family involvement at all system levels

Our system is based on the concept that, in order for a child to be successful, the parent must be engaged. One of the unexpected values of doing the screening tools is that parents become familiar with appropriate expectations for their children at certain ages. Further, it opens the door for communication with the provider on issues that they may have concerns about, allowing the provider to give information and make referrals.

FAMILY INVOLVEMENT IN THE SCHOOLS

Family involvement is highly valued at all three Tiers of PBIS. The PBIS Universal system team has responsibility of providing ongoing parent communication and education regarding the Universal social-emotional curriculum, school-wide expectations, and the overall philosophy and research base of PBIS. There are parent members of the PBIS Universal Teams. Information regarding tiered interventions is provided in parent newsletters. Parents are the entry point of our universal screening system with the parent-completed Pediatric Symptom Checklist. Parent voice and choice is an essential principle in supporting student social-emotional needs. Youth completed Pediatric Symptom Checklists require parent/guardian active consent. Parent/guardian follow up is provided following the triage protocol. Family voice and choice is highly respected as part of the screening process.

PBIS Tier 2 and Tier 3 systems teams are designed for parent membership. Parents are actively participating in some schools, and plans are in place to add parent members to remaining schools. The “systems teams” look at overall data reflect on how the systems are functioning, review effectiveness of interventions, and plan for improvements in the system. Specific children are not discussed at the systems level. Parents are critical members of these teams by offering parent perspective, generating ideas for improvement, and in communicating with other parents. For students receiving Tier 2 interventions, a daily communication tool, the Daily Progress Report, is provided to parents.

This is in place in some schools and being added to the remaining schools. Parent team members provide perspective on the effectiveness of our system and planning for system changes.

Family engagement is the first phase of Tier 3 interventions. Family voice and choice, and child-centered and family-focused principles are key factors in the evidence of effectiveness of the interventions. Teaching and supporting the philosophy of the family’s role is critical in positive outcomes for children, as in “Do with and not to.” Family members and family chosen natural support persons are members of the individualized team for students receiving Tier 3 interventions.

Professional development in promoting these principles is ongoing. Training facilitators for Tier 3 interventions began later in the CMHI implementation, because system infrastructure at Tiers 1 and 2 were priorities in the initial years. Teaching and instilling the principles of family voice and choice, “do with and not to,” will be ongoing. Adequately trained Tier 3 facilitators, as well as school administrators, will continue to be critical.

7.0. Youth involvement, support and development

As introduced in section 4.9 above, youth involvement and leadership has been instrumental in guiding our community’s plan for the development of natural supports, mental health awareness, and suicide prevention. Two needs were identified with action plans implemented.

- A student Wellness Fair was held during a school day in September 2016. Keynote speakers, workshops on many different topics related to mental health, exercise, diet, recreation, positive coping strategies for stress reduction, etc. were offered for all students throughout the day. A booster follow-up wellness day was held during second semester, with planning in process for September 2017. Student involvement as decision makers guided the planning.
- Teens may be reluctant to reach out to adults when in mental health distress or crisis. PAL, Peer Assistance and Leadership, is a nationally recognized evidence-based prevention program that was brought to Quincy Senior and Junior High Schools in 2016. The mission of the PAL program is to enable young people to use their potential to make a difference in their lives, schools, and communities. PAL training nurtures and builds capacities to help youth increase resiliency and build protective factors to help them achieve school and social successes. Trained students learn to adapt the power of peer pressure to influence others positively and, ultimately, they make a difference in the lives of others. Positive peer influence is utilized as a central strategy for addressing issues like bullying, low achievement, at-risk youth, dropout prevention, substance abuse prevention, teen pregnancy, suicide, absenteeism, behavior problems, and other community issues. Staff training was open to Quincy and county school staff members in June 2016 with student leader training in October 2016.

8.0. Clinical staff involvement, support and development

In September 2011, a survey was distributed to all primary care providers in Adams County, including SIU, QMG and BPS. The results were shared with the Blessing Hospital CME and Library Committee to support decision-making for how money should be spent on training for physicians/nurses/mid-level providers working in Primary Care. The questions included:

- What are the best days of the week for you to attend a CME?
- Would you prefer to attend CMEs morning, lunch, or afternoon?
- Regarding children’s mental health, what CME topics are you most interested in?

