RAND CalMHSA California Mental Health Services Authority

Evaluation Report

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Evaluation of the California Multi-County Full Service Partnership Innovation Project

Serious mental illness (SMI), as defined by the Substance Abuse and Mental Health Services Administration, pertains to individuals age 18 and older who either presently have or have experienced within the past year a diagnosable mental, behavioral, or emotional disorder leading to functional impairment that hinders or restricts major life activities.[1] In 2019, 3.9 percent of adults in California experienced an SMI,[2] with higher prevalence among Californians with the lowest incomes.[3] Beyond income, another barrier to sustained wellness and recovery for individuals with SMI is co-occurring substance use disorders, creating complex needs for treatment.

California's Full Service Partnership (FSP) programs aim to address these barriers. FSP programs began as an effort to provide comprehensive and integrated care for people with SMI with the goal of reducing hospitalizations, justice involvement, and homelessness.[4] FSP programs provide comprehensive, recovery-oriented services and share a philosophy of individualized care, often employing intensive case management or assertive community treatment, a community-based service delivery model for people living with severe and persistent mental illness.[5] Some of the FSP programs are directly

KEY FINDINGS

- The initial cohort of six counties participating in the California Multi-County Full Service Partnership (FSP) Innovation Project successfully developed standardized definitions for key populations served, as well as common process and outcome metrics. A subset of the counties succeeded in developing program step-down and graduation guidelines, improved data collection processes, and referral guidelines or processes.
- After the initial development of planned changes to the FSP programs, the extent of on-the-ground implementation and sustainment varied by county and by innovation area.
- Outcomes for FSP participants improved during the first 12 months of involvement. Participants experienced reduced psychiatric inpatient admissions, increased stable housing, and decreased judicial system involvement.
- Improvement in individuals' outcomes increased after participation in the FSP Innovation Project, suggesting that the project facilitated improved quality of care.

operated by counties, while many are provided by nonprofit human services organizations contracted by counties.

FSP programs are funded by the Mental Health Services Act (MHSA), enacted by California voters in 2004 and generated through a 1 percent tax on annual personal income exceeding $1 million. The MHSA seeks to enhance the state's behavioral health system. The MHSA uses a comprehensive approach to better serve individuals and families dealing with serious mental health issues.[6] Community Services and Support constitutes one of the five funding components of the MHSA and encompasses three service categories, one of which constitutes FSP programs.[7]

FSP programs first began as a result of advocacy efforts in California; in 1999, legislation passed to support four pilot projects that funded comprehensive and integrated care for individuals who were at high risk of becoming unhoused, involvement with the justice system, and hospitalization.[8] As of 2021, more than 60,000 individuals were enrolled in FSP programs throughout California, and FSP programs represented a $1 billion annual investment in public funds.[9] There are various types of FSP programs, and each is designed for different age groups and subpopulations, as determined by each county and contracted provider within the county. This approach results in wide variations among FSP program design and eligibility across the state. Typically, people who are eligible for FSP programs have an SMI, are unhoused or at risk of being unhoused, are involved or at risk of being involved with the criminal justice system, and have had frequent visits to the emergency department.[10]

The fundamental principle of FSP programs is to do "whatever it takes" to partner with individuals on their paths to wellness or recovery. FSP programs can provide support beyond mental health services and integrated treatment; the programs can also assist with housing, employment, and education. FSP program services are designed to be as accessible as possible: They are culturally and linguistically appropriate, allow flexibility in terms of service delivery location (e.g., at home or in the community), and employ informal sources of care, such as peer and caregiver support groups. Some unique aspects of FSP programs are provider partnerships with participants and their families in the design of a treatment plan, a low staff-to-participant ratio, around-the-clock access to care, and a team-based approach that provides comprehensive and personalized care to each individual served.

In 2020, the Mental Health Services Oversight and Accountability Commission, the California Mental Health Services Authority (CalMHSA), and an initial group of six counties launched the California Multi-County FSP Innovation Project in partnership with Third Sector, a nonprofit organization that provides technical assistance to the public sector. In collaboration with Third Sector and one another, six counties established a collaboration model that fostered peer learning and county cooperation to enhance FSP programs. Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura counties initially participated in the project, with additional counties joining later. The FSP Innovation Project identified commonalities and differences among FSP programs and practices across counties to inform the design of FSP program innovations.

Third Sector conducted a landscape assessment to gather contextual information in 2020, then worked with the counties on implementation and sustainability of innovations in 2021. Overarching goals of the FSP Innovation Project were identifying a shared understanding of FSP's core components, improving consistency across FSP programs, and developing or enhancing operational processes that are data driven and outcome oriented. To this end,

Abbreviations

CalMHSA	California Mental Health Services Authority
CI	confidence interval
DBH	department of behavioral health
DCR	Data Collection and Reporting System
EHR	electronic health record
FSP	Full Service Partnership
KET	Key Event Tracker
MHSA	Mental Health Services Act
PAF	Partnership Assessment Form
SMI	serious mental illness

Third Sector provided all participating counties with technical assistance in defining key populations and in tracking process and outcome measures and metrics. In addition to these two core innovations, counties chose which additional innovations to work on, according to their individual needs. To this end, Third Sector also provided technical assistance on other topics that varied by county—including defining eligibility for FSP program services, developing criteria to be used to establish that individuals maintained eligibility for services (i.e., the reauthorization process), improving data collection processes, and developing guidelines for enrolling individuals into FSP programs or referring them to other programs. Table 1 shows the types of innovations the counties chose to work on.

This report covers the original six counties, whose locations represent the major regions of California, from Siskiyou County on the northern border of the state to Ventura County and San Bernardino County in Southern California (Figure 1). The participating counties also represent the range of populations in the state, from rural (Siskiyou County) to urban (Sacramento County).

CalMHSA contracted with RAND to conduct an independent, objective evaluation of the Multi-County FSP Innovation Project. RAND is a nonprofit and nonpartisan policy research organization that has extensive experience evaluating California's mental health programs.[11] The RAND team's evaluation examined the period directly following innovation implementation at the end of 2021 through 2023. We conducted a mixed-methods evaluation, with qualitative and quantitative components. The qualitative evaluation collected and analyzed data from semistructured, qualitative interviews with representatives from the participating counties, including department of behavioral health (DBH) leadership, FSP program administrators, and FSP program providers. The interviews focused on the strengths and weaknesses of the FSP Innovation Project, any impacts interviewees noticed in their programs, challenges that arose during the FSP Innovation Project, perceived sustainability of the work, and lessons learned across the counties. The quantitative component analyzed electronic health records (EHRs) and program data to examine the impact of FSP programs on participant outcomes and whether this

TABLE 1
Innovation Activities

Innovation Activity	Definition	Number of Participating Counties
Defining key populations	Standardize the definition of key populations served by FSP programs (e.g., individuals experiencing homelessness)	6
Defining and tracking outcome and process metrics	Identify standardized measures and metrics for tracking what services individuals receive and key health outcomes	6
Step-down (graduation) guidelines	Define stability and recovery indicators as criteria for FSP program graduation	5
Service requirements	Develop minimum FSP program service requirements to adopt as official guidance	3
Reauthorization process	Standardize the processes for reauthorizing FSP program enrollment for those who do not meet step-down criteria	2
Eligibility guidelines	Revise county-specific eligibility guidelines for enrollment in FSP programs	2
Data collection processes	Streamline existing processes or develop new ways of collecting data that can inform care decisions	2
Referral guidelines	Create a standardized FSP program referral form that captures key data	1
Referral and enrollment processes	Create a specific referral and enrollment process for youth FSP programs	1

FIGURE 1

The Six Counties Participating in California's FSP Innovation Project

impact changed over time as a function of participating in the FSP Innovation Project. In this report, we present the evaluation methodology, key findings, and conclusions from qualitative and quantitative analyses, followed by an overarching conclusion.

