HBGI
Healthy Brains Global Initiative

TOWARDS A NEW CONTRACTING MODEL FOR FULL SERVICE PARTNERSHIPS

A consultation and a set of recommendations:

Strengthening existing services, increasing impact and accountability, re-emphasizing recovery, piloting new parallel outcomes contracts (with an emphasis on *purpose*), building the market and investing in the workforce.

Conducted by the Healthy Brains Global Initiative for the Mental Health Services Oversight and Accountability Commission of California, December 2023

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THE HISTORY OF FULL SERVICE PARTNERSHIPS AND THE REASON FOR THIS REVIEW

In enacting Proposition 63, the Mental Health Services Act (MHSA), California voters in 2004 created and charged the Mental Health Services Oversight and Accountability Commission (MHSOAC/Commission) with the responsibility of driving transformational change in public and private mental health systems to achieve the vision that everyone who needs mental health care has access to and receives effective and culturally competent care.

The Commission was designed to empower community members, with Commission membership representing consumers and their families, service providers, law enforcement, educators, and employers, as well as State officials. The Commission puts consumers and families at the center of decision-making, promotes community collaboration, cultural competency, and integrated service delivery. The Commission is committed to wellness and recovery, using its authorities, resources, and passion to reduce the negative outcomes of mental illness and promote the mental health and wellbeing of all Californians.

The MHSA prioritizes addressing several key negative outcomes often associated with unmet or under-met mental health needs. These include: reducing family separations, reducing criminal justice involvement and imprisonment, homelessness, unnecessary hospitalizations and unemployment, school failure and, most generally, prolonged suffering. The goals can be referred to as supporting ***people, place*** and ***purpose*** to achieve wellbeing[1].

For persons not yet experiencing the most severe negative consequences of mental illness, the goals are to prevent disease from emerging or progressing wherever possible, or to intervene early in disease emergence to avoid prolonged and serious consequences including family fracture, homelessness and unemployment. For those whose illnesses have already become severe and disabling, the goals are to work with those persons to design and implement strategies to enhance wellness, promote recovery and build resilience.

[1] See the Appendix on 'outcome domains'.

In furtherance of AB 34 (Steinberg) in 1999 and AB 2034 (Steinberg) in 2022, California's Full Service Partnership (FSP) programs are intended to be recovery-oriented comprehensive services, targeted to individuals who are unhoused, or at risk of becoming unhoused, and who have a severe, chronic mental illness often with a history of criminal justice involvement, and repeat hospitalizations. FSP programs were designed to serve and maintain people in the community rather than to rely on state hospitals or other locked institutions to do so. Advocates and mental health professionals who implemented the first iterations of FSP programs were able to demonstrate that by engaging mental health consumers in their care and providing holistic services tailored to individual needs, FSPs can reduce costs, improve the quality and consistency of care, enhance outcomes, and, most importantly, save lives.

The name – Full Service Partnership – reflects the collaborative relationship between the service provider and the service user or member, and when appropriate the service user's family – as defined by them, through which the provider plans for and provides the full spectrum of community services so that the service user can achieve their goals, through a 'whatever it takes' approach to meeting needs. By supporting recovery with individuals who otherwise would be caught in a cycle of hospitalizations and incarcerations, FSPs help people develop and advance toward personal mental health goals by offering tailored, integrated, goal-driven care. Today, FSPs are core investments of the MHSA and a key element of California's continuum of care, intended to be the bulwark against the most devastating impacts of untreated mental illness.

FSPs represent an estimated $1 billion annual investment in public funds and have tremendous potential to reduce psychiatric hospitalizations, homelessness, incarceration, and prolonged suffering by Californians with severe mental health needs.

As of 2020, more than 60,000 individuals were enrolled in an FSP program, though the numbers currently fully engaged are unclear (with issues around tracking and reporting) and there are questions regarding service user selection and turnover. FSP programming also varies greatly from county to county, with different operational definitions, lack of consistent data processes, and variation in performance.

Several converging factors have prompted policy makers to raise concerns that California's MHSOAC investments in FSPs may not be adequate or that existing contracting and management of FSPs may not be optimal. This includes their ability to address:

- An increasing number of residents living unhoused, many with unmet mental health needs;
- Waiting lists to enter State hospitals for mental health care under felony Incompetent to Stand Trial designations;
- Ongoing reliance on local law enforcement and community hospital care as mental health consumers cycle in and out of mental health crises;
- The relationship between prison incarceration, mental health and homelessness.

