San Mateo has flexibility in how these program-level outcomes are used locally. We'd like your feedback:

Are there additional program-level measures of success that BHRS/providers should examine to understand program trends and outcomes?

- Vocational development and vocational outcomes; evidence-based workforce training / services
- A measure for whole health/wellness for clients; whole-person care of clients
- Accountability for providing 24/7 support and support for loss of social connectedness
- Better definition of what "social supports/social connectedness" means
- Wellness / functioning of organization providing services (i.e. retention, staff satisfaction, etc.)
- What is the system of checks, balances and accountability if measures are not being met?
- Whole-person care and impacts of that - length of life, quality of life, cost on healthcare
- Client's own understanding about how they are doing / how they are progressing
- Gauging if MH stigma is being reduced in the community

How might you adopt the existing adult-focused measures for a child/youth conversation?[1]

- Greater focus on education support and education outcomes
- Cohesiveness of FSP system and and juvenile justice system
- Cohesiveness of FSP system and educational system; capacity of FSP providers to engage with school system
- Connection to other elements of C/Y/TAY care team

(1) The Cohort Working Group focused on program level outcome measures for Adult FSP programs and clients. The next year it will revisit the list with a focus on Child/Youth/TAY FSP programs and clients.

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Adult

Which individual level outcomes should be used to determine readiness to step-down from FSP for Adults

- no incarcerations w/in past 6 months
- has benefits in place
- reduced self-harm
- school attendance and performance
- stable behaviors & symptoms
- compliant with medication
- no complex needs
- keeps appointments without help
- gainfully employed
- engaged in treatment
- no longer needs intensive services
- engaged with justice systems processes
- no psychiatric inpatient stays
- independent

has structure in their daily life - something they are engaged in (art class, library, clubhouse). activities

Meets treatment goals: all the systems that are supporting the client feel that the client is ready. includes the client, case manager, social support system, psych team

client's buy-in -- need this. can people do their own self assessment and decide that they are ready (or not)

has social support through peers and supporting others, whether thru clubhouse, etc. hearing from other peers

Insight into their mental illness / independence: self motivation; readiness to change; willingness to use information

has adequate resources (what does adequate mean)? but do they have benefits, social supports, primary care, etc. should be in place

Has self-identified goals/purpose: spending thor time on things that are meaningful to them

a definition and a sense of self that's not just i am mentally ill. purpose gives a sense of identity

safety net - period of time where someone can be stepped back up, so that if someone needs services they can step back up

built trusting relationship with therapist

obtaining collateral info from the family about what's going on

Stable housing: type of housing, programs supporting with applications, vouchers, subsidies. is someone engaging in that process

