FULL SERVICE PARTNERSHIP
ADULT LEVELS OF CARE COMPARISON CHART

Background

Under the Behavioral Health Services Act (BHSA), county Full Service Partnership (FSP) programs are required to have two levels of coordinated care for BHSA eligible adults and older adults: Assertive Community Treatment (ACT), a stand-alone EBP as the highest intensity level, and FSP Intensive Case Management (ICM), which can be a standardized step-down level from ACT or provided to individuals requiring a lower level of care than ACT. DHCS will not establish requirements for standardized assessments specific to determining FSP levels of care; this is left to counties and to the clinical judgment and discretion of the treating provider. The appropriate level of care should be determined based on an individual's acuity and their eligibility for transition to a less intensive level of care.

ACT is designed for individuals living with complex and significant behavioral health needs who require frequent, intensive, and community-based services. Forensic ACT (FACT) extends this model to individuals who meet the service criteria and who are also involved in the criminal justice system.

FSP ICM offers a comprehensive array of community-based services and can be provided either as a step-down from ACT or as an intervention to avert the need for ACT-level care. FSP ICM is delivered by a multidisciplinary team that incorporates core case management functions—such as assessment, planning, and linkage—with low staff-to-client ratios, assertive outreach, and direct service delivery. FSP ICM is for individuals who may not meet ACT eligibility criteria but still have significant behavioral health needs and can benefit from FSP supports.

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The purpose of this document is to detail the key components of ACT/FACT and FSP ICM as well as the differences between the two levels of care. The tables included below are intended to help distinguish (1) who is best served by which level of care; (2) what the service components are in each level of care; and (3) how the team structures differ between levels of care.

For more information on the BHSA requirements for ACT/FACT and FSP ICM, please see Chapter 7, Section B of the BHSA Policy Manual.

For more information on ACT/FACT service delivery under Medi-Cal, please see the BH-CONNECT EBP Policy Guide and Behavioral Health Information Notice No: 25-009.

Comparative Characteristics of Eligible Populations Served by ACT and FSP ICM

Individuals eligible for ACT and FSP ICM services must meet criteria in all three categories related to *diagnosis, functional impairment, and continuous high-service needs*. Key differences between ACT and FSP ICM eligibility take into consideration the level of care needed to treat an individual based on acuity. Individuals living with more severe needs across diagnosis, functional impairment, and continuous high-services needs may be better suited for ACT.

Table 1. Comparative Characteristics of Eligible Populations Served by ACT and FSP ICM

	ACT/FACT	FSP ICM	Key Differences
Eligibility: Diagnosis	**Have a diagnosis** consistent with SMI or co-occurring SMI and substance use disorder (SUD), according to current Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems criteria and as determined by a clinician. » SMI diagnoses include, but are not limited to, bipolar disorder; schizophrenia; schizoaffective disorder; major depressive disorder with psychotic features; and other psychotic disorders	A current or **suspected,** Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis consistent with a serious mental illness (SMI), serious emotional disturbance (SED), substance use disorder (SUD), which may be co-occurring with SUD. Individuals with a primary diagnosis of intellectual/developmental disabilities (I/DD) are not appropriate for FSP ICM.	Before a person's referral to ACT is accepted by the ACT team, they will have an established diagnosis. Note: ACT teams can provide unbundled SMHS before an FSP participant is authorized for ACT. FSP ICM can be provided to individuals with a suspected DSM diagnosis consistent with SMI, SED, SUD, or co-occurring SMI and SUD.

	ACT/FACT	FSP ICM	Key Differences
	» Most ACT/FACT clients will have a primary psychotic disorder (e.g., schizophrenia, schizoaffective disorder, bipolar disorder with psychosis). ACT is not appropriate for individuals solely diagnosed with SUD, personality disorder(s), or intellectual/development disabilities (I/DD). » An individual appropriate for ACT may need support to recognize their need for help to remain out of crisis and out of the hospital and may be difficult to engage. ACT teams service those in need of committed and persistent assertive engagement to deliver needed services.		
	Example: An individual appropriate for ACT/FACT may have an SMI diagnosis of schizophrenia.	**Example:** An individual appropriate for FSP ICM may be suspected of having a SMI	

