Multi-County FSP Evaluation Project

Final Report 2021-2022

Department of Behavioral Health

Introduction

This the final update and report for Fresno County's Innovation Plan Project Multi-County Full-Service Partnership Innovation Project. Fresno County is one of the six counties (and the initial county approved) to formally participate in the project seeking to learn how to improve the Full Services Partnerships (FSP), the largest component of the Mental Health Services Act. Fresno County spent the past three years working closely with Third Sector and five initial counties to standardize and transform the FSP services.

Fresno County's three-year project was completed in September of 2022. The statewide project continues with Third Sector and new county participants.

The Statewide FSP project's research and collaboration was only slightly delayed by the pandemic, and stakeholder and providers were able to actively participate in the project. Technology was an integral tool for engaging stakeholders and conducting the important work of shifting the way California counties and cities will develop, operationalize, and assess FSP programs to be more data-driven and outcomes-focused.

Background

Fresno County's INN plan was approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the plan June 2019. As such Fresno's plan and work was initiated before the other counties were approved to start and this did place Fresno County on a different cycle than the overall project. Fresno County's involvement concluded in September of 2022.

As an early project participant, Fresno County was able to progress further with some of the project's early work. As a result of the earlier approval, Fresno County's three-year project/funding clock began before others. Fresno County's three-year cycle began earlier than other participating counties due to expending its project funds, but its funding of the statewide and local work are on the same schedule/timeline as the other five counties. Upon conclusion of the Innovation plan term, Fresno County will continue to participate in the project's Learning Community of 11 counties.

Fresno Country expended the allocated funding of $950,000 for this statewide project during the three years. Fresno County began to expend project funds September 3, 2019. The project concluded in September of 2022.

Fresno County's FSP programs are all contracted out to various community providers. Many of Fresno County's FSP programs provide services to specific populations including children and TAY, cultural populations, geographic regions, and individuals with specific service needs (justice-involved individuals, those with co-occurring disorders, etc.). During Fresno County's participation in the project, there were ten FSP programs operating. Below is the list of those FSP programs during this project's term.

- Adult FSP

• Vista- operated by Turning Point of Central California
• Sunrise- operated by Turning Point of Central California
• D.A.R.T. West- operated by TRUN (formerly Mental Health Systems)

- Population-Specific FSPs

• AB 109 FSP- operated by Turning Point of Central California, serving individuals who are justice-involved.
• Enhanced Rural FSP- operated by Turning Point of Central California, serving the rural communities of Fresno County
• IMPACT- operated by TURN (formerly Mental Health Systems, serving individuals with co-occurring disorders
• Culturally Specific Services- operated by The Fresno Center, serving the Southeast Asian population

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- Children's FSP

• Bright Beginnings for Families (ages 0-10yrs of age) — operated by Comprehensive

• Youth Services, Exceptional Parents Unlimited, and Uplift Family Services
• Transition Aged Youth (TAY) Services and Supports FSP—operated by Central Star
• Children & Youth Juvenile Justice Services ACT—operated Uplift Family Services

In all, Fresno County had ten FSP programs operated by seven different community-based organizations. Most providers actively participated in the project, providing valuable insights and perspectives. Some providers and programs struggled to participate fully throughout the project, which provided a learning opportunity for the county regarding ways to support providers to participate in evaluation.

Final Learning

The attached report (Appendix A) developed by Third Sector provides the details of the work and recommendations for Fresno County's FSPs.

The final recommendations provided by the project have provided Fresno County with insights to improve processes, move to standardize FSP criteria, improve program designs to help improve outcomes, and lastly to improve program oversight. The recommendations are being adopted by the Department through work with the Quality Improvement team, Public Behavioral Health (who oversees MHSA activities), and the Contracts Division which oversees the various FSP service agreements.

There were plans to implement the recommendations into new program designs, which would be used in the Request for Proposal (RFP) and subsequent contracting process. At the same time the county anticipates using the current fiscal year (2022-2023) to implement California's payment reform, which will have an impact on all the FSP programs and will be part of new RFP and designs. As such the County is exploring extending all programs by an additional year to navigate payment reform, and in the following year issue the RFPs with new FSP designs using the learning and recommendations from the work of this statewide FSP evaluation.

Appendix

THIRD SECTOR

California Multi-County Full Service Partnership Innovation Project: Year 2

Summary Report

January 2022

Project Overview

Since the passage of the Mental Health Services Act (MHSA) in 2004, California has made significant strides in improving the lives of those living with mental illness.

In particular, Full Service Partnership (FSP) programs support people with the most severe and often co-occurring mental health needs. These MHSA-funded FSP programs are designed to apply a "whatever it takes" approach to partnering with individuals on their path to wellness and recovery. Currently, over 60,000 individuals are enrolled in an FSP program across the state.

Full Service Partnerships represent a $1 billion annual investment of public funds in the well-being of the people of California. This investment has tremendous potential to reduce psychiatric hospitalizations, homelessness, incarceration and prolonged suffering by Californians with severe mental health needs. FSP programming, however, varies greatly from county to county, with different operational definitions and inconsistent data processes that make it challenging to understand and tell a statewide impact story.

In partnership with Third Sector and the Mental Health Services Oversight and Accountability Commission (MHSOAC), a cohort of six diverse counties[1]—Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura—are participating in a 4.5-year Multi-County FSP Innovation Project that leverages counties' collective resources and experiences to improve FSP delivery across California. Additional project partners include the California Mental Health Services Authority (CalMHSA) acting as the fiscal agent and RAND Corporation providing consultation on measurement and conducting the project's post-implementation evaluation.

The Multi-County FSP Innovation Project implements a more uniform, data-driven approach, enhancing counties' ability to use data to improve FSP services and outcomes. The project advances the efforts of LA County's Department of Mental Health FSP transformation, scaling their initial groundbreaking data and outcomes efforts to new geographies and localities with a statewide perspective. Counties leveraged the collective power and shared learnings of a cohort to maximize FSP program impact and ultimately drive transformational change in the delivery of mental health services.

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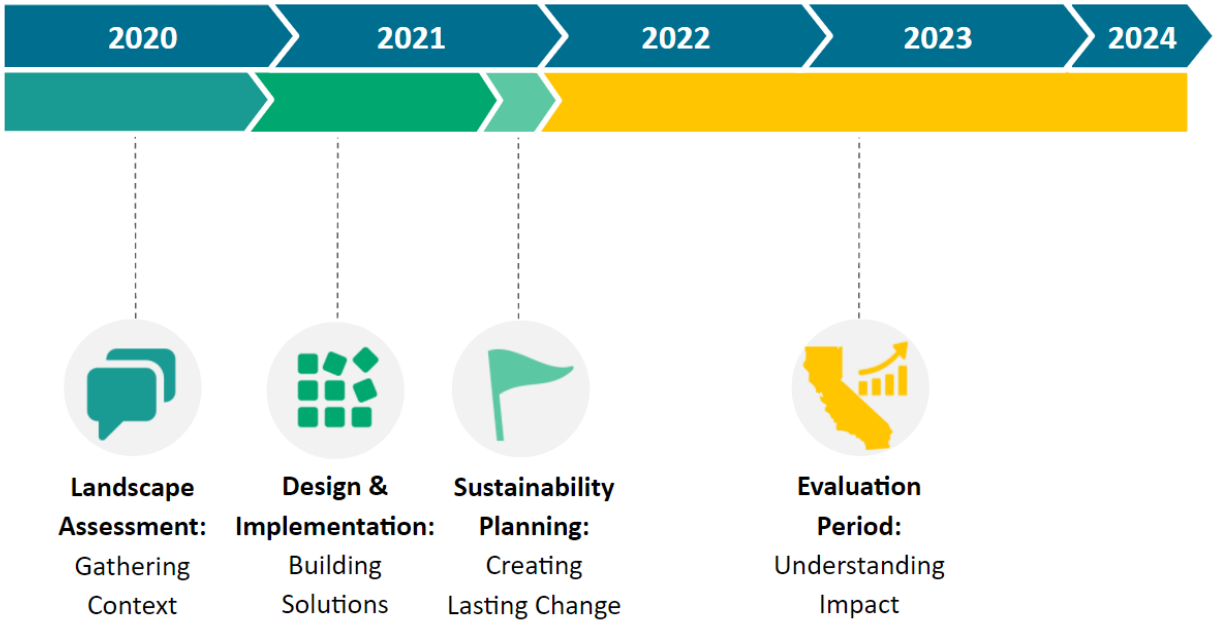
[1] Lake County and Stanislaus County joined this effort in August 2021 and will be implementing changes on a different timeline than the original six counties.

Project Purpose and Goals

The Multi-County FSP Innovation Project aims to shift the way counties design, implement, and evaluate FSPs to a more outcomes-oriented approach by:

1. Developing a shared understanding and more consistent interpretation of FSP's core components across counties, creating a common FSP framework;
2. Increasing the clarity and consistency of enrollment criteria, referral, and transition processes through developing and disseminating readily understandable tools and guidelines across stakeholders;
3. Improving how counties define, collect, and apply priority outcomes across FSP programs;
4. Developing a clear strategy for tracking outcomes and performance measures through various state-level and county-specific reporting tools; and
5. Developing new and/or strengthening existing processes that leverage data to foster learning, accountability, and meaningful performance feedback in order to drive continuous improvement in program operations and outcomes.

Progress To-Date



Landscape Assessment: Gathering Context & Building a Vision

In the beginning of 2020, counties began this effort with a nine-month Landscape Assessment phase to understand FSP program assets and opportunities. Understanding that county mental and behavioral health agencies often work with limited resources, counties created a 'cohort' structure in which the six

counties met regularly to share information, resources, and ideas to promote cross-county learning and plan cross-county activities so counties could more effectively deploy their resources. Through a combination of cohort meetings, conversations with county staff across departments, document review, and stakeholder engagement, counties developed a comprehensive understanding of their similarities and differences across FSP service design, populations, data collection, and eligibility/graduation practices.

The six-county cohort structure was essential to the counties building a collective vision and aligning on project priorities. By the end of the Landscape Assessment phase, the cohort narrowed in on a feasible set of implementation activities that would create data-driven FSP programs and build increased consistency in the way FSPs are designed, operated, and assessed. In addition to work counties underwent together as a cohort, counties also selected activities that were specific to their individual county context.

> **"We need to clarify what FSP stands for and how to implement it in a more detailed fashion. There is a lot of misunderstanding and lack of engagement with what FSP is and how it gets implemented." —Ventura County staff**

Design & Implementation: Building Solutions

In October 2020, counties conducted a 12-month Implementation Phase to build and operationalize three shared **"cross-county"** FSP improvements that counties worked on as a cohort, as well as county-specific "**local county initiatives."**

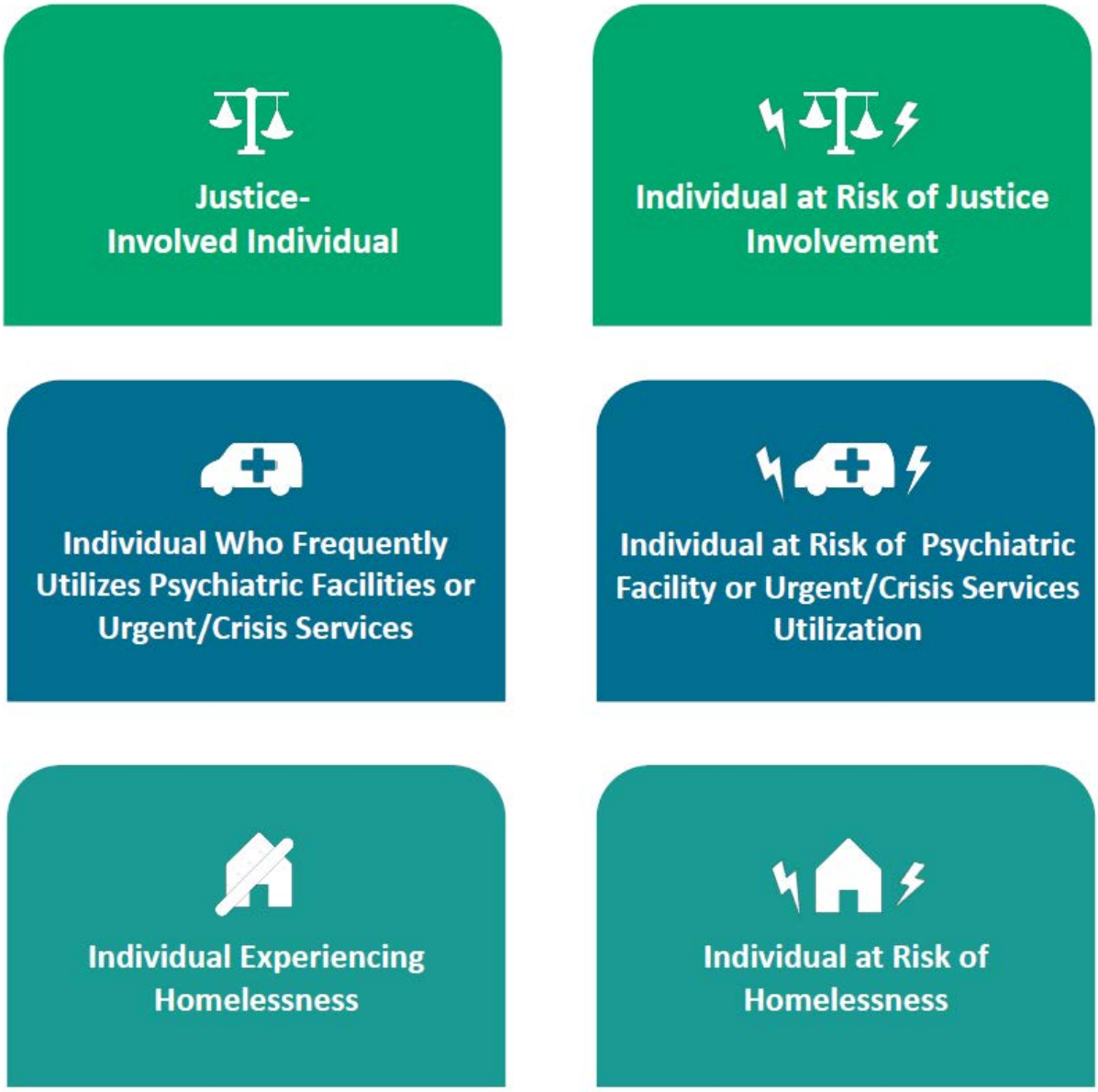
Cross-county activities: Counties embarked on a trailblazing journey to build shared population definitions, outcomes, process measures, and statewide data recommendations, holding more than 30 meetings with more than 25 behavioral health staff. As a result, counties now have more actionable FSP data that they can use to compare and share outcomes across counties and with a broader group of stakeholders, including the service providers and the people that they are serving.

- **Population Definitions:** Counties shared concerns that the lack of standardized definitions for FSP focal populations, both within and between counties, was preventing counties and providers from 1) having a consistent understanding of who is eligible for FSP, and 2) comparing how effectively providers are serving these populations For example, if one county considers a motel stay to be a form of stable housing and another county considers a motel stay to be homeless, it will be difficult to compare outcomes or share best practices for serving individuals experiencing "homelessness").

  To address this challenge, counties drafted definitions for six key FSP populations using as a model Third Sector's work with Los Angeles County to define focal populations for both eligibility criteria and outcomes tracking, best practices from the California Institute for Behavioral Health Solutions (CIBHS), resources currently used by counties, and feedback from additional county staff and the FSP provider community.

THIRD SECTOR

FSP Population Definitions



Outcomes & Process Measures

- **Outcomes & Process Measures:** Because MHSA regulations are somewhat broad in their guidance for what FSPs should be aiming to achieve, participating counties worked together to identify standardized measures for tracking what services individuals receive and how successful those services are. Guided by more than 70 FSP participant interviews and recommendations around evidence-based practices from the project's evaluator, RAND, the counties selected and defined five measures to compare across counties for adult FSP participants.

Increased Stable Housing

Data Source: DCR

A) The number of days that each person experienced (i) stable housing, (ii) temporary housing, and (iii) unstable arrangements during the previous 12-month period

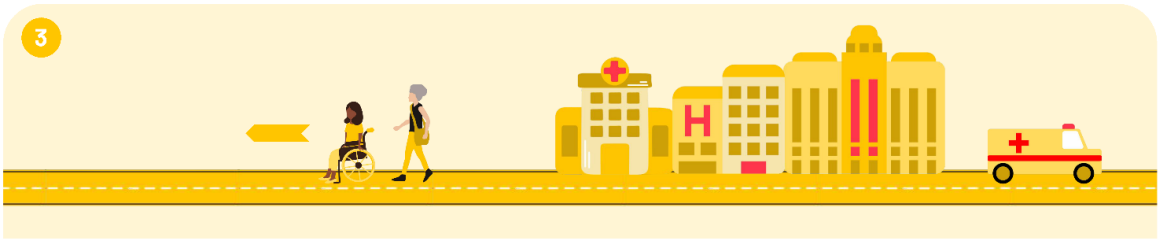
B) The number of times that each person experienced unstable housing/homelessness during the previous 12-month period

Reduced Justice Involvement

Data Source: DCR

A) Whether each person was incarcerated (yes/no) over the previous 12 months

B) The number of arrests that each person experienced during the previous 12 months



Reduced Utilization of Psychiatric Services

Data Source: EHR Systems

Measure #1: Reduced Psychiatric Admissions

A) The number of days hospitalized that each person experienced during the previous 12-month period—in both psychiatric hospitals and general hospitals receiving psychiatric care

B) The number of psychiatric admissions that each person experienced during the previous 12-month period—in both psychiatric hospitals and general hospitals receiving psychiatric care

Measure #2: Reduced Crisis Stabilization Unit (CSU) Admissions

The number of CSU admissions that each person experienced during the previous 12-month period

Increased Social Connectedness

Data Source: DCR

1-item measure: "How often do you get the social and emotional support that you need?" *[Response options include: always, usually, sometimes, rarely, never]*

Frequency & Location of Services

Data Source: EHR Systems

Number and location of the following services received: Individual Therapy, Group Therapy, Rehab Services, Medication Management, Case Management, Housing Services

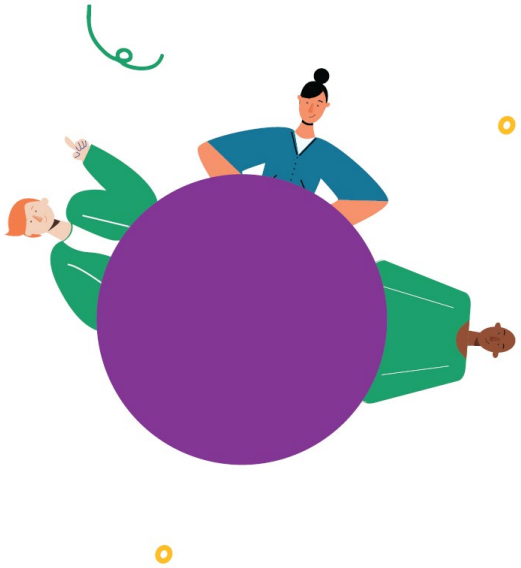
- **State Reporting Recommendations:** County and provider staff both expressed challenges with the current Data Collection and Reporting (DCR) system and articulated a desire for an advocacy initiative to address these challenges and advance efforts for more data-driven programming. To thoroughly understand unique perspectives from across the state, the six-county cohort launched a stakeholder engagement process that involved surveying 17 counties and convening more than 80 FSP providers and program administrators to discuss their experiences and ideas for enhancing the accuracy and functionality of the DCR. The data collected through those forums was compiled into a Data Collection and Reporting (DCR) Recommendations Memorandum that includes actionable system improvement recommendations. Counties then partnered with the County Behavioral Health Directors Association of California (CBHDA), which represents all 58 counties, to open a pathway of collaboration with the Department of Health Care Services (DHCS). Leveraging CBHDA to further the advocacy of this initiative has proven to be an effective strategy and conversations with DHCS are underway.

"We need to improve how we track data to make clinically-relevant, person-first decisions about clients and use clinical data to inform programmatic decisions—a uniform, consistent process to zoom out on length of stay, hospitalizations, and other outcomes."
—Fresno County staff

"All FSP clients have complex needs. We want to validate how hard it is to define success—but a question we're wrestling with is how we can use currently collected data meaningfully to inform our programs, and what information will demonstrate impact.
—Ventura County staff

Statewide Learning Communities and Workshops

- **December 2019**: More than 40 participants from 17 California county agencies and the state Mental Health Oversight Commission (MHSOAC) attended a statewide workshop focusing on building a collective vision for statewide FSP outcomes and discussed the future of FSP Learning Communities.
- **October 2020:** Third Sector, the MHSOAC, behavioral health and provider staff from Fresno and San Bernardino counties, and individuals receiving FSP services co-facilitated a public webinar to share efforts to date to develop shared practices for using data to create more successful FSP services and outcomes across six counties.
- **March 2021:** Third Sector, the MHSOAC, the Departments of Mental/Behavioral Health in San Mateo, Sacramento, and Los Angeles counties, along with individuals from their respective provider and participant communities, hosted a public webinar to share promising approaches to improving cultural responsiveness and reducing outcomes disparities in mental health services.
- **June 2021**: More than 80 participants from 36 California county agencies attended a statewide workshop focusing on 1) identifying the key challenges related to utilizing the DCR system to understand participant progress and develop date-driven service provision and 2) identifying potential solutions to address these challenges.



Local County Initiatives

Counties each identified 2-3 county-specific priority initiative to implemented locally at the same time alongside the cross-county initiatives. While multiple counties pursued the same local initiatives, results varied across the state because of counties' distinct populations, geographies, and needs. Counties were able to efficiently and effectively implement each of these improvements by sharing tools, processes, and ideas, benefiting from a cohort approach even as results show nuanced differences.

Local Initiative	Participating Counties
Graduation Guidelines Standardizing graduation criteria and/or guidelines that balance unique participant needs and system-wide outcomes in making individual graduation decisions, including creating improved definitions of "stability" and "recovery."	Sacramento, San Mateo, Ventura, San Bernardino, Siskiyou
Service Requirements Developing minimum FSP service requirements to adopt as official guidance. These depend on local context and priorities and could include the percentage of field-based services, the availability of telehealth options, housing services, employment services, and peer supports.	San Mateo, Ventura, Siskiyou
Reauthorization Process Standardizing an FSP reauthorization process and/or tools that can be used by counties to more regularly assess whether a participant is ready to stepdown from FSP services.	Fresno, Sacramento
Eligibility Guidelines Revising county-specific FSP eligibility criteria to ensure that counties prioritize FSP services to the highest-need individuals.	San Mateo, Ventura
Data Collection & Reporting Streamlining existing processes and/or developing new data collection methods and reports so that counties and providers can more effectively collect, access, and utilize FSP data to inform care and programmatic decisions.	Fresno, San Bernardino
Referral Process & Guidelines Creating standardized processes and guidelines around FSP referrals including developing consistent referral forms and protocols across providers, drafting a more centralized referral approval process, and/or ensuring a warm hand-off between referral and enrollment.	Fresno, San Bernardino

Fresno

Fresno's Department of Behavioral Health redesigned its processes for referral and enrollment, reauthorization, and data collection and reporting using input from FSP participants, caregivers, providers and cross-departmental county staff. These process improvements will equip staff to make more **data-informed decisions throughout participants' time in FSP**, from the point of referral until graduation.

Sacramento

Sacramento Behavioral Health Services created new guidelines and tools for FSP stepdown and graduation, including operational improvements that will help staff normalize graduation in conversations with participants and prevent individuals from getting "stuck in services." As a result, FSP staff have a shared understanding of "stepdown readiness," which will also **help graduating participants experience a smoother transition**.

