Multi-County FSP Innovation Project

Learning Community Convening

June 7, 2021
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<th>Activity</th>
<th>Description</th>
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| Session 1: Project Updates 3:00-4:15 PM           | Multi-County FSP INN Project Overview  
Nicole Kristy, Third Sector |
|                                                   | Project Update: Cohort Initiatives  
Hilary Carson, Ventura County  
Followed by Q&A |
|                                                   | Project Updates: Sacramento County  
Stephanie Kelly, Sacramento County  
Followed by Q&A |
|                                                   | Project Updates: Fresno County  
Erinn Reinbolt, Fresno County  
Followed by Q&A |
| Session 2: DCR Small Group Discussions 4:15-5:00 PM| Breakout Discussions  
Discuss data reporting, access and other challenges counties encounter using the DCR to develop recommendations for system improvement. |
Third Sector is a 501(c)3 non-profit organization that helps government and communities leverage data and lived experience to improve outcomes.

**Data-Driven Feedback Loop**

- **FUNDING**: Flexible dollars fund coordination, innovation & continuous improvement
- **POLICY**: Policy links dollars to outcomes, increasing spending flexibility & accountability
- **SERVICES**: Measurable outcomes drive data-informed decision making & policy
- **DATA**: Shared data supports the alignment of services with community needs
- **EQUITABLE OUTCOMES**: Internal culture drives and empowers outcomes orientation
- **EXTERNAL RELATIONSHIPS**: External relationships shape how outcomes orientation is implemented
LA County first applied this outcomes focus to FSP, inspiring six additional counties to build the Multi-County FSP INN project

LA County Dept. of Mental Health (LACDMH)

- Third Sector and LACDMH are transforming FSP contracts and services to ensure an outcomes focus, via:
  - Increased focus on relentless engagement
  - Team-based service model
  - Re-designed funding and incentives
  - Improved data and continuous improvement systems

Multi-County FSP Innovation Project

- Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura counties are building outcomes-oriented, data-driven FSPs, with support from Third Sector, RAND, CalMHSA, and the MHSOAC
- Implementation priorities include:
  - Clarifying eligibility, service, and graduation guidelines
  - Improving data collection and measurement strategies
  - Developing a statewide vision for FSP data, outcomes, and continuous improvement
The Multi-County FSP Innovation Project’s 5 goals will build counties’ capacity to collect and use data to improve outcomes

**Multi-County FSP Innovation Project Goals**

*When the Multi-County FSP Innovation Project is complete, counties will have increased capacity for collecting and using data for FSP services. These improvements will not only support participating counties’ clients in their recovery, but they will also be shared to improve the statewide system.*

1. Develop a shared understanding and more consistent interpretation of FSP’s core components across counties, creating a common FSP framework

2. Increase the clarity and consistency of enrollment criteria, referral, and graduation processes through developing and disseminating clear tools and guidelines across stakeholders

3. Improve how counties define, track, and apply priority outcomes across FSP programs

4. Develop a clear strategy for tracking outcomes and performance measures through various state-level and county-specific reporting tools

5. Develop new and/or strengthen existing processes for continuous improvement that leverage data to foster learning, accountability, and meaningful performance feedback
We are leveraging a multi-stakeholder partnership to accomplish these statewide learning goals over the course of 4.5 years

**Plan:** Counties worked with Third Sector and the MHSOAC to build a new partnership that would encourage peer learning, further improvement to FSPs, and accelerate county collaboration

**Landscape:** An 8-month “listening and learning” (Landscape Assessment) phase allowed us to gather context and feedback from County staff, providers, and consumers

**Implement:** 12 months of implementation activities that were informed by a prioritization process that ensures we are meeting government and stakeholder needs

**Sustain:** A 2-month dedicated sustainability period will support counties in cementing collaborative continuous improvement processes

**Evaluate:** During the 2.5-year evaluation period, RAND will assess the contributions of this project to statewide learning and improved FSP outcomes
Multi-County FSP Innovation Project

Cohort Overview

June 7, 2021
To develop a shared understanding of how Counties define, track, and apply outcomes the MC Project developed 3 Workstreams

For this session, we’ll focus on Populations Definitions and Outcomes & Process Measures

**MC Cohort Goals**

1. Develop a shared understanding and more consistent interpretation of FSP’s core components across counties, creating a common FSP framework
2. Improve how counties define, track, and apply priority outcomes across FSP programs
3. Develop a clear strategy for tracking outcomes and performance measures through various state-level and county-specific reporting tools

**Cohort Workstreams**

**Outcomes & Process Measures**
Identify 3-5 outcomes and 3-5 process measures, and associated metrics to track what services FSP clients receive and how successful those services are

**Populations Definitions**
Facilitate process to standardize definitions of FSP populations across all 6 counties

**DCR**
Develop recommendations for revising DCR forms, metrics, and/or DHCS data reports to reduce reporting burden and increase the usefulness of DCR data
Since Counties cannot easily compare client outcomes, the Outcomes & Process Measures WG is developing standard metrics

**Key Challenge:**
Because counties do not currently define and track client outcomes in the same way, they cannot easily compare outcomes achievement or conduct cross-county analyses on the relationship between specific services and outcomes achievement.

