FULL-SERVICE PARTNERSHIPS PUBLIC LISTENING SESSION THEMES REPORT

October 30, 2024, 12 p.m. – 1 p.m. (Pacific Daylight Time)

Total Registrants: 341, Unique Viewers: 167

Question 1

What are some effective models, or service components, to integrate substance use disorder (SUD) into Full Service Partnership (FSP) teams?

Participant Responses

Common Themes

- **Integration of SUD Services into FSP Teams**: Implement medication-assisted treatment (MAT) services in the field. Include registered and certified substance use counselors on the FSP team. Integrate certified providers in a FSP model that can deliver both services in the same clinic and receive full reimbursement. Support client's access to necessary detox services and medications.
- **Multi-Disciplinary Teams (MDT):** Create MDTs consisting of mental health providers, substance use specialists, peer support specialists, and case managers. Coordinate care with clients. Utilize peer support specialists within MDTs.
- **Training and Incentives:** Provide incentives for practitioners to get training in SUD treatment models, including Motivational Interviewing, Cognitive Behavioral Therapy, and Dialectical Behavior Therapy. Retrain all FSP staff to reduce and remove historic biases and differences between mental health and SUD systems of care.
- **System Navigation and Coordination:** Expand SUD system navigation programs to be more field based, especially in interim housing sites. Implement integrated billing and electronic health records systems. Provide financial support for referral and coordination services with local SUD treatment centers.

Other Responses

- **Challenges and Considerations:** Address the issue of clients seeing multiple providers, which can be a result of high turnover rates. Lower barriers to intake for clients and establish wellness centers run by peers for peers. Eliminate blockades to care for people who clearly meet defined eligibility criteria. Simplify certification standards to allow more efficient use of medical personnel in FSPs that have been designed with a mental health focus to give more clients access to both mental health and SUD services. Employ individuals with lived experience.

Question 2

For FSP teams currently implementing Assertive Community Treatment (ACT) and/or Forensic Assertive Community Treatment (FACT), are there lessons learned that can be shared or resources/supports that would have been helpful for implementation?

Participant Responses

Common Themes

- **Implementation of ACT and FACT Models:** Teams currently implementing ACT and/or FACT should share lessons learned and resources. All FSP teams should be implementing an ACT model to support consistency and effectiveness.
- **Client-to-Staff Ratios:** Enforce client-to-staff ratios to support quality care. Support is needed to maintain low case manager-to-client ratios, specifically less than 1:15. Provide clarification on whether the 1:15 ratio applies to the entire team of providers or just the case manager-to-patient ratio.
- **Integration and Cross-Training:** Integration and cross-training of Peer Support Specialists (PSS) with Community Health Workers (CHW) can provide a workforce capable of caring for individuals with complex comorbidities. PSS salaries must reflect their certification, competencies, code of ethics, and scope of practice.
- **Children and Youth FSP Programs:** Clarify whether children and youth FSP programs are required to integrate with SUD services and whether it is necessary for children and youth FSP programs to utilize certain services.
- **Training and Support:** Train all staff on trauma-informed care, harm reduction, and crisis management to support clarity in individual roles and responsibilities. Provide flex funds for clients, after-hours support, employment supports, and field work capabilities.

Other Responses

- **Remote Work Challenges:** Remote work presents challenges in the ACT model, particularly in managing crises when providers are not physically present.

Question 3

What other components should be looked at when serving individuals under Intensive Case Management (ICM)?

Participant Responses

Common Themes

- **Integrated Teams:** Integrate FSP, ACT, FACT, and ICM teams within the same agency. This integration is intended to prevent fragmentation and implement seamless transitions for patients without entirely changing teams and agencies.
- **Flexible Funding:** Provide flexible funding for items related to gaining employment, education, and basic needs, such as clothing and food. This flexibility is critical for enhancing client engagement and supporting community integration. Clarify if it is required to have the Level 1 (ICM) and Level 2 (ACT/FACT) tiers in the FSP funding category and Level 3 (Outpatient Specialty Mental Health Services) tier in the Behavioral Health Services and Supports (BHSS) funding category, or if it is optional for counties to organize the funding categories in this manner.
- **Trauma-Informed Care:** Incorporate trauma-informed care approaches and support MAT for individuals with SUDs. This approach supports care that is sensitive to the trauma experiences of clients.
- **Community Integration:** Develop services that help individuals integrate into their communities by focusing on building networks outside of service providers. This includes helping people find and heal within their community through hobbies, friends, and other social connections.
- **Medical Advocacy:** Accompany clients to medical appointments to help reduce the negative effects of stigma from medical personnel. This advocacy is essential for helping clients receive respectful and appropriate medical care.

