San Mateo County
Health System

August 1, 2014

Dear Colleagues and Community Partners,

This past year Behavioral Health and Recovery Services (BHRS) set out to evaluate its Full Service Partnership (FSP) programs to understand how well FSPs are working from the perspective of administrators, providers and consumers/clients. In May 2013, Davis Y. Ja and Associates, Inc., an independent consulting firm, were contracted to conduct the evaluation. The executive summary and final report is now available on our website at www.smhealth.org/bhrs/mhsa and includes analyses of current services including challenges, successes, recommendations and possible financial incentive models to support ongoing service improvement and consumer/client success.

The Mental Health Services Act (MHSA) was enacted in 2005 and provides a dedicated source of funding to improve the quality of life for individuals living with mental illness; a large component of this work is accomplished through FSPs. FSP programs do "whatever it takes" to help seriously mentally ill adults, children, transition-age youth and their families on their path to recovery and wellness. In San Mateo County there are currently four comprehensive FSP providers, Edgewood Center and Fred Finch Youth Center serve children, youth and transition-age youth (C/Y/TAY) and Caminar and Telecare serve adults and older adults.

Overall Findings and Recommendations
There were common themes that emerged from the interviews and focus groups with FSP administrators, service providers, and consumers and caregivers and included:

- ✓ High level of satisfaction with the Wraparound model for child/youth FSPs and with the Assertive Community Treatment (ACT) approach for adult/older adults. However, there were some challenges with the Wraparound model for TAY and a peer-driven and recovery oriented model may be more appropriate for this population.
- ✓ Challenges with maintaining consistent staffing and providing an ideal spectrum of services with current funding levels.
- ✓ Greater demand than available slots.
- ✓ Insufficient linkages between FSP systems for transitioning C/Y/TAY and community supports for consumers leaving FSP services.
- ✓ Family/caregiver involvement and collaboration as a vital component
- ✓ Insufficient availability of safe, accessible, affordable housing.

Overall, the sense from providers, administrators, consumers and caregivers is that while challenges exist in serving the complex populations targeted by the FSPs, the programs are having a positive impact on the lives of those served.

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While many individuals served through an FSP have shown significant improvements in their lives, we know there is always room for improvement. The findings and recommendations made in this report will help guide our future FSP development, funding allocations and evaluation.

Key Recommendations
✓ Review current referral criteria for child/youth/TAY (BHRS/providers)
✓ Addressing the service gaps between TAY and adult FSP systems and community supports
✓ Explore options for a more integrated model of dependency treatment and medical care, especially for TAY, medically fragile, and older adults
✓ Conduct a needs assessment for specific youth populations, especially those with justice involvement, co-occurring, and psychotic disorders
✓ Provide a provider or BHRS-initiated orientation for new families entering FSP
✓ Identify safe, accessible, appropriate, and affordable housing options for TAY and adult consumers
✓ Clarify whether supportive services are available at housing sites; if not, develop plan for monitoring consumer progress

We also anticipate this report will provide additional impetus to our ongoing dialogue with consumers/clients, family members, service providers and other key community stakeholders about the FSP and related services. We welcome your comments and suggestions after you have had a chance to read through this report by emailing Doris Estremera, MHSA Manager at mhsa@smcgov.org.

Thank you for your continued support.

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Full Service Partnerships

Final Evaluation Report

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Executive Summary

History: Full Service Partnerships (FSPs)

In 2004, the Mental Health Services Act (MHSA) (Proposition 63) was approved by California voters and enacted in January 2005 as an avenue to comprehensively reform California's mental health treatment system. Under MHSA, Community Services and Supports (CSS) was created as one of five program components offering three different types of funding streams: **1)** Full Service Partnerships (FSP); **2)** General System Development Funds; and **3)** Outreach and Engagement Funds. At least 51% of CSS funding is required to be allocated for FSPs, which are designed to meet the specific needs of un-served or underserved children, transitional age youth (TAY), adults, older adults, and their families through an expanded range of services and supports within a recovery framework (Gilmer, 2010; Brown, 2010; CA-DMH, 2009).

California's FSP model was developed following the pilot of various recovery-oriented programs, including Assembly Bill 2034 (AB2034), with a modified version of the Wraparound Model implemented for child/youth/TAY consumers and Assertive Community Treatment (ACT) services for adults and older adult consumers. Both models seek to provide individualized integrated services, flexible funding, intensive case management, and 24-hour access to care.

San Mateo County FSP Programs

Within San Mateo County, the initial FSP programs (Edgewood, Fred Finch, and Telecare) have been fully operational since 2006. A fourth site (Caminar's Adult FSP) was added in 2009. According to San Mateo County's Behavioral Health and Recovery Services Division (BHRS), approximately 250 adults and 90 children, youth, TAY, and their families utilize FSP services through four service providers. Edgewood and Fred Finch use the Wraparound model to serve children, youth, TAY, and their families, while Caminar and Telecare offer Assertive Community Treatment (ACT) services to adults, older adults, and their families.

Edgewood is the contracted provider for child/youth FSP services within San Mateo County, running the *ISIS* program. The program targets seriously emotionally disturbed children/youth

who are at-risk of being moved to a higher level of care (including residential placement, incarceration or hospitalization) and their families. The Wraparound model is used to emphasize the strengths of consumers and their families and to actively engage them in the treatment planning process. An afterschool intensive services component was added in 2010.

Edgewood's Turning Point program targets transitional-aged youth between 16 and 25 years of age who have serious emotional disorders and/or serious mental illnesses and are at-risk of being moved to a higher level of care. Besides using a Wraparound model to work with TAY consumers and their families, Turning Point also utilizes a Drop-in Center located in the community to engage with and provide services to TAY.

Fred Finch is the contracted provider for serving San Mateo children, youth, and TAY placed in temporary out-of-county placements within a 90-mile radius of the Center's Oakland location. Wraparound services are provided to youth between 6 and 17 years of age, as well as supportive services for older adolescents transitioning out of care.

Telecare is the contracted provider for providing FSP services to severely mentally ill adults, older adults, and medically fragile consumers and their families. This program uses an Assertive Community Treatment (ACT) approach to provide services to consumers and their families within the community. Additionally, Telecare also operates housing for adult FSP consumers.

In 2009, **Caminar** was added as a fourth FSP site for providing comprehensive FSP and housing support services to adults, older adults and medically fragile consumers and their families. Caminar's R.E.A.C.H (Recovery, Empowerment, and Community Housing) FSP program provides intensive case management services.

Table 1. SMC FSP Providers and Contracted Consumer Slots

FSP program	Contracted Consumer slots
Edgewood ISIS (In-County children/youth)	40
Edgewood Turning Point (In-County TAY)	40
Fred Finch (Out-of-county TAY)	20
Telecare (In-County Adult/Older Adult)	198
Caminar (In-County Adult/Older Adult)	30

Summary of Evaluation Findings

In May 2013, Davis Y. Ja and Associates, Inc. (DYJA) was subcontracted by BHRS to implement a one-year qualitative evaluation of the child/youth/TAY and adult FSP programs. The evaluation was comprised of the following 5 phases:

1) Planning (BHRS convened planning committee, consumer evaluation panel, document and literature review)
2) Interviews/Focus Groups with FSP Systems-Level Administrators (including BHRS)
3) Interviews/Focus Groups with FSP Service Providers (Administrators/Staff) (including two housing site visits)
4) Interviews/Focus Group with Consumers and Caregivers
5) Data Analysis/Reporting

The following brief summary highlights some of the common themes that emerged during this qualitative evaluation. It is important to note, though, that these findings only reflect the four FSP programs as a snapshot in time. Due to time, resource, and budget limitations, it was not feasible for us to interview all stakeholders nor capture every nuance and context associated with four very different FSP programs serving complex, diverse, and challenging populations in two BHRS systems.

Perception of FSP services

Overall, Edgewood and Fred Finch reported a high level of satisfaction with the Wraparound model for serving FSP child/youth. A strength-based approach, individualized treatment planning, flexibility, team-based approach were cited as advantages of the Wraparound model, particularly in contrast to other treatment modalities.

However, a peer-driven and recovery-oriented model may be more appropriate for TAY populations. TAY consumers also found individual DBT to be the most helpful service provided by the FSPs, while caregivers cited Edgewood's auxiliary family support (including family partners) and focus on the family as a whole unit as invaluable to the family and consumer's success. Challenges specific to implementing the Wraparound model with TAY include family participation and wide gradations in the developmental level of TAY served.

Similarly, Telecare and Caminar also positively perceived the current model of providing FSP services to adults/older adults using an ACT framework. The emphasis on teamwork, creativity, and unity while offering consumers flexibility were cited as advantages of the model. Adult FSP consumers identified support groups, classes, transportation access, and health care access to be the most helpful aspects of FSP services.

Funding/Fiscal Issues

Throughout the FSP system, all four providers reported struggling with funding levels, which have led to challenges with staffing consistency and providing an ideal spectrum of services. However, BHRS was unable to extend a Cost-of-Living Adjustment (COLA) to any provider between FY 2007 and 2013 due to the local recession and reduced availability of funds. A 3% increase is being offered during FY 2014.

Capacity Challenges/Referrals

Universally, all four providers agreed that capacity was an issue due to greater community demand than available slots. Child/youth providers and caregivers also felt that certain populations could benefit from earlier identification and referral to FSP services, especially those with Autism Spectrum Disorder and developmental delays. Competing stakeholder priorities was another highlighted challenge (including length of treatment). Child/youth providers experienced difficulty in meeting the expectations of referral sources while adhering to fidelity of the Wraparound model and family priorities.

Service Delivery/Linkages

Service gaps between the Child/Youth/TAY and Adult systems, as well as between all FSP programs and community resources, were especially highlighted by consumers, families, and the child/youth/TAY providers. There are not enough linkages between the two BHRS FSP systems as consumers needing adult FSP services transition out of the TAY system. Insufficient community resources/linkages/support exist for consumers leaving FSP services, whether due to step-down or program discharge. Multiple caregivers of former TAY FSP consumers also expressed feeling that their family member was either prematurely discharged or there was a lack of clarity and communication around the termination reason.

The lack of a systemic approach and resources for monitoring potential consumer decompensation in the community was a substantial concern of caregivers with a consumer either residing in the community (TAY/adult) or discharged/graduated from FSP services.

Integrated substance abuse treatment services was also cited as a critical missing component of child/youth/TAY FSP services, along with additional resources to meet the unique needs of juvenile-justice involved youth and those with psychotic disorders.

Edgewood also discussed the challenges of engaging TAY at its Drop-in Center following changes in the legal mandate to provide services separately for TAY minors and those over 18 years of age, along with new reporting requirements to caregivers. Currently, MHSA's definition for TAY is 16-24 years of age. Staff and administrators emphasized the importance of using the Drop-in Center for outreach and treatment services, with many feeling that a negotiated solution was essential to the program's success.

Among the adult FSPs, providers have noticed an increasing level of acuity among medically fragile consumers and those with severe substance abuse and co-occurring disorders. Expanding resources for integrated medical care capacity was one solution offered by Caminar administrators. However, a dearth of integrated treatment options still exists for consumers with dependency issues.

Caregivers were also concerned about the high level of staff turnover within the adult FSPs and its impact on consumers' therapeutic relationship.

Caregiver/Family Involvement

A basic orientation to the FSP program and services (by either the provider or BHRS) was a common request mentioned by both child/youth/TAY and adult caregivers and family members. Many families new to FSP services reported being overwhelmed at program entry, not fully understanding the FSP program, or feeling that they needed to navigate "the system" on their own.

Additionally, within the adult FSP system, engagement of family members and caregivers remains challenging for both providers. By the time adult consumers arrive at a FSP, most are already "divorced from their families." Among adult caregivers who are involved, a lack of clarity and consistency seems to exist within the adult FSP system. For example, "whatever it takes" often means different things to different stakeholders and lacks any specific standard definition across the system. Consistent and regular communication from providers was also another challenge mentioned by caregivers, including staff not returning/answering calls or showing up to scheduled meetings. Despite these concerns though, caregivers overall described positive

outcomes from past collaborations with providers and expressed a desire for continued collaborations with treatment teams.

Housing

Availability of safe, accessible, appropriate, and affordable housing for TAY and adult FSP consumers was a consistent concern universally raised by providers, consumers, and their families. Caregivers also identified on-site housing and life skills support services to be critical for monitoring consumer decompensation in the community. Many expressed concern regarding the lack of clarity around whether supportive services are supposed to be available on-site and if they are, what they actually entail.

Summary

In conclusion, this report is intended to provide a snapshot-in-time of the four FSP programs currently contracted by BHRS to serve severely mentally ill children, youth, TAY, adults, and older adults in San Mateo County. As such, the findings presented here need to be interpreted within that context, for it was not feasible to capture every nuance nor talk with every stakeholder affiliated with the FSPs within the allocated timeframe and scope of work of the evaluation.

Overall, the sense from providers, administrators, consumers and caregivers is that while challenges exist in serving the complex populations targeted by the FSPs, the programs are generally perceived to have a positive impact on the lives of those served. BHRS' award of a COLA for FY 2014 will help address some of the funding concerns. The main challenges, as identified by those interviewed, surround:

- reviewing current referral criteria for child/youth/TAY (BHRS/providers)
- addressing service gaps (between TAY and adult FSP systems, resources for expanding community supports)
- exploring options for a more integrated model of dependency treatment and medical care, especially for TAY, medically fragile, and older adults
- needs assessment for specific youth populations, especially those with justice involvement, co-occurring, and psychotic disorders
- provider or BHRS-initiated orientation for new families entering FSP services

- identification of safe, accessible, appropriate, and affordable housing options for TAY and adult consumers
- clarification of whether supportive services are available at housing sites; if not, develop plan for monitoring consumer progress/decompensation

Study limitations include being unable to convene focus groups/interviews with specific sub-populations (older adults, child/youth consumers, out-of-county families/youth, medically fragile adults, un-served individuals), as well systems-wide stakeholders peripherally involved with the FSP program. Recruiting family members and caregivers of adult consumers to participate in this study was also especially challenging. Despite working closely with the adult FSP providers and BHRS, we were unable to successfully recruit a culturally diverse and representative sample. Additional research is needed to assess the extended impact of FSP services, such as through a longitudinal study examining long-term trends.

I. Introduction

In February 2013, the Behavioral Health and Recovery Services (BHRS) Division of San Mateo County Health System issued a Request for Qualifications (RFQ) to qualitatively evaluate their Full Service Partnership (FSP) Programs serving children, youth, transitional-aged youth (TAY), adults, and older adults. The initial FSP programs, funded by the State of California's Mental Health Services Act (MHSA), have been fully operational since 2006. According to BHRS, approximately 250 adults and 90 children, youth, TAY, and their families utilize FSP services through four service providers. Edgewood and Fred Finch use the Wraparound model to serve children, youth, TAY, and their families, while Caminar and Telecare offer Assertive Community Treatment (ACT) services to adults, older adults, and their families.

In May 2013, Davis Y. Ja and Associates, Inc. (DYJA) was subcontracted by BHRS to implement a one-year qualitative evaluation of the FSP program. Core evaluation components include focus groups and individual interviews (with BHRS administrators, FSP consumers and their families, FSP administrators and staff, and other key stakeholders), and review of existing contracts and other relevant documents, as well as participation in a BHRS small planning group, literature review, and the establishment and utilization of a consumer evaluator panel.

II. Literature Review

Full Service Partnerships

History

In 2004, the Mental Health Services Act (MHSA) (Proposition 63) was approved by California voters and enacted in January 2005 as an avenue to comprehensively reform California's mental health treatment system with a diverse range of stakeholders. Under MHSA, California counties may request different kinds of state funding through five program components. Under Community Services and Supports (CSS), three different types of funding streams are available: **1)** Full Service Partnerships (FSP); **2)** General System Development Funds; and **3)** Outreach and Engagement Funds. The California Department of Mental Health requires at least 51% of CSS funding to be allocated for FSPs, which are designed to meet the specific needs of un-served or underserved children, transitional age youth (TAY), adults, older adults, and their families through an expanded range of services and supports within a recovery framework (Gilmer, 2010; Brown, 2010; CA-DMH, 2009). They are also intended to essentially do "whatever it takes" to improve *residential stability* and *mental health outcomes* for those served (Gilmer, 2010).

FSP Services

California's FSP model was developed following the pilot of various recovery-oriented programs, including Assembly Bill 2034 (AB2034). This bill which targeted homeless individuals with serious mental illness and paved the way for: **1)** a "housing first" mandate; **2)** flexible funds; and **3)** standardized reporting of client and program outcomes (UCLA Center for Healthier Children, 2012). FSP programs are considered to be a modified version of the Wraparound Model (for child/youth/TAY consumers) and Assertive Community Treatment (ACT) services (for adults and older adult consumers). Both models provide individualized integrated services, flexible funding, intensive case management, and 24-hour access to care.

According to California Code of Regulations (Title 9, § 3620, 2010), services that fall under the umbrella of FSP services include, but are not limited to:

1. Mental health services and supports
    a. Mental health treatment, including alternative and culturally specific treatments
    b. Peer support
    c. Supportive services to assist the consumer, and when appropriate the consumer's family, in obtaining and maintaining employment, housing, and/or education
    d. Wellness centers
    e. Alternative treatment and culturally specific treatment approaches
    f. Personal service coordination/case management to assist the consumer, and when appropriate the consumer's family, to access needed medical, educational, social, vocational rehabilitative and/or other community services
    g. Needs assessment
    h. ISSP development
    i. Crisis intervention/stabilization services
    j. Family education services
2. Non-mental health services and supports
    a. Food
    b. Clothing
    c. Housing, including, but not limited to, rent subsidies, housing vouchers, house payments, residence in a drug/alcohol rehabilitation program, and transitional and temporary housing
    d. Cost of health care treatment
    e. Cost of treatment of co-occurring conditions, such as substance abuse
    f. Respite care
3. Wrap-around services to children in accordance with WIC Section 18250 et. seq.

In addition, California state regulations require that all FSP participation be voluntary and mandate a focus on providing the services that best assist consumers in the development and advancement toward goals (California Code of Regulations, Mental Health Services Act, 2010).

Wraparound Model (for Children, Youth, TAY populations)

History

Wraparound as a treatment modality arose out of a deep concern about the lack accessibility and availability of effective services for children and youth with severe emotional disturbance, as documented in reports appearing between the 1960s and 1980s (Winters & Metz, 2009). The Child and Adolescent Service System Program (CASSP), part of the National Institute of Mental Health (NIMH), established a system-of-care framework as a means of providing a collaborative network of comprehensive services to children and adolescents with severe emotional disorders. These principles emphasized individualized, strengths-based, family-focused, family participation in every level of the treatment planning and process, enhanced collaboration and coordination between involved agencies, a focus on cultural competence, and the placement of the child or youth in the least restrictive level of care (Winters & Metz, 2009).

Areas emphasized by the national system-of-care model include, but are not limited to, the following principles: community-based efforts, a team-driven process, family engagement and collaboration in treatment, strength-based and needs-based services and supports, cultural competency, flexibility of approach and funding, a balance of formal services and informal supports, an unconditional commitment to serving children families, inter-agency collaboration, and outcome measurement/reporting from the individual to the systemic level (Winters & Metz, 2009). Specific performance measures defined by CMHS for system-of-care grants, include:

1) Increased interagency collaboration as measured by referrals from non-mental health agencies
2) Decreased use of in-patient or residential treatment by 20%
3) Improved child outcomes in areas such as school attendance and law-enforcement contacts
4) Decreased overall functional impairment of youth
5) Increased family satisfaction with services
6) Increased stability of living arrangements and
7) Decreased levels of family stress.

In 1992, the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) established the Comprehensive Community Services for Children and Youth and Their Families (Winters & Metz, 2009). Since then, over 100 projects

throughout the United States have been funded by CMHS to implement system-of-care programs that include a Wraparound approach to service planning for children and adolescents with "serious emotional disturbance" (SED) (Winters & Metz, 2009). According to Winters & Metz (2009), Wraparound's primary target population consists of children and youth with "serious emotional disturbance" or SED, a condition identified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) as associated with significant functional impairments in domains such as school, home, and community. Winters and Metz (2009) also consider multi-system involvement to be typical for children and youth with SED.

Within California, Full Service Partnership (FSP) services using a Wraparound model were established to serve children, youth, and transition-aged youth (TAY) with the highest level of mental health challenges (whether due to illness or circumstance) and their families (Ferguson, 2012). The Children, Youth and Families (CYF) age group consists of children from birth to 18 years old and special-education pupils from birth to age 21, whereas the TAY group covers youth and young adults between 16 to 25 years of age (Ferguson, 2012).

Since its inception, the Wraparound model has undergone refinement in both its definition and methods for assessing fidelity (Bruns, Suter, Force, & Burchard, 2005). The primary components underlying a Wraparound model cover ten principles (Suter & Bruns, 2009):

1) Family voice and choice
2) Team-based
3) Natural supports
4) Collaboration
5) Community-based
6) Culturally competent
7) Individualized
8) Strengths-based
9) Unconditional
10) Outcomes-based

Currently, Edgewood and Fred Finch both use a Wraparound model to provide FSP services to San Mateo County child, youth, TAY and their families.

FSP Research Outcomes: Child, Youth and TAY

Ferguson (2012) notes that in the last decade, research studies have become increasingly focused on determining the outcomes associated with Wraparound interventions. Bruns, et al. (2005) note that despite a presumed degree of "flexibility in application, in sites that have implemented the model with a high degree of quality, Wraparound refers to a specific and definable process, one that follows a sequence of steps and uses a number of specific strategies and methods." Measures such as the Wraparound Fidelity Index (WFI) have been

developed and revised in order to improve assessment of program adherence and its impact on important outcomes (Bruns, et al., 2005). According to Bruns, Suter, and Leverentz-Brady (2006), programs with larger measures of organizational and systems supports were able to achieve higher levels of fidelity to the Wraparound model.

The following summary highlights *some* of the outcomes associated with Wraparound services for children, youth and TAY, as observed in research studies. This list is not meant to be comprehensive, especially identifying and defining more meaningful measures of well-being and progress remains an ongoing and evolving dialogue (Bruns, Burchard, Suter & Force, 2005).

In their 2009 meta-analysis of wraparound outcomes, Suter and Bruns reported 66 effect sizes for the seven studies evaluating outcomes that met their criteria. These were aggregated into categories, including overall effect size of wraparound treatment, which amounted to 0.33. In other words, there was a 33% increase on average in all measures for the youth participating in the studies that were examined (Suter & Bruns, 2009). The authors also found that "assuming normal distribution of outcomes, the average youth receiving wraparound was better off than 63% of those receiving conventional services" (Suter & Bruns, 2009).

Increased Independence/Decreased Out-of-Home Placements: Bruns, et al. (2005) used the Restrictiveness of Living Environment Scale (ROLES) to measure caregiver assessment of living situation restrictiveness before and after their family member's participation in Wraparound treatment. The average living restrictiveness score decreased (improved) from −.06 to −.21, indicating that wraparound may have a moderately positive impact on keeping children and youth in the least restrictive level of care possible (Bruns, et al., 2005). Suter and Bruns (2009) determined an effect size on living situation of 0.44 in their meta-analysis study, meaning an average overall improvement of 44% according to the various measures assessing living situation suitability.

Improved School Performance: Suter and Bruns' meta-analysis (2009) reported a positive effect size of 0.27 on child and youth school functioning within the seven Wraparound outcome studies they examined. The national evaluation of the CMHS wraparound system also reported similar increases in overall school performance for Wraparound participants (Manteuffel, Stephens, & Santiago, 2002).

Decreased Juvenile Justice Involvement: Manteuffel, Stephens, & Santiago (2002) reported on the descriptive and longitudinal outcomes data collected for the national evaluation of

CMHS-funded Wraparound programs and concluded that Wraparound participation decreased juvenile justice involvement. Suter and Bruns (2009) also found an effect size of 0.21 in reduction of juvenile justice involvement for youth having received Wraparound treatment.

Reduced Emergency Service Use: A 2012 UCLA report assessed offset costs for CYF and TAY youth as a result of FSP participation and found that cost-related benefits were especially high for TAY consumers, who tend to experience increased rates of incarceration and hospitalization (UCLA Center for Healthier Children, Families and Communities, 2012). When costs were categorized for CYF and TAY consumers according to physical health, psychiatric care, and criminal justice involvement, the greatest cost reduction appeared in both age groups through decreased justice system involvement (both arrests and days incarcerated) (UCLA Center for Healthier Children, Families and Communities, 2012).

Decreased Impairment: Over the course of their study, Stambaugh et al. (2009) found that 32% of the youth receiving wraparound treatment had moved from clinical range to below borderline range on the Child Behavior Checklist (CBCL), as compared to 62% for the MST-only group and 20% for the MST plus Wraparound group. On the Child and Adolescent Functional Assessment Scale (CAFAS), 36% of youth receiving wraparound moved from marked or severe impairment range at baseline to minimal-to-moderate impairment range by the end of the study, as did 66% of youth receiving MST and 26% of youth receiving both MST and wraparound treatment (Stambaugh et al., 2007). Manteuffel, et al.'s 2002 analysis of the national wraparound system examined longitudinal data for 18,884 children and found that 49.5% of Wraparound participants showed improvement in functional impairment at the two-year benchmark.

Improved Functioning/Quality of Life: Suter and Bruns (2009) determined a positive effect size of 0.25 in overall youth functioning due to Wraparound participation. The national CMHS wraparound evaluation also found that 44.6% of children exhibited clinically significant improvements in behavioral and emotional symptoms two years after starting Wraparound services (Manteuffel, et al., 2002).

Enhanced Strengths: Bruns, et al. (2005) used the Behavioral and Emotional Rating Scale (BERS) Strengths Quotient to measure emotional and behavioral strengths of children and adolescents over the course of receiving Wraparound services. The study authors found an 8.2 point decrease in caregiver perceptions of child strengths (from 117.6 to 109.4) and a decrease of 4.2 among caregivers (from 111.5 to 107.3). However, Wraparound Fidelity Index (WFI)

scores were a significant predictor of change in BERS ratings over time (t[18] = 6.03, p < .001.) (Bruns, et al., 2005). It's worth noting that in Suter and Bruns' 2009 review, only two of the seven studies evaluated included measures of "assets and resiliency" (strengths such as self-efficacy and life satisfaction) and that that data was ultimately deemed insufficient for assessing these domains.

Family Involvement/Satisfaction: In 2005, Bruns, et al. examined items from the 2002 nationally-implemented family satisfaction questionnaire for Wraparound treatment and compared them to scores on the Wraparound Fidelity Index (WFI). Over the course of the study, caregiver satisfaction with services received within the last six months declined from.44 to .34. However, caregiver satisfaction with client progress increased greatly, from .23 to .47 (Bruns, Suter, Force, & Burchard, 2005). For the group of caregivers in this study, fidelity to the wraparound model (as measured by WFI scores) was a significant predictor of increases in caregiver satisfaction with the child's progress over the course of treatment (t [32] = 1.91, p < .10) (Bruns, Suter, Force, & Burchard, 2005).

Pay for Performance/Financial Incentives: Lastly, a study of Wraparound programs across five different California counties identified implementation issues related to referrals and case closures, staffing and training, management information systems, funding, and contextual factors (Ferguson, 2012). Conklin (2008) notes that the funding sources for Wraparound services also warrant analysis in terms of flexibility, regulations, and restrictions. Suter & Bruns (2009) determined that, while the research on Wraparound programs is largely indicative of positive outcomes, the research base is still developing and much still remains to be understood about Wraparound's long-term impact as a model. Garland et al. (2013) sum up the lack of existing research thusly:

"*More research on the impact of performance-based outcome measurement incentives in children's mental health is needed, with attention to the methodological and ethical implications of these incentives."*

ACT Model (for Adults and Older Adults)

History

Assertive Community Treatment (ACT) was developed in the early 1970s at a state hospital in Madison, Wisconsin by Stein and Test to "prevent the revolving door of repeated hospitalizations for persons with severe mental illness" (Morrissey, Meyer, & Cuddeback, 2007,

pg. 528). ACT's main objective centered on increasing accessibility of intensive psychosocial treatment services for Severely Mentally Ill (SMI) individuals by shifting the service setting from an institution (i.e. hospital) to one that was community-based. Strengthening individuals' independent living skills (i.e. learning to do laundry, shop, cook, budget, access public transportation) and securing housing also comprised core ACT components (Morrissey, et al., 2007).

Since its inception, the impact of ACT services has been extensively studied globally and locally. While Canada, England, Australia, and Sweden were quick to replicate the ACT model, the adoption rate in the United States has been slowly gradual throughout the 1980s and 1990s (Morrissey, et al., 2007). Though Weisbord's (1983) study on the cost effectiveness of ACT services identified the State as the primary beneficiary of reduced hospitalization costs among high-users of institutional services, Morrissey, et al. (2007) attributed the slow widespread adoption of the model to resistance by administrators of poorly funded public health systems.

However, beginning in the 1990s, wider acceptance of the ACT model took shape with strong support from the National Alliance on Mental Illness (NAMI), Substance Abuse and Mental Health Services Administration (SAMHSA), and the evidence-based practice movement (Morrissey, et al., 2007). In 2004, California voters passed Proposition 63, also referred to as the California Mental Health Service Act (MHSA) of 2004, which created funding for "Full Service Partnership" (FSP) programs.

According to the National Alliance on Mental Illness (2007), the following are primary principles of the ACT model:

- Primary target population: individuals with severe mental illness
- Team members directly provide individualized, flexible, and comprehensive treatment, support and rehabilitation services, including:
    - Mobile crisis interventions
    - Illness management and recovery skills
    - Individual supportive therapy
    - Substance abuse treatment
    - Skills teaching and assistance with daily living activities
    - Assistance with natural support networks
    - Supported housing and supports in accessing benefits, transportation, medical care, etc.
    - Medication management
    - Peer Supports

- Team members share responsibility for consumers served by the team
- Small staff to consumer ration (approximately 1:10)
- Majority of contacts in community settings
- No arbitrary time limits on receiving services
- Services are available 24/7

The ACT model is also intended to meet the unique needs of specific populations, including severely mentally ill children/youth, transitional-aged youth, adults, and older adults. San Mateo County's adult FSPs extend the ACT model further by specifically aiming to reduce inpatient recidivism through its explicit embrace of a consumer-driven, recovery-oriented approach in working with enrolled consumers (Salyers, 2007; Spaite and Davis, 2005). Other differences between the FSPs and ACT include a focus on housing in all programs and flexible funding for other supports, such as transportation and childcare.

FSP Research Outcomes: Adults and Older Adults

In recent years, research studies exploring the impact of adult FSP services have focused on a variety of outcomes, including emergency room visits, recidivism/criminal justice, quality of care, quality of life and life skills. The following summary is by no means comprehensive, but rather intended to highlight some of the outcomes currently being explored regarding the impact of adult FSPs.

Reducing emergency room visits*:* Brown et al. (2012) examined data for 155,203 adults over an 18-month period (2007-2008) to determine how effectively FSP services reduced emergency room use. Overall, FSP participants were 54% less likely to visit the emergency room after four quarters and 68% less likely after six quarters when compared to a non-FSP sample. Gilmer et al. (2010) reviewed data for 209 FSP consumers and 154 consumers receiving public mental health services in San Diego County between October 2005 and June 2008. In general, FSP consumer usage of emergency services declined by 32% and inpatient use declined by 14%, while outpatient mental health visits increased by 78 visits.

Increased independence: Gilmer et al. (2010) reported a significant decrease in number of homeless days for FSP consumers while the number of days spent in independent/residential living situations significantly increased 99%. Yoon et al. (2010) examined data from the Data Collection and Reporting System (2005-2009) and reported that 52% of FSP participants lived independently, while 4.8% were homeless and 5.3% were in jail. However, certain sub-

populations of FSP consumers were also more vulnerable to being able to maintain independent living, including those who were younger, non-white, female, and diagnosed with co-occurring disorders.

Criminal Justice/Recidivism*:* According to Brown et al. (2010), FSP consumers were 56% less likely to be arrested when compared to non-FSP users of the mental health system. Gilmer et al. (2010) supported this finding and found that FSP consumers reduced criminal justice involvement by 17%.

Services/Outcomes/Functioning/Quality of Life: In general, FSP participants tended to more favorably rate quality/appropriateness of FSP services, as well as outcomes, levels of functioning, and quality of life (Brown et al., 2010; Gilmer et al., 2010).

Family Involvement: According to Chen (2008), key findings suggest that ACT case managers viewed family members as "sources of social connections rather than sources of care" (p.456). Case managers also stressed the importance of respecting consumer requests to include or exclude family members from treatment participation.

Housing: Compelling reductions in homelessness and hospitalizations have been associated with programs providing housing and case management services (Nelson et al., 2007). Overall, the most favorable outcomes related to housing stability appeared in programs providing a combination of housing and supportive services (Nelson et al., 2007). Additionally, Kreindler and Coodin (2010) discovered that substance abuse was the most influential predictor of housing instability, along with age (30 years or younger) and gender (female), while independent housing and neighborhood income were positive predictors for maintaining residential stability. Gilmer et al. (2013) conducted semi-structured interviews with program managers in a qualitative study of FSPs and discovered low fidelity with housing philosophy as well as inconsistent compliance with consumer preferences regarding housing options.

Employment Outcomes: Kirsh and Cockburn (2007) conducted a comprehensive examination of published ACT employment outcomes from 1990 through 2003 and concluded that while employment outcomes varied across studies, ACT consumers overall displayed higher rates of employment as opposed to those enrolled in standard care.

Older Adults: The research literature of psychosocial rehabilitation programs recognizes the importance of addressing the challenges faced by both current and future older adults with SMI (Pratt et al., 2008). For example, while assertive community treatment (ACT), family-based

interventions, and vocational rehabilitation have produced positive outcomes for younger SMI adults, further research is essential to assess whether these models remain as effective with older adults. Most recently, Strobbe et al. (2014) found that elderly consumers in ACT services received faster initial contacts from doctors within the first three months and had a lower treatment dropout rate, suggesting that ACT was able to more successfully engage SMI elderly patients than those with standard treatment. However, overall, there is still a lack of research focused on the effectiveness of ACT services specifically for older adults with SMI.

Additional domains: However, Brown et al. (2010) also discovered no differences between FSP and non-FSP users regarding social connectedness, access to care, and participation in treatment planning.

Cost/Benefit: Positive outcomes among California's FSP adult consumers have led to a reduction in usage and costs related to specific psychiatric, physical health, and criminal justice services, according to a UCLA (2012) study examining cost offsets for new Adults and Older Adults FSP enrollees between 2009 and 2010. However, while Psychiatric, Physical Health, and Criminal Justice service utilization all declined among Adult FSP consumers, the costs of providing Physical Health services to Older Adults (60 years and older) actually increased, indicating that the physical health needs of Older Adults merit further examination.

Other FSP studies examining positive outcomes, service utilization, and cost savings among adult consumers have yielded similar findings. For example, Gilmer (2010) reported a 82% cost offset within San Diego County's FSP program due to positive outcomes and reduction in emergency and inpatient service usage. However, the extent to which these savings carry forward requires further exploration, especially when considering the specific and diverse nuances of populations served by each county.

Summary: Overall, for the studies examined, areas of improved outcomes for FSP consumers are highlighted above. However, this summary represents a very limited review of currently published FSP literature. Though, according to Yoon et al. (2010), sub-populations can be more vulnerable to negative outcomes and continuous FSP participation may be more predictive of positive outcomes.

Pay-for-Performance (P4P) / Incentive-based Model

BHRS has expressed interest in exploring the option of a Pay-for-Performance (P4P) or Incentive-based model for the FSPs. This type of model has been utilized in various sectors, including education, transportation, and, more recently, healthcare (Stecher et al.., 2010). Providers of services, such as teachers or doctors, are incentivized or rewarded for achieving certain goals or outcomes related to increased efficiency and/or improved quality of services. For example, a P4P program could pay or incentivize a healthcare provider (i.e. doctor, hospital, health care organization, medical group, etc.) to improve the quality of care and reduce costs of overused services, thereby improving the overall value of health care (Ryan & Damberg, 2013; Health Policy Brief, 2012; RAND, 2010).

P4P programs could also be called Performance-Based Accountability Systems (PBASs) and be considered one of the Payment Reform Models (PRM). All of these have three main components (goals, incentives, and measures) with explicit measures linked to payment-for-performance on the measures to improve quality of care and use of appropriate services (Schneider, Hussey, & Schnyer, 2011; Stecher et al.., 2010). With the rise of the US health care costs and expenditures, as well as low health statuses, there has been a push toward health care reform, as exemplified by movement away from fee-for-service and towards pay-for-performance. Under the Affordable Care Act, the Medicare program will utilize P4P (called Value-Based Purchasing) for inpatient care and Medicare Advantage plans. This system will be implemented with physicians in 2015 (Ryan & Damberg, 2013; Ryan & Blustein, 2012).

Much of the literature on P4P agrees on the potential and promise of the model. However, there is a lack of evidence and research along with mixed or unclear findings. There is limited evidence of effectiveness and findings show incentives have led to small or no improvements (Health Policy Brief, 2012; Stecher et al.., 2010; Mehrota et al.., 2009; Doran et al.., 2006; Petersen et al.., 2006; Rosenthal et al.., 2005). In a study by Van Herck and colleagues (2010), P4P programs did show significant improvement on process measures, but not necessarily on outcomes. Their systematic review of P4P in primary care/ acute hospital care medicine revealed that intervention effects varied in design and characteristics by context. Therefore, results showed a full spectrum of effects, from absent to strongly beneficial.

More recently, Unutzer and colleagues (2012) used a quasi-experimental design to evaluate a P4P program working with a safety-net population similar to San Mateo County's FSP. After the implementation of the P4P program, participants were more likely to experience timely follow-

up. Time to depression improvement was also significantly reduced. This strongly suggests that this P4P system improved quality of care.

In order to design and implement a successful P4P program, we look to the published literature and associated recommendations (Ryan & Damberg, 2013; Friedberg & Damberg, 2012; Health Policy Brief, 2012; Friedberg et al.., 2011; Stecher et al.., 2010). The following are suggested elements which may contribute to the effectiveness of a P4P system:

1. Goals widely shared among stakeholders (stakeholder negotiations)
2. Clear and observable measures - Quality measures (4 kinds)
    a. Process: provider performance of activities
    b. Outcome: effects of care on patients
    c. Patient experience: patient satisfaction
    d. Structure: facilities, personnel and equipment, including Health IT
3. Identifying Data Sources and aggregating performance data
4. Provide technical assistance to participating providers
5. Improve performance reporting & increase transparency
    a. Measure & address systematic performance misclassification to account for differences in patient mix
    b. Measure and address random performance misclassification with assistance from statistician
    c. Use composite scores appropriately
    d. Conduct sensitivity analyses to understand the implications of methodological choices
    e. Measure the extent to which a report fulfills its purpose
    f. Checking data quality and completeness
    g. Creating performance reports
6. Incentivize both quality attainment and quality improvement
7. Adjust programs dynamically to recalibrate measures and payment thresholds
8. Meaningful incentives (cash, promotions, status, recognition, increased autonomy, and access to training or other investment resources)
    a. Pay incentives that are sufficiently large to motivate a behavioral response
    b. A series of incentives rather than 1 lump sum (continued positive reinforcement)
    c. A series of tiered absolute thresholds better than 1 (i.e. More incentive for higher % screened vs. this much for >75%)
    d. Reducing lag time between care and receipt of incentives increases behavioral response
    e. Withholds have more of an effect than bonuses, but one needs to be cognizant of the negative psychological response (previous research found individuals are more sensitive to incentives when they perceive that they are losing something rather than gaining 21)
    f. Reducing complexity of an incentive plan increases the behavioral response
    g. P4P and incentive payments should be decoupled from usual reimbursement

In addition, Bremer and colleagues made a national effort in 2008 to comprehensively identify P4P programs in behavioral health. They identified 24 specific P4P programs in the mental health and substance abuse treatment fields. The findings show that financial incentives offered in behavioral health P4P programs were often small and further compounded by the lack of valid and practical quality measures in behavioural health. Also, public reporting of results was not widespread. And so some recommendations for implementing effective P4P programs include: engagement of providers in the design of measure and incentives, the use of meaningful incentives, and outreach efforts to increase providers' awareness & knowledge. All of these were included in the extensive list above.

