COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

PROGRAM SUPPORT BUREAU – MHSA IMPLEMENTATION AND OUTCOMES DIVISION

FSP Integration Pilot Project Summary

July, 2013 – June, 2015

Precursor Project: The Increasing Client Service Capacity (ICSC) Learning Collaborative: March 2010 – September, 2011

The Los Angeles County Department of Mental Health (LAC DMH) and 4 contract providers participated in the California Institute for Mental Health's Increasing Client Service Capacity Learning Collaborative to develop and test out and scale up strategies to increase client flow and increase service access. The learning resulted in the establishment of a pilot to expand the scope of Full Service Partnership (FSP) programs to include California Mental Health Directors' Association (CMHDA) Adult System of Care Level of Care 4 and 3 services and serve a slightly broader array of clients.

Providers: Didi Hirsch Mental Health Center (SA 5), Mental Health America- Los Angeles (SA 8), Exodus Recovery Wellness Center (SA 6), Center for Aging Resources – Heritage House (SA 3).

Key Learning That Promoted Increased Flow and Access

- Expectation expressed at the beginning of services that recovery does occur through client and staff consciousness raising.
- Creating a *flexible* service array of recovery-oriented services that reflects stage of wellness and recovery.
- Inclusion of peer-delivered support services.
- Minimize service transitions by creating more robust integrated treatment teams across programs funded within the CSS Plan.
- Create linkages and enhance access to primary care and dental care.
- Utilization of person-centered, strength-based intake processes.
- Utilize effective self-management supports, such as structured group modules to teach client self-sufficiency, coupled with incentives geared toward helping clients connect to their community (DIY Groups and Activity Captain funds).
- Collect and use data for improvement and for decision-making, particularly a recovery measure (the MORS) that is collected monthly and used in team meetings and supervision to facilitate recovery-based, strength-based decision-making.

Over the course of 18 months, the 4 providers:

- Enrolled **455** new clients
- Transitioned **93** clients to lower levels of mental health care
- Transitioned **217** clients to the community, out of the mental health system

FSP Integration Pilot

- As part of a 2 year pilot, 4 adult mental health providers and 2 older adult providers fiscally and programmatically integrated Field Capable Clinical Services (FCCS, level 3) into Full Service Partnership (FSP, level 4) services so that all clients are considered FSP, as long as each client meets FSP criteria as defined in the MHSA CSS regulations.
- Pilot providers included: Adults - Didi Hirsch Mental Health Center, Exodus Recovery, Mental Health America Los Angeles, and Pacific Clinics; Older Adults – Center for Aging Resources and Telecare.

- Eligibility for the newly integrated FSP population is the expanded definition of FSP as defined by the California Department of Mental Health (MHSA CSS Regulations).
- Each client receiving services from a pilot agency is rated monthly on the Milestones of Recovery Scale (MORS) to determine level of recovery as well as rated on 8 care determinants that are matched to level of service need (see below).
- Providers collect FSP outcome data on all clients.
- FCCS funding was transferred to FSP on each agency's financial summary, to be used consistent with FSP services and consistent with the Recovery Model.
- The Older Adult Pilot was initiated in April, 2013 and the Adult pilot started in July, 2013.
- All clients in the pilot are eligible for Client Supportive Services funding, based on LAC DMH Client Supportive Services Guidelines.

Pilot Goals

- Reduce distinct financial service categories and broaden the FSP target population to be consistent with the State regulation, thereby maximizing flexibility in using MHSA funds, enhancing services for clients of varying service intensity, increasing access to FSP services, and best meeting client needs.
- Maximize the number of clients seen (expanded service capacity) and see people sooner in the process before they decompensate.
- Provide the appropriate type and amount of service the client needs in a data-informed manner.
- Increase client program flow (to both improve client functioning and increase service capacity) and determine optimal length of treatment.
  a. Flow from the pilot (Level 4 and Level 3 to Level 2 Wellness Center or Outpatient services).
  b. Flow within the pilot (Level 4 to Level 3).
  c. Determinants used to inform readiness for transition to a lower level of service.
- Ensure services are cost effective.