Qualitative Evaluation: Findings from Interviews

Qualitative interviews were used to answer evaluation questions regarding the implementation and impact of the Multi-County FSP Innovation Project, including strengths and weaknesses, perceived effects, barriers and facilitators, and lessons learned. We also inquired about the sustainability of the changes implemented.

Methods

Sampling and Recruitment

RAND worked with county points of contact to identify potential participants in the qualitative interviews. We requested that these people provide contact information for two groups of individuals: (1) county DBH leadership (i.e., individuals who could speak to how the FSP Innovation Project changed practices and about the strengths and weaknesses of the project) and (2) contracted providers (i.e., individuals who could speak to the impact of the FSP Innovation Project on providers and potentially on individuals served). Points of contact were not given a specific number of individuals to identify in each category, as counties varied in terms of the number of individuals in each of these two roles.

A member of the evaluation team reached out to potential participants via email up to five times to try to schedule an interview. The RAND team conducted 31 semistructured qualitative interviews about the FSP Innovation Project. The qualitative interview sample included 31 completed interviews involving DBH leadership and administrators (n = 14) and FSP providers (n = 17) across the participating counties. The team interviewed between five and eight people from Fresno, Sacramento, Ventura, and Siskiyou counties, and the team spoke with one to four people from San Bernardino and San Mateo counties. An additional 18 key informants were contacted via email up to five times and did not respond to the interview request.

Measures and Metrics

The RAND evaluation team developed a semistructured interview protocol that guided our discussions with participants; it was based on key goals of the FSP Innovation Project, outlined in Table 1. Specifically, the interview protocol covered new activities and changes made as part of the FSP Innovation Project, the implementation process, and any impacts the changes had on staff and for the populations they serve. We also discussed challenges to implementation and lessons learned, sustainability of the new activities, and strengths and weaknesses of the FSP Innovation Project.

Procedures

All of our evaluation procedures were approved by RAND's Human Subjects Protection Committee. Before conducting interviews, we obtained verbal consent from our interviewees. All of our interviews were conducted virtually via Zoom for Government, which is a RAND-approved secure platform for conducting qualitative interviews. Interviewers also received verbal consent to audio record interviews for note-taking purposes. Interviewers took detailed notes during the interview in a Microsoft Excel abstraction form designed based on the interview questions in our interview protocol and then went back to listen to recorded interviews as necessary to fill in the matrix with any important missing details.

In cases in which interviewees asserted that no changes were made as a result of the FSP Innovation Project (n = 2), our protocol was to ask about each activity and change in the interview protocol to ensure that we were not missing important details. With these interviews, we noted that no new changes were reported as the outcome of the interview.

Data Analysis

To analyze the data, our team used the abstraction form described above to pull out recurring themes across the interviews. After each interview, the interviewer filled out the form with the respondent's

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comments related to each topic covered. This method helped outline implementation changes across each county. The abstraction matrix also described implementation barriers and facilitators, the status of implementation changes, findings about sustainability of the changes, and opinions on the FSP Innovation Project overall. The RAND evaluation team used the abstraction spreadsheet for a rapid thematic analysis.[12] Each interviewee filled in their abstraction form, and one other interviewer read the notes to confirm interview results. Major findings were identified by RAND evaluators. Discussion among all team members was used to resolve disagreement about the findings. This method helped highlight implementation changes, challenges, facilitators, and lessons learned.

Results

We identified several broad themes about the strengths and challenges associated with the FSP Innovation Project. In this section, we first describe the accomplishments of the FSP Innovation Project, overall and in terms of the targeted innovation areas. We then discuss lessons learned from implementation, including implications for the overall sustainability of the interventions. We conclude with a summary of findings identified in the interviews.

Impact of the FSP Innovation Project

County leadership worked with Third Sector to identify areas to focus on for implementing interventions (see Table 1). All six participating counties committed to defining key populations and defining and tracking process and outcome metrics. In addition, counties selected a few additional interventions to implement locally based on their priorities. Five of the counties were working on step-down or graduation guidelines. Three addressed service requirements. Two counties focused on eligibility guidelines. Two counties worked on reauthorization processes. Two addressed improving their data collection processes, and one of them also worked on addressing referral guidelines. One county worked on its referral and enrollment processes for youth FSP programs.

Interviewees were asked to share their perspectives on strengths of the FSP Innovation Project and share what changes or new activities they undertook. Across participating counties, four key strengths of the FSP Innovation Project emerged. Information about these key strengths is presented below, followed by impact within the targeted areas of the project.

The Multi-County FSP Innovation Project Helped Reinforce the Program's Mission

FSP programs are designed to provide comprehensive health and social services to support individuals experiencing severe symptoms of SMI and having significant practical needs (e.g., people experiencing homelessness) across California. Some interviewees highlighted how participating in the FSP Innovation Project reminded county leadership, administrators, and providers of exactly what the FSP policies and regulations are and underscored the impor-

tance of focusing on mechanisms that best support their counties' most-vulnerable FSP recipients (e.g., strengths-based models of care). One leadership interviewee discussed the importance of achieving clarity "across the spectrum, from executives down to staffing to now know what an FSP means, what it entails, and what it should look like," as a strength of the project. **Participation reminded counties of their FSP programs' mission.** For example, one administrator remarked that FSP programs should "foster independence and [help individuals served] connect to their community" so that those in the program can ultimately utilize "the lowest level of care possible. . . . [The project was] a reminder to everybody that that's what we're doing."

The Multi-County FSP Innovation Project Facilitated Collaboration Across and Within County FSPs

Representatives from almost all counties spoke to the importance of the **knowledge sharing across and within counties** that was fostered by the FSP Innovation Project. One county administrator stated, "I think we had a lot of really good dialogue in the FSP Innovation Project, and it was great to talk to other counties and see how they were problem-solving. So, I think the information sharing" was a strength. Interviewees from two counties attributed this collaboration to the effective facilitation of the FSP Innovation Project by Third Sector. Within counties, a few interviewees specifically mentioned positive collaboration with providers. One provider shared that they "loved that the project got provider feedback" and that this feedback led to an end product for graduation guidelines. One FSP leader reported that a major accomplishment of the FSP Innovation Project was bringing together county leaders, FSP providers, and individuals served to design innovations. Another noted that such engagement increased FSP provider buy-in related to innovations.

The Multi-County Innovation Project Achieved Buy-in from Leadership, Administrators, and Providers on the Benefits of Increased Standardization and a Population-Based Approach to FSP Planning

Half of the participating counties specifically noted that a strength of the FSP Innovation Project was **increased standardization** (e.g., language, practices, and forms) related to FSP service provision. In general, interviewees reported that increased standardization would help FSP services be delivered to those with the highest level of need in a timely manner by ensuring that programs' capacities are not used up by those with less intensive service needs. One person in a leadership role shared that the project "provided a lot of clarity," and they "think that's had an impact" on developing clearer guidelines. One interviewee noted that increased standardization created an opportunity to serve larger portions of the population. They explained that, prior to standardization, it was easy to focus solely on individual-level needs rather than looking at what best serves the population overall. Creating a standard approach allows room for the diversity of different individuals who might benefit from FSP services, including those across both rural and urban localities.

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The guidelines developed were an "amazing outcome" of the FSP Innovation Project.

Third Sector Staff Were Helpful Facilitators for the Multi-County FSP Innovation Project, but Participants Felt That Project Processes Could Be More Efficient

Project participants identified several ways that **technical assistance from Third Sector was helpful** throughout the project. Some saw "value [in] . . . putting multiple subject-matter experts together and pulling on all their ideas to strategize." Others reported that they appreciated Third Sector's facilitation style. One county administrator said, "Third Sector was a pleasure to work with. They were both welcoming and noninvasive." Participants reported that Third Sector "did a good job of making the big group smaller" by identifying and connecting programs with similar goals and challenges. Others reported that Third Sector summarized and disseminated information that helped them process information shared by subject-matter experts and in discussions.