THE HBGI REVIEW

In 2023, the MHSOAC contracted HBGI to undertake a review of the current FSP contracts.

HBGI were tasked with exploring the performance of FSPs, with a particular focus on contract design and performance management, and describing if and how outcomes-based contracts and/or enhanced performance management systems could improve that performance or otherwise strengthen wider behavioral health delivery. This is a qualitative review drawing on the experience of the HBGI team both in contracting and performance management, and in behavioral health in California.

From July to September 2023, HBGI engaged with policy makers and influencers in Sacramento. We spoke with and learned about FSP delivery from County leaders and their teams in six counties. We then did a 'deep dive' in three of these counties (Nevada, San Francisco and Orange), where we also visited service providers and spoke to service users and other stakeholders. We were joined by a service recipient/advocate (volunteer representative from CalVoices) to ensure we incorporated the lived experience perspective up front.

WHO ARE HBGI

The Healthy Brains Global Initiative (HBGI) was established in 2019 as a 501.c.3 not-for-profit, with the support of WHO, UNICEF, the World Bank and the Wellcome Trust, to address the global lack of understanding and services related to poor mental health - and its causes and consequences. We are using performance-based contracting to create a sea change in the scale and impact of mental health and related services - either contracting and funding directly ourselves or as a technical partner with governments. In all cases, we look to pay for results, not waste, and we generate rich 'live' data on service delivery and outcomes. HBGI is funded by philanthropy and through government contracts.

The HBGI team has a unique depth and breadth of experience in the contracting and performance-management of life-changing services for vulnerable communities. Our previous projects have ranged from leading employment services contracts (for people with multiple social, physical and mental barriers to work) reaching over one million people in a high-income country, to mobilizing performance-based basic and essential health services for 35 million people in a conflict affected low-income country. We have overseen eleven Social and Development Impact Bonds to date, including homelessness, school exclusion and refugee integration. We bring significant experience of leadership in behavioral services in California, as well as across rehabilitation services for veterans.

EXECUTIVE SUMMARY

Key Observations

Main Recommendations

In general, in undertaking this review, HBGI noted that there is variety between counties in the detail of the contracts and considerable variation in the cost per service recipient. In addition, we saw significant differences in the way FSPs are managed by counties and in the service capacity/capability of both contracted providers and County-staffed teams. Overall, however, FSPs across the State seem to have very similar objectives and, on the whole, make up a fairly homogeneous service. Of note, the level of contracting for FSP service provision (as opposed to services being delivered in-house) varies greatly between counties from almost none to almost all, such that any new contracting strategies will have a much larger impact on those counties that are heavily invested in community-based contracts.

During our engagement we were struck, above all, by the highly committed and professional workforce who deliver care to people with very complex histories and ongoing needs. We met inspiring County and contracted provider staff, including some amazing peers, going the extra mile on a daily basis for clients suffering from severe mental illnesses as well as addictions. In addition, we met service users who are remarkable people themselves, and their families, whose stories and hopes for the future were deeply moving.

However, we also observed the tensions currently prevalent in the service as a result of the drive for service provider 'productivity' in terms of the proportion of time they can claim as billable through MediCal. In the FSPs for adults, we saw an emphasis on treatment, with insufficient attention given to the progression of service users towards goals or outcomes (particularly around ***'purpose'***), despite the regulations requiring services to be client-driven and focused on recovery and resilience. In many (but not all) FSPs, the service providers are struggling to recruit and retain staff, and the system is therefore well below its contracted capacity. There is generally inadequate tracking, reporting and reviewing of performance and little to no visibility of which contracts are performing well or badly – which hinders continuous improvement.

We did not explore and have not reported on attempts to address substance use.

This Executive Summary sets out our key observations and main recommendations at a high level. The recommendations are described in detail in the following section.

The appendices to the Report provide the background to these recommendations, with our observations and challenges divided into three separate sections:

1. **Program Performance and Performance Management;**
2. **Supply and Demand, and;**
3. **Workforce.**

We then offer a framework of the 11 questions that high-performing contracts should answer, as well as a definition of the domains of ***People, Place*** and ***Purpose*** that we contend are the three corners of 'community' that a mental health program must address. We analyze the FSPs against this framework and set out the detail of a potential purpose-led outcomes contract.

Finally, we provide some thoughts on the Technical Assistance that will be needed for next steps, without adding to the burden on counties, in implementing any recommendations to strengthen FSP performance that State and counties choose to take forward.