Jarvis (2009) has also been following the Healthcare Reform and stresses the importance of integrating behavioral health with the rest of the healthcare system. He described a 4-part reform, including gaining federally qualified behavioral healthcare center status and obtaining a dedicated federal funding stream that will (in theory) address workforce and capacity issues (similar to San Mateo County's FSPs), provide for behavioral health provider workforce development and offer funding for indigent, uninsured, and underinsured persons who are not currently being served.

Lastly, for federal and state payment methods, he proposes a three prong payment approach: case rate (or flat amount) for prevention, education and care management services, FQHC-like prospective payment system for mental health and substance use services that are part of a formal plan of care (but not included in the case rate), and finally, a bonus-type gain-sharing mechanism (pay-for-performance) where providers who contribute to the reduction in total healthcare expenditures for a given population receive a share of those savings as a bonus.

See *Appendix B* for additional information on Pay-for Performance model.

III. Methods

In May 2013, Davis Y. Ja & Associates, Inc. (DYJA) was subcontracted by BHRS to conduct a one-year qualitative evaluation of the child, youth, TAY, adult and older adults FSPs. Though evaluation activities were initiated the same month, it became evident that a revised timeline was warranted due to BHRS' requests for a preliminary report (due 10/9/13) and updated findings by 12/31/13. Based on our original proposal, the evaluation was to be implemented through five phases (as delineated below). However, due to the new expedited timeline, we decided to implement the phases concurrently.

Phase I – Planning

The first step was meeting with the BHRS planning committee to gather a comprehensive background history regarding FSP implementation. From this meeting, DYJA compiled a working list of key research questions and distributed it to the planning committee for additional feedback. DYJA also began reviewing existing documentation on the FSP programs, including MHSA Annual Update progress reports, meeting minutes, existing contractual agreements with the provider agencies and other relevant documents. DYJA also initiated a literature review on Full Service Partnership models, ACT services and Pay-for Performance/incentive-based models (see above *Literature Review*).

During this phase, DYJA also worked with the BHRS planning committee to identify potential FSP key stakeholders to interview as well as potential candidates for a consumer evaluators' panel. DYJA recruited two former adult FSP consumers and one family member with experience in the Child/Youth/TAY and adult FSP programs to be consumer evaluators. In July 2013, an orientation session was held with the consumer evaluators to introduce them to purpose of the evaluation and discuss their priorities and concerns for evaluation research questions.

Subsequently, input from the BHRS planning committee and consumer evaluators was used to develop the administrator, key stakeholder, and provider staff individual interview and focus group guides, as well as the consumer and caregiver focus group guides. Drafts were distributed to the BHRS planning committee and consumer evaluators for feedback.

Phase II – FSP System Administrators

DYJA conducted in-depth 60 to 90-minute individual interviews with key BHRS administrators/ stakeholders identified by the BHRS planning committee. It was not feasible to interview all of the administrators/stakeholders suggested by the committee. Administrators/ stakeholders interviewed included the BHRS FSP Directors for Adult and Child/Youth/TAY systems, a unit chief, the adult clinical services manager, Office of Consumer and Family Affairs representatives, Child Welfare administrators, Juvenile Probation administrators and WRAP Probation Officers. These interviews provided DYJA with a more comprehensive, systemic perspective regarding FSP implementation within the broader spectrum of BHRS and San Mateo County while highlighting the specific needs of consumers and their families. Discussion around the implementation of a pay-for-performance model was also addressed in several of these interviews. All interviews were recorded. All administrator interviews were completed by December 2013, with emergent themes summarized and presented in this report.

Phase III – FSP Service Providers

At all four of the FSP program sites, in-depth individual interviews were conducted with FSP provider administrators, while focus groups were held with program staff. It was not within the budget or scope of this contract to individually interview each staff member. The main focus of these interviews and focus groups were to capture the process of FSP implementation (including staff-consumer interactions, perceived/actual outcomes, fidelity, and consumer progress), identify barriers, solicit feedback for service delivery improvements (including the use of financial incentive models), and capture successes. All interviews were recorded, with all staff focus groups and administrator interviews completed by December 2013. At the suggestion of BHRS and interviewed stakeholders, DYJA also conducted site visits to two key adult FSP consumer housing sites in March 2014. Emergent themes from the focus groups, individual interviews, and site visits have been summarized and are presented in this report.

Phase IV – FSP Consumers/Family Members

Prior to conducting any consumer/caregiver focus groups, the interview guide was circulated to the consumer evaluators for review and feedback. These interviews were intended to capture consumer and family perspectives regarding the direct impact of FSP services, their personal

histories and stories, and input on FSP service delivery (including barriers/areas for improvement/successes).

Scheduling challenges resulted in a delay of conducting any consumer/caregiver focus groups prior to the first report deadline. This final report includes input from TAY consumers, child/youth/TAY caregivers, and adult FSP consumers and caregivers. All focus groups and individual interviews were recorded, with emergent themes presented in this report. Signed informed consent was secured from each participant prior to the start of each focus group/interview and all participants received a $10 cash incentive upon completion of the focus group or interview.

During November 2013, adult consumer focus groups were held on-site at each of the two adult FSP providers, with logistical support provided by program administrators and staff. The Telecare focus group included eight (8) male consumers. All participants identified English as their primary language, while ethnicities included Caucasian (5), African American (1), American Indian (1), and unknown/refused to state (1). Three (3) of these participants were also prior Caminar consumers.

The Caminar focus group included 10 current Caminar consumers. There were five (5) female participants, two (2) males, and three (3) declined to state their gender. Four (4) consumers identified as Latino/Hispanic, with Spanish as their primary language. However, they were fluent in English and did not require an interpreter for the focus group. The remaining participants identified as either Caucasian (3) or declined to state (3).

In December 2013, DYJA also conducted a focus group with Edgewood's TAY consumers as well as one with caregivers of current and former Edgewood consumers. Edgewood administrators and staff provided logistical support as needed. Both groups were held on-site at Edgewood. The TAY consumer focus group included six (6) current TAY FSP consumers and one (1) graduate. There were six (6) male participants and one (1) female. Their identified ethnicities included mixed (2), Latino/Hispanic (1), African-American (1), Caucasian (1), and declined to state (2). Due to consent/assent requirements and the abbreviated timeline for conducting these focus groups, child/youth consumers were not interviewed.

The child/youth/TAY caregiver focus group included eight (8) family members of current and former Edgewood consumers. While several participants had a family member currently enrolled in either the child/youth or TAY program, there were also two (2) participants whose

family member transitioned from the child/youth program to TAY services, one (1) couple, and two (2) other participants whose family member was discharged against family wishes. Since two of the participants were monolingual Spanish-speaking, the DYJA research staff for this focus group included a bilingual Spanish research assistant who served as an interpreter.

Between January and March 2014, DYJA conducted four individual interviews with caregivers involved with one or both Adult FSP Programs. DYJA also attended the Friends and Family Group at Telecare and conducted a focus group with five attendees. Based on caregiver and BHRS input, DYJA also scheduled and conducted site visits to a Caminar board-and-care housing facility and Telecare's Industrial Hotel in March 2014.

Phase V – Data Analysis

Content analysis was used to identify emergent themes and occurred concurrently with data collection. Budget constraints did not allow for the transcription of each completed interview/focus group. However, DYJA was able to reference audio recordings and comprehensive field observation summary notes throughout data analysis. A benefit of this qualitative study is that the identified themes will be grounded in the data itself and the voices of the participants, as opposed to being driven by a research agenda. To ensure that DYJA accurately captures and interprets participants' voices, the BHRS planning group, consumer evaluators, and key stakeholders will be asked to review and provide input on the final report.

Summary of Key Completed Research Tasks

- **Review of FSP contract and background documents**
- **Literature review of key areas** (Historical background and outcomes related to FSP, ACT, & Wraparound services, Pay-for-Performance, Cost-benefit)
- **Convening of Consumer Evaluator Panel** (with 2 former FSP consumers and 1 family member)
    - Tasks of this panel include reviewing evaluation forms/assessment instruments and providing input on the findings for the final report
- **Attendance of BHRS-FSP Planning Committee meetings**
- **Interviews and Focus Groups with Key FSP Stakeholders**
    - **Interviews: BHRS Administrators and Other Key Stakeholders**
        - Former Adult Services Deputy Director

- Child/Youth Services Deputy Director
- Office of Consumer and Family Affairs staff members (2)
- Adult Services Unit Chief & Clinical Services Manager
- Child Welfare Department administrators (2)
- Juvenile Probation Department administrators (2)
- Juvenile Probation Department Officers (WRAP program) (2)

- **Interviews and Focus Groups: Child, Youth, TAY**
  - **Provider**
    - Edgewood Executive Director (joint interview)
    - Edgewood Youth FSP Director (joint interview)
    - Edgewood TAY FSP Director (interview)
    - Fred Finch Regional Director (joint interview)
    - Fred Finch WRAP Director (joint interview)
    - Focus group with 12 Youth FSP staff (Edgewood)
    - Focus group with 6 TAY FSP staff (Edgewood)
    - Focus group with 3 TAY FSP program managers (Edgewood)
    - Focus group with 4 FSP staff members (Fred Finch)
  - **Consumers (Edgewood only)**
    - Focus group with 7 current/former members of the TAY FSP program
  - **Family Members (Edgewood only)**
    - Focus group with 8 family members of current/former members of the Youth/TAY FSP program
- **Interviews and Focus Groups: Adults and Older Adults**
  - **Provider**
    - Telecare Executive Director (interview)
    - Telecare Clinical Director (interview)
    - Telecare Housing Coordinator (interview)
    - Caminar Executive Director (interview)
    - Caminar FSP Associate Director (interview)
    - Focus group with 15 Telecare FSP staff members
    - Focus group with 6 Caminar staff members (including the Executive Director and FSP Associate Director)

- Interview with 2 Caminar Community Support Workers

- **Consumers**
  - Focus group with 9 current Caminar consumers (held at Caminar)
  - Focus group with 8 current Telecare consumers (held at Telecare)
  - Site visit to Caminar Board-and-Care facility
  - Site visit to Telecare's Industrial Hotel
- **Family Members**
  - Individual interviews with 4 family members of FSP adult consumers
  - Focus group with 5 friends/family members at Telecare's Friends and Family group (some also have experience with Caminar's FSP program)

- **Data Analysis (Preliminary and Final)**
- **Submission of reports** (2 preliminary reports and 1 final report)

IV. Preliminary Findings

Program Descriptions

As previously mentioned, BHRS currently contracts with four service providers for FSP services: Edgewood and Fred Finch serves children, youth, and TAY while Caminar and Telecare works with adults and older adults.

Edgewood

Since 2006, Edgewood has been the primary contractor for child/youth FSP programs since the FSP model was implemented by San Mateo County. Current Edgewood FSP programs for children and youth include Turning Point (40 slots) and ISIS (40 slots). The ISIS program was added through a contract expansion in 2009 to provide intensive school-based services to youth using existing mental health treatment teams. The two FSP programs at Edgewood target seriously emotionally disturbed children/youth who are at-risk of being moved to a higher level of care (including residential placement, incarceration or hospitalization) and their families. The primary goal of the program is to stabilize this high-risk child/youth population in the lowest possible level of care, allowing them to remain with their families and in the community. The program uses the Wraparound model to emphasize the strengths of the consumers and their families and actively engage them in the treatment planning process.

Edgewood has been the primary contractor for the Transitional-Age Youth (TAY) FSP program since the start of the FSP system in San Mateo County. The current Edgewood FSP program for TAY is Turning Point (40 slots), which targets youth aged 16-25 years who have serious emotional disorders and/or serious mental illnesses and are at-risk of being moved to a higher level of care (including residential placement, incarceration or hospitalization). Similar to ISIS, the primary goal of the program is to stabilize this high-risk TAY population in the lowest possible level of care, allowing them to remain in the community. The program also uses the Wraparound model to emphasize the strengths of the consumers and their families and actively

engage them in the treatment planning process. Turning Point additionally utilizes a Drop-in Center in the community to engage with and provide services to TAY.

Fred Finch

The Fred Finch FSP offers 20 slots allocated for San Mateo County children and youth in temporary out-of-county placements within a 90-mile radius of the Center's Oakland location. The FSP's five-member team provides Wraparound services for youth ages 6-17 years as well as support for older adolescents transitioning out of care. Fred Finch's FSP expanded its program in 2010 after the provider was awarded its contract as part of the expansion of San Mateo County's Child, Youth and Transitional Age Youth FSP. During FY 2011-2012, the Fred Finch FSP served 28 youth.

Telecare

Telecare, Inc.'s contract was amended in October 2009 to serve a total of 200 consumers: 75 Adult, 75 Older Adult/Medically Fragile, 40 Community Case Management, and 10 in a new Wellness category. In February 2011, another amendment was added to the Telecare FSP contract to more effectively align program/agency needs with BHRS resources. Thus, 10 case management slots were reduced in order to add 7 intensive slots, and the rest of the savings was shifted to support the Housing Support Program, thereby reducing the total number of slots to 198. During FY 2011-2012, Telecare served 208 adults, older adults, and medically fragile consumers and their families. Telecare also provides up to 90 mixed types of housing units, including augmented board and care, dormitory-style, congregate and supervised living, single room occupancy hotels, shelter and independent living.

Caminar

In October 2009, BHRS added comprehensive FSP services and Housing Support Program services for Adults and Older Adults/Medically Fragile to contracted services with Caminar, for a maximum of 30 additional enrollees. The Caminar R.E.A.C.H (Recovery, Empowerment, and Community Housing) FSP provides intensive case management services, including full-service psychiatric services and injections. During FY 2011-2012, Caminar provided services to 40 unduplicated adults/older adults/medically fragile FSP consumers and their families.

Table 2. SMC FSP Providers and Contracted Consumer Slots

FSP program	Contracted Consumer slots
Edgewood ISIS (In-County children/youth)	40
Edgewood Turning Point (In-County TAY)	40
Fred Finch (Out-of-county TAY)	20
Telecare (In-County Adult/Older Adult)	198
Caminar (In-County Adult/Older Adult)	30

Emergent Themes

As previously mentioned, DYJA used a content analysis framework to identify emergent themes within the child, youth, TAY, adult, and older adult FSP programs. To remain consistent with BHRS' structure of two separate systems for child/youth/TAY and adult/older consumers, our findings will be similarly aggregated in this section and are intended to highlight some of the common points that staff, providers, administrators, consumers, and caregivers have raised throughout the study.

FSP System-wide (Child/Youth/TAY/Adult/Older Adult)

Challenges

Throughout the FSP system, all four providers reported struggling with past and current funding levels, which have led to challenges in maintaining consistent staffing and providing an ideal spectrum of services. However, BHRS was unable to extend a Cost-of-Living Adjustment (COLA) to any provider between FY 2007 and 2013 due to the local recession and reduced availability of funds. A 3% increase is being offered during FY 2014.

Providers also universally agreed that capacity was an issue because there is greater community demand for their services than available slots. Another emerging system-wide theme relates to the service gaps between the Child/Youth/TAY and Adult systems, as well as between all FSP programs and community resources. There are not enough linkages between the two BHRS FSP systems as consumers needing adult FSP services transition out of the TAY system. Additionally, there are insufficient community resources/linkages/support for consumers leaving FSP services, whether due to step-down or program discharge. Availability of safe, accessible housing for TAY and adult FSP consumers was also a consistent concern raised.

Successes

Universally, family/caregiver involvement was viewed as a vital and effective component by all FSP programs. All agreed that increased involvement by more families/caregivers would be a central benefit. Most providers and stakeholders also spoke highly of FSP services as a key contributor to the improvement of mental health services offered in San Mateo County.

Child/Youth/TAY FSP System

This section specifically addresses themes from Edgewood and Fred Finch, the FSP providers serving child, youth, and TAY consumers and their families. As we started talking with Edgewood's TAY FSP administrators and staff, it became apparent that the needs of the TAY population and aspects of Edgewood's Turning Point program were too distinct to be combined with our child/youth findings. Therefore, TAY services will be covered in its own separate section.

There are four main sections below: Edgewood-Child/Youth FSP, Fred Finch, Edgewood-TAY, Consumer/Caregiver. Provider Administrator/staff and BHRS key stakeholder input are summarized by site, followed by an overall synthesis of Consumer and Caregiver input.

Edgewood—Child/Youth

FSP Program (ISIS)

As described by an Edgewood child/youth services administrator, the child/youth FSP program ISIS philosophically engages in a "whatever it takes" treatment approach. ISIS program staff also talked about the importance of giving hope to the highest-risk consumers and their families through FSP services. To accomplish this, Edgewood FSP staff described using a collaborative approach in working with consumers and their families to meet consumer-identified goals and the outcomes outlined in their BHRS contract.

Wraparound Model

Perspectives about the Wraparound model

Overall, Edgewood administrators and staff were satisfied with the Wraparound model for child/youth FSP consumers. The model's strength-based approach, individualized treatment planning, focus on "family voice and choice," and flexibility were frequently cited advantages of the Wraparound model, particularly in contrast to other treatment modalities.

"As an agency, we love providing this program." --Edgewood staff member

Alternatives to the Wraparound model

The importance of peer-driven activities was mentioned in relation to serving child/youth and TAY, but no alternative models were proposed for use with Edgewood's child/youth population. The general consensus seemed to be that the Wraparound model is adequately meeting the needs of the consumers and their family members, and that there is enough flexibility within the model to allow for necessary changes.

Adaptations to the Wraparound Model

Over the years that Edgewood has served as a provider of Child/Youth FSP services, adaptations have been made to both the program and the application of the model, according to Edgewood administrators and staff. An Edgewood administrator described the evolution of the model as a "work in progress," requiring time and experience to build community-level understanding of the program.

According to program staff interviewed, the **ISIS program** allows youth and their families with existing clinical teams in place to receive integrated Wraparound services at Edgewood while maintaining the therapeutic relationship with their primary clinician. ISIS deviates from a typical application of Wraparound model in this manner, but has been successfully implemented at Edgewood. ISIS also reflects the collaborative relationship between BHRS, Edgewood, and key stakeholders (including Child Welfare and Juvenile Probation) in working together to respond to need of child/youth consumers and their families. The **After School Intensive Services program,** which was established in 2010, has also evolved through the years, according to program administrators and staff. It started as a youth center serving youth under 15 years of age, but has since evolved to incorporate a more therapeutic approach, including the addition of support groups and a case manager.

Another adaptation to the model cited by Edgewood program administrators and staff has been in the shift of the family support groups from a more therapeutic focus to serving more of a "normal" or social function.

Treatment

Referrals

According to Edgewood administrators and FSP staff, the success of the referral process for placement in the child/youth FSP program depends on efficient communication between several key stakeholders, BHRS, and Edgewood. While communication in this area appears to have improved throughout the course of providing FSP services, Edgewood administrators and staff also identified several remaining challenges.

Timeliness of referrals – In certain instances, Edgewood staff noticed a need for earlier identification of potential consumers and felt that children aged 4-5 years old and their parents could benefit sooner from a referral (the current minimum age limit is 6 years old). It was also mentioned that consumers with Autism Spectrum Disorder are often referred to the FSP program very late, sometimes too late to achieve substantial treatment progress. According to staff, identifying and referring these consumers earlier would potentially allow Edgewood to better impact consumer progress and more effectively work with consumers and family members.

Insufficient communication regarding referrals - Staff felt that communication with families referred for FSP services needed to be more proactive so that families had the opportunity to familiarize themselves with the program, prepare for next steps, and adequately manage expectations. It has been an issue in the past that consumers and their families were not informed about their transfer of care. In these cases, the first contact by Edgewood was often a surprise. Since these families have already experienced instances of ineffectual treatment options prior to FSP referral, they can be resistant to opening up during treatment.

Insufficient consumer information - Due to the Interagency Placement Review Committee's (IPRC) scheduling limitations, referrals to ISIS are sometimes made with limited information about consumers' cases and needs. This lack of information can result in consumers being placed in the FSP program who are not a good fit for the services Edgewood can provide.

Differing stakeholder priorities - Another frequently cited challenge around referrals relates to the competing different priorities of the referral source, the referred family, and

provider staff. Depending on the referral source (HSA, probation, child welfare, courts, etc.), the expected outcomes and timeframe for achieving progress may differ for individual consumers. Edgewood administrators and staff described difficulties in meeting the expectations of these referral sources while still maintaining fidelity to the principles of the Wraparound model, where family priorities for treatment receive primary attention. In the past, this has led to conflict, and in some cases, to consumers being pulled out of the FSP due to lack of perceived progress according to the referent's priorities.

Sub-populations

Based on feedback from Edgewood administrators and staff, several subpopulations currently being served by ISIS may require additional resources and supports. These populations include: children/youth with Autism Spectrum Disorder, developmental delays, juvenile justice involvement, and co-occurring disorders.

In addition to the referrals issues mentioned in the previous section, there are limited resources to currently support working with consumers with Autism Spectrum Disorder and developmental delays, especially if a child or youth doesn't meet the requirements for an official diagnosis of being developmentally-delayed.

Consumers with juvenile justice involvement, particularly those with violent criminal histories, can be challenging to treat since the program currently lacks the resources to safely and effectively treat severe criminality.

Lastly, while Edgewood currently uses the harm reduction model, ISIS is unable to provide the comprehensive level of care needed by consumers with co-occurring disorders. Thus, consumers with substance abuse issues are currently referred to an outside treatment facility for additional services.

Interventions

Edgewood staff and administrators emphasized the flexibility of the ISIS program as a key factor that allows them to meet the needs of individual consumers on a case-by-case basis.

"Every single thing we do is individualized." -- Edgewood staff member

Important interventions cited by administrators and staff include: the 24-hour crisis line, parent and peer partners as staff members on treatment teams, the strengths-based approach, and flex-funds that can be used on an individual basis to support consumers and their families.

Edgewood staff further described the challenges around the initial stabilization of incoming consumers in crisis mode. In particular, the timeframe expected for stabilization by different referral sources doesn't always match the reality of working with consumers in crisis. (See *Referrals* for more information.)

Another challenge identified by Edgewood administrators and staff is the program's inability to fully meet the range of needs presented by consumers' families, including housing, financial, health/ mental health, and transportation. While Edgewood experiences pressure to stabilize the entire family in order to treat the consumer, the limited resources and referral options available often makes this challenging.

Additionally, staff identified the high rate of staff turnover in both the Turning Point and ISIS programs as difficult for the consumers and their families. (see *Program Funding*)

Consumer Progress/Outcomes Data

Important indicators of consumer progress cited by Edgewood staff and administrators include: reduced frequency of crisis episodes (e.g. hospitalizations, residential placements and justice involvements), increased consumer and family stability, increased consumer coping skills, increased parenting skills and strategies, and increased connections with community supports.

Though FSP administrators and staff engage in data collection efforts to meet funder and state (MHSA) requirements, they also indicated that these efforts and the tracking of consumer outcomes are not standardized. They felt that increased longitudinal tracking of consumer outcomes, along with a feedback mechanism of consumer progress data back to program operators, would be very helpful.

Stepping Down/Levels of Care

According to Edgewood administrators and staff, the current system for stepping-down consumer care is informal. Consumers requiring lower levels of care use services with decreasing quantity and/or frequency. However, one strength of the current system

alluded to by staff lies in its individualized nature, which can accommodate differing levels of care for consumers over time. Staff and administrators described the potential of formalizing and/or adding lower levels of care (e.g. aftercare services) to the step-down system in order to expand capacity and increase effectiveness.

Transitions

We received mixed feedback from staff and administrators regarding the ease and frequency of transitioning from the Child/Youth program to the TAY program.

The transition from the Child/Youth/TAY FSP system to the adult FSP system is also problematic and represents a service gap in the overall FSP system. Currently, there is a perception at Edgewood that the adult system is not willing to take on their consumers.

> *"The adult system doesn't recognize our adult population as their responsibility ... They are still seen as kids in the kid system." -- Edgewood administrator*

Provider Operations

Internal Communication

Edgewood administrators and staff talked about the importance of strong communication in their program. Staff emphasized the value of having diverse Wraparound teams that include all case managers, therapists and family partners - each bringing a different perspective to the treatment team.

External Communication

Edgewood staff described difficulties communicating with referring stakeholders, including Child Welfare social workers and Probation Officers. Issues described included difficulties with reaching stakeholders, scheduling meetings to include stakeholders, and reaching consensus due to philosophical differences regarding priorities for consumer progress.

Program Funding

Program funding issues were frequently cited and impacted a wide range of other factors, including staffing levels and program services. Both Edgewood administrators and FSP staff

mentioned that their contracted funding amount has never been adjusted for cost-of-living increases in San Mateo County.

Impact on Staff

According to staff members, high staff turnover has been a major problem within both the Turning Point and ISIS programs. They felt that staff were leaving because Edgewood has been unable to offer competitive pay rates and other organizations are offering similar positions with higher pay. Therefore, Edgewood's FSP programs are often understaffed with frequent staff transitions, which create an additional strain on existing staff members. The low staff pay scale also means that Edgewood has difficulty attracting and hiring competitive staff. Additionally, staff members also stated that training opportunities have decreased. Staff members who have training and experience in the Wraparound model now train new staff through internal meetings and groups.

Impact on Program Services

According to Edgewood administrators and FSP staff, limited funding has affected program services, including the loss of parent groups (according to administrators). One administrator also expressed concerns about meeting the language needs of new populations in the FSP program. Another administrator described Edgewood's FSP population as becoming increasingly challenging through the years, while the funding has remained stagnant.

Key Stakeholders

Child Welfare

As stated by Child Welfare administrators, the mission of the Child/Youth FSP program is to keep children safe and in their homes. Administrators described the ability to transition Child Welfare-involved kids out of group homes and back to their families through the Wraparound program. Strengths cited include: customized treatment plans based on individual child/youth and family needs, increased consumer/family life and communication skills, and successful achievement of outcomes.

"So far, I am pleased with the outcomes the Wraparound program has produced."
--Child Welfare administrator

One issue cited by Child Welfare administrators is the timing around implementation and termination of Wraparound services. They mentioned that there is often an improper overlap of Wraparound services with child/youth placement in group homes, and that cases often remained open for excessive periods of time while waiting for a closing conference to be scheduled. Challenges in managing FSP program payments due to reporting and communication difficulties regarding consumer status and outcomes were also discussed by Child Welfare administrators. Lastly, they described the potential increase in future demand for Wraparound services as a possible consequence of recent KDA legislation.

Juvenile Probation

Juvenile Probation administrators and staff described many of the issues they have faced in working with the Edgewood FSP programs. Most significant was the inconsistency of services received by their consumers. They stated that many of their cases are not assigned to a primary therapist on the team for an extended period of time and it was difficult getting assistance from additional support staff, including behavioral coaches. The high rates of staff turnover and understaffing at Edgewood were another area of concern since this may result in Juvenile Probation staff assuming a larger role, especially with case management. Juvenile Probation administrators and staff also described desiring more documentation and communication about the services their consumers were receiving through Edgewood, including progress and outcomes reports relevant to the quarterly reports required by the courts for probation cases.

The length of time for Edgewood Wraparound teams to make initial contact with families and initiate services, often exceeding the prescribed 30 days, was cited. Additionally, the funding mechanism for Juvenile Probation consumers, dictates that when consumers are removed from probation, they simultaneously lose access to Wraparound services, which can increase instability. Another major issue mentioned by Juvenile Probation administrators and staff was the lack of integrated substance abuse treatment services available through Edgewood. This is especially critical given the high incidence of substance use among Juvenile Probation-involved youth and the time demands of participating in the FSP program make it impractical for consumers to use outside substance abuse treatment resources.

Positives described by Juvenile Probation administrators and staff include the work of parent/family partners on the treatment team and the successes achieved by consumers when they are working with a consistent and fully-staffed Wraparound team. They also mentioned that they have seen more positive change happening through the ISIS program, possibly due to the smaller, pre-existing treatment team.

However, due to the extent of the issues they have faced with the Edgewood FSP program, Juvenile Probation Officers have also stated that they will likely stop referring consumers to the program and/or terminate existing cases to look for different treatment options for juvenile-justice involved youth and their families.

Adaptations to the Wraparound Model

Both of the Fred Finch administrators endorsed the use of the Wraparound model in their program, with one adding that this model was especially useful for the population being served. The informality of the model, its team-based approach, and the implementation of peer advocates were some of the salient positives particularly relevant to working with out-of-county foster youth. Another administrator held the perspective that "different WRAP programs serve different populations and look differently." Additionally, there's a culture of growth whereby "we're still learning as we go." According to staff, cultural competence was an ongoing learning process, with staff consulting one another as consumer needs are presented.

The Fred Finch FSP has been adapted for their target population (out-of-county foster youth) in two significant ways. Unlike the traditional wraparound model, Fred Finch's FSP also offers individual therapy to consumers in non-traditional settings, sometimes traveling long distances to consumer homes when qualified local providers are unavailable. The second major adaptation, according to an administrator, entails the elimination of a clearly defined length of treatment, though staff also mentioned that this posed a different challenge to staff when consumers did not have a clear length of treatment time.

Mission/Objectives/Goals

When asked about the mission of the FSP program, one staff member explained that it was to serve out-of-county foster youth at risk of unstable placement and reduce the likelihood of needing a higher level of care. Overall, staff members felt that they were able to successfully serve their target population. One administrator mentioned that a basis for the FSP program was also to provide Medi-Cal eligible services to out-of-county youth.

Both administrators and staff addressed placement stability as a primary goal for their FSP youth, with one administrator explaining that this goal was a bigger priority than returning children and youth to San Mateo County since a consumer's stability was highly dependent on the placement and stability of the caretaker and/or family member. As a result, one of Fred Finch's goals is to incorporate the whole family (including siblings) into the treatment process. Administrators and staff also cited improving family communication, parental understanding/quality of life, and providing acceptance and hope as primary FSP program objectives.

Perceived strengths

Communication within Fred Finch's FSP was viewed as frequent and unproblematic, with staff feeling that the program was responsive to staff feedback. One administrator cited the program's smaller size as potentially contributing to the program's efficacy. Staff members appreciated the program's flexibility, especially in serving a diverse population with varying levels of needs and residing in a vast geographic area, as well as the "one-stop shop" nature of the program whereby all treatment could be provided from within the team (as opposed to referring out consumers). Certain staff members also appreciated the autonomy to determine their caseloads and schedules, though the degree of independence could at times be overwhelming.

Perceived challenges (internal)

Staff turnover has been a major internal challenge, according to an administrator, with the loss of staff members taking a toll on the team unit. A staff member estimated that staff members stayed for under a year on average. In the staff focus group, staff seemed to agree that receiving additional feedback from supervisors might increase staff retention. Additional staffing challenges included a lack of male clinicians in the field and a desire to offer additional language capacities. Additionally, according to one administrator, unique challenges to working with Fred Finch's specific population could involve working with unstable or overly stressed foster parents. Staff members also felt frustrated with the amount of paperwork that resulted from trying to make a creative "outside of the box" approach to treatment Medi-Cal billable.

Wraparound services for TAY

According to staff, consumers over the age of 18 are generally not referred to the Fred Finch FSP, though they thought that might change with the new KDA legislation regarding mental health care for foster youth. Both of Fred Finch administrators addressed the shortage of available housing options for TAY as a result of limited funding options.

Funding

When asked about additional services they would like to provide, staff members mentioned family therapy sessions with consumers, which they're unable to do currently due to being "backed up." Both staff and administrators also saw a need to increase staffing for the program's peer (parent and youth) partners. One administrator further discussed the desire to offer some sort of certification program for peer partners since they are a valuable part of the team but often lacked the formal training of the clinicians. While the reduction in funding for trainings appeared to be a system-wide issue, out-of-county trainings were particularly difficult to access for Fred Finch's staff since they are based in the East Bay. Staff expressed interest in more opportunities to receive training or certification in different therapy modalities.

Referrals

When asked about referrals, staff explained that their roles were removed from determining who was admitted to the program. Administrators felt satisfied with BHRS' role in screening referrals and communicating with them about openings and admissions. Neither administrator felt that the program was experiencing any substantial capacity issues.

Interventions

One administrator was enthusiastic about the efficacy of peer partners in teaching practical skills, especially in modeling behaviors for adolescents. Peer partners could also help foster cultural competency, since "even when it's cross-cultural, I [the administrator] feel like they lived experience goes a long way." Additionally, Fred Finch seeks to be "complexity-capable," with an emphasis on providing treatments that were trauma-informed and integrating treatments for substance abuse and mental health issues. Techniques for providing structure were identified as a useful tool by staff and administrators, especially when working with younger children.

Outcomes/Tracking

Stabilization, graduation, and permanency for the program's foster youth were cited as primary outcomes indicative of success by administrators, especially when consumers themselves feel that the program was a good fit for them. Echoing a system-wide theme, the individualized nature of the FSP program was repeatedly discussed, including the opportunity for consumer-directed goals during treatment planning (reviewed every 6 months) and individually defined outcomes. Even the smallest of successes are rewarded, as one staff member talks about "paying attention to the small changes."

Both administrators and staff mentioned the different measures used to track outcomes on state, county, and agency levels. This was connected to concerns about excessive amounts of required paperwork. For example, according to one administrator, the agency was not entering the hard-copy MHSA data they had been collecting for the past three years because they didn't have a corresponding data system. Administrators also felt that there was a "gap" in terms of reviewing outcomes and expressed Fred Finch's intent to adopt the CANS assessment, a measure being considered for statewide use. Staff expressed a desire to receive more information about Fred Finch FSP outcomes back from BHRS.

Stepping Down/Levels of Care

Administrators and staff repeatedly discussed the difficulties associated with identifying qualified local providers to whom they could link consumers as part of the step-down process, which they also call a "soft handoff." One administrator voiced concern that consumers could become dependent on their FSP services due to a dearth of transition options, while others described a resulting incentive to keep cases open just to provide maintenance services. One staff member explained, "Maybe a consumer doesn't need such high-intensity services that we're supposed to be providing, but there's no one to refer them to."

An administrator was also worried about the "longer-term plan for youth who are out of the county and stable." When consumers transition out of Fred Finch's FSP, they may be aging out of care, moving back into San Mateo County (or outside of Fred Finch's service radius), entering a higher level of care (incarceration, group home, etc.) or have reached their goals and are maintaining stability. Youth returning to San Mateo County may need to change providers, sometimes against their choice, since they are stepping down to a lower level of care and Fred Finch does not provide services within San Mateo County. According to staff, transitions out of the Fred Finch FSP are determined in conjunction with the Child and Family Team (CFT) and BHRS at oversight meetings, though staff said that they rarely experienced an excessive amount of pressure from BHRS to close cases. Within the current, informal step-down system, linkages to previously accessed services or providers may be helpful, with BHRS facilitating some of the linkage resources. However, Fred Finch administrators were unfamiliar with how to transition consumers into San Mateo County's adult FSP system.

Communication

The communication between Fred Finch and BHRS was generally regarded in a positive light, with an administrator at the former describing the County as "cohesive and integrative" with "really responsive" staff. Another administrator attested to BHRS' responsiveness to provider feedback and knowledge about resources. However, a few staff members repeatedly expressed that they would benefit from receiving more direct feedback and clearer expectations from all FSP partners/stakeholders.

Collaboration, communication, and responsiveness from Child Welfare social workers were repeatedly echoed challenges voiced by Fred Finch administrators and staff. One administrator called it an "ongoing process" with San Mateo the County to improve communication between Fred Finch and Child Welfare. Additional staff concerns regarding the collaboration with Child Welfare included the perception that social workers appeared relieved to hand off cases, worries about miscommunication resulting in double work, and an overall sense of confusion between the roles and philosophies of Fred Finch and Child Welfare. One staff member explained that, despite the process to improve communication, "there's still a gap of what we do and what they do."

Key Stakeholders

BHRS

According to one BHRS administrator, Wraparound has been a helpful model for working with foster care youth due to its flexibility and convenience. The ability to bring the treatment team to the family is especially appropriate since many foster parents care for multiple children.

Child Welfare

In contrast to Fred Finch's feedback about the lack of clarity around roles and responsibilities, Child Welfare administrators felt that Fred Finch's program has evolved partially in response to Child Welfare's input and that BHRS "was really hearing what we were saying." Both Child Welfare administrators also attested to the difficulty of finding qualified local providers willing to accept Medi-Cal. One of the administrators wanted to ensure that all of Child Welfare's out-of-county cases (approximately 42%) could access

services, since not all of them were located within Fred Finch's service delivery radius. Administrators described having good internal communication about cases returning to in-county placement, but added that implementing the KDA process would necessitate improved communication with providers at the staff level.

Office of Consumer and Family Affairs

Administrators from the Office of Family and Consumer Affairs agreed about the challenges posed by Medi-Cal coverage restrictions and expressed concern about the process of how to "document a recovery-focused program and make it billable."

Juvenile Probation

Though Juvenile Probation rarely works with the Fred Finch FSP, one Probation Officer was impressed by the team's efficiency during the limited interaction with the program.

Wraparound Model

According to one administrator, peer-driven and recovery-oriented models were the best treatment models for us with consumers over the age of 16 years. Challenges specific to implementing the Wraparound model with TAY populations include family participation (not all TAY consumers maintain family contact or are willing to work with family) and a wide gradation in the developmental level of consumers. For example, some consumers experienced conflict between the needs presented by their mental health symptoms and the independence they sought from their caregivers as they matured.

Though Edgewood had considered implementing the ACT model for TAY at one point, the Turning Point program returned to a hybridized Wraparound model. Administrators felt that Wraparound services were still "the best model for this age range."

> *"In our program, all aspects of their lives are conversation. Partially because that's developmentally appropriate - they're trying to figure out who they are and what they think - and our staff are a team of people who are available who care about them 24/7."*
> *-- Edgewood Administrator*

Adaptations to the Wraparound Model

The **TAY Drop-in Center** was established in 2006 to serve transitional-aged youth between 16 and 24 years, as defined by MHSA. It has continued to be a source of tension between BHRS and Edgewood due to differing perspectives. When the Drop-in Center first opened, all TAY consumers from 16 years of age and up were universally eligible for services. However, between 2007 and 2008, TAY youth under 18 years of age were separated from the over 18+ TAY due to BHRS requirements and changes in legal mandates regarding serving minors and adults in the same group setting.