At the same time, some interviewees reported the process of developing innovations via the FSP Innovation Project could have been more efficient. Many interviewees commented on the pace and timing of the FSP Innovation Project. Some found that "repetition, a lack of clarity, [and] a lack of direction" during project meetings prevented important steps and slowed decisions about innovations. One interviewee described the process as "pretty slow moving" but noted that the project gained momentum once participants understood relevant program details. A different interviewee reported that they had hoped that the time invested in the FSP Innovation Project would have resulted in a "final product that we can use, . . . [such as] tool[s] that can support [project] work." Another interviewee suggested that inviting key decisionmakers and clarifying the roles of project participants may have improved the effectiveness of the project. That interviewee shared that it "would have been good to have one person per county who was the ultimate decider. It was difficult to have good final product [decided on by] committee."

Project Accomplishments by Targeted Innovation Activities

Table 1 provided an overview of the innovation activities targeted by one or more participating counties. In this section, we describe their accomplishments in each of these areas, in turn.

Defining Key Populations

Counties collaborated successfully to define six key populations for eligibility and outcomes tracking, using the best practices of the California Institute for Behavioral Health Solutions—a behavioral health consultancy with expertise in California systems of care—to aid their process.[13] The participating counties acknowledged that the absence of standardized definitions for their populations created difficulties in understanding who is eligible for FSP programs. Additionally, it was challenging to assess the effectiveness of programs across counties because their definitions do not always align. For instance, one county may consider living in a motel as stable housing, while another county may classify it as a form of homelessness—relevant to both key populations and outcome metrics (see the next section).

One county discussed the need to update guidelines for defining its key populations, noting that the guidelines developed were an "amazing outcome" of the FSP Innovation Project. Another county emphasized the importance of reminding its team to focus on its target population through a behavioral health lens. Although many individuals in the county have needs that the program can assist with, it is crucial to determine whether the FSP program is the appropriate program for them to participate in or whether better-suited programs exist that can also connect them to necessary resources, thus ensuring that the right participants are enrolled in the FSP programs.

One leadership interviewee noted, "We are now safeguarding this program for those who really need it." Ultimately, **the FSP Innovation Project aided in providing clarity and specificity around populations served** for the counties that prioritized this metric.

Defining and Tracking Outcome and Process Metrics

In this targeted innovation activity, the counties made efforts to improve their outcome and process metrics, with dedicated endeavors toward cross-county standardization and staff retraining. **The counties successfully identified common process metrics**, such as the number of encounters for services—for example, individual therapy, group therapy, rehabilitation services, medication management, case management, and flex funding provided to support housing. **Counties also established key outcome metrics**, including increased stable housing, reduced justice system involvement, reduced utilization of psychiatric services, and increased social connectedness.

Interviews revealed that most of the data needed to inform the cross-county metrics were already collected as part of standard FSP care and statewide requirements, so few changes to data collection and tracking processes were needed. However, the brief social connectedness measure required additional data collection—which most counties were not able to immediately implement. An interviewee also noted that the social connectedness measure "is sustainable and gives qualitative insight to case managers." Although most of the data already existed, it was not easy to pull them in a consistent manner that enabled examination of common metrics using the data. To this end, a Third Sector contractor worked with counties to develop a template that all counties could integrate into their processes, drawing on the common metrics identified through the FSP Innovation Project. Each county could upload its data and receive the same output for its outcome metrics.

Step-Down (Graduation) Guidelines

Overall, the FSP Innovation Project's **efforts to define graduation and step-down guidelines were successful**, with all five of the counties that engaged in this targeted innovation activity establishing revised guidelines. Three of the five participating counties reported successfully establishing and implementing common step-down guidelines as part of the innovation process. The other two counties shared that they developed guidelines but had yet to implement them. The impact of these guidelines appeared to vary across the counties. Leadership at one county described this process as "smoothing out the edges" around what graduation and stepping down looks like for their participants and that the multi-county work groups were helpful for developing definitions and gaining clarity around graduation.

Two of the interviewed counties identified best practices for graduation guidelines through a collaborative process between FSP program providers and county mental health departments. One county noted that the primary impact of these discussions was to increase awareness that FSP participants should not be indefinitely enrolled in FSP programs. An FSP program provider from another county described an increased effort to track progress and increase the number of graduations since being involved in those discussions. Similarly, another FSP provider reported that because of the FSP Innovation Project, the clinic spends time in staff meetings discussing participants and the frequency of contact to determine whether they could be eligible for a different program. The providers ask the question, "Does this person need us?" If not, "Do we have other, better-suited options for this client?"

Counties facilitated on-the-ground implementation of the new guidelines using such strategies as incorporating step-down criteria into provider contracts as optional guidelines, developing a training for providers and poster-sized guidelines to share with all agencies, developing and implementing a graduation binder, and offering a transition program prior to graduation. A county noted that the graduation binder was a small change that improved the step-down process and helped their participants "feel more hopeful. This binder shows them their journeys and the successes they have accomplished."

Service Requirements

Three counties worked to develop minimum requirements for services offered by FSP programs. The impact of this effort was mixed, with varying outcomes and efforts across the three participating counties. One member of county leadership reported that their county successfully established a set of mandatory FSP service requirements, which included psychotherapy. Another county representative explained that service requirements depend on local context and priorities and could include the percentage of field-based services, the availability of telehealth options, housing services, employment services, and peer supports. The third county did not discuss any innovations made to service requirements during our interviews. The low number of participating counties makes it challenging to interpret interview findings on service requirement innovation goals.

Reauthorization Process

Two counties worked to standardize the processes for reauthorizing FSP enrollment for those who do not meet step-down criteria. Again, the impact of the FSP Innovation Project was mixed for this targeted innovation activity. One county revised its reauthorization processes. This county collaborated closely with its providers and mentioned the need for good communication between leadership and providers when discussing precarious changes, such as reauthorizations, and emphasized that the goal of reauthorization is to build capacity in programs by ensuring that the right individuals get reauthorized and others are appropriately assessed for readiness to step down. The county has its FSP providers "submit info about why someone is in the program each year" to assess their reauthorization and explained that it is working with FSP programs to "help them see the impact of discharge." The other county did not report implementing changes to its reauthorization process. As above, it is challenging to interpret these findings, because only two counties targeted the reauthorization process as part of the FSP Innovation Project.

Eligibility Guidelines

Two counties worked to revise county-specific eligibility guidelines for enrollment in FSP programs. **Both counties successfully established FSP eligibility guidelines, and representatives reported that their work on FSP eligibility criteria was beneficial to their counties.** One interviewee discussed gaining "clarity" around eligibility guidelines for their programs. The individual discussed developing an improved and more clearly targeted population. The FSP Innovation Project helped streamline eligibility guideline processes. The other county discussed gaining clarity around the definitions of *homelessness* and *medical necessity*. Representatives were able to review the eligibility guidelines of other counties through the project and adjust some of their eligibility criteria. One interviewee shared that their "county developed very detailed guidelines."

Data Collection Processes

Two counties **successfully streamlined existing data collection processes or developed new ways of collecting data that can inform care decisions**. Representatives from one county shared that they developed a universal referral form in a centralized location so that participant-specific information can be assessed quickly as needed. They noted developing processes to collect data at multiple points so that participant goals can be recorded and assessed over time. An interviewee explained that "it takes a whole team to stay consistent in collecting information" and that "it helps us. It helps the client, and it helps the tracking system." Representatives from the other county described using the Level of Care Utilization System (LOCUS) form and score sheet and adding these data to their caseload tracking.