KEY OBSERVATIONS

The themes that emerged during our review of the FSPs are as follows:

The FSPs deliver significant clinical impact and savings in reduced hospitalization and incarceration.	The Child FSPs help young people (and to an extent their families) deal with trauma and move on. The Adult FSPs save lives, stabilizing people with serious mental illness and wrapping care around them.
Targeting individual-level outcomes on the Adult FSPs would enhance program quality and impact.	Targeting positive, personal outcomes, as opposed to just focusing on high level clinical impact, would improve outcomes for individuals, be a more effective performance driver and in the end have a more profound population impact.
Across the domains of *People, Place and Purpose,* Adult FSPs need to strengthen their focus on *Purpose*.	In other words, the culture of these FSP services should be rebooted towards one where pursuing meaningful life goals with clients is primary, rather than relegating this as secondary to clinical goals. Such a reframe of focus can be achieved by changing what is measured/reported and by baking incentives for successfully fostering purpose in life into the funding of contracts.
The culture of the service needs a reboot.	It is not incentivized to do *'whatever it takes'* but *'whatever we can bill'*. The service has become homogeneous (whether full 'fidelity' or not to a particular model) and is losing its ability to respond to individual needs. It emphasizes treatment not recovery. It is a medical model emphasizing what is wrong with a person.
There is an urgent need to start reporting operational performance across the State on a regular basis.	This reporting would include a comparison of the performance between contracted providers and between in-house government versus contracted provision. Not doing so significantly decreases accountability and limits potential performance improvement (such as best practice sharing) both within and between very different geographies. At present, no County knows how any other County is performing and no one knows who the best providers are in each County or across the State.

There is a lack of systematic performance management (such as monthly performance reviews).	This is partly because of a lack of meaningful performance measures (including progression of service users towards their individual goals/outcomes). It is also due to a lack of performance management experience and tools in both providers and County teams. In small counties, it is also the lack of an adequate budget.
Attempts to use incentive-based payments with providers have not proven successful to date.	In counties that have been implementing incentive payments to drive performance, results have been unsatisfactory. This is in large part because they are not tied to meaningful, operational performance targets and the potential fiscal rewards are not large enough to garner attention.
The FSP system is running at about 70% of its capacity.	Though principally because of the difficulty recruiting and retaining staff, access to FSP services can be difficult, confusing, and often traumatic for service users and their families.

MAIN RECOMMENDATIONS

We recommend, in response, that the State and counties consider how to strengthen their FSPs and service offer, and gather learning in order to inform future FSP contract revisions, in two ways: firstly, through implementing several new performance-based pilot programs, and, secondly, through introducing new performance management and reporting standards. It is suggested that the same rigor in performance management could be applied, possibly as a subsequent step, across all levels of care.

The detail of the pilot programs should be designed in response to the specific context of each County and in consultation with all stakeholders. However, as a starting point, we draw on our experience in multiple country contexts as well as in California to describe 3 possible pilots:

1. A new, purpose-led outcomes contract to run in parallel with current FSPs. The service providers will be paid largely on the basis of the individual outcomes they deliver for service users in the domain of ***Purpose.*** The example we give here is a program targeting educational or professional training participation and sustained employment outcomes (i.e. helping service users find and keep jobs).

2. An extension to a current FSP contract to create a Follow-On program with lighter-touch support for service users ready to progress on from the intensity of an FSP, possibly emphasizing the use of peers for ongoing engagement and support. Service users will also be supported to draw up an Action Plan and select the outcomes they would like to achieve. This could be delivered by the FSP provider or in partnership with a Club House type program such as Fountain House.

3. A new, place-based outcomes contract.
    a. An outcomes contract aiming for the impact of a reduction in criminal recidivism rates. A 'through the gate' service to be delivered partly inside and partly outside of jails with the service provider paid for each person reconnecting outside, being accommodated, and achieving purpose (such as employment), as evidence of their re-entry into the community.
    b. An outcomes contract targeting a designated locality of homeless people, such as an 'encampment', i.e. where a group of homeless people have established themselves and formed a de facto community. This contract, to run in phases, would initially engage the community to learn what they want to achieve, then, move to a phase with the service provider paid to deliver the practical, measurable and verifiable outcomes selected by the community.

In our observations section below, we also address the potential for additional 'market stewardship', investing in building the capacity of providers and creating opportunities to share best practices. We further recommend the development of a State-wide workforce strategy, to address the huge pressures on staffing.