**Key Activities:**
*Convene Cohort Working Group to…*
- Identify & prioritize 3-5 outcomes and process measures
- Develop shared metrics to measure these outcomes
- Connect to populations definitions to disaggregate outcomes & better understand disparities in achievement

**Prioritized Outcomes & Process Measures:**

**Outcomes**
- Increased Stable Housing
- Decreased Justice Involvement
- Decreased Utilization of Psychiatric Facilities
- Increased Social Connectedness

**Process Measures**
- Frequency of specific services*
- Location of services

*The Cohort is still determining which services to prioritize. Candidates include group therapy, individual therapy, medication management, and rehabilitation services.

**Where We Are Today:**
Over the summer the Working Group will develop metrics to track these outcomes & process measures.
Since it is difficult for Counties to share data-driven learnings, the Population Definitions WG is developing standard definitions.

**Key Challenge:**
Population definitions are not standard within or across counties for priority populations served within the FSP program, making it difficult to:

1) make data-informed decisions for sub-populations within each County
2) compare data and share best practices across Counties

**Key Activities:**
Convene Cohort Working Group to...

- Identify 3-5 priority population terms that counties have historically defined differently
- Develop consistent definitions for each population
- Gather feedback from providers and other County stakeholders to finalize definitions

**Prioritized Definitions:**

- Experiencing Homelessness
- At Risk of Homelessness
- High Utilizer of Psychiatric Facilities or Urgent/Crisis Services
- At Risk of Utilization of Psychiatric Facilities or Urgent/Crisis Services
- Justice Involved [Individual]
- At Risk of Justice Involvement

**Where We Are Today:**
The Working Group is gathering feedback from broader stakeholders on County teams and providers in Counties; we will spend time this summer incorporating that feedback and finalizing the definitions.
Together, the Cohort WGs enable data-informed decision making to occur within & across Counties for priority FSP populations

Cohort Working Group Goals: *Within Counties*

*Enabling Counties to make data-informed improvements to how providers serve FSP’s priority sub-populations by creating:*

- A consistent framework to assess how effectively different FSP programs are supporting FSP’s priority populations to achieve outcomes
- Data analysis and data sharing processes that illuminate the correlation between specific services & outcomes achievement

*Leveraging standard population definitions for other County priorities including:*

- San Mateo and Ventura plan to leverage these definitions to develop eligibility criteria
- San Bernardino County may leverage these definitions on their electronic referral form

Cohort Working Group Goals: *Across Counties*

*Enabling participating Counties to compare outcomes & services and share best practices for the FSP population and priority sub-populations by:*

- Defining a shared set of program outcomes and determining which priority populations these outcomes should be tracked for
- Identifying a shared list of services to analyze their connection to outcomes achievement across different geographies

*Enabling any county that is interested in adopting this project’s outcomes tracking framework to:*

- More effectively understand how their FSPs are performing compared to other counties’ programs
- Share and leverage best practices from other counties to improve service provision to clients
Multi-County FSP Innovation Project

Sacramento County Implementation Summary

June 7, 2021
Sacramento BHS had two priorities for implementation:

1. Standardize an FSP client **stepdown readiness review** process or tools that can be used to more regularly assess whether a client is ready to step-down.

2. Develop **graduation criteria** that balance ISSPs and system-wide outcomes in making individual graduation decisions, including improved definitions of “stability” and “recovery”.
Audience Poll

On your phone / computer, navigate to Slido.com and type in code “june7”
Poll: How would you describe the FSP stepdown process in your county?

- Inconsistent with programs
- Not very structured
- Time frames of length of time with progress/stabilization can vary
- Treatment based, medical necessity, not very structured
- Pretty good
- Graduating
- Inconsistent
- Unclear
- Variable
- Subjective
- Available
- Lacking
- Helpful
- Not fast enough
- Needs work
- Varied
- Collaborative
- Not sure
- Available
- Needs improvement

Varies by the nine FSP program, not necessarily consistent, however each one serves different populations.

No longer hospitalized, incarcerated, homeless or DCFs involvement in the past 6 months to a year.
What we heard from FSP clients, staff, and experts

“Slowly ease me into the transition process, not, ‘Oh we’re done with you, hope you have a good life’

“It’s more like a 20-foot drop and you hope there is water at the bottom”

“A data-driven approach is important: instinct may not be reliable”

Clients

Providers

Experts
Using their feedback, we reimagined the FSP stepdown process and mapped it out visually.