Following that transition, Edgewood staff members struggled to successfully engage with TAY in the Drop-in Center, particularly given new requirements on reporting minors' whereabouts to parents/caregivers. Edgewood staff and administrators expressed frustration with the changes to the Drop-in Center and detailed the challenges they have had in providing effective programming to TAY within the framework laid out by BHRS. Specific challenges included

youth losing the mentor figures they previously had in the combined groups with older TAY and maintaining trust with TAY while meeting reporting requirements to parents and caregivers. Multiple provider administrators have also disagreed with the mandate to separate the TAY populations, emphasizing that a broader age range was part of the official MHSA definition for TAY and that they hadn't experienced any significant problems when both populations were combined. Staff and administrators emphasized the importance of using the Drop-in Center for outreach and treatment services, with many feeling that a negotiated solution was essential to the program's success.

Additionally, the Edgewood administrators discussed how their TAY consumers benefitted from adding harm reduction and youth development interventions. DBT (Dialectical Behavioral Therapy) was noted as having been a particularly helpful addition for use with TAY populations, with the program adding additional staff to support life skills development.

Individuals with psychotic disorders or symptoms of psychosis were a specific TAY subpopulation identified by administrators as being especially challenging to serve. These consumers tend to be more difficult to engage, meaning that specific adaptations to the Wraparound model's timeline may be required, in addition to psychiatric stabilization, prior to initiating family conferencing.

Funding issues

One Edgewood administrator summarized the lack of resources for TAY consumers with "their needs aren't being met in a way that matches their true need." Another reported that very few services or resources were available to the 18-to-25 year old age group and noted that Turning Point was deeply in need of more resources to serve consumers with co-occurring or substance abuse disorders since staff lacked formal partnerships and consistent access to San Mateo County resources for this kind of treatment.

A scarcity of affordable housing was another main concern for TAY youth in the program - a concern that was echoed by other providers and partners. Administrators also felt a need to build more partnerships to identify TAY-specific housing and create a spectrum of appropriate housing options. Lastly, from an administrative perspective, the TAY FSP program was in need of expansion so that slots for Wraparound and a moderate level of step-down care could both be offered.

Service Gaps

One administrator felt that the mission of the TAY program was to connect un-served consumers to treatment:

> *"There's an expectation that the TAY program is serving not just those who are connected to County providers but … [that] the TAY program is there to step in when there's someone who isn't connected, who has a high level of need—those who have fallen through the cracks." -- Edgewood Administrator*

However, Turning Point's ability to meet the complex needs of referred individuals with Autism Spectrum Disorder and/or developmental delays was alluded to by administrators. One concern is that "Expectations are that somehow we will magically... heal these youth" even though clinics feel unprepared to serve these individuals.

Stepping Down/Levels of Care

TAY FSP consumers in need of linkage with adult mental health services mostly transition into San Mateo County's clinic model according to Edgewood administrators. Barriers to linking consumers with the adult system frequently were mentioned in our discussions. One interviewee stated that clinics would not accept referred adult consumers if they were not currently on medication or diagnosed with an adult serious mental illness (SMI). According to another, part of the difficulty of transitioning consumers into the adult system was due to a systemic disagreement over responsibility for TAY consumers.

While it was rare for TAY consumers to enter the adult FSP system because of its stricter eligibility criteria, approximately 1 to 3 TAY consumers annually require adult FSP services. For TAY with higher levels of impairment, the referral process could take six months to a year due to adult system capacity issues, leaving them to remain in Turning Point until 24 or 25 years of age before being getting accepted into an adult FSP. Otherwise, according to one administrator, "TAY youth who are stepping from the highest level or acuity into the adult-typical system have a huge gap."

Another TAY program administrator talked about the inconsistencies in San Mateo County resources for consumers who are 25-26 years of age but still required supportive services. These consumers are often referred to a County transitions team but stakeholders and partners

seem to have different age ranges and cutoffs for TAY, resulting in no consistent continuum of care for them.

Key Stakeholders

BHRS

From the perspective of BHRS administration, development of a maintenance level for stepping down TAY FSP consumers was important due to capacity issues, a waitlist, and the need for more slots. Additional challenges included identifying housing options for about half of the TAY consumers and the lack of funding available for additional drop-in centers. Overall, BHRS recognized that TAY consumers were particularly complex to serve and treatment needs to be tailored to their developmental level. Substance abuse was also a critical issue, especially because sometimes “TAY don't think they're recovering from anything” though a treatment philosophy of “resilience” may be more applicable.

Legal issues leading to the separation of minors and adults in the TAY drop-in centers were also addressed. This separation occurred in part due to concerns over age differences in relationships. Additionally, while BHRS could manage the transition of TAY consumers into the adult FSPs, it was important to note that though the criteria for adult FSP programs were less inclusive, "the equal program [to Edgewood’s Turning Point] doesn't always exist in the adult world."

BHRS also provided Edgewood with feedback that the Family Conferencing Model may not be a good fit for use with consumers from different cultural backgrounds and/or the TAY population.

Juvenile Probation

One of the foremost concerns of Juvenile Probation administrators was the lack of program-integrated substance abuse counseling and treatment for which the TAY population has a "heavy need." When asked about substance abuse services, one consumer stated, “They provide it, they want you to do it to help you out, but they won’t force you.” Additionally, Probation Officers have had TAY consumers in need of adult FSP services but who are denied access due to the stricter criteria of the adult system. Therefore, in order to continue services, a case would have to be opened with

BHRS/mental health. Both Probation Administrators expressed concerned about having to step in to ensure that TAY step-downs also involve a continuation of services, with one remarking that ensuring a smooth handoff should “be the role of the primary WRAP case manager.”

Office of Consumer and Family Affairs (OCFA)

Overall, the OCFA administrators were supportive of the “Supporting Emerging Adults” program and the positive impact of the drop-in centers on TAY participants. However, OCFA did receive at least one grievance from a TAY FSP consumer who was aging out of the program and reluctant to enter the adult FSP system.

Child Welfare

Child Welfare administrators were firmly in agreement about the need for increased housing for the TAY population. One administrator reported that the older youth really liked the drop-in center and expressed a desire for additional locations within San Mateo County. Child Welfare administrators also valued the therapeutic consistency that the Wraparound model offered the TAY population and agreed with the challenges of meeting TAY at their specific developmental level, stating "We don't give up on our older children, but then the challenge is how to engage those youth."

Child, Youth, and TAY Consumers and Caregivers

Overall, consumers and caregivers participating in the focus groups genuinely reported a positive impression of Edgewood, the FSP program, services received, and the resources made available to them. Even when bringing up significant issues, they simultaneously acknowledged that Edgewood is well-intentioned and successful in many aspects. A common theme seemed to be logistical difficulties and a lack of communication/ transparency from the beginning of the FSP referral process through discharge or graduation. The following themes were identified as being particularly salient to the experiences of the consumers and caregivers interviewed.

Referrals

Many of the caregivers described a wish for a basic orientation to Edgewood and the FSP program after admission. Participants described not receiving any information about Edgewood's FSP program at time of admission and having to wade through a lot of initial meetings and logistics as they tried to navigate the program and system on their own. Many caregivers also discussed not having a clear understanding of the program's treatment philosophy and what the FSP program entailed. One participant felt that this lack of transparency and communication prevented them from being able to take advantage of services when they were needed the most. Most participants described their entry into the FSP program as being a time of severe crisis, with circumstances further exacerbated by confusion around the purpose or scope of FSP services. Caregivers also emphasized that they thought it would be most effective to receive a heavy and immediate degree of interventions at program entry, and then have services subsequently tapered back as needed. The caregivers did agree, however, that the FSP philosophy was very useful despite taking time to "click."

> *"We could have hit the ground running a lot better if we had known more about the moving parts." –Edgewood Caregiver*

Key Services

Several TAY consumers found individual DBT to be the most helpful service provided by the FSP program, although one consumer stated that earlier iterations of the DBT groups were difficult, restrictive, and "a lot of people are not fully invested in that kind of group."

Caregivers were also asked to identify the key services of the Edgewood FSP program that they viewed as essential to the care of their child and their family. Some of the most appreciated interventions included the 24-hour crisis line (with responder access to consumer/family files), family partners, DBT workshops, and social outings for consumers and families to connect with one another. Caregivers highly valued the program's skills training on effective parenting techniques and how to support their loved ones (especially when consumers may not yet have been ready to learn skills on their own). Other key services included goal planning and support for consumers in school.

Life Skills

Multiple participants emphasized the program and staff's helpfulness in teaching fundamental life skills (i.e., riding a bus, managing a schedule). One program graduate described the personal transformation experienced during their tenure at Edgewood and the process of tackling mental health symptoms while making improvements in other areas of life. The consumers also appreciated the vocational support that Edgewood provided and attributed much of their success in finding and maintaining jobs to that program component.

"It's really the simple things that are the hardest … Edgewood really helped me through those goals." – TAY consumer

Interpersonal Skills

Many TAY described having incredibly limited interpersonal skills when they entered the program. Through participation at Edgewood, their peer relationships have now become significant and rewarding. They enjoyed having the opportunity to experience "normal" social experiences with fellow consumers (especially on group outings and activities) and described mentor-like relationships among peers, whereby consumers with a longer program stay oriented and supported newer ones.

Family Support

In addition to services received through the Edgewood FSP, TAY consumers also discussed the auxiliary support provided to families by Edgewood, including food, transportation, and family outings. Caregivers described these additional supports as crucial to the program's successes. Edgewood's focus on treating the family as a whole

unit was an emergent theme throughout all of the services mentioned by caregivers. One caregiver reported that Edgewood's family support services assisted them with employment, housing, and developing a student plan so that the caregiver could attend college, learn English, and improve future job options. According to the caregiver, the program also helped integrate the family and improve their overall quality of life.

Housing

Housing is a critical part of the TAY program, as reported by TAY consumers and staff members, and fundamental to supporting progress in other key aspects of the program:

"How can you expect someone to make any progress towards their mental health when they're homeless?" – Edgewood TAY staff member

At least one consumer described the instability of housing received through Edgewood and the placement being an inappropriate fit, saying: "I've moved all over the place … [it] was not a safe area for me."

Across the board, consumers and staff agreed that housing options, resources, and supported services are a crucial component to program success and vulnerable to insufficient funding.

"We work with this population where we still have a lot of opportunity to make things better ... we still have all this time to teach them the skills so that they can be more independent and they can learn to manage their symptoms and hopefully make a future that is worth living for them, but if we don't have the appropriate resources, how can we make this happen?" -- Edgewood TAY staff member

Additional Resources

When asked which services/resources they enjoyed and would like to see more of at Edgewood, multiple TAY stated that they really liked the outings and social group activities. A few also talked indirectly about how hard it was to get around the county without a bus or train pass, something that Edgewood might be able to provide if allocated more resources. Several mentioned expansions that could be made to the

program to increase the amount and variety of services provided through the Drop-in Center.

"Hopefully they get better funding and more people to help." –TAY Consumer

Challenges

TAY consumers discussed challenges associated with organizing families to participate in treatment, including caregiver difficulties with getting time off from work and having transportation funds available to attend events at Edgewood. Consumers also alluded to previous issues arising from the Drop-In Center's distance from Edgewood's headquarters, which could lead to communication challenges or impede relationship building with less-available staff: "It was really hard, especially when you have a better connection with the peer partners than you have with the team." This issue has improved in recent years as the treatment teams have become more integrated and started to offer more in-person services.

"They've really improved all around." – TAY consumer

Other issues brought up by caregivers include the complicated legality associated with their child's transition to adulthood, including the supports needed to provide treatment/support to emerging adults and serve TAY youth with significant discrepancies between their emotional and chronological ages. One caregiver mentioned difficulties with having consumers admitted to the TAY/adult FSP programs despite demonstrated need, which could indicate a service gap between providers and the two FSP systems.

Staffing

Consumers described the impact that Edgewood staff members have had on their treatment experiences. Caregivers were extremely appreciative of Edgewood staff for their dedication, availability, and calmness under pressure. They especially valued how the program involved and gave agency to the entire family, with some describing the program as "life-saving." The bonds with key staff members were also highly appreciated, along with the wealth of information received through those relationships. Some caregivers mentioned that certain staff went "above and beyond" in the level of attention and services they provided to consumers.

Peer and Family Partners

Both consumers and caregivers viewed the family partners as being a substantial part of their experiences with Edgewood, indicating that they would like to see additional peer and family partners added to staff.

"You feel like you're not the only one having troubles at home, or you're not the only one really struggling, and you know, it really helps. I wish they could do it more often."
--TAY consumer

On the whole, consumers were extremely appreciative of the peer partners and described how much the program had transformed their fundamental abilities to communicate, connect, and relate to one another. Additionally, the peer partners encouraged consumers to be more social and promoted participation in social events and activities.

"The peer partners here really do a good job communicating with everyone, and trying to get everyone active and to participate and socialize." –TAY consumer

Challenges

The high level of staff turnover at Edgewood and loss of significant therapeutic relationships were perceived by TAY to be a frequent obstacle in the treatment process. A few individuals expressed feeling hurt and discouraged by the departure of an Edgewood staff member, with one TAY stating that Edgewood was prone to losing male clinicians. Many agreed that having a same-gender therapist/case manager was crucial to them. On the whole, consumers strongly felt that frequent staff turnover can hinder a consumer's progress and wellbeing.

"They wouldn't tell me why he left … He was the best, he was always there for me, he always knew what to say, he could relate to what I'd been through … To this day, I miss him." --TAY consumer

Caregivers emphasized how damaging the loss of significant staff members could be to both consumers and caregivers. Some described how their loved ones had formed

bonds with certain staff members, only to see them abruptly leave the program. Such departures could contribute to consumers "shutting down," decompensating, and becoming more reluctant to engage with future clinicians. This issue seemed to especially pertain to children and youth with pre-existing challenges in engaging and connecting with others.

Stepping-Up/Stepping-Down Services

Caregivers discussed a potential resistance by Edgewood staff or administrators to consider stepping up care when needed. Apparently, several participants felt that their loved ones could have benefitted from residential treatment, but did not get the sense from Edgewood that it would be an option. One caregiver whose child transitioned from the Child/Youth FSP program into residential care stated that while the process was difficult, the higher level of care was necessary and beneficial given the severity of the child's needs. The caregiver appreciated the argument against residential care but explained that Edgewood seemed to have a bias against it to the point of not informing caregivers about it. Another participant also mentioned that the school system was very reluctant to refer to outside services, especially similar ones deemed as expensive as residential treatment.

Discharge/graduation

Consumers described the goal-setting process that happens as a part of Edgewood's treatment program. Goals cited by consumers included greater independence, educational attainment, and employment. One consumer talked about Edgewood's flexibility with deciding when to graduate a consumer, saying: "I should have left last year but I wasn't ready… If you're not ready, you can stay."

Challenges

Multiple caregivers with a family member no longer enrolled in the TAY FSP expressed feeling that their family member was prematurely discharged with a lack of clarity and communication regarding the termination reason. Many didn't understand why their child had been discharged or what their options were moving forward. Some felt that Edgewood refused to address these questions and concerns beyond explaining that the consumer had been in the program for too long or no longer needed FSP services.

Caregivers with discharged family members also tended to feel that other services in the community did not adequately address their child's needs. The lack of a substantive

step-down option (or services comparable to the FSP) appears to be a critical issue, with many family members feeling somewhat abandoned or worried about how to care for their family members in the vacuum following termination of services. Additionally, there seemed to be differences in the treatment and service linkages available depending on the referral source. The lack of quality housing for graduated TAY was also a central concern highlighted by caregivers, with some youth returning to toxic home environments if there were no other housing options available.

Adult FSP System

This section addresses themes from interviews and focus groups with Telecare and Caminar administrators, providers (staff/community support workers), adult FSP consumers and caregivers. Input from key stakeholders, BHRS administrators, and DYJA site visits are also included in this section, which presents broad systemic themes first, followed by site-specific findings.

There are four main sections below: Overall adult FSP services, Caminar FSP, Telecare FSP, Consumer/Caregiver. Provider administrator/staff and BHRS key stakeholder input are summarized by site, followed by an overall synthesis of Consumer and Caregiver input.

Perspectives about Adult FSP Services: Strengths and Challenges

Telecare and Caminar administrators and staff both positively perceived the adult FSP model (based on an ACT framework) as fostering teamwork, creativity, and unity while offering consumers flexibility and reducing staff burnout. Instead of consumers "having a single lifeline, they now have a net" and FSP staff are able to respond to consumer crises with a team approach reflecting a multi-disciplinary perspective and skill-set.

> "It is absolutely imperative in my opinion to use the Assertive Community Treatment model because many of the individuals that get referred to [Caminar] are in need of that level of outreach and support." – *Caminar Administrator*

However, there are also challenges to the current adult FSP model, including consumer difficulty with adjusting to an intensive team-oriented approach and, particularly for older adults, confusion in meeting with an array of different staff on a daily basis. Lastly, many staff members have not received formal training on the FSP/ACT model due to a lack of available funding (on the State level and within their own agencies) and time constraints. However, overall, both adult FSP providers agree that the strengths of the model greatly outweigh the challenges.

Fiscal Issues

Fiscal issues consistently appear throughout the majority of themes emerging from both the interviews and focus groups regarding adult FSP services, including: housing, staff turnover,

and communication within the FSP agencies and between key stakeholders. Administrators and staff believe staff turnover could be reduced if competitive salaries were offered and BHRS provider contracts reflected cost-of-living increases. Though staff value their work with the adult FSPs, some have been forced to relocate out of San Mateo County due to a lack of affordable housing, resulting in commutes of over 2+ hours. The lack of funding has also directly influenced the availability of staff trainings and increased workloads for existing staff (due to new staff transitions).

> *"Reflected in the budget needs to be a more livable wage to operate this program that is highly needed and valued in this community." – Telecare Staff Member*
>
> *"We've been going through a transition, maybe the last 7-8 months. We've been having new employers, new people coming in, people going out, so it's been difficult for both Caminar, all the programs and then for the clientele because they have one case manager, that case manager leaves, they get another one, it's been so much, just so much transition." –Caminar Staff Member*

At Caminar, staff turnover has also greatly affected the workload balance of remaining FSP staff, especially among Community Case Workers, including staff assuming more responsibilities and hours than required. Sometimes this occurs at the expense of educational pursuits, though immediate management and fellow staff have remained encouraging and supportive of those pursuing education goals.

> *"My supervisor was like, "You need to go back to school." I was like, "How am I able to go back to school if we're short-staffed? If I go back to school, I might not be able to work some nights." [My supervisor still said]: "Oh well, I'd rather you go back to school." – Caminar Staff Member*

Consumer Outcomes/Progress

Both adult FSP providers consider themselves increasingly outcome driven, with one provider stating: "We have reduced homelessness by 99%." Outcome tracking and provider evaluation will be more thoroughly discussed in subsequent sections.

Step-Down/Lower Levels of Care

Historically, the idea of consumers graduating from an Adult FSP was nonexistent. While some staff still operate with the assumption that the FSP "never really lets go of anyone," providers are increasingly embracing a recovery-oriented belief and practice by graduating stable consumers to a lower level of care. Both adult FSP providers have initiated a step-up/step-down process whereby a consumer's progress is assessed and those eligible for a lower level of care are identified. At least one provider shared: "Last year was 10% step-down but previous years, it was almost none. So that was a big change."

Referral meetings with BHRS occur at least biweekly and have been regarded as positive and useful from both providers' perspective. In collaboration with San Mateo County, providers are able to utilize a step-down system and move consumers to a lower level of care when deemed appropriate by all parties. Providers have found this process beneficial both for consumers who are not fully utilizing all FSP services consistently while simultaneously increasing internal capacity to serve additional consumers. Providers have also begun training case managers to engage consumers in discussions regarding transitioning and/or graduating to lower levels of care when appropriate.

Several challenges have appeared regarding the step-down process though. One relates to developing and instituting a formal set of graduation criteria when treatment plans are highly individualized. Additionally, according to one Telecare administrator, consumers are often stabilized through a complex network of supports provided through their intensive team. As team members become better acquainted with a consumer during the stabilization process, indicators of potential decompensation are also identified and monitored. When a consumer is stepped-down, she/he also loses the "safety net" offered by an intensive team. Therefore, according to this administrator, a better understanding of predictors of stabilization and/or decompensation would improve outcomes for consumers transitioning to a lower level of care.

Family Involvement

While the adult FSPs attempt to engage families and caregivers throughout a consumer's treatment, such as through monthly family/friends support groups, this remains a difficult area to address. By the time adult consumers arrive at a FSP, most are already "divorced from their families." The balance between helping consumers become independent agents while engaging friends, family, and caregivers in their recovery process can be a challenging one.

Of the families involved with the Adult FSPs, providers emphasized the importance for caregivers to gain an understanding of their family member's mental illness. From staff's perspective, as this occurs, some family members have actually become comfortable directly reaching out to individual case managers and becoming active participants in the treatment planning process (with consumer authorization).

Caminar

Mission, Goals, and Objectives

Caminar described the adult FSP program's mission as being focused on improving consumers' quality of life through the use of consumer-centered treatment modalities, including providing ACT services to consumers in their communities.

> *"[Generally the mission] is really about trying to support consumers in the most appropriate consumer-centered manner, to have them live in the least restrictive environment possible here in San Mateo County…"It takes a village to help these consumers and really support them." – Caminar Administrator*

Caminar staff identified reducing the rates of psychiatric hospitalizations and unnecessary medical emergency room visits caused by minor medical issues or drug-seeking behaviors as the primary FSP program goal/objective. While actively working to reduce the negative consequences associated with mental illness, Caminar staff also engages consumers to achieve progress in positive areas of life, including gainful employment, volunteer work, and returning to school.

> *"Another goal/objective is working cooperatively in a harmonious manner with individuals, professionals in the system of care, with consumers with family or whoever else may be in their support system and getting them to progressively be more independent." – Caminar Administrator*

According to the Community Case Workers, increased independence is a vital objective for FSP consumers. One staff member states, "One of the goals, I think, is to have them live by themselves, completely." Many consumers reside in board and care facilities and share a living

space with roommates. Caminar's intention is to have consumers eventually live by themselves, reduce reliance on other people, and assume more personal responsibility, whether it be taking medication regularly or independently using public transportation. However, another staff member recognizes that not all FSP consumers may be able to function in independent living environments and will continue to benefit more from a structured environment.

Another goal of the FSP program is preventing out-of-county placement. One exception is when a consumer needs substance abuse treatment from an out-of-county facility. According to a Caminar administrator, an underlying rationale for the above goals and objectives is to reduce additional costs incurred by the most severely mentally ill consumers since the FSP program is relatively expensive to implement.

Target Population, Population Served, and Complex Consumers

According to a Caminar administrator, Caminar's FSP consumers are those in most need of intensive services. The program serves a diverse, severely mentally ill target population typically viewed to be un-served and/or underserved in San Mateo County's mental health system. Over the years, Caminar consumers have reflected an increasing level of acuity, with the most complex consumers often falling into two categories: 1) medically fragile and 2) those with severe substance abuse and co-occurring disorders.

One administrator estimated that slightly more than half of the consumers served have one or more chronic medical issues. The medically complex consumers pose an additional challenge in that much staff time and effort revolves around coordinating their medical care, including scheduling medical treatment appointments that consumers often don't attend. One administrator expressed a need for increased integrated medical care capacity at Caminar, such as a nurse or nurse practitioner on staff to provide applied medical care to consumers. Consumers with co-occurring disorders also present unique service delivery challenges, including the lack of inpatient and outpatient treatment options for consumers with dependency issues.

> *"You have to be really careful, you can't overlook anything. This particular client is diabetic; we have to monitor him doing his blood every day and watch it really closely. I'm on that phone if it's over three hundred. I mean, no if and or buts. We have to watch everything he does, as far as his medication."- Caminar Staff Member*

Over time, Caminar has continued to make adaptations to services in order to address the specific needs of complex consumer populations, including culturally-diverse, justice-involved, and/or developmentally-delayed consumers. Since many of Caminar's consumers are becoming fragile elderly adults, the lack of fiscal resources to appropriately serve them remains a key staff concern. Staff also mentioned that the LGBT community is not largely represented within the adult FSP program.

> *"A lot of it really is developing a really good relationship with the consumer where they feel supported and they feel we trust them and that we are there consistently treating them with fairness and consistency." – Caminar Administrator*

Lastly, medication compliance by FSP consumers remains a challenging area to address. The Community Support Workers' main role is not only to monitor medication use but also includes persuading unwilling consumers to comply with their medication treatment plan. For example, some consumers will mimic swallowing their medication and then dispose of it when the Community Support Workers are not looking.

> *"It is definitely challenging when they don't want to take their meds, because then it's on you because we're going around, making sure they're taking them…so it's like it could be on us, and it could jeopardize our job." – Caminar Community Support Worker*

Services

Caminar described a multitude of services provided through the FSP program. Services highlighted by staff and administrators as important for clients included intensive case management services, service coordination, transportation and linkages and housing support (see *Housing*). Caminar also discussed the Warm Line, which is available 24/7 to clients for issues ranging from emotional support to medication management. Other services mentioned included vocational services and supported educational services. One administrator summarized the services provided by Caminar as holistic advocacy for clients, saying:

> *"Advocating for consumers is an art and science in and of itself that we are always working on." -Caminar Administrator*

Housing

Based on input from Caminar staff and administrators, housing has emerged as a major component of FSP services. Through the FSP program, Caminar has developed independent and supported living environments as an alternative to licensed board and care facilities.

> *"There is a direct correlation, there is no doubt in my mind, that when you get people that have been living on the street, and/or they're frequently homeless or have various environmental stressors, [in housing], their quality of life improves, their stability improves, their self worth and self-image improve." – Caminar Administrator*

Caminar consumers have been housed with family members, in licensed board and care facilities, skilled nursing facilities, or in their own apartments. While housing options exist for consumers (depending on their particular needs), finding appropriate and affordable housing remains a crucial component and challenge for Caminar. From the perspective of Caminar staff, not all consumers and even staff members are completely satisfied with their housing situation, particularly in terms of feeling safe. A community support worker states, "We had someone that got hired and then quit because she didn't feel safe [delivering medications]." Many of the most vulnerable consumers struggling with poverty, disabilities, and/or co-occurring disorders often require the most assistance with housing.

> *"Some of the houses I go to, I'm like, "What, you live here?"…some of the houses are cold, I'm like, "Why is it so cold in here?"…some of the clients, they'll be like, "I don't want to live here", some of them don't feel safe." –Caminar Community Support Worker*

In addition, Caminar staff members also expressed concern about the limited food options accessible to consumers close to their housing. Even the Community Support Workers were unclear about how many and which food outlets were located within a reasonable vicinity of the housing sites. Some consumers are given a monetary allowance but sometimes that still isn't enough to ensure that they have adequate food access since "some clients, they're anti-social, so they don't even want to get out of the house" (according to a staff member).

As one Caminar administrator states, "Housing is at a crisis point" and it remains a high priority and staff are frequently trouble-shooting solutions and options. Housing resources have proven

to be more difficult to find since the recession. Another housing challenge rests with the difficulty of finding housing managers who are willing to take consumers with vouchers.

Successes

Caminar identified many successes with their FSP program, which is grounded in their philosophy that recovery can mean different things to different people. One administrator described how every imaginable aspect of a consumer's life can improve through the FSP program. For example, over the past year, more consumers have graduated than in prior years due to staff engagement of an increasingly proactive and mindful approach along with earlier conversations with consumers around discharge planning. Despite an increase in successful discharges, an administrator also acknowledged that some consumers will need to be in the FSP program for life. Key areas where Caminar perceives consumer success include:

- Increasing access to more natural supports
- Increasing consumer independence (i.e., taking public transit)
- Increasing employment/education skills
- Identifying consumer goals
- Identifying consumer-centered tasks (i.e. areas consumers can help themselves)
- Teaching consumers to avoid the stigma of mental illness
- Partnerships with local resources to access more stable housing
- Successfully graduating consumers
- Increasing rates of consumers entering less intensive case management services and
- Providing consumers with the skills to maintain sobriety
- Increased consumer participation in groups
- Increased medication compliance of consumers

> *"We have had so many successes, not just in graduation rates or finite outcomes … it's the joy and gratefulness that almost all of our consumers seem to have."*
> *– Caminar Administrator*
>
> *"When I first started, there were some clients that didn't really like coming to group to where now…I think there's more FSP clients that are willing to come to groups, which I think is a success because some of them, they're anti-social, they don't like people, they just want to deal with their case managers." - Caminar Staff Member*

Challenges

Challenges identified by Caminar administrators and staff, especially for the next round of FSP funding, include:

- Increasing access to housing, including flexible housing options for consumers with substance abuse issues
- Increased access to food options near consumer's housing
- Increasing access to substance abuse treatment resources
- Improving access to applied medical care/resources for integrated medical care and
- Increased field outreach/support for consumers
- Increased funding to support social activities.

An ideal addition to the Caminar FSP program would be either a SMC or Caminar-owned building providing consumers their own room, with a Caminar employee residing on-site full-time. Other identified needs include more outreach and support for consumers (especially regarding treatment engagement), check-ins (particularly during the winter months), and outreach to individuals who have not yet been referred to Caminar or engaged by BHRS in any capacity. One staff member advocated for a funding increase going towards consumers' social activities, stating:

> *"For the clients, if there would be able to be more outings for them, so they can get out and have fun. Some of them, they're just home, that's why they sleep and are depressed cause they don't have nothing else to do. If they're not in a group, they're at home. Groups are like an hour, so pick them up, go to group, take them home, and they just do the same thing." –Caminar Staff Member*

Communication

On the whole, the communication between Caminar and BHRS has vastly improved since the inception of the Adult FSP program. The bimonthly meetings have proved to be extremely helpful for identifying consumers ready to step up/down in their level of care. However, there have also been coordination challenges between Caminar and San Mateo County case managers concerning consumer discharge and medication management. Some of these

coordination challenges have subsequently delayed timely access to services for some FSP consumers.

Caminar administrators and staff have made it a priority to attend all meetings and trainings required and suggested by San Mateo County. Yet, sometimes they feel that their time could be used more productively used working with consumers. Also, when external agencies do not share the same level of understanding regarding the ACT/FSP Model and staffing structure, communication challenges have occurred, such as tracking consumers' medication changes following hospital discharges.

Pay-for-Performance

Caminar consistently tracks consumers stepping down into less intensive case management services as well as outcomes related to hospitalizations, recidivism, and changes in housing situations. Though Caminar administrators and staff appear to be open to implementing a Pay-for-Performance model, their main concern is how their staffing structure would be maintained within such a model, especially since ACT dictates a specific staff-to-consumer ratio.

Another expressed concern relates to consumers having marginalized prognoses when they are referred into the FSP, making it difficult to demonstrate positive changes through currently tracked outcomes markers. It may be difficult to come up with a standardized formula for incentives since treatment planning and outcomes are so individualized for each consumer.

Another issue presented was that consumers in the FSP programs are aging and becoming increasingly medically complex, thus requiring more hospitalizations and/or higher levels of care.

> "Penalizing a program on things that are beyond our control is not an easy thing. It's not good for morale." – *Caminar Administrator*

Possible outcomes that could be used to develop an incentive-based contract model, as suggested by a Caminar administrator, include: housing, treatment engagement of consumers, and graduating consumers to a lower level of care.

Mission, Goals, and Objectives

The perceived mission of Telecare's Adult FSP is to promote health and wellness while connecting consumers with the necessary services that support stabilization and assisting them with their path toward recovery. Built into Telecare's mission statement is the belief that all consumers have the potential to recover and live as independently as possible.

> *"To take the most challenging consumers who have not been successful anywhere and do literally anything and everything we can possibly think of to turn their trajectory into one of health and wellness." –Telecare Administrator*

One Telecare Administrator states that an overall challenge of the Adult FSP is walking the line between helping consumers become independent versus providing services to meet their needs.

Telecare recognizes that the goals and objectives of the FSP may appear different, depending on the respondent. The goals and objectives for Telecare's consumers are collaboratively created between consumers and their treatment teams. While some consumers share similar long-term goals held by BHRS, such as increasing employment and access to education, staff also assist consumers with progress towards more immediate short-term goals, including maintaining proper hygiene, reducing drug intake, and participating in support groups.

> *"Consumers can be narrowly focused in what they think is success and a part of our job is to help them expand that and acknowledge it when it is happening because they can be very critical of themselves."* - Telecare Staff member

In summary, Telecare's staff/administrators and consumers share the following goals and objectives with BHRS:

- Reducing rates of hospitalization, incarceration, and homelessness
- Increasing consumers' quality of life, including concerns of older populations

- Increasing employment and access to education opportunities
- Reunifying families
- Building bridges with community resources (i.e., family, church, 12-step programs) and
- Promoting recovery-oriented philosophy.

Target Population, Population Served, and Complex Consumers

The intended target population for Telecare's Adult FSP is low-functioning individuals with severe mental illness who are unable to manage in the community without additional supports. In recent years, Telecare has observed a growing number of fragile elders as well as consumers with a higher level of acuity among their clientele. Telecare staff members and administrators do not feel the intended population accurately represents whom they actually serve. For example, Telecare has experienced an increase in the number of FSP consumers with diabetes and requiring dialysis as well as developmentally-disabled consumers. Both of these groups were not part of the original target population.

All Telecare consumers are considered to be complex and, according to one administrator, consumers tend to be referred to Telecare after exhausting all other options. Most (if not all) are seriously mentally ill individuals with prior exposure to the mental health and legal system.

> *"We don't turn people away, we don't say no…the extra mile is only the beginning."* – *Telecare Administrator*
>
> *"We don't know a consumer and a consumer does not know us until we've actually gone through their first crisis with them."* – *Telecare Administrator*

Telecare staff considers consumers with severe drug and alcohol problems to be particularly challenging, especially when their family members have strong religious backgrounds intolerant of any drug use. As an agency, Telecare's philosophy embraces the right of all consumers to make their own decisions. While this policy of allowing consumers to make seemingly unhealthy decisions may have negative consequences on the perception of consumers or the program, it still remains consistent with Telecare's central philosophy. One Telecare

administrator reported that when staff are faced with consumers making unhealthy choices, they continue to support the consumer and work with them on addressing needs and goals.

Telecare staff and administrators described the population served as having a high level of need for medical care. A Telecare administrator reported on the steps the agency has taken to meet the needs of these complex consumers, including staffing a nurse practitioner and working flexibly with BHRS. However, health care and integrated healthcare were also highlighted as a direction of future growth for Telecare and the FSP program in San Mateo County.

Services

Since 2006, Telecare's Adult FSP program has expanded by 30%. Additionally, in 2008, BHRS transferred responsibility for housing adult FSP consumers from an external agency to Telecare and augmented their contract to fund this additional component. Currently, Telecare offers a plethora of what they perceive to be excellent services that actively promote health and wellness, including psychiatry, housing, employment and educational services, medical care, bilingual speaking staff members and a 24/7 crisis line.

Housing

Telecare staff and administrators consider housing to be "paramount" and the single most important service provided to consumers. However, they also report that the biggest challenge lies in finding behaviorally supportive and appropriate housing for consumers.

> *"You know, typically, they need to be in a place that will tolerate the fact that they're up in the middle of the night, pacing … someway to support them in making healthier decisions day in and day out." – Telecare Administrator*

Oftentimes, according to one Telecare administrator, housing options available to consumers are located in less desirable neighborhoods due to escalating housing costs. Another housing challenge Telecare faces is dealing with the stigma associated with mental illness within communities. As stated by Telecare administrators, "San Mateo is a very conservative community" and mental illness is not always well tolerated.

Recovery

Recovery is a significant theme that has emerged from the interviews and focus groups with Telecare administrators and staff members. As one Telecare administrator stated: "Fixing is

instant; healing is gradual. Healing is a long-term process. Healing is where recovery really is." Therefore, Telecare staff view recovery as a fluid process in which consumers are able to progress and digress from self-directed goals, even though "the County's vision of recovery for adults might be tracked very differently from their own." From their perspective, BHRS prioritizes and defines consumer progress through reliance on quantitative outcomes, such as hospitalizations and recidivism. Yet, staff members consider smaller milestones as a positive step towards recovery, such as a consumer "smoking marijuana instead of methamphetamine." From the staff's perspective, a universal definition of recovery does not exist since, within the FSP program, goals are intended to be highly consumer-driven and individualized. Many of Telecare's staff members also have a variety of connections to lived experiences which is perceived as beneficial for consumers and illustrates that recovery is possible for everyone, states a Telecare administrator.

Successes and Challenges

Keys areas of success, as identified by Telecare FSP staff, include the following:

- Increasing rates of consumer participation in part time work to 17%
- Reducing rates of homelessness and hospitalization
- Reducing consumers' drug use and
- Increasing consumers' quality of life and well-being.

While Telecare staff feels that they have positively impacted their consumers' lives, they also recognize the need for additional external resources to support their complex consumers, along with the volume of FSP consumers served and an anticipated increase of consumer needs. Telecare's adult FSP program has continued to expand despite limited resources and while they have identified possible solutions to current constraints, they are unable to implement any of them without additional financial resources.

Communication

While communication within Telecare operates relatively smoothly, communication with external stakeholders warrants improvement. According to one Telecare administrator, though TAY are rarely referred to Telecare, when it does happen, increased communication between the TAY provider and Telecare would be beneficial for both parties.

"I think it would be ideal if we were reaching back into the youth system, the TAY system a little bit, to build those relationships beforehand. Not just with the members but with the agency as well, to see what's working and what's not." – Telecare Administrator

Historically, the relationship between Telecare and BHRS has been a trusting one. Telecare administrators perceive BHRS as supportive, especially in providing Telecare with "the things they need" and maintaining consumers prior to their entry into the FSP. Conversely, Telecare administrators state "if something is not working, we're going to own it and fix it." However, with the recent BHRS staffing changes and turnover, especially among management, Telecare administrators also expressed uncertainty and anxiousness regarding whether this level of support can be maintained in the future.

Performance Evaluation

In addition to complying with local and state requirements for data collection of outcomes data, Telecare also internally tracks consumer progress through Business Intelligence. According to Telecare administrators, it's not clear how BHRS uses the data they submit and how the agency/FSP program is evaluated on specific outcomes based on the submitted data.

In the meantime, Telecare has begun implementing a step up/step down process for consumers. However, markers to identify when a consumer is ready for a different level of care still need to be clarified in collaboration with BHRS, consumers, and other stakeholders.

Pay-For-Performance

Two different perspectives on the Pay-for-Performance Model have emerged among Telecare administrators. While one administrator was skeptical of a model "focused on meeting numbers" and foresaw a decline in quality of care and service, another administrator was open to learning more about the impact of a pay-for-performance model and optimistic about the potential benefits an incentive-based model could offer to staff members. For example, "the expectations are high. And these people meet them. And it would be really great to say if we can continue to meet those expectations, then there's something more I can offer you."