RECOMMENDATIONS

Performance-based contracts

Performance Management

The following recommendations are a starting point. They are a place holder, offered as a menu of possibilities for counties to consider and, in some scenarios, for the State to facilitate (e.g. by declaring that performance-based contracting is an approved use for unspent Innovation (INN) funding up front and by taking on the central funding of performance management capacity building). Any service enhancements to be taken forward by a County must be co-created with the full range of relevant stakeholders including service users, families and advocates, as well as key local and State administrators.

As the counties have different supply-demand challenges and will be looking for different improvements to FSPs (and their wider mental health system) in ways specific to their own jurisdiction, there will be different use cases from County to County. Along these lines, the smaller counties may look to partner with larger neighbors and co-commission services or purchase Technical Assistance to implement some of the specific performance management tools together. It would be time-consuming and costly to commission Technical Assistance on a County-by-County basis. A central contract, administered perhaps by CalMHSA, could be more efficient.

The recommendations below describe ways to enhance service offerings through ***performance-based contracts***[2] and improved ***performance management***.

[2] Further research and guidance on performance-linked contracting can be found in the publications of a number of organizations, including Brookings Institution, Oxford University's GOLab, Social Finance (UK and USA), UBS Optimus Foundation, and the social investor, Bridges Outcomes Partnerships.

PERFORMANCE-BASED CONTRACTS

As a place holder, we describe here three approaches to piloting performance-based contracts:

1. A new, purpose-led outcomes contract running alongside FSPs;
2. An amendment to FSP contracts to create a Follow-On program;
3. A new, place-based outcomes contracts (jail and/or 'encampment community').

The objective of these pilots are:

- To strengthen the service offer, widening service scope, bringing a greater emphasis on recovery, delivering more, high-quality outcomes for more service users;
- To help State, counties and providers learn more about performance-based contracting and facilitate a move from pilots to wider application;
- To provide an opportunity to understand better the needs of existing FSP service users as well as people pre-FSP and post-FSP;
- To test the ability of services to deliver if they move away from 'level of need' as the segmentation model.

These are suggestions based on the observations set out in this Report. They are all focused on adults. Counties may identify different opportunities specific to their context and population, which could be developed into outcomes contracts according to their specification. All the pilot durations suggested below are for face-to-face program delivery, with some additional time for tracking of outcomes and final evaluation at the end. Up to six months should also be allowed upfront for collaborative contract design (including agreement on the weighting of performance-linked payments), procurement and mobilization.

Given all the changes currently impacting FSP contracts, it is not proposed that changes are made to them mid-stream. However, counties with FSPs to be retendered in the summer of 2024 might consider how elements of the recommended pilots below could be used to amend or form new contracts (possibly with a hybrid model that pays the provider partly on the basis of billing 'productivity' and partly linked to outcomes).

1. A PARALLEL PURPOSE-LED OUTCOMES CONTRACT

The simplest, and possibly strongest, model to pilot would be an employment outcomes program. Following a mobilization period of three to six months, this pilot will run for two years, with a further six months following the end of face-to-face delivery, when employment outcomes can continue to be tracked (and paid).

- Emphasizing the two outcomes of ***employment starts*** and ***employment being sustained;***
- With three *interim payments* to the service provider for developing an Action Plan with each person (including a short and long-term job goal), and for optional participation in formal training and supported employment;
- With two *outcomes payments* to the provider, one for each person starting a job and the second for each person who sustains that employment for at least three months[3];
- With 65% of the payments attached to these two outcomes (split 50/50 between them);
- The training and supported employment payments can be 'rolled up' and paid on top of the job start if the person moves straight to work.

The employment must be in a 'good job', which will be defined in advance and meet minimum criteria in order to qualify – ideally 'competitive employment' in the open labor market. Key features will include things like hours of work, salary level, health and safety, and travel to work time. It may mean helping someone working in the 'grey economy' to formalize that work.

As far as the relationship between this program and the existing FSPs in the area goes:

- The FSP can refer someone into the employment program, and that individual can participate in both at the same time;
- The employment program can also recruit direct from outside FSPs as long as the individual meets pre-determined criteria, to be agreed (such as a diagnosed mental illness and/or addiction).

Appendix V sets out further detail on such a contract.

2. AN EXTENSION TO AN FSP CONTRACT TO CREATE AN FSP FOLLOW-ON

To address the concerns about Adult FSPs holding on to service users and blocking the program so others cannot be referred, counties could pilot the extension of an FSP, with an add-on Follow-On contract, i.e. for service users who no longer require the full intensity of an FSP but do need ongoing support. This could test the value for service users of moving on, establish the cost of such lighter-touch support, and cost-effectively create additional capacity in the FSP.