	ACT/FACT	FSP ICM	Key Differences
		diagnosis such as a mood disorder.	
Eligibility: Functional Impairment	Have **significant** functional impairment, defined as one or more of the following: » Consistent **inability** to perform practical daily tasks needed to function in the community such as maintaining personal hygiene; meeting nutritional needs; caring for personal business affairs (e.g., paying bills); obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to oneself and one's possessions; » Persistent or recurrent **failure** to perform daily living tasks, except with **significant support** or help from others such as friends, family, or relatives	Have a **moderate to significant** functional impairment. Moderate to significant means that the impairment might be consistently problematic (but not disabling) OR that the impairment is occasionally significant (but the individual experiences more stability MOST of the time). Functional impairment can include: » Consistent **difficulty** performing practical daily tasks needed to function in the community such as maintaining personal hygiene, meeting nutritional needs, caring for personal business affairs, obtaining medical, legal, and housing services, recognizing and avoiding common dangers or hazards to oneself and one's possessions;	ACT is best suited for individuals who are unable to function independently without intensive, ongoing support. In contrast, FSP ICM typically serves individuals who experience consistent difficulty (the acuity can vary over time), but generally can still function with moderate support: » Individuals living with significant functional impairment that **consistently impedes** them from performing daily tasks, sustaining safe housing and employment, and/or need significant support from others may be best served by ACT. This may include constant inability to maintain clothing, shelter, and/or meet nutritional needs. A subset of individuals best

	ACT/FACT	FSP ICM	Key Differences
	(e.g., dependent on others for food, isolative, unable to use transportation independently); » **Consistent inability** to be employed at a self-sustaining level or to carry out homemaker roles; and/or » **Inability to** maintain a safe living situation (e.g., repeated evictions or loss of housing, under a mental health (LPS) conservatorship). A person who would benefit from ACT may not recognize functional limitations or needs as assessed by the treatment team. They may feel conflicted, distrustful, hesitant or ambivalent about engaging in treatment, particularly if they have had negative or traumatic experiences with behavioral health entities in the past. The team and others may experience their presentation as challenging to engage. This suggests a need for	» Persistent or recurrent **difficulty** performing daily living tasks, except with **moderate support** or help from others such as friends, family, or relatives; » **Difficulty** maintaining consistent employment at a self-sustaining level or to carry out homemaker roles; and/or » **Difficulty** maintaining a safe living situation (e.g., repeated evictions or loss of housing).	suited for ACT may also exhibit disruptive behavior and be resistant to engagement. » In contrast, individuals with lower acuity (moderate to severe) functional impairment who find it **consistently difficult** (but are not unable) to perform daily tasks, sustain safe housing and employment, and/or need moderate support from others may be best served by FSP ICM. They may need intense support for short periods of time. **Questions to consider when determining the appropriate level of care for an individual:** » Would this individual be at risk of institutionalization (e.g., LPS conservatorship, jail or long-stay hospital)

	ACT/FACT	FSP ICM	Key Differences
	consistent and persistent engagement to deliver necessary services while honoring the individual's perspective, experiences and goals.		without this intervention? If yes, ACT may be the best intervention. » Does the individual present with safety concerns (e.g., disruptive behavior or risk of harm to self or others)? If yes, depending on symptom presentation, hospitalization followed by an ACT referral may be an appropriate intervention.
	 **Example:** An individual appropriate for ACT/FACT is more likely to experience institutionalization without the support of an ACT team.	 **Example:** An individual appropriate for FSP ICM may live independently, but struggle with some daily tasks OR may live independently most of the time, but occasionally experience serious disruption.	
Eligibility: Continuous High-Service Needs	Have an indicator of continuous high-service needs, as evidenced by one or more of the following: » **High use of** psychiatric hospitalization or psychiatric emergency services » Intractable (persistent or recurrent) severe major symptoms (e.g., affective, psychotic, impulsive, suicidal);	Have an indicator of continuous moderately high-service needs or relatively low service needs with occasional periods of high-service needs, as evidenced by one or more of the following: » **Risk of** hospitalization or crisis/ emergency care without this service; » Intractable (persistent or recurrent) severe major symptoms (e.g., affective, psychotic suicidal);	ACT is better for individuals who frequently experience psychiatric crises, have a history of high service utilization, and/or whose mental health challenges are severe enough to be considered a disability. » Other indicators that an individual may need ACT include an inability to keep self or others safe, longstanding or substantial periods of untreated