Assessing Pilot Success

- The determinants of level of care are:
  1. Client's current MORS score.
  2. Client is unable to manage his/her own financial resources and requires formal or informal money management.
  3. The client is not ready or is unable to coordinate his/her own transportation needs to and from appointments, education and occupation activities, and or other meaningful life activities.
  4. The client requires formal or informal assistance with 2 or more of the following ADLs: hygiene, shopping, feeding, household chores, preparing meals, transferring, walking.
  5. The client requires at least once per week contact with staff to coordinate his/her care.
  6. The client requires formal or informal assistance or support to manage his/her medication.
  7. The client requires assistance or support to manage community relations and minimize disruptive behaviors.
  8. The client has been stable at the current MORS score for less than six months.
- The "Rules for Assigning Level of Care" are addressed in the attached document [Attachment A].
- Providers consider outcomes data in the following areas: 1) FSP Integration Pilot Project Aggregate Client Change in Level of Care; 2) Analysis of Length of Treatment; 3) Aggregate Analysis of Improvement in MORS Score; and 4) Aggregate Client Need for Assistance with Particular Determinants (Change Over Time) [See Charts 1 – 4].

Elements of Success in Transitioning Clients from Level 4 to 3

- Stable housing
- Access to a variety of treatment options for substance use
- Family reintegration and the role of the FSP team as either a broker or family finder

- Stable medication through establishing shared decision making, client preparation and trust building, client education
- Employment/education and increasing meaningful roles for clients through creating a menu of options, IPS Supported Employment, employing job developers, increasing client motivation to work, addressing the risk of loss of SSI.
- Improving physical health through service co-location, peer health navigation, provider screening and identification of health issues.
- Creating stable income
- Establishing some form of health insurance
- Transportation options for clients, including educating peers on options
- Recreational opportunities – identify client preferences, community resources and establish peer support and partnerships
- Create social connections via cultural celebrations and opportunities in communities
- Identify spiritual interests and options
- For additional details, see FSP Integration Pilot Best Practice Elements for Success [Attachment B].

The Impact of the Pilot

- Clinical decision-making once guided solely by clinician judgment has evolved to the use of the Determinants to help measure client need and guide service delivery.
- The Determinants have helped guide clients' transition from one level of care or need to another.
- The pilot has facilitated the creation of a provider developed culture of sharing information, challenges, and successes.
- Client care has been delivered with the use of data-driven decision making.
- Thirty-five (35) percent of clients were dis-enrolled due to meeting goals or moving to lower level of care.
- For specific impacts, see attached "Benefits of FSP Integration Pilot" [Attachment C].

RULES FOR ASSIGNING LEVEL OF CARE

(For use with level of care determinants grid)

LEVEL OF CARE	RULE PARAMETERS
5 Residential/inpatient services for people who are gravely disabled or are currently a danger to self or others	**1. If MORS score is a 1 then LEVEL OF CARE is a 5**
4 **High Intensity Community Based OP**	**1. If MORS score is a 2 or 3, then LEVEL OF CARE is a 4** **and/or** **2. If sum of determinants equals 5 or more, then LEVEL OF CARE is a 4** **and/or** **3. If sum or determinants equals a 3 or 4 *and* one of those determinants is required weekly care coordination, then LEVEL OF CARE is a 4**
3 **Moderate Intensity Community Based OP**	**1. If sum of determinants equals 3 or 4 *and* required weekly care coordination IS NOT one of those determinants, then LEVEL OF CARE is a 3** **and/or** **2. If sum of determinants is 2 or less *and* MORS score is 4 or 5, then LEVEL OF CARE is a 3** **and/or** **3. If sum of determinants is 2 or less *and* MORS score is 6 or 7 *and* the client has been stable at the current MORS score for less than 6 months, then LEVEL OF CARE is a 3**
2 **Wellness Services**	**1. To be determined: All other clients not meeting above rules will be assigned to LEVEL OF CARE 1 OR 2.**
1 **Recovery Maintenance**	**1. To be determined: All other clients not meeting above rules will be assigned to LEVEL OF CARE 1 OR 2.**