Work Group #2 identified a need for well-qualified mental health providers trained in evidence-based practices to treat infants, children, and adolescents. The Mental Health Network Coordinator had the responsibility of identifying and engaging mental health providers in Adams County in the following process:

- Identifying all mental health providers in agencies and private practice and compiling a resource guide.
- Surveying all Mental Health Providers to obtain an assessment of the age ranges for which they are trained to serve, evidence-based practices for which they are trained, payment options, and evidence-based practices that they have interest in learning. Information collected was entered into a spreadsheet and updated regularly to allow other providers to make more informed decisions when making referrals. The spreadsheet was shared with local service providers.
- A Mental Health Training Committee was formed and met on several occasions to review survey results, identify service needs/gaps, and identify a training model to support through ILCHF grant funds.
- The training committee, comprising representatives from across the county, prioritized the training needs and determined the training approach/timeline that would best meet the local agency needs. While staff are often able to attend one day of training, when a training modality requires multiple days, it can be challenging for an agency where staff are required to meet a certain number of billable hours. In these cases, we have been creative in scheduling trainings to accommodate their need to meet a minimum number of billable units each month. For example, a four-day training on Theraplay was scheduled with two days in the last week of one month, and two days in the first week of the following month. Another training event was scheduled for two half-days to accommodate the need for line staff to be able to do their “regular” jobs, in addition to having training. Often, school staff receive trainings

during late afternoon, evenings, week-ends, or summer to alleviate the requirement for substitute teachers, etc. By considering these types of needs, you decrease the barriers that staff and agencies have to attendance at training events.

- Clinician Professional Development in evidence-based practices was provided as outlined in Section 4.4 above. CMHI funding provided training opportunities to any mental health professionals from schools, community agencies, primary care, and private practice. The result allows for children and their families to access trained professionals through multiple options.

9.0. Stakeholder and community orientation, training and communication

Our system has relied heavily on already established partnerships to support and promote the goals and activities of the ACCMHP. Those partnerships include: the AOK Network, Substance Abuse Coalition, United Way Health Delegation, and the Mental Health Authority Training Committee.

Throughout the life of the project, we have sought feedback from providers and families, through interviews and surveys to identify ways to improve the system.

Data and information have been shared through a newsletter, through email, through participation in community events, and through press coverage.

10.0. System level advocacy

Every phase of the planning and development has involved some degree of advocacy for the enhancement and support of the system. No specific activities were identified in our plan to address this.

11.0. Financing

11.1. Purchasing/contracting

Over the course of the grant period, SIU (SIU School of Medicine) had subcontracts with Blessing Health System (Blessing), Cornerstone, Transitions of Western Illinois (TWI), Adams County Special Education Association (SEA), University of Illinois Springfield (UIS), Quincy Medical Group (QMG), and Cornerstone. While SIU was the lead fiscal agent, SIU shared leadership of the grant activities with TWI and SEA.

SUBCONTRACT WITH TRANSITIONS OF WESTERN ILLINOIS (TWI)

- *2012 (From September 2011 thru December 2012).* TWI was part of the lead team on the grant (TWI, SIU and SEA). TWI provided an Executive Committee member at .20 FTE who would supervise the project manager. The project manager was a full-time position (1.0 FTE) responsible to the Executive Committee for the grant project. She oversaw project staff, general oversight of project, and oversight of data collection and local evaluation strategies and reports, uploaded cross-site data elements in a timely manner, and worked with SIU Evaluators and Center for Clinic Research staff. This position established and coordinated the Provider Roundtable monthly meetings and was responsible for communicating recommendations to the Executive Committee and/or the MHP Steering Committee. The project manager worked closely with the Executive Committee, preparing grant documents, participating in required grant meetings with ILCHF, had overall responsibility for implementation phase activities, project staff, and their activities to assure adequate and appropriate progress was made. TWI also requested that an administrative staff position (.10 FTE) would be available to support the project manager to assist with report writing and to prepare information for the Executive Committee. This position was to assist with the scheduling of meetings, as needed. In addition, a clinical psychologist was provided by TWI at .25 FTE to provide data compilation and participate as a trans-disciplinary team member. This position was responsible for gathering assessment outcomes, collating reports, chairing the staffing, and writing final recommendations and reports to the referral agencies/providers and families. The clinical psychologist was available to consult with professionals in regard to how best

to implement recommendations. The trans-disciplinary team member/social worker was a .10 FTE. The social worker's role was to complete a social-emotional history on each case. A doctoral student position at .25 FTE assisted the clinical psychologist with evaluations and consultation with professionals and/or families in implementation behavioral interventions with children at high risk. Fringe benefits on salaries were reimbursed at a rate of 30%. Money was allocated to TWI for actual costs documented for assessment team coaching/professional services provided to caregivers and other professionals for contracted providers on an, as needed basis. Additionally, supplies were reimbursed.