Adult

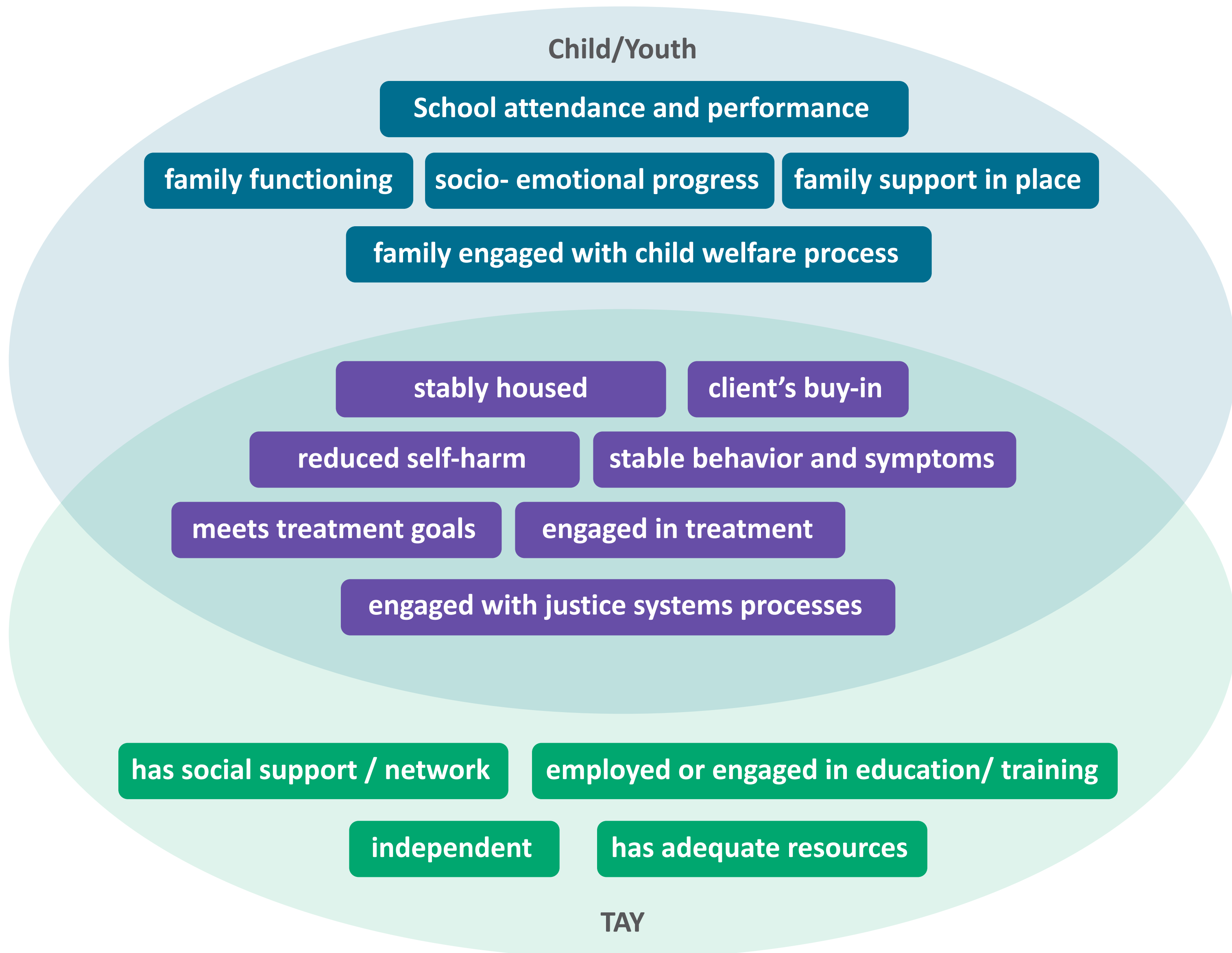
Discussion: How do we ensure that clients feel included and comfortable with conversations about step down?

- Whatever the method is, do it routinely and consistently.
  - Ongoing convo about how the client is doing, engaging in treatment and how they think the services is going.
  - How we adjust to that along the way, i.e. feedback-informed treatment
  - How does the client feel like the provider is supporting them?
- Starts the moment that they enter the program → What goals would you like to achieve? How are you doing with your goals? Talk about the readiness for next steps right from the beginning. It's an open conversation from the start.
- Self-assessment tool for the client to understand their own progress
- Have conversations with clients
- Coordinate and build out services to be consistent; review contracts to ensure that we are getting what we are asking for, including regular conversations with clients
- Some people may ask to get out of the program even if they are not ready. Can the specialists look into the case and give them support; build a relationship to convince the person to keep trying towards their goals

Other Notes:

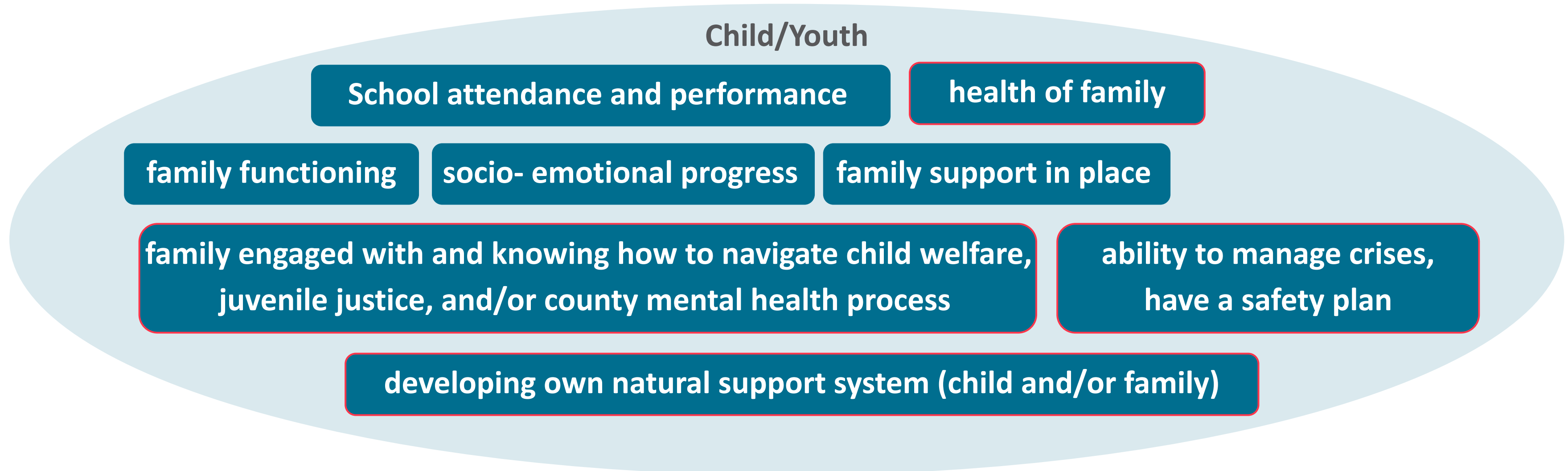
- Tiered system where client can stay with same provider is better than transitioning agencies
- No tool exists to measure all of these things -- this is a starting point statewide
- What are we stepping down to?
  - Moving from multiple touchpoints a week to ~one per week
  - Concern around conservatorship for example → independence; this is a slightly different situation but could imagine this could occur
- FSP can't be successful unless the rest of the system can coordinate to make things happen. E.g., if someone needs hospitalization for stabilization, hospital needs to be willing to coordinate to keep someone there for 2 weeks if that's what's needed, not just 3 days.
  - Client centered, client outcomes focused, not just cost savings, etc.
  - Entire system needs to work together and be fluid, be communicating
- Goes beyond just client buy-in and WRAP plan → how does someone take what they've learned, embrace it, make it their own, and carry it forward
- If there is a contractual shortcoming, look at the root cause as to why. if agency is struggling to get nursing staff on board, looking at it as a system issue; "why"