	ACT/FACT	FSP ICM	Key Differences
	» Co-existing SUD of significant duration; » High risk or a recent history of being involved in the criminal justice system; » Inability to participate in office-based services; » Living in sub-standard housing, experiencing homeless, or at imminent risk of becoming homeless; » Clinically assessed to be able to live more independently if intensive services are provided.	» Co-existing SUD of significant duration; » High-risk or a recent history of being involved in the criminal justice system; » Inability to participate in traditional office-based services. » Living in substandard housing, experiencing homeless, or at at-imminent risk of becoming homeless; » **Living in housing,** but clinically assessed to need more intensive services to maintain housing**;** » **Living in an inpatient bed or in a supervised community residence,** but clinically assessed to be able to live more independently if intensive services are provided; and/or	psychosis, inconsistent or intermittent medication adherence leading to persistence or recurrence of symptoms, and a substantial duration of difficulty with untreated or refractory symptoms and functional challenges that suggest the need for long-term support to reach safety and stability. In contrast, FSP ICM is beneficial for individuals who need intensive services to prevent hospitalization or homelessness, especially if this issue is acute rather than chronic. **Questions to consider when determining the appropriate level of care for an individual**: Does this individual have periods of greater stability but need a support network in place for when a period of acute instability occurs? If yes, they may be best served by FSP ICM.

	ACT/FACT	FSP ICM	Key Differences
		» **Risk of returning to unsheltered homelessness** after being placed in interim housing, or risk of returning to homelessness after being placed in permanent supportive housing without this service.	
	 **Example:** An individual appropriate for ACT/FACT may struggle with severe symptoms and medication participation on a daily basis, leading to frequent police involvement or ED use without the daily support of a team.	 **Example:** An individual appropriate for FSP ICM may maintain housing and employment most of the time but have occasional psychiatric crises OR may have periods of social or employment instability.	

Comparative Overview of Service Components in ACT and FSP ICM

Both ACT and FSP ICM share the same service components, but are intended to be scaled up or down according to level of care and the needs of the FSP individual.

Table 2. Comparative Overview of Service Components in ACT and FSP ICM.

	ACT/FACT	FSP ICM	Key Differences
Service Components	» Assessment » Crisis Intervention » Medication Support Services » Peer Support Services » Psychosocial Rehabilitation » Referral and Linkages » Therapy » Treatment Planning » Co-occurring capability expectations are outlined in Chapter 7, Section B.3.5 of the BHSA Policy Manual and Medication Management and Other Clinical Support section of the BH-CONNECT EBP Policy Guide, page 14.	» Assessment » Crisis Intervention » Medication Support Services » Peer Support Services » Psychosocial Rehabilitation » Referral and Linkages » Therapy » Treatment Planning » Co-occurring capability expectations are outlined in Chapter 7, Section B.3.5 of the BHSA Policy Manual.	While the service components may be the same or similar across ACT and FSP ICM, service delivery should be appropriately tailored based on level of care provided. In addition, the level of intensity of crisis services varies across ACT and FSP ICM » ACT teams are expected to provide crisis support 24 hours a day, seven days per week. » In contrast, FSP ICM teams are not required to be "on call" 24 hours a day, seven days per week. » The level of need may vary for both ACT/FACT and ICM, but in general ACT is comparable to a "hospital outside the hospital" and

	ACT/FACT	FSP ICM	Key Differences
			ICM is an intensive, community-based service.

Comparative Overview of ACT and FSP ICM Team Models

Both ACT and FSP ICM are multidisciplinary, team-based models of care that share key service components. While the core functions of these teams, such as care coordination, clinical support, and recovery-oriented services, are similar across ACT and FSP ICM teams, provider ratios and caseload vary based on the level of care provided.