- 2013. The Executive Committee member, project manager, administrative staff, clinical psychologist, social worker remained in 2013. The doctoral student was no longer included. Money was allocated to TWI for actual costs documented for assessment team coaching/professional services, provided to caregivers, and to other professionals for contracted providers on an as-needed basis (slight increase in support). Additionally, supplies were reimbursed.
- 2014. The grant funding for the Executive Committee member was reduced to .10 FTE. The project manager, administrative staff FTE, clinical psychologist, social worker grant financial support remained consistent from 2013. New in 2014, money was allocated for actual costs documented for consultation and direct professional services, provided on a contractual basis by a system-of-care psychiatrist on an as-needed basis. Also, money was allocated for gift cards for evaluation data collection incentives, and grant dollars remained for supplies.
- 2015. The Executive Committee member remained at .10 FTE. The clinical psychologist was reduced to .20 FTE. A mental health professional (.50 FTE) worked with school staff to develop processes for the provision of Tier 2 interventions within the school setting. A counselor/trans-disciplinary team member, an LCPC, (.10 FTE) was subcontracted for non-clinical participation in the School Mentoring Project for four sessions and for non-clinical participation in planning and programming. The program manager was no longer employed by TWI; employment was moved to SIU. Supply dollars also stopped. Fringe benefits were reimbursed at 30% by the grant on all salaries. Funding continued at a reduced rate for consultation and direct professional services, provided on a contractual basis by a system-of-care psychiatrist on an as needed basis. Money continued to be allocated for gift cards for evaluation data collection incentives.

In May 2015, an amendment was made to the contract, the executive member's FTE was increased to .15 FTE (.05 FTE increase) to assume additional leadership activities related to Community Base Wraparound Planning. The clinical psychologist's time also came to an end due to her transitioning to another agency within the project.

SUBCONTRACT WITH ADAMS COUNTY SPECIAL EDUCATION ASSOCIATION (SEA)

- 2011/2012. SIU subcontracted with SEA for the time of an Executive Committee member at .15 FTE who would supervise the Mental Health Network Coordinator (MHNC) (1.0 FTE). The MHNC was responsible for coordinating screening data and assuring that any child with a positive screen was further evaluated, appropriate information releases were obtained, and appropriate intervention plans were implemented with outcomes monitored. Additionally, this position coordinated the trans-disciplinary evaluations; set appointments and determined what professionals were needed on a case-by-case basis. There was also an assistant Mental Health Network position contracted at 1.0 FTE to support the MHNC, providing data collection in the schools and making appropriate referrals for children with positive screening results, as well as maintaining a database for both local and cross-site evaluation. Fringes were reimbursed at a rate of 20%. In addition, there was a social-emotional coach and support who worked with classroom teachers to suggest low-level psychosocial/educational interventions for identified children to prevent problems from escalating into more severe emotional/behavioral problems. Money was provided for supplies and equipment.

- *2013. Amended to read as follows:* The Executive Committee member will be a .15 FTE and will supervise the Mental Health Network Coordinator. The Mental Health Network coordinator will be a 1.0 FTE and will be responsible for coordinating screening data and assuring that any child with a positive screen is further evaluated, appropriate information releases are obtained, and appropriate intervention plans are implemented with outcomes monitored. Additionally, this position will also coordinate the trans-disciplinary evaluations; setting appointments and determining what professionals are needed on a case by case basis. The assistant Mental Health Network position will be a 1.0 FTE to support the Mental Health Network coordinator, providing data collection in the schools, and making appropriate referrals for children with positive screening results, as well as maintaining a database for both local and cross-site evaluation. Fringe benefits on these salaries will be reimbursed at rate of 20% of salaries. Additionally, \$1,200 for supplies, and \$31,600.00 for (8) mentoring sessions designed to provide teaching professionalism in Adams County with the skills necessary to gain tier one (universal) and tier two (small group) classroom interventions for children will be reimbursed upon receipt of documentation of cost.
- *2014. Amendments:* The executive committee member was reduced from .15 FTE to .05 FTE. An additional 100 hours of funding was allocated for unanticipated work for the trans-disciplinary team. Additionally, SEA started offering mentoring sessions. These sessions were designed to provide teaching professionals in Adams County with the skills necessary to gain tier one (universal) and tier two (small group) classroom intervention for children. Three sessions were funded during this year.
- *2015. Amendments:* The assistant Mental Health Network position was reduced to .20 FTE. Two mentoring sessions were offered that year. Two community trainers for Wrap Around sessions were reimbursed. In addition, funds were allocated to cover the cost to train law enforcement in Mental Health First Aid.

SUBCONTRACT WITH BLESSING HEALTH SYSTEMS (BLESSING)

A subcontract was put in place between SIU and Blessing Health System. Blessing was to place a mental health professional who would provide clinical mental/behavioral health assessments and treatment to children in the Blessing Physician Services practice location at 729 Broadway, Quincy, IL in both Family Medicine and Pediatric Departments. The care coordinator would be responsible for tracking children with positive screens, assessments, referrals and outcomes, and entering data into databases for the local and cross-site evaluations. At the primary site of evaluation, Blessing's care coordinator assured that appropriate referrals were made, releases signed, further assessments accomplished, and appropriate interventions completed. The care coordinator was also responsible for assuring that information was obtained and shared between providers and referral sources. Fringe benefits were based on salaries of the aforementioned positions and reimbursed at rate of 30% of salaries paid on behalf of the grant. Any cost of benefits provided over the 30% were provided in-kind by Blessing Health System to the care coordinator. Costs of benefits provided over 30% to the mental health professional was provided in-kind by TWI.