BHRS

According to BHRS administrators, "there is not a clear understanding among the staff at the County of the population the Adult FSP really serves." Compounding this lack of clarity is the concern that the current referral process does not proactively identify potential adult FSP consumers early enough to be preventative. Rather, a referral occurs once a consumer is already in crisis, so that "we're managing for today but we're not building for tomorrow" according to an Adult FSP provider-administrator. To address this concern, BHRS is currently in the process of implementing a formal referral process with a referral committee in place. The increasing levels of acuity among all FSP consumers suggest a need to reassess eligibility and referral criteria to ensure that they're realistic for the actual target populations referred to and entering the adult FSPs.

BHRS and FSP adult providers identified the lack of a formalized communication process to be a challenge. According to BHRS administrators, "we don't know when to talk to each other and when not to talk to each other." Confusion over roles and what information needs to be communicated between stakeholders can be a source of frustration.

Adult FSP capacity also remains an issue since "the Adult FSPs are basically always at capacity; therefore consumers have to wait, and that's not a good thing."

Office of Consumer and Family Affairs (OCFA)

Each Adult FSP Provider has a formal grievance policy where consumers and/or caregivers can document their complaints. An escalated second-level option is for consumers to file a grievance directly with the Office of Consumer and Family Affairs. From OCFA's perspective:

> *"Consumers are not feeling heard [at the provider level]. Equality is not translating" --OCFA Administrator*
>
> *"Consumers either do not know about it [provider grievance procedures], or do not care to use it." --OCFA Administrator*

Conversely, OCFA hypothesizes that "consumers are afraid of retaliation" because when consumers contact OCFA, they oftentimes do not want their provider to be aware that they've filed a complaint.

OCFA has also received grievances filed by adult FSP providers prior to any resolution attempts with the consumer first. However, recent implementation of program monitors to follow-up with grievances has appeared to improve communication between OCFA and the adult FSPs.

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Two critiques of the Adult FSP Providers offered by OCFA are: 1) the lack of recovery- oriented services and 2) a lack of family involvement. From OCFA's perspective, the Adult FSPs services do not reflect a recovery- oriented approach and they are unaware of consumers graduating to lower levels of care. OCFA perceives that the National Alliance on Mental Illness's (NAMI) discontent arises from the implementation of ACT by the adult FSPs without very much family member involvement.

> *"I'm not sure what the balance is, but I don't think they've got it right; of how to help folks to be independent and recovery-oriented without the family members being there…there is something missing there." -OCFA Administrator*

Adult FSP Consumers

This section addresses themes from the two adult FSP consumer focus groups with Caminar and Telecare consumers.

Perspectives about the Adult FSPs: Mission & Program

Consumers described the FSPs as a "hands on, personal, and one on one" supportive program which provided emotional stability and assistance with critical services, such as social security, transportation, medication, and housing. One consumer claimed, "They're always there for you; it's just a very comforting feeling."

Transitioning to a lower level of care and becoming more independent were also identified as FSP goals by consumers, with one stating, "You always have hiccups, road bumps, whatever you want to call them, but all in all, it's been a good experience." All consumers in the focus groups appeared invested in the FSP program and actively utilized FSP services.

Referral Process

Many of the participating consumers were referred by BHRS and entered the program relatively quickly following referral, with wait times ranging from the next day to three months. Initially, some consumers were unclear about what FSP services exactly entailed when invited to the program. One consumer stated, "I didn't know a lot even after they talked to me." Another consumer was confused regarding their transition from Caminar to Telecare. However, overall, consumers did not articulate any specific criticisms of the FSP referral system.

Consumer Goals

Consumer-identified goals varied from reduction of negative behaviors (i.e., staying out of the hospital and off the streets) to increased positive outcomes, including reuniting with one's family, participating in employment and volunteer opportunities, and becoming medically-stable and substance-free. Other mentioned goals included: becoming a productive individual in society, increased independence, and decreased reliance on the mental health system. Consumers were recognized the positive impacts resulting from participation in FSP services, with one commenting being now "better situated to be on the outside than before."

Stepping Down/Levels of Care

Consumers perceived the level of care they receive as individualized and ongoing. Though some articulated lowering their level of care as a goal to recovery, others were unable to foresee stepping down of care as a viable option quite yet. Consumers did not perceive an expectation from their providers that they would always remain in the FSP, with one consumer stating: "It's up to you, what you want to do." Another consumer also found it helpful to have the option of lowering their level of care, commenting: "I've been scared that when I become really independent…I'm afraid that I'm gonna lose that support but it's kinda been my experience that being in the FSP, they kinda work with you as you're going, you know? They don't just - see you're doing alright and let you go."

Housing

Across the board, FSP adult consumers were equally vocal regarding their dissatisfaction with housing options available in San Mateo County, specifically regarding location and lack of security/safety. When probed further, one consumer responded: "Well, they're not very good. The housing options are nil." Another consumer felt that those deciding to work with the offered housing options, as opposed to seeking independent housing, were given priority. In this instance, the individual decided to live with family members, which possibly led to not being given a rental check until three months later. This individual also strongly felt that if they had chosen a housing option offered by the provider, the rental check would not have been delayed.

Consumers with dependency issues also often relapsed due to their housing location. One particular consumer felt "set up for failure," being housed in a living situation rampant with drug use. Subsequently, this individual relapsed and has continued to use drugs. While some consumers were satisfied with their housing options, most viewed access to desirable housing as a continued challenge.

Family Involvement

Overall, from consumers' perspectives, the current level of family involvement has been sufficient. Consumers are able to visit and contact their families as desired. However, a number of consumers have lost contact with their families and/or have family members become deceased. The perception from consumers is that it is their family members' decision regarding whether or not to be involved. In some cases, the case manager acts as a messenger between consumers and their families: "Caminar and my case manager, especially, she's kinda acted like in the middle…cuz I had a fallout with my family and she communicates with my family. So

other than being a challenge, it's been a success because my family is getting to understand more." Family involvement within the FSP has generally been positively perceived as an opportunity for family members to better understand their loved ones' mental illness. Numerous consumers spoke about reuniting with their family as a goal they hold for themselves.

Grievances

While some consumers are aware of and feel comfortable utilizing the grievance policy, others are not. Consumers are aware of the location of forms and contact telephone numbers for filing a grievance but, overall, seem reluctant to using these methods. One consumer has been reluctant to file a complaint, citing discomfort with documenting the issue, as required by the grievance policy. Another consumer stated, "I don't know exactly how the process is for writing a complaint." Some perceive the grievance policy to be a low staff priority because it is rarely discussed, while others fear differential staff treatment as a result of having complained. For example, one consumer stated: "I just don't want to make waves, I mean, I'm lucky these people took me back in…I'm lucky, I just don't want to make waves, because I notice when I do that, it gets around to the staff and it makes their jobs harder and they don't really want to help you."

Caminar Consumers

Treatment Planning

Consumers appear to diverge into two schools of thought regarding treatment planning at Caminar. Some viewed it as a collaborative process while other consumers felt they had little stake in their own treatment and perceived the staff's own agenda as being pushed instead of their own (i.e. case managers' "expectations are too high"). However, consumers reported being given the opportunity to disagree and, in general, believe that staff is open to feedback. Overall, the majority of consumers are able to plan their treatment with their team and find psychiatrists who are open to feedback regarding their prescribed medications.

> *"I've tried a lot of things until now … it seems like it's working. So through a lot of trial and error, there's some success today and that's because they were open to suggestions and they were listening to me." - Caminar Adult FSP Consumer*

Meaningful Interventions

The key meaningful interventions indentified by Caminar consumers are: support groups, classes, access to transportation, medication management, and access to health care. For one consumer, the support groups and classes have been beneficial for transitioning from nicotine cigarettes to an electronic one, especially due to feedback from peers in the smoking cessation support group. The interactive nature of support groups, along with the creation of a community of peers, were also identified as positive, helpful elements, along with educational groups. For example, the diabetes group has equipped participants with information to make better informed decisions regarding diet and interpretation of food labels.

Access to transportation was another highly regarded key intervention by consumers, with many either physically unable to use public transportation or lacking access to a reliable car. Staff members are able to coordinate transportation for consumers or pick-up consumers. Lack of reliable transportation access would severely limit consumers' ability to attend medical appointments and program functions/activities. Consumers see a need for an increased number of drivers because "it puts a lot of responsibility on a couple of people that have to work extra hard."

Perceptions of Staff

Generally, consumers at Caminar perceived their case managers in a positive light – they "don't treat you like they're better than you, they treat you like a friend." Most consumers felt they are accurately and culturally matched with case managers. Consumers also viewed their case managers at Caminar as "highly motivational" and not complacent, as opposed to case managers at the San Mateo County level. Consumers are unaware of any staff members with lived experience, though they believe there may be a benefit.

> *"I've had a lot, a lot of case managers since I've been in mental health, and this is the first time I actually, you know, see things working out cuz she understands where I'm coming from." – Caminar Adult FSP Consumer*

Medication Treatment

Telecare consumers were vocal regarding the dissatisfaction with their medication treatment and the lack of involvement regarding planning/treatment decisions around medication. One consumer felt like a guinea pig due to the constantly changing medications and expressed unease when psychiatrists "give medication not knowing whether it will work." Another older consumer reported having bad experiences with medications that resulted in feelings of "sick, nervous and shaky." Yet another consumer described the difficulty of stabilization and past distrust regarding receiving care and medication:

> *"It feels like someone is out to get you, you feel naked that you're being care for as an adult. Someone is handling your finances and someone is handling your medication…things are going into your body and dictate if you're going to make it through the next day." – Caminar Adult FSP Consumer*

Although the older consumers had negative medication experiences, at least one younger consumer spoke to successes experienced at Telecare, specifically with the program's assistance with hospitalization release, medication treatment, and helpfulness of on-staff psychiatrists and medication counseling.

Desired Additional Services

Not all consumers appeared to share the same understanding or awareness of services offered by Telecare. For example, when one consumer mentioned job placement as an additional beneficial service that could be offered, peers in the group quickly stated that Telecare does indeed offer job placement.

Telecare also works with consumers struggling with substance abuse problems, with staff perceived as "being open to and honest about what can and can't be done regarding drug use." From the consumers' knowledge, drug treatment programs do not exist within Telecare, although, if needed, Telecare can connect consumers to external resources offering drug treatment and sober living options. However, consumers reported these external drug treatment options to be ineffective.

An additional desired service suggested by an older consumer relates to services focused on building community among older adults since “there is nothing for the seniors here, no program, nothing stimulating.”

Communication with Staff

Telecare consumers associated the high level of staff disorganization with the high caseload required of each team. Two consumers echoed the same sentiment that “Telecare is filling the most need with the least cost.” According to consumers, there have been numerous occasions when staff have not returned phone calls in a timely manner as a result of being overworked - It is “hard to get in contact when you need to.” Consumers have learned to repeatedly remind case managers to follow-up on pending issues and ensure that they are resolved. Overall, though, Telecare staff are viewed as competent and respectful, with “most consumers agree[ing] they do what they can with what they have.”

Adult FSP – Caregivers

This section summarizes key themes based on interviews and focus groups with caregivers who have experience with one or both of the adult FSP programs. If content is not specified as referring to Telecare or Caminar specifically, it represents FSP system-wide feedback.

Perspectives about the Adult FSPs: Mission & Program

According to one caregiver, a lack of clarity and consistency exists within the Adult FSP system regarding the FSPs' overall mission and implementation. For example, "whatever it takes" often means different things to different stakeholders and lacks any standard specificity regarding what the FSPs are actually implementing. Additionally, there is a perception that while the FSPs respond to crises, underlying issues are not adequately addressed.

> *"The system is always knocking down the flames but never putting out the fire."*
> *– Adult FSP Caregiver*

Several central goals of the FSP program, as described by family members, include:

- keeping consumers safe
- setting people on the road to recovery
- keeping consumers out of the hospital and in the community by making sure they are on the proper medication and
- making sure consumers don't do harm to themselves or to others.

They also discussed the important role that Telecare has played for them, with one calling the FSP program a relief service for caregivers. With essential services covered, family members are more able to focus on addressing higher-level issues.

> *"On balance, the relief and assistance that we've had … is far better than nothing. If I were giving them a grade score, I would give them a C+ or a B-. Certainly better than passing." – Family member referring to services through Telecare*

However, one family member expressed concerns that Telecare's treatment approach appears more reflective of a drug treatment model than one for addressing mental health issues. Additionally, many family members felt that while Telecare's FSP services allowed consumers

to maintain stability, they fell short of improving consumers' overall well-being. Another family member also expressed the desire for more strength-based, proactive approaches.

> *"I think the Full Service Partnership could be better in many ways; I'm not sure that they're all that consistent." – Family member referring to services through Telecare*

Referral Process

In addition to the chaos and confusion during a family member's entry into a FSP, caregivers also expressed feeling that they didn't have a choice about providers or what services to access. There was an overall sense that families had to navigate the system on their own through trial and error. Caregivers described facing many obstacles in trying to figure out the system on their own and to understand accessibility and availability of services.

Compounding this challenge was the lack of communication directly with caregivers regarding what other options existed for their family member. One caregiver stated that programs seemed to be competing with each other and were deliberately not being open about other outside resources that were options. All caregivers called for increased transparency regarding available programs and resources, including the type and level of services offered by each one. For example, one suggested the creation of a pamphlet with side-by-side comparisons of the services and programs available through BHRS/San Mateo County. This resource would be helpful for caregivers navigating San Mateo County's referral process to find the best fit for their family member.

Key Services

Family involvement and housing were two major areas identified by caregivers as both vital to consumers and in need of improvement. Other key areas addressed were life skills, job support, and integrated health.

Family Involvement

In the current adult FSP system, caregivers are required to take the initiative if they desire to be part of the treatment team. One caregiver described a lack of provider awareness and internal organizational sense that caregivers should be part of the treatment team, with family members often needing to remind providers of their desire and interest in being active treatment team participants:

"There are caring families out there that want to be a part of the solution."
–Adult FSP Caregiver

"If the provider and the family and the consumer don't all work together, nobody is going to get well. Nobody is going to be in any kind of recovery." –Adult FSP Caregiver

Caregivers also discussed the need for families to provide ancillary services and fill "in the gaps" when FSP services were deemed inadequate or insufficient, including hiring additional outside help or stepping in themselves to improve outcomes. Several family members recounted instances of needing to be an advocate for their family member and expressed concern that consumers whose family members were not actively involved in their treatment plans may not be experiencing the same level of advocacy in the program.

Communication

Communication between the FSP providers and family members continues to be a challenging area, according to caregivers. Cited examples included the need to frequently contact providers with updates about the consumer and share concerns about decompensation, challenges with the consumer consent process (and authorization to release information to family members), and the overall lack of regular updates from FSP providers, sometimes spanning several months. One caregiver also expressed frustration with the difficulty of getting even basic information regarding their family member, with case managers either not answering the phone or returning calls.

"We know that our kids are ill … If [Telecare] is going to be the [agency] to manage it, I would like to see more consistency ... Otherwise [my son] can just stay in an institution where he will get better care. If he's supposed to be in the community, then let's get this level of care better." - Adult FSP Caregiver

Developing stronger, productive relationships with providers was a desire cited by at least one caregiver who's experienced adversarial relationships with staff. Other concerns cited by caregivers include "blaming the families for the problem" and providers taking deliberate steps to prompt family members to transfer out of the program.

"The providers come and go, but the family and the consumer … it's a life sentence." – Adult FSP Caregiver

"We are not each other's enemy—we have to work together." - Adult FSP Caregiver

"One person used that word enabling and I just said, "Don't ever use that word with us. We are not enabling anything. We're trying to advocate for what we feel needs to happen for us to help you help our son." - Adult FSP Caregiver

Despite these concerns, caregivers overall described positive outcomes arising from past collaborations with providers and individual staff members and expressed a desire for continued collaboration with treatment teams.

Therapeutic Relationship

Caregivers stressed the importance of the therapeutic relationship in engaging clients during the treatment process and throughout recovery, viewing it to be a critical function of the FSP program. One caregiver recognized that while the engagement process may be the hardest part of the therapeutic relationship, it is also essential to consumer's ability to make progress. Therefore, providers and staff need to "get consumers out of their comfort zone and get to know them" in order to build a stronger and sustainable consumer-provider relationship.

One family member suggested adding a reward system for consumers actively engaged in treatment and working towards recovery, including working with them to set attainable goals, bench marks, and milestones to increase their sense of hope and self- worth.

Another concern raised by caregivers is that the family is often not explicitly involved as active participants in developing the initial care plan. As one family member described, caregivers then frequently have to step in at the last minute during a crisis, as opposed to being involved from the beginning or having a shared understanding of the care plan from its inception.

Housing

Caregivers perceived housing to be a critical component of the FSP program and understood the challenges of working with a difficult consumer population to find and maintain housing. However, they also expressed dissatisfaction with available FSP

housing options and the limited success in working with providers, who they felt were often inflexible with accommodating housing adjustments. Provider reliance on unlicensed board-and-care facilities for housing consumers was another critical concern raised by caregivers, who often found poor conditions and a lack of experienced/qualified staff at these facilities.

All family members expressed a desire to see housing quality improve and for additional supportive services and resources to be added. Other housing issues raised by caregivers include poor housing quality, concerns about neighborhood safety, on-site substance use, level of cleanliness of unit/building, and lack of on-site supportive services.

"To do whatever it takes does not mean you put people in board-and-cares that are unlicensed with people that do not know about mental illness and yell at clients and feed them slop. That is not whatever it takes, that is inhumane and it's warehousing."

- *Adult FSP Caregiver*

Supportive Services (Housing)

Caregivers expressed concern regarding the lack of clarity around whether supportive services are supposed to be provided on-site at FSP housing locations and if so, what these services actually entail. Many family members also described dissatisfaction with the limited activities available on-site once their family member has entered housing. Currently, on-site supportive services appear to be either completely absent, inconsistently offered (Telecare housing), or insufficient in provider-managed housing units.

Several caregivers also mentioned the Industrial Hotel in particular and shared concerns about consumers' ability to maintain self-care due to limited independent living/life skills. For example, one caregiver's family member lost basic living skills through the course of their illness and needed additional on-site support services that weren't provided, subsequently impacting their independent living situation.

The lack of easy access to food and other resources was another concern, with one caregiver recalling instances at one specific housing site where consumers were required to secure food on their own, such that "he spends his time what you'd call hunting and gathering just trying to survive."

Caregivers also identified specific on-site support services that would be beneficial for consumers, including life-skills training, occupational therapy to improve functioning and quality of life, and cleaning services for the housing units.

"I would like to see the Telecare FSP graduate from that level of just being a trouble-shooting agency." – Adult FSP Caregiver

Additional Resources Desired

According to caregivers, additional resources needed include an expansion of the Jobs Plus program to employ more consumers and a need for more integrated healthcare within the adult FSP program.

Transitions/Levels of Care

Several caregivers described the difficulties they have experienced when their family member has had to transition between different levels of care, such as stepping up to a locked facility and then subsequently returning to the community. Communication between all providers does not necessarily consistently occur during transitions. For example, when a Telecare consumer transitioned levels from Telecare, medication information was not effectively communicated and resulted in changes to medication type and dosage that caused additional challenges. Several family members also expressed the need for a respite center to provide transitional services to consumers stepping down from institutional care.

Staffing

Caregivers expressed concerns about FSP staffing, including the high levels of staff turnover and the educational credentials of staff. One caregiver stated that there were not enough skilled professionals involved on the "front lines" of consumer care. Therefore, the staff members with the most frequent daily contact with the consumers often have the least amount of education and awareness of mental illness. For example, one caregiver claimed that uneducated staff may cluster all consumers sharing the same diagnosis into one group but be unable to discern subtle differences between these consumers to identify complex and unique individual needs.

All family members agreed that Telecare is understaffed and overwhelmed by both the number of consumers and the severity and complexity of the individuals served. Family members also expressed concern that staff members reflect inconsistent levels of experience, training, and

compassion towards consumers. They described some staff members as being skilled and conscientious, leading to experiences where they felt "staff have shown they really care." However, they also felt that there have been many situations where staff appeared to be lacking skills or acted irresponsibly. Issues with staff responsibility and follow-through on tasks were also raised, with a family member filing a grievance to switch case managers on at least one occasion. In summary, family members felt that there are levels of professionalism, skills, and ability that are absent or inconsistent among Telecare staff members.

While Telecare staff are accessible and, in some cases, responsive to listening about a family's concerns, communication can also be inconsistent, with family members often required to aggressively seek out Telecare staff in order to receive any information. Caregivers expressed the need for a more consistent level of communication and performance from staff, for both consumers and family members involved.

Overall, family members were extremely positive about the Telecare staff nurses. All family members agreed that having nurses on staff has been really important for the overall well being of consumers and that the staff nurses have been very supportive. Additional healthcare services and increased time with a psychiatrist or therapist were cited as desired services that would be beneficial for consumers.

BHRS Involvement

Accountability

Caregivers expressed that BHRS should provide better accountability and oversight of the FSP program and the providers. One caregiver suggested a "blind-check" system to randomly audit providers and access compliance with the FSP mission and program requirements.

Family members agreed that standards for professionalism and level-of care also need to be more explicitly clarified, and in some cases, enhanced. Besides a lack of transparency and accountability, they feel that consistent standards of care are nonexistent within and between programs. Caregivers requested that measures be implemented to ensure additional oversight and accountability to the County as well as to consumers and family members. BHRS, providers, and caregivers need to have a shared, common understanding of FSP program expectations, which would also facilitate dialogue between provider staff and caregivers.

Funding

Caregivers also expressed concern that BHRS' funding process creates obstacles for building consistency and stability in the FSP program at a provider-level. Providers need to be given sufficient funding so they can provide the best possible services:

"[Providers] need to be able to keep their programs robust and healthy and their staff strong." –Adult FSP Caregiver

Specifically, some family members expressed concern that the level of Telecare FSP funding is insufficient for providing the "highest level of care" as described in the mission statement. One family member also mentioned that Telecare staff have expressed that they are under-staffed and under-funded for the level of work required.

Housing Site Visits

In March 2014, DYJA staff conducted site visits to a Caminar board-and-care home and Telecare residential hotel, at the suggestion of interviewed caregivers and BHRS. This section summarizes the themes that emerged from those visits, which also included individual interviews with key housing staff and attendance of a community meeting with consumer residents.

Caminar Housing Site

The house residents were not available during our site visit. This section summarizes our interview with the housing staff.

Site Description

The Caminar facility we visited was a board-and-care (unlicensed) home contracted to house up to six females, with five slots allocated to FSP consumers. The facility included 3 bedrooms, 2 bathrooms, a kitchen, dining room, basement, and back yard. During our visit, the facility was at full capacity, with two consumers sharing each bedroom and three housed in the master bedroom. The home is family-operated, with at least one family staff member on-site at all times. The Caminar Housing Coordinator described this care home as transitional and

independent in nature. However, according to NAMI's definitions of housing options, it appears to be closer to a supervised group housing facility.

Goals and Objectives

Despite not being familiar with the overall mission of the FSP program (from both BHRS and Caminar's perspectives), the Caminar Housing Coordinator was able to articulate that the main goal of transitional housing was to prepare consumers for independent housing in the future:

> *"We're preparing them to be infused in the community later on, they're not gonna be here for the rest of their lives. They're here only in transition." –Housing Coordinator*

The Housing Coordinator's duties include: regular cleaning of the house, preparing three meals a day with snacks, coordinating with Caminar case managers, reminding clients of medical appointments and maintaining an on-site presence for unforeseen emergencies and crises.

Successes

The convenient and accessible location of the housing site is perceived as contributing to consumer progress towards attaining independence. Many basic amenities are located nearby, including public transportation, grocery food options/drug stores, the library, and recreational centers.

> *"I think Caminar is very successful in encouraging them to take the bus. Most of them are, actually all of them except for one, take the bus which is very good because they are more independent." - Housing Coordinator*

While clients are encouraged to take the bus to go swimming and to the library, the Walking group has continued to experience challenges with consumer participation. Over time, the Housing Coordinator has also observed positive changes in consumers' attitudes towards programs and services offered by Caminar, another indicator of success. One example of consumer progress, as described by the Housing Coordinator:

> *"When she first started, she wouldn't even look at the bus… Caminar provided her with a Clipper card, they put money on the Clipper card and now she takes the bus. She goes up to buy her stuff, she goes swimming and she uses the Clipper card. She takes the bus so that is successful."- Housing Coordinator*

Enforcing house rules is another tool utilized by the Housing Coordinator to assist consumers with acquiring basic life skills to maintain independent housing in the community:

"I keep telling them, you guys, your success here, part of that success will be me, meaning I'm very strict with rules, I'm strict with cleanliness…You know you have to pick up after yourself because you have no 24-hour maid here. So then implementing that will inoculate in their mind that "I have to be like this" so that when they get out of here they will be a good example in the community and they can live on their own."
–Housing Coordinator

Challenges

Housing challenges that were identified by the Housing Coordinator include: 1) stigma in the community, both among potential landlords and neighbors; 2) unclear expectations regarding emergency protocol; and 3) limited living space attributed to the limited funding available.

Stigma

Stigmatizing attitudes among potential landlords and neighbors has continued to be one of the biggest challenges and barriers to locating more affordable housing in the community.

"That house is for rent, a big house, six bedrooms, five bedrooms which is perfect for us. At least we have more space, you know and all that. But if I have to rent that, I have to divulge that this is gonna be like- I will take care of people from mental health. It's maybe not just mental health. Say the owner of the house says, "Oh if it is going to be for business, then we don't like it." So it's a really big challenge."- Housing Coordinator

When the Housing Coordinator has been obligated to disclose that the purpose of the rental is to provide housing for individuals with mental health disabilities, potential landlords have not responded favorably. Resentment among neighbors in the community has also evolved into confrontations, due to feelings that those with mental illness should be not residing in their neighborhood and concerns that their presence will lead to declining property values. Over time, however, Caminar caseworkers have worked with consumers to mitigate these concerns and arrive at constructive solutions for both consumers and neighbors. For example, consumers' gathering in the front of the home to smoke cigarettes was a common complaint from neighbors. Subsequently, consumers now have a smoking area in the back of the house.

Emergency Protocol

"So what will I tell 911? This is not a medical emergency but a psychological emergency." - Housing Coordinator

Lack of clarity from Caminar regarding how to address and seek assistance for non-medical emergencies was a concern raised by the Housing Coordinator. In one incident, a consumer began to exhibit suicidal tendencies due to a medication change and the Housing Coordinator was unsure of whether to call 911 since this was a non-medical psychological emergency. The reluctance to primarily rely on calling 911 to resolve consumer issues also stems from concerns about negative impressions from neighbors should either the police and/or medical personnel be a regular presence at the home. Therefore, the Housing Coordinator encourages consumers to refrain from calling the police/911 for unwarranted matters and attempts to work with them to find creative solutions to their concerns first, if feasible. However, this is not possible in every instance.

Limited Space and Funding

This housing site currently accommodates six female consumers in a three-bedroom house. To maintain an on-site presence, the Housing Coordinator and two family members interchangeably occupy a single bedroom that's similar in size to a small bathroom. While the consumers do not appear with the limited space in the house, the Housing Coordinator would like to expand the kitchen and dining room areas. However, this is not a feasible option due to financial constraints and city permit requirements. An alternative solution would be working with Caminar to locate a larger board-and-care home so that consumers and staff could each have their own rooms. Housing all consumers at one site would also contribute to cost savings (time/mileage) since community support workers currently deliver medication to consumers across a range of housing sites.

Additionally, the facility has never received a cost of living increase, despite costs for facility operations (including service fees, plumbing and home repairs, overhead expenses, and rental insurance) having significantly increased in recent years. This has also made it difficult to hire any potential staff/caregivers since "for us to hire somebody, I don't think we can afford it," being able to only offer $10 an hour.

Family Involvement

From the perspective of the Housing Coordinator, family members are actively encouraged to visit consumers at their housing site and those without actively involved family have displayed noted signs of depression.

Grievance Policy

The housing coordinator is not familiar with the formal grievance policy. However, any housing issues or concerns are addressed during the mandatory weekly house meetings, which include the Housing Coordinator/staff, a Caminar case manager, and all FSP consumers. If issues remained unresolved following this house meeting, the Caminar case manager works with the individual client to find the best possible agreed upon solution.

Substance Use Issues

Substance use is not tolerated at this housing site and is grounds for eviction if a consumer repeatedly returns home intoxicated or under the influence. When a consumer is discovered to be using substances, the Housing Coordinator writes them up and submits a copy to their Caminar case manager. If the consumer continues to use substances, Caminar then issues a letter notifying them that they will need to move to new housing within 30 days. The Housing Coordinator does not have the resources to provide constant supervision required for substance-using consumers.

Key Services

All services and interventions are provided off-site at Caminar, besides the weekly house meetings. Although the Housing Coordinator has a professional background in Critical Care Nursing, Caminar has clearly conveyed that any medical issues involving consumers should only be addressed by designated Caminar nurses and it is the responsibility of Community Support Workers to deliver and monitor consumers' medication use. However, the Housing Coordinator may provide auxiliary support to consumers if needed (i.e. verbal reminders to take medication or fast in advance of a medical test).

Communication

The Housing Coordinator meets with the assigned Caminar case manager weekly during house meetings and also regularly communicates with Caminar case managers by phone. HIPAA regulations prohibit the use of email regarding consumers. When case managers are

unavailable, the Housing Coordinator can access the Warm Line for emergencies. Overall, the Housing Coordinator feels that communication with Caminar has been going well, stating "one thing I like with Caminar and the case mangers now, they are so much hands-on and we communicate and work as a team."

Telecare Site Visit

In addition to touring the Industrial Hotel (managed by Telecare), DYJA staff also observed a consumer community meeting and interviewed the Telecare Housing Coordinator. The tour allowed DYJA staff to observe the physical space and on-site programming repeatedly referenced by interviewees. The community meeting was also critical for providing us with an authentic perspective regarding consumers' lives, issues, and concerns at the Industrial Hotel.

Site Description

The Industrial Hotel is Telecare's 'in-house' housing and situated in a challenging South San Francisco neighborhood. As a supportive housing site, 24-hour staffing and medication support are available on-site. The two-story hotel is comprised of single-occupancy studio apartments equipped with TVs, mini fridges, and microwaves. Besides shared bathroom facilities on each floor, there is also a communal kitchen, laundry room, and a large common room with tables, chairs, and couches.

While the majority of residents are Telecare consumers, several Caminar and BHRS clients also reside at the Industrial Hotel. Residents are generally segregated by gender on each floor, with Telecare staff offices located at the front of the building. Telecare case managers regularly visit the Industrial Hotel to check-in with on-site staff and provide services to consumers. On-site housing staff also update the entire treatment team through periodic e-mails.

> *"We take the worst of the worst. And when we get the worst of the worst, [the Industrial Hotel] is the setting we have for them." - Telecare Staff*

Challenges

Many of the concerns brought up by previous interviewees were visible during the site visit, including issues with safety, cleanliness, health, and the overall well-being of hotel residents. During the community meeting, residents discussed issues with the quality of their living

environment, individual rooms, and communal spaces. This included an earlier outbreak of bed bug and the replacement of broken, outdated, or otherwise limited furnishings and supplies.

Consumers and family members also mentioned the lack of staff professionalism as a concern. For example, one consumer alluded to an incident of being yelled at and scolded by a staff member for bringing up an issue with a smoke detector. Other consumers similarly expressed anxiety about their living conditions at the hotel but did not always feel consistently supported by staff in voicing these concerns.

Another issue expressed by consumers was the limited availability of on-site activities and programming for residents. Many also felt that life skills training for independent living would be beneficial.

From the provider's perspective, identifying housing options for the seriously mentally ill population in San Mateo County has been fraught with many obstacles, especially since general housing criteria in the community appears to be too rigid for Telecare clients. According to Telecare's Housing Coordinator, additional challenges include working with individuals on limited incomes, who may also have a combination of credit/financial, criminal justice, and/or mental health issues.

Working with landlords has also proved difficult, both due to the stigma around mentally illness and the perception of Telecare being a for-profit organization.

> *"My toughest sell is … landlords being aware and being willing to give the mental health people a chance. Everybody deserves a chance." - Telecare Housing Coordinator*

The implementation of a crisis management house was suggested as a possible alternative to a locked facility for providing a transitional place for clients in crisis who require more intensive services.

> *"[The Industrial Hotel] is the last stop on the train. If you don't make it here, you're probably going to go to a locked facility." – Telecare Housing Coordinator*

V. Recommendations

Key areas for consideration are highlighted below and compiled based on input from the key stakeholders interviewed for this report. It's important to note that these recommendations reflect a snapshot in time of the FSP programs and need to be placed within situational and historical contexts. The sample we interviewed is also not representative of all stakeholders, FSP consumers, and their families. For example, lack of or limited funding and its impact on services is a pervasive theme that appeared in almost all of our interviews. However, according to BHRS, no provider received a Cost-Of-Living Adjustment (COLA) between 2007 and 2013 due to the local recession and lack of available funds. In 2014, a 3% COLA increase is being awarded to BHRS providers. Suggested action items and updates have been included where appropriate.

Child/Youth/TAY FSPs

Funding/Fiscal Issues

- Increased cost-of-living increases and funding increases from BHRS to reflect level of services provided/needed (including TAY housing), meet the needs of complex consumer populations served, and reduce staff turnover

  Notes/updates:

  - Staff turnover and the abrupt loss of the therapeutic bond was a strong concern expressed by caregivers and TAY consumers
  - BHRS is offering a 3% COLA increase for FY2014

Referrals

- Earlier identification of children/youth most in need of FSP services, especially children with autism spectrum disorder and developmental delays
- Ensuring referrals contain all necessary information of consumer/family profiles and needs, especially critical for determining if a family is a good fit for the FSP (information flow from BHRS to provider)
- Increased in-county capacity for serving child/youth/TAY consumers

Recommended Action Items:

- Establish working committee (BHRS, providers, consumers) to review current FSP referral criteria, specifically for identifying children/youth with special developmental needs and their families
- Annual BHRS review of FSP referral criteria and tracked data, with input from providers and caregivers
- Review by BHRS and providers to identify systematic areas of missing information and develop information flow plan; establish regular meetings (at minimum quarterly) to review/identify checkpoints
- Assess impact on demand for Wraparound services from recent Katie A. legislation (BHRS monitoring of referrals to determine if legislation increases demand for FSP services)

Service Delivery/Linkages

- Providers' availability of both male and bilingual clinicians on staff and greater maintenance of staff stability
- Development of stronger BHRS linkages between Child/Youth/TAY and Adult FSP systems to address service gaps (i.e. systemic disagreement over responsibility of TAY consumers)
- Stronger systemic linkages and transition between the Child/Youth and TAY FSP systems
- Intense concentration of services at program entry to stabilize consumer/family
- Community resources/linkages to assist consumers and their families with maintaining stability, especially while waiting for an available FSP slot, during step-down, and following discharge/graduation
- Affordable housing options in desirable locations for TAY consumers, whether through partnerships or creating a spectrum of appropriate housing options
    - Supported services on-site at housing locations
- Additional resources to:
    - Address the unique needs of complex consumer populations (developmental delays, autism spectrum disorder, juvenile-justice involved, co-occurring disorders, non-English speaking families)

- Meet consumers' family needs (i.e. housing, financial, health/mental health, transportation, etc.) to stabilize the family unit
- Offer additional services (therapy/counseling/peer support) to meet the needs of complex young adult consumers
- Ensure cultural competence (Fred Finch)
- Increase support foster families
- Provide family therapy sessions with consumers
- Increase staffing and training opportunities for peer/family partners and to ensure consistent quality of services provided by these partners
- Ensure continued availability of harm reduction and life skills development interventions (including job skills training/placement) for TAY
- Address the needs of TAY with psychotic disorders, symptoms of psychosis, and/or co-occurring/substance abuse disorders
- Increase services available to TAY aging out of the FSP services but still requiring supportive services (address inconsistent stakeholder/partner age eligibility requirements once a TAY is referred to the County transitions team)
- Expand the TAY FSP to increase slots for Wraparound and a moderate level of step-down care simultaneously
- Fund additional drop-in centers for TAY
- Ensure continued funding for TAY social activities and outings
- Additional support to consumer families to facilitate participation in treatment (i.e. transportation costs, ability to secure time off from work for program events, navigating complicated legality associated with TAYs' transition to adulthood)
- Offer comparable step-down community resources for children/youth/TAY prematurely discharged from FSP services

- Implement an integrated substance abuse treatment option
- Negotiating increased Drop-in Center programming (Edgewood) that meets consumers needs while addressing BHRS legal/liability concerns of mixed youth/young adult (over 18+) populations
- For Juvenile Probation children/youth/TAY:
  - Timely assignment of a primary therapist

- Timely assistance from additional support staff
- Making initial contact with families and initiating services within 30 days of referral
- Coordinating discharge planning with Juvenile Probation (when child/youth are removed from probation, they also lose access to Wraparound services which can increase instability)
- Ensuring justice-involved TAY have access to adequate mental health services in the adult system (Probation Administrators talked about stepping in to ensure TAY step-downs also involve a continuation of services, though they felt that should be the role of the consumer's primary FSP case manager)

Recommended Action Items:

- Annual BHRS review of providers' current staffing plan to ensure gender and cultural representation reflects those of consumers and their families served
- BHRS development of a streamlined, coordinated service transition protocol for TAY consumers requiring access to adult FSP services, including identification of service gaps
- Development of a coordinated service transition protocol by Edgewood for consumers transitioning between child/youth and TAY FSPs
- Outreach by BHRS case manager to consumers and families awaiting FSP placement or entering step-down to connect them with available community supports which can assist with maintaining stability
- Conduct housing needs assessment, especially for on-site supportive houses; explore possible partnerships with housing corporations/non-profit organizations to identify affordable, safe, appropriate housing options

  Note: Despite research consistently showing that a supportive housing model provides stability to severely mentally ill consumers, improves outcomes, and offsets institutional costs, they remain in short supply, both in San Mateo County and elsewhere. The recent recession, shortage of affordable housing in San Mateo County, escalating housing costs/expenses, capped funding rates, and stigma of housing severely mentally ill individuals have substantially limited options in desirable geographic areas as well as landlords willing to work with FSP providers and consumers. Creative housing solutions, such as Kansas' "health home" model or County-owned housing, may warrant further exploration.
- BHRS clarification (requested by caregivers/families) if on-site supportive houses are included in the FSP scope of services and if they are, which specific services should be offered

- In light of funding limitations, BHRS review and prioritization of requested "additional resources" with providers. Key areas include: addressing needs of specific consumer populations, auxiliary family supports, staff/family partner trainings, funding for social activities (TAY, graduated families), community resources for discharged consumers/families (non-graduate).
- BHRS assessment of integrating substance abuse treatment options into current FSP programs. Otherwise, is there a way to bridge this service gap within the BHRS system?
- Establish work group between BHRS, Edgewood, and Juvenile Probation to address concerns and develop protocols for justice-involved youth

Step-up/step-down

- A more formalized aftercare/step-down system which utilizes family and community strengths and resources
    - Identification of qualified Medi-Cal local providers to refer/link out-of-county FSP children/youth during the step-down process ("soft handoff")
    - A "longer-term plan" for out-of-county youth transitioning out of the Fred Finch FSP to ensure stability, including linkages to the adult FSP system if needed and local community resources
    - Developing a more formal maintenance level of care for TAY FSP consumers to increase capacity and address county need for more slots
    - Resources to maintain "community" after graduation (i.e. monthly social events for former consumers/families, support groups)
    - Safe, supervised housing options (with life skills assistance) for TAY

Recommended Action Items:

- BHRS/providers to develop and implement a protocol for connecting consumers and families to directly with community resources, especially critical for out-of-county youth transitioning back into San Mateo County.
- Explore feasibility of funding "aftercare" resources. Do providers have existing supports for agency graduates?