The Follow-On can be delivered by the existing FSP provider extending their service/team or in partnership with another organization.

Under this model:

- The FSP service providers will be paid an incentive for each service user progressing, with an agreed Action Plan, to their FSP Follow-On;
- The Follow-On includes a lighter touch of engagement, with larger caseloads, possibly with an emphasis on peer support;

[3] Evidence from elsewhere suggests that once the individual has reached three months, their chances of continuing are high.

- In drawing up the Action Plan, the service user will agree two desired outcomes in each of the domains of People, Place and Purpose (they will select these six outcomes from a list of measurable, verifiable outcomes in each domain drawn up during contract design);
- The service provider will be paid with a mix of budget reimbursement and additional payments for when each service user achieves the outcomes that they selected across the three domains;
- The service user will have an opportunity to overperform against base targets for the outcomes and earn up to 30% extra as a result;
- There will be monthly reporting on service user contact and outcomes achieved;
- The Follow-On could be subcontracted to or delivered in partnership with another provider, such as a Club House;
- The service user can select to return to the full FSP at any time (though may need to wait until a place becomes available).

Following mobilization, the pilot will run for two years, at which point the contracting body, the service provider and the service users must consider if and how ongoing support remains.

3. PLACE-BASED OUTCOMES CONTRACTS

Rather than targeting populations on the basis of individual characteristics, such as a mental health condition or a personal history of hospitalization, it is possible to target services by *place*. Poverty or social exclusion tend to be highly centered in certain locations/communities. Targeting services by place potentially escapes the artificial segmentation by 'level of need', which simply does not reflect the nature of exclusion or mental illness. It enables, if focused on outcomes, a more personalized response, with less prescription upfront of how each individual's need is expressed. It can embrace the nature, culture and role of community.

Piloting services by place is also an opportunity for focused collaboration between different system players. In particular, it could be used to reinforce collaborative working with Justice (notably the jails) and Homelessness, possibly as co-contractors. It will additionally provide further insights into eligibility for FSPs in both these populations.

a. In the case of jails, the recommendation is to contract a service provider who will:

- Deploy a team to be based partly in the jail and partly on the 'outside';
- Deliver an enhanced 'through the gate' service;
- Have payments attached to three key outcomes, with outcomes (as above) agreed with the service user from preselected options, with an emphasis on reconnecting, accommodating and finding purpose (ideally employment);
- As above, be able to earn extra from overperforming against base targets;
- Have monthly reporting (and reviewing) of service activity (i.e. number of people actively engaged) and the outcomes measures;
- Track the impact on reoffending on an ongoing basis.

The eligible population will be everyone spending time in the jail(s). A mental health assessment will be undertaken by the service provider (if there is no existing, recent diagnosis) to inform impact evaluation.

Following mobilization, the pilot will run for a minimum of two, ideally three years (with a period of tracking beyond that). This pilot is an excellent opportunity to attract new service providers, though that will require a big enough and long enough contract. There are providers demonstrating high performance in this space who are not currently delivering FSPs in California. There is a good evidence base on what can be delivered at what cost.

b. In the case of homelessness, the evidence base is weaker and it will be harder to price outcomes payments at the outset. Therefore, a staged move to outcomes payments is proposed. The recommendation is to contract a service provider to:

- Be accountable for achieving outcomes with a designated homeless community, such as an encampment (c.50 to 100 people per contract);
- Deploy intensive/assertive case management into the community, to be paid for the first six months entirely on a budget reimbursement model;
- Agree with the community how they would like to express outcomes across the three domains of ***People, Place*** and ***Purpose*** (within certain criteria, i.e. they must be relevant, measurable and verifiable);
- Start delivering outcomes;
- Agree, six months in, the 'rate card' with the County, i.e. what outcomes are being paid for and how much for each one;
- Receive, from six months on, outcomes payments to cover 50% of the previous budget reimbursement, with an opportunity for the service provider to overperform against baseline targets by 30%;
- Deliver for a further 12 months and then review the outcomes, the targets and the payments once more, and potentially revise again;
- Complete delivery two and a half years after first community contact (plus six to 12 months of tracking beyond).

A NOTE ON THE WEIGHTING/PERCENTAGE OF PAYMENTS LINKED TO PERFORMANCE

There are no definitive guides to how to weight payments to incentivize performance.

First of all, it is important to have clear deliverables which emphasize outcomes. Having strong performance management in place to track, record, report and review progress against these can be the greatest driver of performance.

