Full Service Partnership (FSP) Transformation FAQ

Background

FSP transformation is an evolving initiative that will include iterative cycles of refinement in policy and implementation. Some aspects of transformation will be clarified once implementation is underway and feedback is gathered from providers to determine best practices for FSP moving forward. This document is produced by the DMH-UCLA Public Mental Health Partnership (PMHP) with input and review from the LA County Department of Mental Health (DMH).

What is the overarching vision of FSP transformation?
FSP transformation aims to increase focus on persistent and committed engagement of clients with severe mental illness/severe emotional disturbance with high levels of need, provision of services from a team-based and comprehensive approach, and use of client outcome data to help ensure high-quality care. The transformation process will involve integrating FSP programs (i.e., age groups and specialty sub-programs) and positioning teams to serve the full range of the FSP focal population to increase capacity and accessibility of services. Priority client-level outcomes (outlined below) will guide incentive payment structures for providers to encourage improved treatment outcomes among FSP clients. The transformation initiative is intended to enhance consistency and coherence across FSP teams while allowing sufficient flexibility to retain unique strengths and innovations among providers and programs.

How can providers offer feedback about successes and challenges related to FSP transformation to guide on-going DMH planning efforts?
PMHP offers multiple learning exchanges that will serve as a vehicle to gather feedback from providers. PMHP will collect and synthesize lessons learned and ongoing issues related to transformation efforts and help communicate relevant information to DMH. We host forums for DMH to disseminate on-going information to providers, and for directly operated and contracted providers to share learning amongst peers. Currently, learning exchanges for the following groups are available: FSP supervisors, psychiatrists and psychiatric nurse practitioners, case managers, and FSP navigators. If you are interested in joining a learning exchange, please email us at pmhp@mednet.ucla.edu.

What is the timeline for FSP transformation?
As of July 1, 2021, age groups and FSP specialty programs will become integrated (discussed further below). Incentive payments related to some priority outcomes (also outlined below) will be implemented as of July 1, 2021. Staffing ratios are expected to align with the 1:10-12 guideline as of July 1, 2021.

Team Model, Staffing & Salaries

What is a team model of service delivery?
A team model of service delivery is based on the notion that clients will be served by an entire FSP team with varied expertise. One team member will continue to serve as the client's primary clinician, but clients should be seen by multiple team members regularly. For example, a typical client should meet with at least 2 or 3 different team members on a regular basis. Most or all team members should serve each client in some manner at some point in time. Rather than thinking of an individual provider as carrying a separate caseload, it is recommended that the

team view workloads as spread across all providers on a team (see FSP Service Exhibit for further team operational policies).

What staffing patterns will be expected for Adult FSP?
The table below outlines Adult FSP staffing patterns **recommended** by DMH:

Recommended Staffing for Adult Teams Serving 100 Clients (up to 120)	FTE
Team Leader / Program Manager=Supervising Clinician	1.0
Licensed or Waivered Clinicians (e.g., LCSW, LMFT, Psychologist) At least 2.0 of 4.0 FTEs must be licensed	4.0
Case Managers/Community Health Workers/Medical Caseworkers At least 3.0 of 4.0 FTEs must include: Housing Specialist (i.e. has completed certification) Employment Specialist Substance Use Specialist	4.0
Peer Specialists/Community Health Workers	2.0
Psychiatrist	1.0
Nurses (RN, BSN, or Psychiatric Technician) At least 1.0 of 2.0 FTEs must be RN	2.0
Administrative Support Staff	1.0
Data and Billing Specialist/Quality Assurance Staff	1.0
TOTAL	**16.0**

Recommended Staffing for Adult Teams Serving 50 Clients (up to 60)	FTE
Team Leader / Program Manager=Supervising Clinician	0.5
Licensed or Waivered Clinicians (e.g., LCSW, LMFT, Psychologist) At least 1.0 of 2.0 FTEs must be licensed	2.0
Case Managers/Community Health Workers/Medical Caseworkers/Peer Specialists Expertise/experience must include: Lived Experience, Housing, Occupational Therapy/Employment, and Substance Use	3.0
Psychiatrist	0.5
Nurse (RN, BSN, or Psychiatric Technician) At least 0.5 of 1.0 FTE must be RN	1.0
Administrative, Data and Billing/Quality Assurance Support Staff	1.0
TOTAL	**8.0**