Communication

- Improved consistent communication between stakeholders around:
    - Stakeholder/family priorities, agency philosophies, clarification of roles, feedback, and expectations (especially when different parties have competing priorities, which has resulted in consumers being pulled out of the FSP)
    - Negotiation of consistent treatment timelines between FSP providers, BHRS, key stakeholders
    - Orientation of families to the FSP program and provider following referral (and before first contact by Edgewood) (especially critical for overwhelmed families who are new to FSP services)
    - Coordination with Child Welfare around termination of Wraparound services for children/youth in group homes (cases often remain open for excessive periods of time while awaiting a closing conference to be scheduled)
    - Increased documentation and communication regarding services received by juvenile justice-involved children/youth (including as required for quarterly reports to the courts for probation youth)
    - Accessing higher levels of care (i.e. residential treatment) with demonstrated consumer need and informing families of all options (i.e. school system reluctance to refer to outside services)
    - Improved transparency and communication during discharge process with families, including termination reasons, all available options, and orientation to community resources
- Providing more internal feedback to staff (by program administrators) (Fred Finch)

Recommended Action Items:

- BHRS/Provider joint presentation of the FSP program to other stakeholders to increase awareness of the program's goals and services
- Provider orientation of new families to their FSP program and available services prior to program entry (consumer start date)
- Establish work group of agency stakeholders (BHRS, providers, Child Welfare, Juvenile Justice, etc.) to review and clarify documentation, communication, treatment timeline, and discharge expectations
- Provider development of a clear and consistently implemented discharge protocol so families are clearly informed of termination reasons and available options

Data Tracking/Outcomes

- Standardization of state, local, and county recovery-oriented outcomes measures and databases to eliminate excessive paperwork
    - Implement longitudinal tracking of consumer outcomes
    - Implementation of a feedback mechanism from BHRS so FSP providers and stakeholders are regularly updated with documentation of consumer progress/outcomes and provider performance
- Reducing amount of paperwork to ensure services provided are billable to Medi-Cal

Recommended Action Items:

- BHRS review of currently instituted data collection instruments; standardize where possible to reduce redundancy
- BHRS tracking of longitudinal consumer outcomes on an annual basis, with findings (and provider performance feedback) presented to providers and stakeholders annually

Staff Training

- Creative training options (including teleconferencing/online) to minimize time and resource disruptions (especially for out-of-county FSP programs)
- Additional training opportunities to address areas identified by staff: different therapy modalities
- Establishing a Recovery Philosophy Training for key stake holders (Office of Consumer Affairs)

Recommended Action Items:

- BHRS identification and communication of online/teleconferencing training opportunities to providers
- Office of Consumer Affairs to establish an annual training on “Establishing a Recovery Philosophy” to FSP providers and systems-wide stakeholders

Adult FSPs

Funding/Fiscal Issues

- Cost of living and funding increases to reflect level of services provided/needed, meet the needs of complex consumer populations served, and reduce staff turnover

  Notes/updates:

  - BHRS is offering a 3% COLA increase for FY2014

- Additional funding to support housing options in more desirable and safe areas, especially sober living facilities
  - Identifying housing managers willing to accept FSP consumers with vouchers
  - Offering on-site supported services at housing locations
  - Conducting community outreach to address the stigma associated with mental illness
  - Ensuring those deciding to seek independent housing options (i.e. live with family) in the interim receive equal priority as those opting for housing options offered by the adult FSP programs
  - SMC or Caminar-owned building to provide clients individual rooms with a full-time provider employee staffed on-site (Caminar)
  - Creating apartment complexes to house all Telecare consumers (consumer recommendation)
- Increased funding for additional staff providing transportation (Caminar)
- Increase funding for social outings for consumers (Caminar)
- Identifying a Pay-for-Performance structure that encompasses realistic outcomes markers and does not penalize providers for working with complex, challenging, and aging consumer populations (which often require individualized progress markers)
- Increased funding for additional staff/resources (to increase more consistent staff-consumer communication and follow-up/minimize staff burn-out)

Recommended Action Items:

- Conduct comprehensive housing needs assessment, especially for on-site supportive houses; explore possible partnerships with housing corporations/non-profit organizations to identify affordable, safe, appropriate housing options

- If on-site support services are not required to be offered, provider should develop plan for regular monitoring of consumer progress/decompensation in the community

  Note: Despite research consistently showing that a supportive housing model provides stability to severely mentally ill consumers, improves outcomes, and offsets institutional costs, they remain in short supply, both in San Mateo County and elsewhere. The recent recession, shortage of affordable housing in San Mateo County, escalating housing costs/expenses, capped funding rates, and stigma of housing severely mentally ill individuals have substantially limited options in desirable geographic areas as well as landlords willing to work with FSP providers and consumers. Creative housing solutions, such as Kansas' "health home" model or County-owned housing, may warrant further exploration.

- If BHRS is still considering a Pay-for-Performance model, presentations to providers to explain how this will be implemented and solicit provider input regarding service, performance, and fiscal impact.

Referral Process

- Earlier identification of adult consumers most in need of FSP services
- Increased capacity for serving more adult consumers
- Review current referral/eligibility criteria to ensure better congruency between the intended target population and FSP consumers actually served
    - Establishment of a formal referral process and BHRS-led review committee

Recommended Action Items:

- Establish working committee (BHRS, providers, consumers) to review current FSP referral criteria, specifically for identifying un-served adults/populations and determining if current FSP consumers reflect the intended target population
- Annual BHRS review of FSP referral criteria and tracked data, with input from providers and caregivers

Service Delivery/Linkages

- Need for integrated, in-county, effective medical and substance abuse treatment services (i.e. nurse/nurse practitioner on staff to provide applied medical care; access to inpatient and outpatient substance use treatment services)

    - Implement an integrated substance abuse treatment option/more treatment options for consumers with dependency and/or co-occurring disorders (consumers reported external drug treatment options as being ineffective)

- Comprehensive review of all available FSP services and regular outreach to educate FSP consumers on available services
- Community resources/linkages to assist consumers with maintaining stability, especially while waiting for an available FSP slot, during step-down, or at time of discharge/graduation
- Adequate resources to address needs of complex consumer populations (i.e. health issues, developmental delays, co-occurring disorders, culturally-diverse, older adults, justice-involved, LGBT)
- Increased outreach/support for consumers (i.e. treatment engagement, check-ins, identifying individuals not yet engaged with BHRS)
- Increased focus on services/interventions with community-building, social components for older adults
- Increased outreach/relationship-building with older adults around medication support
- Increased accessible food options easily accessible to clients and within close proximity to their housing (Caminar)

Recommended Action Items:

- BHRS assessment of integrating dependency treatment and medical care options into current FSP programs. Otherwise, is there a way to bridge this service gap directly within the BHRS system? Consumers have also reported that external drug treatment options have been ineffective.
- Provider orientation of all consumers and families to the FSP program and available services prior to program entry/consumer's start date. Regular outreach (annual at minimum) to consumers and families, especially if specific FSP services change, are amended or eliminated.
- Outreach by BHRS case manager to consumers and families awaiting FSP placement or entering step-down/discharge to connect them with available community supports which can assist with maintaining stability
- In light of funding limitations, BHRS review and prioritization of requested "additional resources" with providers. Key areas include: addressing needs of specific consumer populations, outreach/support for consumers and un-served individuals, medication support for older adults, community-building (especially for older adults)

Step-Up/Step-Down

- A more formalized aftercare/step-down system which:
    - utilizes family and community strengths and resources
    - recognizes highly individualized treatment goals
    - ensures consumers can access the "safety net" offered by their intensive team
    - relies on consistent markers to identify consumers ready for a change in level of care

Recommended Action Items:

- BHRS/providers to develop and implement a protocol for connecting consumers and families to directly with community resources (step-down) or new primary providers (step-up)
- BHRS/providers to develop standardized criteria for determining consumer readiness for a change in level of care

Grievances

- Increased consumer and adult FSP provider awareness/outreach regarding grievances/service impact
- Increased consumer voice around medication management and involvement with planning/treatment decisions around medications

Recommended Action Items:

- Provider inclusion of Office of Consumer Affairs grievance pamphlet in orientation materials at program entry
- Annual Office of Consumer Affairs presentation of grievance policies to consumers
- BHRS/provider development of a protocol addressing consumer input in medication decisions (prescription and use)

Staff Training

- Establishing a Recovery Philosophy Training for key stake holders (Office of Consumer Affairs)
- Additional training opportunities to address areas identified by staff: medication, self-defense, motivational interviewing, substance abuse treatment, FSP/ACT (updated trainings) and review of clinical skills
- Creative training options (including teleconferencing/online) to minimize time and resource disruptions

Recommended Action Items:

- BHRS identification and communication of online/teleconferencing training opportunities in areas of interest identified by providers
- Office of Consumer Affairs to establish an annual training on "Establishing a Recovery Philosophy" to FSP providers and systems-wide stakeholders

Data Tracking/Outcomes

- Tracking consumer activities outside of FSP programming:
    - How are consumers spending their days?
    - What are expected positive behaviors?
- Standardization of recovery-oriented outcomes (which also account for individualized treatment plans and consumer goals) and databases
- Better understanding and monitoring of predictors of stabilization/decompensation to improve outcomes for consumers transition to lower levels of care

Recommended Action Items:

- BHRS review of currently instituted data collection instruments; standardize where possible to reduce redundancy
- BHRS review of current outcomes indicators to ensure recovery-oriented outcomes and positive behaviors are also tracked
- BHRS tracking of longitudinal consumer outcomes on an annual basis to identify predictors of stabilization and decompensation, with findings (and provider performance feedback) presented to providers and stakeholders annually

Family Engagement

- Increased education, outreach, and engagement of consumer families to expand understanding and awareness of their family member's mental illness, reduce stigma, and encourage treatment participation
    - Increased family engagement in the therapeutic process (OCFA)
- Consistent consumer/family orientation to FSP services and what the FSP program entails at program entry

Recommended Action Items:

- Provider implementation of regular monthly support groups for consumers' families members to educate them on their family member's mental illness, reduce stigma, and increase opportunities for treatment participation

Communication/Coordination

- Implementation of a formal communication process between BHRS, adult FSP providers, and stakeholders to clarify roles and required information to be shared
- Implementation of a feedback mechanism from BHRS so FSP providers are regularly updated with documentation of consumer progress/outcomes and provider performance based on local, county, and state data collection requirements
- Improved communication/coordination between Caminar and BHRS case managers regarding consumer discharge, medication management, and timely access to services
- Improved communication with external agencies/stakeholders to ensure all parties share the same understanding regarding the FSP/ACT model and staffing structure (i.e. notifying Caminar FSP staff of consumers' medication changes following hospital discharges)
- Development of stronger linkages and communication between the TAY and Adult FSP systems to address service gaps and facilitate transition of TAY consumers to adult FSP services
- Concern about impact of BHRS' frequent staff turnover and change in management on level of support from BHRS
- More consistent communication/administrative follow-up between staff-clients (Telecare)

Recommended Action Items:

- BHRS/Provider joint presentation of the FSP program to other stakeholders to increase awareness of the program's goals and services
- Establish work group of agency stakeholders (BHRS, providers, other stakeholders, etc.) to review and clarify documentation, communication, treatment timeline, and treatment/discharge expectations
- Annual BHRS presentation to providers regarding consumer outcomes and provider performance based data collection requirements
- BHRS development of a streamlined, coordinated service transition protocol for TAY consumers requiring access to adult FSP services, including identification of service gaps
- Establish concrete timelines/expectations for Telecare staff communication and administrative follow-up on behalf of clients, with the recognition that FSP program staff are frequently in the field and serve proportionally more adult consumers

Caregiver Recommendation

- Better outreach to clarify to caregivers/family members the mission of the FSP program and how it's operationalized (by BHRS and the providers)
- Build understanding and transparency with consumers and caregivers about the FSP program services and standards, from time of referral
- Increase proactive involvement of caregivers by FSP providers
- Implementing regular "Check-In" meetings discussing consumers' progress or decline; attended by case managers and family members/caregivers.
- Improve quality of housing options, including review of placing consumers in unlicensed board and care facilities
- Clarify and/or operationalize definition of supported housing services and full service partnership
    - Improve and/or expand services provided through on-site supported housing
- Improve and/or expand additional key services including jobs program, life-skills training, integrated healthcare, and activities that build consumer engagement

- Increase BHRS oversight and accountability of providers and communication with family members and other stakeholders about this process

Recommended Action Items:

Note: Caregiver recommendations that have already been addressed as "recommended action items" and will not be repeated in this section.

- Provider development of an action plan to more proactively engage caregivers and family members, such as regular "check-in" meetings with FSP case managers
- Convene working group (BHRS/providers/family members) to review current oversight/ accountability measures and develop protocols for ensure more consistent and regular communication with caregivers

VI. Conclusion

In conclusion, this report is intended to provide a snapshot-in-time of the four FSP programs currently contracted by BHRS to serve severely mentally ill children, youth, TAY, adults, and older adults in San Mateo County. As such, the presented findings need to be interpreted within that context, for it was not feasible to capture every nuance nor interview every stakeholder affiliated with the FSPs within our allocated timeframe and scope of work.

Overall, the sense from providers, administrators, consumers, and caregivers is that while challenges exist in serving the complex populations targeted by the FSPs, the programs are generally perceived to have a positive impact on the lives of those served. BHRS' award of a COLA for FY 2014 will help address some of the funding concerns. The main challenges, as identified by those interviewed, include but are not limited to:

- reviewing current referral and eligibility criteria to earlier identify those in need of services and ensure the intended population is served
- addressing the service gaps (between child/youth/TAY/adult FSPs, community supports, specific needs of complex populations, auxiliary family supports)
- exploring options for a more integrated model of dependency treatment and medical care, especially for TAY, medically fragile, and older adults
- conducting a needs assessment for specific populations, especially justice-involved youth, consumers with co-occurring and/or psychotic disorders, medically fragile, older adults
- orienting new consumers/families to the FSP program prior to program entry to ensure transparency and begin building the therapeutic bond
- identification of safe, accessible, appropriate, and affordable housing options for TAY and adult consumers
- clarifying whether supportive services are available at housing sites; if not, develop plan for monitoring consumer progress/decompensation in community settings
- instituting a regular feedback mechanism to providers regarding consumer outcomes and provider performance (based on data collection)

- instituting regular communication and follow-up timelines between adult FSP staff, consumers, and their families.

In addition, the findings in this report should also be interpreted with the following study limitations in mind. These include being unable to convene focus groups/interviews with specific sub-populations (older adults, child/youth consumers, out-of-county families/youth, and medically fragile adults), as well systems-wide stakeholders peripherally involved with the FSP program. Recruiting family members and caregivers of adult consumers to participate in this study was especially challenging. Despite working closely with the adult FSP providers and BHRS, we were unable to successfully recruit a culturally diverse and representative sample.

Thus, this report should be considered a starting point for future discussions regarding the long-range impact of FSP services in San Mateo County. Though "recommended action items" were included in the previous section, one of our intents with this evaluation was to provide a neutral forum for administrators, providers, consumers, and family members to share their views about the FSP program. To ensure that the presented findings and recommendations remained genuinely grounded in the voices of the participants, and also because we do not possess all the historical and situational contexts associated with the FSPs, we refrained from drawing generalizing conclusions in this report and decided instead to synthesize the data as it was presented to us. Review of the information presented in this report alongside any available institutional/outcomes data would be a helpful next step towards creating a more comprehensive understanding of FSP services and its impact.

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Appendix B: Pay for Performance Literature Summary

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RAND (2010). Health Care Pay For Performance. *RAND Corporation.* Retrieved from	http://www.rand.org/topics/health-care-pay-for-performance.html	"Pay for performance" rewards doctors, hospitals, and other health care providers for attaining targeted service goals, like meeting health care quality or efficiency standards.
Ryan, A. M., & Damberg, C. L. (2013). What Can the Past of Pay-for Performance Tell Us About the Future of Value-Based Purchasing in Medicare? *Healthcare, 1*: 42-49.	As mandated by the Affordable Care Act, the Medicare program has implemented pay-for-performance (P4P), or Value-Based Purchasing, for inpatient care and for Medicare Advantage plans, and plans to implement a program for physicians in 2015. In this paper, we review evidence on the effectiveness of P4P and identify design criteria deemed to be best practice in P4P. We then assess the extent to which Medicare's existing and planned Value-Based Purchasing programs align with these best practices. Of the **seven identified best practices** in P4P program design, the Hospital Value-Based Purchasing program is strongly aligned with two of the best practices, moderately aligned with three, weakly aligned with one, and has unclear alignment with one best practice. The Physician Value-Based Purchasing Modifier is strongly aligned with two of the best practices, moderately aligned with one, weakly aligned with three, and has unclear alignment with one of the best practices. The Medicare Advantage Quality Bonus Program is strongly aligned with four of the best practices, moderately aligned with two, and weakly aligned with one of the best practices. We identify enduring gaps in P4P literature as it relates to Medicare's plans for Value-Based Purchasing and discuss important issues in the future of these implementations in Medicare. (41): incentive payments in HQID accrued disproportionately to hospitals that cared for the least disadvantaged patients when payouts were based on high quality attainment alone, but that the change in incentives to reward improvement led to greater	P4P: payers should explicitly link provider reimbursement with performance on quality measures P4P implemented nationally by Medicare (inpatient care) (3) and Medicare Advantage plans and starting 2015 will be implemented for physicians as part of Physician Value-Based Payment Modifier.(4) International P4P efforts (5)… unknown whether P4P has potential to be cost-effective in improving quality (6) & value of care (7). By 2004, 37 separate P4P programs in US, almost all by private payers in OP setting (8), and by 2006, more than ½ of the HMOs used P4P (9), and most state Medicaid programs using some form (10). Van Herck et al. (19) found that P4P programs tended to shower greater improvement on process measures compared to outcomes, that the positive effects of incentives were generally greater for initially low performers compared to higher performers, that it was unclear how the magnitude of incentives impacted the effectiveness of P4P programs 7 criteria reflecting “best practice”: Choose measures that have room for improvement Promote awareness of the program Coordinate program design (performance measures & payout criteria) across payers(public & private) Incentivize both quality attainment and quality improvement

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	payments accruing to hospitals that cared for more disadvantaged patients. [IF BASED ON HEALTH, HIGHER SES GET BETTER PAYOUTS, IF IMPROVEMENT OF HEALTH, LOWER SES BETTER PAYOUT] Choice of performance measures, ARGUABLY THE MOST CRUCIAL ELEMENT OF p4p>> FOCUS ON IMPACT ANALYSIS AND WHETHER DIFFERENT MEASURE DOMAINS, AND PERHAPS INDIVIDUAL MEASURES, MAY BE MORE RESPONSIVE TO THE PROGRAM.	Adjust programs dynamically to recalibrate measures and payment thresholds Pay incentives that are sufficiently large to motivate a behavioral response Provide technical assistance to participating providers. Design of the Medicare Advantage Program aligns most strongly with best-practice criteria, compared to Hospital Value-Base d Purchasing & Physician Value-Based Purchasing Modifier
Friedberg, M. W., & Damberg, C. L. (2012). A Five-Point Checklist to Help Performance Reports Incentivize Improvement and Effectively Guide Patients. *Health Affairs, 31(3)*: 612-618.	Public reports of provider performance on measures of the quality, costs, and outcomes of health care can spur improvement and help patients find the best providers. However, the likelihood that these benefits will materialize depends on the methods underlying each performance report. This paper presents a five-point methodological checklist to guide those who want to improve their performance reporting methods. The central goal is to help report makers minimize the frequency and severity of provider performance misclassification and avoid adverse unintended consequences of reporting. We believe that if those who produce the reports publicly explain how they address each checklist item, this increased transparency will encourage more rigorous methods and improve the chances that reports will lead to better, more efficient care	Measure & address systematic performance misclassification to account for differences in patient mix Measure and address random performance misclassification with assistance from statistician Use composite scores appropriately Conduct sensitivity analyses to understand the implications of methodological choices Measure the extent to which a report fulfills its purpose.
Friedberg, M. W., Damberg, C. L., McGlynn, E. A., & Adams, J. L. (2011). Methodological Considerations in Generating Provider Performance Scores for Use in Public Reporting: A Guide for Community Quality Collaboratives. *Agency for Health Research and Quality, No. 11-0093*: 107. [White paper]. Retrieved from http://www.ahrq.gov/legacy/qual/value/perfscoresmethods/perfscoresmethods.pdf	Public reports of health care providers' performance on measures of quality, cost and resource use, patient experience, and health outcomes have become increasingly common. These reports are often intended to help patients choose providers and may encourage providers to improve their performance. At the July 2009 National Meeting of Chartered Value Exchanges (CVEs) hosted by AHRQ, CVE stakeholders identified a dilemma: Two organizations could, by making different methodological decisions, use the exact same data to produce divergent public performance reports that send conflicting messages to patients and providers. In response to this dilemma, AHRQ commissioned RAND Corporation to develop a white paper to identify methodological decision points that precede publication of a performance report and to delineate the options for each. Our overall aim in developing this white paper is to produce a resource that is useful to CVEs and other community	This report is intended to help CVEs understand different types of measurement error, how sources of error may enter into the construction of provider performance scores, and how to mitigate or minimize the risk of misclassifying a provider. Again, the methods decisions generally involve important tradeoffs. There are rarely clear "right answers," and value judgments underlie most decisions. Chartered Value Exchanges (CVEs) are multistakeholder community quality collaboratives: support agenda of quality transparency via public reporting of physician and hospital performance. Key Tasks: Negotiating Consensus on Goals and “Value Judgments” of Performance Reporting Selecting Measure that will be used to evaluate Provider

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	collaboratives as they consider the range of available methodological options for performance reporting. This white paper reviews a number of methodological decision points that CVEs and other community collaboratives may encounter when generating provider performance scores. The paper also discusses the advantages and disadvantages associated with various choices for each of these decision points.	Performance Identifying Data Sources and aggregating performance data Checking data quality and completeness Computing provider-level performance scores Creating performance reports
Schneider, E. C., Hussey, P. S., & Schnyer, C. (2011). Payment Reform: Analysis of Models and Performance Measurement Implications. *RAND Technical Report. Retrieved from* http://www.rand.org/pubs/technical_reports/TR841.html	In the United States, policymakers are increasingly turning to performance measurement as a cornerstone of health care payment reform. With the support of the National Quality Forum (NQF), the RAND Corporation conducted this evaluation, cataloging nearly 100 implemented and proposed payment reform programs, classifying each of these programs into one of 11 payment reform models (PRMs), and identifying the performance measurement needs associated with each model. A synthesis of the results suggests near-term priorities for performance measure development and identifies pertinent challenges related to the use of performance measures as a basis for payment reform. Our intent is that this report will be useful to a broad range of stakeholders with an interest in the appropriate use of standardized performance measures to improve the quality and efficiency of health care delivery for all of the people of the United States Patient Protection and Affordable Care Act (PPACA) of 2010: designed to achieve two interrelated goals: quality improvement and cost containment (6). **Payment Reform Models (PRMs**) include explicit measures of quality & tie payment to performance on those measures so that quality improvement will be driven by financial incentives to providers for the use of clinically appropriate services, efforts to make care more patient-centered through coordination and integration of a patient's care among providers, and incentives to invest in patient safety.	Balance COST CONTAINMENT GOALS (reverse fee-for-service incentives to provide more services, provide incentives for efficiency, manage financial risk, align payment incentives to support quality coals) and QUALITY GOALS (increase or maintain appropriate and necessary care, decrease inappropriate care, make care more responsive to patients, promote safer care) 11 PRMs: Global payment Accountable Care Organizations (ACO) shared savings program Medical home Bundled payment Hospital-physician gainsharing Payment for coordination Hospital P4P – receive differential payments for meeting or missing performance benchmarks Payment adjustment for readmissions Payment adjustments for hospital-acquired conditions Physician P4P Payment for shared decisionmaking → blended models rely on blended measurement strategies
Stecher, B. M., Camm, F., Damberg, C. L., Hamilton, L. S., Mullen, K. J., Nelson, C., Sorensen, P., Wachs, M., Yoh, A., Zellman, G. L., & Leuschner, K. J. (2010). Are Performance-Based Accountability Systems Effective? Evidence from	During the past two decades, performance-based accountability systems (PBASs), which link financial or other incentives to measured performance as a means of improving services, have gained popularity among policymakers. For example, the No Child Left Behind (NCLB) Act of 2001 (Pub. L. 107-110) combined explicit expectations for student performance with well-aligned tests to measure achievement,	The study suggests that PBASs represent a promising policy option for improving the quality of service delivery in many contexts. Creating an effective and **successful design requires careful attention to the selection of incentives, performance measures, and implementation issues, as well as rigorous evaluation to monitor the program's effectiveness & adjust the system, as appropriate, and given the context in which it is to**

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Five Sectors. *RAND: Research Briefs, RB:9549.* Retrieved from http://www.rand.org/pubs/research_briefs/RB9549.html	and it included strong consequences for schools that did not meet performance targets. In the transportation sector, cost plus time (A+B) contracting has become a popular means of streamlining and speeding up highway construction projects, while, in health care, there are more than 40 hospitals and more than 100 physician/ medical group performance-based accountability programs (popularly dubbed P4P) in the United States. Although PBASs can vary widely across sectors, they share three main components: **goals** (i.e., one or more long-term outcomes to be achieved), **incentives** (i.e., rewards or sanctions to motivate changes in behavior to improve performance), and **measures** (formal mechanisms for monitoring service delivery or goal attainment). But, while the use of PBASs has spread in the public sector, little is known about whether such programs are having the desired effect or how to design them to be as effective as possible. To address this gap, a RAND study examined several examples of PBASs, large and small, from a range of public service areas. The study focused on nine PBASs, drawn from five sectors: child care, education, health care, public health emergency preparedness (PHEP), and transportation. Under the right circumstances, a PBAS can improve the effectiveness & efficiency of services for the public; however, existing evidence for the PBAS effectiveness is rare. PBASs are often created without consensus on key design issues. The selection of incentives & performance measures have proved challenging. To be measured, **performance must be defined precisely**	**operate** Transportation: A+B highway construction ideal case b/c they get bonus for completing projects in an accelerated time frame – construction firms have control over relevant inputs & processes involved, & know the health & safety standards work will be judged. Education – NCLB testing with public reporting and other incentives -> change in teacher behavior that improved measured outputs, but less attention to long-term outcomes/goals. "teaching to the test" Healthcare: small financial incentives – modest effects on quality of care delivered. Elements that contribute to effectiveness: A goal that is widely shared among all stakeholders Unambiguous and easy to observe measures (focus on performance measures that matter and that people can influence: inputs, outputs &/or relative improvement) Incentives that apply to individual or orgs with control over relevant inputs and processes Meaningful incentives (cash, promotions, status, recognition, increased autonomy, and access to training or other investment resources) Few competing interests or requirements Adequate resources to design, implement, modify, and operate the PBAS Harder to measure long-term outcomes and even harder to allocate the funds to the individual or organization being incentivized.
Mehrotra, A., Sorbero, M. E., & Damberg, C. L. (2010). Using the Lessons of Behavioral Economics to Design More Effective Pay-for Performance Programs. *The American Journal of Managed Care, 16*(7): 497-503.	OBJECTIVES: To describe improvements in the design of pay-for-performance (P4P) programs that reflect the psychology of how people respond to incentives. STUDY DESIGN: Investigation of the **behavioral economics** literature. METHODS: We describe 7 ways to improve P4P program design in terms of frequency and types of incentive payments. After discussing why P4P incentives can have unintended adverse consequences, we outline potential ways to mitigate these. RESULTS: Although P4P incentives are increasingly popular, the healthcare literature shows that these have had minimal effect. Design improvements in P4P programs can enhance their effectiveness. CONCLUSION: Lessons from	In US P4P incentives are used by half of all commercial HMOs and found in contracts with ambulatory physicians, hospitals and nursing homes (1-5). Much of the published literatures (2, 3, 7) on the effect of P4P conclude these incentives have resulted in small or no improvements. Some say the premise underlying P4P is flawed (8), while others say magnitude of the incentives has been insufficient (9). Or maybe the design does not reflect the psychology of how ppl respond to incentives. Most evaluations have measured change in performance based on quality metrics (2, 3). – need to consider more proximal goal, & to improve quality, p4p programs have to change the behavior

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	behavioral economics may greatly enhance the design and effectiveness of P4P programs in healthcare, but future work is needed to demonstrate this empirically. For a given amount of money, we suggest that the greatest behavioral response will occur with more frequent and smaller payments. We believe that establishing several stepped absolute thresholds and decoupling incentive payments from usual reimbursement may be more effective than current P4P designs. Lotteries and nonmonetary incentives are presented as other mechanisms to increase the behavioral response of physicians. Potential ways to mitigate unintended consequences: Teaching to the test – program addresses and extensive array of output, a broad dashboard of performance measures Intrinsic vs. extrinsic motivation	of physicians, to increase the time and resources they allocate to quality improvement. 7 features that could improve p4p programs: A series of incentives rather than 1 lump sum (continued positive reinforcement) A series of tiered absolute thresholds better than 1 (ie. More incentive for higher % screened vs. this much for >75%) Reducing lag time btw. care and receipt of incentives increases behavioral response Withholds have more of an effect than bonuses, but one needs to be cognizant of the negative psychological response (previous research found individuals are more sensitive to incentives when they perceive that they are losing something rather than gaining 21.) Reducing complexity of an incentive plan increases the behavioral response P4P and incentive payments should be decoupled from usual reimbursement. "in kind" rewards may be a stronger driver of change than cash reward of same amount
Rosenthal, M. B., Frank, R. G., Li, Z., & Epstein, A. M. (2005). Early Experience with Pay-for-Performance From Concept to Practice. *Journal of the American Medical Association, 294*(14): 1788-1793. doi: 10.1001/jama.294.14.1788.	**Context** The adoption of pay-for-performance mechanisms for quality improvement is growing rapidly. Although there is intense interest in and optimism about pay-for-performance programs, there is little published research on pay-for-performance in health care. **Objective** To evaluate the impact of a prototypical physician P4P program on quality of care. **Design, Setting, and Participants** We evaluated a natural experiment with pay-for-performance using administrative reports of physician group quality from a large health plan for an intervention group (California physician groups) and a contemporaneous comparison group (Pacific Northwest physician groups). Quality improvement reports were included from October 2001 through April 2004 issued to approximately 300 large physician organizations. **Main Outcome Measures** Three process measures of clinical quality: cervical cancer screening, mammography, and hemoglobin A_{1c} testing. **Results** Improvements in clinical quality scores were as follows: for cervical cancer screening, 5.3% for California vs. 1.7% for Pacific Northwest; for mammography, 1.9% vs. 0.2%; and for hemoglobin A_{1c}, 2.1% vs. 2.1%. Compared with physician groups in the Pacific	One area that is particularly controversial is whether to reward providers (i.e., hospitals, medical groups, and/or physicians depending on the program) according to attainment of a predetermined level of performance or according to improvement. Paying according to the level of performance is common to the majority of pay-for-performance programs.1 Critics, however, have worried that physicians or hospitals that have historically performed above the targeted level will have no incentives to improve because they can receive the bonus simply for maintaining the status quo.1 Moreover, providers whose performance is initially much below the target may have weak incentives to attempt to improve their performance when the target seems infeasible to reach. On the other hand, paying for improvement may fail to reward the best providers for whom improvement is likely to be substantially more difficult because of ceiling effects. We evaluated a natural experiment in pay-for-performance conducted within one of the nation's largest health plans, PacifiCare Health Systems. In 2003, PacifiCare began paying its

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	Northwest, the California network demonstrated greater quality improvement after the pay-for-performance intervention only in cervical cancer screening (a 3.6% difference in improvement [*P* = .02]). In total, the plan awarded $3.4 million (27% of the amount set aside) in bonus payments between July 2003 and April 2004, the first year of the program. For all 3 measures, physician groups with baseline performance at or above the performance threshold for receipt of a bonus improved the least but garnered the largest share of the bonus payments. **Conclusion** Paying clinicians to reach a common, fixed performance target may produce little gain in quality for the money spent and will largely reward those with higher performance at baseline. The number of health plans and purchasers in the United States that have adopted pay-for-performance mechanisms for quality improvement is growing rapidly.[1-3] However, most of these programs are in the early stages of trial, evaluation, and adjustment.	California medical groups bonuses according to meeting or exceeding 10 clinical and service quality targets. We examined the performance of California medical groups, which were subject to pay-for-performance, and a contemporaneous comparison group in the Pacific Northwest (Oregon and Washington) over time to address 3 specific questions: What changes in clinical quality of care were associated with the adoption of pay-for-performance? How much did the plan pay out in performance bonuses? How were the rewards distributed across the network relative to quality improvement? Although there is intense interest in and optimism about pay-for-performance programs among many policy makers and payers, there is little published research on pay-for-performance in health care.[4-6] In fact, there are only a few studies demonstrating that pay-for-performance leads to improved quality of care.[7-10]
"Health Policy Brief: Pay-for-Performance," Health Affairs, October 11, 2012	"Pay-for-performance" is an umbrella term for initiatives aimed at improving the quality, efficiency, and overall value of health care. These arrangements provide financial incentives to hospitals, physicians, and other health care providers to carry out such improvements and achieve optimal outcomes for patients. Pay-for-performance has become popular among policy makers and private and public payers, including Medicare and Medicaid. The Affordable Care Act expands the use of P4P approaches in Medicare in particular and encourages experimentation to identify designs and programs that are most effective. This policy brief reviews the background and current state of public and private pay-for-performance initiatives. In theory, paying providers for achieving better outcomes for patients should improve those outcomes, but in actuality, studies of these programs have yielded mixed results. This brief also discusses proposals for making these programs more effective in the future. - Affordable Care Act – encourages improvement in quality of care, some P4P – Accountable Care organizations (group of providers that agree to coordinate care and be accountable for quality and costs of services provided), Hospital Value-based purchasing (rewarded on performance on set of quality measures and how much improve from baseline), Physician quality reporting (incentive to report data to CMS, and if not done by 2015, reduced payments from Medicare)	Fee-for-service leads to increased costs by rewarding providers for the volume and complexity of service they provide. 1990s, managed care arrangements to reduce excessive or unnecessary care (ex: paying providers by capitation, or a lump sum per patient to cover a given set of services) – concerns for compromised quality and constraints on patients having access to providers of their choice. - 2000s (IOM reports) Deficiency in qualities of US health care led to P4P as way for payers to focus on quality, with expectation that it will also reduce costs. - P4P: bonus to health care providers if meet or exceed agreed-upon measures OR improvement over time. Can also impose $ penalties for those who fail to reach goals or cost savings. Limited evidence of effectiveness…. Quality measures of 4 kinds: Process: performance of activities that contribute to positive health Outcome: effects of care on patients (controversial b/c outcomes are often affected by other factors) Patient experience: patient satisfaction Structure: facilities, personnel and equipment (HIT) 40+ private-sector P4P programs exist, including in CA, managed

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	Medicare Physician Group Practice Demonstration – 10 large physician group practices received bonuses if they achieved lower cost growth than local controls & met quality targets → improved quality but reduction in growth of spending for most, but cost reductions greatest for 15% who were dual eligible (Medicare/caid) with complex, chronic conditions.	by Integrated Health Association, 2001 & MA's Alternative Quality Contract 2009 (budget including P4P bonuses rather than pay for separate services – Harvard in 1st year: reduced spending and improved quality); CMS uses value-based purchasing program. Concerned for poorer & disadvantaged populations – might exacerbate racial/ethnic disparities b/c providers might avoid at risk patients. (lower-income areas in CA received lower P4P scores, and a group that served elderly black & Medicaid patients)
Unutzer, J., Chan, Y., Hafer, E., Knaster, J., Shields, A., Powers, D., & Veith, R. C. (2012). Quality Improvement with Pay-for-Performance Incentives in Integrated Behavioral Health Care. *American Journal of Public Health, e1-e5.* doi:10.2105/AJPH.2011.300555	Objectives. We evaluated a quality improvement program with a pay-for-performance (P4P) incentive in a population-focused, integrated care program for safety-net patients in 29 community health clinics. Methods. We used a quasi-experimental design with 1673 depressed adults before and 6304 adults after the implementation of the P4P program. Survival analyses examined the time to improvement in depression before and after implementation of the P4P program, with adjustments for patient characteristics and clustering by health care organization. Results. Program participants had high levels of depression, other psychiatric and substance abuse problems, and social adversity. After implementation of the P4P incentive program, participants were more likely to experience timely follow-up, and the time to depression improvement was significantly reduced. The hazard ratio for achieving treatment response was 1.73 (95% confidence interval = 1.39, 2.14) after the P4P program implementation compared with preprogram implementation. Conclusions. Although this quasi-experiment cannot prove that the P4P initiative directly caused improved patient outcomes, **our analyses strongly suggest that when key quality indicators are tracked and a substantial portion of payment is tied to such quality indicators, the effectiveness of care for safety-net populations can be substantially improved**. There is very limited experience with P4P incentives in behavioral health care,13 and we know of no published studies of such incentives in the context of population-focused, primary care–based collaborative care programs.	Behavioral health problems are among the most common and disabling health conditions worldwide, and often co-occur with chronic medical conditions.1 When these problems are not effectively treated, they can impair self-care and adherence to medical and mental health treatments and are associated with increased mortality and increased overall health care costs.2 Currently, the most robust research evidence for improving mental health outcomes in primary care comes from studies of collaborative [integrated] care programs for common mental disorders, such as depression.5, where PCPs are part of a collaborative care team that may include nurses, clinical social workers, psychologists, and psychiatrists who can support medication management prescribed by PCPs and provide evidence-based mental health treatments in 1* care. Washington State Mental Health Integration Program (MHIP) was initiated in 29 community health clinics in the 2 most populous counties in Washington State representing the metropolitan Seattle–Tacoma area in late 2007. In 2010, the program was expanded to over 100 community health clinics and 30 community mental health centers statewide. 2009 – Implemented P4P incentive program: contingent on meeting several quality indicators: timely follow-up, psychiatric consultation, tracking of psychotropic meds. Compared 2008-2009 to 2009-2010 Participating clinics and providers received regular feedback on their quality indicators through the web-based clinical tracking system and training and technical assistance to help improvement on these indicators through an all-day in-person training workshop for care coordinators and monthly webinars provided by the University of Washington AIMS Center

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		Require substantial investments in and commitment to quality infrastructure, in particular the ability to track systematically the quality and outcomes of care provided.13 At a program level, the timely availability of data on quality and outcomes of care enables the implementation of meaningful and effective P4P incentive programs.
Druss, B. G., & Mauer, B. J. (2010). Health Care Reform and Care at the Behavioral Health – Primary Care Interface. *Psychiatric Services, 61*(11): 1087-1092. doi: 10.1176/appi.ps.61.11.1087.	The historic passage of the Patient Protection and **Affordable Care Act in March 2010 offers the potential to address long-standing deficits in quality and integration of services at the interface between behavioral health and primary care**. Many of the efforts to reform the care delivery system will come in the form of demonstration projects, which, if successful, will become models for the broader health system. This article reviews two of the programs that might have a particular impact on care on the two sides of that interface: Medicaid and Medicare patient-centered medical home demonstration projects and expansion of a Substance Abuse and Mental Health Services Administration program that co-locates primary care services in community mental health settings. The authors provide an overview of key supporting factors, including **new financing mechanisms, quality assessment metrics, information technology infrastructure, and technical support that will be important for ensuring that initiatives achieve their potential for improving care.**	Multiple randomized controlled trials have found that team-based interventions improve quality of care for and outcomes of common mental health and substance use disorders in primary care (1,2) and the delivery of primary medical care in specialty behavioral settings (3) Patient-Centered Primary Care Collaborative – a patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety (http://www.pcpcc.org/about/medical-home) general medical and mental health conditions but also for the key processes associated with clinical integration—effective communication (transfer of information across providers), coordination (shared understanding of goals and roles), and continuity of care (uninterrupted delivery of services across levels of care) (33) – no validated measures exist yet (34)
Bremer, R. W., Scholle, S. H., Keyser, D., Knox Houtsinger, J. V., & Pincus, H. A. (2008). Pay for Performance in Behavioral Health. *Psychiatric Services, 59*(12): 1419-1429. doi: 10.1176/appo.ps.59.12.1419.	*Objective:* Pay for performance is a rapidly expanding strategy intended to improve the quality and value of health care in the United States. The application of this strategy for behavioral health has not yet been systematically examined. **This article presents the results of a targeted national effort to identify [as comprehensible as possible] pay-for-performance programs in behavioral health and describe their core components**. *Methods:* The authors describe pay-for-performance programs currently being implemented in the mental health and substance abuse treatment fields. On the basis of responses from 109 screening informants who were identified as being likely to have knowledge of existing pay-for-performance programs, the authors identified 24 specific pay-for-performance programs and interviewed 28 individuals associated with these programs. The semistructured interview protocol consisted of 36 questions assessing the core program components. *Results:* Thirteen programs targeted behavioral health specialists or substance abuse treatment providers.	The Rosenthal and colleagues' review (10) makes no mention of pay-for-performance programs in behavioral health, and the Leapfrog Group's compendium lists only two examples among 91 records (11). This is despite the toll that mental and substance use disorders take on the American population. For each program, we collected information on seven core components: types of sponsors (for example, private or public), targeted disorders and treatments, provider eligibility, measures and data used, incentive and reward structure, obstacles to program implementation, and strategies for success. The program descriptions were organized into two tables: core components of pay-for-performance programs targeting behavioral health specialists and substance abuse treatment providers (Table 1) and core components of pay-for-performance programs targeting primary care providers and multispecialty groups (Table 2)

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	Eleven programs targeted primary care providers. Depression was the most common of the behavioral health conditions targeted**. Financial incentives offered in behavioral health pay-for-performance programs were often small. Many programs struggled to obtain accurate and valid data on quality and outcomes of care, and the public reporting of results was not widespread. On the basis of this analysis, the authors recommend a number of actions to improve the implementation and impact of behavioral health pay-for-performance programs on quality of care**. *Conclusions:* The authors reaffirm the finding identified by the Leapfrog Group's "Rewarding Results" initiative—that is, pay for performance is not a magic bullet that alone will improve quality and control costs. Although pay-for-performance programs hold promise for advancing the overall performance of the U.S. health care system, more intensive efforts aimed at strengthening the quality infrastructure in behavioral health will be required.	**The most common obstacle to program implementation cited was the lack of valid and practical quality measures in behavioral health:** 7 of the 24 measured depression, but mainly b/c sponsors & participating providers were able to agree on the standardized measures…. Impossible to address other disorders in their programs. **Tying incentives to specific behavioral health outcomes also difficult** – 2 programs' incentives based on the use of tool, not outcomes achieved. One based on improvements in outcomes (had to fax results… authors feel might be too burdensome). **Many respondents said providers were often unwilling or unable to collect additional measures.** **Strategies**: buy-in from providers to collect measureable data. (One health plan coalition had higher degree of success b/c able to agree on one common set of performance measures & then each health plan negotiated specific financial incentive for each provider group – satisfied b/c require to meet just one set of performance criteria) Larger provider groups and larger incentives were more successful. Key factors that were identified in the successful implementation of behavioral health pay-for-performance programs by leaders of these programs include the engagement of providers in the design of measures and incentives, the use of incentives that are meaningful (financially), and outreach efforts to increase providers' awareness and knowledge. - *Adopt a longitudinal perspective on quality measurement*: focus initially on offering incentives to providers for developing structures of care that support quality improvement, followed by incentives for using these structures to enhance the quality improvement process and, ultimately, for measuring the outcomes of these processes. - *Develop outcome measures that are valid, practical to implement, and have buy-in from multiple stakeholders* - *Link accountability to responsibility* - *Enhance the focus on behavioral health so that it is large enough to have an impact on provider behavior*: incentives for behavioral health outcomes need to be large enough to matter to the provider.