Summary of Current Stepdown Process

- Providers deliver services to FSP clients: Staff build rapport with clients, support their treatment goals, and offer wraparound services.
- Providers identify clients to stepdown: Staff may or may not actively talk to clients about graduation as a goal or communicate a belief that recovery is possible.
- Providers confirm decision to stepdown: Because of this, clients may not think of FSP as time-limited; some clients stay in services for years.
- 60-day transition period begins: Determining readiness for stepdown is an art, not a science. Each provider, program, & client follows a custom process, usually assessing stepdown readiness on an ad hoc basis.
- Client steps down to T-CORE or IST: Providers can reference multiple data sources (LOCUS, ANSA, CANS, frequency of hospitalization, housing stability, treatment plan), but they do not use data in a consistent way.
- Individual service coordinators meet with clinical directors before confirming a decision to discharge a client. Clients are consulted and give their consent to be stepped down.
- Treatment staff, CFTs, and clients, not Sacramento BHS, have the final word on discharge decisions.
- In this transition period, providers prepare clients for stepdown, titrating services to build independent functioning and forming a client plan for continued access to housing, financial, and other supports.
- This transition process is not coordinated with stepdown program staff who will receive graduated clients.
- FSP clients do not regularly graduate and step down to lower-acute programs, leading to challenges with program capacity.
- When they do, clients experience the transition as a steep drop-off in care; in some cases, they lose their housing supports, which are tied to FSP funds.

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Vision for a New, Improved Stepdown Process

- Providers use recovery-centered language & communicate that graduation is a goal of FSP from day one. This framing helps mitigate dependence.
- Providers frequently check-in (via Strengths Model) & assess clients. Data is used consistently. ANSA & other sources help staff make stepdown decisions at the program & individual level.
- BHS contract monitors offer a next level of oversight, discussing with clinical directors. Supervisors play active roles in addressing counter-transference.
- The transition planning process is longer, about 6 months, & coordinated with stepdown programs. Programs titrate levels of care internally (e.g. SCAR).
- Staff treat grad as a celebratory event. Clients continue to receive housing supports. Graduation creates new capacity to accept clients and place them in their first-choice programs.
We worked with provider staff to define “graduation readiness” across age groups and subpopulations\(^1\)

- **Adult & Older Adult**
  - no longer needs intensive services
  - no recent justice interactions
  - no recent hospitalizations
  - client’s buy-in
  - independent
  - has social support

- **Child & Family**
  - stably housed
  - meets treatment goals
  - has adequate resources
  - reduced self-harm
  - stable behaviors & symptoms

- **TAY**
  - engaged in treatment
  - setting self-identified goals

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\(^1\) Builds on the ACT Transitional Readiness (ATR) Scale, developed by Gary Cuddeback
Staff used data sources to define each readiness indicator—important for consistent operationalization

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<tr>
<th>Graduation Criteria</th>
<th>Definition / How it gets operationalized</th>
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| has adequate resources | ● EHR\(^2\) client demographics report shows access to resources (e.g. benefits, income, employment, community or school-based)  
● EHR linkages has check mark (case mgmt referrals)  
● TAY/Adult: ANSA shows access to resources with improved strengths, reductions & needs scores of 0 or 1 (risk behaviors, behavioral/emotional needs, trauma)  
● Children/TAY: CANS shows reduced or low risk scores of 0 or 1 (caregiver, transition to adulthood)  
● Children/TAY: Discharge summary shows resources youth is referred or connected to |

Potential Data Sources

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<tr>
<th>LOCUS</th>
<th>KETs</th>
<th>Housing Data</th>
<th>Treatment Plan</th>
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<tr>
<td>ANSA</td>
<td>PAF</td>
<td>Hospital Data</td>
<td>Core Assessment</td>
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\(^2\) EHR may include Avatar, EMR, CARS, or other systems used by different provider agencies
Poll: Does your county have criteria for graduation from FSP?

- No, maybe in practice, but not written criteria: 46%
- Yes, individual programs do, but they are not shared across programs: 32%
- No, we could really use more clarity about how grad decisions are made: 16%
- Yes, written criteria are shared across programs: 5%
Multi-County FSP Innovation Project

Fresno County Implementation Summary

June 7, 2021
Fresno DBH 2020 Implementation Activities

**REAUTHORIZATION PROCESS**
Develop a process in which FSP providers communicate to DBH at regular intervals where FSP clients are in their treatment plans in order to assess reauthorization needs.

**CHILD REFERRAL & ENROLLMENT**
Develop a standardized youth FSP referral and enrollment process with enhanced communication between DBH and contracted providers.