- These rules should be used during the initial assessment phase to assign a level of care at enrollment
- These rules should be used monthly during a clinical staff discussion to reassess clients and their progress along the recovery continuum
  - Level of care assignments should be utilized to facilitate client flow toward lower levels of care
  - Specific determinants should be utilized to identify barriers to recovery, develop objectives and design interventions to help clients move along the recovery continuum

FSP Integration Pilot Best Practice Elements for Success

A) Elements of Success in Moving Clients to Level 3

1) Stable housing
    - Identify strategies to identify housing options
    - Goal of permanent supportive housing

2) Sobriety/harm reduction
    - Access to variety of treatment options
    - Willingness to engage (stage of change)

3) Family reintegration (rebuilding family relationships)
    - Family psycho-education
    - Willingness of staff to serve as broker
    - Family finding

4) Stable medication regime
    - Client-informed /shared decision making
    - Client preparation and trust building
    - Client education

5) Employment/education/meaningful role
    - Identify menu of client-desired options
    - Individual Placement and Support (IPS)
    - Identify job and employment opportunities
    - Job developers
    - Client motivation
    - Risk of loss of SSI

6) Physical health
    - Co-location with physical health
    - Peer health navigation
    - Provider screening and identification of health issues

7) Stable income
    - Government benefits or employment (see above)
    - Benefits specialists
    - SSI/SSDI Outreach, Access, and Recovery EBP (SOAR)

8) Health insurance
    - Medicaid

9) Utilize transportation
    - Check for EBP
    - Foothill Transit/other bus companies
        - Community outreach and education
    - Rider Relief Program (vouchers and tokens)

- Peer education

10) Recreational outlet
    - Menu of recreational opportunities
    - Identify client preferences
    - Identify community resources
    - Peer support/partnership

11) Social connections
    - Cultural celebrations
    - Menu of social opportunities
    - Need to expand beyond internal (within the agency) relationships

12) Spiritual connection
    - Identify spiritual desires
    - Identify spiritual options

B) <u>Elements of Success in Creating Improvement in Each of the Determinants</u>

1) MORS Score
    - Community integration (finding meaningful role in the community)

2) Money Management
    - Teaching people how to manage their money

3) Getting Where You Need to Go
    - Learning how to use public transportation/Access