Table 3. Comparative Overview of ACT and FSP ICM Team Models

	ACT/FACT	FSP ICM	Key Differences
Team Structure	ACT teams include a diverse array of behavioral health practitioners, including: » A designated ACT team lead » A psychiatrist or psychiatric prescriber » Registered nurses » One or more employment specialists » At least one AOD counselor or other practitioner with training or experience providing SUD services » One or more peer support specialists » Other qualified staff	FSP ICM teams may include a mix of full-time and part-time providers, including: » FSP ICM team lead » A psychiatrist or other prescriber » Registered nurses/Licensed Vocational Nurses » Peer support specialists » Other qualified staff Given the lower acuity of individuals typically served in FSP ICM compared to ACT, some teams may choose to utilize more RN and peer specialist time to better meet individual needs.	All ACT teams are expected to have a licensed clinician serve as the ACT team lead. FSP ICM teams may designate a licensed clinician to serve as the FSP ICM team lead, but are not required to. Additionally, while FSP ICM teams include many of the same provider types as ACT, they serve individuals with a lower acuity than ACT, and may include a higher ratio of non-licensed practitioners compared to ACT teams.

	ACT/FACT	FSP ICM	Key Differences
Team Functions	ACT is a self-contained, team-based service that is expected to serve the following key functions: » Provide the majority of services that an individual needs, including therapy, crisis services when needed, supported employment and other recovery supports, care for co-occurring SUDs, and linkages to needed social services and supports. » ACT teams should rarely, if ever, refer individuals to external behavioral health providers for management of their SMI and/or co-occurring SUD, unless the individual requires intensive SUD treatment (e.g., SUD residential or inpatient withdrawal management). ACT teams should include at least one AOD counselor or other practitioner with SUD training or experience that can provide co-	FSP ICM is a self-contained, team-based service that is expected to serve the following key functions: » FSP ICM teams provide services based on individual needs and may refer individuals to additional services the team cannot provide such as crisis services, supported employment, and care for co-occurring SUDs. » FPS ICM teams are comprised of a mix of full-time and part-time team members. » FSP ICM teams provide persistent and committed engagement to lower acuity individuals. » FSP ICM provides integrated, time-unlimited service delivery. » FSP ICM teams provide linkages to physical health services (e.g., hygiene, dental) and other	ACT teams have full responsibility for client care and service delivery and should rarely refer individuals to external providers for behavioral health management. ACT teams members must be full-time and engage in regular team meetings (generally daily). ACT teams service individuals who may be ambivalent about engagement in treatment despite severity of need. Compared to FSP ICM, ACT teams may need to be more persistent in assertive engagement. Unlike ACT, FSP ICM teams may include part-time team members and may not meet as frequently as ACT teams.

	ACT/FACT	FSP ICM	Key Differences
	occurring SUD treatment, including arranging for or providing Medication-Assisted Treatment (MAT) when appropriate. ACT teams should include a psychiatrist or other prescriber who is a fully integrated member of the team. » ACT teams are expected to participate in regular (generally daily) team meetings to help coordinate care, facilitate information sharing, and help team members remain apprised of an individual's treatment progress. In addition: » ACT is primarily field-based and teams are comprised of dedicated (i.e., full time) team members. » ACT teams provide persistent and committed engagement.	supportive services (e.g., food, transportation, housing) as needed.	

	ACT/FACT	FSP ICM	Key Differences
	» ACT provides integrated, time-unlimited service delivery. » ACT teams provide linkages to physical health services (e.g., hygiene, dental) and other supportive services (e.g., food, transportation, housing) as needed.		
Caseload	A full-size ACT team should include at least 10 FTE and serve a caseload of 80-110 individuals. FACT teams include at least one team member with lived experience related to the criminal justice system.	FSP ICM teams may vary in size, but should not serve more than 25 individuals per 1 FSP ICM practitioner. While FSP ICM guidance does not specify number of FTEs, counties should align the staffing model with the needs of the individuals receiving services.	ACT teams of 10 FTE typically serve 80-110 individuals. FSP ICM teams may include fewer FTE and/or serve a larger caseload than ACT teams. For example, a FSP ICM team of 10 FTE would serve a caseload of approximately 250 individuals, and a team of 4 FTE would serve a caseload of approximately 100 individuals.