Blessing is not able to bill for mental health services, so they chose to co-locate mental health professionals from Transitions of Western Illinois. A separate contract was drawn up between Blessing and TWI. This model was unique because we had physicians and a care coordinator employed by Blessing. The mental health professional was employed and co-located by TWI. This required many communication/releases to be signed between the two organizations/patients to create the integrated approach.

Over the grant years (as mental health billing became sustainable), funding from ILCHF was reduced and the cost shared by Blessing and TWI was increased, specifically for the mental health professional. The care coordinator has many roles that were sustained by Blessing under the Care Coordination Department. As a result, the care coordinator joined the Care Coordination Department and continued duties from the ILCHF grant funding.

SUBCONTRACT WITH QUINCY MEDICAL GROUP

Quincy Medical Group was to hire a mental health professional to provide clinical mental/behavioral health assessments and treatment to children in the Quincy Medical Group practice location at 1025 Maine, Quincy, IL. The care coordinator would be responsible for tracking children with positive screens, assessments, referrals and outcomes, and entering data into databases for the local and cross-site evaluations. At the primary site of evaluation, Quincy Medical Group, the care coordinator would assure that appropriate referrals are made, releases signed as needed, further assessments accomplished, and appropriate interventions completed. The care coordinator was responsible for assuring that information was obtained and shared between providers and referral sources. Fringe benefits based on salaries of the aforementioned positions was reimbursed at rate of 30% of salaries and paid on behalf of the grant. Like Blessing, QMG picked up the cost of any benefits that went over the 30%. Like Blessing, as time went on, revenue was generated from the mental health billing. Cost shared by QMG increased and grant funding decreased to make these positions sustainable.

QMG's grant needs changed over time and the subcontracts proved that. In addition to getting the integrated mental health services off the ground, they were working on getting the QMG Assessment Center running. This positioned SIU to use ILCHF grant dollars to support those efforts. Some of those additional funding opportunities (by grant year) included:

- *In 2012 and 2013.* Occupational & Speech Therapy services for participation in the trans-disciplinary provider team and assessments/consultations of referred patients up to 320 hours at \$35.00 per hour and local health professional services were being provided as needed, per the grant requirements not to exceed \$2,000.00.
- *2014.* Speech therapy services for participation in the trans-disciplinary provider team and assessments/consultations of referred patients were paid up to 320 hours at \$35 per hour. Psychometrician services to allow for the administration of psychological testing were paid up to 520 hours at \$25.00 per hour.
- *2015.* In 2015, QMG needed grant dollars to support a clinical psychologist position in serving children insured by Medicaid and identified as ICG or Individual Children Grants by gathering assessment outcomes, collating reports, and chairing the staffing and writing final recommendations and reports to referral agencies/providers and families. The clinical psychologist was available to consult with professionals regarding how to best implement recommendations. Once again, benefits were covered up to 30% of the .10 FTE. The remaining cost of benefits was covered by QMG.

SUBCONTRACT WITH CORNERSTONE

In April 2015, Chris Parker, LCPC changed employers. He had worked for TWI up to this point. The steering committee wanted Mr. Parker to continue the work he was doing in the school mentoring project. Therefore, the subcontract with TWI was amended in April 2015. A new subcontract was drawn up by SIU for execution with Cornerstone to continue Mr. Parker's work in the schools from April–December 2015, through his employment with Cornerstone.

SUBCONTRACT WITH UNIVERSITY OF IL SPRINGFIELD—DAVID RACINE

- *2015.* SIU subcontracted with U of I Springfield for evaluation services, which included:
 - Receive and review all evaluation data that the University obtains from primary care providers, schools, and others participating in the initiative.
 - Use collected data to track changes in what happens to children over time.
 - Explore how data might be used to help explain what happens to children that is already being collected, or planned for collection, on building a qualified and adequately trained workforce, integrating mental health service into primary care, increasing cross-system information sharing, and providing assessment.

-
- Study provider advice on ways in which evaluation of training supported by the initiative may be improved.
 - 2016. The contract was amended so that the subcontractor would continue the first and second tasks into 2016, with the goal of preparing and presenting the annual local evaluation report early in calendar year 2016.
 - 2017 and 2018. The subcontractor was to complete the local evaluation report due in 2017 and final local evaluation report due February 2018.

Not specific to any subcontract discussed, there was a lesson learned. In order to assure the data required for evaluation was received, it needed to be listed as a condition of payment in the contract.