4) Activities of Daily Living
    - All seven items on Determinant #4

5) Coordinating Care

6) Managing Medication

7) Interpersonal Relationships

BENEFITS OF FSP INTEGRATION PILOT

IMPACT AREA	PRACTICE/PROCESS BEFORE PILOT	IMPROVEMENT IN PRACTICE /PROCESS AFTER PILOT
FINANCIAL ALLOCATIONS IMPACT ON CLIENT NEEDS AND TRANSITIONS	1) Clients have remained in an FSP (L-4) program even though they are engaged/stable because available dollars have existed at FSP level. FCCS (L-3) programs have been consistently underfunded/at capacity system wide. 2) Due to FCCS financial limitations, clients have had difficulty transitioning effectively from FSP (L-4) to lower levels of care.	1) The Pilot has allowed participating agencies to learn/demonstrate the management of funds based upon the clinical needs of the client(s), with the ability to move clients easily within levels of care (L-4, L-3) and design relevant service delivery packages to best meet their needs. 2) Clients who ultimately move to a lower level of care experience less recidivism, with a more comfortable transition from L-3.
CLIENT SUPPORTIVE SERVICE (CSS) FUNDS	1) LAC DMH's guideline regarding the restriction of access to CSS funds* outside of the traditional FSP program have prevented clients from moving into lower level services (L3, L2), thus limiting capacity at L4. * CSS funds are most frequently utilized to assist clients with: • Housing subsidies and moving expenses • Eviction prevention • Supplement to expenses of daily living for clients without SSI • Transportation expenses • Educational/employment expenses and materials 2) CSS funds can only be used to pay salaries for Peer Staff within FSP programs, thereby limiting the use and of Peer staff and the overall effectiveness of the workforce.	1) Expanded FSP program makes CSS funds available to both L-4 and L-3 clients. a) Allows for extension of housing subsidies, thus granting more time for clients to access and be approved for permanent housing. b) Clients can be accommodated with daily expense supplements while waiting long periods for SSI to be approved. c) Clients further along the recovery scale can utilize CSS funds for educational/employment expenses. 2) Additional Peer staff may be utilized a lower level of care, where they are very effective.
NAVIGATOR BASED FSP AUTHORIZATION PROCESS	Referrals to Service Area FSP programs have been controlled by Navigators, with variable response times -- sometimes slow and sometimes no response to requests for authorization for enrollments/dis-enrollments submitted by providers. This has negatively affected not only enrollments/dis-enrollments, but also continuity of care in transitions between levels of care.	1) Program clinical staff is empowered to assess and enroll clients to the appropriate level with the use of the DMH Focal Population Notification form process, allowing for rapid enrollment at the program level. 2) Program clinical staff can quickly dis-enroll clients who are ready to graduate to a lower level of care, creating client flow and making more room for new clients entering FSP.
ADMISSION/ENROLLMENT GUIDELINES	Highly restrictive guidelines were established for admission to FSP programs.	Expanded FSP guidelines allow SMI individuals to access treatment prior to decompensation (see attached examples).
PILOT SPECIFIC CLINICAL TOOLS		Clinical tools developed for use by pilot agencies have influenced assignment and use of specific objectives and interventions, helping to move clients along the recovery continuum. Determinants and scoring rules are beginning to shape clinical practice and improve client flow.

FSP INTEGRATION PILOT
SUCCESSFUL EXAMPLES OF CARE PREVENTING DECOMPENSATION

1. A client who was recently enrolled in the Pilot lives in his car and, although he had no history of chronic mental illness, over the last year he had been experiencing depression symptoms that were increasing in severity and his homelessness and chronic untreated health complaints posed a risk to his mental stability. According to the psychiatrist, his prognosis was poor for symptoms to remit without treatment, and instead was likely to worsen. Due to his lack of history of mental health services, a traditional Level 4 referral would not have been approved. Because the agency was able to "fast track" enroll him into the Pilot, they were able to ameliorate the barriers to symptom reduction and ensure that his immediate mental and physical health needs were addressed before becoming critical and necessitating hospitalization, when he would have qualified under the County's old stricter Level 4 definition.

2. A 56 year old woman with a long history of mental illness stemming from trauma related to a violent upbringing in Columbia had multiple hospitalizations usually precipitated by suicidal thoughts/attempts. She had remained out of the hospital for several years prior to enrollment due to self- medicating with alcohol and the support of a significant other. After the significant other died, the client struggled with both her depression and alcoholism. Rather than seeking hospitalization, she was referred to an FCCS program and then transitioned into the Pilot. Since enrollment, client has embraced all the interventions offered through the FSP Pilot. Client has not required hospitalization and has experienced longer periods of sobriety than she had at any other time in her adult life.

3. A 30 year old woman, having just completed an in-patient drug rehab program, sought mental health services. At assessment, she identified a long-standing mood disorder and frequent suicidal ideation but had a history of only 2 prior hospitalizations, neither of which was in the past several years. She would not have qualified for traditional FSP but was enrolled in the Pilot. At enrollment, client was provided housing, case management, therapy and medications. She has psychiatrically stabilized, remained sober, is now working full time, and is in the process of regaining custody of her 3 children.

4. A 49 year old man was referred having reported a history of multiple incarcerations, though none for the previous 3 years. He had received no prior mental health services but had been self- medicating with crack cocaine. When sober, he reported experiencing depression, periods of confusion, inability to manage daily stresses and paranoia. Since being enrolled in the Pilot and provided with medications, case management and rehab therapy, he's completed two semesters at a community college, remained sober, and is currently living back with his significant other and their child.