Other Responses

- **Cultural Sensitivity Training:** Train providers on Tribal practices and conduct outreach to their communities for services and education regarding new benefits.

Question 4

Are there opportunities for counties and providers to partner with local entities to implement Individual Placement and Support (IPS)?

Participant Responses

Common Themes

- **Partnerships and Collaborations:** Collaborate with the Department of Rehabilitation to provide employment supports for individuals with disabilities.
- **Educational Pathways:** Utilize resources from community colleges to provide additional educational opportunities for IPS participants. Continue and expand collaborations with Workforce Partnership to provide paid internships, particularly for justice-involved individuals who are being cross-trained as Health Care Home Services (HCHS) providers. Leverage community colleges for career counseling and vocational training programs.
- **Employment and Benefits:** Enhance understanding of the benefits and the impact of employment on eligibility for continued benefits. Clarify the effects of employment on Social Security benefits and the Ticket to Work program. Identify and leverage incentives for local entities to partner with service providers.

Other Responses

- **Family Involvement:** Develop strategies to involve family members in treatment plans for adults in FSPs.

Question 5

How are counties and providers that are currently providing High Fidelity Wraparound (HFW) services aiming to ensure that these services are moving toward fidelity for the Behavioral Health Services Act? Are there specific areas of technical assistance that are needed?

Participant Responses

Common Themes

- **Training and Certification:** Train children's providers on HFW services and consider certification requirements for delivering HFW services to access bundled rates. Review the current training providers and determine if changes or additional providers are needed to meet the training requirements.
- **Standard Outcomes Assessment:** Develop and mandate a standard outcomes assessment based on the Behavioral Health Services Act fidelity model.
- **Utilization of Fidelity Tools:** Implement the Wraparound Fidelity Index and team observation to measure fidelity and support adherence to the wraparound model. Include Community-Defined Evidence Practices (CDEP) in the High-Fidelity Wraparound discussion because this is even more applicable for children and family services.

Other Responses

- **The Center of Excellence:** Support understanding the role of the Center of Excellence in providing training and conducting fidelity reviews for state-required programs.

Question 6

Please provide feedback on the proposed levels of care.

Participant Responses

Common Themes

- **Fragmentation of Services:** Fragmentation of services across different teams and agencies leads to patients being shuttled around different agencies, which can be detrimental to their care and should be limited.
- **Transitions of Care:** Transitions from ICM level to outpatient care can cause significant disruption for consumers. When multiple providers are involved, it can lead to a lack of continuity in care. Support in-person handoffs from one level of care to another to minimize disruption. There should also be mechanisms for individuals to move back to higher levels of care (e.g., FSP) if needed. Develop swift intervention at key care transition points
- **Continuity of Care:** Continuity of care is crucial, especially for Specialty Mental Health Services (SMHS) and FACT/ACT/FSP. Maintain continuity of care by keeping services within the same agency and providing a single point of contact for clients in FSP and ICM programs. Establish presumptive eligibility for FSP programs for people at critical transition points—including those with serious mental illness, co-occurring SUDs, experiencing homelessness, exiting incarceration or institutionalization, following repeated mental health crises, or hospitalizations.
- **HFW and Age Groups:** Clarify whether HFW is required for children and youth (birth to 17) and whether FSP services are required for ages 18-25.
- **SUD Services:** Clarify if individuals with serious SUDs can access FSP services and consider how outpatient SUD services will be managed during step-down transitions.

Other Responses

- **Outreach and Engagement:** Build outreach and engagement into both FSP and ACT models. Allow outreach and engagement as standalone services for hard-to-engage individuals, as adoption of FSP and ACT may take a long time. To reduce state and county cost pressures, recommend that counties not be

required to enroll eligible individuals beyond the number of available FSP slots available through Behavioral Health Services Act funding.