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		- *Experiment with new models for improving performance and rewarding quality* - *Do not assume that one size fits all:* Targeted approaches
Jarvis, D. (2009). Healthcare Payment Reform and the Behavioral Health Safety Net: What's on the Horizon for the Community Behavioral Health System. *National Council for Community Behavioral Healthcare.* Retrieved from http://www.djconsult.net/resources-1/case-rate-info	The American healthcare system is broken. It is too expensive, leaves tens of millions of Americans exposed to poor health outcomes and economic ruin, and has driven many healthcare providers from the field in search of less stressful work. At current rates, this troubled system will grow from 17 percent of the U.S. economy in 2009 to 21 percent by 2020, a doubling of costs from $2.5 to $5.2 trillion per year. Experts from across the political and economic spectrum agree that this trend will seriously damage the competitiveness of American businesses and prevent the federal and state governments from meeting other critical obligations. The sheer magnitude of these challenges appears to be forging a coalition of consumers, public policy experts, healthcare providers, hospitals, and insurance companies that is getting closer each day to agreement on how to address the **three key components of healthcare reform – universal coverage, payment system reform, and delivery system redesign**. While it is not yet clear how universal coverage will unfold, there is a clear consensus about the methods for improving quality and containing costs – healthcare reform must include simultaneous reengineering of the payment and delivery systems. Healthcare reform efforts are already underway in the public and private sectors. Testing of new methods for organizing and funding care in the areas of *chronic medical conditions and potentially avoidable complications* provides a window into how general healthcare reform will occur. Medical homes are being piloted to manage the health status of persons with chronic medical conditions, while bundled payment pilots are testing risk and reward arrangements for acute care episodes. Together, these types of efforts are leading to three fundamental system improvements – healthcare will become better coordinated; prevention, early intervention and disease management services will grow with a corresponding decline in secondary and tertiary care; and errors and overuse will be disincentivized by replacing fee for service payments with risk and reward financial arrangements. This paper has been written to explore these issues in order to bridge the current gap between efforts within the behavioral health community and those of general healthcare reformers.	To-date, there has been very little healthcare reform design work focused on the needs of Americans with serious mental health and substance use disorders and the challenges faced by community behavioral healthcare organizations. A set of funding and structural problems have resulted in a public behavioral healthcare system that is lacking in essential payment and regulatory supports necessary for success – in many cases to a much greater degree than the general healthcare system. These topics, though seemingly mundane, take on real-world demographic characteristics but who does not have a serious mental disorder. This stunning disparity clearly indicates that, whatever the situation within the general healthcare system, even more extreme challenges confront the behavioral health safety net system and the people it is intended to serve.. - 2001 Institute of Medicine (IOM) report, *Crossing the Quality Chasm: A New Health System for the 21st Century* described the components of an effective healthcare system, including the need to have a supportive payment and regulatory environment that supports provider organizations in developing & maintaining high performing patient-centered teams that can assist individuals in achieving optimal health. - Community Behavioral Healthcare Organizations face many barriers: funding shortages, fragmentation (from federal policy changes - 50 states/50 sets of rules), fee for service, fixed fee payments, Medicaid-only systems (two-class system), SMI/SED system designs (criteria that restrict services to adults with Serious Mental Illness and youth with Serious Emotional Disturbances) Challenges of such reform: workforce & capacity issues, CBHO demand, and serving the indigent, uninsured & underserved. 4 initiatives to address challenges faced by CBHOs: Medical Homes re-envisioned as person-centered healthcare homes Federal and State Payment Methods – address disincentives that hinder right care at right time & place. Federally Qualified Behavioral Healthcare Centers with benefits and responsibilities to shore up safety net delivery system Dedicated Federal Funding Streams – support workforce development & FQBHCs to serve uninsured and underinsured

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	The paper then examines four behavioral health payment reform and delivery design changes that can help bring the behavioral healthcare community into alignment with general healthcare reform. **Quadrant IV** **The Population:** Moderate to high behavioral health and moderate to high physical health complexity/risk. **The Model:** Person Centered Healthcare Home: primary care capacity in a behavioral health setting, including medical nurse practitioner/primary care physician, nurse care manager, wellness programming, screening/tracking for health status concerns, and stepped care to a full-scope healthcare home. Access to the array of specialty behavioral health.	persons with SMH/SUD Federal & State Payment Method Changes: Case Rate layer of funding for prevent, edu and care management services that aren't FFS. FQHC-like prospective payment system: Current Procedural Terminology (CPT) & Healthcare Common Procedure Coding System (HCPCS) codes… claims for certain category – predetermined price. So regardless of services provided, pay established fee. Bonus-type gainsharing – providers who contribute to reduction in total healthcare expenditures for given population receive share of savings as bonus.
Dale Jarvis & Associates (2012). "Public Behavioral Healthcare Payment Reform Principles". Retrieved from http://www.djconsult.net/resources-1/case-rate-info	**9. Build in Pay for Performance:** Add one or more pay for performance layers that counter disincentives that have been built into the system and incentivize desired performance; base the design on the identified performance measures. **10. Bend the Cost Curve and Share the Savings:** Work to ensure that total healthcare expenditure growth rates are reduced, and providers, payers, private and public purchasers and patients all share in the savings arising from payment reform. 11. **Eliminate Non-Value-Added Administrative Requirements:** Structure the payment systems in such a way as to minimize provider, payer and patient administrative costs that do not add value.	**12. Build In Transparency at Every Level:** Build transparency into the payment system so that patients, providers and purchasers understand how providers are paid, and what incentives the payment system creates for providers. 13. **Create Realistic Implementation Plans:** Structure the implementation so that it's phased over time with clear and attainable deadlines; planned evaluation for intended and unintended consequences; and mid-course corrections.

Appendix C: Evaluation Materials

Includes: Interview guides for all major interview categories, housing site visit protocol, staff and consumer/ caregiver demographics surveys and consumer/caregiver consent forms.

- General Adult Administrator Interview Guide
- Child Welfare Department Interview Guide
- Probation Department Interview Guide
- General Child/Youth/TAY Administrator Interview Guide
- Office of Consumer and Family Affairs Interview Guide
- Child/Youth Staff Focus Group Guide
- TAY Staff Focus Group Guide
- Adult Staff Focus Group Guide
- TAY Consumer Focus Group Guide
- Adult Consumer Focus Group Guide
- Housing Site Visit/Interview Guide
- Staff Focus Group Demographics Survey
- Caregiver Focus Group Demographics Survey
- Consumer/ Caregiver Evaluation Participation Consent Form

Administrator:	Date:
DYJA Interviewer:	**In-Person Interview**

General Administrator Information

1. **Name**
2. **Current/Recent Position Held**
   a. Please describe duties /responsibilities.
3. **Experience**
   a. How long have you been working at BHRS? In what capacity/capacities?*
   b. How long have you been working for BHRS in your current capacity?
   c. How long have you been working in the behavioral health field? (Describe experience/positions)
   d. Academic degrees/accreditations
4. **Demographics**
   a. Gender
   b. Race/Ethnicity

Notes:

Interview Guide – San Mateo Full Service Partnership County *Administrators*

General Perceptions About the FSP/Wraparound Model

1. **Tell me about the mission of San Mateo County BHRS Full Service Partnership (FSP) for children/youth/Transitional Aged Youth (TAY).**
   a. Ask for a description of the program and its implementation in San Mateo County.
   b. What was the San Mateo County (SMC) vision for implementing FSP child/youth/TAY services? *(i.e. why was a FSP model selected as opposed to other treatment models)*
   c. What is your understanding of the child/youth/TAY FSP program's goals and objectives?
   d. Do you think BHRS staff and FSP stakeholders share your understanding?

2. **Tell me what you think about FSPs and/or Wraparound as a treatment modality for child/youth/TAY populations.**
   a. How do you think your colleagues feel about FSP/Wraparound as a treatment model?
   b. Have you received formal training in the FSP/Wraparound model?
      i. *If no,* how did you become familiar with the model?
      ii. *If yes,* please describe the FSP trainings you received. Was the training part of a county-level adoption of the FSP/Wraparound model?
      iii. Were the trainings helpful?
      iv. How could the trainings be improved?
   c. Are regular trainings still offered to FSP providers/staff, now that CIMH has discontinued state-funded trainings?
3. **What have been challenges of incorporating the FSP/WRAPAROUND model in San Mateo County for child/youth/TAY clients?**
4. **What have been positives of incorporating the FSP and/or WRAPAROUND model in San Mateo County for child/youth/TAY clients?**
5. **How do you think the FSP/WRAPAROUND model has been adapted to meet the needs of San Mateo County child/youth/TAY clients?**
6. **Is there an alternative treatment model that you feel would work better in San Mateo County for child/youth/TAY clients?**

7. **Is there pressure to follow FSP and/or WRAPAROUND model?**
   a. If so, where does the pressure come from?

8. **How has the adoption of FSP/WRAPAROUND changed the way BHRS manages services for child/youth/TAY mental health clients in San Mateo County?**
   a. What are the obstacles (including financial)?
   b. How would an Incentive-Based or Pay-for-Performance contract affect BHRS, outcomes, stakeholders, clients, and FSP services offered?

Organizational Climate

1. **Tell me about <u>BHRS</u> staffing for the youth/child/TAY FSP programs (Fred Finch/Edgewood).**
   a. What are core BHRS staff positions?
   b. *Probe: What areas require more staffing?*
2. **Tell me about the resources/support BHRS provides to the FSP program.**
   a What internal and systemic resources does BHRS offer to support the FSP child/youth/TAY program?
   b. How does the BHRS infrastructure support these FSP services?
3. **Tell me about the challenges you face within BHRS in the management of child/youth/TAY FSPs.**
   a. *Probe for systemic issues, workload balance, staffing levels, staff conflict, budget, etc.*
   b. What do you think BHRS staff's challenges are in managing the current child/youth/TAY FSPs?
      i. How do you think they respond to these challenges?
      ii. Is there institutional support for addressing these challenges?
4. **Tell me about the successes you've experienced within BHRS as a result of implementing the child/youth/TAY FSPs.**
5. **Tell me about communication between BHRS and FSP key stakeholders, such as consumer groups and collaborating agencies (<u>NOT providers</u>).** *(i.e. probation, child welfare, courts, NAMI)*
   a. Who are the key stakeholders involved with the child/youth/TAY FSPs?
   b. Is there a stakeholder group regularly convened by BHRS to discuss the FSPs?
   c. *If yes,* how frequently are these meetings held?
      i. Who attends these meetings?
      ii. Who sets the agenda?
      iii. Have you attended these meetings?
      iv. How are FSP issues handled? Are meetings interactive?

If no, is there another venue where child/youth/TAY FSP issues are addressed *(i.e., another BHRS meeting with collaborating partners, internally with BHRS staff only)*?

d. What have been challenges with stakeholder/collaborating agency relationships? *(including communication)*

e. What has worked well with stakeholder/collaborating agency relationships? *(including communication)*

f. Is there institutional/department (BHRS) openness to input from staff, community members, and other stakeholders?

   i. How is this input implemented? Is there a systemic protocol?

6. Tell me about communication between BHRS and the FSP providers (Fred Finch/Edgewood).

a. Are regular meetings held with both FSP providers to discuss progress, concerns, updates, and/or issues?

b. *If yes,* how frequently are these meetings held?

   i. Who attends these meetings? Do meetings include both providers?

   ii. Who sets the agenda?

   iii. Have you attended these meetings?

   iv. How are child/youth/TAY FSP issues handled? Are meetings interactive?

   If no, is there another venue for child/youth/TAY FSP providers to address updates, concerns, issues?

c. What have been challenges in working with the child/youth/TAY FSP providers? *(including communication)*

d. What has worked well with the two child/youth/TAY FSP providers? *(including communication)*

e. How well do you feel the two child/youth/TAY FSP providers understand BHRS' mission with FSP services?

f. How are client/caregiver complaints and grievances addressed? (i.e. changing providers/therapists in the system)

   i. What mechanisms are available for caregivers to communicate concerns to providers and be involved in the therapeutic process?

Characteristics of Child/Youth/TAY FSP Treatment Programs

1. **Tell me about the referral process for mental health clients in San Mateo County—how are clients identified and admitted into the FSP program?**
   a. What are the successes and challenges of the referral and admission process?
   b. How are client capacity issues addressed? (by FSP providers and systemically within BHRS)
   c. What are challenges regarding client access to FSP services? (i.e. reaching specific populations, long waitlists, barriers, etc.)
2. **What clients are targeted by FSP interventions?**
   a. Do you feel the actual clients served by FSP providers match the target population?
      i. How is client eligibility determined? Who determines?
   b. How do FSP interventions meet the needs of the target population and the community?
   c. How are the interventions culturally appropriate for the clients served?
   d. Are some interventions more effective for certain client populations? How/why?
      i. How do the FSPs meet the needs of the most complex child/youth/TAY clients? *(including dual-diagnosed, developmentally delayed, juvenile justice)*
      ii. Do FSPs have the resources to meet the needs of complex clients?
   e. Are there mechanisms in place to help youth transition into the adult FSPs? Is there a service gap between systems?
3. **Tell me about the most important key interventions used by the two child/youth/TAY providers.**
   a. What services/interventions are available to FSP clients?
      i. Are there different goals/objectives for each FSP provider?
   b. What do you believe is the recovery/treatment philosophy of San Mateo County?
   c. How do FSP interventions align with this philosophy?
   d. Do clients have adequate access to specialty services (i.e. medical, medication management)?
   e. What have been some challenges with housing FSP clients? Specific sub-groups?
      i. Is there adequate capacity for housing and supportive services (i.e. maintain housing)?
4. **For each key intervention, what changes do you expect?**
   a. *Probe for initial vs. long term change.*
   b. How long do you feel it takes for a client to achieve meaningful change?
   c. How do you feel the housing component is being managed?
      i. Are there housing gaps that affect specific client populations?

5. How do people change in the FSP program?

a. What skills do clients need to learn to help them maintain progress?

b. How can BHRS and the child/youth/TAY FSPs support clients and caregivers in maintaining stability (i.e. independent housing)?

c. What areas of positive change have you noticed among FSP clients?

(Probe: defining positive outcomes)

d. Are there outcomes not currently tracked that you would like see incorporated to assess FSP program impact?

6. Tell me about clients' trajectory through the FSP program. Would consideration of a step up/down system be helpful/relevant for child/youth/TAY clients?

a. How would a step system benefit clients?

b. What might be challenges of implementing this system?

c. Do you feel this would effectively increase provider capacity to serve more clients in need of intensive services?

d. If a step system was to be implemented, what kind of BHRS/FSP resources are available to help clients maintain stability once they've leveled to less intensive services?

e. If children/youth eventually age out of the FSP system, are there adequate linkages in place to help the client access transitional services (i.e. into adult FSPs) and maintain progress, using a recovery model? (As opposed to becoming eligible for FSP adult services due to intensive need)

f. Tell me about your thoughts on the role of provider relationships. During step-down transitions, could the client remain with at least one preferred provider?

g. Why would a client not succeed in a FSP placement?

7. How are child/youth/TAY FSP providers evaluated on their performance?

a. Does BHRS have a data department or position dedicated to data/IT needs?

b. How are data reports/findings communicated to FSP providers and stakeholders?

c. Who is responsible at BHRS for supervising the child/youth/TAY FSP providers and keeping them accountable to contracted services and outcomes?

i. How does BHRS ensure that provider staff are qualified and adequately trained for assigned positions?

ii. Is there a BHRS contracted manager assigned to each FSP provider?

d. What processes are tracked by the FSP providers and/or by BHRS?

e. What client outcomes are tracked by the providers and/or BHRS?

f. How are providers held accountable for client experience and outcomes? *(including staff training, vs. "babysitting" a client)*

g. Are there adequate staffing levels to meet client needs? – How is this determined?

h. How do clients/caregivers provide feedback to providers and/or BHRS? (i.e. Can/how do clients/caregivers directly access providers/BHRS with concerns?)

i. What system is in place to respond to client/caregiver feedback?

j. How are productive relationships with caregivers cultivated? *(i.e. accessibility to provider for clients over 18/emancipated youth/wards of court who don't want family involvement, education, information)*

k. How important is it for a FSP provider to reflect a "learning organization" culture?

8. What are key (successful) elements or lessons learned from the current FSP program and/or providers that should be included in the next round of funding?

9. What are key elements that should be considered and/or addressed in the next round of funding?

Wrap Up

1. Are there any questions that I should have asked you?

2. Do you have any questions for me?

3. What is the most important thing to understand from your perspective?

Interview Guide – San Mateo County FSP *Administrators Child Welfare*

Administrators:	Date:
DYJA Interviewer:	

Walk Through

To be completed by DYJA Interviewer

1. Description of first contact:

a. What happened when you first called the agency (busy signal, voicemail, automated greeting, live person etc)?

b. How difficult was it to get in contact with the program?

c. How long did it take you to schedule an appointment?

2. Description of the program site:

a. Provide a real description of the program site.

b. What did you think of the site on first entering?

- Overall, does the site look like a clinic? A prison? A ward? Etc.

c. What are the waiting room conditions? (i.e. is environment warm/cold; cleanliness; physical comfort; welcoming)

d. Does the physical space appear adequate (i.e., office space, group meeting rooms, individual meeting space, common areas, etc.)

e. Is there someone there to greet you and answer your questions?

3. Documents to ask for:

a. Request program material (i.e., brochures, pamphlets, etc.) that may contain the program mission/goals and objectives

b. Request Job Descriptions of key FSP staff or key staff assigned to FSP.

General Administrator Information

1. **Name**
2. **Current/Recent Position Held**
   a) Please describe duties /responsibilities.
3. **Experience**
   a) How long have you been working at Child Welfare? In what capacity/capacities?*
   b) How long have you been working for Child Welfare in your current capacity?
   c) How long have you been working in the behavioral health field? (Describe experience/positions)
   d) Academic degrees/accreditations
4. **Demographics**
   a) Gender
   b) Race/Ethnicity

General Perceptions about the FSP/Wraparound Model

1. **Tell me about the mission of San Mateo County BHRS Full Service Partnership (FSP) for children/youth/Transitional Aged Youth (TAY).**
   a. Ask for a description of the program and its implementation in San Mateo County.
   b. What do you think is the San Mateo County (SMC) vision for implementing FSP child/youth/TAY services? *(i.e. why was a FSP model selected vs. other treatment models)*
   c. What is your understanding of the child/youth/TAY FSP program model, including its goals and objectives?
   d. Do you think Child Welfare staff, (see 2a below) BHRS staff and FSP stakeholders share your understanding?
   e. What do you consider to be Child Welfare's role in SMC's vision for implementing child/youth/TAY FSP services?

2. **Tell me what you think about FSPs and/or Wraparound as a treatment modality for child/youth/TAY populations.**
   a. How do you think your colleagues feel about FSP/Wraparound as a treatment model?
   b. Have you received formal training in the FSP/Wraparound model?
      i. *If no,* how did you become familiar with the model?
      ii. *If yes,* please describe the FSP trainings you received. Was the training part of a county- level adoption of the FSP/Wraparound model?
      iii. Were the trainings helpful?
      iv. How could the trainings be improved?
   c. Do Child Welfare case managers receive regular trainings on FSP as a treatment modality for child/youth/TAY populations?

3. **What have been challenges of incorporating the FSP/WRAPAROUND model in San Mateo County for child/youth/TAY clients?**

4. **What have been positives of incorporating the FSP and/or WRAPAROUND model in San Mateo County for child/youth/TAY clients?**

5. **How do you think the FSP/WRAPAROUND model has been adapted to meet the needs of San Mateo County child/youth/TAY clients?**

6. **Is there an alternative treatment model that you feel would work better in San Mateo County for child/youth/TAY clients?**

7. **Is there an expectation to follow FSP and/or WRAPAROUND model?**
   a. If so, what is the source of that expectation?

8. **How has the adoption of FSP/WRAPAROUND changed the way Child Welfare and BHRS manages services for child/youth/TAY mental health clients in San Mateo County?**
   a. What are the obstacles (including financial)?
   b. How would an Incentive-Based or Pay-for-Performance contract affect BHRS, outcomes, stakeholders, clients, and FSP services offered?

Characteristics of Child/Youth/TAY FSP Treatment Programs

1. **Tell me about the referral process for mental health clients in San Mateo County—how are clients identified and admitted into the FSP program?**
   a. What are the successes and challenges of the referral and admissions process?
   b. What is Child Welfare's role in the referral and admissions process?
   c. How are client capacity issues addressed? (by FSP providers and systemically within BHRS)
   d. What are challenges regarding client access to FSP services? *(i.e. reaching specific populations, long waitlists, barriers, etc.)*
   e. Following referral and FSP admission, what is Child Welfare's role in monitoring client progress? *(i.e. appropriateness of FSP-level of services)*

2. **What clients are targeted by FSP interventions?**
   a. Do you feel the actual clients served by FSP providers match the target population?
      i. How is client eligibility determined? Who determines?
   b. How do FSP interventions meet the needs of the target population and the community?
   c. How are the interventions culturally appropriate for the clients served?
   d. Are some interventions more effective for certain client populations? How/why?
      i. How do the FSPs meet the needs of the most complex child/youth/TAY clients? *(including dual-diagnosed, developmentally delayed, juvenile justice)*
      ii. What additional resources (within FSP programs and BHRS system-wide) may be needed to meet the needs of complex clients?
   e. Are there mechanisms in place to help youth transition between child/youth and TAY? Into the adult FSPs? Is there a service gap between systems?

3. **Tell me about the most important key interventions used by the two child/youth/TAY providers.**

a. What services/interventions are available to FSP clients?
b. What do you believe is the recovery/treatment philosophy of San Mateo County?
c. How do FSP interventions align with this philosophy?
d. Do clients have adequate access to specialty services *(i.e. medical, medication management)*?
e. What have been some challenges with housing FSP child/youth/TAY clients? Specific sub-groups?
    i. Is there adequate capacity for housing and supportive services *(i.e. maintain housing)*?
    ii. How do you feel the housing component is being managed?
    iii. Are there housing gaps that affect specific populations?

4. For each key intervention, what changes do you expect?

a. *Probe for initial vs. long term change.*
b. How long do you feel it takes for a client to achieve meaningful change?

5. How do people change in the FSP program?

a. What skills do clients need to learn to help them maintain progress?
b. How can Child Welfare, BHRS and the child/youth/TAY FSPs support clients and caregivers in maintaining stability (i.e. independent housing)?
c. What areas of positive change have you noticed among FSP clients? *(Probe: defining positive outcomes)*
d. Are there outcomes not currently tracked that you would like see incorporated to assess FSP program impact?

6. Tell me about clients' trajectory through the FSP program. Would consideration of a step up/down system be helpful/relevant for child/youth/TAY clients?

a. What might be challenges of implementing this system?
b. Do you feel this would effectively increase provider capacity to serve more clients in need of intensive services?
c. If a step system was to be implemented, what kind of BHRS/FSP resources are available to help clients maintain stability once they've leveled to less intensive services?
    i. How would client progress be tracked so stepped-down clients are monitored and treated before reaching a level of acute need for intensive services?

d. If children/youth eventually age out of the FSP system or leave court jurisdiction, are there adequate linkages in place to help the client access transitional services (i.e. into adult FSPs, back into community) and maintain progress, using a recovery model? (As opposed to becoming eligible for FSP adult services due to intensive need)
e. Tell me about your thoughts on the role of provider relationships.
    i. Within Child Welfare, how would a client/caregiver's assigned case manager impact the therapeutic process *(i.e. advocacy, primary relationship in the BHRS system)*?
f. Why would a client not succeed in a FSP placement?
g. How does the FSP/Child Welfare work with the court system when clients are under court jurisdiction?

7. How are child/youth/TAY FSP providers evaluated on their performance?

a. How does Child Welfare track and evaluate the progress of FSP clients *(i.e. outcomes)*?
    i. Is there an integrated process within BHRS for client case reviews and tracking?
    ii. Who evaluates treatment effectiveness/impact? (i.e. Child Welfare? FSP? Courts?)
b. How are data on FSP clients gathered and shared with FSP providers, BHRS, and/or other stakeholders?
c. What client outcomes are tracked by Child Welfare/BHRS?
d. How do clients/caregivers provide feedback to Child Welfare, providers and/or BHRS? *(i.e. Can/how do clients/caregivers directly access Child Welfare/providers/BHRS with concerns?)*
    i. What systems are in place to respond to client/caregiver feedback and grievances? *(i.e. changing providers/therapists in the system)*
e. How are productive relationships with caregivers cultivated and maintained? *(i.e. accessibility to provider for clients over 18/emancipated youth/wards of court who don't want family involvement, education, information)*
    i. What mechanisms are available for caregivers/clients to be active participants in the therapeutic process?
f. How important is it to the FSP program that BHRS and/or Child Welfare reflect a "learning organization" culture?

8. What are key (successful) elements or lessons learned from the current FSP program?

9. What are key elements that could be improved in the next iteration of child/youth/TAY FSP services?

Organizational Climate

1. **Tell me about <u>Child Welfare</u> staffing for the youth/child/TAY FSP programs.**
   a. What are core Child Welfare staff positions assigned to the FSP program?
   b. *Probe: What areas require more staffing?*

2. **Tell me about the resources/support BHRS and Child Welfare provide to the FSP program.**
   a. What internal and systemic resources does BHRS offer to support the FSP child/youth/TAY program?
   b. How does the BHRS infrastructure support these FSP services?

3. **Tell me about the challenges you face within Child Welfare in the management of child/youth/TAY FSP cases.**
   a. *Probe for systemic issues, workload balance, staffing levels, staff conflict, budget, etc.*
   b. What do you think Child Welfare staff's challenges are in managing the current child/youth/TAY FSPs?
      i. How do you think they respond to these challenges?
      ii. Is there institutional support for addressing these challenges?

4. **Tell me about the successes you've experienced within BHRS/Child Welfare as a result of the implementation of the child/youth/TAY FSPs.**

5. **Tell me about communication within Child Welfare regarding the FSPs.**
   a. How are staff members kept informed of internal and external communications, including case reviews?
   b. What works well and what doesn't regarding communication in your department?
   c. What would your staff say about the your department's openness to input, from staff, community members, and other stakeholders?

6. **Tell me about communication between Child Welfare and other BHRS departments involved with the FSPs.**
   a. Are regular meetings convened <u>within</u> BHRS to discuss progress, concerns, updates, and/or other issues associated with the child/youth/TAY FSPs and/or clients?
   b. *If yes,* how frequently are these meetings held?
      i. Who attends these meetings?
      ii. Who sets the agenda?
      iii. Have you attended these meetings?
      iv. How are FSP issues handled? Are meetings interactive?

If no, is there another venue where child/youth/TAY FSP issues are addressed *(i.e., another BHRS meeting with collaborating partners, internally with BHRS staff only)*?

c. What have been challenges working with other BHRS departments? *(including communication)*

d. What has worked well with other BHRS departments? *(including communication)*

e. Is there institutional/department (BHRS) openness to input from staff, community members, and other stakeholders?

   i. How is this input implemented? Is there a systemic protocol?

7. Tell me about communication between Child Welfare and the FSP providers (Fred Finch/Edgewood).

a. Are regular meetings held with both FSP providers to discuss progress, concerns, updates, and/or issues?

b. *If yes,* how frequently are these meetings held?

   i. Who attends these meetings? Do meetings include both providers?

   ii. Who sets the agenda?

   iii. Have you attended these meetings?

   iv. How are child/youth/TAY FSP issues handled? Are meetings interactive?

   If no, is there another venue for child/youth/TAY FSP providers to address updates, concerns, issues?

c. What have been challenges in working with the child/youth/TAY FSP providers? *(including communication)*

d. What has worked well with the two child/youth/TAY FSP providers? *(including communication)*

e. Are there unique aspects/challenges to working with Fred Finch, as an out-of-county provider? (including communication)

8. Tell me about communication between Child Welfare and other FSP key stakeholders, such as consumer groups and collaborating agencies (NOT providers). *(i.e. probation, courts, NAMI)*

a. Who are the other key stakeholders involved with the child/youth/TAY FSPs?

b. Is there a stakeholder group regularly convened by BHRS to discuss the FSPs?

c. *If yes,* how frequently are these meetings held?

   i. Who attends these meetings?

ii. Who sets the agenda?
iii. Have you attended these meetings?
iv. How are FSP issues handled? Are meetings interactive?

If no, is there another venue where child/youth/TAY FSP issues are addressed *(i.e., another BHRS meeting with collaborating partners, internally with BHRS staff only)*?

d. What have been challenges with stakeholder/collaborating agency relationships? *(including communication)*
e. What has worked well with stakeholder/collaborating agency relationships? *(including communication)*

Wrap up

1. **Are there any questions that I should have asked you?**

2. **Do you have any questions for me?**

3. **What is the most important thing to understand from your perspective?**

Interview Guide – San Mateo County FSP *Administrators Probation*

Administrators:	Date:
DYJA Interviewer:	**In-Person Interview**

Walk Through

To be completed by DYJA Interviewer

1. Description of first contact:

a. What happened when you first called the agency (busy signal, voicemail, automated greeting, live person etc)?

b. How difficult was it to get in contact with the program?

c. How long did it take you to schedule an appointment?

2. Description of the program site:

a. Provide a real description of the program site.

b. What did you think of the site on first entering?

- Overall, does the site look like a clinic? A prison? A ward? Etc.

c. What are the waiting room conditions? (i.e. is environment warm/cold; cleanliness; physical comfort; welcoming)

d. Does the physical space appear adequate (i.e., office space, group meeting rooms, individual meeting space, common areas, etc.)

e. Is there someone there to greet you and answer your questions?

3. Documents to ask for:

a. Request program material (i.e., brochures, pamphlets, etc.) that may contain the program mission/goals and objectives

b. Request Job Descriptions of key FSP staff or key staff assigned to FSP.

General Administrator Information

1. **Name**
2. **Current/Recent Position Held**
   a) Please describe duties /responsibilities.
3. **Experience**
   a) How long have you been working at Probation? In what capacity/capacities?*
   b) How long have you been working for Probation in your current capacity?
   c) How long have you been working in the behavioral health field? (Describe experience/positions)
   d) Academic degrees/accreditations
4. **Demographics**
   a) Gender
   b) Race/Ethnicity

General Perceptions about the FSP/Wraparound Model

1. **Tell me about the mission of San Mateo County BHRS Full Service Partnership (FSP) for children/youth/Transitional Aged Youth (TAY).**
   a. Ask for a description of the program and its implementation in San Mateo County.
   b. What do you think is the San Mateo County (SMC) vision for implementing FSP child/youth/TAY services? *(i.e. why was a FSP model selected vs. other treatment models)*
   c. What is your understanding of the child/youth/TAY FSP program model, including its goals and objectives?
   d. Do you think Probation staff, (see 2a below) BHRS staff and FSP stakeholders share your understanding?
   e. What do you consider to be Probation's role in SMC's vision for implementing child/youth/TAY FSP services?

2. **Tell me what you think about FSPs and/or Wraparound as a treatment modality for child/youth/TAY populations.**
   a. How do you think your colleagues feel about FSP/Wraparound as a treatment model?
   b. Have you received formal training in the FSP/Wraparound model?
      i. *If no,* how did you become familiar with the model?
      ii. *If yes,* please describe the FSP trainings you received. Was the training part of a county- level adoption of the FSP/Wraparound model?
      iii. Were the trainings helpful?
      iv. How could the trainings be improved?
   c. Do Probation officers receive regular trainings on FSP as a treatment modality for child/youth/TAY populations?

3. **What have been challenges of incorporating the FSP/WRAPAROUND model in San Mateo County for child/youth/TAY clients?**

4. **What have been positives of incorporating the FSP and/or WRAPAROUND model in San Mateo County for child/youth/TAY clients?**

5. **How do you think the FSP/WRAPAROUND model has been adapted to meet the needs of San Mateo County child/youth/TAY clients?**

6. **Is there an alternative treatment model that you feel would work better in San Mateo County for child/youth/TAY clients?**

7. **Is there an expectation to follow FSP and/or WRAPAROUND model?**
   a. If so, what is the source of that expectation?

8. **How has the adoption of FSP/WRAPAROUND changed the way Probation and BHRS manages services for child/youth/TAY mental health clients in San Mateo County?**
   a. What are the obstacles (including financial)?
   b. How would an Incentive-Based or Pay-for-Performance contract affect BHRS, outcomes, stakeholders, clients, and FSP services offered?

Characteristics of Child/Youth/TAY FSP Treatment Programs

1. **Tell me about the referral process for mental health clients in San Mateo County—how are clients identified and admitted into the FSP program?**
   a. What are the successes and challenges of the referral and admissions process?
   b. What is Probation's role in the referral and admissions process?
   c. How are client capacity issues addressed? (by FSP providers and systemically within BHRS)
   d. What are challenges regarding client access to FSP services? *(i.e. reaching specific populations, long waitlists, barriers, etc.)*
   e. Following referral and FSP admission, what is Probation's role in monitoring client progress? *(i.e. appropriateness of FSP-level of services)*

2. **What clients are targeted by FSP interventions?**
   a. Do you feel the actual clients served by FSP providers match the target population?
      i. How is client eligibility determined? Who determines?
   b. How do FSP interventions meet the needs of the target population and the community?
   c. How are the interventions culturally appropriate for the clients served?
   d. Are some interventions more effective for certain client populations? How/why?
      i. How do the FSPs meet the needs of the most complex child/youth/TAY clients? *(including dual-diagnosed, developmentally delayed, juvenile justice)*
      ii. What additional resources (within FSP programs and BHRS system-wide) may be needed to meet the needs of complex clients?
   e. Are there mechanisms in place to help youth transition between child/youth and TAY? Into the adult FSPs? Is there a service gap between systems?

3. **Tell me about the most important key interventions used by the two child/youth/TAY providers.**
   a. What services/interventions are available to FSP clients?
   b. What do you believe is the recovery/treatment philosophy of San Mateo County?
   c. How do FSP interventions align with this philosophy?
   d. Do clients have adequate access to specialty services *(i.e. medical, medication management)*?
   e. What have been some challenges with housing FSP child/youth/TAY clients? Specific sub-groups?
      i. Is there adequate capacity for housing and supportive services *(i.e. maintain housing)*?
      ii. How do you feel the housing component is being managed?
      iii. Are there housing gaps that affect specific populations?