Initial BHRS brainstorm of which individual level outcomes to use to determine readiness to step-down from FSP for C/Y/TAY



C/Y/TAY

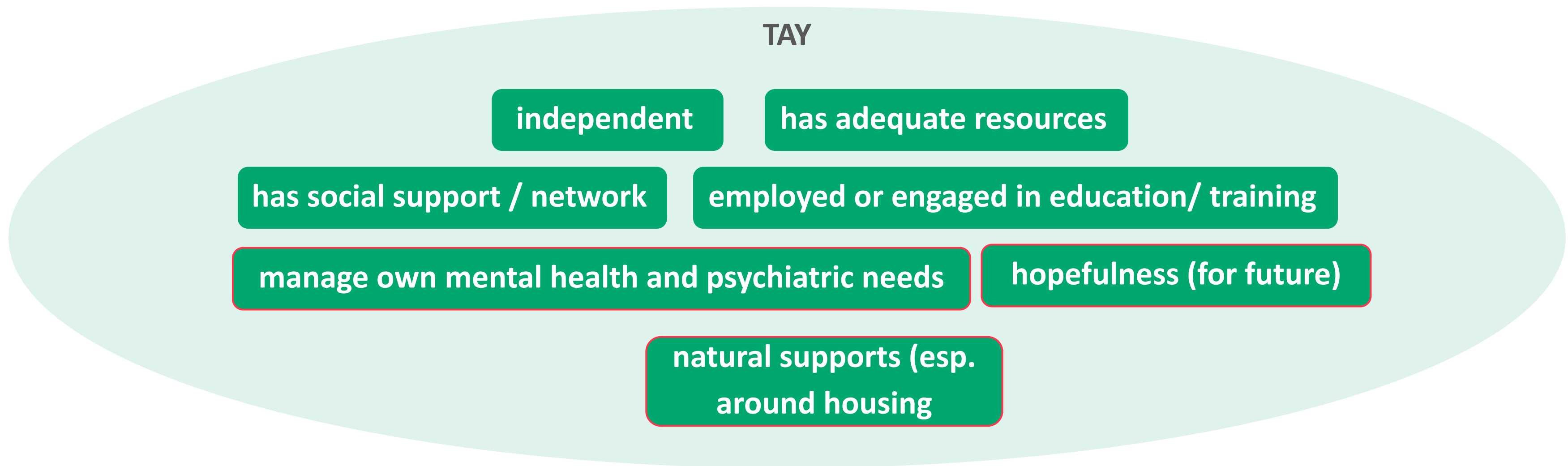
What changes/additions would you make to the individual level outcomes that should use to determine when FSP services are no longer needed for Child/Youth FSP clients?



Notes:

- School attendance and performance
  - What about children who are not going to school?
  - Measure should not be yes/no, but be able to measure actual engagement, involvement, and performance (i.e. staying the the classroom, learning is happening)
  - How to take into consideration a school systems or classrooms readiness for children with FSP needs? -- FSP and educational systems are not structured to work well together
- Whole family if affected when child is ill so measure of how family is learning how to support their child
  - Parent and other siblings need to be considered

What changes/additions would you make to the individual level outcomes that should use to determine when FSP services are no longer needed for Child/Youth FSP clients?