What staffing patterns will be expected for Child & Young Adult FSP?
Child and Young Adult FSP should have the following core team members who are versed in developmental issues related to the target population: Mental Health Clinician (MSW, MFT), Intensive Care Coordinator, and Case Manager/Intensive Home-Based Service Provider. In addition, it is **recommended** that teams also include the following: Parent Advocate/Partner and/or Peer Advocate, and Clinical Supervisor. Lastly, teams should partner with or ensure access to the following specialists based on clients' needs and those of their families: Psychiatrist, Occupational Therapist, Physical Therapist, Respite Caregiver, Housing Specialist (and any other team member based on client need). Please refer to the FSP Child & Young Adult Service Exhibit for further details on staffing and team operations-related expectations.

Can staff work part-time on the FSP team?
It is recommended that staff are fully dedicated to the FSP program, and not split between different programs. Exceptions may include psychiatrists/nurse practitioners and team leaders working on small teams.

What are the new staffing ratios?
The new staffing ratio is one (1) staff member for every 10 – 12 clients. The ratio is designed to allow high quality care to meet FSP client needs.

Which team members should be included in the calculation of the client to staff ratio?
All team members are included with the exception of team leader, administrative support, and psychiatrist/psychiatric nurse practitioner. Non-prescribing nursing staff (i.e., RN, LVN) are included in determining client to staff ratio.

How would this ratio be used in assessing a team's capacity?
Team capacity can be assessed using the above ratio. For instance, if there are 8 FTE providing services on a team – excluding the team leader, administrative support, and psychiatrist or NP – the team should serve between 80 and 96 clients (8*10-8*12).

Does a Substance Use Counselor need to be certified by a statewide recognized certifying board to work on an FSP team?
Our understanding is that certification for substance abuse counselors is not a requirement. The Substance Use Counselor is a team member with expertise and additional experience working clinically with individuals with substance use.

What is the expectation regarding team meetings?
FSP teams are expected to meet frequently (at least 4 days per week for teams serving 100 clients or more) with all or most team members present. Team meetings work best if conducted every day, but smaller teams in particular may decide to meet slightly less frequently (e.g., 2-3 times per week). Team meetings should include a review of all clients by the whole team. Teams should also develop communication strategies to ensure members are made aware of time-sensitive or high-risk client situations immediately. The service exhibit contains additional parameters regarding team meetings and client contact expectations.

What steps are being taken to help ensure salary parity between DMH directly operated and contracted FSP programs?
DMH is setting standardized salary rates to bring contracted provider staff salaries closer to parity with DMH counterparts. DMH will provide increased funding to support agencies in achieving this aim. Contracted agencies will ultimately have discretion related to the manner in which staff salaries are structured. Salary parity will apply to clinicians on FSP teams in particular.

Program Structure

How will FSP programs be structured with regard to age groups?
FSP will serve two over-arching age groups moving forward; Child and Young Adult FSP will serve individuals from 0 – 20 years old and Adult FSP programs will serve those 21 years of age and older. DMH has indicated they will continue matching clients with team/agency areas of expertise, including age-related expertise. For example, navigators will attempt to assign older

adults to teams/agencies that have a history of serving this group and are particularly skilled in this area.

Will a program serving TAY clients (16-19) need to transfer them immediately to a child program if the agency will only have Adult FSP moving forward?
Our understanding is that integration of programs into new age groups is not intended to be burdensome to clients. DMH has suggested that TAY-age clients do not need to be transferred out of their current program if it is in their best interest to remain enrolled in current services (even after July 1, 2021). New enrollments into FSP should adhere to the new age-related program requirements. We encourage providers to consult with FSP Administration about clients on a case-by-case basis.

What will it mean to integrate AOT into FSP? Will FSP providers be doing all of the tasks currently performed by the AOT teams?
FSP teams will take on tasks required for AOT clients, but AOT staff will continue to conduct the outreach and engagement process as usual. Some aspects of referral and workflow processes related to the integration of AOT are still being developed by DMH. To help providers become familiar with AOT procedures and requirements generally, a prerecorded, 3-part training series on AOT is available on PMHP's website and directly linked HERE. It is also anticipated that more live trainings will be delivered in the future by AOT, hosted by PMHP.