This can be strengthened by connecting payments to delivery. Where exactly along the 'results chain' (of inputs, outputs, outcomes and impact) these payments are attached and their relative weighting will depend on a number of factors, including: the time taken between each step along that chain; the cost of each step; the evidence of attribution between them; the maturity of the service provider market, and; the scale and duration of the contracts.

It is important for the contracting body and the service provider both to build a fully-costed model of potential performance. This enables them to price it accurately and to understand the implications of any outcomes-based payments for cashflow.

On the whole, attaching payments to impacts may be too far from delivery to act as a performance driver – and too costly in terms of upfront working capital requirements. The closer they are connected to outcomes the better, as long as these are practically measurable and verifiable.

They must be large enough as a percentage of the total contract to get the attention of the service provider. If they are too small – as in the current incentive contracts being used for FSPs in some counties, in a range of 2 to 6% – then the service provider will simply look to spend up to the core funding and any incentive will simply be a 'nice to have'. The authors of this report have seen 20% attached to performance (typical in World Bank training programs) also fail to shift behavior and service culture. It is important to note that in all these instances there has also been inadequate performance management to mitigate this.

The Human Resources Agency in New York contracted a variety of employment programs with between 70 to 100% linked to outcomes[4]. The Employment Zones in the UK, based on USA pay-for-performance programs, had around 80% tied to job starts and sustained employment[5].

See Appendix II for more on the characteristics of high-performing contracts.

[4] Armstrong D., Byrne Y., Patton L. and Horack S. (2009) *Welfare to work in the United States: New York's experience of the prime provider model,* Research Report No. 614, Department of Work and Pensions, London.

Desai S., Garabedian L. and Snyder K. (2012) *Performance-Based Contracts in New York City: Lessons Learned from Welfare-to-Work,* Rockefeller Institute Brief, State University of New York

[5] Griffiths, R. and Durkin, S. (2007) *Synthesising the evidence on Employment Zones,* London: Research Report No 449, Department for Work and Pensions.

PERFORMANCE MANAGEMENT

In addition to the contract pilots detailed above, it is recommended that counties (and State) consider developing and requiring new standards in:

1. Performance reporting;
2. Performance management.

1. PERFORMANCE REPORTING

There is an opportunity to enhance significantly FSP performance through implementing new performance reporting standards. This will deploy a powerful driver of performance. It will increase (and be seen to increase) accountability (at every level) and will facilitate the sharing of best practice. It will provide additional incentive to innovate and encourage a flourishing and vibrant market of service providers.

It is recommended that each County publishes monthly (within a fortnight of the end of the previous month), a dashboard comparing the performance of all FSP providers in that County (by age group/type of FSP), reporting:

- Total number on the program (and as a % of contract total 'slots');
- Number of new starts in the month;
- Number of people progressing positively on in the month;
- Number of people lost from the program (e.g. returning to prison or disappearing or moving away) in the month;
- Total cost of delivery that month (and as a % of contracted monthly cost);
- Percentage of caseload seen once in-person in the month;
- Percentage of caseload seen twice or more in-person in the month (for more than 30 minutes each time);
- Number of people moving off the street and into accommodation;
- Percentage of people in supported accommodation;
- Percentage of people in independent accommodation (including with family);
- Percentage of people engaged in a 'meaningful activity' (according to a clear definition);
- Number of people securing a 'purposeful outcome' (e.g. starting school, training, volunteering or employment, as selected by the service user) in the month;
- Case manager caseload sizes.

In order to do this, of course, the service providers will have to submit a monthly report for each contract. This can be a basic Excel file.

Twice a year, the State should publish a consolidated view, reporting the performance of the top and the bottom 20 contracts in each category, the average across the State, and the performance of the top 20 providers in terms of financial contract value.

On an annual basis, a service-user satisfaction score, based on a survey, can be added to the consolidated view.

2. PERFORMANCE MANAGEMENT

Alongside the implementation of new reporting standards, there is an opportunity to improve the performance management at State, County and service provider level. It is recommended that at a County and service provider level this includes:

- Agreed *operational* performance measures (and targets) with service providers that are relevant to the contract and context (e.g. the MediCal billing), and that also encompass the measures recommended in the new monthly reports;
- New monthly Performance Packs, which report these performance measures, in-month, cumulatively and trending over time. This reporting should take a whole contract view, as well as tracking activity and ***progress*** by individual and by cohort (e.g. everyone who started in a particular quarter);
- 'Exception reports' to highlight anyone not being contacted or not progressing as desired;
- A Performance Board to meet on a monthly basis to review performance, to which the service provider's local program manager presents the Performance Pack and their report, with membership possibly to include County contract manager or monitor, and other stakeholders (such as a service user, peer or NAMI representative);
- The review and amendment of contracts, as necessary to add/improve 'step in rights' to be implemented in the event of under-performance.