Representatives from one county explained that implementation is still in development and noted that it was too early to measure impact, and representatives from the other county said that their implementation is complete but did not mention any notable impact during the interview.

Referral Guidelines

One county aimed to create a standardized FSP referral form that captures key data. This county reported that it **successfully developed both paper and online referral forms and created revised referral processes**. The referral form included a checklist with referral criteria and the required referral processes.

Interviewees described the implementation process as ongoing and thus impact is not yet known.

Referral and Enrollment Processes

One county **successfully developed a referral and enrollment process for youth FSP programs**. First, the county reviewed referrals and noticed a lack of standardization across providers. The county "worked with providers to narrow down information needed" and implemented this feedback into its process. The county then established a revised process for reviewing the eligibility of referred youth for enrollment in FSP programs. It developed a checklist for use by DBH staff to support the screening process for program entry. The county also worked to train referring providers on the requirements for admission to youth FSP programs to reduce the number of inappropriate referrals that require screening.

Lessons Learned About the Implementation and Sustainment of Multi-County FSP Innovation Project Changes

The qualitative interviews conducted as part of this evaluation revealed several lessons related to the implementation and impact of the FSP Innovation Project.

Shared decisionmaking between FSP leaders and program staff facilitated implementation. Interviews highlighted the importance of including providers in the shared decisionmaking process. Some interviewees reported that engaging FSP providers in implementing innovations was generally well received by providers because the engagement was collaborative in nature and not punitive. Some credited Third Sector for working "so closely with providers throughout the process [that] the rollout of new policies and procedures went smoothly, with no pushback." Similarly, others reported that collaboration between FSP leaders and providers prevented implementation delays. For example, one county received feedback that the providers using a newly developed step-down tool found it to be helpful, especially because the providers helped co-design the product. Interviews revealed that it was important to communicate early and often with the providers who will be responsible for implementing new policies and guidelines. Those counties that had more provider input seemed to have an easier road to implementation.

Co-designing and implementing a countywide standardized referral form helped some counties improve their communication, participant data collection, and care coordination. One county worked collaboratively with its FSP program providers in reviewing each program's referral forms to identify common elements and reach a consensus on the most-essential items for inclusion in the final standardized referral form to be used by all FSP program providers. This co-design process highlighted the importance of communication between FSP leaders and FSP providers, as well as among FSP providers. This communication resulted in consensus about standard data elements in the referral form, despite program differences. One county reported that a paper-copy version of this standardized referral form had been implemented, although the online version of the form had not yet been incorporated into the county's EHR system. An interviewee noted, "It is so helpful to have something like this in place for care coordination." An interviewee from another county reported that the standardized form was very similar to the one that was previously used in their county, so the county did not expend resources on implementing a revised form. This example suggests that a shared decisionmaking process can facilitate implementation by easing the adoption of FSP Innovation Project innovations, increasing the spread of systems that work across counties, and reducing effort spent implementing unnecessary changes.

Some FSP providers reported insufficient dissemination of the innovations and training on how to implement them. Some counties took different approaches to disseminating innovations and training FSP staff. One county included the innovations it created for step-down criteria as a recommendation in its FSP provider contracts. The county also produced email notifications, informational posters, and provider trainings that were designed to disseminate information about project innovations. Interviews suggested that these dissemination materials were not sufficient to create changes among FSP staff. Some provider interviewees reported being unaware of FSP innovations, including step-down guidelines.

Overall, workforce recruitment and retention may be a critical factor in the successful implementation and sustainment of efforts associated with the FSP Innovation Project.

Other provider interviewees shared that counties did not follow up after the initial email announcement introducing these guidelines and resources.

Interviews revealed that FSP staff and providers require additional training on innovations developed during the FSP Innovation Project. One county's representatives discussed the need for additional funding to provide training around the new interventions and processes. A different county's representatives explained that staff were trained to ask about social connectedness, but the uptake had been inconsistent and challenging. Another county's representatives noted that "guidelines have been shared but we still need to work on developing trainings to ensure uniform implementation and uptake." Overall, both county leadership and providers discussed the need for training to understand and implement the innovations.

Some structural and contextual factors inhibited the implementation of innovations developed as part of the Multi-County FSP Innovation Project. Some interviewees reported challenges in making changes to **information technologies** to correspond with the innovations in defining and tracking FSP outcomes. For example, some counties noted that incompatibilities between state- and county-data EHR systems resulted in workflow problems and redundancies.

Workforce shortages were cited as a barrier to the implementation of the FSP Innovation Project. These shortages were reported by county administrators and FSP providers and appeared to be exacerbated during the COVID-19 pandemic. Two interviewees discussed spending months trying to fill positions in their FSP programs, which prevented them from implementing new processes or procedures related to the programs because they did not have the adequate staff to train and implement the changes. For example, one county developed a new referral and enrollment process that required county staff to review incoming participant referrals. A preexisting staffing shortage resulted in delays in the review process. As a result, this county reassigned county staff to conduct these reviews, taking these staff away from work on other important projects. Another county reported that staffing shortages were a barrier to implementing FSP service requirements because county FSPs did not have the bandwidth to meet these requirements. Other interviewees highlighted burnout as a significant workforce issue that is a barrier to sustaining innovations from the FSP Innovation Project, with some being reluctant to ask more of strained staff. Overall, **workforce recruitment and retention** may be a critical factor in the successful implementation and sustainment of efforts associated with the FSP Innovation Project.

Participants in the FSP Innovation Project also suggested that the sustainment of project efforts would be influenced by larger policy and program changes in California. Interviews revealed that impending statewide changes to mental health care financing and health department recordkeeping preceded or coincided with intended changes proposed by the FSP Innovation Project. In multiple interviews, respondents reported concerns about dealing with the possible impact of statewide payment reform at the same time that they were implementing FSP innovations. Program administrators and providers also reported that changes in their countywide EHR platform may also create strains that disrupt the sustainment of efforts associated with the FSP Innovation Project. Staff reported feeling that they

had lower capacity to implement changes developed by the FSP Innovation Project because they focused resources on preparing for these other wide-scale changes. One county leader pointed out that "implementation of something like this has to be timed really well" to prevent contextual factors from disrupting progress.

Early Lessons Learned About the Impact of Innovations

Innovations developed as part of the Multi-County FSP Innovation Project increased adherence with guidelines on the enrollment, retention, and graduation of individuals served. A major focus of the FSP Innovation Project was the standardization of criteria used to determine which individuals served were eligible for FSP services. In general, interviews with county leaders and FSP providers indicated that the innovations designed as part of the FSP Innovation Project have resulted in changes to the enrollment, retention, and graduation practices used by FSPs. Broadly, the interviews suggested that FSP services are more consistently reserved for people who have the highest severity of mental health symptoms and co-occurring vulnerabilities related to housing instability, frequent hospitalization, and interactions with the criminal justice system. FSP providers shared that there is a high demand for services for people who do not meet this overall criterion but that the innovation process resulted in higher levels of adherence to enrollment, retention, and graduation guidelines. One interviewee noted that some individuals served "want housing but don't want to engage in any form of treatment. We have to remind the [individuals served] and referring parties that we are not a housing program; it is only one component of our program." Several county leaders and providers reported that the FSP Innovation Project resulted in collaborative audits of the census of individuals served to ensure that they met criteria for FSP services. Stated differently, **the FSP Innovation Project resulted in changes to ensure that the high-intensity services provided by FSP programs are reserved for the most-vulnerable individuals served**.

These innovations also created unintended service gaps. Refining enrollment criteria to ensure that FSP programs are provided only to those with severe symptoms resulted in an unintended gap in services for those with moderately severe symptoms. For example, one county reported that youth ages 0–5 with moderately severe symptoms had previously been served by a county FSP program. After changes to enrollment guidelines, these youth were no longer eligible for FSP and instead were placed on waiting lists for other programs. This county reported that families of children with moderately severe symptoms now struggle to find providers trained in evidence-based practices to care for these children. More broadly, several interviewees reported that these changes to enrollment created problems in connecting individuals with care in a timely manner.