San Bernardino

San Bernardino's Department of Behavioral Health developed new adult FSP referral forms, data reports, and graduation guidelines with input from more than 72 stakeholders. With these changes, individuals can access FSP services more quickly and participate in their own transition planning. FSP staff now have **data tools to understand program-level outcomes** (including population disparities) and inform programmatic decisions.

San Mateo

San Mateo Behavioral Health and Recovery Services designed new eligibility, service, and graduation guidelines across its child FSP system of care, leading to **more consistent and recovery-oriented programs** for young people living with SED or SMI. These program improvements will be reinforced with updated RFPs, provider contracts, and county policies in 2022.

Siskiyou

Siskiyou County Behavioral Health Services developed new guidelines for FSP services and graduation, building on Strengths Model case management to integrate a recovery-oriented approach. With this additional structure and clarity, staff are now equipped to prioritize individuals with the most intense needs and deliver services in a team environment, and participants have a greater role in **defining wellness and recovery** for themselves.

Ventura

Ventura County Behavioral Health developed guidelines for FSP eligibility, services, and graduation, leading adult programs to become more consistent, responsive, and better equipped to provide intensive wraparound care. These changes give staff **greater treatment flexibility and team support**, leading to better participant experiences and outcomes within FSP.

"Slowly ease me into the transition process, rather than abruptly changing services. Not, oh we're done with you. Hope you have a good life."

—Sacramento County FSP participant

"Service delivery guidelines are being written as we go along, adapting to the needs of program staff. Staff have freedom to be creative and we don't want to stifle this, but we've had staff changes, so there's definitely a need to actually write down service guidelines."

-Ventura County staff

Sustainability Planning: Creating Lasting Change

In October 2021, the six-county cohort began preparing for RAND's evaluation and ongoing cross-county data sharing and continuous improvement (CI) processes. During this time, a second wave of counties—Lake and Stanislaus—joined the Multi-County FSP Innovation Project and began attending meetings to offer additional insights into the cross-county activities and data processes they will eventually be implementing as part of the cohort.

This phase of the project has included efforts to customize the Enhanced Partner-Level Data (EPLD) templates that counties can use to standardize how they share and analyze state-reported DCR data. Counties will continue meeting monthly to discuss the progression and interim results of the evaluation and to further build out shared data reporting capabilities. Ultimately, these monthly meetings will transition into a recurring forum where participating counties can share outcomes data with one another, identify best practices, and strategize new operational improvements to pilot.

Evaluation Period: Measuring Progress

The six counties and RAND Corporation will continue working together on the project's two-and-a-half-year evaluation phase. RAND will conduct both quantitative and qualitative analyses to assess participant outcomes and plans to release final evaluation results in 2024. *Please see "A Look Ahead" on pp. 14 for more details.*

Stakeholder Insights

Effective stakeholder engagement leverages their knowledge and experience to provide a deeper understanding of challenges on the ground, while identifying goals and solutions that solve for the needs articulated by stakeholders. For the Multi-County FSP Innovation Project, these key stakeholders included FSP participants, participants' primary caregivers, and service providers. Third Sector and participating counties engaged representatives from each of these groups to better understand FSP programs from their perspectives. The project launched two iterative stakeholder engagement initiatives: one to learn about participants' experiences in FSP and prioritize challenges to address, and another to inform the design and implementation of solutions at the county and cohort level.

Stakeholder Engagement by County and Statewide

- **Fresno** - 32 participant interviews | 70 provider survey responses | 10 provider focus groups with 29 staff
- **Sacramento** - 32 participant interviews | 7 provider focus groups with 40 staff
- **San Bernardino** - 24 participant interviews | 10 provider survey responses | 4 provider focus groups with 23 staff | 2 peer and family advocate focus groups with 5 staff
- **San Mateo** - 27 participant interviews | 4 provider focus groups with 20 staff
- **Siskiyou** - 23 participant interviews | 2 provider surveys | 4 provider focus groups 30+ staff
- **Ventura** - 41 participant interviews | 8 provider focus groups with 48 staff
- **Cohort** - 57 survey responses from 17 California counties

Participant feedback played an important role throughout the project by helping counties and Third Sector understand the goals and needs of those being served. Participants were asked about their experience enrolling in or stepping down from FSP to a less-intensive level of service, services that were important for them, and goals they hoped to achieve. These participant insights became the basis for prioritizing cross-county outcomes and process measures.

"I want to be a 'normal person.' I don't want to be labeled a mental health patient."
—San Bernardino FSP participant

"Social isolation is a problem for me in a small town with nowhere to go. This has made getting kind of meaningful social interaction really difficult to acquire."
—Siskiyou County FSP participant

"Success would be for me, at least a semester of school, getting my own apartment. And feeling like less of a mental health case, and more of a, I guess, normal person."
—Fresno County FSP participant

One key "win" from this process was the decision to put more focus on measuring increased social connectedness, an outcome that has been historically difficult to track but was consistently named by participants as critical to their recovery journey. Insights from FSP participants also served as the basis for building participant-centered step down processes and criteria in five counties.

Provider feedback also played an important role in not only determining which implementation activities to pursue, but also in determining which outcomes and process measures to prioritize, how adult FSP focal populations should be defined, and what changes would need to be made to state reporting to ensure that counties and providers could better implement data-driven programming and team operations. At the cohort level, provider feedback was largely collected through digital surveys; even so, providers in several counties participated in recurring workgroups to build county-specific solutions, including new referral processes, step down guidelines, and service guidelines. By co-designing these

innovations with behavioral health and provider staff, counties now have "buy-in" across their stakeholders to effectively operationalize new policies and processes.

Stakeholder Engagement Lessons Learned and Best Practices

1. **Ground decisions about policies and operational practices in FSP participant experience**, including data reporting and outcomes measurement.
2. **Engage stakeholders early and often** in order to maximize the amount of time spent hearing from the community and ensure their voices are included in not only the design of the solution, but also the articulation of the challenge.
3. **Compensate FSP participants for their engagement** to recognize the value of their time and contributions.
4. **Leverage both county advocates and third-party facilitators** as necessary to surface deeper insights and bridge potential trust gaps.
5. **Use trauma-informed and healing-centered techniques** to reduce harm and avoid re-traumatization, especially when discussing sensitive topics.
6. **Train staff in cultural competency,** equipping them with language and tools to facilitate discussions about identity and culturally specific needs with participants.

Cross-County Collaboration Lessons Learned

Cross-county projects involve significantly more stakeholders, adding complexity to coordination and decision-making processes. With thoughtful planning, flexibility, and human connection, these challenges can be successfully navigated and lead to powerful collaborations with far-reaching impacts.

1. **Consider which activities are appropriate for statewide standardization vs. local customization.** In other words, some areas are ripe for statewide collaboration: outcome definitions, metrics, and data collection are appropriate to pursue collectively to achieve a unified result, such as shared state data reporting requirements. Other activities should be customized to a local context. For example, counties can pursue parallel processes for eligibility, step down, and service design while still sharing resources and learnings across counties. This creates efficiencies while honoring counties' distinct geographies, populations, and histories.
2. **Maintain a flexible approach tailored to individual county needs while pursuing a shared vision.** State collaborations inevitably draw counties of varying sizes, structures, resources, and internal cultures. Recognizing these differences upfront can provide context and help mitigate challenges, allowing each county to pursue a shared vision while following a unique path.
    - ***Work-planning and meeting cadence:*** Counties range in their staff capacity and dedicated project resources, making a uniform workplan and meeting cadence infeasible. Mitigation strategies can include:

- Shifting scheduled meetings to independent work, allowing counties to work at their own pace;
- Sequencing activities so that staff are not managing multiple initiatives simultaneously (e.g. local county and cohort work);
- Adjusting the volume of activities based on counties' capacity. This requires participants to understand the anticipated workload and make clear commitments at the time they select activities to implement.

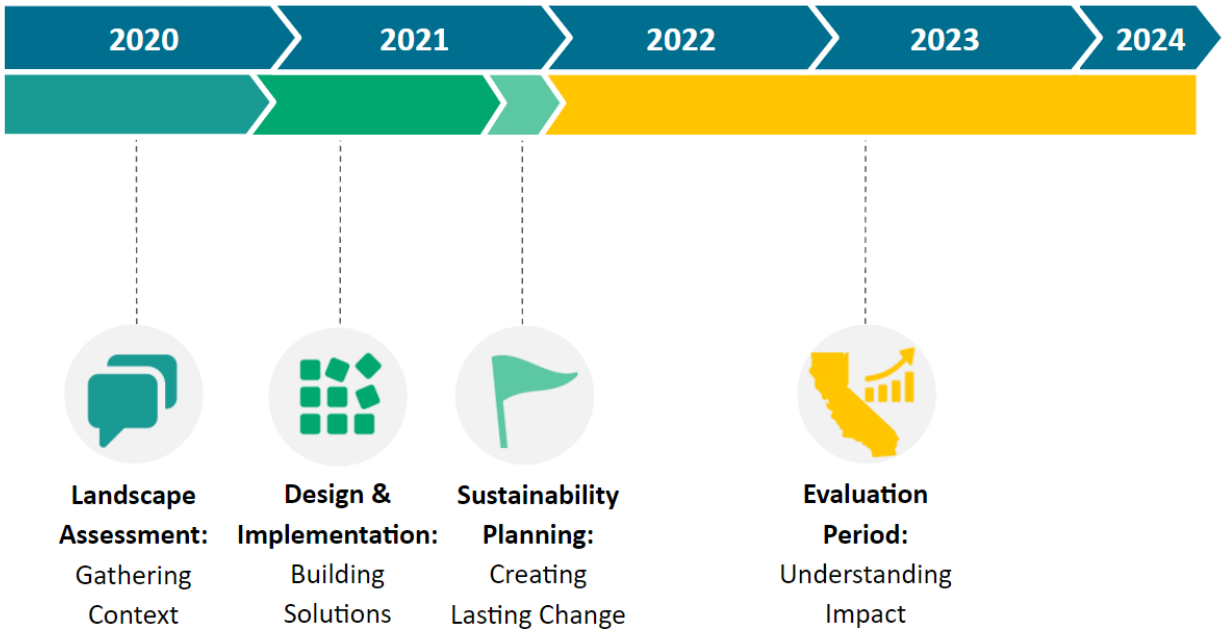
- ***Communication:*** When running multi-year projects with large numbers of stakeholders and many phases of work, one can expect a healthy amount of staff turnover and reorganization. Recognizing that this can create information gaps and challenges with the level of project buy-in from new staff, it is important to establish robust communication practices. Mitigation strategies can include:
  - Setting upfront expectations for an iterative process that will be regularly revisited based on external feedback from providers, individuals served, and other key stakeholders;
  - Clearly documenting group decisions and the rationale behind these decisions;
  - Continuously referring back to shared project goals to keep everyone aligned on the shared vision; and
  - Streamlining communications and centralizing action items in one place.

- ***Implementing new processes***: Counties with well-developed data infrastructure may face more challenges with innovating and operationalizing changes, compared to those with less infrastructure. For example, some counties were able to adopt new data fields with relative ease, while counties with established practices hesitated to change or replace their existing practices. Internal county administrative processes and decision-making culture also play a role when advocating for change. Mitigation strategies can include:
  - Facilitating conversations about the tradeoffs of standardizing data practices, which may involve changing and creating potential redundancies with counties' existing data infrastructure;
  - Ensuring county staff and department leaders can commit to implementing solutions; and
  - Clearly identifying areas where all counties are open to innovating their processes to align with each other.

3. **Value informal learning as highly as formal meetings and project structures.** While cross-county meetings were a structured forum for designing and delivering on specific cross-county activities, these touch points also served as a valuable opportunity for the six counties to informally learn from one another and share best practices. In addition to the regularly scheduled agenda topics, counties also used this time to exchange insights around streamlining data reporting practices, effectively leveraging flexible funding, and developing annual reports. Counties recognized the inherent value in these informal, peer-to-peer interactions, and plan to utilize the relationships formed during the project to continue meeting regularly and reaching out to one another for ad-hoc support.

Overall, there is tremendous value in a cross-county cohort model when counties are able to identify appropriate areas of standardization across initiatives and approaches and share knowledge continuously throughout the project and beyond. As the Multi-County FSP Innovation Project expands, new counties that join can expect to benefit from the expansive lessons learned from the original six-county cohort. New counties will also be able to adopt the standardized innovations developed by the original cohort; and while joining the project on a later timeline may limit the ability to modify some of the previously developed solutions, it can also provide greater flexibility in timeline and structure to pursue more locally customized initiatives.

A Look Ahead

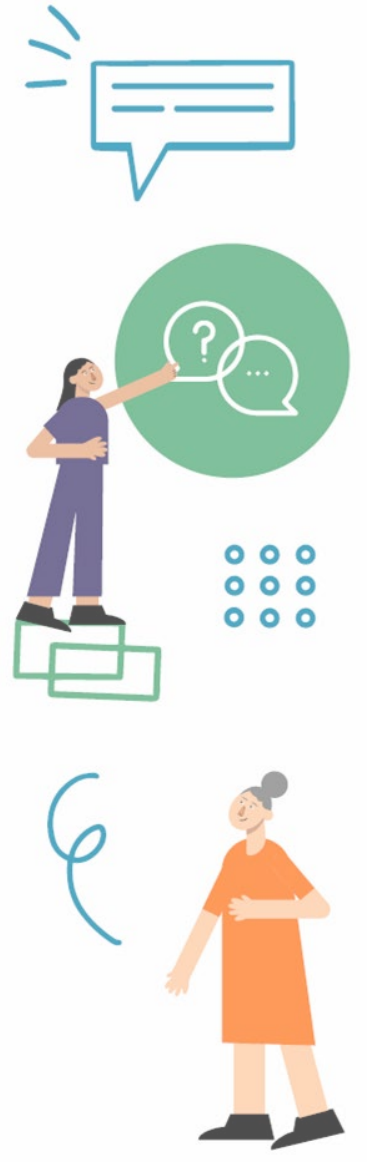


The original six counties and the evaluator, RAND, will continue working together through mid-2024 on the project's 2.5-year evaluation phase. The first pull of baseline data will take place in January of 2022 and data collection will continue every six months thereafter. RAND will also be conducting qualitative interviews to understand if and how participants perceive the changes that counties have made to their FSP operations as a result of this project's effort. Throughout 2022, counties will be meeting monthly to discuss the evaluation, troubleshoot data sharing and data cleaning challenges, develop consistent reporting practices across counties, share data on standardized metrics, and examine data trends that could lead to future operational improvements.

In addition to the ongoing evaluation and continuous improvement activities for the original six counties, the work of the Multi-County FSP Innovation Project will continue through a second wave of counties, Lake and Stanislaus, that joined the project in the fall of 2021. Lake and Stanislaus participated in the final

stages of the cross-county work undertaken by the six-county cohort and will adopt the outcomes, process measures, and population definitions as defined by the project. In 2022, these two counties will build on this work and identify several county-specific activities to pursue over the next year with Third Sector's technical assistance. RAND's evaluation period for these two additional counties will begin in mid-2023.

Third Sector and the eight participating counties believe the strategies piloted on the Multi-County FSP Innovation Project have the potential to increase the **consistency**, **quality**, and **effectiveness** of care across the state. Learnings from the project and its evaluation will be shared broadly with the intent to advocate for wider adoption and shape statewide policy and programming. The Multi-County FSP Innovation Project highlights the potential of cross-county collaboration to ignite a statewide movement dedicated to improving mental health services for individuals with the greatest needs.



Project Partners

County Partners

Fresno County Department of Behavioral Health

Fresno County is located in the heart of California's Central Valley. Fresno County Department of Behavioral Health serves individuals across 6,000 square miles, encompassing mountain enclaves, urban neighborhoods of California's fifth largest city, and rural communities. In partnership with its diverse community, the Department is dedicated to providing quality and culturally responsive behavioral health services to promote wellness, recovery, and resiliency for individuals and families.

Sacramento County Behavioral Health Services

Sacramento County has a population of more than 1.4 million individuals and is known for its multi-cultural diversity. Situated in the middle of California's Central Valley, Sacramento County extends from the low delta lands between the Sacramento and San Joaquin rivers north to about ten miles beyond the State Capitol and east to the foothills of the Sierra Nevada Mountains. Sacramento County Behavioral Health Services' mental health system of care includes 260 programs/agencies involving county and contract operated mental health services that deliver services to approximately 32,000 children and adults annually. BHS pursues intentional partnerships with the diverse communities in Sacramento County and with the goal of improving the wellness of community members.

San Bernardino County Department of Behavioral Health

San Bernardino County is the largest county in the contiguous United States with just over 20,000 square miles of land that encompasses urban, suburban, rural and frontier terrain. According to California Department of Finance estimates for 2018, San Bernardino County had a total population of 2,174,931 with a projected growth of 28% between 2020 and 2045. San Bernardino County's Department of Behavioral Health (DBH) aims to promote wellness, recovery, and resilience that includes the values of equity, community-based collaborations, and meaningful inclusion of diverse FSP participants and family members. As such, San Bernardino County DBH serves over 150,000 individuals over a broad continuum of services each year.

San Mateo County Behavioral Health and Recovery Services

Located in the Bay Area, San Mateo County is bordered by the Pacific Ocean to the west and the San Francisco Bay to the east. Within its

455 square miles, nearly three quarters of the county is open space and agriculture remains a vital contributor to our economy and culture. Behavioral Health and Recovery Services (BHRS), a Division of San Mateo County Health, provides prevention, treatment and recovery services to inspire hope, resiliency and connection with others and enhance the lives of those affected by mental health and/or substance use challenges. BHRS is dedicated to advancing inclusion, health and social equity for all people in San Mateo County and for all communities.

Siskiyou County Behavioral Health Services

Siskiyou County is a geographically large, rural county with a population of 43,724 persons, located in the Shasta Cascade region of Northern California. Approximately 6,350 square miles, Siskiyou County, is geographically diverse with lakes, dense forests, and high desert. Siskiyou County Behavioral Health (SCBH) is a small Behavioral Health program and is the sole provider of the Full Service Partnership Program (FSP). SCBH is committed to partnering with the participants of this Innovation Project to better define FSP criteria and improve the data collection points to assist our FSP participants toward graduation and mental wellness. SCBH strives to deliver culturally, ethnically, and linguistically appropriate services to the community and recognizes the importance of these values in service delivery.

Ventura County Behavioral Health

Ventura County is situated along the Pacific Coast between Santa Barbara and Los Angeles counties. The county offers 42 miles of beautiful coastline along its southern border, and the Los Padres National Forest makes up its northern area. Ventura County Behavioral Health works to promote hope, resiliency and recovery for FSP participants and their families by providing the highest quality prevention, intervention, treatment, and support to persons with mental health and substance abuse issues.

Technical Assistance and State Partners

Third Sector

Based in San Francisco and Boston, Third Sector is one of the leading implementers of outcomes-oriented strategies in America. Third Sector has supported 20+ communities to redirect over $800M in public funds to data-informed, outcomes-oriented services and programs. Third Sector's experience includes working with the Los Angeles County Department of Mental Health (LACDMH) to align over $350M in annual MHSA FSP and Prevention and Early Intervention (PEI) funding and services with the achievement of meaningful life outcomes for over 25,000 Angelenos; transforming $81M in recurring mental health services in King County, WA to include new performance reporting and continuous improvement processes that enable the county and providers to better track monthly performance relative to peers and against specific, county-wide performance goals; and advising the County of Santa Clara in the development of a six-year, $32M outcomes-oriented contract intended to support individuals with serious mental illness and complex needs through the provision of community-based behavioral health services.

California Mental Health Services Oversight & Accountability Commission (MHSOAC)

In enacting Proposition 63, the Mental Health Services Act, California voters in 2004 created and charged the Mental Health Services Oversight and Accountability Commission with the responsibility of driving transformational change in public and private mental health systems to achieve the vision that everyone who needs mental health care has access to and receives effective and culturally competent care. The Commission was designed to empower stakeholders, with members representing FSP participants and their families, service providers, law enforcement, educators, and employers. The Commission puts FSP participants and families at the center of decision-making. The Commission promotes community collaboration, cultural competency and integrated service delivery. The Commission is committed to wellness and recovery, using its authorities, resources, and passion to reduce the negative outcomes of mental illness and promote the mental health and wellbeing of all Californians.

RAND Corporation

The RAND Corporation is a nonprofit, nonpartisan research organization headquartered in Santa Monica, California. RAND Health Care is a research division within RAND dedicated to promoting healthier societies by improving health care systems. We provide health care decision makers, practitioners, and the public with actionable, rigorous, objective evidence to support their most complex decisions. RAND has an extensive portfolio of mental health research and evaluation. Notably, we have been conducting independent, county-funded evaluations of the MHSA for almost a decade, including an evaluation of LA County DMH's FSP program and extensive work evaluating CalMHSA's statewide PEI programs. For more information, you can access over 80 reports on RAND evaluations of MHSA-funded programs at https://www.rand.org/health-care/projects/calmhsa/publications.html.

California Mental Health Services Authority (CalMHSA)

The California Mental Health Services Authority (CalMHSA) is a Joint Powers Authority (JPA) of the County and City public mental health departments that provides program management, administrative, and fiscal intergovernmental structure for its Members. A central component of CalMHSA's vision is to continually promote systems and services arising from a commitment to community mental health. CalMHSA administers local, regional, multi-jurisdictional, and statewide projects on behalf of the County and City public mental health departments.

Multi-County FSP Innovation Project

Fresno Project Overview Slides

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Origins of the Multi-County FSP Innovation Project

The Opportunity for Improvement

California has made significant strides since the creation of the Mental Health Services Act (MHSA). However, client data and concerns raised by county mental health directors suggest that counties still struggle to achieve and understand the impact of the intended outcomes for Full Service Partnership (FSP) programs.

An Initial County Pilot

From 2018 – 2021, the Los Angeles County Department of Mental Health partnered with Third Sector to transform FSPs into more outcomes-oriented and data-informed programs that reflect the spirit of doing “whatever it takes.”

The Multi-County FSP Collaboration

In 2020, six counties – Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura – launched the Multi-County FSP Innovation Project to leverage their collective resources and experiences to transform how data is used to continuously innovate and improve FSPs across California. In the fall of 2021, two additional counties – Lake and Stanislaus – joined the project.

Project Vision and Shared Goals

When the Multi-County FSP Innovation Project is complete, counties will have an improved ability to collect and use data that illuminates **who FSP is serving, what services they receive, and what outcomes are achieved**. Findings from each county will contribute to **statewide recommendations to create more consistent FSPs** that deliver on FSP's "whatever it takes" promise.

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

Project Timeline*

Landscape Assessment: Gathering Context

Design & Implementation: Building Solutions

Sustainability Planning: Creating Lasting Change

Evaluation Period: Understanding Impact

Project counties and the MHSOAC contributed $8.3M of state and local funding to support the multi-year collaboration

Project Roles & Responsibilities

Counties: The participating counties are Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura. Lake and Stanislaus joined the project as a Wave 2 in August 2021.

Third Sector: Third Sector is providing project management, outcomes-focused technical assistance, and implementation support.

RAND: RAND is providing data and outcomes technical assistance, data cleaning and quality improvement support, and conducting the overall project evaluation.

CalMHSA: CalMHSA is serving as the project's fiscal intermediary, including contract and fiscal management as well as administrative oversight.

MHSOAC: The CA Mental Health Services Oversight and Accountability Commission (MHSOAC) supported the Innovation planning process as well as the development of statewide project resources and Learning Community events.

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Landscape Assessment: Counties began by gathering context about their FSP programs, then prioritized changes

PROGRAMMATIC LANDSCAPE

Map current FSP programmatic landscape, including practices for referral, enrollment, services, stepdown, and data collection

IMPLEMENTATION ACTIVITY SELECTION

Facilitate provider and county conversations to choose activities to implement at both a local level and statewide

Impact: **Counties developed a comprehensive understanding of their similarities and differences across FSP programs and practices, leading to clear next steps for piloting change.**

Fresno County Implementation Activities

Fresno County Department of Behavioral health collaborated with providers to select the following activities to work on during the Multi-County FSP Innovation Project.