A small County with limited bandwidth might require monthly reporting from the service provider and copies of minutes/actions arising from their monthly Performance Board, then attend the Board in person on a quarterly basis.

Investing in the development of the service providers, alongside strengthened performance management, the State and the counties should consider their role as 'market stewards', as described above. This should include:

- Organizing periodic events (every six months in the counties and annually across the State) to bring together service providers. Collectively to review performance and share lessons;
- Developing a strategic workforce plan.

Further detail on this 'stewardship' role and on suggestions to address the workforce problem is set out in the first appendix below.

APPENDIX I:
OBSERVATIONS AND CHALLENGES

Here follows the observations and challenges on the basis of which these recommendations were made. They are divided into the following sections:

1. *Program performance and performance management;*
2. *Supply and demand;*
3. *Workforce/staffing.*

PROGRAM PERFORMANCE AND PERFORMANCE MANAGEMENT

Our key takeaways regarding performance and performance management are that the FSPs deliver vital, life-saving interventions which create a significant saving in the costs of hospitalization and incarceration. However, the current definition of success is limiting. There is an emphasis on treatment over recovery. The notion of 'Purpose' is largely missing from Adult FSPs and the voice of the service user is being lost. Services are generally homogeneous with little flexibility or personalization. This is not just exacerbated, but largely driven, by the focus on MediCal billing (however necessary this might be). The lack of any transparent performance reporting, including a comparison of all contracts/providers within each County and across the State, is limiting performance in a number of ways. There is an opportunity to invest in and grow the provider market.

In relation to the performance and performance management of the FSPs, we offer the following ***observations,*** with further detail on all of these following.

On the objectives and performance of FSPs:

- The success of FSPs (notably Adult FSPs) is defined generally as a reduction in homelessness, hospitalization and incarceration;
- FSPs appear successful in delivering this (and in delivering a cost saving as a result);
- Day-to-day performance measures focus on total caseload size ('slots'), number of staff, and 'productivity' in terms of number of minutes billable through MediCal;
- The service is in a period of transition, with a focus on billing and new documentation and, in some places, new IT.

On contracts, payments and assurance:

- Contracts to service providers include 13 pages of detailed 'look up tables' on all the activities that can be billed;
- Payments to providers are not linked to performance, though some small incentive payments have been piloted;
- The cost of FSPs varies greatly between counties (as does the percentage of the total MHSA budget allocated and disbursed);
- Caseload sizes are small and there is a high level of 'supervision' within each contract.

On performance reporting and performance management:

- Reporting on FSP performance varies greatly, as does program monitoring, though there is little proactive performance management;
- Small counties have very limited resources to manage contracts.

On service content – standardization versus personalization:

- On the whole, this is a homogenous service with little flexibility;
- On Child/Youth FSPs, the service users move on after 12 to 18 months, whereas on Adult FSPs they may remain for many years;
- The role of families changes, as far as the FSPs are concerned, as the service user becomes an adult;
- Some Adult FSPs have started to include an employment advisor in the team, though without any performance targets;
- FSP contracts and providers range in size, with some very small, local providers used to strengthen community engagement.

On housing:

- Finding affordable, available housing is a challenge everywhere.

It must also be noted:

- One of the biggest constraints on performance is the difficulty in recruiting and retaining staff.

Alongside these observations, we offer the following ***challenges and possible responses.***

On FSP performance – stability or independence, standardization or flexibility:

- Defining success in these terms (a reduction in homelessness, hospitalization and incarceration) is too simple and de-emphasizes consideration of service user wellbeing;
- These are not actually 'outcomes' but 'impacts';
- The prevalent service culture is the 'medical model', identifying what's wrong with people;
- Service users (on the Adult FSPs in particular) are not moved towards wellbeing and independence and connectedness;
- The notion of 'Purpose' as an outcome to pursue with clients receiving FSP is missing from the program and its accountability/audits;
- There is limited lighter touch support available for a service user to move on to after an FSP;
- Objectives/outcomes are defined and imposed top-down, not by service users (or families or communities);
- Calling the number of billable minutes 'productivity' is a misleading misnomer;
- Targeting on billable minutes creates a tension at the center of these services;
- 'Flex funds' are available in many places (to pay for incidental things like clothes) but these are tightly controlled by the counties;
- Services with rigid caseloads and targets for billing struggle to be flexible in line with service user need.