Interviews revealed a similar issue associated with innovations in graduation criteria. One interviewee stated that the "lack of [an] intermediate step

The interviews suggested that FSP services are more consistently reserved for people who have the highest severity of mental health symptoms and co-occurring vulnerabilities related to housing instability, frequent hospitalization, and interactions with the criminal justice system.

Improvements in adherence to FSP enrollment, reauthorization, and graduation criteria created a dilemma for programs that lacked alternative practical supports for those who did not meet FSP enrollment criteria and for those who were ready for graduation from FSP programs.

between [the FSP] level . . . [and lower levels of care] . . . makes implementation of graduation difficult. It feels like a big leap" for individuals who received intensive support from FSPs to transfer to typical outpatient treatment. Other interviewees reported that they had difficulty finding lower-intensity services that had availability to enroll those individuals who graduated from FSPs. Some FSP providers reported that individuals served were hesitant to lose the long-standing, trusting relationships that they developed with FSP providers and to establish relationships with new providers upon meeting graduation criteria. Some providers reported that they took steps to fill the gap created by the FSP Innovation Project. For example, some reported that they supported individuals served through the transition to new providers and remained in contact with them until they were engaged in appropriate lower-level care. FSP providers reported that they took these steps to ensure that individuals who graduate from FSPs do not experience a relapse in the severity of their symptoms as a result of transitioning to a lower level of care.

FSP administrators and providers reported that programs had historically offered services to those who did not meet criteria for FSP programs to more easily provide participants with housing, transportation, and financial support. Improvements in adherence to FSP enrollment, reauthorization, and graduation criteria created a dilemma for programs that lacked alternative practical supports for those who did not meet FSP enrollment criteria and for those who were ready for graduation from FSP programs. For example, FSP providers pointed out that when individuals served by FSP programs experience improvements in their mental health and functioning, they may still need housing support. One service provider said, "We can refer [individuals served] back to DMH [the Department of Mental Health—i.e., a DBH], but they can't afford to spend $1,400 to $1,500 on an apartment, because that is all of their income." Many reported that these individuals served could lose vital housing and transportation supports if they are referred to a lower-intensity level of care.

Representatives from some counties reported that they faced policy and administrative barriers to addressing the practical needs of individuals who did not qualify for or who graduated from FSP programs. FSP administrators reported that, with the exception of FSP funding, policies create separate pools of funding for mental health services and housing services. Interviewees reported that one county had housing funds for program participants but faced administrative barriers in using these funds. One leader reported that the "biggest change is around our . . . use of basic-needs funding. There was a lot of underutilization of those funds. . . . We are waiting on fine tuning some stuff with our fiscal department to be able to use" this funding more efficiently. **Policy changes may be needed to increase access to practical and financial supports for people who do not meet enrollment criteria for, or who graduate from, FSP programs.**

FSP administrators and providers advocated further development of a full continuum of care to mitigate service gaps caused by improved adherence to FSP criteria. FSP programs that had good access to a full continuum of care that spanned low- to high-acuity services reported fewer gaps in services for people who did not qualify for FSP services or who were ready for graduation from an FSP program. FSP providers described a need for a care continuum in which individuals served could work with a single provider while receiving more or less intensive care based on their needs. Individuals served would benefit because they would not be required to switch providers when they moved across different levels of care. Developing a full continuum of care may also address concerns about supportive housing and transportation needs for individuals served (see the previous section). Additionally, having a full a continuum of care within a given provider organization would facilitate more rapidly increasing the intensity of services for individuals served when their symptoms or circumstances changed. For example, when discussing criteria that disallow the reauthorization of services to people who have not attended an FSP appointment, one interviewee said, "I would always fear that, at the 60-day mark, we discharge [an individual served by an FSP program who has engaged in care], and a week later they are hospitalized and have to be reenrolled" and experience a delay in receiving services. Organizations that offered FSP services as part of a full continuum of care could avoid delays in transitioning individuals to both higher- and lower-acuity services.

Discussion

Interviews with county staff and FSP providers highlighted important interventions that were implemented across the six participating counties. **Counties successfully developed standardized definitions for key populations:** individuals experiencing homelessness, those with justice system involvement, and those at risk of experiencing homelessness and justice system involvement. This standardization will help create clarity around eligibility for programs and the effectiveness of FSP programs. **All counties successfully identified common process and outcome metrics**, which can be used to measure the success of their programs and facilitate cross-county conversations about FSP processes and outcomes. Several **counties succeeded in creating step-down and graduation guidelines to clarify when program participants are ready to move to a lower level of care and free up FSP capacity** for those who need the services. With respect to innovations pursued by a small number of counties, two counties successfully implemented improved data collection processes and two others reported changes in referral guidelines or referral and enrollment processes. Counties varied in the extent to which they implemented standardized service requirements and reauthorization processes.

After the initial development of innovations, there were variations in the sustained success of implementation efforts, with some counties reporting little on-the-ground implementation of the processes designed in the innovation projects and others sharing success stories with implementation and confidence in sustainability over time. **Involving providers in the changes seemed to facilitate the successful implementation of innovations.**

Findings suggest that **increased provider training may facilitate on-the-ground implementation of the innovations**. It will also be important for future innovation projects to **address step-down options** for those who do not require FSP-level care, in light of concerns about service gaps as an unintended consequence of increased attention to enrollment and graduation criteria. These gaps in care cannot be fully addressed by the Multi-County FSP Innovation Project, but they contributed to concerns for the ongoing sustainability of the successfully made changes.

Quantitative Evaluation: Findings from Patient Data

The quantitative component of the evaluation analyzed EHR and program data to answer evaluation questions about (1) the impact of FSP programs on participant outcomes and (2) whether this impact changed over time as a function of Multi-County FSP Innovation Project participation. We conducted a pre-post comparison of key outcomes for 2,555

FSP program participants, looking at changes within individuals served over time.

Methods

Study Data

We evaluated the effectiveness of FSP programs on improving participant outcomes by comparing data that covered the year prior to a participant's enrollment in an FSP program with data covering the first 12 months after enrollment to assess whether outcomes improved after enrollment. Our analyses relied on two primary data sources: the MHSA FSP Data Collection and Reporting System (DCR) and EHRs from the counties' DBHs. The DCR system includes the Partnership Assessment Form (PAF), which is completed when a participant enrolls in an FSP program; the Quarterly Assessment Form (3M), completed every three months of participation; and the Key Event Tracker (KET) data that contain records for each change in a participant's housing, employment, or education. The EHR data identify each time a service is provided to an FSP participant and includes the type of service and the date on which it was provided.

We also evaluated the potential impact of a county's participation in the FSP Innovation Project by comparing changes in FSP participant outcomes prior to the start of the project with outcomes after the project ended.

The FSP Innovation Project's design and implementation phase with the first cohort of counties took place from October 2020 through October 2021, and we requested DCR and EHR data for all FSP participants who enrolled at any time from July 1, 2019, through October 31, 2023.

Outcome Metrics

The outcome metrics selected for the FSP Innovation Project were associated with the success of FSP programs and were carefully aligned with the primary objectives of the DBHs and FSP programs. The metrics were selected by participating counties through a collaborative process guided by Third Sector (Table 2). The outcomes were to increase stable housing, reduce the utilization of inpatient psychiatric services, reduce justice system involvement, and increase social connection.

We assessed the impact of FSP participation on these outcomes by comparing their values in the year prior to enrollment to the first year of participation. All outcome metrics with the exception of social connection were tracked in the DCR data. Data for the 12 months prior to enrollment were captured on the PAF through a series of items that covered housing status, inpatient psychiatric admissions, and arrests.