4. **For each key intervention, what changes do you expect?**
   a. *Probe for initial vs. long term change.*
   b. How long do you feel it takes for a client to achieve meaningful change?

5. **How do people change in the FSP program?**
   a. What skills do clients need to learn to help them maintain progress?
   b. How can Probation, BHRS and the child/youth/TAY FSPs support clients and caregivers in maintaining stability (i.e. independent housing)?
   c. What areas of positive change have you noticed among FSP clients? *(Probe: defining positive outcomes)*
   d. Are there outcomes not currently tracked that you would like see incorporated to assess FSP program impact?

6. **Tell me about clients' trajectory through the FSP program. Would consideration of a step up/down system be helpful/relevant for child/youth/TAY clients?**
   a. What might be challenges of implementing this system?
   b. Do you feel this would effectively increase provider capacity to serve more clients in need of intensive services?
   c. If a step system was to be implemented, what kind of BHRS/FSP resources are available to help clients maintain stability once they've leveled to less intensive services?
      i. How would client progress be tracked so stepped-down clients are monitored and treated before reaching a level of acute need for intensive services?

d. If children/youth eventually age out of the FSP system or leave court jurisdiction, are there adequate linkages in place to help the client access transitional services (i.e. into adult FSPs, back into community) and maintain progress, using a recovery model? (As opposed to becoming eligible for FSP adult services due to intensive need)
e. Tell me about your thoughts on the role of provider relationships.
    i. Within Probation, how would a client/caregiver's assigned officer impact the therapeutic process *(i.e. advocacy, primary relationship in the BHRS system)*?
f. Why would a client not succeed in a FSP placement?
g. How does the FSP/Probation work with the court system when clients are under court jurisdiction?

7. How are child/youth/TAY FSP providers evaluated on their performance?

a. How does Probation track and evaluate the progress of FSP clients *(i.e. outcomes)*?
    i. Is there an integrated process within BHRS for client case reviews and tracking?
    ii. Who evaluates treatment effectiveness/impact? (i.e. Probation? FSP? Courts?)
b. How are data on FSP clients gathered and shared with FSP providers, BHRS, and/or other stakeholders?
c. What client outcomes are tracked by Probation/BHRS?
d. How do clients/caregivers provide feedback to Probation, providers and/or BHRS? *(i.e. Can/how do clients/caregivers directly access Probation/providers/BHRS with concerns?)*
    i. What systems are in place to respond to client/caregiver feedback and grievances? *(i.e. changing providers/therapists in the system)*
e. How are productive relationships with caregivers cultivated and maintained? *(i.e. accessibility to provider for clients over 18/emancipated youth/wards of court who don't want family involvement, education, information)*
    i. What mechanisms are available for caregivers/clients to be active participants in the therapeutic process?
f. How important is it to the FSP program that BHRS and/or Probation reflect a "learning organization" culture?

8. What are key (successful) elements or lessons learned from the current FSP program?

9. What are key elements that could be improved in the next iteration of child/youth/TAY FSP services?

Organizational Climate

1. **Tell me about <u>Probation</u> staffing for the youth/child/TAY FSP programs.**
   a. What are core Probation staff positions assigned to the FSP program?
   b. *Probe: What areas require more staffing?*

2. **Tell me about the resources/support BHRS and Probation provide to the FSP program.**
   a. What internal and systemic resources does BHRS offer to support the FSP child/youth/TAY program?
   b. How does the BHRS infrastructure support these FSP services?

3. **Tell me about the challenges you face within Probation in the management of child/youth/TAY FSP cases.**
   a. *Probe for systemic issues, workload balance, staffing levels, staff conflict, budget, etc.*
   b. What do you think Probation staff's challenges are in managing the current child/youth/TAY FSPs?
      i. How do you think they respond to these challenges?
      ii. Is there institutional support for addressing these challenges?

4. **Tell me about the successes you've experienced within BHRS/Probation as a result of the implementation of the child/youth/TAY FSPs.**

5. **Tell me about communication within Probation regarding the FSPs.**
   a. How are staff members kept informed of internal and external communications, including case reviews?
   b. What works well and what doesn't regarding communication in your department?
   c. What would your staff say about your department's openness to input, from staff, community members, and other stakeholders?

6. **Tell me about communication between Probation and other BHRS departments involved with the FSPs.**
   a. Are regular meetings convened <u>within</u> BHRS to discuss progress, concerns, updates, and/or other issues associated with the child/youth/TAY FSPs and/or clients?
   b. *If yes,* how frequently are these meetings held?
      i. Who attends these meetings?
      ii. Who sets the agenda?
      iii. Have you attended these meetings?
      iv. How are FSP issues handled? Are meetings interactive?

If no, is there another venue where child/youth/TAY FSP issues are addressed *(i.e., another BHRS meeting with collaborating partners, internally with BHRS staff only)*?

c. What have been challenges working with other BHRS departments? *(including communication)*
d. What has worked well with other BHRS departments? *(including communication)*
e. Is there institutional/department (BHRS) openness to input from staff, community members, and other stakeholders?
    i. How is this input implemented? Is there a systemic protocol?

7. Tell me about communication between Probation and the FSP providers (Fred Finch/Edgewood).

a. Are regular meetings held with both FSP providers to discuss progress, concerns, updates, and/or issues?
b. *If yes,* how frequently are these meetings held?
    i. Who attends these meetings? Do meetings include both providers?
    ii. Who sets the agenda?
    iii. Have you attended these meetings?
    iv. How are child/youth/TAY FSP issues handled? Are meetings interactive?

    If no, is there another venue for child/youth/TAY FSP providers to address updates, concerns, issues?
c. What have been challenges in working with the child/youth/TAY FSP providers? *(including communication)*
d. What has worked well with the two child/youth/TAY FSP providers? *(including communication)*
e. Are there unique aspects/challenges to working with Fred Finch, as an out-of-county provider? (including communication)

8. Tell me about communication between Probation and other FSP key stakeholders, such as consumer groups and collaborating agencies (NOT providers). *(i.e. child welfare, courts, NAMI)*

a. Who are the other key stakeholders involved with the child/youth/TAY FSPs?
b. Is there a stakeholder group regularly convened by BHRS to discuss the FSPs?
c. *If yes,* how frequently are these meetings held?
    i. Who attends these meetings?
    ii. Who sets the agenda?
    iii. Have you attended these meetings?
    iv. How are FSP issues handled? Are meetings interactive?

    If no, is there another venue where child/youth/TAY FSP issues are addressed *(i.e., another BHRS meeting with collaborating partners, internally with BHRS staff only)*?

d. What have been challenges with stakeholder/collaborating agency relationships? *(including communication)*
e. What has worked well with stakeholder/collaborating agency relationships? *(including communication)*

Wrap up

1. **Are there any questions that I should have asked you?**

2. **Do you have any questions for me?**

3. **What is the most important thing to understand from your perspective?**

Interview Guide – San Mateo Full Service Partnership County (Child/Youth/TAY)
Administrators

Administrator:	Date:
DYJA Interviewer:	

General Administrator Information

1. **Name**
2. **Current/Recent Position Held**
   a. Please describe duties /responsibilities.
3. **Experience**
   a. How long have you been working at BHRS? In what capacity/capacities?*
   b. How long have you been working for BHRS in your current capacity?
   c. How long have you been working in the behavioral health field? (Describe experience/positions)
   d. Academic degrees/accreditations
4. **Demographics**
   a. Gender
   b. Race/Ethnicity

Interview Guide – San Mateo Full Service Partnership County *Administrators*

Organizational Climate

1. **Tell me about the mission of San Mateo County BHRS Full Service Partnership (FSP) for adults.**
   a. Ask for a description of the program and its implementation in San Mateo County.
   b. What was the San Mateo County (SMC) vision for implementing FSP adult services?
   (i.e. why was a FSP model selected as opposed to other treatment models)
   c. What is your understanding of the adult FSP program's goals and objectives?
   d. Do you think BHRS staff and FSP stakeholders share your understanding?
2. **Tell me about <u>BHRS</u> staffing for the FSP adult programs (Telecare/Caminar).**
   a. What are core BHRS staff positions?
   b. *Probe: What areas require more staffing?*
3. **Tell me about the resources/support BHRS provides to the FSP program.**
   a What internal and systemic resources does BHRS offer to support the FSP adult program?
   b. How does the BHRS infrastructure support adult FSP services?
4. **Tell me about the challenges you faced within BHRS in the management of the adult FSPs.**
   a. *Probe for systemic issues, workload balance, staffing levels, staff conflict, budget, etc.*
   b. What do you think BHRS staff's challenges are in managing the current adult FSPs?
      i. How do you think they respond to these challenges?
      ii. Is there institutional support for addressing these challenges?
5. **Tell me about the successes you've experienced within BHRS as a result of implementing the adult FSPs.**

6. Tell me about communication between BHRS and FSP key stakeholders, such as consumer groups and collaborating agencies (<u>NOT providers</u>). *(i.e. probation, conservator's office, NAMI)*

a. What are the key stakeholders involved with the adult FSPs?

b. Is there a stakeholder group regularly convened by BHRS to discuss the adult FSPs?

c. *If yes,* how frequently are these meetings held?

i. Who attends these meetings?

ii. Who sets the agenda?

iii. Have you attended these meetings?

iv. How are adult FSP issues handled? Are meetings interactive?

If no, is there another venue where adult FSP issues are addressed *(i.e., another BHRS meeting with collaborating partners, internally with BHRS staff only)*?

d. What have been <u>challenges</u> with stakeholder/collaborating agency relationships? *(including communication)*

e. What has <u>worked well</u> with stakeholder/collaborating agency relationships? *(including communication)*

f. Is there institutional/department (BHRS) openness to input from staff, community members, and other stakeholders?

i. How is this input implemented? Is there a systemic protocol?

7. Tell me about communication between BHRS and the adult FSP providers (Telecare/Caminar).

a. Are regular meetings held with both adult FSP providers to discuss progress, concerns, updates, and/or issues?

b. *If yes,* how frequently are these meetings held?

i. Who attends these meetings? Do meetings include both providers?

ii. Who sets the agenda?

iii. Have you attended these meetings?

iv. How are adult FSP issues handled? Are meetings interactive?

If no, is there another venue for adult FSP providers to address updates, concerns, issues?

c. What have been <u>challenges</u> in working with the adult FSP providers? *(including communication)*

d. What has <u>worked well</u> with the two adult FSP providers? *(including communication)*

e. How well do you feel the two adult FSP providers understand BHRS' mission with the FSP services?

f. How are client/caregiver complaints and grievances addressed? (i.e. changing providers/therapists in the system)
   i. What mechanisms are available for caregivers to communicate concerns to providers and be involved in the therapeutic process?

General Perceptions About the FSP/ACT Model

1. **Tell me what you think about FSPs and/or ACT as a treatment modality.**
   a. How do you think your colleagues feel about FSP/ACT as a treatment model?
   b. Have you received formal training in the FSP/ACT model?
      i. *If no,* how did you become familiar with the model?
      ii. *If yes,* please describe the FSP trainings you received. Was the training part of a county-level adoption of the FSP/ACT model?
      iii. Were the trainings helpful?
      iv. How could the trainings be improved?
   c. Are regular trainings still offered to FSP providers/staff, especially now that CIMH has discontinued state-funded trainings?
2. **What have been some of the challenges of adopting the FSP/ACT model in San Mateo County?**
3. **What have been some of the positives of adopting the FSP and/or ACT model in San Mateo County?**
4. **How do you think the FSP/ACT model has been adapted to meet the needs of San Mateo County clients?**
5. **Is there an alternative treatment model that you feel would work better in San Mateo County for adult clients?**
6. **Is there pressure to follow FSP and/or ACT model?**
   a. If so, where does the pressure come from?
7. **How has the adoption of FSP/ACT changed the way BHRS manages services for adult mental health clients in San Mateo County?**
   a. What are the obstacles (including financial)?
   b. How would an Incentive-Based or Pay-for-Performance contract affect BHRS, outcomes, stakeholders, clients, and FSP services offered?

Interview Guide – San Mateo Full Service Partnership County *Administrators*

Characteristics of Adult FSP Treatment Programs

1. **Tell me about the referral process for mental health clients in San Mateo County—how are clients identified and admitted into the FSP program?**
   a. What are the successes and challenges of the referral and admission process?
   b. How are client capacity issues addressed? (by FSP providers and systemically within BHRS)
   c. What are challenges regarding client access to FSP services? (i.e. reaching specific populations, long waitlists, barriers, etc.)
2. **What clients are targeted by FSP interventions?**
   a. Do you feel the actual clients served by FSP providers match the target population?
      i. How is client eligibility determined? Who determines?
   b. How do FSP interventions meet the needs of the target population and the community?
   c. How are the interventions culturally appropriate for the clients served?
   d. Are some interventions more effective for certain client populations? How/why?
      i. How do the FSPs meet the needs of the most complex adult clients? *(including dual-diagnosed and developmentally delayed)*
      ii. Do FSPs have the resources to meet the needs of complex clients?
   e. Are there mechanisms in place to help youth transition into the adult FSPs? Is there a service gap between systems?
3. **Tell me about the most important key interventions used by the two adult FSP providers.**
   a. What services/interventions are available to FSP clients?
      i. Are there different goals/objectives for each adult FSP provider?
   b. What do you believe is the recovery/treatment philosophy of San Mateo County?
   c. How do FSP interventions align with this philosophy?
   d. Do clients have adequate access to specialty services (i.e. medical, medication management)?
   e. What have been some challenges with housing FSP clients? Specific sub-groups?
      i. Is there adequate capacity for housing and supportive services (i.e. maintain housing)?
4. **For each key intervention, what changes do you expect?**
   a. *Probe for initial vs. long term change.*
   b. How long do you feel it takes for a client to achieve meaningful change?
   c. How do you feel the housing component is being managed by the FSP provider/Telecare?
      i. Are there housing gaps that affect specific client populations?

5. How do people change in the FSP program?

a. What skills do clients need to learn to help them maintain progress?

b. How can BHRS and the adult FSPs support clients and caregivers in maintaining stability (i.e. independent housing)?

c. What areas of positive change have you noticed among adult FSP clients?

(Probe: defining positive outcomes)

d. Are there outcomes not currently tracked that you would like see incorporated to assess FSP program impact?

6. Tell me about clients' trajectory through the FSP program. Would consideration of a step up/down system be helpful?

a. How would a step system benefit clients?

b. What might be challenges of implementing this system?

c. Do you feel this would effectively increase provider capacity to serve more clients in need of intensive services?

d. If a step system was to be implemented, what kind of BHRS/FSP resources are available to help clients maintain stability once they've leveled to less intensive services?

e. If the expectation is that an adult client will eventually be discharged from a FSP (recovery model), are there adequate linkages in place to help the client access transitional services and maintain progress?

f. Tell me about your thoughts on the role of provider relationships. During step-down transitions, could the client remain with at least one preferred provider?

g. Why would a client not succeed in a FSP placement?

7. **How are adult FSP providers evaluated on their performance?**
    a. Does BHRS have a data department or position dedicated to data/IT needs?
    b. How are data reports/findings communicated to FSP providers and stakeholders?
    c. Who is responsible at BHRS for supervising the adult FSP providers and keeping them accountable to contracted services and outcomes?
        i. How does BHRS ensure that provider staff are qualified and adequately trained for assigned positions?
        ii. Is there a BHRS contract manager assigned to each FSP provider?
    d. What processes are tracked by the FSP providers and/or by BHRS?
    e. What client outcomes are tracked by the providers and/or BHRS?
    f. How are providers held accountable for client experience and outcomes? *(including staff training, vs. "babysitting" a client)*
    g. Are there adequate staffing levels to meet client needs? – How is this determined?
    h. How do clients/caregivers provide feedback to providers and/or BHRS?
    i. What system is in place to respond to client/caregiver feedback?
    j. How are productive relationships with caregivers cultivated? *(i.e. accessibility to provider for clients over 18 who don't want family involvement, education, information)*
    k. How important is it for a FSP provider to reflect a "learning organization" culture?
8. **What are key (successful) elements or lessons learned from the current FSP program and/or providers that should be included in the next round of funding?**
9. **What are key factors that should be considered and/or addressed in the next round of funding?**

Wrap up

1. **Are there any questions that I should have asked you?**
2. **Do you have any questions for me?**
3. **What is the most important thing to understand from your perspective?**

Interview Guide – San Mateo County FSP Eval – Office of Consumer & Family Affairs
SMC *Administrators*

Administrators:	Date:
DYJA Interviewer:	**In-Person Joint Interview**

Walk Through

To be completed by DYJA Interviewer

1. Description of first contact:
   a. What happened when you first called the agency (busy signal, voicemail, automated greeting, live person etc)?
   b. How difficult was it to get in contact with the program?
   c. How long did it take you to schedule an appointment?
2. Description of the program site:
   a. Provide a real description of the program site.
   b. What did you think of the site on first entering?
      i. Overall, does the site look like a clinic? A prison? A ward? Etc.
   c. What are the waiting room conditions? (i.e. is environment warm/cold; cleanliness; physical comfort; welcoming
   d. Does the physical space appear adequate (i.e., office space, group meeting rooms, individual meeting space, common areas, etc.)
   e. Is there someone there to greet you and answer your questions?
3. Documents to ask for:
   a. Request program material (i.e., brochures, pamphlets, etc.) that may contain the program mission/goals and objectives
   b. Request Job Descriptions of key OCFA FSP staff.

General Administrator Information

1. **Name**
2. **Current/Recent Position Held**
   a. Please describe duties /responsibilities.
3. **Experience**
   a. How long have you been working at BHRS? In what capacity/capacities?
   b. How long have you been working for BHRS in your current capacity?
   c. How long have you been working in the behavioral health field? *(Describe experience/positions)*
   d. Academic degrees/accreditations
4. **Demographics**
   a. Gender
   b. Race/Ethnicity

Interview Guide – San Mateo County FSP Eval – Office of Consumer & Family Affairs
SMC *Administrators*

General Perceptions about the FSP/Wraparound/ACT Model

1. **Tell me about the mission of San Mateo County (SMC) BHRS Full Service Partnership (FSP) for <u>children/youth/Transitional Aged Youth (TAY)</u>.**
   a. Ask for a description of the program and its implementation in San Mateo County.
   b. What do you think is the San Mateo County (SMC) vision for implementing FSP child/youth/TAY services? *(i.e. why was a FSP model selected vs. other treatment models)*
   c. What is your understanding of the child/youth/TAY FSP program models, including its goals and objectives?
   d. Do you think BHRS staff, FSP stakeholders, and FSP providers share your understanding?

2. **Tell me what you think about FSPs and/or Wraparound as a treatment modality for <u>child/youth/TAY populations</u>.**
   a. How do you think your colleagues feel about FSP/Wraparound as a treatment model?
   b. Have you received formal training in the FSP/Wraparound model?
      i. *If no,* how did you become familiar with the model?
      ii. *If yes,* please describe the FSP trainings you received. Was the training part of a county-level adoption of the FSP/Wraparound model?
      iii. Were the trainings helpful?
      iv. How could the trainings be improved?
   c. Are regular trainings still offered to San Mateo County BHRS staff, now that CIMH has discontinued state-funded trainings?

3. **Tell me about the mission of San Mateo County BHRS's Full Service Partnership (FSP) for <u>adults</u>.**
   a. Ask for a description of the program and its implementation in SMC.
   b. What do you think is the San Mateo County vision for implementing FSP adult services? *(i.e. why was a FSP model selected vs. other treatment models)*
   c. What is your understanding of the adult FSP program model, including its goals and objectives?
   d. Do you think BHRS staff, FSP stakeholders, and FSP providers share your understanding?

4. **Tell me what you think about FSPs and/or ACT as a treatment modality for <u>adult, older adult and medically fragile populations</u>.**
   a. How do you think your colleagues feel about FSP/ACT as a treatment model?
   b. Have you received formal training in the FSP/ACT model?
      i. *If no,* how did you become familiar with the model?
      ii. *If yes,* please describe the FSP trainings you received. Was the training part of a county-level adoption of the FSP/ACT model?
      iii. Were the trainings helpful?
      iv. How could the trainings be improved?
   c. Are regular trainings still offered to San Mateo County BHRS staff now that CIMH has discontinued state-funded trainings?

5. **What have been challenges of incorporating the FSP model in San Mateo County?**
   a. The **FSP/Wraparound** model for Youth? For TAY?
   b. The **FSP/ACT** model for adults?

6. **What have been the positives of incorporating the FSP model in San Mateo County?**
   a. The **FSP/Wraparound** model for Youth? For TAY?
   b. The **FSP/ACT** model for adults?

7. **How do you think the FSP model has been adapted to meet the needs of San Mateo County consumers?**
   a. How has the **FSP/Wraparound** model been adapted for San Mateo County Youth? For TAY?
   b. How has the **FSP/ACT** model been adapted for San Mateo County adults?

8. **Is there an alternative treatment model that you feel would work better in San Mateo County?**
   a. For youth? For TAY?
   b. For adults?

9. **Is there an expectation to follow the FSP, ACT and/or WRAPAROUND models?**
   a. If so, what is the source of that expectation?

10. **How has the adoption of the FSP model changed the way San Mateo County provides services for mental health consumers?**
    a. **What are the obstacles (including financial)?**
    b. **How would an Incentive-Based or Pay-for-Performance contract affect consumer outcomes, stakeholders, and FSP services offered?**

Characteristics of FSP Treatment Program – **cover child/youth/TAY/adult**

1. **Tell me about the referral process for mental health consumers in San Mateo County—how are consumers identified and admitted into the FSP program? (child/youth/TAY/adult)**
   a. What are the successes and challenges of the referral and admission process?
   b. How are consumer capacity issues addressed? (by BHRS and by FSP providers)
   c. What are challenges regarding consumer access to FSP services? *(i.e. reaching specific populations, long waitlists, barriers, etc.)*

2. **What consumers are targeted by SMC's FSP?**
   a. Do you feel the actual consumers served by SMC's FSP providers reflect the intended target populations?
      i. How is consumer eligibility determined? Who determines?
   b. How do FSP interventions meet the needs of the target population and the community?
   c. How are the interventions culturally appropriate for the consumers served?
   d. Are some interventions more effective for certain consumer populations? How/why?
   e. How do providers meet the needs of the most complex consumers *(including dual-diagnosed, developmentally delayed, juvenile justice, medically fragile, older adults, etc.)*
      i. What additional resources may be needed to meet the needs of complex consumers?

f. Are there mechanisms in place to help consumers transition between FSP systems? (Child/youth → TAY → adult FSPs)? Are there service gaps between systems?

3. Tell me about the most important key interventions used by the SMC child/youth/TAY/adult FSP programs.

a. What services/interventions are available to FSP consumers?
b. What do you believe is the recovery/treatment philosophy of San Mateo County?
c. How do the interventions offered by the four FSP providers align with this philosophy?
d. How long do you feel it takes a consumer to achieve meaningful change?
e. Do consumers have adequate access to specialty services *(i.e. medical, medication management)*?
f. What have been some challenges with housing? Specific sub-groups?
   i. Is there adequate capacity for housing and supportive services *(i.e. maintain housing)*?
   ii. Are there housing gaps that affect specific consumer populations?

4. How do people change in the FSP program?

a. What skills do consumers need to learn in the FSP to help them maintain progress?
b. Are there specific FSP interventions/services considered more meaningful/impactful by consumers/caregivers?
c. How can BHRS and the providers support consumers and caregivers in maintaining stability *(i.e. independent housing)*?
d. What areas of positive change have you noticed among FSP consumers?
(Probe: defining positive outcomes)
e. What access issues have consumers/caregivers experienced with their case managers? *(i.e. after hours/weekend accessibility, helpfulness during hospitalizations, case manager support with changing living situations/housing)*
f. Are there outcomes not currently tracked that you would like see incorporated to assess FSP program impact?

5. Tell me about consumers' trajectory through the FSP program. Would consideration of a step up/down system be helpful/relevant for consumers?

a. How would a step system benefit consumers?
b. What might be challenges of implementing this system?
c. Do you feel this would effectively increase provider capacity to serve more consumers in need of intensive services?
d. If a step system was to be implemented, what kind of BHRS/FSP resources are available to help consumers maintain stability once they've leveled to less intensive services?
   i. How would consumer progress be tracked so that stepped-down consumers are monitored and treated before reaching a level of acute need and intensive services?

e. If children/youth eventually age out of the FSP system, are there adequate linkages in place to help the consumer access transitional services *(i.e. into adult FSPs)*/back into the community and maintain progress, using a recovery model? *(vs. becoming eligible for FSP adult services due to intensive need)*

f. Tell me about your thoughts on the role of provider relationships. During step-down transitions, could the consumer remain with at least one preferred provider?

g. How is provider care transferred once a consumer leaves the FSP? *(i.e. if a consumer has built a strong connection with a primary provider)*

h. Why would a consumer not succeed in a FSP placement?

6. How are FSP providers evaluated on their performance?

a. Does San Mateo County have a data department or position dedicated to data/IT needs?

b. How does San Mateo track and evaluate the progress of FSP consumers?

c. How is FSP data gathered and shared, within BHRS and with stakeholders?

d. What consumer outcomes are tracked by providers and/or BHRS?

7. How do FSP providers/BHRS receive and use feedback from consumers, caregivers and community members?

a. What is the role of the Office of Consumer/Family Affairs (OCFA) within BHRS?

i. How does OCFA interface with the FSP programs?

b. How are relationships with caregivers cultivated? *(i.e. accessibility to BHRS/provider for consumers over 18/emancipated youth/wards of court who don't want family involvement, education, information)*

c. What mechanisms are available for consumers/caregivers to communicate feedback and concerns to BHRS/providers and be involved in the therapeutic process? (Especially for TAY youth over 18/considered adults and not engaged with adult SMC services)

d. What systems are in place to respond to consumer/caregiver feedback?

i. Are consumers/caregivers active participants in treatment planning?

ii. How are consumer/caregiver complaints and grievances addressed? *(i.e. changing providers/therapists in the system)*

iii. What have been some of the prevalent grievances raised by consumers/caregivers regarding the FSP program?

iv. Is the current BHRS system adequate for addressing challenges/grievances?

v. What have been some of the challenges of the current system?

vi. What have been some of the success of the current system?

e. What BHRS/provider resources are available to support caregivers?

f. What have been some of the challenges for FSP consumers, caregivers and community members? Successes?

g. How important is it for the SMC FSP provider to reflect a "learning organization" culture?

9. What are key (successful) elements or lessons learned from the current FSP programs?

10. What are key elements that could be improved in the next iteration of FSP services?

Organizational Climate

1. Tell me about staffing for the FSP programs.
- a. What areas require more FSP staffing? (within BHRS/FSP providers)
- b. How does BHRS ensure that qualified staff fill FSP positions?
- c. Are there adequate staffing levels to meet consumer needs? – How is this determined?
- d. How does BHRS ensure consistent FSP staff levels are maintained?

2. Tell me about the resources/support BHRS provides to the FSP program.
- a. What internal and systemic resources does BHRS offer to support the FSP programs?
- b. How does the BHRS infrastructure support these FSP services?

3. Tell me about the challenges you face within BHRS in the Office of Consumer and Family Affairs and in working with the FSP programs.
- a. *Probe for systemic issues, workload balance, staffing levels, staff conflict, budget, etc.*
- b. What do you think BHRS staff's challenges are in working with the current FSPs?
  - i. How do you think they respond to these challenges?
  - ii. Is there institutional support for addressing these challenges?

4. Tell me about the successes you've experienced as a result of implementing the FSPs, both among consumers/caregivers and within BHRS.

5. Tell me about communication (within BHRS) regarding FSPs.
- a. How are staff members kept informed of internal and external communications?
- b. What works well and what doesn't regarding communication in your agency?
- c. What would your staff say about the BHRS's openness to input, from staff, community members, and other stakeholders?

6. Tell me about communication between OCFA, BHRS and any other key stakeholders, including juvenile probation, child welfare, NAMI, housing, etc.
- a. Who are the key stakeholders involved with the FSP programs?
- b. What have been challenges with stakeholder relationships?
- c. What has worked well with stakeholder relationships?
- d. Is there agency openness to input from stakeholder partners?
- e. How are consumers/caregivers integrated into stakeholder relationships?

7. Tell me about communication between OCFA, BHRS, and FSP providers.

a. Are regular meetings held with providers to discuss progress, concerns, updates, and/or issues within the FSP consumers/system?

b. *If yes,* how frequently are these meetings held?

i. Who attends these meetings?

ii. Who sets the agenda?

iii. Have you attended these meetings?

iv. How are FSP issues handled? Are meetings interactive?

If no, is there another venue for child/youth/TAY FSP providers to address updates, concerns, issues?

c. What have been challenges in working with providers? *(including communication)*

d. What has worked well with providers? *(including communication)*

Wrap up

1. Are there any questions that I should have asked you?

2. Do you have any questions for me?

3. What is the most important thing to understand from your perspective?

Focus Group Guide – San Mateo Full Service Partnership *Youth*

Program:
Date:
DYJA Interviewers:

Walk Through

To be completed by DYJA Interviewer

1. Description of first contact:
    a. What happened when you first called the agency (busy signal, voicemail, automated greeting, live person, etc)?
    b. How difficult was it to get in contact with the program?
    c. How long did it take you to schedule an appointment?
2. Description of the program site:
    a. Provide a real description of the program site.
    b. What did you think of the site on first entering?
        i. Overall, does the site look like a clinic? A prison? A ward? Etc.
    c. What are the waiting room conditions? (i.e. is environment warm/cold; cleanliness; physical comfort; welcoming
    d. Does the physical space appear adequate (i.e., office space, group meeting rooms, individual meeting space, common areas, etc.)
    e. Is there someone there to greet you and answer your questions?
3. Documents to ask for:
    a. Request program material (i.e., brochures, pamphlets, etc.) that may contain the program mission/goals and objectives
    b. Request Job Descriptions of key staff participating in focus group.

General Focus Group Staff Information

(*Have staff complete form)*

1. Name
2. Demographics
    a. Gender
    b. Race/Ethnicity
3. Current Position Held
    a. Length of time in current position
4. Experience
    a. Academic degrees/accreditations
    b. How long have you been working in the behavioral health field? (*months/years*)
    c. How long have you been working at this agency? (*months/years*)
    d. Are you a person in recovery?

I. Introduction of DYJA staff and purpose

"Hi everyone, thank you all so much for being here today. My name is () and I am a researcher for Davis Y. Ja and Associates/ DYJA. This is my colleague, (); she is a researcher as well. DYJA is an outside agency that San Mateo County has contracted with to better understand its Full Service Partnership Programs (FSPs) that are funded through the Mental Health Services Act (MHSA). We (DYJA) do not work for the California Department of Mental Health or MHSA, and are not involved with any funding decisions regarding San Mateo County's FSPs. Through our project, we will be speaking with administrators, staff, consumers and caregivers at each of the four adult and youth FSP sites to gain a more comprehensive picture about the FSP services you provide, its impact on consumers and caregivers, as well as successes and input for areas of improvement. We will accomplish this through a variety of individual interviews and focus groups.

"Today, during this focus group, we will be asking you questions about The Provider's FSP. Again, our goal is to gain a better understanding of the services you provide, including what has worked well and what could be improved, both at The Provider and within San Mateo's overall FSP system.

We will be taking notes and recording our discussion today – this helps us during data analysis and for referencing points of discussion. The Provider and BHRS will not have access to the notes or recording. After we have finished transcribing the discussion, we will erase the recording. Any comments you make today will be presented anonymously in our report. With this in mind, we hope that you will be as open and honest as possible today. And we welcome the opportunity to collaboratively work with you to capture a snapshot of how the FSP program serves children, youth and transitional-aged youth (TAY) in San Mateo County, including what makes these services unique to San Mateo County.

"We have 1.5 hours to talk today. During that time, we would like to cover about five main areas. I will be leading the conversation, and may have to limit discussion of a topic if we're running out of time. There will be some time at the end for additional comments. If you have additional comments after the focus group, please also feel free to send them to me via e-mail.

Are there any questions so far?

If you are uncomfortable with participating, you are free to leave now, or at any point during the discussion. You can also decline to respond to any question at any time. I'm going to go around the room to ask people if they consent to participating in the focus group discussion and to being recorded.

Wait for verbal consent from all participants.

II. General Perceptions About FSP Model (including Wraparound)

1. Tell me about your understanding of San Mateo County's Full Service Partnership program's mission.
   a. What is your understanding of the program goals and objectives?

2. Tell me about your understanding of The Provider's Full Service Partnership program's mission.
   a. What is your understanding of the program goals and objectives?
   b. How do you see The Provider's FSP program fitting into the larger San Mateo County BHRS system?

3. Tell me what you think about the whole idea of FSPs and/or Wraparound.
   a. Probe for agency support for implementing FSP/Wraparound
   b. Is there pressure to follow FSP and/or ACT model?

4. What are some of the challenges of adopting the FSP Model and/or Wraparound?

5. What are some of the positives of adopting the FSP Model and/or Wraparound?

III. Implementation of the FSP/ Wraparound Models

1. Tell me about the referral process for your program.
   a. What have been the successes and challenges of the referral and admission process?
   b. Is your program able to accommodate all potential clients?
      i. If not, how are capacity issues dealt with by your program?
   c. How are TAY needs addressed in the Provider FSP program? If a TAY needs adult FSP services, are there referral linkages into the adult FSP program?

2. What clients are targeted by the Provider's FSP interventions?
   a. How do the clients you serve reflect the intended target population?
   b. How do the interventions you provide meet the needs of the target population and the community?
   c. How are the interventions culturally appropriate for the clients you serve?
   d. Are some interventions more effective for certain client populations? How/why?
   e. Are there any populations or client needs not currently met by the Provider FSP program?

3. Tell me about the most important key interventions of your program.
   a. How does The Provider's FSP program reflect a recovery-oriented approach?

4. For each intervention, what changes do you expect?
   a. Probe for initial vs. long term change.
   b. How long does it take for a client to achieve meaningful change?
   c. What skills do clients need to acquire to maintain their progress?

5. Of the interventions you use, has your program modified any of them over time?
   a. How have your interventions evolved to meet the needs of the population served and community?

6. Of the interventions you use, ask the following for each:
   a. What do you like about this intervention?
   b. What are the challenges (to clients and program)? Compare in terms of:
      i. Clinical practice
      ii. Quality of care
      iii. Different client populations
   c. How are clients and caregivers impacted?
   d. How is the impact of this intervention assessed?

7. Tell me about your clients' trajectory through your program.
   a. How do you define progress for your clients?
   b. How do you measure and track client progress?
   c. How do clients transition out of The Provider FSP services?
      i. If clients are discharged, are there after care services to help them maintain progress?
      ii. Is there transition between the child/youth FSP and TAY program? Into adult care, if needed?…
      iii. What are some of the challenges and successes?
   d. How are family members involved in your program?
   e. How is feedback from clients, family members and the community incorporated by your program/agency? (i.e. concerns, grievances etc.)

8. Are there options for stepping-up or stepping-down care as needed?
   a. If yes, how? How do these options benefit clients in their recovery?
   b. If no, how would clients benefit from adding these options?

IV. Staffing

1. Tell me about staffing here for The Provider's FSP program.
   a. Probe: in what areas do you need more staff?
   b. What are your core staff positions?
   c. What is your staff to client ratio?

2. Tell me about communication within your agency/ within your program.
   a. How are staff members kept informed of internal and external communication?
   b. What works well, what does not regarding communication in your agency?
   c. What would your staff say about the program's openness to input?
   d. Probe for responsiveness of agency/program administrators to staff input
   e. Tell me about the resources/support the agency provides for FSP program staff. (i.e. IT/data needs, offices supplies, janitorial services.)

3. Tell me about the successes and challenges of working in The Provider's FSP.
   a. Probe for workload balance, staffing levels, staff conflict, etc.

4. Tell me about staff meetings.
   a. Who sets the agenda?
   b. What is the frequency of the meetings?
   c. How are case reviews handled?
   d. How are program issues handled?
   e. Are the meetings interactive?

V. Training

1. Have you received training in FSP and/or Wraparound model?

2. Tell me about the trainings
   a. Was this training part of an agency or program-level adoption of the model?
   b. Was the training helpful?
   c. Describe the training.

3. After training, how does your agency/program support what you have learned?
   a. Are tool kits provided following trainings?
   b. How often do you use these resources?
   c. What are the strategies in place for learning new treatment methods? (i.e. practice with feedback, supervision, coaching)
   d. What methods are used to follow-up or obtain feedback from staff?
   e. How do the interventions work after training?
   f. Are the interventions easy to follow (manuals)?

4. What steps are taken to maintain fidelity to FSP/Wraparound standards?

VI. Wrap up (10 Minutes)

1. Are there any questions that I should have asked you?

2. Do you have any questions for me?

3. What stands out to you the most about the FSP program at The Provider?

Focus Group Guide – San Mateo Full Service Partnership *TAY*

Program:
Date:
DYJA Interviewers:

Walk Through

To be completed by DYJA Interviewer

1. Description of first contact:
    a. What happened when you first called the agency (busy signal, voicemail, automated greeting, live person, etc)?
    b. How difficult was it to get in contact with the program?
    c. How long did it take you to schedule an appointment?
2. Description of the program site:
    a. Provide a real description of the program site.
    b. What did you think of the site on first entering?
        i. Overall, does the site look like a clinic? A prison? A ward? Etc.
    c. What are the waiting room conditions? (i.e. is environment warm/cold; cleanliness; physical comfort; welcoming
    d. Does the physical space appear adequate (i.e., office space, group meeting rooms, individual meeting space, common areas, etc.)
    e. Is there someone there to greet you and answer your questions?
3. Documents to ask for:
    a. Request program material (i.e., brochures, pamphlets, etc.) that may contain the program mission/goals and objectives
    b. Request Job Descriptions of key staff participating in focus group.

General Focus Group Staff Information

(*Have staff complete form)*

1. Name
2. Demographics
    a. Gender
    b. Race/Ethnicity
3. Current Position Held
    a. Length of time in current position
4. Experience
    a. Academic degrees/accreditations
    b. How long have you been working in the behavioral health field? (*months/years*)
    c. How long have you been working at this agency? (*months/years*)
    d. Are you a person in recovery?

I. Introduction of DYJA staff and purpose

(Lauren, 5 minutes)

"Hi everyone, thank you all so much for being here today. My name is () and I am a researcher for Davis Y. Ja and Associates/ DYJA. This is my colleague, (); she is a researcher as well. DYJA is an outside agency that San Mateo County has contracted with to better understand its Full Service Partnership Programs (FSPs) that are funded through the Mental Health Services Act (MHSA). We (DYJA) do not work for the California Department of Mental Health or MHSA, and are not involved with any funding decisions regarding San Mateo County's FSPs. Through our project, we will be speaking with administrators, staff, consumers and caregivers at each of the four adult and youth FSP sites to gain a more comprehensive picture about the FSP services you provide, its impact on consumers and caregivers, as well as successes and input for areas of improvement. We will accomplish this through a variety of individual interviews and focus groups.