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 reports or methods so that DBH and providers can more effectively collect, access, and use FSP data to inform care decisions

Fresno also participated in a cohort of six project counties and pursued the implementation activities below

FSP POPULATION DEFINITIONS

Standardize definitions of FSP populations (e.g., homeless, justice-involved, high utilizer of psychiatric facilities, etc.)

OUTCOME & PROCESS METRICS

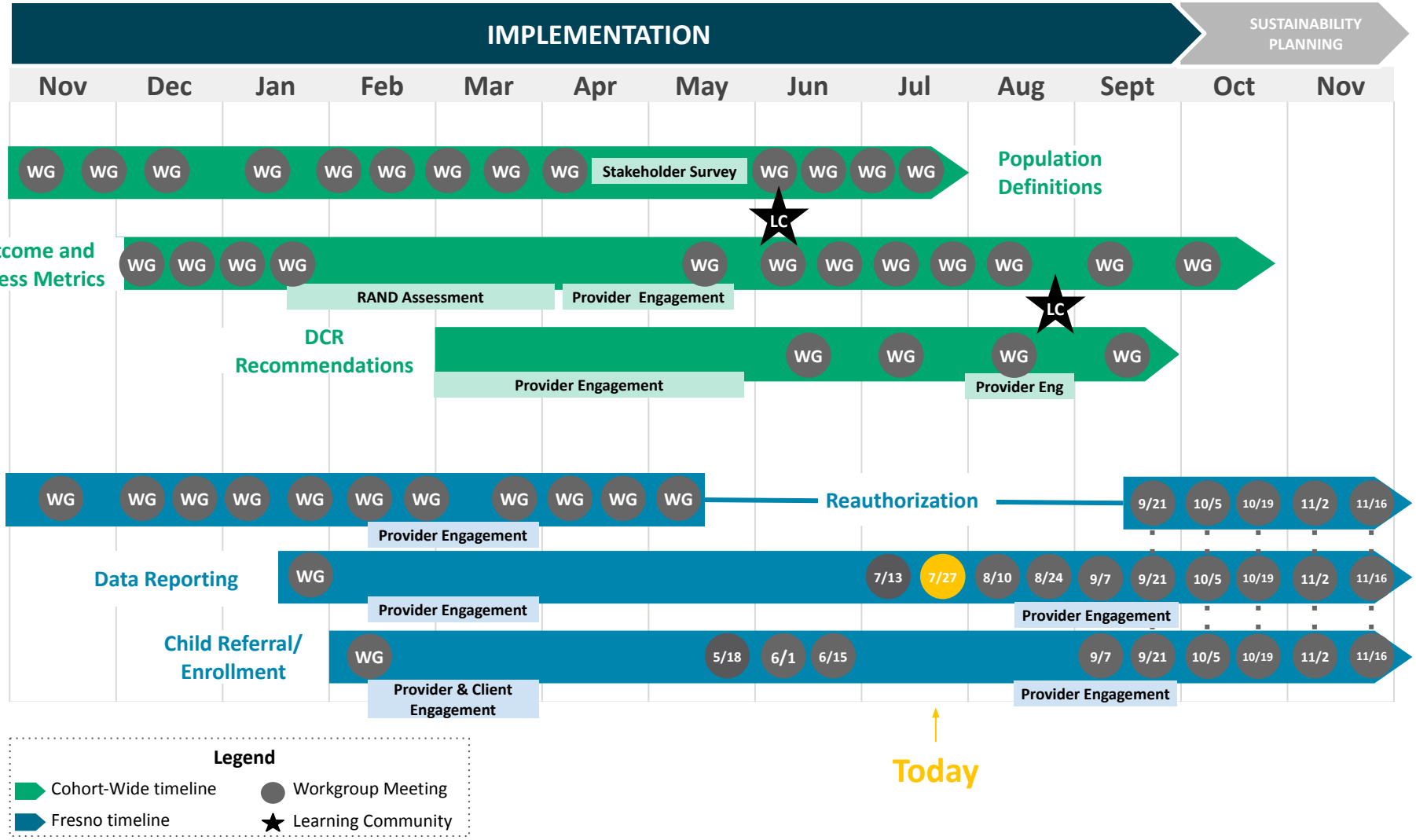
Identify priority outcomes and process measures to track what services FSP clients receive and the success of those services

STATEWIDE DATA RECOMMENDATIONS

Develop recommendations for revising Data Collection & Reporting (DCR) forms, metrics, and/or data reports to increase the utility of state data

Impact: Counties developed a shared understanding of who FSP serves, what outcomes it achieves, and how these outcomes should be measured.

Implementation Workplan Summary: Fresno



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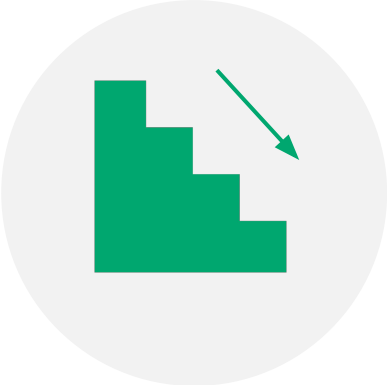
Comparison of Local Implementation Activities

County-Specific Activities	County Selections					
Description	**Fresno**	**Sacramento**	**San Bernardino**	**San Mateo**	**Siskiyou**	**Ventura**
Service Guidelines				X	X	X
Eligibility Guidelines				X		X
Graduation/Step Down Guidelines		X	X	X	X	X
Reauthorization Process	X	X				
Referral Forms & Protocols			X			
Data Collection & Reporting	X		X			
Youth Referral & Enrollment Process	X					

Sacramento County Implementation Activities

Sacramento County Behavioral Health Services (BHS) collaborated with providers to select the following activities to work on during the Multi-County FSP Innovation Project.



CLIENT STEP DOWN PROCESS

Develop a standardized FSP client stepdown readiness review process, supported by tools that help the County more regularly assess whether a client is ready to step-down while centering client needs and desires.

STEP DOWN GUIDELINES

Develop standardized graduation guidelines to support staff in making individual stepdown and graduation decisions while considering ISSPs and system-wide outcomes. Guidelines include improved definitions of “stability” and discussion prompts.

San Bernardino County Implementation Activities

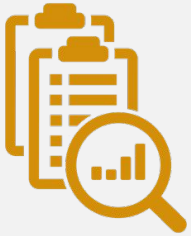
San Bernardino County Department of Behavioral Health collaborated with providers to select the following activities to work on during the Multi-County FSP Innovation Project.

REFERRAL FORMS & PROTOCOLS

Create a consistent referral process and form across adult FSP programs and develop protocols for FSP referrals between entities that ensure for warm hand-offs

STEP DOWN GUIDELINES

Develop protocols on how to approach step down in a way that is responsive to clients' individual recovery journeys while ensuring that FSPs focus on building the client skills necessary to successfully step down



DATA COLLECTION & REPORTING

Update existing and/or develop new data reports that allow providers and departmental staff to more effectively access and utilize client data to understand outcomes and inform care decisions

San Mateo County Implementation Activities

San Mateo County Department of Behavioral Health and Recovery Services collaborated with providers to select the following activities to work on during the Multi-County FSP Innovation Project.

ELIGIBILITY CRITERIA

Revise county-specific FSP eligibility criteria to ensure that counties **prioritize FSP services to the highest-need clients**.

SERVICE REQUIREMENTS

Develop **minimum service requirements of FSP to adopt as official guidance**. E.g.: % of field-based services, telehealth options, housing and employment services offered, peer supports available, etc.

STEP DOWN GUIDELINES

Develop **standardized graduation guidelines** to support staff in making individual stepdown and graduation decisions while considering ISSPs and system-wide outcomes. Guidelines include improved definitions of "stability" and discussion prompts.

Siskiyou County Implementation Activities

Siskiyou County Behavioral Health Services (BHS) collaborated with their provider staff to select the following activities to work on during the Multi-County FSP Innovation Project.

SERVICE GUIDELINES

Develop an FSP Service Exhibit that includes staffing, caseloads, FSP levels of care, and housing and SUD support guidelines to adopt as official guidance

STEP DOWN GUIDELINES

Define indicators of recovery (including how those indicators are tracked in data) to lay the foundation for developing FSP graduation criteria

Ventura County Implementation Activities

Ventura County Behavioral Health collaborated with providers to select the following activities to work on during the Multi-County FSP Innovation Project.

ELIGIBILITY GUIDELINES

Revise county-specific FSP eligibility criteria to ensure that counties prioritize FSP services to the highest-need clients.

SERVICE GUIDELINES

Develop minimum service requirements of FSP to adopt as official guidance. E.g.: % of field-based services, housing and employment services offered, peer supports available, etc.

STEP DOWN GUIDELINES

Develop standardized graduation guidelines to support staff in making individual stepdown and graduation decisions while considering ISSPs and system-wide outcomes.

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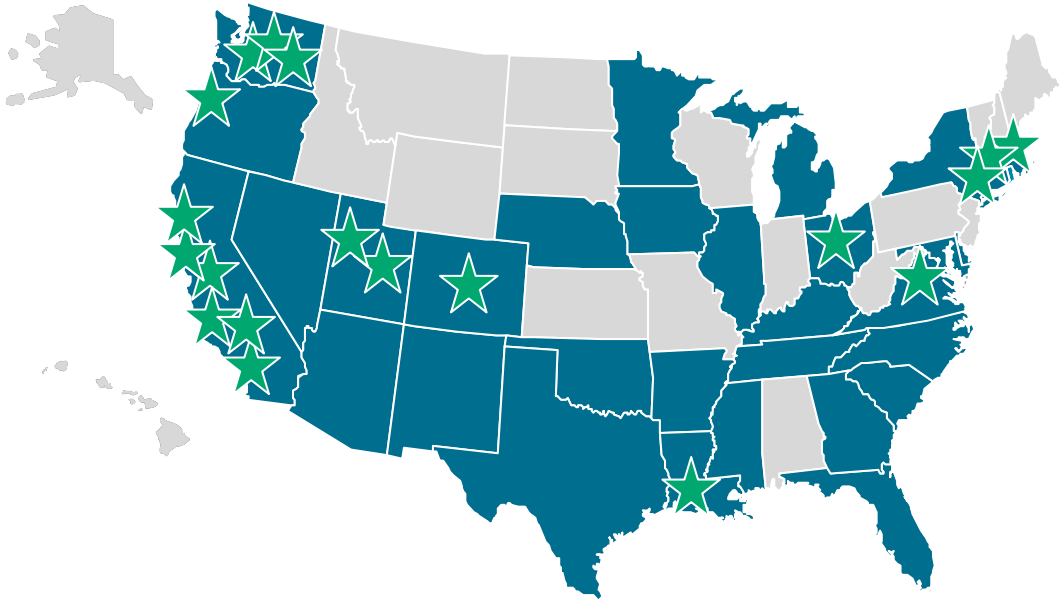
Third Sector is a 501(c)3 nonprofit that works to transform public systems to advance improved and equitable outcomes

Third Sector Projects



19

Launched Outcomes Contracting Projects

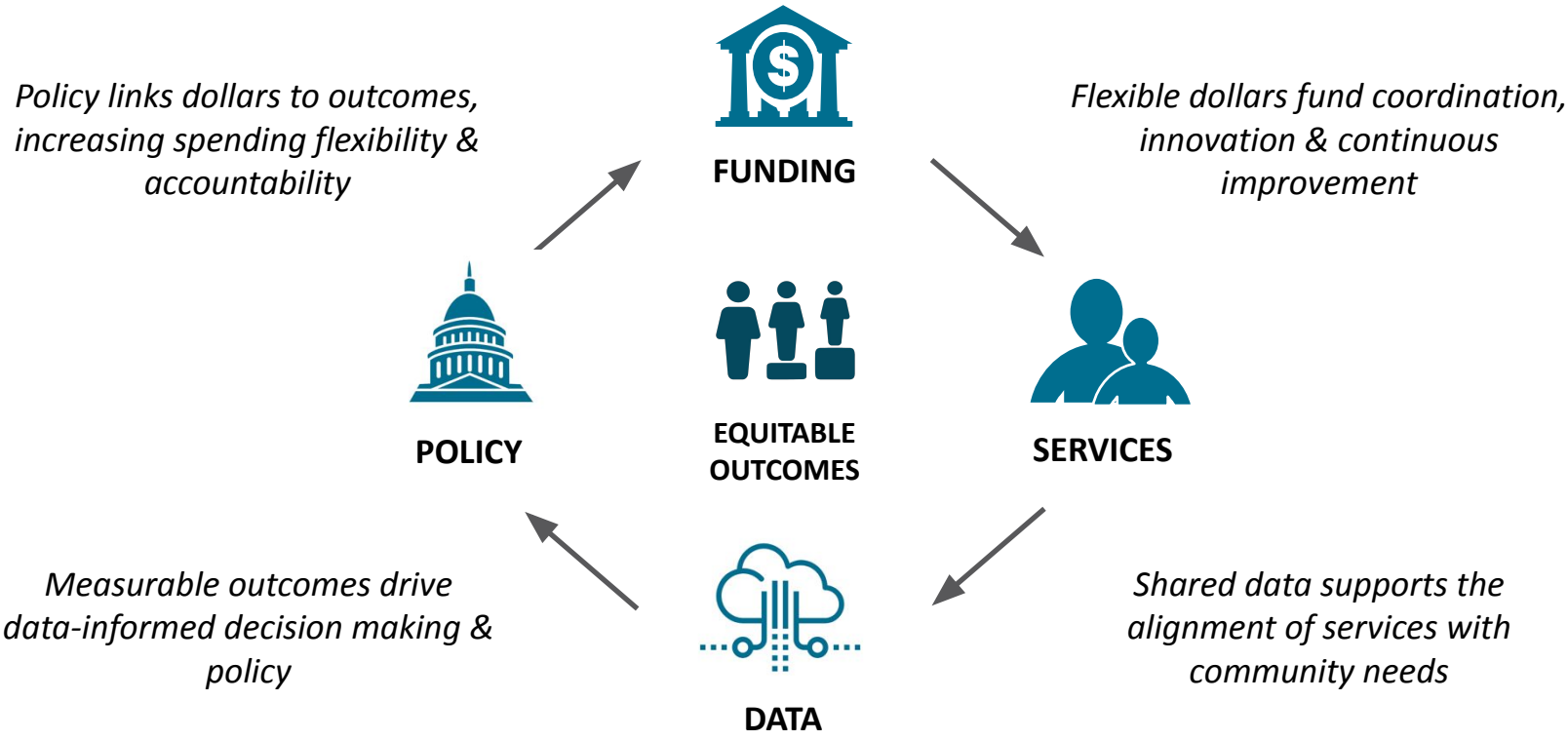
75+

Consulting Engagements

Since 2011, Third Sector has worked with 40+ communities to deploy more than $1.2 billion in government resources toward improved outcomes

Third Sector uses six building blocks to help government partner with communities for more efficient, effective, and equitable human services

Outcomes Orientation Building Blocks



INTERNAL CULTURE
drives and empowers outcomes orientation

EXTERNAL RELATIONSHIPS
shape how outcomes orientation is implemented

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Multi-County FSP Innovation Project

Fresno County Landscape Assessment Synthesis

October 2020

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Overview

In partnership with the Mental Health Oversight and Accountability Commission (MHSOAC), a cohort of six counties—Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura —are participating in a 4.5-year Multi-County FSP Innovation Project that will leverage counties' collective resources and experiences to improve FSP services across California. The Multi-County FSP Innovation Project is additionally supported by the California Mental Health Services Authority (CalMHSA) acting as the fiscal agent and RAND Corporation supporting the project's 2.5-year post-implementation evaluation. 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.

The Multi-County FSP Innovation Project is divided into two major stages.

- **Stage 1: Third Sector Technical Assistance**, January 1, 2020 to November 30, 2021. This stage is then divided into three discrete phases.
    - *Phase I: Landscape Assessment*, January 1, 2020 to September 30, 2020
    - *Phase II: Implementation*, October 1, 2020 to September 30, 2021
    - *Phase III: Sustainability*, October 1, 2021 to November 30, 2021
- **Stage 2: Post-Implementation Evaluation**, December 1, 2021 to June 30, 2024

Throughout the *Landscape Assessment Phase*, Third Sector and the six participating counties focused on understanding each county's FSP context in further detail through engaging with county staff, FSP providers, and individuals currently or recently enrolled in FSP to better understand each county's local community assets and opportunities, existing FSP program practices, and performance on existing outcomes measures. In particular, Third Sector facilitated regular workgroup conversations with DBH staff, engaged FSP providers through several focus groups and a digital survey, and met with individuals served by FSP for one-on-one interviews.

This report serves as a summary of key learnings and insights from Third Sector's Work with Fresno County Department of Behavioral Health (DBH) during the *Landscape Assessment Phase*. Worksheets from workgroup sessions with Fresno DBH—focused on the topics of FSP Data Collection, Subpopulation Characteristics, Eligibility & Graduation Processes, and FSP Services Overview—can be found in the Appendix of this document. In addition, the Appendix also contains a synthesis of Third Sector's FSP provider and client engagements.

Project Goals and Activities

The Multi-County FSP Innovation Project has five project goals:

Goal 1	Develop a shared understanding and more consistent interpretation of FSP's core components across counties, creating a common FSP framework.
Goal 2	Increase the clarity and consistency of enrollment criteria, referral, and graduation processes through developing and disseminating clear tools and guidelines across stakeholders.
Goal 3	Improve how counties define, track, and apply priority outcomes across FSP programs.
Goal 4	Develop a clear strategy for tracking outcomes and performance measures through various state-level and county-specific reporting tools.
Goal 5	Develop new and/or strengthen existing processes for continuous improvement that leverage data to foster learning, accountability, and meaningful performance feedback.

Based on stakeholder perspectives, local context, and county priorities, Fresno County selected three implementation activities to execute locally, as well as three implementation activities to design and execute collectively as a cohort of six counties during the *Implementation Phase*.

1. **Reauthorization Process:** Standardize an FSP client reauthorization process and/or tools that can be used by counties to more regularly assess whether a client is ready to step-down from FSP services.
2. **Youth Referral & Enrollment Process:** Develop a standardized youth FSP referral and enrollment process in which the county is involved in processing and/or approving referrals to contracted FSP providers.
3. **Data Collection Processes:** Facilitate a process to 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.

Additionally, through participation in the six-county cohort, Fresno County will pursue three cohort-wide implementation activities with the other five participating counties.

1. **FSP Population Definitions:** Identify and standardize definitions for a subset of key populations served by FSP programs. E.g., serious mental illness (SMI), co-occurring, justice-involved, successfully housed, etc.
2. **Outcomes & Process Metrics:** Identify 3-5 outcomes and 3-5 process measures and associated metrics to track what services individuals enrolled in FSP receive and how successful those services are.
3. **DCR Recommendations:** Develop recommendations for revising the Data Collection & Reporting (DCR) system. This could include suggested revisions to DCR forms, metrics, and/or Department of Health Care Services (DHCS) data reports in order to reduce reporting burden and increase the usefulness of DCR data.

Over the next year, Fresno County and Third Sector will collaborate on these Fresno-specific implementation activities and cohort-wide activities. Learnings from the *Landscape Assessment Phase* will be used to inform the implementation of new strategies and approaches, both in Fresno County and across the six-county cohort.

FSP Program Overview

Fresno has eight FSP programs that serve individuals across the lifespan: older adults (OA; ages 60+), adults (ages 26 to 59), transition-age youth (TAY; ages 18 to 25), and children (ages 0 - 18). Fresno's FSP programs are summarized in the table below.

Program	Provider(s)	Populations Served
Vista	Turning Point	Adults diagnosed with severe mental health disabilities (Schizophrenia, Major Depression, or Bipolar Disorder) and who may be experiencing homelessness, drug and alcohol addictions, frequent hospitalizations, incarcerations, legal troubles, family issues, or job loss.
Rural FSP	Turning Point	Children, TAY, adults, and older adults living with serious emotional disturbance or severe mental health diagnosis (Schizophrenia, Major Depression, or Bipolar Disorder) and who may be experiencing homelessness, Substance Use Disorders (SUD), frequent hospitalizations, incarcerations, legal troubles, family issues, or job loss. Intended to serve individuals residing in rural areas of the county, the program has eight locations throughout the Fresno County region.
First Street Center AB109	Turning Point	TAY, adults, and older adults diagnosed with severe and persistent mental health and co-occurring issues, referred by the County of Fresno, Probation Department who are involved in the legal system under AB 109 Public Safety Realignment.
Transitional Aged Youth (TAY)	Central Star Behavioral Health	TAY who need recovery-oriented outpatient mental health services that provide individuals with opportunities to utilize their strengths and abilities to gain independence and self–sufficiency in the community.
Living Well Center	The Fresno Center	Members of the Southeast Asian community who need culturally linguistic mental health services.
IMPACT	Mental Health Systems Inc.	Adult and older adult individuals with co-occurring diagnosis, who access the following more than average: crisis services, emergency rooms, hospitals, detoxification services, and/or jails.

Bright Beginnings (BB)	Comprehensive Youth Services, Exceptional Parents Unlimited, and Uplift Family Services	Youth (0-10) with complex behavioral health needs with issues of attachment and bonding, serious emotional disturbance (SED), learning, development, disruptive behaviors, or poor socialization.
Assertive Community Treatment (ACT)	Uplift Family Services	Youth (10-18) involved in the criminal justice system with severe mental health and substance abuse issues. Individuals may have significant functional impairments, high use of acute psychiatric hospitals or psychiatric emergency services, and high risk or recent history of juvenile justice involvement.

Population Characteristics

As noted in the table above, Fresno's FSP programs serve specific subpopulations, including:

- Adults, children, and TAY experiencing **homelessness** or at-risk of homelessness
- Adults, children, and TAY with a history of **justice involvement** or at-risk of justice involvement
- Adults with a **chronic history of psychiatric service utilization**
- Adults experiencing a **co-occurring disorder**
- Adults from **Southeast Asian communities and backgrounds**
- Adults, children, and TAY residing in **rural communities**

More detailed information about these subpopulations can be found in the ***Basic Population Characteristics Worksheet***, found in the Appendix.

Key Population Challenges

During workgroup conversations with DBH and the provider community, staff members noted several specific subpopulations that have a unique set of needs and thus have sometimes been more challenging to enroll, serve, and step down from FSP than other sub-populations. Several of these key populations are summarized below:

- Individuals with **co-occurring disorders** are challenging to serve due to the lack of inpatient beds available to them and the limit placed on the number of times beds can be accessed. These individuals tend to remain enrolled in FSP programs, such as IMPACT, for longer than individuals receiving services from other FSPs.

- DBH staff noted that identifying **TAY** that are eligible for FSP has been difficult. Once TAY are in FSP, they are often less likely to engage with services and more likely to leave programs. Due to their transient nature, they can also be hard for providers to locate and re-engage in services
- **Specific cultural groups** within Fresno County need robust culturally competent services to effectively enroll and serve them through FSP. Individuals identifying as Southeast Asian, for example, can be challenging to enroll, perhaps due to culturally enforced stigma about SMI and distrust of Westernized treatment approaches. Though DBH is working to improve services for other underserved cultural groups (e.g. the Latinx population), there is always an opportunity for DBH and providers to increase their culturally competent service offerings.
- **Homeless individuals** can be challenging to enroll in FSP, as DBH does not currently operate homeless outreach teams and most individuals are identified through inpatient hospitals or word of mouth.
- **Infants and young children** are difficult to serve in FSP as there are very few providers that specialize in this age group.
- Individuals residing in **rural communities** can be challenging to serve, particularly individuals with co-occurring disorders, as there are more SUD services in the city of Fresno.