5. A 60 year old African American male who frequently wandered the streets and hoarded vehicle parts was referred by the Inglewood Police Department. Client's basic life skills were severely impaired, and included difficulty managing money and social isolation. Upon enrollment, client's speech was disorganized, client was suspicious of others, and client refused medication. With FSP Pilot enrollment, the client became medication compliant, entered therapy, accepted case management, and has built a close working relationship with staff. Client now has insight into his symptoms, has maintained housing, and obtained part-time employment.

FSP Integration Pilot Project

Aggregate Client Change in Level of Care

Change in Level of Care Over a 6 Month Period	Month of Enrollment											
	February 2014 to July 2014 (N=26)		March 2014 to August 2014 (N=39)		April 2014 to September 2014 (N=35)		May 2014 to October 2014 (N=35)		June 2014 to November 2014 (N=35)		July 2014 to December 2014 (N=24)	
	N	%	N	%	N	%	N	%	N	%	N	%
Level 4 to Level 3	0	0%	0	0%	0	0%	0	0%	0	0%	2	8%
Level 4 to Level 2	12	46%	29	74%	25	71%	23	66%	19	54%	13	54%
Level 3 to Level 2	6	23%	3	8%	2	6%	2	6%	8	23%	4	17%
Maintained Level 4	1	4%	0	0%	0	0%	0	0%	0	0%	1	4%
Maintained Level 3	1	4%	3	8%	1	3%	4	11%	0	0%	0	0%
Level 4 to Level 5	0	0%	0	0%	1	3%	1	3%	2	6%	1	4%
Level 3 to Level 4	1	4%	1	3%	1	3%	2	6%	1	3%	2	8%
No Contact with Consumer	0	0%	1	3%	3	9%	3	9%	2	6%	1	4%
Issues with Enrollment Status	5	19%	2	5%	2	6%	0	0%	3	9%	0	0%

Analysis of Length of Treatment

A. Pre-Pilot FSP average length of stay (LA County DMH data)	VS.	Average length of stay for clients coming in at Level 4 starting October 1st
B. Pre-Pilot FCCS average length of stay (LA County DMH data)	VS.	Average length of stay for clients coming in at Level 3 starting October 1st

Aggregate Analysis of Client Improvement

Milestones of Recovery Scale Intake/Follow Up Contingency Table

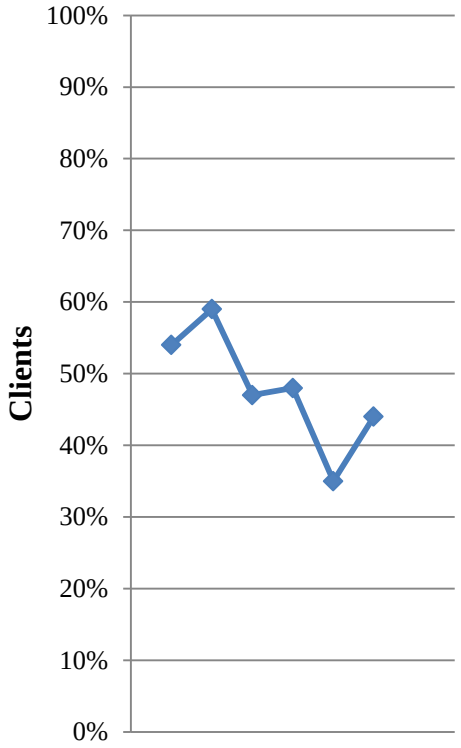
					FOLLOW UP																	
				N at Follow up																		
				% at Follow up																		
				% Change from Intake																		
					1		2		3		4		5		6		7		8			
	N at Intake	% at Intake			Extreme Risk		Experiencing High Risk Unengaged		Experiencing High Risk Engaged		Poorly Coping Unengaged		Poorly Coping Engaged		Coping /Re-habilitating		Early Recovery		Advanced Recovery		Missing or No Data	
			1	Extreme Risk																		
			2	High Risk, Unengaged																		
			3	High Risk, Engaged																		
INTAKE			4	Poorly Coping, Unengaged																		
			5	Poorly Coping, Engaged																		
			6	Coping, Rehabilitating																		
			7	Early Recovery																		
			8	Advanced Recovery																		
				Missing or No Data																		