"Today, during this focus group, we will be asking you questions about Edgewood's FSP. Again, our goal is to gain a better understanding of the services you provide, including what has worked well and what could be improved, both at Edgewood and within San Mateo's overall FSP system.

We will be taking notes and recording our discussion today – this helps us during data analysis and for referencing points of discussion. Edgewood and BHRS will not have access to the notes or recording. After we have finished transcribing the discussion, we will erase the recording. Any comments you make today will be presented anonymously in our report. With this in mind, we hope that you will be as open and honest as possible today. And we welcome the opportunity to collaboratively work with you to capture a snapshot of how the FSP program serves children, youth and transitional-aged youth (TAY) in San Mateo County, including what makes these services unique to San Mateo County.

"We have 1.5 hours to talk today. During that time, we would like to cover about five main areas. I will be leading the conversation, and may have to limit discussion of a topic if we're running out of time. There will be some time at the end for additional comments. If you have additional comments after the focus group, please also feel free to send them to me via e-mail.

Are there any questions so far?

If you are uncomfortable with participating, you are free to leave now, or at any point during the discussion. You can also decline to respond to any question at any time. I'm going to go around the room to ask people if they consent to participating in the focus group discussion and to being recorded.

Wait for verbal consent from all participants.

II. General Perceptions About FSP Model (including Wraparound)

1. Tell me about your understanding of San Mateo County's Full Service Partnership program's mission.
   a. What is your understanding of the program goals and objectives?

2. Tell me about your understanding of Edgewood's Full Service Partnership program's mission.
   a. What is your understanding of the program goals and objectives?
   b. How do you see Edgewood's FSP program fitting into the larger San Mateo County BHRS system?

3. Tell me what you think about the whole idea of FSPs and/or Wraparound.
   a. Probe for agency support for implementing FSP/Wraparound
   b. Is there pressure to follow FSP and/or ACT model?

4. What are some of the challenges of adopting the FSP Model and/or Wraparound?

5. What are some of the positives of adopting the FSP Model and/or Wraparound?

III. Implementation of the FSP/ Wraparound Models

1. Tell me about the referral process for your program.
   a. What have been the successes and challenges of the referral and admission process?
   b. Is your program able to accommodate all potential clients?
      i. If not, how are capacity issues dealt with by your program?
   c. How are TAY needs addressed in the Edgewood FSP program? If a TAY needs adult FSP services, are there referral linkages into the adult FSP program?

2. What clients are targeted by Edgewood's FSP interventions?
   a. How do the clients you serve reflect the intended target population?
   b. How do the interventions you provide meet the needs of the target population and the community?
   c. How are the interventions culturally appropriate for the clients you serve?
   d. Are some interventions more effective for certain client populations? How/why?
   e. Are there any populations or client needs not currently met by the Edgewood FSP program?

3. Tell me about the most important key interventions of your program.
   a. How does Edgewood's FSP program reflect a recovery-oriented approach?

4. For each intervention, what changes do you expect?
   a. Probe for initial vs. long term change.
   b. How long does it take for a client to achieve meaningful change?
   c. What skills do clients need to acquire to maintain their progress?

5. Of the interventions you use, has your program modified any of them over time?
   a. How have your interventions evolved to meet the needs of the population served and community?

6. Of the interventions you use, ask the following for each:
   a. What do you like about this intervention?
   b. What are the challenges (to clients and program)? Compare in terms of:
      i. Clinical practice
      ii. Quality of care
      iii. Different client populations
   c. How are clients and caregivers impacted?
   d. How is the impact of this intervention assessed?

7. Tell me about your clients' trajectory through your program.
   a. How do you define progress for your clients?
   b. How do you measure and track client progress?
   c. How do clients transition out of Edgewood FSP services?
      i. If clients are discharged, are there after care services to help them maintain progress?
      ii. Is there transition between the child/youth FSP and TAY program? Into adult care, if needed?…
      iii. What are some of the challenges and successes?
   d. How are family members involved in your program?
   e. How is feedback from clients, family members and the community incorporated by your program/agency? (i.e. concerns, grievances etc.)

8. Are there options for stepping-up or stepping-down care as needed?
   a. If yes, how? How do these options benefit clients in their recovery?
   b. If no, how would clients benefit from adding these options?

IV. Staffing

1. Tell me about staffing here for Edgewood's FSP program.
   a. Probe: in what areas do you need more staff?
   b. What are your core staff positions?
   c. What is your staff to client ratio?

2. Tell me about communication within your agency/ within your program.
   a. How are staff members kept informed of internal and external communication?
   b. What works well, what does not regarding communication in your agency?
   c. What would your staff say about the program's openness to input?
   d. Probe for responsiveness of agency/program administrators to staff input
   e. Tell me about the resources/support the agency provides for FSP program staff. (i.e. IT/data needs, offices supplies, janitorial services.)

3. Tell me about the successes and challenges of working in Edgewood's FSP.
   a. Probe for workload balance, staffing levels, staff conflict, etc.

4. Tell me about staff meetings.
   a. Who sets the agenda?
   b. What is the frequency of the meetings?
   c. How are case reviews handled?
   d. How are program issues handled?
   e. Are the meetings interactive?

V. Training

1. Have you received training in FSP and/or Wraparound model?

2. Tell me about the trainings
   a. Was this training part of an agency or program-level adoption of the model?
   b. Was the training helpful?
   c. Describe the training.

3. After training, how does your agency/program support what you have learned?
   a. Are tool kits provided following trainings?
   b. How often do you use these resources?
   c. What are the strategies in place for learning new treatment methods? (i.e. practice with feedback, supervision, coaching)
   d. What methods are used to follow-up or obtain feedback from staff?
   e. How do the interventions work after training?
   f. Are the interventions easy to follow (manuals)?

4. What steps are taken to maintain fidelity to FSP/Wraparound standards?

VI. Wrap up

1. Are there any questions that I should have asked you?

2. Do you have any questions for me?

3. What stands out to you the most about the FSP program at Edgewood?

Focus Group Guide – San Mateo Full Service Partnership *Staff*

Program:
Date:
DYJA Interviewers:

Walk Through

To be completed by DYJA Interviewer

1. Description of first contact:
    a. What happened when you first called the agency (busy signal, voicemail, automated greeting, live person etc)?
    b. How difficult was it to get in contact with the program?
    c. How long did it take you to schedule an appointment?
2. Description of the program site:
    a. Provide a real description of the program site.
    b. What did you think of the site on first entering?
        i. Overall, does the site look like a clinic? A prison? A ward? Etc.
    c. What are the waiting room conditions? (i.e. is environment warm/cold; cleanliness; physical comfort; welcoming
    d. Does the physical space appear adequate (i.e., office space, group meeting rooms, individual meeting space, common areas, etc.)
    e. Is there someone there to greet you and answer your questions?
3. Documents to ask for:
    a. Request program material (i.e., brochures, pamphlets, etc.) that may contain the program mission/goals and objectives
    b. Request Job Descriptions of key staff participating in focus group.

General Focus Group Staff Information

(*Have staff complete form)*

1. Name
2. Demographics
    a. Gender
    b. Race/Ethnicity
3. Current Position Held
    a. Length of time in current position
4. Experience
    a. Academic degrees/accreditations
    b. How long have you been working in the behavioral health field? (*months/years*)
    c. How long have you been working at this agency? (*months/years*)
    d. Are you a person in recovery?

Focus Group Guide – San Mateo Full Service Partnership *Staff*

I. Introduction of DYJA staff and purpose

"Hi everyone, thank you all so much for being here today. My name is () and I am a researcher for Davis Y. Ja and Associates/ DYJA. This is my colleague(); she is a researcher as well. DYJA is an outside agency San Mateo County has hired to evaluate its Full Service Partnership Programs funded through the Mental Health Services Act (MHSA). Through our evaluation we will be speaking with administrators at the BHRS and partner agencies, with administrators and staff at each of the four FSP providers and with consumers and caregivers. This focus group will help to figure out what is working well at The Provider and identify areas for improvement.

"We will be asking you questions about the Full Service Partnership program here at The Provider which were developed in partnership with the BHRS planning committee and three consumer evaluators. We will use your feedback for the report we submit to the BHRS. We are taking some notes and making a recording of the discussion today for our own use during the analysis phase; The Provider and BHRS will not have access to the notes or recording, and after we are finished analyzing the discussion, we will erase the tape. Any comments you make today will be presented anonymously in our report. We will take great lengths to prevent identification of individual people's comments. With this in mind, please try to be as open and honest as possible when responding to our questions.

"We have 1.5 hours to talk today. During that time we want to cover about six topics. I will be leading the conversation, and may have to limit discussion of a topic if we're running out of time. There will be some time at the end for additional comments, and at the conclusion of the focus group, if you have additional comments, please send them to me via e-mail.

Are there any questions so far?

If you are uncomfortable with participating, you can feel free to leave now, or at any point during the discussion. You can also decline to respond to any of the questions. I'm going to go around the room ask people if they consent to being participating in the focus group discussion and to being recorded.

Wait for verbal consent from all participants.

II. General Perceptions About the FSP Model (including ACT)

1. Tell me about your understanding of San Mateo County's Full Service Partnership program's mission.
a. What is your understanding of the program goals and objectives?

2. Tell me about your understanding of The Provider's Full Service Partnership program's mission.
a. What is your understanding of the program goals and objectives?
b. How do you see The Provider's FSP program fitting into the larger San Mateo County BHRS system?

3. Tell me what you think about the whole idea of FSPs and/or ACT.
a. Probe for agency support for implementing FSP/ACT
b. Is there pressure to follow FSP and/or ACT model?

4. What are some of the challenges of adopting the FSP Model and/or ACT?

5. What are some of the positives of adopting the FSP Model and/or ACT?

III. Implementation of the FSP/ ACT Models

1. Tell me about the referral process for your program.
a. What are the successes and challenges of the referral and admission process?
b. Is your program able to accommodate all potential clients?
    i. If not, how are capacity issues dealt with by your program?
c. How does The Provider's FSP program work with the TAY FSP program? i.e. TAY youth who need adult services

2. What clients are targeted by The Provider's FSP interventions?
a. How do the clients you serve match the target population?
b. How do the interventions you provide meet the needs of the target population and the community?
c. How are the interventions culturally appropriate for the clients you serve?
d. Are some interventions more effective for certain client populations? How/why?
e. Are there any populations or client needs not currently met by the The Provider FSP program?

3. Tell me about the most important key interventions of your program.
a. How does The Provider's FSP program reflect a recovery-oriented approach?

4. For each intervention, what changes do you expect?
a. Probe for initial vs. long term change.
b. How long does it take for a client to achieve meaningful change?
c. What skills do clients need to acquire to maintain their progress?

5. **Of the interventions you use, has your program modified any of them over time?**
   a. How have your interventions evolved to fit the population and community?

6. **If yes, ask the following for each intervention:**
   a. What do you like about this intervention?
   b. What are the challenges (to clients and program)? Compare in terms of:
      i. Clinical practice
      ii. Quality of care
      iii. Different client populations
   c. How do clients respond?
   d. How is the impact of this intervention assessed?

7. **Tell me about your clients' trajectory through your program.**
   a. How do you define progress for your clients?
   b. How do you measure and track client progress?
   c. How are family members involved in your program?
   d. How is feedback from clients, family members and the community incorporated by your program/agency? i.e. concerns, grievances etc.

8. **Are there options for stepping-up or stepping-down care as needed?**
   a. If yes, how? How do these options benefit clients in their recovery?
   b. If no, how would clients benefit from adding these options?

IV. Staffing

1. Tell me about staffing here for The Provider's FSP program.
   a. Probe: in what areas do you need more staff?
   b. What are your core staff positions?
   c. What is your staff to client ratio?

2. Tell me about communication within your agency/ within your program.
   a. How are staff members kept informed of internal and external communication?
   b. What works well and what doesn't regarding communication in your agency?
   c. What would your staff say about the program's openness to input?
   d. Probe for responsiveness of program administrators to staff input
   e. Tell me about the resources/support the agency provides for FSP program staff. i.e. IT/data needs, offices supplies, janitorial services.

3. **Tell me about the successes and challenges you face here.**
   a. Probe for workload balance, staffing levels, staff conflict, etc.

4. **Tell me about staff meetings**
   a. Who sets the agenda?
   b. What is the frequency of the meetings?
   c. How are case reviews handled?
   d. How are program issues handled?
   e. Are the meetings interactive?

V. Training

1. Have you received training in FSP and/or ACT model?

2. Tell me about the trainings
- a. Was this training part of a program-level adoption of the model?
- b. Was the training helpful?
- c. Description of the training

3. After training, how does your program support what you have learned?
- a. Are tool kits provided following trainings?
- b. How often do you use these resources?
- c. What are the strategies in place for learning new treatment methods? (i.e. practice with feedback, supervision, coaching)
- d. What methods are used to follow-up or obtain feedback from staff?
- e. How do the interventions work after training?
- f. Are the interventions easy to follow (manuals)?

4. What steps are taken to maintain fidelity to FSP/ACT standards?

VI. Wrap up

1. Are there any questions that I should have asked you?

2. Do you have any questions for me?

3. What stands out to you the most about the FSP program at The Provider?

Focus Group Guide – San Mateo FSP *TAY Consumers*

Program:
Date:
DYJA Interviewers:

Walk Through

To be completed by DYJA Interviewer

1. **Description of first contact:**
    a. What happened when you first called the agency *(busy signal, voicemail, automated greeting, live person, etc)*?
    b. How difficult was it to get in contact with the program?
    c. How long did it take you to schedule an appointment?
2. **Description of the program site:**
    a. Is there someone there to greet you and answer your questions?
    b. Provide a real description of the program site.
    c. What did you think of the site on first entering?
        i. Overall, does the site look like a clinic? A prison? A ward? Etc.
    d. What are the waiting room conditions? *(i.e. is environment warm/cold; cleanliness; physical comfort; welcoming)*
    e. Does the physical space appear adequate? *(i.e., office space, group meeting rooms, individual meeting space, common areas, etc.)*

General Focus Group Consumer Information

(C*omplete form <u>WITH</u> Consumers; remind consumers about confidentiality)*

1. Name
2. Age
3. Demographics
    a. Gender
    b. Race/Ethnicity
4. Experience
    a. How long have you been a resident of San Mateo County?
    b. How long have you been in Edgewood's TAY FSP program?
    c. How/why were you referred to Edgewood's TAY FSP Program?
    d. Before you were referred to the Edgewood TAY Program, what other services were you receiving in San Mateo County? *(including mental health, medication, physical health care, substance use counseling, another FSP, etc.)*
    e. Were you given a choice about entering the TAY FSP program?
        i. If so, did you receive any information about Edgewood before you started the program? *(i.e. information about who they were/how they operate)*

I. Introduction of DYJA staff and purpose

(Interviewer's Name, 5 minutes)

"Hi everyone, thank you all so much for being here today. My name is Interviewer Name and I work for Davis Y. Ja and Associates (DYJA). This is my colleague, Interviewer Name. DYJA is an outside agency working with San Mateo County to better understand the TAY Full Service Partnership Programs (FSPs) you are receiving. We do not work for California's Department of Mental Health and do not have anything to do with FSP funding or program decisions made by San Mateo County and Edgewood.

Today, we will be asking you questions about the TAY FSP services you have received through Edgewood. Our goal is to better understand these services, including what has worked well and what could be improved.

We will be taking notes and recording our discussion today. Edgewood staff and BHRS will not have access to our notes or recording. We will delete the recordings after we have written out today's discussion. Any comments you make in this group will not affect the services you currently receive and will be presented anonymously in our report. So, we hope you will be as open and honest as possible.

We have 1.5 hours to talk today. During that time, we will cover five main areas. Interviewer's Name and I will be leading the conversation and may have to limit discussion of a topic if we're running out of time. There will be some time at the end for additional comments.

If you have additional comments after the focus group, feel free to email them to me. My email address is on the consent form. To maintain confidentiality, all emailed comments will be reported anonymously and deleted after we have summarized them.

Are there any questions so far?

If you do not want to participate, you are free to leave now. You can also leave at any point during the discussion and decline to answer any question at any time. We are going to be handing out consent forms now. We will walk you through the form. Please sign at the end of the form if you agree to participate in this focus group and to being recorded. A $10 cash incentive will be given out at the end to each person who participates and finishes this focus group.

Hand out consent form. Verbally review/read aloud consent form. Wait for signatures and collect. Make sure you have a signed consent from everyone before proceeding.

II. General Perceptions About FSP Program

Interviewer's Name (15 minutes)

1. **What do you think is the mission/goal of Edgewood TAY's FSP program?**
   a. What do you think are the program goals and objectives?

2. **Overall, what do you think about the FSP program here?** *(including the team-based model and the mix of services/supports you receive)*

   a. **DYJA Interviewers to briefly state SMC's FSP goals to the group. (3-4 sentences)**

   (Note: Question about mission/goal of SMC's FSP program has been deleted)

   b. Ask: Do you feel San Mateo County is meeting these goals through Edgewood's TAY FSP program? How/how not?

III. Implementation of the FSP *Interviewer's Name (30 Minutes)*

1. **How were you referred to the FSP Program?**
   a. What were the successes and challenges during this process?
   b. Is there anything you would change about the referral process?

2. **Tell me about your experiences over time with the TAY FSP program.**
   a. Do you actively participate in treatment planning with staff?
      i. If yes, how? If no, why not?
      ii. Are you given opportunities to disagree? How?
      iii. How has this process worked? Successes? Improvements?
   b. How do you define **meaningful** progress for yourself?
      i. *Probe: ideas on meaningfully measures of goals/outcomes for consumer growth/recovery (i.e. getting dressed 5 days in a row; NOT state/county defined measureable outcomes)*
      ii. What are your goals (from participating in the FSP)?
      iii. How do you define recovery for yourself?
   c. How does the Edgewood TAY program define progress for you?
   d. Are there options for increasing or decreasing your level of care as needed?
      i. If yes, how? How do these options help you in your recovery?
      ii. If no, how would you benefit from adding these options?

3. **What are the most important services you use through the FSP program?**
   (Note: Ask for specifics; BHRS is interested in whether wraparound model is helpful for TAY)
   a. What do you like about these interventions?
      i. Which activities have been the most **meaningful** for you? *(vs. to keep busy, etc.)*
   b. What do you dislike about these interventions?
      i. What have been some challenges of these interventions?
   c. What would you change about these interventions?
      i. Are there services in your TAY FSP program that focus on wellness and recovery (vs. case management/medication focus)?
      ii. If so, how can these services be highlighted and promoted?
      iii. If not, what would be helpful services to include?
   d. What new skills have you learned?
      i. How has your life changed from being in Edgewood's TAY FSP? *(i.e. improved? Declined?)*
   e. What changes have you noticed in yourself? *(Probe for initial vs. long term change.)*

4. **Tell me about your access to housing with Edgewood.** *(Note: May not be relevant for TAY.)*
    a. How do you feel about your housing options?
    b. What are some of the successes and challenges you've faced with housing?
    c. Are there other supports not currently provided by your FSP that you feel you need to maintain your housing? *(i.e. money management, learning to cook, learning other independent living skills)*

5. **Are there any interventions not currently being offered by your FSP program that would be helpful?**

6. **Is there an expectation that you will always use FSP services (transition to the adult FSP system)?**
    a. **(For current consumers)** Has there been any discussion by staff about a transition or aftercare plan?

7. **(For discharged consumers)**
    a. Why did you leave the FSP program?
    b. Did staff develop a transition plan with you?
    c. Were you aware of aftercare and/or community resources that were available to you?
        i. What were they?
        ii. What would have been helpful to have known?
    d. What were some of the successes and challenges of the discharge process?

8. **If you have issues or problems while you are in the Edgewood TAY program, does Edgewood have a grievance process in place? What is it? Do you use it?**
    a. Have you ever filed a grievance? (If yes, what was your experience?)
    b. What is your impression of Edgewood's openness to working with you on specific issues and problems *(i.e. grievances with the program)*?
    c. Have there been barriers/challenges influencing your decision on whether or not to file a formal grievance or bring up an issue with FSP services?
    d. How open is Edgewood to feedback from consumers, family members, and the community?

9. **How are family and/or community members involved in your FSP program?**
    a. Are there ways you would like to see family members/caregivers/community members more involved?
    b. What have been successes of family/caregiver involvement in your program?
    c. What have been challenges of family/caregiver involvement in your program?

IV. Staffing

Interviewer's Name (15 minutes)

1. **Tell me about staffing for Edgewood's TAY FSP program.**
   a. Which staff work the closest with you?
   b. Do you feel you have adequate access to staff, including your case manager? *(i.e. after hours, weekends, during crisis mode, hospitalizations)*
      i. If you have been hospitalized, did you feel your case manager was helpful during the time you were in the hospital? *(i.e. visits)*
      ii. If you needed to change your living situation, how helpful was your case manager?
      iii. How has your case manager(s) helped you? *(Probe: Successes/challenges)*
   c. Are there any areas that require more staff?

2. **Tell me about the staff here.**
   a. Do you feel the FSP staff here is qualified?
   b. Are there staff who have had similar (lived) experiences as yours? Have they been helpful?

V. Wrap up

Interviewer's Name (10 Minutes)

1. **Are there any questions that I should have asked you?**

2. **Do you have any questions for me?**

3. **What stands out to you the most about the Edgewood TAY FSP program?**

Focus Group Guide – San Mateo FSP *Adult Consumers*

Program:
Date:
DYJA Interviewers:

Walk Through

To be completed by DYJA Interviewer

1. **Description of first contact:**
    a. What happened when you first called the agency *(busy signal, voicemail, automated greeting, live person, etc)*?
    b. How difficult was it to get in contact with the program?
    c. How long did it take you to schedule an appointment?
2. **Description of the program site:**
    a. Is there someone there to greet you and answer your questions?
    b. Provide a real description of the program site.
    c. What did you think of the site on first entering?
        i. Overall, does the site look like a clinic? A prison? A ward? Etc.
    d. What are the waiting room conditions? *(i.e. is environment warm/cold; cleanliness; physical comfort; welcoming)*
    e. Does the physical space appear adequate? *(i.e., office space, group meeting rooms, individual meeting space, common areas, etc.)*

General Focus Group Consumer Information

(C*omplete form <u>WITH</u> Consumers; remind consumers about confidentiality)*

1. Name
2. Age
3. Demographics
    a. Gender
    b. Race/Ethnicity
4. Experience
    a. How long have you been a resident of San Mateo County?
    b. How long have you been in the FSP program?
    c. How were you referred to the FSP Program?
    d. Before you were referred to your current FSP Program, what other services were you receiving in San Mateo County? *(including mental health, medication, physical health care, substance use counseling, another FSP, etc.)*
    e. Were you given a choice about receiving services from an FSP provider?
        i. If so, did you receive any information about the provider? *(i.e. information about who they were/how they operate)*

Focus Group Guide – San Mateo FSP *Adult Consumers*

I. Introduction of DYJA staff and purpose

"Hi everyone, thank you all so much for being here today. My name is () and I am a researcher for Davis Y. Ja and Associates (DYJA). This is my colleague, (); she is a researcher as well. DYJA is an outside agency that San Mateo County is working with to better understand the Full Service Partnership Programs (FSPs) funded by the Mental Health Services Act (MHSA). We do not work for the California Department of Mental Health or MHSA and are not involved with any funding decisions related to San Mateo County's FSPs.

Today, during this focus group, we will be asking you questions about the FSP services you have received through FSP Program. Our goal is to better understand the services you have received, including what has worked well and what could be improved.

We will be taking notes and recording our discussion today – this helps us during data analysis and for referencing points of discussion. FSP Program and BHRS will not have access to the notes or recording. We will delete the recordings after we have written out today's discussion. Any comments you make today will not impact the services you receive and will be presented anonymously in our report. With this in mind, we hope that you will be as open and honest as possible.

We have 1.5 hours to talk today. During that time, we will cover five main areas. Sye-Ok and I will be leading the conversation, and may have to limit discussion of a topic if we're running out of time. There will be some time at the end for additional comments.

If you have additional comments after the focus group, please also feel free to send them to me via email. My email address is on the consent form. All emailed comments will be reported anonymously. To ensure confidentiality, individual emails will be deleted after we have summarized them.

Are there any questions so far?

If you are uncomfortable with participating, you are free to leave now, or at any point during the discussion. You can also decline to answer any question at any time. We are going to be handing out consent forms now. We will walk you through the form and ask that you sign at the end of the form if you agree to participate in this focus group and to being recorded.

Hand out consent form. Verbally review/read aloud consent form. Wait for signatures and collect. Make sure you have a signed consent from everyone before proceeding.

II. General Perceptions About FSP Program

1. **What do you think is the mission/goal of San Mateo County's Full Service Partnership program?**
   a. What do you think are the program goals and objectives?

2. **What do you think is the mission/goal of The Provider's's Full Service Partnership program?**
   a. What do you think are the program goals and objectives?

3. **Overall, what do you think about the FSP program here?** *(including the team-based model and the mix of services/supports you receive)*

   a. Briefly state SMC's FSP goals. (3-4 sentences)

   b. Do you feel San Mateo County is meeting these goals through the FSP program?

III. Implementation of the FSP

1. **How were you referred to the FSP Program?**
   a. What were the successes and challenges during this process?
   b. If you could change anything about the referral process, what would it be?

2. **Tell me about your experiences over time in the FSP program.**
   a. Do you actively plan your treatment with staff?
      i. If yes, how? If no, why not?
      ii. Were you given opportunities to disagree? How?
      iii. How has this process worked? Successes? Improvements?
   b. How do you define **meaningful** progress for yourself?
      i. *Probe: ideas on meaningfully measures of goals/outcomes for consumer growth/recovery*
      ii. What are your goals (from being in the FSP)?
      iii. How do you define recovery for yourself?
   c. How does The Provider define progress for you?
   d. Are there options for increasing or decreasing your level of care as needed?
      i. If yes, how? How do these options benefit you in your recovery?
      ii. If no, how would you benefit from adding these options?

3. **What are the most important services you use through the FSP program? (Ask for specifics)**
   a. What do you like about these interventions?
      i. Which activities have been the most **meaningful** for you? *(vs. to keep busy, etc.)*
   b. What do you dislike about these interventions?
      i. What have been some challenges of the interventions you have received?
   c. What would you change about these interventions?
      i. Are there services in your current FSP program that focus on wellness and recovery (vs. case management/medication focus)?
      ii. If so, how can these services be highlighted and promoted?
      iii. If not, what would be helpful services to include?

d. What new skills have you learned?
    i. How has your life changed from being in The Provider's FSP? *(i.e. improved? Declined?)*
e. What changes have you noticed in yourself? *(Probe for initial vs. long term change.)*

4. Tell me about your access to housing with The Provider
a. How do you feel about your housing options?
b. What are some of the successes and challenges you've faced with housing?
c. Are there other supports not currently provided by your FSP that you feel you need to maintain your housing? *(i.e. money management, learning to cook, learning other independent living skills)*

5. Are there any interventions not currently being offered by your FSP program that would be helpful?

6. Is there an expectation that you will always stay in this FSP program?

7. (For discharged consumers)
a. Why did you leave the FSP program?
b. Did staff develop a plan with you when you were transitioning out of the FSP?
c. Were you aware of aftercare and/or community resources that were available to you?
    i. What were they?
    ii. What would have been helpful to have known?
d. What were some of the successes and challenges of the discharge process?

8. If you have issues or problems while in the FSP, does The Provider have a grievance process in place? What is it? Do you use it?
a. Have you ever filed a grievance? (If yes, what was your experience?)
b. What is your impression of The Provider's openness to working with you on specific issues and problems *(i.e. grievances with the program)*?
c. Have there been barriers/challenges that have affected your decision on whether or not to file a formal grievance or raise an issue about FSP services received?
d. How open is The Provider to feedback from consumers, family members, and the community?

9. How are family members and/or community members involved in your FSP program?
a. Are there ways you would like to see family members/caregivers/community members more involved with the program?
b. What have been successes of family/caregiver involvement in your program?
c. What have been challenges of family/caregiver involvement in your program?

IV. Staffing

1. **Tell me about staffing here for The Provider's FSP program.**
   a. Which staff work the closest with you?
   b. Do you feel you have adequate access to staff, including your case manager? *(i.e. after hours, weekends, during crisis mode, hospitalizations)*
      i. If you have been hospitalized, did you feel your case manager was helpful during the time you were in the hospital? *(i.e. visits)*
      ii. If you needed to change your living situation, how helpful was your case manager during that process?
      iii. How has your case manager(s) helped you? *(Probe: Successes/challenges)*
   c. Are there any areas that require more staff?

2. **Tell me about the education and experience level of staff here.**
   a. Do you feel the FSP staff here is qualified?
   b. Are there fellow consumers with lived experience on the staff? Have they been helpful?

V. Wrap up

1. **Are there any questions that I should have asked you?**

2. **Do you have any questions for me?**

3. **What stands out to you the most about the FSP program at The Provider?**

Housing Site Visit/Interview	**Date:**
DYJA Interviewer:	**In-Person Interview**

Walk Through

To be completed by DYJA Interviewer

1. Description of first contact:
    a. What happened when you first called the agency (busy signal, voicemail, automated greeting, live person etc)?
    b. How difficult was it to get in contact with the program?
    c. How long did it take you to schedule an appointment?
2. Description of the housing site and outside the housing site:
    a. Provide a real description of the program site.
    b. What did you think of the site on first entering?
        i. Overall, does the site look like a clinic? A prison? A ward? Etc.
    c. What are the waiting room conditions? (i.e. is environment warm/cold; cleanliness; physical comfort; welcoming
    d. Does the physical space appear adequate (i.e., office space, group meeting rooms, individual meeting space, common areas, etc.)
    e. Is there someone there to greet you and answer your questions?
    f. Note the physical environment outside the housing site. Are neighboring houses run down? Does the location appear safe?
    g. Is their access to basic amenities such as public transportation and food (look for bus-stops and grocery stores).

General Administrator Information

1. **Name**
2. **Current/Recent Position Held**
    a. Please describe duties /responsibilities.
3. **Experience**
    a. How long have you been working at The Provider? In what capacity/capacities?
    b. How long have you been working for The Provider in your current capacity?
    c. How long have you been working in the behavioral health field? (Describe experience/positions)
    d. Academic degrees/accreditations
4. **Demographics**
    a. Gender
    b. Race/Ethnicity

Housing Site Visit/Interview

General Perceptions about the Adult FSP

1. **Tell me about the mission of San Mateo County BHRS Full Service Partnership (FSP) for adults.**
   a. Ask for a description of the program and its implementation in San Mateo County.
   b. What do you think is the San Mateo County (SMC) vision for implementing FSP Adult services?
   c. What is your understanding of the Adult FSP program model, including its goals and objectives?
   d. Do you think BHRS staff and FSP stakeholders share your understanding?

2. **Tell me about the mission of The Provider's Full Service Partnership (FSP) program for adults.**
   a. Ask for a description of the program and its implementation.
   b. What is your understanding of The Provider's Adult FSP program's goals and objectives?

Characteristics of Adult FSP Supported Housing Program

What are the goals and objectives of The Provider's Supported Housing Program?

1. **What clients are targeted by The Provider's FSP Housing Program**
   a. How are clients identified and placed into your housing site?
   b. Do you have adequate capacity to house the FSP clients?
   c. What are the room options for FSP clients? Are their multiple clients sharing a room?
   d. How is the housing here culturally and behaviorally appropriate for the clients served?
   e. Is maintaining housing stability more effective for certain client populations? How/why?
      i. How does The Providers housing meet the needs of the most complex adult clients? *(including dual-diagnosed, substance abuse, developmentally delayed, criminally-involved, medically fragile or older adults)*

2. **Tell me about the most important housing key services provided here.**
   a. What housing services/interventions are available to FSP clients
   b. Do clients have adequate access to specialty services (i.e. medical, medication management)?
   c. Do clients have access to basic amenities such as public transportation and food?
   d. What additional services within housing are needed?
   e. What have been some challenges with housing FSP adult clients? Specific sub-groups?
      i. Are there housing gaps that affect specific client populations?

3. **What changes have you seen in FSP clients in the housing program??**
   a. What skills do clients need to learn to help them maintain housing stability?
   b. i. What are the expectations of clients? Are they expected to clean their rooms?
   c. How can BHRS and The Provider support clients and caregivers in maintaining stability *(i.e. independent housing)*?
   d. What areas of positive change have you noticed among FSP clients?
      (Probe: defining positive outcomes)

Housing Site Visit/Interview

4. **How are FSP clients able to voice concerns regarding any issues in housing??**
    a. How do clients/caregivers provide feedback to the Housing Staff?
    b. What systems are in place to respond to client/caregiver feedback?
        i. How are client/caregiver complaints and grievances addressed?
    c. How are relationships with caregivers cultivated? *()*
        i. What mechanisms are available for caregivers to communicate concerns and be involved in the housing process?
5. **What are the successes and challenges faced within housing?**

Organizational Climate

1. **Tell me about the resources/support The Provider provides to this Housing program.**
    a. What internal and systemic resources does The Provider offer to support this housing program??
    b. Which staff members from The Provider do you communicate regularly with?
2. **Tell me about the resources/support BHRS provides to the The Provider Adult FSP program.**
    a. What internal and systemic resources does BHRS offer to support the FSP adult program at The Provider?
3. **Tell me about the housing challenges you face within The Provider in the management of adult FSPs.**
    a. *Probe for systemic issues, workload balance, staffing levels, staff conflict, budget, etc.*
    b. What do you think The Provider staff's challenges are in working with housing the current adult FSPs?
        i. How do you think they respond to these challenges?
        ii. Is there institutional support for addressing these challenges?
4. **Tell me about the successes you've experienced within The Provider as a result of implementing housing for the adult FSPs.**
5. **Tell me about communication (within agency) regarding the FSP clients.**
    a. How are staff members kept informed of internal and external communications?
    b. What works well and what doesn't regarding communication in your agency?
    c. What would your staff say about the program's openness to input, from staff, community members, and other stakeholders?

Housing Site Visit/Interview

6. **Tell me about communication between The Provider and BHRS.**
   a. Are regular meetings held with BHRS and/or other stakeholders (i.e. The Provider) to discuss housing progress, concerns, updates, and/or issues within the adult FSP clients/system?
   b. *If yes,* how frequently are these meetings held?
      i. Who attends these meetings?
      ii. Who sets the agenda?
      iii. Have you attended these meetings?
      iv. How are adult FSP issues handled? Are meetings interactive?
      If no, is there another venue for adult FSP providers to address updates, concerns, issues?
   c. What have been the challenges The Provider faces in working with BHRS? *(including communication)*
   d. What has worked well with BHRS? *(including communication)*

Wrap up

1. **Are there any questions that I should have asked you?**
2. **Do you have any questions for me?**
3. **What is the most important thing to understand from your perspective?**

Staff Focus Group

Demographics Survey

Please complete and return to DYJA staff.

1. Name

2. Gender

3. Race/ Ethnicity

4. Current Position

5. Time in Current Position (Months, Years)

6. Academic degrees/accreditations

7. How long have you been in the behavioral health field? (Months, Years)

8. How long have you worked at (Provider)?

9. Are you a person in recovery?

Caregiver Focus Group

Demographics Survey

Please complete and return to DYJA staff.

Date Completed:

1)	**Name**
2)	**Gender**
3)	**Race/ Ethnicity**
4)	**Language/ Cultural Background**
5)	**How long have you been a resident of San Mateo County?**
6)	**How long has your family member been in the (Provider) FSP?**
7)	**Has your family member ever completed an FSP Program?**
8)	**Has your family member ever transitioned to a lower level of care from an FSP?**
9)	**How was your family member referred to the (Provider) FSP Program?**

10) Before being referred to the (Provider) FSP Program, what other services was your family member receiving in San Mateo County? (including mental health, medication, physical health care, substance use counseling, another FSP, etc.)

11) Was your family member given a choice about entering the (Provider) FSP program?

a) **If so, did your family receive any information about the (Provider) FSP program before starting the program?** (i.e. information about who they were/ how they operate)

San Mateo County Full Service Partnerships

Consumer/Caregiver Evaluation Participation Consent Form

In May 2013, Davis Y. Ja and Associates, Inc. (DYJA) was contracted by the San Mateo County Behavioral Health and Recovery Services (BHRS) department to conduct a qualitative evaluation of the San Mateo County Full Service Partnership (FSP) program serving youth, transitional-aged youth, and adults. DYJA is an independent consulting firm specializing in the research and evaluation of mental health and substance abuse treatment services. Since 1990, DYJA has been providing research and evaluation services to non-profit agencies, municipalities, and counties in the San Francisco Bay Area and throughout the United States.

If you decide to participate in this study, you will be asked to attend **up to** two interviews and/or focus groups held by a DYJA staff member. The interviews/focus groups will consist of questions about your experiences with the FSP services *you/your loved one* has received. *All interviews/focus groups will be recorded.* The recordings will be deleted after we have summarized our findings. Each interview or focus group will last **up to 1 1/2 hours**, and you will receive a cash incentive (or equivalent) of **$10.00** for each interview/focus group you complete.

Your comments during the interview/focus group will help us to better understand the impact of services provided by San Mateo County's FSP program. DYJA does not work for the California Department of Mental Health (DMH) and is not involved in any funding decisions by either DMH or BHRS.

We will be summarizing our findings and recommendations in reports to BHRS and other FSP stakeholders. We may also publish our findings in a journal. However, all of the information in our reports will be summaries of what many people have told us. Your answers will always be grouped with other people's answers and will never include your name or identifying information.

CONFIDENTIALITY: The things you tell us during the interview or focus group will be kept confidential. That means we will not tell anyone what you have told us. However, there are rare times when we cannot promise to keep information private. The law says that the project staff and the study team must report when a person lets us know that a child, elderly person, or sick adult has been abused or neglected. We must also report if we believe someone is a serious danger to himself/herself or to other people.

WITHDRAWL FROM PARTICIPATION: You are completely free to decide whether or not to be in this study. The services *you/your loved one* receive from the FSP program will not depend

on, nor be affected by, the decision to participate in this study. If you decide to participate, you can also choose, at any time, to stop participation.

If you have any complaints/concerns about the study, you can call Davis Ja, Ph.D., DYJA Principal Evaluator (415-585-2773).

POTENTIAL RISKS: Though participation in this study most likely will not harm you, you can always call or talk to a staff member at DYJA or San Mateo County BHRS if you become concerned about the study.

This study does not have anything to do with Immigration Services. We will not tell anyone about your immigration status. Your participation in this study will not harm or help your immigration situation.

If you have any questions regarding the evaluation study, please contact Davis Y. Ja, Ph.D. of DYJA at 415-585-2773.

BY signing this, I **AGREE** THAT I FULLY UNDERSTAND THIS CONSENT FORM AND AM WILLING TO PARTICIPATE AND BE RECORDED IN DYJA'S EVALUATION OF THE FULL SERVICE PARTNERSHIP PROGRAMS.

_____ _____

(Consumer/Caregiver Name, Printed) (Signature)

_____

(Date)

_____ _____

(DYJA Staff Name, Printed) (Signature)

_____

(Date)

Copy 1: DYJA files
Copy 2: FSP Participant