11.2. Provider payment rates: discussed elsewhere

11.3. Revenue generation and system reinvestment: discussed elsewhere

11.4. Billing and claims processing

Regarding Mental Health Integration in primary care, the three different primary care sites were unique in how they integrated or placed mental health in their settings. Blessing was not able to bill for mental health services, so mental health therapists were co-located from TWI. This was explained further in section 1.1. Then Transition would bill for the mental health services provided at Blessing. Quincy Medical Group is a Rural Health Clinic (RHC) and able to bill for their own mental health services. At the time of implementation, SIU was a Rural Health Clinic. In July 2015, SIU became a Federally Qualified Health Center (FQHC). The biggest difference between a RHC and a FQHC was difference in pay. Both received an encounter rate from IL Medicaid. Now, FQHC does that with Medicaid and Medicare. With Medicare, Behavioral Health is an established encounter rate of \$250, which is paid like regular Medicare visits, leaving the patient with only a small deductible, such as \$30, which then usually goes to a second insurance to pay. The fee for behavioral health being an RHC was \$63.47; being an FQHC the rate was \$59.12. This was specific to Medicaid.

11.5. Utilization of ILCHF grant funds over time

As mentioned earlier, funding from the grant decreased while revenues increased, which supported financial sustainability for many positions.

12.0. Information management

12.1. Protecting child/family privacy

See below.

12.2. Sharing information among systems

Each of the agencies that participated in the system had to address internal information management policies and procedures. Planning meetings and other work among partners was required to determine the best ways to collect consistent data for evaluation.

Sharing information for treatment purposes remained dependent on the use of individual consents and/or releases of information signed by a parent and/or child.

12.3. Electronic medical records

Initially, there was much talk about incorporating the screening tools into the Electronic Health Record. This would reduce provider's resistance by saving time during the well child check and putting the information right in front of the doctor. The tools selected by the project—the ASQ 3 and ASQ SE—were not designed to be utilized in this way.

During the planning year, staff and the Executive Committee members participated in meetings regarding the Health Information Exchange because Quincy is in one of the first regions to be receiving this change, which permits HIPAA compliant exchange via electronic methods. The plan that was being initiated would address mental health last, so it was decided that this wasn't pertinent to our system. We decided that we would revisit it again when the system is in place for mental health.

13.0. Quality improvement

See Section 4.7

14.0. Evaluation

Collection of Cross-site data was seen by many as a barrier to our system. Data collected was either not helpful to our community or was less helpful than other things possible to collect. In particular, the cohort was exhausting, became a barrier to engagement of partners, and did not align with care for patients.

The initial guidance regarding local evaluation was not clear, and we relied on the cross site for feedback on the impact of the project. We learned that we could have created a more robust local evaluation that gave our community valuable information about the impact of the project locally.

15.0. Impact for children/families from the care system improvements

In 2016, 11,829 mental health screenings were completed in Adams County, 6,350 of these within Quincy Schools. Through the years of the CMHI, outcomes have included: 1) Engagement of all three primary care sites in screening, care coordination, and mental health integration. 2) PBIS (Positive Behavior Interventions & Supports), a three-tiered model of prevention, identification, early intervention, and intervention has been implemented and expanded through combined school district and ILCHF funds. This model has included screening, triage, and intervention. 3) Extensive professional development in research-based therapies specific to infant, child, and adolescence mental health. 4) Addition of the Quincy Medical Group Assessment Center. 5) Expansion of school integrated mental health services. 6) Decreasing stigma and increasing literacy around children's mental health through Youth Mental Health First Aid courses (three local, certified instructors). 7) Cross-system Wraparound facilitation training, a person-centered planning model to support those with complex mental health needs.

Children and their families have access to screening, early identification, and services through multiple entry points in our system. Schools and primary care providers allow opportunities with reduced stigma.

16.0. External technical assistance and consultation

Most of the external technical assistance was provided through NTI at site visits. Dr. Ira Chasnoff provided several significant training events to providers and to physicians. His influence was powerful at Quincy Medical Group in convincing administration to adopt a clinic wide screening process.

Early on we provided the AAP Toolkit as a support for clinics. This tool has forms and processes that are standardized.

We engaged trainers from EDOPC to provide initial trainings at all three clinics on the utilization of the ASQ tools.

17.0. Cultural competence

Key Informant interviews included faith leaders in the African American community. They readily agreed that stigma was significant in both the faith and local minority communities. With that in mind, whenever possible, we included special efforts to reach out to the community. We offered Mental Health First Aid to specific audiences and partnered in activities, such as the Back to School Fair, to have a presence in the community.

It has long been an observation in our community that we need to recruit minority providers; however, Quincy has a relatively small minority population, and many providers who are black or Latino, can command higher wages in a more diverse community. For that reason, Community providers recruit minority providers at all levels of the system.

A barrier, identified prior to the beginning of our grant, is that poverty also creates a cultural barrier between providers and those living in poverty, especially those with generational poverty. Our community has had several Ruby Payne trainings and Poverty simulations to increase provider awareness of the culture of poverty. Poverty simulations are generally provided through the U of I Extension Center.

MHFA has been a provider to the faith community, including a predominately black church, interested in myth busting the commonly held belief that you can “pray away” mental illness. Members of this church, in particular, reach out to the provider network, as needed. As they do so, they are opening the doors for other partnerships between the provider network and the community.