**DATA COLLECTION & REPORTING**
Streamline existing and/or develop new data collection reports or methods so that counties and providers can more effectively collect, access, and utilize FSP data to inform care decisions.
We conducted provider focus groups to understand their perspective on reauthorization

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<th>DBH Needs &amp; Wants</th>
<th>Provider Feedback</th>
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<td><strong>Right People, Right Place:</strong> DBH wants to ensure FSP is serving the appropriate people at the appropriate time and at appropriate level of care given limited slots.</td>
<td><strong>Leverage Current Processes:</strong> Providers are already justifying medical necessity for FSP on an ongoing basis and emphasized that they do not keep clients in FSP if they do not need such a high level of care.</td>
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<td><strong>Strengthen the Narrative:</strong> Service reductions and/or budget cuts will prompt program reviews. The more information DBH has about why individuals are staying in FSP programs, the better story DBH can tell about the need for FSP slots.</td>
<td><strong>Use Existing Data:</strong> Providers feel they are already sending reauthorization data through annual treatment plans, Core Assessment forms, and Reaching Recovery. They recommend adding new data fields to existing forms if necessary.</td>
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<td><strong>Leverage Current Processes:</strong> Providers are already justifying medical necessity for FSP on an ongoing basis and emphasized that they do not keep clients in FSP if they do not need such a high level of care.</td>
<td><strong>Understand Use of Data:</strong> Providers want to further understand DBH’s rationale, including why additional data is needed and how data will be used and shared. Providers would like to see more aggregate, quantitative data that can identify trends.</td>
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As a result of provider feedback, we developed an updated reauthorization process (DRAFT)

**Process Map Key**
- **Provider**
- **Communication**
- **DBH**
- **Data**

1. FSP provider submits reauth form via Avatar every 12 months
2. Avatar notifies the FSP coordination team of a new reauth request
3. FSP coordination team approves or denies reauth request in Avatar
4. Avatar notifies the FSP provider about the status of their reauth request
5. The FSP coordination team runs a report from Avatar to track reauthorization trends

*Data are uploaded as .doc files for programs that don’t use Avatar as their primary electronic health record*
Poll: Does your county track FSP reauthorizations?

No 75%

Yes 25%
Next Implementation Activity: Child Referral & Enrollment Process

**CHILD REFERRAL & ENROLLMENT**

Develop a standardized youth FSP referral and enrollment process with enhanced communication between DBH and contracted providers.

**Provider Feedback**
- “The big biggest thing that impacts our waitlists is turnover of staff. As long as we can retain staff we can get people in quickly.”
- “We are not against sharing information, but don’t want it to hold up the process.”
- “If a clinician is reviewing who is trained in this population, that is one thing. But majority of clinicians in county come from the adult side.”
- “We only have one person at the agency who has access to Avatar [EHR] to enter info.”

**Client Feedback**
- “It was an easy process... very seamless.”
- “There was not really a waiting period. It probably took less than 2 months from the time I called them to when services started.”
- “The waitlist was really frustrating.”
- “Checking in a little more [would be helpful], even just to say ‘Hey you’re on the waiting list, we didn’t forget about you.”
Poll: How involved is your county in the FSP referral approval process? *(1 = not involved, 5 = approve all incoming referrals)*

Score: 4.2
Final Implementation Activity: Data Collection & Reporting

DATA COLLECTION & REPORTING

Streamline existing and/or develop new data collection reports or methods so that counties and providers can more effectively collect, access, and utilize FSP data to inform care decisions.

Provider Feedback

“We would like a better data collection system that is user friendly and easy for us to access when data is needed for outcomes measurement.”

“We do a lot of double documentation.”

“The DCR annual report is more user friendly than the data collection.”

“It would be much easier if we could have direct access to data.”

“Disaggregated data would be great to have.”

“It’s better to learn how to effectively use what we have to understand and synthesize the data, and then find ways to practically apply the data.”

“We would like a better data collection system that is user friendly and easy for us to access when data is needed for outcomes measurement.”
**Poll:** What is the most valuable data point or report that is shared between your county and providers?

- Amount of time to enroll a client into FSP
- FSP Roster Reports
- FSP outcomes
- Outcome compliance
- Service billing
- Housing
- OQ outcomes
- Service frequency of crisis intervention
- Mhsa data
- Jail
- Reduction in hospitalization or crises
- Enrollment for compliance

**Hospitalizations**

- CANS
- Direct service
- PAF
- Timeliness
- ANSA
- Enrolment reports
- The amount of contacts per week
- Incarcerations
- Outcomes data
- 3m Currency
- Length of time of contact
- CANS improvement every quarter
- ANSA highlights both client needs AND strengths
Data Collection and Reporting
Small Group Discussions
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