Referral & Enrollment

Adult and TAY FSPs

Referral Process

The adult and TAY programs (Vista, Rural FSP, First Street Center AB109, TAY FSP, Living Well Center, IMPACT) follow a similar FSP referral process. Common referral sources for these programs include other FSP providers, walk-ins, self-referrals, and—for the majority of individuals served by FSP—psychiatric emergency services (PES), inpatient units, and crisis response/stabilization teams. For specific FSP programs, referrals may come from other sources. For example, referrals for Rural FSP often come from rural outpatient clinics in central and northern Fresno, and referrals for TAY FSP often come from the Department of Social Services (DSS).

Referrals from the agencies listed above are sent to DBH via the MHSA FSP Referral Form, which requests elements such as client history (e.g. incarceration, hospitalization, homelessness, general mental health history), current diagnoses, and medication. Recovery Needs Level data—which measures elements such as overall functioning, previous legal involvement, substance abuse, current residence, current medications, engagement in services and supports, and current symptoms—is included if available, though this is uncommon for inpatient facilities. FSP Referral Forms are sent to a single DBH team member who reviews the forms to determine FSP eligibility and acuity level and to assign

individuals to a specific FSP program. In cases where there is little client information available on an FSP Referral Form, the DBH team member tries to find additional information by looking at other agency data, including hospital records, discharge summaries, provider notes, and court reports.

Many of Fresno's FSP programs are at capacity—IMPACT, for example, rarely has available FSP slots, while Rural FSP often has more openings than other Fresno FSPs. If there are more referrals than FSP slots available, the DBH team member who processes referrals prioritizes individuals based on SMI diagnosis, severity, urgency of need, hospital utilization, age, and support networks available to the individual. The team member chooses the most serious cases to enroll in FSP and keeps individuals who can't be placed into FSP on their radar in case slots open up. If the referred individual is not entered into FSP, DBH provides information to the referring agencies on other available services. Currently assigned slots and the number of slots available are tracked through a weekly census report sent from providers to DBH.

This process is the same for all adult and TAY FSP programs except for First Street Center AB109. Referrals for this program go directly from the Fresno County Probation Department to Turning Point, the program provider. Individuals are screened at Probation by a Turning Point Intake Specialist, and if they meet the criteria for FSP, they are referred for services.

Enrollment Process

Once individuals are referred to an FSP program, DBH notifies the provider of referral by email or phone, shares the FSP Referral Form, and may connect with the provider on how to initiate contact with the individual. Once the provider connects with the individual, the intake process begins. The provider's Personal Service Coordinator (PSC) fills out the Partnership Assessment Form (PAF), a DHCS-required client intake form that captures elements such as the individual's referral source, history of residential information, education, employment, financial support, legal involvement, emergency intervention, and substance abuse. Providers may contest eligibility if an individual does not meet criteria upon further assessment, but in practice, providers typically accept all referrals from DBH.

Referral and Enrollment Processes: Strengths

DBH staff members noted the following assets regarding the adult and TAY referral and enrollment process:

- Adult FSPs use a single referral form and process and have one DBH staff member who reviews all referrals. This streamlining of the referral process allows for flexibility for DBH to make enrollment decisions based on previous history with the referring agencies. Because one staff member handles all referrals, she brings extensive knowledge to FSP enrollment decisions.
- Referring agencies are beginning to leverage Reaching Recovery data when initiating referrals.
- Even if referral forms are incomplete, access to external agency data on individuals referred to FSP helps fill in gaps in assessing an individual's current situation.

- DBH recently implemented a bi-directional form that can identify criteria for middle, moderate, and severe mental illness based on behavioral observations. This form helps staff think more specifically about what behaviors that constitute levels of care look like.

Referral and Enrollment Processes: Opportunities

DBH staff members noted the following challenges and opportunities for improvement regarding the adult and TAY referral and enrollment process:

- Anyone can submit the MHSA Referral Form, so it is unclear in practice who specifically should do so.
- Having a single staff member from DBH (who has other responsibilities in addition to fielding FSP referrals) handle FSP referrals can sometimes cause referrals to pile up.
- Lack of alignment on a definition of SMI may affect the interpretation of FSP eligibility criteria.
- Encouraging more consistent use of and enabling access to the Reaching Recovery suite at various referral points (especially inpatient facilities) is a priority. This will provide more consistent, complete data to the DBH team when making FSP placement decisions.
- Slot capacity has been a challenge for the last several years; many adult and TAY FSP programs have limited capacity for new referrals.

Adult/TAY Referral & Enrollment: Project Solutions

The **FSP Population Definitions** cohort activity will help address current varied interpretations of FSP eligibility criteria by creating alignment and shared definitions of FSP terms such serious mental illness (SMI), co-occurring, justice-involved, successfully housed, etc.

Child FSPs

Referral Process

Unlike the adult and TAY FSPs, the two child FSP programs (Bright Beginnings and ACT) receive and operate referrals independent of DBH. For BB, individuals are referred directly to the provider using the BB Program Referral Form, which contains demographic information, diagnostic considerations, health/mental health history, housing status, and the referral source. Referrals often come from the Fresno County Department of Behavioral Health Children's Outpatient program, physicians, and schools. In the past, a DBH clinician was dedicated to overseeing BB referrals and was located near the BB office, but this position has not been staffed for the past few years. For ACT, potentially eligible individuals are identified on the ACT Referral Form, which contains similar information to the BB Program Referral Form. Referrals typically come from the Fresno County Behavioral Health Court, Probation, Department

of Behavioral Health, Crisis Centers, and schools. Upon receipt of a referral, the ACT Clinical Program Manager reviews the ACT Referral Form and exchanges information with the referring party.

Enrollment Process

Similar to the adult and TAY FSPs, both BB and ACT use a youth version of the PAF for intake. This form records client benefits, physical health status, substance use, and custody information. The PAF is filled out by the provider and submitted to the Data Collection and Reporting (DCR) system.

Referral and Enrollment Processes: Strengths

DBH staff members noted the following assets regarding the child referral and enrollment process:

- BB consistently has capacity. ACT usually has fewer slots available, however.
- For ACT, screening by the Behavioral Health Court assists with determining eligibility and timely access.
- Because ACT is closely coordinated with the Behavioral Health Court and Probation team, there's usually less of a challenge in connecting justice-involved individuals with the providers. This holds true at the adult level for AB109 as well.

Referral and Enrollment Processes: Opportunities

DBH staff members noted the following challenges and opportunities for improvement regarding the child referral and enrollment process:

- The process of placing children and youth into FSP is not overseen by DBH. Instead, providers have unique processes and procedures. This can create inconsistencies in the application of standards for admission and can complicate oversight and monitoring.
- The bidirectional form used at the adult level is not yet used in child and youth FSP programs.
- In the past, there have been issues with the time gap between referral and enrollment into BB.

Child Referral & Enrollment: Project Solutions

The **Youth Referral and Enrollment Process** project activity will address opportunities for improvement in this area by developing a standardized youth FSP referral and enrollment process in which the DBH is involved in processing and/or approving referrals to contracted FSP providers.

Services & Outcomes

Staffing Model & Composition

Once individuals are enrolled in an FSP program, they will be assigned a primary case manager, who will collaborate and share decisions with a multidisciplinary team. All DBH FSP programs follow this team-based model. Multidisciplinary teams can include case managers, clinicians, nurses, peer specialists, housing specialists, and—depending on the specific FSP program—other specialists as well. All FSP programs have clinicians and case managers dedicated solely to FSP except for Rural FSP, whose clinicians work across its three levels of care. Additionally, all of Fresno's FSP programs have nurses and psychiatrists on staff to provide care to individuals served by FSP. For some programs—such as Vista, IMPACT, and BB—psychiatrists work part-time for the program.

Most of Fresno's FSP programs maintain an approximately 15:1 client to case manager caseload, though caseloads vary slightly by provider:

- **Vista**: 17:1
- **Rural FSP**: 12:1
- **First Street Center AB109**: 15:1
- **TAY**: 15 - 17:1
- **Living Well Center**: N/A
- **IMPACT**: N/A
- **Bright Beginnings (BB)**: 8 - 15:1 (depending on the provider)
- **ACT**: 15:1

More details on the staff composition of each FSP program can be found in the ***Services Overview Worksheet*** in the Appendix.

Location of FSP Services

All of Fresno's FSP programs use a combination of field-based services and office settings to work with individuals served by FSP. Some programs—such as Rural FSP, BB, and ACT—are almost entirely field-based. For First Street Center AB109, case managers often take their clients to another location to provide services, given many of these individuals live in group homes. Though many case managers spend time in the field, finding psychiatrists who provide field-based care is a challenge, especially when they are only contracted part-time. In rural areas, psychiatrists may be particularly challenging to access, and many individuals prefer in-person psychiatric services rather than telepsychiatry.

Most FSP providers also provide telehealth services, and while FSP provider staff feel that they are equipped to provide these services, they also indicated certain challenges, especially during COVID-19. It can be difficult to assess individual wellbeing via teletherapy and individuals with acute conditions do

not always respond well to telehealth. Certain services are best provided in-person, including providing medication and facilitating group meetings with individuals served by FSP. For individuals that rely on group-based services for socialization and coping, telehealth services may be particularly challenging. Additionally, telehealth software is not always the most user-friendly, and wifi and phone issues can pose barriers to engaging with individuals served by FSP.

Data Collection and Reporting

Adult and TAY FSPs

Fresno's FSP programs use a variety of assessments to track individuals' progress in recovery while they are enrolled in FSP services. Adult and TAY FSP programs use two DHCS-required forms to track life changes and outcomes: the Key Event Tracking (KET) form and the Quarterly Assessment (3M) form. KETs are completed by administrative staff at key event changes in an individuals' life and track changes to their partnership status, housing, education, employment, legal involvement, and emergency intervention. 3Ms are completed quarterly by FSP direct service staff and track sources of financial support, legal involvement, health status, and substance abuse. KETs and 3Ms are submitted to the DCR so that the County and State can track the effectiveness of FSPs.

In addition to KETs and 3Ms, adult and TAY FSP programs use a suite of Reaching Recovery (RR) tools. This suite was implemented by the county in July 2016 and contains four measures that assess changes in recovery across multiple domains: the Recovery Needs Level (RNL), Recovery Marker Inventory (RMI), Consumer Recovery Measure (CMI), and Promoting Recovery in Organizations (PRO). The RNL and RMI are completed by clinicians quarterly to assess individuals' progress and needs. The CMI is completed quarterly by clients with their case managers and assesses their perception of their recovery across five dimensions: hope, symptom management, personal sense of safety, active growth orientation, and satisfaction with social networks. RR data is stored in Avatar, Fresno's electronic health record (EHR) system. This EHR system also tracks the services provided to individuals in FSP and is used for billing purposes. Not all providers use Avatar as their EHR; some have developed their own EHR systems.

Child/Youth FSPs

BB and ACT do not use RR tools but do use the state-required KETs and 3Ms. Child FSP providers all use the Child and Adolescent Needs and Strengths (CANS) and the PSC-35. Depending on the provider, various other outcomes measures (e.g. CEDE, CBCL, ECBI, PSI, PSM, UCLA RI) may be used to further assess child behavior, child needs, caregiver stress, and caregiver-child relationships. The frequency with which factors such as homelessness and justice involvement are measured varies by provider for both child and adult FSPs.

Data Collection & Reporting: Opportunities

DBH staff members noted the following challenges and opportunities for improvement regarding FSP data collection and reporting:

- Once a year, DBH shares an outcomes report using DCR data with providers. Otherwise, minimal aggregated data is shared with providers, though DBH does provide some feedback to providers in vendor meetings. Some providers have access to the RR dashboard, but this may only be available to staff with EHR access, which in some cases may only be administrative and data staff.
- Data-driven decision-making is limited and ad hoc. Data collected is not always used to drive decisions about care at a systems level.
- Avatar accessibility varies by provider, which impacts how providers use and input Reaching Recovery tools. For example, Turning Point documents in Avatar and has access to the full suite of RR tools, while Mental Health Systems Inc. does not have access currently.

Data Collection & Reporting: Project Solutions

To increase outcomes-orientation and data-driven decision-making in Fresno's FSP care, the county will focus on the following outcomes and data-focused activities:

Outcomes & Process Metrics: Identify 3-5 outcomes and 3-5 process measures and associated metrics to track what services individuals enrolled in FSP receive and how successful those services are. This cohort-wide activity will contribute a statewide understanding of the core elements, goals, and metrics of FSP.

Data Collection Processes: Facilitate a process to 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.

DCR Recommendations: Develop recommendations for revising the Data Collection & Reporting (DCR) system. This could include suggested revisions to DCR forms, metrics, and/or Department of Health Care Services (DHCS) data reports in order to reduce reporting burden and increase the usefulness of DCR data. This cohort-wide activity will increase the utility of the state-required DCR system to providers and DBH.

Other Service Challenges

DBH staff members noted the following challenges and opportunities for improvement regarding FSP housing and billing:

- **Billing and reimbursement:** Medically necessary reimbursement withholds providers from doing things they see as important for individuals served by FSP; for example, reimbursement for TAY FSP have not seen intensive home-based services in recent audits. Additionally, there is varied knowledge across providers on what can be billed towards FSP.

- **Housing:** A core component of FSP for many individuals is access to housing. Opportunities to provide housing can include lease agreements held by providers, MHSA funding that can be used for housing vouchers, child welfare and residential treatment services, and training to connect to housing opportunities. However, housing remains limited, especially long-term housing, and the MHSA funding account is often underutilized.

Step-down & Graduation

Step-Down

During an individual's time in FSP, the case manager regularly reviews the individual's treatment plan and qualitative data (e.g. RR measures, PAFs, KETs, 3Ms) on at least a quarterly basis. The individual's treatment team convenes with the case manager to discuss whether the individual is still benefiting from FSP and continues to need a high level of services. The decision to step-down an individual to a lower level of care is made in collaboration with the individual served by FSP—and with caregivers for children and youth in FSP—and the treatment team directly connects the individual to the lower level of care by scheduling the first appointment and taking the individual to that appointment. This process is typically a warm hand-off, with the provider remaining heavily engaged throughout and putting considerable effort into the hand-off. All adult and child FSPs follow a similar step-down process.

However, there are a limited number of appropriate "middle ground" levels of care between FSP and traditional outpatient levels of care, which can make stepping individuals down from FSP difficult. Across adult and TAY FSPs, Rural FSP is the only program that has multiple levels of care in house. Vista only offers FSP levels of care, but Turning Point, the Vista provider, offers lower levels of care. Turning Point will often step down individuals to those levels of care or to private or group practices that provide psychiatric services. The child FSP system does not have as full of a continuum of care as the adult FSP system. In particular, there are very few infant and early childhood providers to step down young children from FSP. If there is an option to discharge individuals to no services or hold them at "inappropriate" levels of care, providers will usually default to providing care.

Graduation

Once an individual is ready to graduate from FSP—assessed using specific discharge criteria, the RNL (for adults), and recent service utilization—a case conference meeting is scheduled so that appropriate discharge planning can occur and follow-up resources can be offered to the individual by the assigned PSC. Discharge issues such as medication refills and transfers of information will also be finalized with the individual. At Turning Point, the Assistant Director completes all appropriate MHSA discharge paperwork, referral forms, and the KET to update discharge status, though it is common practice to keep an individual's case open for 90 days after officially disenrolling. A similar process is followed at other FSP providers.

Individuals may be referred to a variety of providers and outpatient centers by DBH as part of their individual discharge plans. Adults may be referred to the Metro Area Outpatient Clinic, while children and youth may be referred to the Heritage Center Children's Services. Individuals may also stay connected with DBH for psychiatry services or may be linked to outside psychiatry services.

Sometimes, individuals who meet graduation criteria are not discharged. For example, individuals may be kept longer if they are still in the Behavioral Health Court. In that case, the provider may look at an individual's history in tandem with short-term improvements and may keep the individual for a longer period of time to ensure stability.

Non-Graduation Discharge

Individuals may be disenrolled from FSP even if they have not met the recovery improvements for graduation. Individuals in First Street Center AB109 are disenrolled from the program after probation is complete. While they can be referred to another FSP program, some do not end up getting connected with other FSP care, and the transition can nonetheless be challenging for individuals.

For children and youth, a common reason for non-graduation disenrollment is that youth "age out" of FSP services. DBH has noted that this is the default discharge process, and that very few go on to TAY and adult FSP. TAY experience this as well—they are typically too low acuity to qualify for adult FSP programs. Depending on age, individuals may be linked to Heritage or Metro for outpatient care. If an individual depends on FSP for housing, this transition may be particularly challenging.

Disenrollment Data

Disenrollment data is not easily available in the DCR. Though technically this data is tracked in the KET form, accessing the data requires running a special report that has not been verified. Limited information is captured by DBH following discharge. For children and youth, providers conduct a Post Discharge Youth Services Survey two weeks post-discharge for youth and their families to provide feedback about the services they received from the FSP provider. Additionally, once an individual leaves FSP, DBH does not have a way to track how this individual is maintaining stability unless they come back

into the system. DBH—in particular the Contracts Division—is trying to build capacity to track more information post-discharge.

Step-Down & Graduation: Opportunities

DBH staff members noted the following challenges and opportunities for improvement regarding step-down and graduation processes:

- There is a lack of clarity across FSP programs on what constitutes "graduation" and when to transition individuals to "step down" levels of care. Clear definitions of SMI and of symptomatology that indicate an individual is ready to graduate from FSPs, as well as standardization of discharge and step down criteria, may mitigate this challenge.
- Previous attempts to open up slots for new individuals served by FSP have focused on expanding programs instead of discharging individuals who may be ready to step-down to lower levels of care. Some individuals stay on FSP for a long time, contributing to the bottleneck in enrollment.
- While children and youth come into FSP with an exit strategy, adults typically do not.

Step-Down & Graduation: Project Solutions

The **Reauthorization Process** activity will standardize an FSP client reauthorization process and/or tools that can be used by counties to more regularly assess whether a client is ready to step-down from FSP services. This activity will increase consistency across providers as to when to assess a client for step-down from FSP.

Additionally, the **FSP Population Definitions** cohort activity will improve county-wide understanding of terms such as SMI.

Multi-County FSP Innovation Project

Fresno County Provider Engagement Synthesis

August 2020

OVERVIEW

In July 2020, the Third Sector team conducted four 90-minute focus groups with Fresno County's Full Service Partnership (FSP) providers. This included two focus groups with child/youth FSP providers and two focus groups with adult/older adult FSP Providers. Staff such as clinicians, clinical directors, program directors, and supervisors participated in these focus groups, representing all of Fresno's eight FSP programs and seven FSP provider organizations.

TABLE 1: Fresno FSP Program and Provider Representation in Engagement

FSP Program	Age Group(s)	Provider Organization
Vista	Adult	**Turning Point of Central California**
Rural Mental Health (RMH) FSP	All ages	
AB109, AKA First Street Center	Adult	
IMPACT, AKA Co-Occurring Disorders FSP	Adult	**Mental Health Systems**
Cultural Specific Services	Adult	**The Fresno Center**
Bright Beginnings for Families (BBFF)	Child	**Comprehensive Youth Services (CYS); Exceptional Parents Unlimited (EPU); Uplift Family Services**
Children & Youth Juvenile Justice Services ACT	Child	**Uplift Family Services**
TAY Services & Supports FSP	TAY	**Central Star Behavioral Health**

In addition, to ensure a wide range of input was collected from each provider organization, Third Sector also distributed a digital survey for FSP provider staff to anonymously provide input on their experience delivering FSP services. A total of 72 provider staff completed the survey, with representation from each of Fresno's FSP programs and providers.

CHART 1: FSP Provider Response to Digital Provider Survey

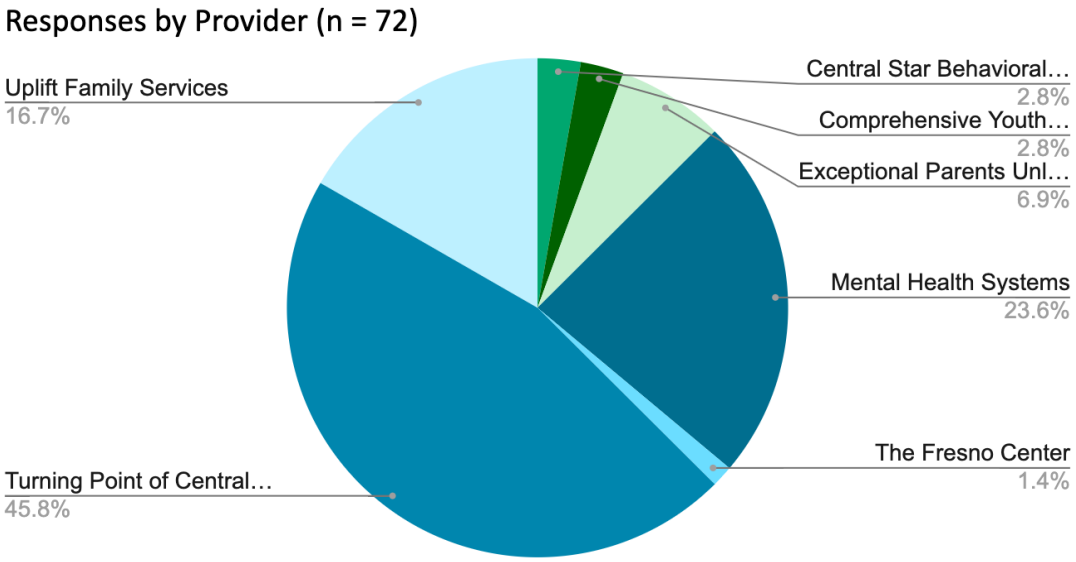


CHART 2: FSP Program Response to Digital Provider Survey

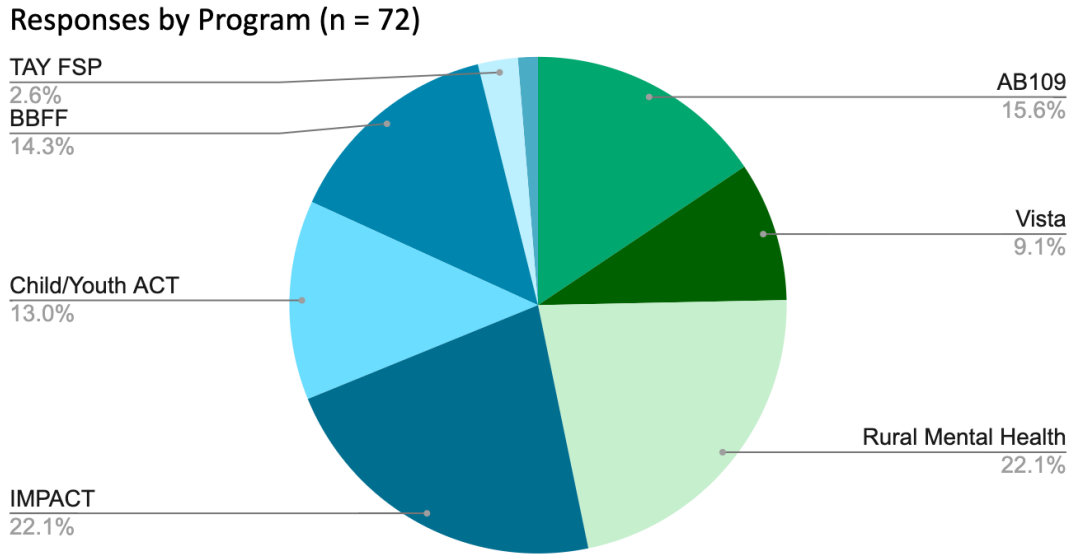
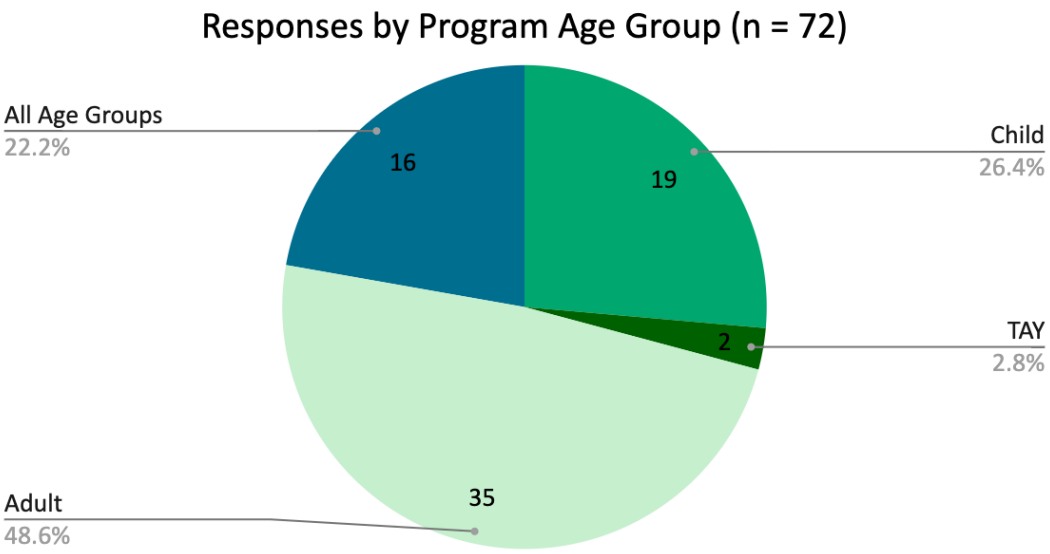


CHART 3: FSP Program Response to Digital Provider Survey by Age Group



The focus groups and digital survey focused on the following themes:

1. **FSP Services & Outcomes**: What do wellness and recovery look like for individuals enrolled in FSP, what outcomes are providers well-equipped to help their FSP clients achieve, and what are the greatest challenges providers face in helping FSP clients achieve their recovery goals?
2. **FSP Enrollment & Graduation**: How are individuals referred to, enrolled in, and graduated or stepped down from FSP, and what is and isn't working well about these processes?
3. **FSP Data & Evaluation:** What data collection forms or tools are most helpful in making FSP care decisions and measuring outcomes, which are least helpful, and what additional types of tools or information would be useful?

