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IPRTF Behav. Health
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Gaps and Challenges in Service Coordination

Silos, Discontinuity, and Weak Handoffs:

Lack of Aftercare and Connecting Care

Need a point of contact outside of the ED to help connect the public to services in the community

Increased wrap around and intensive CM for true Housing First Programs

Inpatient and outpatient providers won't take referals from jail, espcially for medication mgmt

Connection to MH services (meds, CM, etc.) BEFORE leaving jail or One Central

Rapid mobility (team) for transition from discharge to stability support

Little access to medical prescribers

More police BH joint outreach

Cross system outreach with ongoing care coordination as necessary

Quick response to diagnostic resources and MH interventions

Monitoring Accountability

Lack of trust between agencies; fear of taking on new referals (over-whelmed system)

LE and Social Services/BH don't have time to develop relationships

Involuntary commitments released too soon

Lack of coordination bwtn SUD + MH for co-occuring

Lack of communication between siloed services

Ineffective Outreach

People slip through the cracks because they don't want offered services

Outreach should be highly mobile and flexible

Staffing Resources

Compassion vs. Wisdom (need more training)

Unmet Needs

Medically Fragile Individuals

Medication mgmt post jail discharge

Misc.

Care plan due by medicaid is not read or shared

Solutions - Service Coordination

Cross Agency Director/Specialists

Cross-system teams that work together for complex clients and identify "Responsible Agency / Program" for case mgmt. clients within multidisciplinary tream

Consider a central place "hub" for referal

Shared system of care with accountability

Community based care coordination

Partnerships between behavioral health + criminal justice systems

Care coordination navigator

Ownership of system by all partners

Outreach in the home

Continuum of care to follow ppl into housing

Training / Skills building for professionals

Better utilization and understanding of LRO process / Option

Trauma informed care commitment to long term relationship building by caregivers and contacts (fire/police)

Reach beyond traditional social services

Support economic opportunity income building activities

Gaps and Challenges in System Communication and Informational Sharing

Poor relationships with public/clients

Personal bias of responders (frustration, perpetuate dis-trust cycle)

Trauma informed trainings needs for those to create engagement

Client voices in solution
Relationship building

Law Enforcement Smaller town: talk them into egagement is best

Progressive engagement
Hope yields - buy in to engagement

Poor administrative follow-up

LRO's not enforced

Hospital unable to figure out what they want (We stabilize them, info exchange is a barrier, care plan due by medicaid not read or shared)

Access to Client Data

Communication after ITA for follow-up

Communication after ITA to improve follow-up

Database / Communication tools
Ability to communicate more effectively with law enforcement within the community

Info exchange is a barrier

Don't have consistent way to share information
Communication / Database platform for multi-agency sharing
Barriers to sharing BH client info w/ law enforcement

Not enough social service staff available after 8-5 M-F / No actionable info for L.E. after hours from soc svs, BH (e.g. meds, diagnosis, triggers, which agency servicing client, etc)

Coordinated communication need

Solutions - System Communication and Information Sharing

Centralized Database Management and Access

System for sharing data efficiently and legally, client-specific
With a responsible agency for maintaining the info system
Database sharing (forums/webpages/faq) "facebook" for MH providers and supportive agencies and City of Bellingham
Technology that allows data sharing
Information sharing in place: -BPD - Detox -Triage -Hospital - Medical -LHM -Housing -Crisis -CPT -HOT
Resource guide for police officers
Can't share presonal info, access system
Coordinated communication / Info sharing for best outcomes
The ability to sign one document to enable information sharing (SS + HE Exchange)
Technology that allows data sharing

Shared definitions and criteria

Who is it that we can't serve?
Clear way to identify 'x' of highest utilizers

What's the minimum data set of interest to each team member?

Language defining appropriate term to identify people

Gaps and Challenges in Resource Allocation

Behavioral Health and SUD Treatment Svcs

Lack of B.H. svcs for medicare beneficiaries

No effective Tx for some (e.g. personality disorders)

Psych unit should be staffed to deal w/ behavior instead of calling LE for support

Workforce issues: Trauma, Stigma, Sexual Orientation and Transgender

Agency / Person to do legwork necessary to get MH/Substance Tx

Substance abuse and treatment increase

More case managers + mental health services

More IOP or PACT options

Limited Services at Jail

Expanded behavioral health svcs @ jail

Release from jail for 71.05 proceedings

More BH services in the jail

Staff Investment

Lack of Stable + Trained staff (retention issues)

Housing and On-site Services

Lack of housing access

Need for co-occuring recovery house

Need different housing options: safe camps, safe parks, tiny homes shelter

Flexible MH services that can deliver services in homes when a MH crisis occurs to help keep folks stable. *embedded in housing programs

Insufficient Scope

High needs but not eligble for housing, not chronic

Shelter for folks not eligible for LHM

People with personality disorders

People with trauma so bad they can't move forward

Physical / Geographic Problems

Transportation and lack of resources in the county

Hospital

Hospital and resources

Redesign of hospital care management = reduced MHP out of compliancy with 3 hr rule prior to calling DMHP = potential to drop 72 hr commitments then release to community untreated without MH treatment. Recommend: staff for social workers/MHPs

With SJMC Behavioral health redesign, increase in pyschiatrist provider time to avoide inabliity to take SBC's

Solutions with Resource Allocation

Areas for Expansion / Funding Wishlist

Effective BH treatment w/in the jail and place to evaluate

skills integration training - personal agency and autonomy skill training

Alternative Housing Options (safe camp, safe park, tiny houses)

Creating services that meet clients where they are and use progressive engagement for coordinated services

How to support involuntary commitments outside of jail system

dedicating highly skilled resources to this effort

Misc.