Level of Care Intake/Follow Up Contingency Table

					FOLLOW UP									
				N at Follow up										
				% at Follow up										
				% Change from Intake										
					5		4		3		2		1	
	N at Intake	% at Intake			Inpatient or Residental Care		High Intensity Community Based Outpatient		Moderate Intensity Community Based Outpatient		Wellness Centers and Standard Outpatient		Recovery Maintenance Client Run Centers	Missing or No Data
			5	Inpatient or Residential Care										
			4	High Intensity Outpatient Care										
INTAKE			3	Moderate Intensity Outpatient Care										
			2	Wellness Centers and Standard Outpatient										
			1	Recovery Maintenance and Client Run Centers										
				Missing or No Data										

Aggregate Client Need for Assistance with Particular Determinants (Change Over Time)

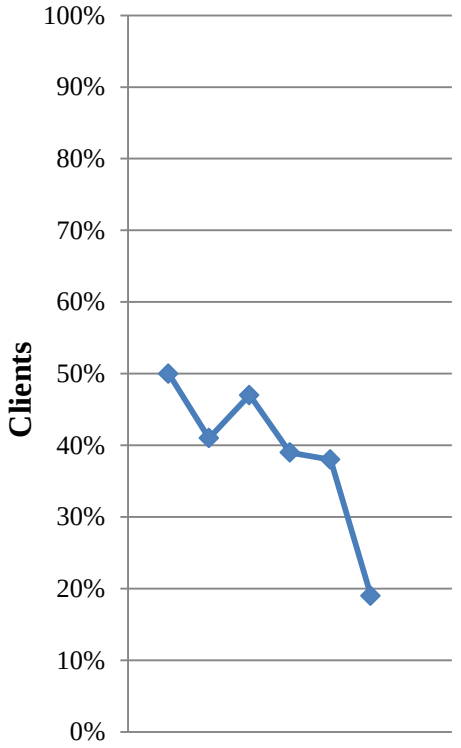
(1) Money Management



	Admiss	Mo 2	Mo 3	Mo 4	Mo 5	Mo 6
MoneyMgt	25	24	18	16	9	7
Total	46	41	38	33	26	16
Percentage	54%	59%	47%	48%	35%	44%

*Only includes members with data at the initial point

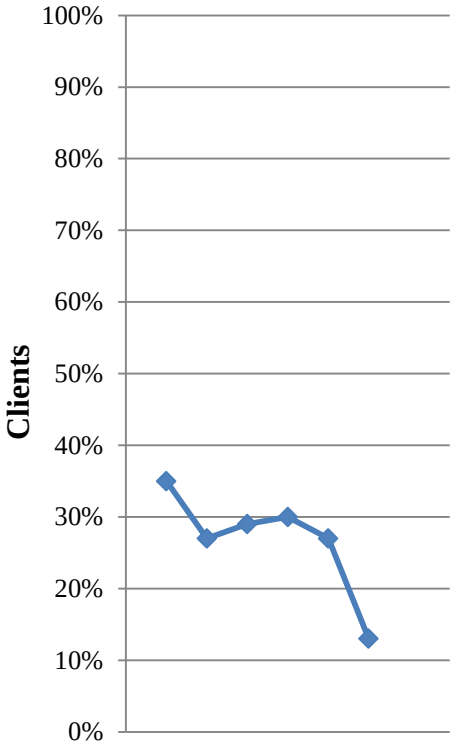
(2) Transport



	Admiss	Mo 2	Mo 3	Mo 4	Mo 5	Mo 6
Transport	23	17	18	13	10	3
Total	46	41	38	33	26	16
Percentage	50%	41%	47%	39%	38%	19%