18.0. Sustainability/longevity of the leadership

Leadership chose project staff, in part based on their past role in the community, and the potential for continued long-standing involvement. Staff and many of the agency representatives will continue to work within the children’s mental health system in either the same or different roles.

While there has been some change in the administrative leadership of the project, all three staff hired have remained with the project, even though each role has changed during that time.

The Project Manager position was initially a full-time employee, dedicated to project management, facilitation, and evaluation. After the initial project planning and implementation phases, the role has been reduced to a .55 FTE and will not be continued beyond the grant. Project leadership will be retained through the oversight of the United Way Mental Health Community Solutions team, and the organizational leadership of each partner. The person employed as the Project Manager was chosen for her strength in community networking, facilitation, and project implementation. The role will not continue beyond the ILCHF funded grant; however, the staff person will remain active in the community in other child, family, and youth serving roles.

A Mental Health Network Coordinator was hired to facilitate development of the professional network required for the system of care. Primary responsibility was coordination of professional development opportunities, engagement of various clinical personnel, and engagement of schools. The person employed in this role was formerly a school social worker and had extensive experience in the PBIS model and in Wraparound facilitation. This role is no longer funded, and the staff person has returned to work as the school social work coordinator. In this role, she has the ability to impact the continued expansion of screening, triage, and referral within the county.

The Primary Care Mental Health Coordinator was hired as a part-time staff person, with the responsibility of assisting primary care in integrating behavioral health into their practices. The staff person chosen for this role had previously worked within the primary care settings and the community to develop a program to assure services for uninsured and underinsured adults. The role will not be retained beyond the grant.

19.0. Plans for preparing the next generation of system leaders

It will not be easy to prepare our community to lead and thrive in the changing world of healthcare/mental health care/and schools.

SIU Center for Family Medicine-Quincy is a residency program, and the new physicians being trained in this model will be more likely to incorporate the following values into their own practices:

-
- Cultivate a community that is shaped by genuine respect for individual differences and that values inclusivity, equity, and compassion.
 - Promote the fundamental importance of health and well-being in a balanced, fulfilling life.
 - Foster a climate where all members of the community can safely learn and grow.
 - Embrace universal screening, the use of anticipatory guidance, integrated behavioral health, and referral.

The inclusion of the ACCMHP in the larger community health system, under the leadership of the United Way of Adams County, will assure that each new generation of providers will be trained in, as well as contribute to, the growth and ongoing development of the system.

Quincy Public Schools serve most of the youth within Adams County. ILCHF funding since 2010 has been instrumental in our district's affirmation and commitment to supporting student social-emotional needs, Pre-Kindergarten through 12th grades. In July 2018, all QPS students from Kindergarten through 5th grade will be restructured into five learning communities and will be in new buildings by 2019. QPS has added new leadership positions, social-emotional student administrative managers, with the primary responsibility of leading the multi-tiered systems of support (PBIS). One student support family liaison will be employed in each of the five schools. Similar positions have been added to the junior and senior high schools. The commitment to these vital staff positions will assure that new programming/additional interventions to our PBIS system will be implemented with fidelity. Staff members within the system are trained to sustain the training needs of newly hired staff for the future. The mental health network coordinator has also mentored other school mental health professionals in their training skills at all levels of the school-based system.

Adams County
Children's Mental Health Partnership

System of Care Development
and Implementation Manual

Appendices

Appendix A.1. Clinical consultation for child and adolescent mental health providers

Mental Health providers serving children of Adams County have a new resource available. The Adams County Children’s Mental Health Partnership has formed the Child Consultation Group specifically for the purpose of providing individual, child consultation to therapists/agencies needing assistance. The process is designed to be a consultative, problem-solving opportunity to determine whether further evaluation or assessment might be helpful and to recommend evidence informed intervention strategies.

CHILD CONSULTATION GROUP members include:

Mary Dobbins, MD, *Child Psychiatrist, Pediatrician*

Jessica Patel, PhD, *Clinical Child Psychologist*

Chris Parker, LCPC, *Therapist, Clinical Supervisor*

Angel Knoverek, *Therapist, Trauma Specialist*

Eryn Beswick, *Director of Special Education*

The CHILD CONSULTATION GROUP will review one referral per month. Referrals brought to this level of consultation would be those children and families where:

- Multiple treatment approaches have been attempted
- Referring therapist has used his/her agency’s internal consultation/clinical supervision process
- Consultation/problem-solving with all providers of service to this child/family has occurred
or
- A child has received an assessment and the therapist needs assistance with implementing the clinical recommendations

The CHILD CONSULTATION GROUP will provide clinical recommendations to the referring therapist.