The following sections outline high-level takeaways from the focus group discussions and survey results for each of these themes.

THEME 1: FSP SERVICES & OUTCOMES

What Does Wellness & Recovery Look Like?

The best metrics of wellness & recovery are developed in collaboration with each FSP client and, if relevant, their family. Adult providers indicated that wellness and recovery in adult FSP clients can be indicated by a variety of factors, including but not limited to:

- Decrease in homelessness (access to housing),
- Decrease in incarceration,
- Increase in an overall sense of wellbeing,
- Increased engagement in FSP programming,
- Decreased hospitalization,
- Obtaining employment and/or education, and
- Medication compliance.

In particular, adult providers noted that gaining access to housing plays a significant role in client wellbeing and is often a precursor to helping stabilize the client and addressing other wellness factors.

According to one adult provider, "What wellness looks like to the client may look different than the person serving them." Given this, providers noted that the most successful measures of client wellbeing are determined when a client's care team works in collaboration with the client to determine their individual treatment goals.

Adult and child/youth providers indicated that there are often several cultural implications for what client wellness looks like, as individuals from different cultures may have different milestones for identifying mental health wellbeing. For example, The Fresno Center pointed out that in working with Fresno's Southeast Asian population through their FSP programs, they often need to work with the individual's family: "We're not just treating the FSP client, we are treating the whole family."

For younger children, recovery is more preventative in nature and looks like functional behavior, i.e., socializing with friends and participating in age-appropriate activities. For older children, recovery can be both preventative and early intervention, i.e., decreased criminal behavior, decreased substance use, and improved school performance. Child/youth providers noted that the concept of recovery has expanded in recent years to look more at a child's holistic context. Under this lens, recovery for children can also look like making sure the entire family (siblings and parents) have their mental health needs addressed.

Services Strengths

The ability of child/youth FSP providers to provide mental health services for client family members is an asset. Child/youth providers stressed the need for additional family serves. In addition, providers from

the BBFF program indicated that a new contract allowing BBFF providers to provide services to siblings has been extremely helpful in meeting the needs of the family.

Flex funding is a useful and core component of FSP. Both adult and child/youth providers said that flex funding is very helpful to augmenting billable services to ensure that clients are getting their needs met

Collaboration between FSP programs and staff is an asset. Both adult and child/youth providers pointed to the collaboration between FSP programs and staff as providing an important net to serving FSP clients. This is particularly helpful in the referral and step-down process.

Services Challenges & Solutions

Providers, particularly from child/youth programs, cited staff turnover as a key challenge. One provider noted, "We're always behind. We're treading water." Providers' ability to help clients recover is only as strong as the quality of their staff. High staff turnover means that providers constantly have to onboard less-experienced staff who are not as equipped to help clients recover. FSP staff require a lot of training to do the work well, not only in evidence-based practices and therapy, but also in community resource navigation and benefits establishment. Onboarding and training new staff is a constant provider burden that negatively impacts service delivery.

This challenge is exacerbated for providers providing infant mental health, where up to 18 months of training can be necessary to build the expertise required to serve this population. This challenge is also exacerbated in the rural community, where RMH clinicians are trained to serve both adults and children.

Staff also noted that because staff salaries are lower than other agencies/organizations, it is harder to retain competent staff. Providers noted that additional financial resources would help provide more flexible programming, support staff training, and increase staff salaries

Child/youth providers asked for more consistent standards for directly-operated (DO) and contracted providers. Some providers feel like DBH allows its directly-operated providers more flexibility than contracted providers in adjusting their operations, services, and data collection processes. As one contracted provider described it, "I feel like the ugly stepchild." Thus, providers asked for more standard service and operational expectations between DO and contracted providers

Adult and child/youth providers struggle to enroll and serve specific sub-populations. Providers indicated the following populations as being challenging to serve and requiring additional resources, training, and support from the county:

- **Uninsured clients:** Providers do not have the budget to serve all of the uninsured clients in need of FSP; Providers' allocation of MHSA dollars remains flat despite the rising costs of service and salaries

- **Spanish-speaking populations:** In can be challenging to serve Spanish-speaking clients due to the limited number Spanish-speaking clinicians/specialists
- **Black individuals and their families**
- **Southeast Asian individuals and their families**
- **LGBTQ+ individuals**
- **Gang affiliated-youth**, especially for the rural population

Adult providers noted that treating co-occurring FSP clients poses an added challenge. Adult providers indicated that treating individuals in FSP with co-occurring Severe Mental Illness (SMI) and Substance Use Disorder (SUD) is particularly challenging, and adult providers would like to see more support, training, and resources devoted to care for co-occurring individuals in FSP.

Some providers mentioned that part of the challenge of treating individuals with co-occurring SMI and SUD is that case managers coming from a SUD background can have a different approach than case managers with a background in mental health services. One adult provider noted, "Individuals with SMI and SUD have often been turned away from services. In general, there are fewer opportunities available for these individuals to gain access to treatment."

Child/youth FSP providers echoed this sentiment, stating that the SUD supports for children/youth are minimal, especially in rural counties.

Adult and child/youth providers identified that additional training for FSP case managers would be helpful. Providers indicated a need for increased department-wide training for FSP case managers. One adult provider noted, "The efficacy of a case manager depends on the quality of training provided by the organization. Without rigorous, organization-wide training, there will be high variance in the quality and efficacy of FSP case managers." Both adult and child/youth providers requested additional training support from DBH (e.g., basic components of FSP, EBPs, culturally sensitive services, telehealth, etc.), especially for new staff. They indicated that DBH was great at providing initial training in FSP, but these have dropped off and thus new staff members have not benefited from them.

More specifically, an adult provider noted the need for additional training from the county on billing for dual-coverage. They feel that they receive little to no support from the county on billing and insurance training and would like to see more support in that area.

Another adult provider expressed appreciation for the amount of cultural training that DBH offers. However, they noted that, given the varied cultural backgrounds of individuals enrolled in FSP, the provider community would love to see more FSP cultural training.

Adult providers would like to see a shift to assets-based Medi-Cal billing away from the current deficit-based system. On the topic of FSP billing, one adult provider noted, "Mental health training and resources are all wellness- and recovery-based, but billing to Medi-Cal is largely deficit-based." This current system

of billing shifts attention away from the asset-based elements of recovery and disincentivizes focusing staff time on these elements. From these insights, the adult providers agreed that it would be helpful to see a shift in Medi-Cal billing from deficit-based to asset-based.

Provider Survey Responses: FSP Service Questions

Which sub-populations have been most challenging to enroll and/or serve in FSP?

1. 23 out of the 51 individuals who responded to this question named **individuals experiencing homelessness** as a challenging population to enroll/serve. Reasons included:
    a. Difficulty engaging and/or locating this population (7 respondents included this reasoning)
    b. The sense that many individuals experiencing homelessness want to maintain their independence and do not want to follow rules (that a Board and Care might impose, for example) or treatment plans (3 respondents included this reasoning)
    c. The limited housing resources for this population (2 respondents included this reasoning)
    d. The sense that some individuals experiencing homelessness are only interested in FSP for housing resources; once they find out that housing options are limited, these individuals tend to disengage entirely from services (1 respondent included this reasoning)
    e. Some individuals experiencing homelessness prefer living on the streets (1 respondent included this reasoning)
    f. The stresses that these individuals experience that prevent them from focusing on treatment; "you need to be stable to focus on treatment" services (1 respondent included this reasoning)
2. 15 out of 51 respondents named **specific cultural or racial groups** as challenging to enroll/serve:
    a. Six respondents named **Asian or Southeast Asian populations** as difficult to serve, with several individuals specifying the Hmong and Laotian population. Individuals identified stigma and lack of trust in service providers as the reasons for the challenge
    b. Four respondents generally named **non-English speakers** as challenging to enroll/serve due to both the language barrier and stigmas around mental health treatment that can exist in certain communities
    c. Three respondents name the **Latinx population** as difficult to enroll/serve due to stigma as well as a language barrier
    d. Two respondents named the **African-American population** as difficult to enroll/serve due to stigma in their community around mental illness
3. 11 out the 51 respondents named **individuals with SUD** as a challenging population to serve. Six respondents indicated the reason for this being the limited number of inpatient treatment facilities/medical detoxification facilities that serve individuals with co-occurring SUD and SMI
4. Four respondents named **sex offenders** as a difficult population to serve/enroll due to a lack of resources available for serving this population (e.g., housing resources, SUD treatment facilities, etc.)
5. Three respondents named the **uninsured population** as a challenging population to enroll/serve, with one respondent explaining "Even though we have funds to cover those

individuals the budget has a cap and therefore there have been times where we have not been able to accept uninsured clients."

What outcomes do you feel you are well-equipped to help your FSP clients achieve? Why? E.g., Obtaining housing, reducing justice involvement, reducing hospitalizations, increasing social connectedness, etc.

1. 25 out of 51 respondents indicated that they are well-equipped to help clients reduce psychiatric hospitalizations/inpatient psychiatric involvement
2. 21 out of 51 respondents indicated that they are well-equipped to help clients obtain housing and/or maintain housing stability
3. 16 out of 51 respondents indicated that they are well-equipped to help clients increase social connectedness
4. 14 out of 51 respondents indicated that they are well-equipped to help clients to stabilize/cope with their diagnosis
5. 12 out of 51 respondents indicated they are well-equipped to help clients reduce justice involvement
6. 8 out of 51 respondents indicated that they well-equipped to help clients reduce substance use

Please name 1-3 primary challenges that impede your ability to serve your FSP clients effectively.

1. 11 out of 51 respondents named the lack of housing options/board and cares available for FSP clients
2. 8 out of 51 respondents named challenges working with clients with SUD, who do not necessarily want to be engaged or served
    a. 6 respondents also named the lack of SUD treatment options as a challenge to serving this population
3. 7 out of 51 respondents named a general lack of engagement and challenges locating clients
4. 6 out of 51 respondents named staff turnover as a major challenge, with a number of participants naming non-competitive salaries as the reason for the high turnover rates
5. 4 out of 51 respondents indicated that COVID-19 has made it more challenging to effectively serve FSP clients

Please name 1-3 ways that Fresno Department of Behavioral Health could better support you to effectively deliver FSP services.

1. 11 out of 51 respondents indicated a desire for increased funding to increase salaries and expand programming
    a. 2 respondents specifically requested that DBH fund providers to match FCSS salaries
2. 9 out of 51 respondents requested assistance establishing more transitional and permanent housing resources

3. 5 respondents requested more training, including:
    a. Empathy training
    b. Population-specific training
    c. General FSP training, especially for new staff
4. 4 respondents requested assistance identifying additional residential SUD treatment options for the SMI population

Program-Specific Highlights

1. Respondents working with younger children (ages 0-6) identified several challenges unique to their programs:
    a. Three participants indicated that they would benefit from clearer guidelines/training for serving the infant mental health (IMH) population
    b. Three participants indicated that several mandated tools are not relevant or validated for the IMH population including CANS, PSC-35, screening tools, POC, and assessment reports
    c. One participant indicated that there is an unmatched shortage of clinicians specialized in Infant-Family Early Childhood Mental Health; “If meaningful data is missing from the ‘big picture’, this gap will continue to grow and remain invisible in the ‘eyes’ of the policymakers/decision-makers when determining what's effective, not effective for various target populations.”
2. Respondents working with the AB109 population identified several challenges unique to their program:
    a. Three respondents named that it is an impediment to an AB109 client’s success to have their tenure in AB109 FSP based on their probation status as opposed to their mental health stability
        i. “This time restriction is based on probation status vs. recovery status. Negatively impacting the success rates for moderate and high-risk offenders.”
        ii. “On average, the AB 109 population serves a term of four months to one year. This is often insufficient time to stabilize severe symptoms and to complete treatment goals.”
        iii. “A client does not fully recover within one year or less that they are with FSC-FSP, since this program cannot keep clients for long after they have completed their probation period through Fresno County Probation. A lot of them still need FSP Level of care, but they get sent to DBH to get evaluated, which I personally don't believe that it can be determined since we as a program have been working with the client.”
    b. One respondent indicated a desire for additional FSP programs to refer FSP clients to once they complete probation but are still in need of FSP services; “Too many clients are denied the same level of care once they complete because there is no space available in another FSP program”
    c. One respondent requested that the AB109 FSP contract be amended to allow the program to serve clients based on the recovery status as opposed to their probation status

THEME 2: FSP ENROLLMENT & GRADUATION

Enrollment Strengths

Adult providers generally feel that the referral and enrollment process is clear and simple. Adult providers stated that they think the FSP client referral process from DBH is generally very smooth. In particular, counties stated that the process of county approval and referral isn't typically very lengthy. If needed, providers have the ability to decline referrals, though this does not happen often.

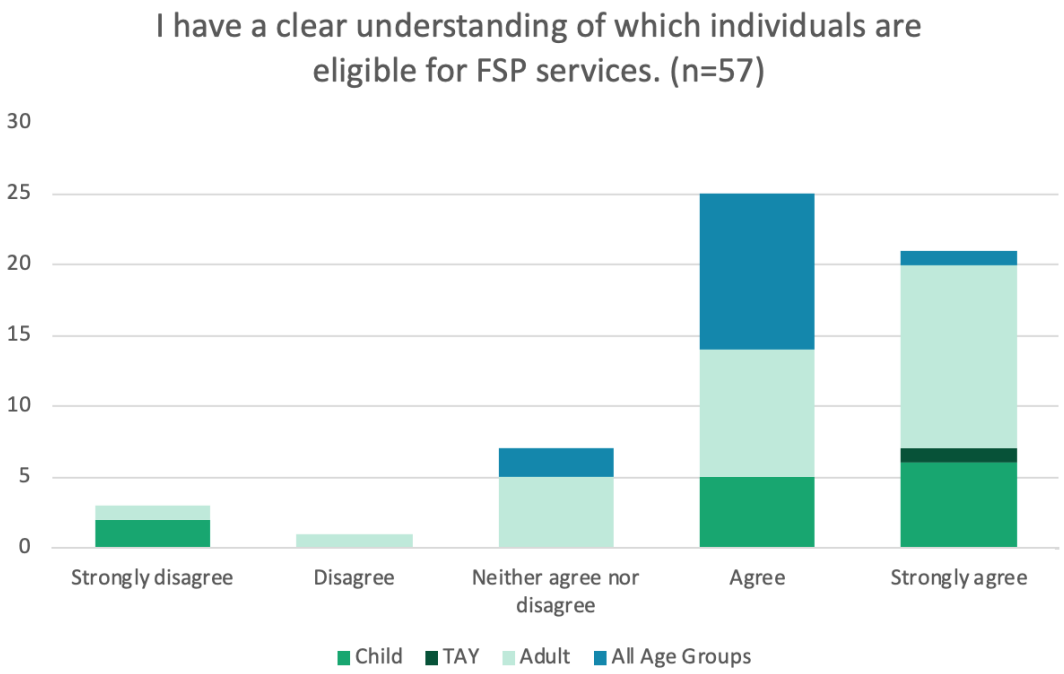
Specifically, Turning Point's AB109 program staff indicated that their referral and enrollment process from the probation department is very smooth and works well, stating that they typically have "a steady flow of clients coming in" from probation.

Both adult and child/youth providers also indicated that the eligibility guidelines for FSP are clear.

Child/youth providers appreciate their autonomy to make enrollment and placement decisions and are able to triage clients effectively. Families can self-refer directly to any one of the three providers and the providers will coordinate with one another to triage the individual to the appropriate provider/program. Child/youth providers appreciate the autonomy they have in making enrollment and placement decisions: "We control clients coming in who can enroll as we have room and space, as opposed to needing to enroll whoever the county sends."

An exception to this is that for ACT, there is a contractual clause that they cannot DBH referral on a waitlist: "This solved the problem for DBH, but not for us."

CHART 4: Survey Respondent Response to Eligibility Understanding Questions



Enrollment Challenges & Solutions

In the FSP referral process, adult and child/youth providers would like to see more data on clients from referring agencies. Though providers feel the adult FSP referral process is clear and simple, they noted that having access to additional information on the referred client would enable them to make a smoother transition and more successfully enroll the client. They indicated that information received on the referral form can be vague depending on how much effort the referral source puts into completing the referral form. In particular, providers indicated the following client information would be helpful to have during the referral process:

- **The current location of the client** at referral, as the client's most recent place of residence does not always match where they are residing at referral.
- **Previous addresses** would also help providers locate where the client is at referral. Adult providers indicated that it is sometimes difficult to track the client down at referral.
- **Awareness that the client is being referred** before the referral form is sent. This would give the adult providers more time to prepare for the client and work on identifying their current location.
- **More detail on or subcategories for "previous mental health history,"** as this section of the referral form can have vague responses from the referral source.
- **More data on client hospital visits**, where possible.
- **Court document access**, such as custody documentation.
- **Information about families' work schedules** to help plan child visits and treatment planning.

Clients entering FSP are not always aware of the purpose of the program. Adult providers suggested that it would be helpful for DBH to provide a uniform "pre-education" for clients and referring agencies explaining who FSP is for and what services the program entails. Child/youth providers noted that it would be helpful to have support in linking families to appropriate legal supports (e.g., Legal Aid) to help them navigate the court system and access appropriate documentation to enroll children in FSP.

This challenge is exacerbated for AB109 FSP providers. Since clients' participation in the program is a required part of their probation, staff can find it very challenging to build trust with the individuals and encourage them to engage in services.

Both adult and child/youth providers struggle with limited program capacity. Some providers cited that they struggle to enroll new clients due to limited program capacity. As one child/youth provider noted, "It used to be a smoother referral process but now we're scrambling." This challenge is particularly pertinent for infant mental health FSP providers, where there are more limited clinicians and case managers to serve that population.

Graduation Strengths

Adult providers appreciate having autonomy and flexibility in making FSP graduation determinations. Adult providers see their autonomy in making FSP care decisions, including the decision to graduate or step down a client from FSP, as a core strength. A staff member from Rural Mental Health pointed out, "Rural areas of Fresno often have a lack of resources. Each case is so individual as to what recovery looks like. Having the independence to decide what an individual's recovery looks like works well for us. I wouldn't actually change it." BBFF and ACT providers indicated that they have a clear definition for when clients are ready to graduate or step down to lower levels of care, which helps anchor the treatment plans in working towards these end goals.

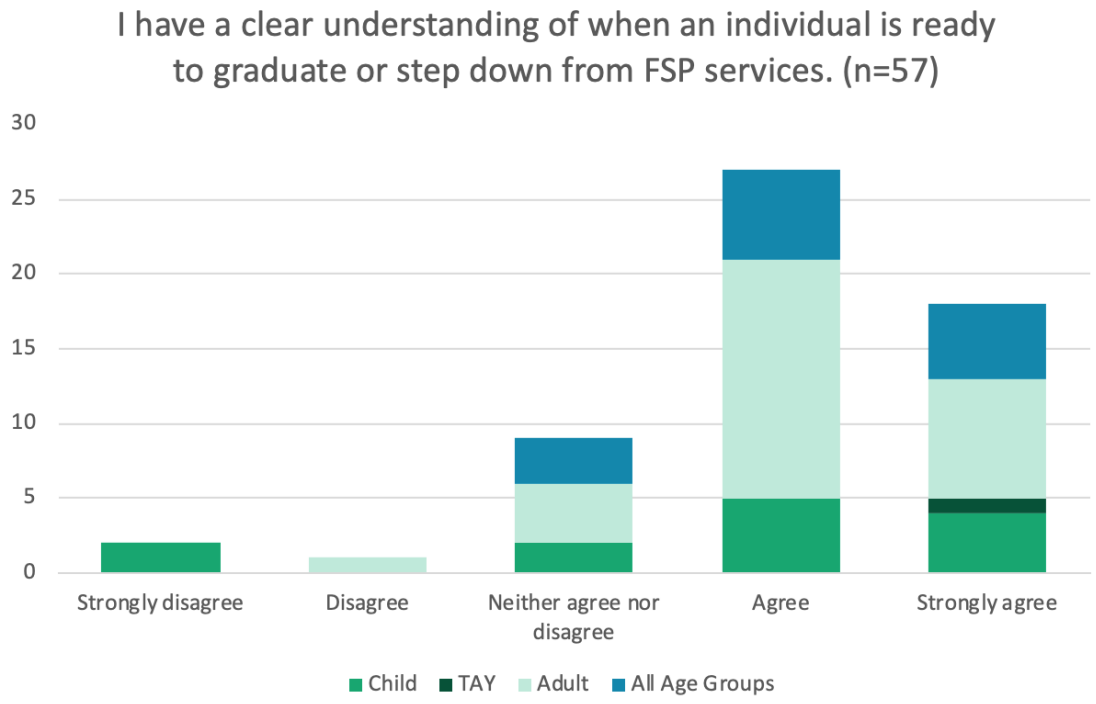
Given this appreciation for care decision autonomy, providers expressed concern that increased standardization (e.g., through rigid graduation standards) could hamper this flexibility and possibly lead to unnecessary trauma reintroduced into the clients' lives.

Programs that operate multiple levels of care benefit from the ability to retain clients throughout their recovery journey. The Vista program offers four different levels of care. Every client is reviewed on a quarterly basis to determine if they are still at an appropriate level of care. This review takes place in collaboration with the client's case manager, PSC supervisor, and program director. Similarly, Rural FSP providers indicated that they benefit from having multiple levels of mental health care internal to their clinic; this allows them to transition clients more seamlessly between levels of care. BBFF utilizes a variety of modalities, all within FSP, to make level of care decisions. This system allows for the increased flexibility of an individual's treatment level.