*Only includes members with data at the initial point

(3) ADL

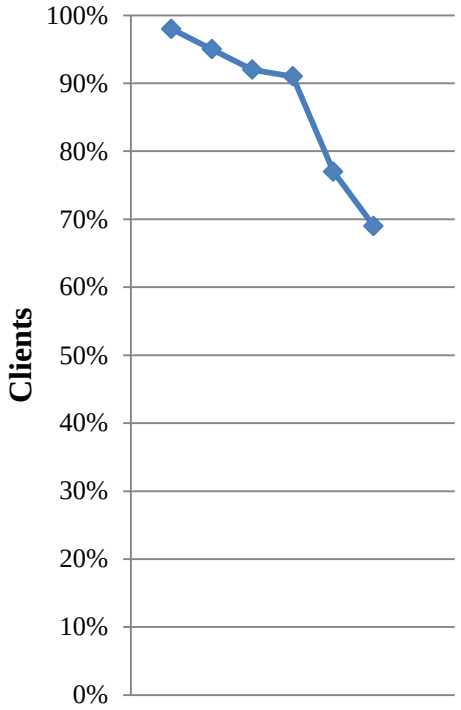


	Admiss	Mo 2	Mo 3	Mo 4	Mo 5	Mo 6
ADL	16	11	11	10	7	2
Total	46	41	38	33	26	16
Percentage	35%	27%	29%	30%	27%	13%

*Only includes members with data at the initial point

Aggregate Client Need for Assistance with Particular Determinants (Change Over Time)

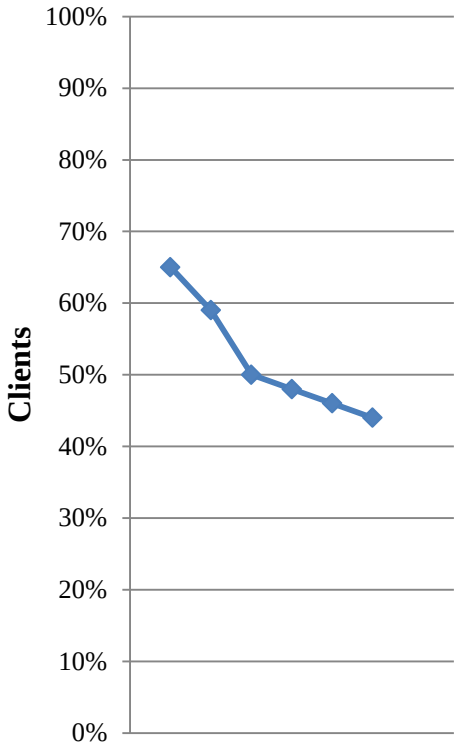
(4) Weekly Care Coordination



	Admiss	Mo 2	Mo 3	Mo 4	Mo 5	Mo 6
WklyCoord	45	39	35	30	20	11
Total	46	41	38	33	26	16
Percentage	98%	95%	92%	91%	77%	69%