TABLE 2

Outcome Metrics Selected by the FSP Innovation Project

Outcome Metric	Definition
Days of stable housing	The number of days during the 12 months pre- and postenrollment that a participant experienced stable housing in a home in which they hold the lease or share in the rent or mortgage, with adult family members, or in a single-room occupancy (must hold lease)
Number of mental health inpatient admissions	The number of times during the 12 months pre- and postenrollment that a participant was admitted to a psychiatric hospital or general hospital to receive psychiatric care
Number of mental health inpatient days for those with an admission	The number of days during the 12 months pre- and postenrollment that a participant with an admission experienced in psychiatric hospitals or general hospitals to receive psychiatric care
Ever arrested (yes or no)	Was the participant arrested during the 12 months pre- and postenrollment?
Number of arrests for those with at least one	How many times was the participant arrested during the 12 months pre- and postenrollment?
Social connectedness (Likert scale, never to always)	How often did the participant get the social and emotional support they needed during the 12 months pre- and postenrollment?

NOTE: DCR PAF and KET data are used to compute all but social connectedness. Counties planned to add social connectedness to the 3M assessment, but we did not receive any data that included this measure.

These items had the following structure: "How many times in the past 12 months did you live with a family member?" and "How many days during the past 12 months did you live with a family member?"

The 12 months prior to a participant's enrollment was the only period covered by items in the PAF, so we created outcome metrics before and after enrollment that covered 12 months. Data for the first 12 months of participation after enrollment were captured in the KET. Even though data included enrollment through October 2023, we limited our study to participants who enrolled July 2019 through October 2022 to observe a complete 12 months of FSP participation. For participants who enrolled through October 2022, we used KET data through October 2023 to compute the outcomes following enrollment.

Counties agreed to add a measure of social connection as part of the FSP Innovation Project, but adding a new measure was challenging, and the counties were unable to implement this during the data collection period we examined. Therefore, we were unable to assess the impact of FSPs on social connection.

Service Utilization

FSP participants commonly receive case management, rehabilitation, medication management, and psychotherapy, among other services. We used EHR data to count the number of each type of service FSP participants utilized during the first 12 months of their enrollment and then used these counts to evaluate whether there is an association between utilization of these services and outcomes for FSP participants. FSP participants received services after enrollment, so we did not have EHR service data for the time prior to enrollment. We were unable to discern a causal relationship between receiving services and participant outcomes because we could only observe both, without differentiation, during the same period.

Although our outcome metrics were consistently coded in the DCR data, there was variation in how counties recorded services. The DCR assessments and KET data were specified by the state. Counties were able to add a few measures of their own (such as social connection), but the existing measures were coded the same. There was no such consistency in the EHR data because of differences in how counties coded their services and in EHR providers. We reviewed service codes in the EHR data we received and classified them into the following categories:

- case management
- individual therapy
- group therapy
- medication management
- rehabilitation services.

Housing services were not separately identified from case management in most counties' EHRs. Consequently, we used case management services rather than housing services as a predictor of housing outcomes.

Statistical Models

To estimate the association between FSP participation and changes in outcomes, we compared each of the outcomes in Table 2 for the 12 months *prior* to FSP enrollment with the first 12 months of FSP participation. This model answered the question, "Did FSP participants demonstrate improvement before versus after participation?" In other words, did they get better over time?

We estimated models with a pre-post structure:

$$Y_{it} = m_0 + m_1 post_{it} + m_2 y2020_i + m_3 y2021_i + m_4 y2022_i + \varepsilon_{it},,$$

where Y_{it} is the outcome for participant i in time period t (pre-post), $post_{it}$ is an indicator for the first 12 months after enrollment in an FSP program, and $y2020_i$–$y2022_i$ are indicators for the year in which participant i enrolled. The coefficient estimate, m_1, is our estimate of the association between participation in an FSP program and each outcome. We included calendar-year indicators to control for state-level external effects, such as state policies or societal changes, that could also influence the outcomes. For instance, a statewide initiative about housing could inadvertently affect the housing stability outcomes for FSP participants, and the COVID-19 pandemic could affect service utilization. By controlling for these external factors, the model seeks to isolate the effect of FSP participation from other statewide changes. We did not include county indicators to

Participants experienced an average increase of 128 days of stable housing in the first year of FSP participation. The total number of psychiatric admissions decreased on average by 2.5 admissions.

keep the focus on the general effect of FSP participation rather than on comparing performance across different counties. This approach aligns with the report's goal of evaluating the statewide effectiveness of FSP programs, assuming that a program's influence on outcomes is consistent across California. We used maximum likelihood to estimate the association and cluster standard errors by county and participant identification number to account for the hierarchical structure of the data.

To estimate the association between FSP service utilization and participant outcomes, we focused on the first 12 months of FSP participation and regressed each outcome on the number of times a participant received each type of service:

$$Y_i = m_0 + m_1 casemanagement_i + m_2 individualtherapy_i + m_3 grouptherapy_i + m_4 rehabservices_i + m_5 medicationmanagement_i + m_6 y2020_i + m_7 y2021_i + m_8 y2022_i + \varepsilon_i,$$

where Y_i is the outcome for participant *i*, each of the five service types represent the count of services received by participant *i* during the first 12 months of FSP participation, and $y2020_i$–$y2022_i$ are indicators for the year in which participant *i* enrolled. The coefficient estimates, m_1–m_5, are the estimates for how the intensity and type of services provided by FSPs are associated with participant outcomes. We used maximum likelihood to estimate the association and cluster standard errors by county to account for the hierarchical structure of the data.

To estimate the association between a county's participation in the FSP Innovation Project starting October 2021 and potential changes in FSP participant outcomes, we compared each FSP participant's outcomes before and after enrollment in a program and added an indicator that identifies when that enrollment occurs in months after the start of the FSP Innovation Project. This model answers the question, "Is participation in the FSP Innovation Project associated with greater improvement in outcomes over time?"

We estimated models with a pre-post structure and included a term that captures the interaction between the first 12 months of FSP participation (*post* from our equation above) and the year of enrollment after the end of FSP Innovation Project (November 2021 through October 2022):

$$Y_{it} = m_0 + m_1 post_{it} + m_2 post_{it} X innovation_t + m_3 y2020_i + m_4 y2021_i + y m_5 y2022_i + \varepsilon_{it},$$

where Y_{it} is the outcome for participant *i* in time period *t* (pre-post enrollment in an FSP program). As in the previous equation, $post_{it}$ is an indicator for the first 12 months after enrollment in an FSP program. The interaction term, $post_{it} X innovation_t$, is the interaction between the first 12 months after enrollment in an FSP program for a participant and the end of county participation in the FSP Innovation Project. This term captures moderation of the FSP program effect—whether the effect increases or decreases as a function of FSP Innovation Project participation. The terms $y2020_i$–$y2022_i$ are indicators for the year in which participant *i* enrolled. The coefficient estimate, m_2, is our estimate of the incremental association between participation in an FSP program and each outcome after the end of the FSP Innovation Project.

The forms of the models depend on the distributions of the outcomes. The number of days of stable housing and the length of stay for psychiatric admissions are distributed normally and use linear models to estimate these associations. The number of psychiatric admissions is a count of relatively rare events and has an excess of zeros, so we used zero-inflated negative binomial models to estimate these associations.[14] Whether a participant is arrested is a yes-no outcome. We used a common approach in modeling outcomes of this form and estimated this association with a logit model. We reported the average marginal effect, or the average effect in the population of FSP participants of a change in the variable of interest on the outcome.

Results

Data Description

We received DCR data for 2,555 FSP participants enrolled from July 2019 through October 2022, across six participating counties. We needed each participant's PAF record to identify outcomes prior to enrollment in an FSP program, and we received PAF records for 2,143 (84 percent) of the participants, so our analyses are based on this subgroup of participants. To identify outcomes during FSP participation, we needed both the DCR KET data on key events, such as changes in housing status, and the EHR data. Among the participants we analyzed, 69 percent had at least one event record, and 88 percent had at least one EHR record.