Both adult and child/youth providers put considerable effort and coordination into ensuring clients have a smooth transition and step-down from FSP. Providers indicated that they put significant effort into ensuring that clients stepping down from FSP have as smooth a transition as possible. This includes coordinating with the next provider and sometimes even transporting the client to the step-down clinic location. Providers often engage with the step-down organization to communicate about the client. "We often engage with each other and know each other really well. We can connect as providers to find out what worked well and not so well in engaging the client."

Providers start planning for client transition well in advance of their step down from FSP. For example, one provider staff from Turning Point Rural Mental Health mentioned that RMH prepares their FSP clients for step-down from FSP for at least six months before the transition. In addition, Turning Point noted that many of their FSP step-down options are physically nearby, making it easier to transition the client to the next provider.

CHART 5: Survey Respondent Response to Graduation Understanding Questions



Graduation Challenges & Solutions

Though adult and child/youth providers try their best to ensure a smooth transition from FSP, the process often has administrative challenges. Though providers put considerable effort into ensuring a client's smooth transition from FSP, provider staff encounter challenges with the step-down process that, if improved, could lead to a smoother transition for clients.

For example, adult providers indicated that to refer a current FSP client to a new provider agency, they must refer the client back to DBH and "close" the client out of their administrative system. Once the client is referred to the new organization, there is a chance that the client will not show up to the new provider or will not mesh well with their new case manager. However, at this stage, it is logistically challenging to "re-open" the client back into the original provider's system. This can cause a rocky transition and an unnecessary gap in the client's care.

AB109 clients' graduations are based on their probation status rather than their mental health wellness. AB109 staff feel frustrated with the short tenure of the AB109 program, indicating that introducing clients to a new program after AB109 can "reintroduce distrust, trauma, and hesitation around engaging with services." One staff member mentioned that they had an AB109 client who told them, "I feel like I need to re-offend so I can stay with you on probation." Given these challenges, many AB109 staff would like to extend the length of the program and allow their clients to stay with them until they no longer need an FSP level of care, or at least until they can identify another appropriate program to place the client into.

Even though other programs do not have as distinct of a program length as AB109, other providers echoed similar sentiments to AB109 staff. One provider staff noted, "It doesn't make sense to uproot our clients who are traumatized and transition them to another program. We need to reconsider how we make shifts between providers and services." Other providers agreed with this statement and explained that the FSP RFP process can increase client anxiety around step-down. "Clients may see that their tenure is a maximum of five years, and they become worried about that."

For all adult and child/youth providers, there are limited step-down options available from FSP. Several providers noted that they often decide to not step a client down from FSP due to a lack of appropriate step-down options available for the client. Programs that cited the most success with step-down often provided multiple levels of care, and thus are able to step down clients to other internal programs.

For example, The Fresno Center explained that there are very few specialty mental health programs in Fresno that specifically serve the SE Asian population. They noted, "It is challenging to refer our clients out to another program because there are few resources available. Due to the specific cultural needs of our clients and the language barrier, it is difficult to find appropriate external resources for our clients."

Providers also specified that there is a "steep cliff" to FSP in that there are few lower levels of care with capacity. This is especially the case when a current FSP client has high mental health acuity but does not necessarily qualify for FSP services.

Housing is very linked to FSP, making it hard to transition lower-acuity adult clients out of FSP. Another factor that contributes to the "steep cliff" of FSP is that many clients are reliant on FSP for housing and other forms of financial support. One adult provider noted, "Housing is a big reason why some clients are in FSP, so we typically need to find alternate housing for a client when we are considering stepping them down from FSP." The linkage of housing and FSP causes many adult providers to keep clients in FSP even when they are no longer in need of FSP-level care. Adult provider staff pointed out this decision is partly motivated by the fact that a client's stability is closely linked to their access to housing. Disrupting a client's connection to housing could reintroduce trauma and anxiety in the client's life, causing an even rockier transition out of FSP.

Child/youth providers indicated that it would be helpful to have better tracking of premature disenrollment from FSP. Several providers mentioned that they have a high drop out and do not consistently track the reason for drop out. A solution that was suggested was to develop a tool for providers to better track the reason for dropouts so that providers can better understand the deeper issues of why individuals are not completing the program.

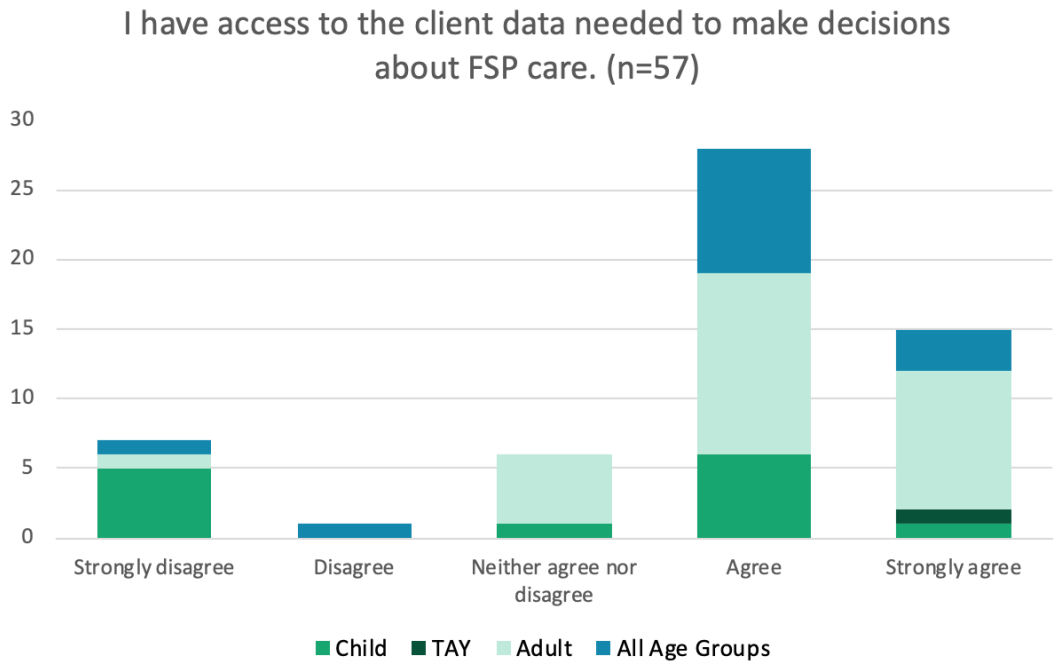
THEME 3: FSP DATA & EVALUATION

Data & Evaluation Strengths

Both adult and child/youth providers cited various program-specific reflections on FSP data and evaluation, including:

- Adult FSP providers appreciate having access to client Reaching Recovery data.
- Child/youth ACT has created its own internal tools to track "KETs" (e.g., hospitalizations) so that they can actively see and analyze this data.
- Child/youth providers indicated that the reporting burden is not as intense for FSP as it is for some other programs that providers contract for.
- Providers also indicated that data from Evidence-Based practices is helpful to track client progress

CHART 6: Survey Respondent Response to Client Data Question



Data & Evaluation Challenges and Solutions

Easier and more universal access to Avatar would be beneficial for all providers. Providers noted that external agencies such as jails and hospitals do not utilize one consistent EHR, making it challenging for providers to get external information on clients (e.g., information on a client's hospitalizations). Providers noted that psychiatric hospitals are not always diligent about reporting incidents in Avatar, leading to mixed or inaccurate information available on prior client hospitalizations.

Providers themselves have mixed access to Avatar, with MHS and The Fresno Center stating that they have limited access to the system. Given this, providers stated that it would be helpful for all providers and external agencies to have increased and more universal access and use of Avatar.

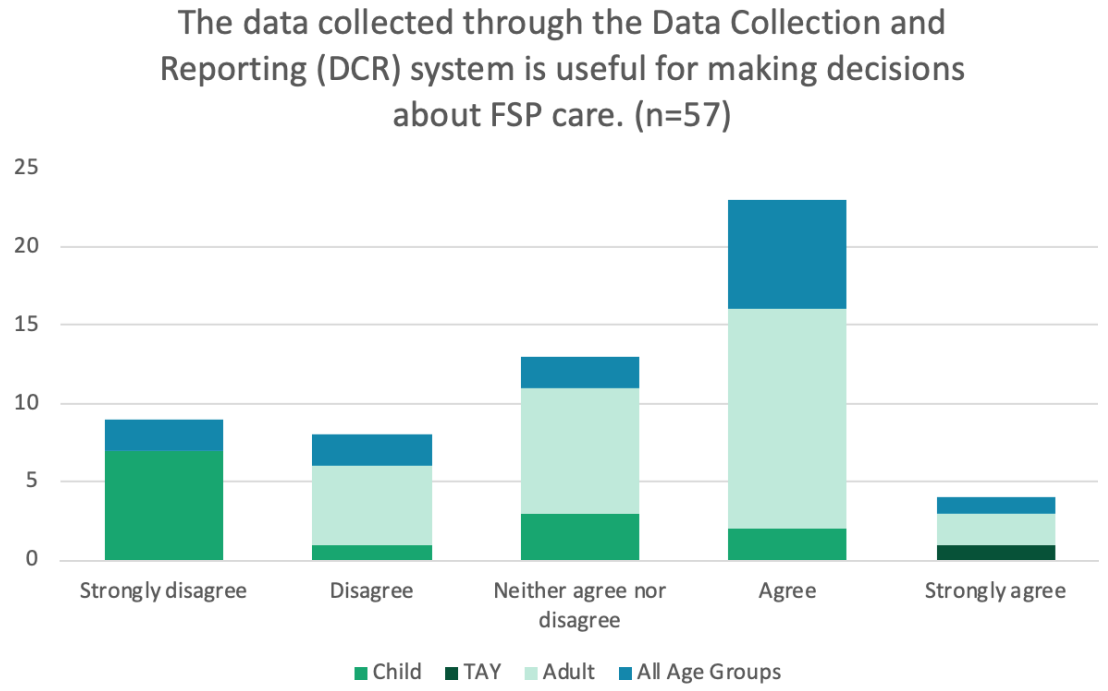
Both adult and child/youth would like increased access to DCR data and quicker turnaround time in requesting DCR changes. In general, providers find the current DCR system is not very helpful for informing provider FSP care decisions. One adult provider staff noted, "We use the DCR because we have to, not because it is the best tool in the whole world."

One adult provider noted that when they request specific ideas for changes to the DCR from the county, there is often a delay or lack of response. This provider mentioned that they would like the ability and agency to make more changes to the DCR as provider staff, without the lag in turnaround time in going through the county.

"The biggest problem with the DCR is that we don't easily have access to the DCR data. We get the data back once a year from the county. So, if we are trying to make informed decisions based on this information, the data is already a year out of date." All providers were in agreement that it would be beneficial to have more access to DCR data beyond the annual reports that are shared with them from the county.

The downsides of receiving DCR data on an annual basis was emphasized by the AB109 provider team. They explained that given the short tenure of their program (often 8-12 months), the DCR reports they receive from the county on an annual basis often will not apply to their current cohort of FSP clients.

CHART 7: Survey Respondent Response to DCR Question

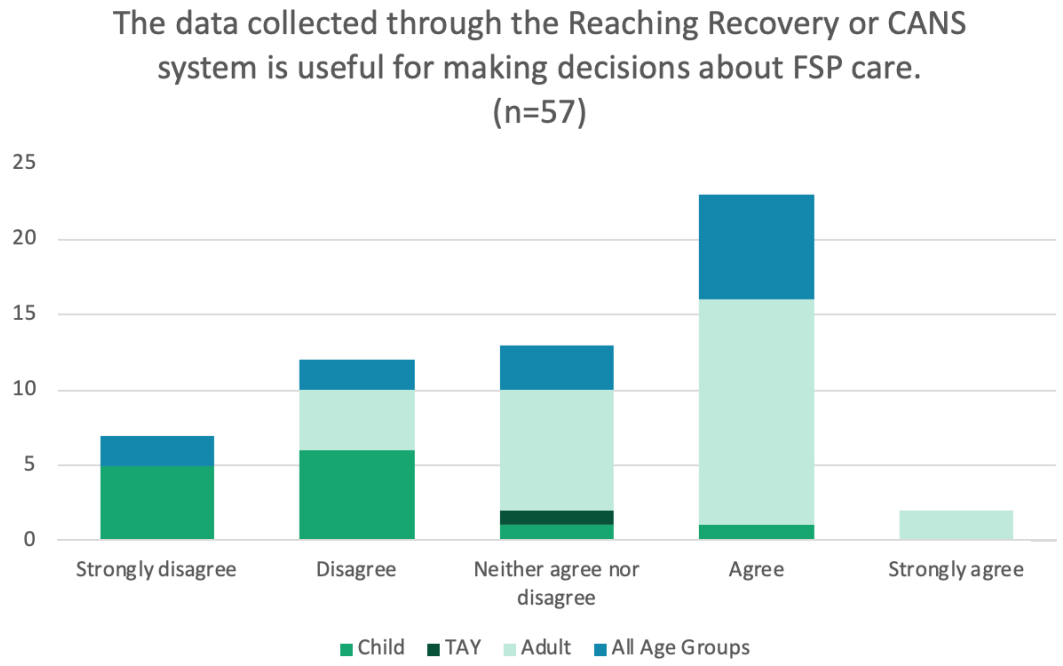


Child/youth providers requested that the DCR and other forms be modified to better match the youth population, particularly for infants. The data collection tools that Fresno utilizes (e.g., referral form, assessment tool, CANS, etc.) are not relevant or validated for the infant mental health population, which leads to erroneous and burdensome data collection for this population

Child/youth providers also noted that they do not think the CANS is a useful tool for tracking youth client outcomes.

Similarly, adult providers would appreciate increased access to data and tools from the Reaching Recovery system. Adult providers stated that they use Reaching Recovery data as one of many tools and methods to determine clients' level of care placements and whether they are still eligible for FSP. Some providers noted that they only have access to individual-level Reaching Recovery data (e.g., RNL), meaning that they can only use Reaching Recovery for individual care decisions. They expressed interest in gaining access to additional Reaching Recovery tools to help them make widespread program decisions.

CHART 8: Survey Respondent Response to Reaching Recovery/CANS Question



Both adult and child/youth would like to see the creation of better outcomes tracking tools. As one child/youth provider noted, "The county could help us look at outcomes tools in partnership so that they truly reflect the work we're doing as a program." Some child/youth providers wished that DBH did not enforce tools that aren't appropriate to certain populations, and rather, give providers the ability to use tools that are more meaningful to them.

Providers asked for more data reports that show individual client data and aggregate trends. Providers feel like they cannot have data-informed treatment or make data-informed graduation decisions without consistently seeing their data.

Providers also suggested that the county develop FSP client surveys that are geared towards providing more regular, real-time feedback from clients

Provider Survey Responses: Data & Evaluation Questions

What data, tools, and/or guidelines would help you enroll and develop treatment plans for new FSP clients?

1. 11 out of 34 respondents to these questions discussed the need for more client history to make appropriate assessment and treatment planning decisions. These included:
    a. General access to previous mental health records, including:
        i. Historic assessment/screening results (e.g., Reaching Recovery Scores, M-FAST Miller Forensic Assessment of Symptoms Test results, Brief Symptoms Inventory 18, STRONG-R Static Risk Needs Offender Guide)
        ii. Hospital stays and discharges
        iii. Discharge packets
        iv. Previous treatment plans, if applicable
        v. Previous care notes, if applicable
        vi. Medication history
        vii. Successful or failed attempts with specific treatments/services
        viii. A comprehensive timeline of diagnoses, including notes from hospitals with rational on clients previous diagnosis, if applicable
        ix. Current symptoms/level of impairment
        x. Current ability to meet ADLs
    b. History of justice involvement
    c. History of homelessness
    d. History of SUD
    e. History of conservatorship
2. 4 out of 30 respondents mentioned the need for improved screening and or assessment tools, noting that there may be more efficient tools available

What data, tools, and/or guidelines would help you serve current FSP clients?

1. 5 respondents said that a more comprehensive history of impairment/symptoms and access to mental health records would help inform service decisions.
2. 4 respondents indicated that Reaching Recovery is a useful tool to making service decisions
3. 3 responses indicated a desire to have better access to the client data they report, e.g., better access to data stored in AVATAR and DCR data, to assess client progress and make appropriate treatment changes

What data, tools, and/or guidelines would help you determine when a client is ready to graduate or step down from FSP?

1. 4 respondents stated that RNL scores are a useful tool for determining when clients are ready for graduation
2. 3 respondents indicated that consistent guidelines on what stages of change should look like for clients would be helpful in making graduation determinations
3. 2 respondents discussed the need for more information about adequate step-down services, e.g., a flowchart detailing the highest intensity to lowest intensity services

TAKEAWAYS FOR PROJECT PLANNING

The Fresno County FSP provider community elevated numerous program strengths, challenges, and solutions across the themes: services & outcomes, enrollment & graduation, and data & evaluation. These provider insights confirm several of the draft implementation options explored in prior DBH x Third Sector workgroup meetings.

Outlined below are the implementation options the Third Sector team believes should be prioritized based on insights from provider engagement.

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

- **New Implementation Option:** Facilitate a process to ensure that directly-operated and contracted providers have consistent service and operational expectations (Potential New Implementation Option)

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

- **Implementation Option 2A:** Standardize data collected during the client referral and enrollment processes to better understand which sub-populations are disproportionately underserved by FSP
- **Implementation Option 2D:** Develop new enrollment processes that reduce the time between initial FSP referral and enrollment
- **New Implementation Option:** Facilitate a process to revise the graduation criteria for AB109 FSP to ensure that it aligns with client recovery as opposed to probation status (Potential New Implementation Option)

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

- **New Implementation Option:** Identify and/or develop client surveys to regularly assess client well-being and/or client perception of recovery (Potential New Implementation Option)

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

- **Implementation Option 4B:** Recommend specific changes to the required DCR metrics and fields (removing, adding, and/or changing required measures)
- **Implementation Option 4C:** Mock-up potential new standardized reports for the state to share back with counties that would increase the usefulness of DCR data
- **Implementation Option 4D:** Identify data from other state agencies that would be useful to link to validate FSP outcomes at the state / local level

- **Implementation Option 4F:** Mock-up new and regular data reports that could be used to help the county, provider community, and community members better understand outcomes achievement across programs
- **New Implementation Option:** Revise the data tools that providers use to collect FSP data (Potential New Implementation Option)
- **New Implementation Option:** Facilitate a process to develop or identify data collection forms/tools that would be more appropriate for the IMH populations (Potential New Implementation Option)

Multi-County FSP Innovation Project

Fresno County FSP Client Engagement Synthesis

October 2020

OVERVIEW

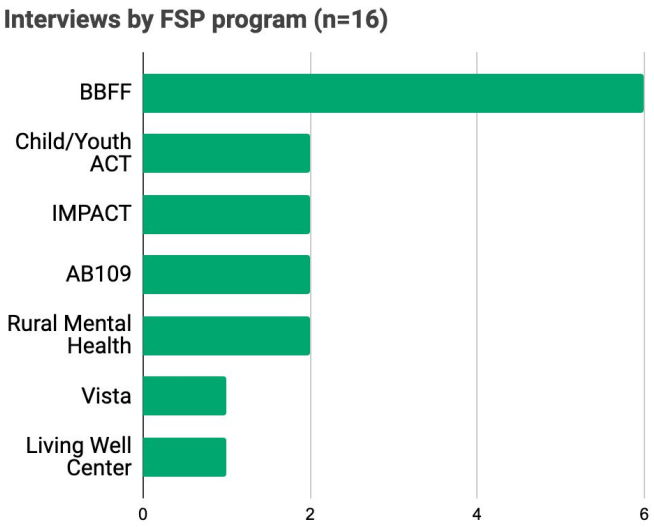
From July to September 2020, Third Sector engaged in one-on-one interviews with individuals receiving FSP services from seven programs and six FSP providers in Fresno County. These interviews took place in the form of 30-minute phone calls with eight adults enrolled in FSP services and eight caretakers of children in FSP. As compensation for participation in these conversations, individuals were provided with a Visa gift card worth $35.00.

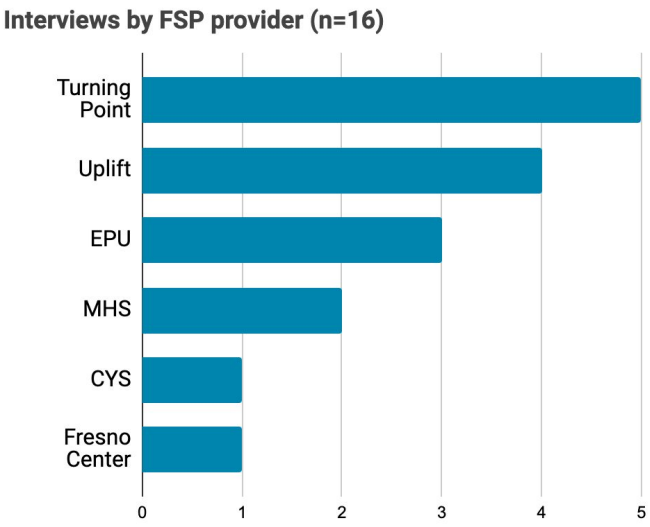
The purpose of these interviews was to better understand FSP clients' goals and needs, how FSP helps achieve these goals, and where there are gaps in the services they receive. These insights will inform client-centered solutions to be developed through the Multi-County FSP Innovation Project over the next year.