What will happen to specialty FSP programs?
All previous sub-specialty populations (e.g., forensic, homeless) will be integrated into a unified FSP program and teams will be expected to serve the full range of clients meeting FSP focal population criteria.

Will DMH support training time for teams to broaden their expertise to meet transformation aims?
Agencies will be responsible for allocating resources/staff time to receive the training necessary to meet transformation aims and provide high-quality care. PMHP will continue to make trainings addressing a range of skills and competencies for FSP service delivery available to teams. Trainings will be provided live via zoom and through on-line self-paced learning modules tailored to FSP-related topics (e.g., recovery-oriented, team-based, and trauma-informed care).

What changes to navigation and/or referral processes based on transformation (e.g., integration of FSP specialty programs) can be expected?
FSP Administration is currently working on revising potential changes to referral workflows and/or other operational processes that may need modification as a result of transformation. Details regarding such changes will be refined iteratively and disseminated by DMH in the coming months.

Outcomes & Incentive Payments

What FSP Adult outcomes will be connected to incentive payments?
Adult FSP outcome domains related to incentive payments include enrolling priority populations, reducing psychiatric emergency department visits, increasing housing, and retaining justice-involved clients. Performance incentives will be awarded at the agency site level based on a measurement cycle occurring every 6 months. Agencies will need to complete OMAs for at least 80% of total clients enrolled in FSP to be eligible for performance incentives. The DMH outcomes division will be providing enrollment and outcome reports to providers on a regular

basis moving forward so that agencies can track their eligibility for incentive payments as well as use these data for quality improvement-related efforts.

When will FSP Adult incentive payments begin?
Providers will receive incentive payments for the first Adult FSP priority outcome, enrolling and retaining priority populations, starting in FY 2021-22. Incentive payments related to the remaining priority outcomes will be implemented starting in FY 2022-23 and FY 2023-24.

What FSP Child & Young Adult outcomes will be connected to incentive payments and when will they begin?
Priority outcomes for Child & Young Adult FSP upon which incentive payments will be based include reduced psychiatric hospitalizations. Performance incentives will be awarded at the agency site level based on a measurement cycle occurring every 6 months. Agencies will need to complete OMAs for at least 80% of total clients enrolled in FSP to be eligible for performance incentives. Incentive payment eligibility for Child & Young Adult FSP providers will be implemented beginning in FY 2022-23.

Are there changes to OMAs that we should anticipate? Will DMH provide training related to these changes?
OMA baseline measures, KECs and 3-month measures will be shortened and streamlined. For example, DMH has announced that social support categories and benefits questions are being removed from all OMAs. On the Baseline and the 3M, physical health questions, substance abuse, legal, and School/Education/Training questions have been reduced. Similarly, the KEC will be simplified. Changes to OMAs are still being finalized and may be in flux. DMH has indicated that training related to OMA changes will be available once the revised forms are finalized. Training on how to enter data in the new FSP OMA application will also be offered once the application is ready to go live. Please check the DMH Outcomes website for training dates/times and/or contact FSP administration staff for further information.

Will OMAs based on previous age groups (i.e., Child, TAY, Adult, Older Adult) still be required?
Yes. Though FSP services will be delivered based on Child/Young Adult or Adult age groups only, OMA forms/data points reflecting previous age break-downs will continue to be required. This is due to state requirements for data reporting protocols that distinguish between the 4 age groups. Every county must report data to the Department of Health Care Services in the same way for Full Service Partnership.

Will there be changes to the OMA submission process and database?
DMH is working on streamlining processes between SRTS and NAPPA to lessen data-entry burden for administrative staff. Focal population criteria will continue to be collected. Provider information will be pulled from SRTS and NAPPA, and views of authorized client lists that include basic enrollment information may be used to launch outcomes collection for clients. There is a long-term plan for providers to be able to submit data through a data exchange portal. DMH will provide updates on progress related to these proposed changes.