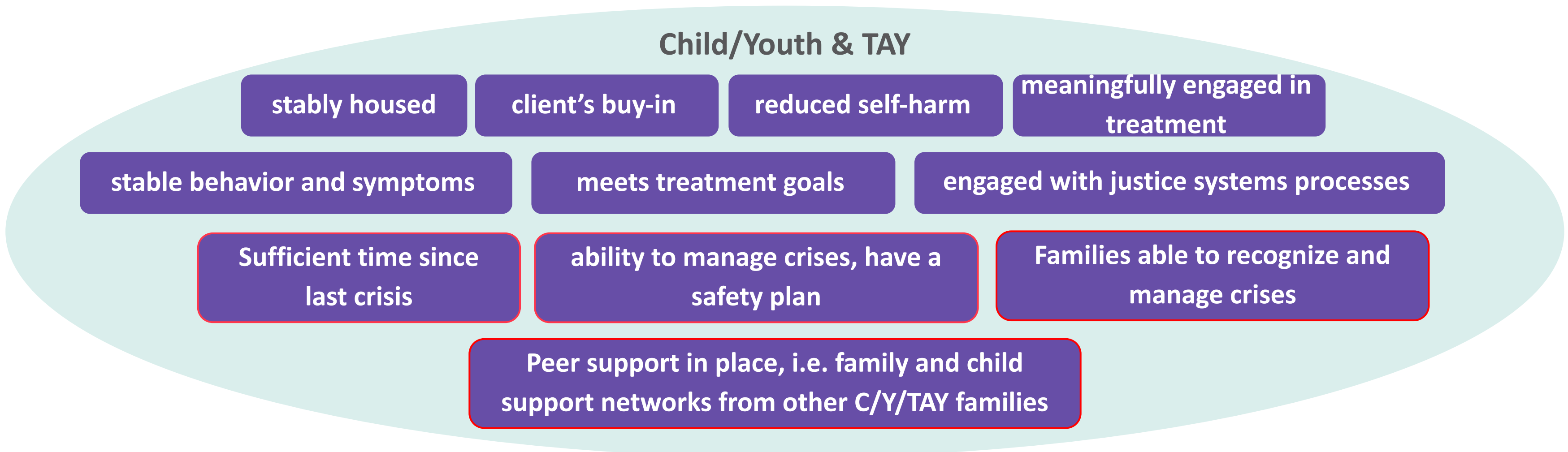


Notes:

- TAY might need more time to achieve stability, i.e. moving from foster care to own housing
- Intergenerational trauma and its connection to lack of hopefulness
- When TAY are discharged from hospital and home is not an option, struggle to find housing placement (i.e transitional housing)

C/Y/TAY

What changes/additions would you make to the individual level outcomes that should use to determine when FSP services are no longer needed for Child/Youth FSP clients?



Notes:

- Minimum level of maturity / ability to problem solve under stress and if they are to ever be in crisis again
- Mental health / first aid training should be required → the outcome of which would be families that are able to navigate their child's crisis and know what to do (i.e. recognize and be able to manage at home)
  - More community education and training around mental health challenges that FSP individuals face
- Ability to provide step-down services within their FSP program, i.e. pull out pieces one team member at a time and step people down before they graduate all within the same program / agency
  - Challenging to do right now because contracted to provide a certain number of services / hours per month
- Key Event Tracker (KET) - the concept behind this form is really good
- Is there way to more formally connect CANS and ANSA to treatment goals and determining when it's time to start stepping down?
- Involving families in step-down process piece by piece +1
- Peer support for families of C/Y/TAY FSP clients to provide normalcy for kids and parents; getting to know people in similar life situations; self-built support networks from within FSP
  - So that there is a pool of people with shared experience after step-down / graduation

Discussion: How do we ensure that clients and families feel included and comfortable with conversations about step down?

Notes:

- Describing and promoting wellness model, as opposed to medical model +1
    - Quality of life indicators
- Giving a sense of what wellness looks like so they have an idea of what the goal is
- Be clear about what is happening during the step-down process and what does it look/feel like -- need to mitigate some of the fear and retriggering that sometimes happens around this
    - WHat will still be available
    - Making more things available
    - Being flexible about that process
- benefits counseling
- Having every component in place (housing, medical, etc.) so someone can transition off
- Need to be capturing trauma at intake to support if a client may need longer time to heal