TABLE 1: Fresno FSP Program and Provider Representation in Client Engagement

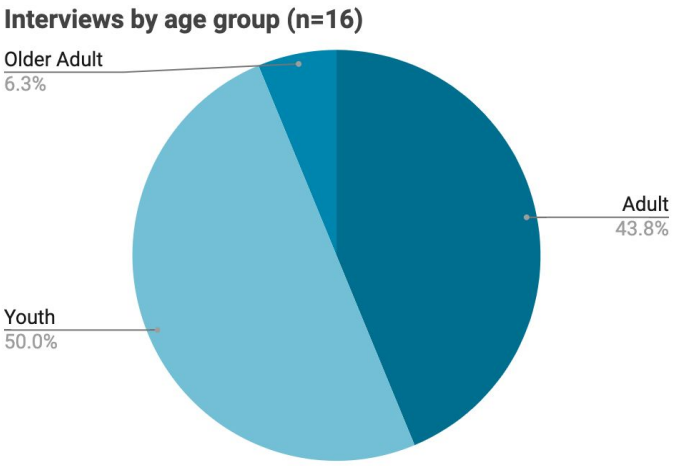
FSP Program	Age Group(s)	Provider Organization
Vista	Adult	**Turning Point of Central California**
Rural Mental Health (RMH) FSP	All ages	
AB109, AKA First Street Center	Adult	
IMPACT, AKA Co-Occurring Disorders FSP	Adult	**Mental Health Systems (MHS)**
Cultural Specific Services	Adult	**The Fresno Center**
Bright Beginnings for Families (BBFF)	Child	**Comprehensive Youth Services (CYS);** **Exceptional Parents Unlimited (EPU);** **Uplift Family Services**
Children & Youth Juvenile Justice Services ACT	Child	**Uplift Family Services**

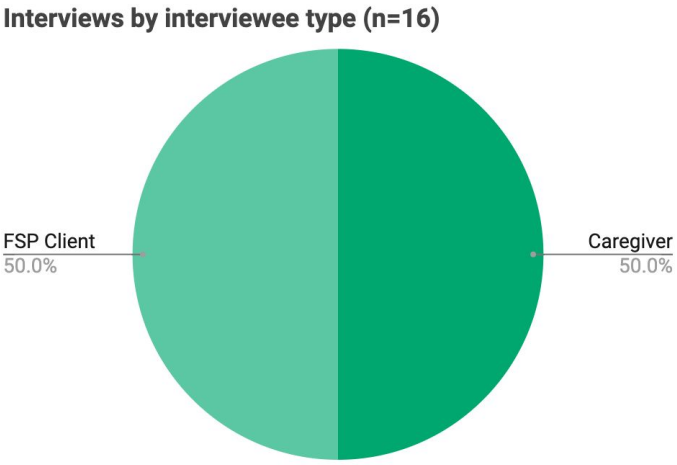
CHARTS 1 & 2: Client Interviews by FSP Program and Provider



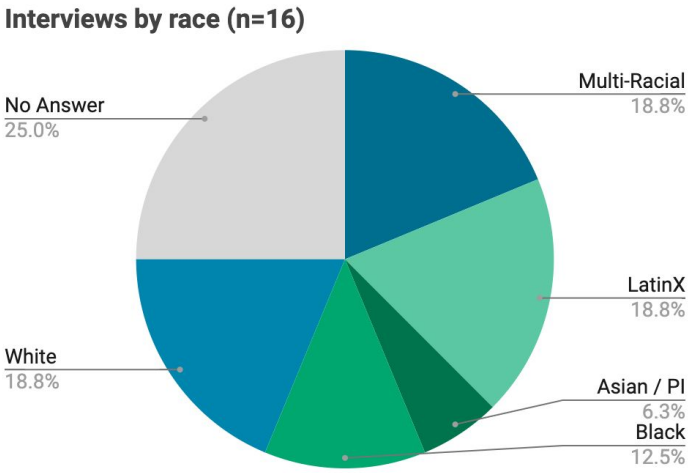


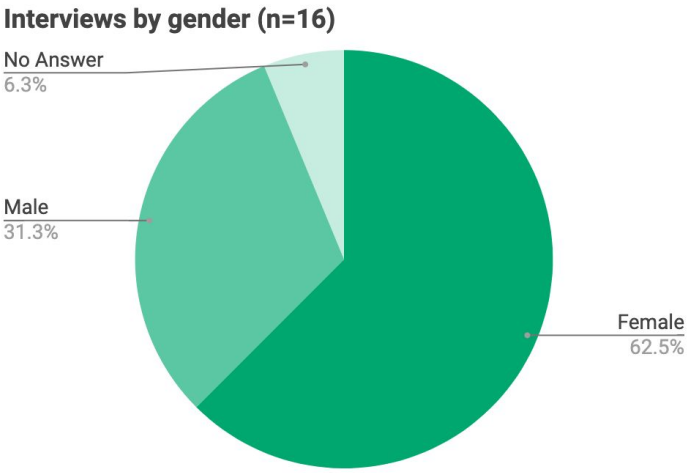
CHARTS 3 & 4: Client Interviews by Age Group and Interviewee Type





CHARTS 5 & 6: Client Interviews by Race and Gender





FSP Client Interviews: Introduction and Consent

Each interview was led by one Third Sector team member or by the client's case manager. Before beginning the interview, the interviewer described the purpose of the interview and asked for verbal consent from the client to proceed. The interviewer explained that the level of detail the client wanted to share in their answers was entirely up to them and that the information shared would be anonymized.

The interviewer explained to the client that any sort of retaliation for participating in the interview or providing negative feedback is prohibited, and if retaliation were to occur, the client was advised to follow their county's problem resolution process.

Once receiving consent from the client to proceed with the interview, the interviewer proceeded by asking questions about the client's experience receiving FSP care and taking written notes on the client's responses.

FSP Client Interviews: Example Questions Asked

General Questions

1. I would love to hear more about your experience at [Client's FSP Provider]. Can you tell me a little about how it's been going?
2. Who do you see at [Client's FSP Provider]?
3. How long ago did you start seeing them?
4. Would you be willing to share why you started seeing your care team at [Client's FSP Provider]?
5. How often do you meet with your care team at [Client's FSP Provider]?

Steps to Goals

6. What are your goals for participating in these mental health services or for mental health wellness in general?
7. What progress have you made towards your goals?
8. How does your care team help you achieve your goals?
9. How could [Client's FSP Provider] better support you in accomplishing your goals?

Optional Demographic Questions

1. What is your race?
2. What is your gender?
3. Are there any other identities that you'd like to share with us?

FSP CLIENT JOURNEY

Below, Third Sector has synthesized key takeaways from the FSP client interviews related to how they experience their journey through FSP.

Enrollment in FSP

Why do children enroll in FSP?

For children, FSP enrollment was often linked to behavioral issues, with caretakers of children enrolled in FSP naming "meltdowns" and anger issues as the primary reason for enrollment.

> "One day I was at the park, at our old apartment which was in a complex. She got so mad, I turned around, and she literally ran away from me, and I lost her for an hour and a half. I was knocking on everyone's doors. To god's blessing, I knocked on this woman's door and she was like 'yeah, here she is she just walked right in."

> "There were a lot of problems, he cried a lot, and when he started growing up he would get angry at everybody, his brothers, he would fight them and everything."

A number of caretakers stated that their children had ADHD. Caretakers named that their children had Asperger syndrome or were on the autism spectrum, were grappling with depression or anxiety, and/or had suicidal thoughts or thoughts of self-harm. Some caretakers indicated that their children were dealing with a number of these issues simultaneously.

> "He has ADHD. He has a combination of anxiety, separation anxiety, and depression. And it's not getting any easier."

Multiple caretakers also mentioned poor school performance as a primary reason for FSP. Regardless of whether school performance was mentioned, a theme throughout the child FSP caretaker interviews was the perception that the school system had failed to help their children.

> "They didn't listen to me. They told me to look outside the school for therapy: 'we can't control her, you're going to have to either look outside the school.'"

Why do adults enroll in FSP?

For adults, many individuals named that their enrollment in FSP was related to their need to manage or cope with their mental health.

> "I was in a big mess and needed mental health services"
>
> "I just had a mental illness or disorder that I have to actually understand coping and be independent, while I have mental health going on, so that's one of them."

A number of adults named coming from the justice system as a reason for enrollment in FSP. One individual indicated that he entered FSP by court order. Some individuals came to FSP to obtain substance use treatment. Many individuals came to FSP services in need of housing.

> "I couldn't take it anymore. I needed help with my meth addiction because I thought I was blacking out from all of this trauma."

Goals for FSP

What are the goals of children in FSP and their caretakers?

Many caretakers indicated that their primary goal for their children was to have better anger control and fewer violent outbreaks.

> "One of our main goals right now is working on her anger, doing breathing techniques to help her calm herself down. We think a lot of the anger stems from losing family."
>
> "Being able to regulate herself. She's angry, lashes out. Not to have violent outbursts [...] that's the goal, eventually right."
>
> "He has quite a few of them, can't remember all of them, but to control his compulsive behaviors, of course, coping skills so when he gets angry he won't be destructive. I mean there's a couple more, but if I remember, those are the main ones. He's really compulsive, he almost burned down the house once."
>
> "One of the major goals is to reduce her tantrums and not be so physically aggressive."

Several caretakers also named improving their children's ability to socialize with other children.

> "It would be amazing to be able to communicate with other kids, have not a normal life, but at least be like a regular kid."
>
> "To be with other kids his own age"

Other common goals included calming their children's ADHD, improving communication skills, and improving coping skills. Many caretakers discussed a desire to communicate more effectively with their children and better address the mental health needs of their children.

> "I needed services to figure out how to parent someone like that. So different from the other kids [...] eventually he needed to be in a group home, he was becoming a threat to me and his siblings. [...] his sister was having a hard time with their brother leaving. [...] My sister was addicted to meth. Uplift had to help me be an effective parent to them. My sister is in prison. It's known that they

won't see her until they are adults. It's taken a toll on both of them. I needed help on how to parent them, help them through that the best I could."

What are the goals of adults in FSP?

Many adults in FSP focused on goals such as housing, benefits establishment, education, and employment. Underlying many of these goals was the desire to be "independent" or "useful."

"Success would be for me, at least a semester of school, getting my own apartment. And me feeling like, less of a mental health case, and more of a, I guess, normal person. My therapist asks me 'what is normal?' and I don't really know. But I don't want to feel so needy and dependent, I want to be independent."

"Going to work, helping my mom and dad around the house, not feeling like I am a burden to them. I want to go back to work, I don't really care where just back to work and feel better."

Other individuals focused on goals such as increased mental health stability, improved coping skills, increased self-awareness, and being part of a community.

"Have peace of mind with not worrying all the time about things that I have lost"

"Learning and understanding emotions and words that are used. Also, seeing the actions of a character or a person."

"To do well and go back to the community. I understand that I do have mental health issues and that community is one part where people social, and society."

"I'm not looking for a job, I am more into looking at my health and focusing on my own wellness."

Some individuals named goals related to continuing services.

"From here, my goals are to continue with my therapy."

"My goal is to attend meetings and stuff that help me."

Another individual named graduation from services as a goal.

> "I would say, completing and getting all of my certifications. I just got one today for completing my Phase 1, moving up in the program itself. Getting my foot out the door."

Experience in FSP Services

What are the experiences of children and their caretakers in FSP services?

Therapy: Caretakers most commonly named therapy as the most helpful service for their children.

> "Therapy was relevant to her needs"
>
> "He loves her (therapist)"

***Two-Generational Support*:** Caretakers emphasized how crucial it is that their children's care teams support them alongside their children. This support can include teaching parenting skills, connecting caretakers to resources, and providing therapy.

> "I really love Uplift. Can say more than before, my kids as they're starting to get it, open up and stuff. I even talk to my kids' therapist like they're mine. So I just really think all together it's a great program."
>
> "They even emailed me resources, that way I can get counseling that I need. When losing my dad."
>
> "We had sessions every week. One session she would talk to him (child), and another session she would talk to me."

***Field Services*:** Caretakers named how critical it has been that their children's care teams are able to make home visits. From caretakers' perspectives, not only do these home visits help support caretakers with their hectic schedules, but they also provide an important opportunity for care teams to see how the children interact in their home environment, which might look different than how the children act in a clinic.

> "Sometimes I can't make it out here. Even through COVID, they will figure out how we can meet. Sometimes I'm like 'Hey I have to reschedule the appointment' and they'll figure it out. They'll work with her."

> "Since Uplift comes to the house, they saw how my other kids react to kids, the reactions, and what our family is like. They're here on our worst days, like when my daughter is melting down, slamming doors. That was everything for them to see the dynamics in our house."
>
> "The therapist would come over and play with him, play basketball with my son, and my son really liked it, and he let his friends join, and that's a good way for my kid to open up."

***Team-based services*:** One caretaker named the importance of having both a clinician and case manager serve their child.

> "I think the combination of having the therapist and behavioral support is huge. Having two people who know what's going on, that are communicating with each other, they can get through to one another when the other can't. There are extra accountability and support for both of them. Trying to hold my kids accountable, it's tough. But to have a therapist, a behaviorist, and mom who are saying the same things as you, they are more likely to listen to them. So by them saying 'let's work on this week.' I can't do this by myself. So to have a couple of other people working on it is great."

What are the experiences of adults in FSP services?

One-on-One Therapy: Individuals named one-on-one therapy as crucial towards their progress in FSP.

> "I have a therapist and it's going well. It's actually going very well. She's very understanding."
>
> "My therapist, she started at IMPACT then went into private practice. There are maybe 300 clients at IMPACT and I was the only one that she took to private practice. So I thought what a MIRACLE, someone was finally looking out for me. To get me going in the right damn direction. Now I'm doing good, well much better, there will always be something but YAY. "

Group Therapy: Individuals also discussed the importance of group therapy in helping them on their journey towards recovery, especially in relation to developing coping skills and building social skills.

> "Group class where I'm going to be educated about our mental health to understand what's going on, coping skills, and find our way around. That's what changed me, understanding others, and the way they talk to me, before I didn't know at all. To be able to speak up and say things I need to say, or ask for help, and that's pretty much it."

Housing, employment, & education support: Individuals discussed how valuable it has been for their care teams to support them to meet their goals related to housing, employment, and education. Many of these individuals strongly credited their care teams with the progress they have made towards achieving these goals.

> "I moved into a beautiful place, and I mean really, it was wonderful for me. A studio and now a one-bedroom, it's a gated community, and it's all IMPACT people, so we socialize, and we have our own groups, and keep us empowered and to keep going."
>
> "Assistance with getting housing, disability income, food stamps, and other paperwork that I usually need help with."
>
> "My outpatient counselor helped me with my resume, cover letter, the formatting, and all that stuff."
>
> "They're helping me get into school, job hunting, resume, help me apply for school. I remember every Tuesday or Wednesday, my clinician would take me out and turn in resumes."

What are clients' overall experiences with care teams?

Overwhelmingly, both caretakers and adult FSP clients had positive experiences with their care teams and expressed deep gratitude for their relationships and sense of support. Some themes permeated throughout both the child FSP and adult FSP interviews.

Care teams build personal and trusting relationships with caregivers and children. Both caretakers and adult FSP clients discussed the almost familial relationship they have with care teams. It was clear through these interviews that the ability of care teams to build trust and closeness with those they serve is a central component to helping individuals achieve success in FSP.

> "Well, I know she talks her through a lot of things, and because sometimes Lilly doesn't want to talk to me, she doesn't want to talk to anyone else in the house. But she does want to talk to [her case manager]. [Her case manager] gets her to open up more."
> "My therapist is helpful of course, but it's mainly talking to [my child's] family advocate. She actually is talking to us on a friendlier level than a therapist. And that, actually is what I like more."
>
> "I've been going to therapy, they help me with any situation that I need. It's gotten to a point that I can call them friends, even though it's a professional setting. It's really helping them out. I remember my first case manager. He became a best friend to me."

"There are people there who aren't doing it for a paycheck, or because they need to provide for their families. They're doing it because they've been in mental health situations themselves, either they were addicts, or taking care of relatives with a disability, and this was their calling. They've shared their stories with me and it creates rapport, and makes us feel way more comfortable going there. That makes me feel like I'm on a good team, and I'm not scared anymore, which is a really good thing. It's really helpful."

"She knew how to listen to me. I could just be totally open, I was comfortable, you know I was guarded for so long I didn't want to let anyone in. She made me comfortable enough to open up. I still have weekly meetings with her. I know you're not supposed to be friends, but we're friendly."

"They are on my side."

Both caretakers and adult FSP clients discussed how care teams will go "above and beyond" to meet client needs. This can involve being available to individuals at almost all times and providing extremely flexible services, truly embodying FSP's "do whatever it takes" approach.

"I should also add, I appreciate how available they are, via text especially. I usually get a text that day, instead of waiting until the assigned session. If they know my kids are having a bad day or something, they are super flexible. I feel incredibly supported in that way too."

"I'm just glad that [my child] can at least see [their case manager] over zoom. And I have her phone number so I'm able to text her or call her. If [my child] is having a really really bad day, if I can't get her to talk to me, or calm down, I can text [their case manager] and tell her there is an issue. I want to say 9 out of 10 times she calls me right after I text her."

"They're good ladies. One of the best. Y'know, very supportive, helpful. I wouldn't change them for anything. When the virus was going on, they brought me some food. I was worried about school, I'm a single parent, I received a check, and she brought pants for my grandson. They're nice, they give me clothes when he grows out of it."

"They've helped in any situation that you need, whether at the beginning or getting on Medi-Cal, when I felt like I couldn't do something, they helped me with that problem."

"They have the tools and resources to get what we need, for any program or certification, they'll do a phone call and talk to the person too for the person to qualify or apply for. They'll be there to help fill out an information form, so they can help us."

Both caretakers and adults discussed their appreciation for the supportive and positive environments that their care teams cultivate. From the interviewees' perspective, the support and positive affirmation that they receive from their care teams is a crucial factor in their success.

> "I adopted my kiddos when they were 3, 5, and 7. We have gone through therapy the whole time and seen a few different therapists. This was the first time that I had someone tell me that I was doing everything right, and it's not my fault."
>
> "They constantly tell me 'you can do anything you want to do' or 'you can do it.' I've never had a father, so they're like second fathers to me. They're always in my ear, saying 'you can do this.' Like they're constantly with me, even though they're not with me."
>
> "It's rare that I can speak highly about anybody. They met all my needs that I need. Y'know that I was longing for. Someone to hear me, understand me, relate to me, conversation. They encouraged me to know it's not my fault, it's normal. They made me feel good."
>
> "I would recommend Turning Point to any mental health program or anything, they make you feel welcome, and open and supported, and communicate that you are gonna be able to understand. So at Turning Point, it's a place where you can take your time. It might be hard times or confusing at first to figure out the isolation, or hearing voices, but they really care. Cause those things cost you suicide, so they treat us like a community that's just normal. They really help us to come back to the community."

In addition to these themes shared between child and adult FSP, a number of adult FSP clients also discussed the importance of care teams holding them accountable to their goals. Individuals named a number of ways that their care teams help them stay accountable to their goals, including coaching, consistently checking in on individuals' progress, or rewarding clients for goal achievement.

> "Well, now, they're telling me to apply to schools. I asked them a long time ago to keep me accountable. My case manager told me that he would hold me accountable to it. They're telling me to go online, and apply. They're always asking me 'Have you applied?'"
>
> "They keep me on the right track and keep me going forward"
>
> "They always tell me that I need to dig myself out of this hole that these people put me in."

Goals and Progress Towards Goals

How have children and their caretakers in FSP progressed towards their goals?

Reduction in behavioral issues: Many caretakers named behavioral improvements in their children through their involvement in FSP services, including less "acting out" and fewer "meltdowns."

> "She tries to act right and behave"
>
> "The meltdowns are less aggressive easier to manage"

Improved mood and coping skills: Caregivers also discussed improved moods in their children, naming fewer thoughts of self-harm and less depression. A number of caregivers credited their children's improved coping skills with the improvement in mood.

> "He was able to beat depression, suicidal thoughts."
>
> "His outlook, way of coping and dealing with life, to where it wasn't pressing down on him and couldn't do anything."
>
> "[Child] was able to start coping better. He was able to realize the dark thoughts that he had wanted to hurt himself"

Increased communication/emotional awareness: Caregivers discussed how their children are better able to open up to them about their emotions and thoughts.

> "We have seen a slight improvement in her telling us her scariest thoughts. Before she would act out and when we asked her 'what were you thinking when you did this' she would say 'nothing.' But now she's able to say 'I wanted to hurt you.' Which is horrible, obviously I don't want to hear that, but at the same time, I'm glad she is able to tell me those things. One time she said: 'Mom, I feel like I want to hurt myself, kill myself, lock up the knives...' as scary as that was, it was also a huge moment."
>
> "We're able to express to each other how we feel. We can say 'she made me upset' or 'Hey mom I don't like that' so then I can find a way to help her. Instead of going over and smacking her."

Improved school performance: One caregiver noted her child's improved school performance.

> "He did awesome in summer school, I got his certificates."

Improved parenting skills in supporting children with behavioral issues: In terms of their own progress, caretakers discussed how they have improved their parenting skills through FSP.

> "I tell her, 'It's okay to get upset,' but I talk her through it, help her breathe, give her space and time. Literally, I've never had that sort of patience. I would always smack her on the head, or on the bottom, and I learned that I have to watch, listen to what she's saying. I've learned what words do not help her, and there are certain words that do trigger a person's behavior. Find a way to explain why you say those words."
>
> "I learned a lot of new parenting techniques from them. And, how to forgive myself. For letting my sister down for not keeping them in my home. That was a struggle for me."

Limited or no progress: While most caregivers discussed the success their children have seen in FSP, a number of caregivers indicated that they have not seen much progress in their children's behavior and moods. Progress in FSP has become even more challenging due to COVID-19 (see "COVID-19 Implications" for more details).

> "They had to graduate him, not because he met goals, or because he was able to achieve what they wanted him to [but because he wasn't improving]. He's a smart young man. They graduated him, he learned what they were teaching him, knew how to apply, but he refused to do it. He could repeat to you any lesson I gave, but it did not matter to him."
>
> "Not much helped...Not much changed."
>
> "Lately he hasn't been opening up to [his therapists]."

How have adults in FSP progressed towards their goals?

Improved mental stability and coping skills: Similar to in child FSP, individuals focused on their increased stability, largely credited to their improved coping skills.

> "I learned how to deal with my disability, cope with the voices, and the hallucinations that I see. I have accomplished enough to make me feel that I am ok."
>
> "Well, I'm definitely not paranoid anymore. Well, I am still, but it's way less than what it used to be. I used to be paranoid about everything. My self-esteem has gone up tremendously."

Sustained housing: A number of individuals stated that FSP has helped them obtain and maintain stable housing.

Benefits establishment: A number of individuals named benefits establishment as a goal that FSP had helped them achieve.

Improved familial relationships: One individual discussed how FSP has helped him improve his relationship with his family.

> "My relationship with my family has improved, a while back when I was sick...well, I'm still sick, but when I was really bad, and did a bunch of things to my family, they kicked me out. A few years later after that things are starting to go better."

Holistic Improvements: Many individuals talked about their improvements in a more holistic sense, talking about generally having a better outlook, being happier, or simply feeling like they are "in a good place."

> "I got a stable home, I am married, and I am happy."
>
> "Oh, everything. My outlook on life. I mean everything. I can't stress that enough."
> "I feel really good, secure for the first time for a long time, that my life is back on track and heading in a good direction. I've been down so long but it's finally going up. I'm grateful every day. There's something every day."

COVID-19 Implications

Throughout the interviews, many individuals discussed how detrimental COVID-19 has been to their or their child's progress. This arose more in interviews with caretakers but certainly was elevated by adult FSP clients as well. While a number of individuals discussed appreciation for how care teams have been

able to adapt under the current circumstances, it is clear that COVID-19 has a major effect on impeding the progress of individuals in the program.

> "Right now it's kinda hard with COVID. What can I tell you...it's not too good because my son doesn't want to do the sessions through the phone, he doesn't like it. He gets a lot of anxiety. Right now, I could tell you that it's so-so."
>
> "Once COVID hit, everything was on hold."
>
> "Um, COVID is just so hard that is my main thing right now. They were making such good progress and everything is just... [my child] has just gone downhill. I don't know, I just feel like it's out of our hands."
>
> "It's been back to square 1. Or not even square 1, back to 0."

SUGGESTIONS FOR IMPROVEMENT

While caretakers and adult interviewees overwhelmingly spoke positively about FSP services and care teams, interviewees did name a number of areas for improvements.

How could FSP better serve adults?

More counseling services: One adult mentioned the need for more counseling support.

> "Having more counseling because I haven't been in counseling in a long time and I think I should go back in there and see what I can learn about myself because I have changed a lot this past year."

Ensuring safe housing placements: One adult indicated that the first housing unit that IMPACT placed him in was not safe.

> "When I was first with IMPACT they threw me into this place that was really bad. There were roaches, no hot water, it was really bad."

That said, the individual went on to say that the IMPACT team was able to rehouse him in a much safer and more pleasant environment. This exemplifies the need to not only locate housing for individuals but to ensure that the housing environment is conducive to their progress.

How could FSP better serve children?

Better psychiatric support: A number of caretakers discussed how it has been difficult to obtain adequate psychiatric support. While caretakers discussed the ease at which they're able to reach their children's therapist and case manager, they lamented how difficult it is to reach their children's psychiatrist or obtain consistent support. From caretakers' perspectives, this limited access can have significant effects on their children's ability to make progress.

> "I just think we need to have a number to call and get answers. Two months ago my son went crazy on the meds. So I stopped giving him the meds because I didn't know what to do. I never got answers, I had to wait a month to talk to the doctor. I just wish there was a number to call in case something happens."
>
> "My boy saw a psychiatrist. But It was through a TV screen, the doctor was in LA. I only met him once. I guess if we could find local doctors, that would be better. My boys would check out halfway through [...]. They didn't feel like they should do that."