KETs are completed only when a key event occurs, such as a change in housing status. The absence of a KET form is meant to indicate that there was no change to record, and we analyzed the data assuming that this was accurate (i.e., no KET indicated no event). However, a limitation to this data collection method is that we could not definitively distinguish between whether the individual served did not experience any events or whether they experienced an event but a form was not completed. However, we think that if there are missing data, the evaluation findings are unlikely to be affected in a systematic manner.

Association Between Changes in Outcomes and Participation in FSPs

FSP participants experienced significant improvement on average for all of the outcomes we evaluated, except length of stay in a psychiatric inpatient setting (Table 3). The changes reported in the last column on the table represent the average change after controlling for the year of enrollment in an FSP. Participants experienced an average increase of 128 days of stable housing in the first year of FSP participation (95 percent confidence interval [CI]: 120 to 136 days), compared with the 12 months prior to enrollment. Both the likelihood of being arrested (–26 percent; 95 percent CI: –23 percent to –29 percent) and the number of arrests (–0.5, 95 percent CI: –0.2 to –0.8) among those with any arrest decreased on average for FSP participants. The total number of psychiatric admissions decreased on average by 2.5

TABLE 3

Change in Participant Outcomes from One Year Prior to Enrollment in an FSP Program and One Year Postenrollment

Outcome Metric	Average During Year Preenrollment	Average During Year Postenrollment	Change in Average Value After Controlling for Year of Enrollment[a]
Number of days of stable housing	120.6	248.8	128.2***
Ever arrested (%)	31.0	5.1	–26.4***
Number of arrests for those with at least one	1.8	1.4	–0.5**
Number of psychiatric inpatient stays	1.6	0.1	–2.5***
Length of stay for those with an admission (days)	55.6	41.0	–15.3

NOTE: * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

[a] Estimated difference in outcomes (postenrollment – preenrollment) for FSP participants based on a regression model controlling for year of enrollment. The values reported in this table are the marginal effects from the model estimates based on the maximum likelihood, with standard errors clustered at the county and participant levels.

admissions (95 percent CI: –1.7 to –3.3), but the average annual length of stay for those who had at least one admission did not change significantly.

Service Utilization

Table 4 summarizes utilization by FSP participants of key services during the first 12 months following their enrollment. Case management was the most common service, utilized by 94 percent of FSP participants, with an average of 22 services or roughly once every two weeks. Rehabilitation services were also utilized an average of 22 times during the year by 84 percent of participants. Most participants (82 percent) utilized medication management services, and fewer than half (41 percent) utilized individual or group therapy. It is possible that participants received case management as part of rehabilitation or medication management services, and it also possible that participants received additional services during a visit that were coded as case management.

Association Between Service Utilization and Changes in Outcomes

Service utilization is associated with each of the outcomes we evaluated (Table 5). Each use of therapy by an FSP participant is associated with an average decrease of 0.009 arrests (95 percent CI: –0.0001 to –0.016), an average decrease of 0.01 psychiatric inpatient admissions (95 percent CI: –0.0004 to –0.01), and an average decrease of one day in the length of stay for those who were admitted (95 percent CI: –0.7 to –1.3). Medication management utilization is

TABLE 4

Summary of Key Service Utilization in the 12 Months Following Participant Enrollment in an FSP Program

Service	Enrollees with Any (%)	Average Number of Services	Minimum	Median	Maximum
Therapy	40.6	4.9	0	0	183
Medication management	82.4	9.1	0	5	114
Rehabilitation services	84.4	22.2	0	13	281
Case management	93.6	21.9	0	13	265
Any of above types of services	100.0	59.7	1	44	416

TABLE 5

Estimated Difference in Participant Outcomes Associated with Amount of Service Utilization

Services	Days of Stable Housing	Any Arrests? (%)	Number of Arrests Among Those with Any	Number of Psychiatric Inpatient Admissions	Length of Stay (Days) for Those with an Admission
Therapy	–0.1	–0.2	–0.009*	–0.01**	–1.0**
Medication management	1.4***	–0.2***	–0.02*	–0.001*	0.4
Rehabilitation services	0.8*	–0.1***	0.02***	–0.0	–0.3
Case management	–0.6*	0.1***	–0.001	0.001*	0.3*

NOTE: The estimated change is based on regression model controlling for year of enrollment. The values reported in this table are the marginal effects from the model estimates based on maximum likelihood with standard errors clustered at the county level. The statistically significant values are in shaded cells.

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

associated with increased days of stable housing (1.4 days, 95 percent CI: 1.0 to 1.8), decreased likelihood of arrest (−0.2 percent, 95 percent CI: −0.1 percent to −0.3 percent) and the number of arrests (−0.02, 95 percent CI: −0.001 to −0.04), and decreased psychiatric admissions (−0.001, 95 percent CI: −0.00004 to −0.002). Rehabilitation service utilization is associated with increased stable housing (0.8 days, 95 percent CI: 0.1 to 1.5), decreased likelihood of arrest (−0.1 percent, 95 percent CI: −0.04 percent to −0.3 percent), and *increased* number of arrests among those with at least one (0.02, 95 percent CI: 0.01 to 0.04).

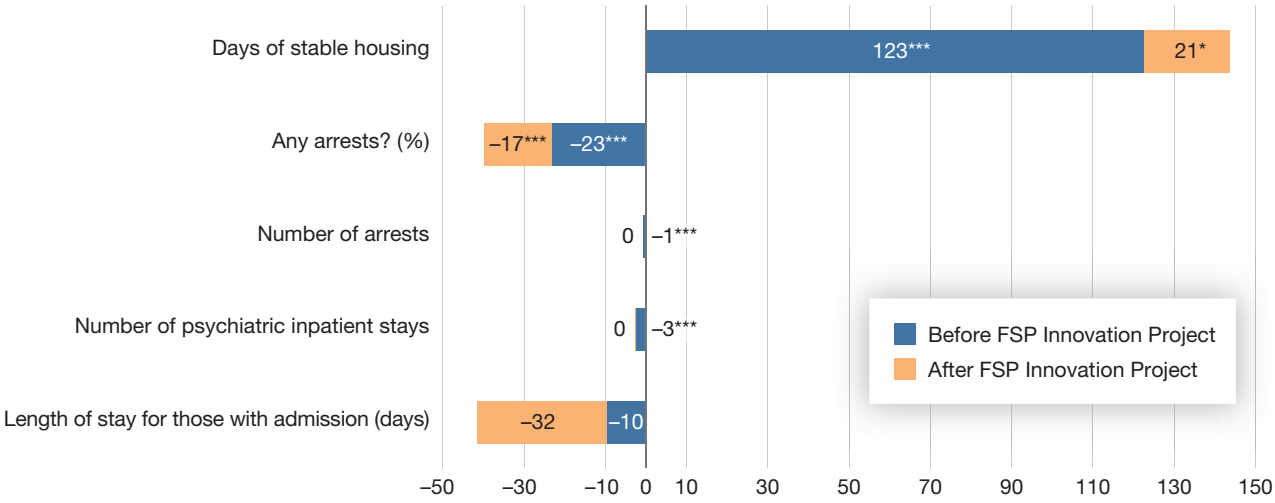
Case management utilization is associated with a *decrease* in the number of days of stable housing (−0.6 days, 95 percent CI: −0.01 to −1.1) and *increased* likelihood of arrest (0.1 percent, 95 percent CI: 0.07 percent to 0.12 percent). These counterintuitive associations highlight the challenges in interpreting these results. It is possible that increased case management causes declines in some outcomes, but it is also possible (and more likely) that more-complex FSP participants with worse outcomes on average utilize more case management. We were unable to distinguish among the possible causal relationships and can only estimate an association.