A referral will require:

1. Signed consent of the parent/guardian and child 12 years or older.
2. Referral documents provided to the Mental Health Network Coordinator
3. Case presentation to the group on the scheduled date of consultation

To refer a child to the Child Consultation Group and receive the required referral documents, please contact:

Appendix A.2. Mental health coordinator

Child consultation group referral information

Name *DOB (month/date/year)*

Parent/Guardian *Resides With*

Address *City*

Referred By *Agency*

School *Grade*

Primary care Provider

Other Medical Provider(s)

Appendix A.3. Exchange of information

Adams County Children’s Mental Health Partnership Exchange of Mental Health, Medical, Legal and/or Educational Information

PAGE 1 OF 2

Name: _____ **Birth Date:** _____

I am allowing these providers to communicate and exchange information for the purpose of:

- Multi-Agency Staffing Child Consultation Group Other (specify) _____

If I check the box, I consent to information and record exchange with that provider.

Child Consultation Group organizations:

- Adams County Special Education Association
 Chaddock
 Quincy Medical Group
 SIU School of Medicine
 Transitions of Western Illinois

Other providers specific to this child/family:

- Blessing Health Systems
 Child and Family Connections
 Cornerstone: Foundations For Families
 School _____

Type(s) of Information

(Please check appropriate information to be shared)

- Medical (including results of past medical assessment, treatment, results of treatment, recommendations)
- Psychiatric/Psychological (including diagnosis, assessment, treatment plans, current/past treatment progress, medication history, recommendations)
- Educational (including attendance, conduct, expulsions, suspensions, special education, assessment, social history, individual education plans, progress in meeting educational goals, educational recommendations)
- Child Welfare (including incidents resulting in DCFS involvement, Comprehensive Assessment, service plans, progress service plans, placement history, reports to courts, recommendations)
- Legal (arrests, convictions, probation social history, progress on probation, detentions, recommendations)

Appendix A.3. Exchange of information

Adams County Children’s Mental Health Partnership Exchange of Mental Health, Medical, Legal and/or Educational Information

PAGE 2 OF 2

MY SIGNATURE BELOW WILL INDICATE THAT I HAVE READ AND UNDERSTAND THE INFORMATION INDICATED ABOVE TO BE DISCLOSED AND THE INFORMATION THAT FOLLOWS. I understand:

1. That information will only be disclosed when this document is completed and signed by me and witnessed, except as provided by Federal and State Regulations on confidentiality.
2. That this consent may be modified or revoked by me at any time upon written request to the party releasing the information, except to the extent that action has already been taken in reliance on this authorization.
3. That this consent automatically expires one year from date of signature or on _____ whichever earlier.
4. That I have the right to inspect or copy information to be released.
5. That failure to consent to such a release of information means that consultation with the Child Consultation Group will occur.
6. The agency/person receiving information under the terms of this consent are not allowed to further release or disclose said information to any other entity without my specific written consent.

EFFECT OF GRANTING THIS AUTHORIZATION: The protected health information described above may be disclose and/or received by persons or organizations that are not health plans, covered health care providers, or health clearinghouses subject to federal health information privacy laws. However, any mental health, substance abuse, genetic test or HIV/AIDS information disclosed pursuant to this authorization may not be further disclosed, except pursuant to y authorization.

I am willing that a reproduction of this consent be accepted with the same authority as the original.

SIGNATURE OF CLIENT*: _____

SIGNATURE OF PARENT/GUARDIAN: _____

DATE: _____ WITNESS: _____

*Who may sign: 1) Client must sign if 12 years of age or older; 2) Parent/guardian may if client is 12-18 years of age; 3) Parent/guardian must if client is under 12 years of age; 4) If client is 18 years of age and has a guardian, guardian must sign

Child Consultation Group Case Presentation Outline

Name _____ DOB _____
Parent/Guardian _____ Resides with _____
Address _____ City _____
Referred by _____ Agency _____
School _____ Grade _____
Primary Care Provider _____
Other Medical Provider/s _____

Key treatment issues to be presented to the group (details provided in referral)

-
-
-

Child Information

- Current medical and mental health diagnoses
- Treatment and diagnostic history (details provided in referral)
- Brief Medical/developmental history (include significant prenatal, birth, and early development)
- Current medications (include all medical, psychotropic, over-the-counter, and natural supplements)
- Complete medication history
- Current and past legal status (DCFS, probation, parole, charges pending, etc.)
- Current school status (IEP (include eligibility categories), 504, behavior Interventions, achievement, attendance, credits, enrollment stability, etc)

Family Information

- Current and past community supports (formal and informal)
- Current and past significant medical/mental health information
- Current and past legal status (DCFS, probation, parole, charges pending, etc.)
- Child and Family strengths

Mental Health Treatment Plan Summary

- What treatment methods have been tried?
- What part/s of the treatment plan have worked/are working?

School Follow Up Letter/Screening at Registration

School Letterhead)

(insert date here)

Dear _____:

You may remember completing the social-emotional *Checklist* as part of school registration for _____. This checklist is like other types of screening we do at school (such as vision, hearing, speech) and the information gathered can help us learn more about a student's social-emotional development. The checklist results are a reflection of your responses on the day it was completed. Your child's checklist shows that he/she had elevated scores in one or more of the following areas of social-emotional development:

- _____ Increased difficulty in managing stress and may keep this to him/herself.
- _____ Increased difficulty in managing emotions and getting along with others.
- _____ Increased difficulty in focusing and paying attention.