Policy level front door decision making group (youth?) who's eligible to serve and how to overcome barriers

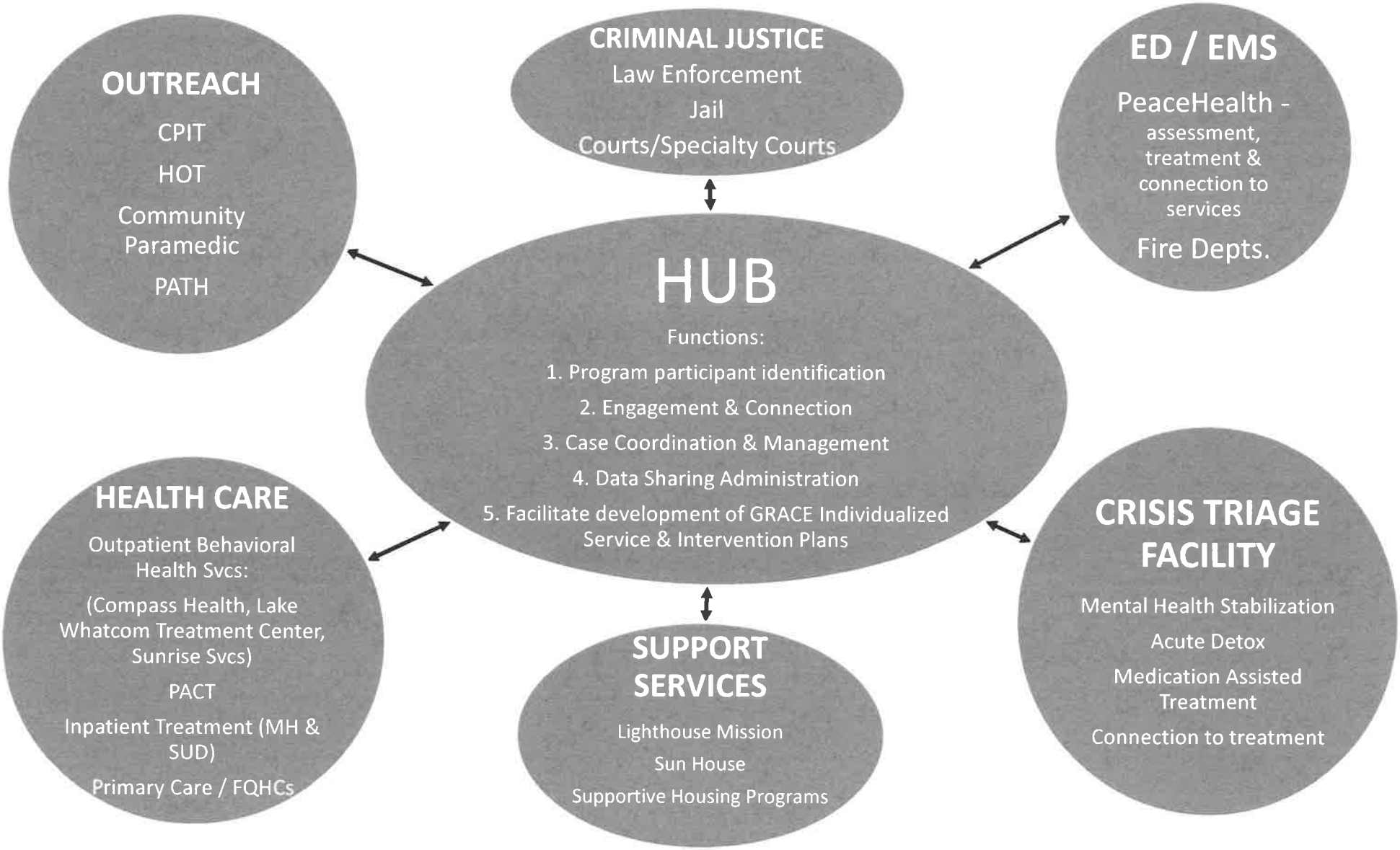
How to support involuntary commitments outside of jail system

Convene broader conversation about funding

The problems are very evident downtown

Gaps and Challenges with Scale	
Medical Respite/Recovery beds -> same for SUDs treatment and MH treatment	*Integrated Housing Support Services*
Loss of services (housing, insurance, etc.) during incarceration	Lack of housing with on-site services Low barrier shelter Housing first
Scale: We have effective interventions they are not yet funded to scale	Supported housing (too little) Housing after jail, treatment, psych unit
Need capacity in: AFH, SNF for some	Lack of mobile MH and medical services in housing For homeless youth: more housing, timely, available
Limited by federal funding requirements	Housing for meth-affected individuals
Siloed eligibility definitions	*BH / Soc. Svc Professionals* Lack of support to individuals Lack of substance abuse treatment
	M.H. Long-term outpatient care for people ineligible for medicaid
	Medication management Case managers More focus and resources for vulnerable families to prevent future high utilizers Create more dedicated resources (housing, care providers, etc.)
Scale / Expansions Solutions	
Drop-in center (Continue)	Contiuum of housing with service enriched options
Stable/consistent/trained outreach and ICM capacity to meet needs. In and out of city limits w/ mobile staff.	Lack of patient supportive treatment
Increase options where to go	Bring services to where people are

FUNCTIONAL STRUCTURE



ADMINISTRATIVE STRUCTURE