*Only includes members with data at the initial point

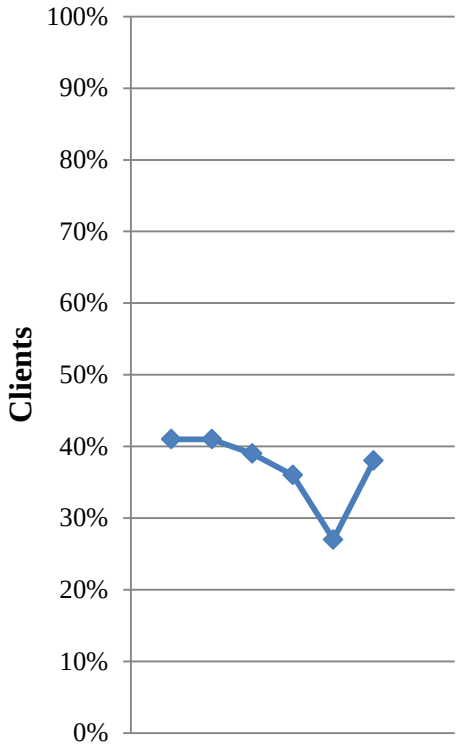
(5) Med Management



	Admiss	Mo 2	Mo 3	Mo 4	Mo 5	Mo 6
MedMgt	30	24	19	16	12	7
Total	46	41	38	33	26	16
Percentage	65%	59%	50%	48%	46%	44%

*Only includes members with data at the initial point

(6) Comm Relations

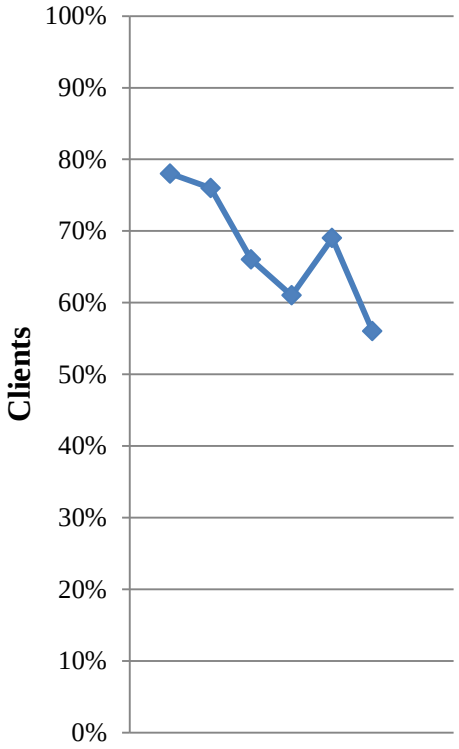


	Admiss	Mo 2	Mo 3	Mo 4	Mo 5	Mo 6
CommRels	19	17	15	12	7	6
Total	46	41	38	33	26	16
Percentage	41%	41%	39%	36%	27%	38%

*Only includes members with data at the initial point

Aggregate Client Need for Assistance with Particular Determinants (Change Over Time)

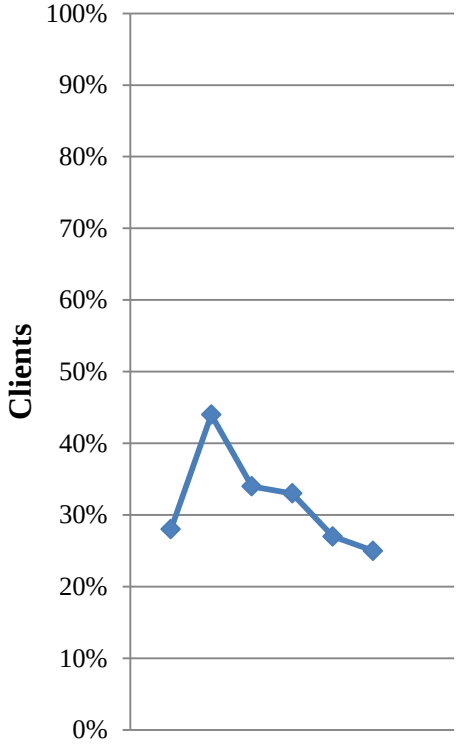
(7) Stable < 6 Months



	Admiss	Mo 2	Mo 3	Mo 4	Mo 5	Mo 6
Stable<6Mos	36	31	25	20	18	9
Total	46	41	38	33	26	16
Percentage	78%	76%	66%	61%	69%	56%

*Only includes members with data at the initial point

(8) Flex Funds



	Admiss	Mo 2	Mo 3	Mo 4	Mo 5	Mo 6
FlexFunds	13	18	13	11	7	4
Total	46	41	38	33	26	16
Percentage	28%	44%	34%	33%	27%	25%

*Only includes members with data at the initial point