Family therapy service offerings: Some caretakers discussed how valuable it would be for FSP therapists to provide family therapy, either with siblings or caretakers.

> "I wanna do a [family therapy] thing for me and [my child]."
>
> "My only thing, and I've mentioned this to [case manager], is it would be great to have sibling therapy. I would have loved for them to do sibling therapy. Before then I wanted to get my daughter in, but she had just turned 7. They don't fight as much now because they each have their own personal therapy, like a one-on-one. I would have loved that. Because my other daughter is also in therapy."

Individual caretakers named several other areas where they would like to see improvement in FSP, including:

Improved 24/7 access to care:

> "It really sucks because after 5 pm you can't talk to anybody. You can text the team, or call them, but if your kid has a crisis you have to call those hotlines and it's not helpful you know. It's just a hassle."

Need for occupational therapy:

> "Well definitely she would need, not here, but she needs OT, she's almost 6 and very sensory...so that's the only thing I'm hoping we can accomplish. That's the only thing she really needs. Like she would walk into the cafeteria and dart out. Little things like that. She talks super loud. Sensory is just really big for her."

Peer support:

> "Peers from CYS, to practice the skills that they have learned, whether it's anger management. They can in a therapeutic session, still have structured play, just to support, reiterate the skills outside of partners, therapy one-on-one. Structured activities, practicing whatever they need to that day."

More two-generational support:

> "You'd be amazed at how bad I am as a parent. I cry myself to sleep, sometimes I want it to be night so that I can go to sleep, and he can rest. And they tell you, it's gonna take some time. But it's hard when your son breaks your stuff, and you have to be a mom for one kid and others. And you don't have much support. They tell you, 'Oh call this, or them' No. The point is not just to call people. The point is to have more support from the facility."

Incentives for children who show progress:

> "They might not have money, but I think they should bribe the kids more like, giving them $5 gift cards like they do give them prize boxes you know? I think they should give the therapist more options to help the kids. Like raffles, or incentives, like 'you know you're improving', and more support. Support for the team, support for the parents."

More fun programming for care teams:

> "Imagine if they had more support. Like days where they say 'okay, let's come in and have a fun day.' Imagine how much improvement these kids could have. There's not enough support for parents with kids with ADHD. ADHD isn't the worst thing in the world, but it's still hard. Imagine if your facility had more stuff it would be amazing."

More support linking children to residential/inpatient settings:

> "Other counties will do referrals to residential/inpatient, but Fresno county will not do that. When I'm in crisis, trying to find a place for my child. I have to be the intermediary between the group home, therapist, and it puts me in a tough spot. As little as I know...I don't want to be taken advantage of because I have no referral. I don't want to put her in a place that isn't good. The best thing that happened was she got sent to the hospital in Fremont and the doctor there knew a place where she would get [a short inpatient stay] and he referred her there, but I haven't gotten anything from Fresno. I actually read an online chat group for adoptive parents, there are about 400 parents represented in groups [in Fresno County]. A lot of people have had the same experience as me, and no one knows where to go for help."

More support for non-English speakers:

> "More support, more everything, especially for non-English speakers. There are parents who don't speak good English...It doesn't matter because my son speaks English and I do too, but other parents don't speak it like I do."

Reduced staff turnover:

> "It's sad that we lost a couple of people along the way to new jobs, others just moved on."

Multi-County FSP Innovation Project

Fresno Implementation & Continuous Improvement Phases
Provider Engagement Synthesis

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Providers noted opportunities for improvement through this activity, as well as challenges that may not be directly addressed

Hopes

- Benefiting from a more robust, system-wide step down review process (esp. for providers with less infrastructure in place)
- Leveraging and streamlining data tools that are already used (e.g. Reaching Recovery)
- Improving communication with DBH and other providers
- Maintaining focus on client care, not submitting reports
- Allowing providers to deliver better care to clients while making their jobs easier
- Continuing to incorporate providers' needs

Fears

- Developing a standardized process that may not take into account current provider-specific practices and fit the needs of each providers' unique populations
- Creating additional reporting and paperwork burden
- Setting an expectation of clients being on a timeline

Other Key Challenges

- Stepping down clients who need injections
- Finding subsidized housing for clients
- Not able to bill for clients who must be held at FSP level (but are ready to step down) due to waitlists
- Clients do not always want to use other outside supports, which can make gradual transitioning a challenge

Adult & TAY FSP Provider Feedback

Adult & TAY providers expressed **frustration** at the idea of another form and **confusion** about the rationale behind the reauthorization process and information contained in the draft reauthorization form.

Reauthorization Form Feedback:

- ***Leveraging Current Processes:*** Providers are already justifying medical necessity for FSP on an ongoing basis and emphasized that they do no not keep clients in FSP if they do not need such a high level of care.
- ***Using Existing Data:*** Providers feel they are already sending most of the draft reauthorization form data through annual treatment plans, the biannual Core Assessment form, and Reaching Recovery. They recommend adding new data fields to existing forms if necessary.
- ***Clarifying the Rationale:*** Providers want to understand DBH's rationale for this process and form, including why additional data is needed and how data will be used and shared. Providers feel that aggregate, quantitative data is more valuable than individual-level, qualitative data if identifying trends is DBH's goal.
- ***Removing Client Interest Question:*** Providers noted that client interest in services can change from day to day, and that this may not be the most valuable data point to include.

Discharge Form Feedback:

- ***Sharing Discharge Data:*** Providers track detailed discharge records internally and are receptive to the idea of sharing this information with DBH.
- ***Testing DCR Discharge Data:*** Providers also report discharges through the DCR, but system challenges may hinder the accuracy. They suggested comparing DCR data to provider internal records before deciding to use the DCR as a sole source of discharge information.

Child FSP Provider Feedback

Child providers expressed **concern** over lack of trust by DBH and **confusion** about the rationale behind the reauthorization process and information contained in the draft reauthorization form.

Reauthorization Form Feedback:

- ***Clarifying the Rationale:*** Similar to the Adult & TAY providers, Child providers also want to understand DBH's rationale for this process and form, including why additional data is needed and how data will be used and shared. Providers feel that the current information on the draft form will not give DBH valuable insight into their effectiveness and outcomes, if that is DBH's goal.

  Child providers specifically want to understand whether DBH believes they are keeping clients in FSP for too long. If so, they are willing to have that conversation and their preference would be to hold regular meetings with DBH to discuss their rationale for continuing to serve any clients DBH has questions about (noting that most children stay in FSP for 12+ months).

- ***Facilitating Trust:*** Hearing about the reauthorization process caused Child providers to question whether DBH trusts them to make reauthorization decisions.
- ***Improving Communication:*** Providers want opportunities for regular, direct communication with DBH leadership about one another's needs and priorities.
- ***Removing Client Interest Question:*** Similar to the Adult & TAY providers, Child providers questioned the rationale behind asking for interest, given that families who do not engage with services for 30+ days are discharged.
- ***Designing for Non-Avatar Users:*** Providers that use other EHRs shared that any changes to required fields in the treatment plan / core assessment in Avatar will require them to make burdensome system adjustments.

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Provider Feedback: Child FSP Referral Process

Provider Feedback Themes from the March 15th Child Referral Focus Group

- **Clarifying the Rationale:** Child FSP providers are willing to share referral information with DBH (as long as it does not delay current processes) but want to understand the rationale for DBH playing an "approver" role for child referrals.
- **Preference For No Additional Forms:** Providers feel it is not a good use of time to complete a separate referral from to submit to DBH and would rather 1) share the existing referral data that they track in their EHR, or 2) DBH use existing data in Avatar to understand the reason for the referral.
- **24-Hour Turnaround for Intake:** Child FSP providers typically schedule client intakes within 24 hours (with a goal of 10 days maximum) of receiving a referral and feel it is important that the referral process is expedient and does not delay care delivery for clients.
- **Staff Turnover:** Child staff turnover is the primary variable impacting providers' waitlists. It isn't uncommon for Child FSP providers to invest in training staff (e.g., The Incredible Years or other EBPs) who then get hired by other organizations offering higher salaries. Turnover of Spanish speaking staff is also a challenge contributing to waitlists.
- **DBH Referral Reviewer Experience:** Providers are concerned that the DBH staff approving referrals won't have training or experience specific to the infant / child FSP population.
- **Avatar Access:** If DBH were to require referral information to be submitted through Avatar, this would create a burden for providers who only have one staff person who can access Avatar.

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Provider Feedback Summary: Data Collection & Reporting

Providers appreciate (and desire more) regular access to DBH data: Youth and adult FSP providers appreciate when DBH shares regular data (like quarterly access data) so they can identify areas of strength and opportunity in their programs. Providers **feel that they provide a lot of data to DBH and desire the ability to access more of it on a regular basis**.

Duplicate data entry is normal (and burdensome) for providers: Because providers have limited access to Avatar / DCR data and perceive DCR data as incomplete, they often **record the same data separately on their own systems** (e.g., separate EHRs, local spreadsheets). Some programs capture additional, non-duplicative data in these systems that aren't captured in DBH systems (e.g. the specific names of hospitals that clients have visited).

Different providers have different data needs: Provider prefer to interact with FSP data in different ways based on several characteristics, including their organization's size, primary EHR system, and client age group (e.g. children vs. adults). For example, **large providers enjoy having access to raw data to run their own analyses, whereas smaller providers appreciates receiving reports from DBH**.

Providers desire more communication with DBH: Both youth and adult providers expressed a desire for **more communication from DBH** on how data will be used, why it is important, and how it will be shared. Providers would also like **more opportunities to meet with DBH** to discuss shared data.

Positive Provider Feedback: Data Collection & Reporting

Quarterly Access Reports: Youth and adult FSP providers **find the quarterly access reports helpful** for understanding whether their programs are connecting clients with services in a timely manner. Some providers shared that **seeing positive results on these reports gives them motivation and a sense of being appreciated by DBH.**

Reaching Recovery Data Visualizations: Providers find the **graphics used to display Reaching Recovery data useful for sharing with clients** because the graphics visualize clients' progress over time.

Provider Challenges: Data Collection & Reporting

Datasystem Access: Most providers only have **one person with DCR access**, which makes it challenging to use and update DCR data. It's also **challenging to access raw aggregate data from Avatar** for analysis.

Receiving Limited Data From DBH: Providers feel that **they submit a lot of data to DBH but don't receive much in return** (e.g. results of client feedback surveys, reports on hospitalization outcomes)

DCR Data Accuracy: Several providers mentioned that they are **unable to close client files in the DCR because of technical issues / errors** between the medical record and the DCR system. This challenge is common and providers feel that they aren't receiving the issue resolution support they need.

DCR Data Relevance: **Child FSP providers perceive the DCR as irrelevant** to their population (e.g., "source of income" field), which is frustrating for both staff and families who have to answer the DCR questions.

Tracking Alternative Treatments: **Avatar doesn't track alternative forms of treatment / healing** that are culture-specific and impactful in the lives of clients.

DBH IT Capacity: **Providers perceive DBH's IT team as having a long queue of jobs** and a limited ability to respond to their inquiries about data.

Reaching Recovery Training: Providers see RR as a big benefit, but they also feel that **DBH's training on using RR is not as robust as it could be**. For example, trainings don't cover how to use RR with clients.

Provider Recommendations: Data Collection & Reporting

Sharing High-Priority Data: In addition to access reports, providers would like **DBH to share data on the following topics:** *hospitalizations, crisis services, incarcerations, housing placement attempts, substance use treatment attempts, expired ROIs, employment, education, and client feedback surveys*.

Disaggregate Data: Providers want to focus on high-need areas and high-risk populations and would find it **valuable to have client data disaggregated by variables like race, diagnosis, age, etc.**

Timely Data Access: In an ideal world, providers would like to have **real-time access to the data** they submit to DBH. However, receiving **reports on a more frequent basis** would also be helpful (e.g., monthly).

Access to Sisense: Providers feel that Sisense data can help support their programs and they are interested in having **more comprehensive access to the dashboards.**

Regular DBH & Provider Working Groups: Providers want **more communication and collaboration with DBH**. One of their recommendations was a regular working group meeting between DBH staff and providers to discuss data trends and continuous improvement opportunities.

Flexible Time Series Data: Providers want the ability to **query data based on different date ranges** to track trends over time.

Change Due Dates in Reaching Recovery: Providers would like **clearer / more specific due dates in RR**, as opposed to date ranges (e.g., “January 31, 2020” instead of “Q1 2021”).

Contents

Uplift Feedback Summary

Uplift feels that reducing reporting burden is a necessary first step to being able to track data that would be most valuable to the children and families that they serve

- **Duplicate data entry remains challenging,** especially given that Uplift enters data needed to inform treatment into their own EHR and other agency (e.g. DSS) databases in addition to Avatar.
- **Uplift feels that DBH may already have access to data** that is requested from Uplift regarding ACT (through Avatar or other county data systems).
- **Ad hoc data requests from DBH can be difficult to manage** when they come every month (quarterly preferred), on short notice, and when DBH asks for data Uplift is not currently tracking.
- **Enabling batch uploads for CANS and DCR data** would meaningfully reduce administrative burden for providers and alleviate frustrations about perceived unresponsiveness to previous requests.
- **Uplift is frustrated by the frequent addition of new forms**, which are challenging to complete without extra resources, and prefers minor additions to existing forms.
- **Uplift has interest in receiving additional data from DBH BUT does not have capacity to help track new data** (e.g. placement information, social worker changes, days in hospital, units in hospital).

Turning Point Feedback Summary

Turning Point would like better access to aggregate Reaching Recovery data, with more options for searching, filtering and aggregating that data

- **Aggregate program-level Reaching Recovery data** to be able to look at aggregate outcomes data over the course of a fiscal year
- **Filters on Reaching Recovery data** to look at program effectiveness for different demographics groups (e.g. age range, gender identity, racial/ethnic/cultural identity)
- **Real-time access to DCR data** to be able to inform treatment and programmatic decisions (recognizes this may be challenging)

Disclosure

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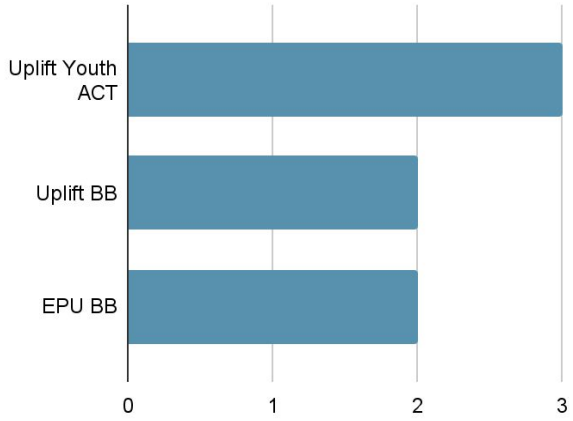
Multi-County FSP Innovation Project

Fresno Implementation Phase Caregiver Engagement Synthesis

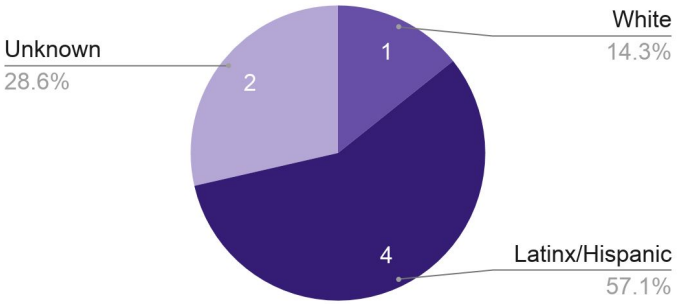
Fresno Caregiver Engagement Overview

- In March – April 2021, Third Sector interviewed **7 caregivers** of **13 children total** receiving services from three Fresno FSP providers/programs: Uplift Youth ACT, Uplift Bright Beginnings, and Exceptional Parents Unlimited Bright Beginnings.
- Third Sector conducted one-on-one interviews by phone and compensated caregivers with $40 Visa gift cards.
- The purpose of the Referral & Enrollment FSP caregiver interviews was to gain feedback on the referral and enrollment processes of Fresno's Child FSP providers from the perspectives of caregivers of child clients.

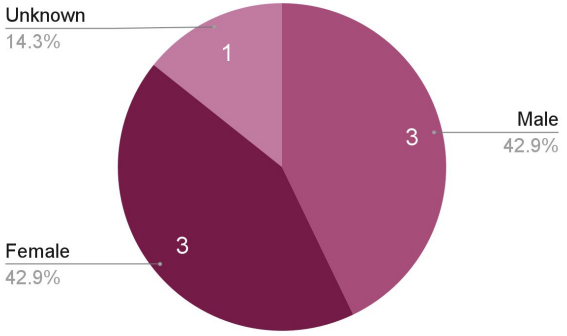
Child FSP Program



Child Race



Child Gender



Caregiver Feedback: Themes Summary

Caregiver Feedback Themes from 1:1 Interviews in March

- **Positive Experiences with Child FSP Programs:** Most caregivers felt that the Bright Beginning and Youth ACT programs had both supported them as parents and helped their children make progress, citing frequent contact and non-judgemental listening as two major program assets.
- **Diverse Referral Pathways:** Caregivers were referred through a variety of methods to Fresno Child FSP programs, and valued both the autonomy to choose a program for their child and the ease that having existing connections within provider organizations can lend to the referral process.
- **Time to Enrollment:** Most caregivers felt the enrollment process went quickly and smoothly, and caregivers who experienced longer waits mentioned that the provider checking in with them regularly while on the waitlist was/would be valuable.
- **Challenge of Meeting New People:** Most caregivers highlighted meeting and opening up to new people as the most challenging part of beginning services, and a suggestion was made to have the child's assigned therapist do their intake (instead of another staff member).
- **Other Challenges & Suggestions:** Other suggestions included providing program information in new locations (e.g. schools), better training for staff working with children with trauma and foster care backgrounds, additional training in EMDR (eye movement desensitization and reprocessing) therapy, and hiring staff with specific gender identities.

Positive Experiences with Child FSP Programs

Key Takeaways

- Most caregivers felt that the Bright Beginning and Youth ACT programs had both **supported them as parents and helped their children make progress**.
- In particular, caregivers highlighted **frequent contact and non-judgemental listening** as being valuable.

Strong Support for Caregivers:

- *They take time to listen and give me a weekly briefing. They are just there. It's amazing having the extra support and knowing that I am not alone.*
- *I have had nothing but a wonderful experience with Uplift. They are flexible, courteous, and the therapists are amazing. I have called my therapist out of nowhere to talk...I can't say enough good things.*
- *Uplift has been pretty good about supporting me as a parent, especially when my son started BB.*
- *They are there, even sometimes after hours. I can text them and I know in the morning they will reply back.*

Visible Progress with Children:

- *He went from hitting me and my mom and me calling the cops on a weekly basis to him being caring and loving and giving me kisses and hugs again.*
- *He's come so far and it wouldn't have been possible without them.*
- *I can just keep talking about how wonderful their program is. I cannot stress enough how they changed my relationship with my youngest.*

Diverse Referral Pathways

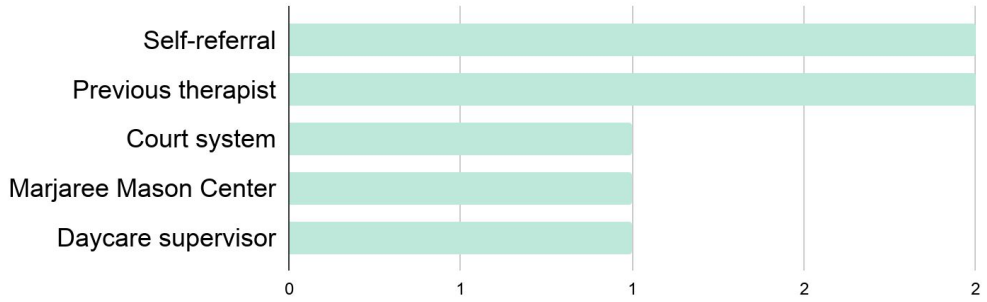
Key Takeaways

- Caregivers were **referred through a variety of methods** to Fresno Child FSP programs, including self-referral, through the court system, and through other care and/or social service providers.
- Caregivers **valued having the autonomy to choose a program** for their child and those who had **existing connections within the provider organization** highlighted that this makes beginning care easier.

Value of Autonomy & Relationships in Referrals:

- *Since I picked EPU, it helped me be a little stronger about feeling able to voice my opinion on things.*
- *She [previous therapist] made the referral to Uplift, which didn't take long because she knew someone at Uplift.*
- *It was an easy process. I was able to transition [from another Uplift program to BB] right away, very quick – it was very seamless.*

Referral Methods



Time to Enrollment

Key Takeaways

- Most caregivers felt the **enrollment process went fairly quickly and smoothly**, though a couple of caregivers experienced 6+ month wait times.
- The waiting process is challenging, so **providers checking in with caregivers while they are on the waitlist** can provide helpful support to caregivers.

(Mostly) Smooth, Quick Enrollment Processes:

- *I remember pursuing Uplift a few years ago and they said there was a 6-month wait. This time I only waited a few weeks between my initial call and intake...everything went smoothly and it happened pretty fast.*
- *There was not really a waiting period. It probably took less than 2 months from the time I called them to when services started.*
- *There was a little bit of a wait period [less than 6 months] but it wasn't that long and he was still receiving other services while we were waiting.*
- *I would describe it as a smooth process. I was actually expecting to take longer than it actually did.*
- *Just the waitlist that was really frustrating. You get amped up, and then 8 months later nothing has happened...I did not feel supported while on the waitlist.*

Value of Checking in While on the Waitlist:

- *The one part that was hard was the waiting...it was about 6 months but I was in constant contact with Tom.*
- *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." Even an email to say where you are on the list.*

Challenge of Meeting New People

Key Takeaways

- Most caregivers highlighted **meeting and opening up to new people as the most challenging part** of beginning services, both for the caregivers and their children.
- Caregivers acknowledged this as a **natural part of starting services**, and there were not many concrete suggestions for how to improve the process of developing new relationships.
- One caregiver suggested **having the child's assigned therapist also do their intake**.

Challenge of Meeting New People:

- *Meeting new people and learning new techniques was the challenging part. But knowing someone there [at Uplift] previously made the transition easier.*
- *The hardest thing about opening up is that the lady who did my child's intake was not the same person who became her therapist. It's hard to be vulnerable, to talk to one person and then another and start over...It would be better to do intake with the therapist.*
- *The most challenging part is getting used to the people and new routine. It's nerve wracking when you don't know anybody and you're sitting there trying to explain your life to them.*

Other Challenges & Suggestions

Key Takeaways

- A couple of caregivers expressed a desire for **staff that matched the gender identities of their children.**
- All caregivers mentioned **challenges related to Covid and hoped to return to in-person care.**
- One caregiver suggested that **Uplift provide more information in churches, the court system, CPS, and schools**, which may be helpful for families who come from cultures where seeing doctors is stigmatized.
- A couple of Uplift Youth ACT caregivers wanted **staff to be better trained on EMDR** and staff with greater experience **working with children who have been in the foster system and experienced extensive trauma.**

Diversifying Staff:

- *He's not going to talk to a female therapist...it's important that they find male therapists.*
- *She really wanted to see a female, but there are like no other female psychiatrists in Fresno that I know of.*

Gaining More Specific Experience:

- *Overall I had an amazing experience at Uplift but my daughter just was not getting what she needed. They are trained in EMDR but I think they are very new at it.*
- *New things come out like EMDR that I would like to see incorporated more.*
- *Her therapist was just not experienced with kids who have had an extensive trauma background.*
- *One thing is that our private therapist has the experience that they do not. She has worked with the foster care system and understands the issues a lot better than [Uplift] therapists do.*

Additional Feedback:

- *Crisis teams are the worst. Every one of them has probably said something that they should not have to me.*

Disclosure

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