This does not necessarily mean there is a social-emotional issue for your son/daughter. However, it is important for you to be aware in case you have additional concerns or become concerned in the future.

If you would like more information about what your child's social-emotional *Checklist* means, or if you have concerns for your child, you may call: _____.

We have enclosed some information on social-emotional development you might find helpful: *Snapshots of your Child's Social and Emotional Well-being*.

During this school year, students will be learning about social-emotional development through *Second Step* lessons. They will be taught skills for learning, strategies for dealing with stress, managing emotions, and problem solving.

Warm regards,

Principal

School Follow Up Letter / Screening in Health Class

Date

Dear Parent/Guardian:

The Positive Behavior Interventions and Supports (PBIS) program, "Be a Blue Devil," at QHS continues to grow. PBIS is an initiative funded by the Illinois State Board of Education. This program provides a decision-making framework that guides and promotes effective academic and behavioral interventions to benefit all students at QHS. As part of this program, we are attempting to gather further information about our student population to help us gain a better understanding of our student's needs.

With this in mind, students in our health classes have just completed a unit of study related to social, emotional, and mental health. To help us learn more about our students and their social and emotional needs, we are asking each student to complete a short checklist during health class. This checklist is a social-emotional screener and is similar to vision and hearing screenings that are completed at school. The checklist is confidential and will be reviewed only by student support staff. The results of this screener will not be shared in your child's health class. School support staff will contact you by letter or by phone if the checklist completed indicates a concern.

Parent permission for the screener was received during school registration. This screener will be completed in health class on November 9, 2012. If you would prefer that your child NOT participate, please contact your child's health teacher. If you have any questions, please feel free to contact your child's guidance counselor.

Sincerely,

Principal _____



Social-Emotional Checklist – Parent completed

Student Name: _____ **Student ID#:** _____

School: _____ Date of Birth: _____

Grade: _____ Teacher/Counselor: _____

Completed by: _____ Date completed: _____

	Please mark under the heading that best fits your child		
	Never	Sometimes	Often
1. Feels sad, unhappy			
2. Feels hopeless			
3. Is down on him or herself			
4. Worries a lot			
5. Seems to be having less fun			
6. Fights with others			
7. Does not listen to rules			
8. Does not understand other people's feelings			
9. Teases others			
10. Blames others for his or her troubles			
11. Refuses to share			
12. Takes things that do not belong to him/her			
13. Fidgety, unable to sit still			
14. Daydreams too much			
15. Distracted easily			
16. Has trouble concentrating			
17. Acts as if driven by a motor			

Does your child have any emotional or behavioral problems for which she/he needs help? No Yes

Appendix A.7. Social Emotional Checklist—Parent Completed

Additional comments: _____

This instrument is based on the Pediatric Symptom Checklist (psc.partners.org): Jellinek, M., et al. (1988)

Office Use Only			
I items 1-5	E items 6-12	A items 13-17	Total
<input type="text"/> ≥ 5	<input type="text"/> ≥ 7	<input type="text"/> ≥ 7	<input type="text"/> ≥ 15

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Dear Parent/Guardian:

Positive Behavior Interventions and Supports (PBIS) continues to grow at _____ School. We are asking parents to help us learn more about our students and their social/emotional needs. The more we know about our students, the better we can become at supporting minor school challenges before they become bigger problems. We want to be proactive in supporting our students!

Please complete the attached checklist and return it during school registration. The student support team will review the checklist and will follow up with you if additional information or support is recommended for your child at school.

Please feel free to contact the school office at _____ if you have any questions.

Sincerely,

School Principal

QMG Pediatric Developmental Screening Procedure for FP/Peds providers

Reception staff will mail out ASQ 3 and ASQ-SE to all scheduled well child visits (0-5 years) two weeks prior to the scheduled appointment. A letter explaining the forms and asking the parents to complete and return forms at the next visit will be attached.

Reception staff will ask for forms upon check-in for all well child visits. If parents do not have the forms, reception staff will reprint and provide forms for parents to complete while waiting. For children 5-18, reception staff will provide PSC-17 forms at check-in for completion prior to seeing the provider.

Reception staff will deliver completed forms to the office nurse for scoring. Nursing staff will score forms and notify physician of results.

Physician will be able to discuss scores and concerns with patient/family at the visit. Physicians are able to bill code 96110 for each screening tool completed. Billing is often justified based upon the physician's intellectual interpretation of the results and overhead costs for mailings, scoring, etc. We recommend using V202, V799 or V793 diagnosis codes for billing. Mostly the providers are using the V202 which is getting paid.

A patient label should be affixed to completed forms and forwarded to Bryan Main in Behavioral Health for entering into our database.

FOR MORE INFORMATION

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