Association Between County Participation in the FSP Innovation Project and FSP Program Outcomes

We examined outcomes for FSP participants who enrolled prior to the FSP Innovation Project with those who enrolled from November 2021 through October 2022, examining their data through October 2023. **FSP participants who enrolled after the start of the FSP Innovation Project experienced greater improvement in two of the outcomes we evaluated than participants who enrolled prior to the project** (Figure 2). The total length of the two-color bars in Figure 2 represents the estimated change in outcomes for those who enrolled after the FSP Innovation Project began. The blue section of the bar represents the estimated change for enrollees who enrolled prior to the FSP Innovation Project, and the orange section represents the difference in the change for enrollees who enrolled after it began. After counties began participating in the FSP Innovation Project, the days of stable housing increased an additional 21 days (95 percent CI: 2.7 to 39.1) for their FSP participants. The likelihood of arrest decreased by an additional 17 percentage points (95 percent CI: –7 percent to –26 percent). There were significant decreases in

FIGURE 2

Estimated Change in Participant Outcomes Associated with a County's Participation in the FSP Innovation Project



NOTE: The estimated change is based on a regression model controlling for year of enrollment. The values reported in this figure are the marginal effects from the model estimates based on the maximum likelihood, with standard errors clustered at the county and participant levels.

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

After counties joined the FSP Innovation Project, the improvement in outcomes increased for their FSP participants.

the number of arrests and the number of psychiatric inpatient admissions prior to the FSP Innovation Project, but there was no significant change in this pattern after counties began participating. The additional change in psychiatric inpatient length of stay after participating is not significant.

Discussion

Outcomes for FSP participants improved during the first 12 months of participation relative to the 12 months prior to participation: **Participants experienced increased stable housing, decreased justice system involvement, and reduced psychiatric inpatient admissions.** The amount of FSP services that participants utilize is associated with changes in outcomes, but we were unable to determine whether associations are causal because our data lack a control group. In most cases, utilizing more services yielded improvements in outcomes, but utilization of case management is associated with fewer days of stable housing and an increase in the likelihood of arrests. This may be because more-complex cases that would otherwise have much worse outcomes require more case management. Nonetheless, FSP participants experienced improved outcomes on average, and the provision of most services is associated with improvement.

We found that **after counties joined the FSP Innovation Project, the improvement in outcomes increased for their FSP participants**. This finding suggests that the FSP innovations might have led to changes in the quality of care that the individuals served received or to changes in the appropriateness of the population that FSP programs serve. The qualitative data indicated that counties' identification of common metrics might have led to more-consistent use of measurement-based care, which could improve quality of care and, in turn, outcomes. At the same time, several counties succeeded in establishing guidelines for readiness to graduate from FSP programs and move to a lower level of care; this innovation might have increased capacity for individuals at the higher level of need that FSP programs are intended to serve. These higher-need individuals may be more likely to experience significant change in response to FSP participation.

Conclusion

Overall, there is evidence that the Multi-County FSP Innovation Project led to improvements in processes and outcomes among the first cohort of six participating counties. Counties worked with each other and Third Sector to successfully implement standardized definitions, measures and metrics, guidelines, and processes necessary to improve program implementation. However, there was considerable variation in the extent to which innovations were implemented on the ground and sustained after the initial innovation development and implementation period was over. Nonetheless, **we found evidence that FSP participants experienced improved outcomes in key areas, including stable housing, justice system involvement, and psychiatric hospitalizations, and that these improvements increased after counties participated in the FSP Innovation Project**. We cannot definitively attribute these improvements in outcomes to the project, but our findings may suggest that there was improved quality of care or improved targeting of FSP programs to those most in need of these high-intensity services.

Given the initial successes of the FSP Innovation Project and the lessons learned about its implementation and impacts, it may be helpful to expand the innovations to additional counties across the state—with attention to such issues as need for provider training in the innovations and step-down care options.

Notes

[1] Substance Abuse and Mental Health Services Administration, "Mental Health and Substance Use Disorders."

[2] Substance Abuse and Mental Health Services Administration, "Mental Health and Substance Use Disorders."

[3] California Health Care Foundation, *Mental Health Care in California*.

[4] Mental Health Services Oversight and Accountability Commission, *Report to the Legislature on Full Service Partnerships*.

[5] Title IV-E Prevention Services Clearinghouse, "Assertive Community Treatment."

[6] California Department of Health Care Services, "Mental Health Services Act."

[7] California Department of Health Care Services, "MHSA Components."

[8] Mental Health Services Oversight and Accountability Commission, *Report to the Legislature on Full Service Partnerships*.

[9] Third Sector, *California Multi-County Full Service Partnership Innovation Project*.

[10] Mental Health Services Oversight and Accountability Commission, *Report to the Legislature on Full Service Partnerships*.

[11] RAND Corporation, "Publications."

[12] Vindrola-Padros and Johnson, "Rapid Techniques in Qualitative Research."

[13] California Institute for Behavioral Health Solutions, homepage.

[14] Cameron and Trivedi, *Microeconometrics*.

References

California Department of Health Care Services, "Mental Health Services Act," webpage, undated. As of February 9, 2024: https://www.dhcs.ca.gov/services/mh/Pages/MH_Prop63.aspx

California Department of Health Care Services, "MHSA Components," webpage, undated. As of February 9, 2024: https://www.dhcs.ca.gov/services/MH/Pages/MHSA-Components.aspx

California Health Care Foundation, *Mental Health Care in California: Waiting for Care*, July 2022. As of February 9, 2024: https://www.chcf.org/wp-content/uploads/2022/07/MentalHealthAlmanac2022.pdf

California Institute for Behavioral Health Solutions, homepage, undated. As of February 15, 2024: https://www.cibhs.org/

Cameron, A. Colin, and Pravin K. Trivedi, *Microeconometrics: Methods and Applications*, Cambridge University Press, 2005.

Mental Health Services Oversight and Accountability Commission, *Report to the Legislature on Full Service Partnerships*, January 25, 2023. As of February 9, 2024: https://mhsoac.ca.gov/wp-content/uploads/SB-465-Report-to-the-Legislature_approved_ADA.pdf

RAND Corporation, "Publications," webpage, undated. As of February 15, 2024: https://www.rand.org/health-care/projects/calmhsa/publications.html

Substance Abuse and Mental Health Services Administration, "Mental Health and Substance Use Disorders," webpage, last updated June 29, 2023. As of February 9, 2024: https://www.samhsa.gov/find-help/disorders

Third Sector, *California Multi-County Full Service Partnership Innovation Project: Progress Report*, March 2021. As of February 9, 2024: https://www.thirdsectorcap.org/wp-content/uploads/2021/03/Multi-County-FSP-INN-Progress-Report_March-2021.pdf

Title IV-E Prevention Services Clearinghouse, "Assertive Community Treatment," webpage, last reviewed April 2023. As of February 9, 2024: https://preventionservices.acf.hhs.gov/programs/483/show

Vindrola-Padros, Cecilia, and Ginger A. Johnson, "Rapid Techniques in Qualitative Research: A Critical Review of the Literature," *Qualitative Health Research*, Vol. 30, No. 10, August 2020.

About This Report

This report describes the evaluation of the California Multi-County Full Service Partnership Innovation Project. Mental Health Service Act (MHSA) innovation projects seek to promote innovations that improve mental health outcomes for individuals and communities.

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CalMHSA

CalMHSA is an organization of county governments working to improve mental health outcomes for individuals, families, and communities. Prevention and early intervention programs implemented by CalMHSA are funded by counties through the voter-approved MHSA (Prop. 63). Prop. 63 provides the funding and framework needed to expand mental health services to previously underserved populations and all of California's diverse communities.

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