On performance tracking and reporting:

- Legislators and the general public do not know anything about FSPs and their impact;
- There is no comparative performance reporting and this is a major limitation;
- Comparing performance is still possible across different services and geographies;
- Reporting performance drives higher performance;
- Without reporting comparative performance, it is impossible to identify and learn from best practice.

On quality assurance:

- The layers of 'supervision' in services provide some assurance of quality but it is not always systematic;
- This ad hoc quality assurance may not mitigate the perverse incentives of targeting billable minutes;
- When counties report on FSP performance, it is often disconnected from operations and there is a weak feedback loop.

On IT systems:

- Most providers are double or triple keying into different IT systems;
- Most of the IT systems do not facilitate better case management;
- The transition to a new IT system in half of the counties has some teething issues.

On introducing outcomes contracts:

- The small incentive payments trialed in some counties have not worked;
- It may not be the right time to revisit existing FSP contracts and change the terms;
- Piloting some outcomes contracts in parallel with FSPs could strengthen service provision and build capacity in the system for a future shift more widely to outcomes payments.

On building provider capacity and the market:

- The State and the counties have an important role to play as 'market stewards';
- There must be comparative performance reporting (at every level) across the State;
- The homogeneity of providers limits learning;
- There are a number of things that can be done to make the market more attractive and to attract new players;
- Using very small providers has advantages but it may be advisable to use a 'prime contractor' (with an outcomes contract) to manage this.

These observations and challenges/possible responses are set out in detail below.

OBSERVATIONS IN DETAIL

FSP OBJECTIVES AND PERFORMANCE

There is generally agreement across all parts of the system that the objectives of the FSPs are to move people into accommodation, reduce hospitalizations and reduce incarcerations.

These are described as the 'outcomes' that the FSPs are seeking to deliver. Counties typically report periodically on their achievement of these – at a high level – such as comparing the number of days of incarceration of a cohort in the 12 months prior to and after starting on the FSP.

Performance across these three measures appears high, at least for the providers and counties that we met.

The State would like to verify this by matching the reporting by the providers with databases in justice and in health, but this is proving problematic.

The principal performance measures used by most counties and providers on a day-to-day basis are:

- The total number of service users registered with a provider;
- The total number of staff employed, in all the various positions, and their caseload sizes;
- So-called 'productivity', by which they mean the amount of time (measured in terms of minutes) that the service (and each member of staff) is able to claim as Medi-Cal dollars.

In some counties, providers are given additional objectives, which might include things like the time taken to start a new referral and producing/maintaining the necessary documentation. Counties vary between having objectives mainly around processes and those who have more aggregate measures.

The level of documentation required has increased with current changes to the system, and some counties have reduced the number of additional objectives in an attempt to mitigate this. This has included no longer requiring providers to report on service user engagement in meaningful activities.

There have also been changes regarding what is admissible or inadmissible as billable activity, with the removal of travel and administration time. The impact of this on the finances of the FSPs is yet to be understood. It is likely to have a particularly big impact in rural areas given the greater distances travelled to visit service users.

CONTRACTS, PAYMENTS AND ASSURANCE

This view of performance is generally reflected in contract design.

The contracts issued to the service providers are, on the whole, highly complex, including up to 13 pages of 'look up tables' describing the billable activities and their codes.

Payments to service providers are not currently linked to performance but some counties have been trialing the use of incentive payments to providers.

These have either offered an additional payment of between 2% and 10% over and above the contract value, or a similar percentage has been deducted from the contract value to be earned back if certain criteria are met. The criteria in most cases have been largely process-or compliance-oriented, such as time taken from referral to program start, level of interaction with service users and maintenance of the required documentation. In one County, the provider can earn an additional $1,500 for each person they step down from the program. In the majority of cases, the providers have failed to meet all the required criteria and no incentive payments have been made.

There is considerable variation in the cost of FSPs between counties.

Per service user, the cost is $17,000 in one County and $30,000 in another, and the range may actually be wider across all counties. This is said to be because of variations in wages and housing costs. To state it in such terms is indicative of the way the program is viewed as standard across all users. This is the allocated cost per person per annum on the provider's total contracted caseload. It is not possible to suggest any correlation or otherwise between cost and performance because of the lack of data.

Caseload sizes are generally small, starting as low as 10 per Case Manager on some programs.

These are contractually defined, so if there is insufficient staffing, the provider cannot take on referrals and the overall capacity of the FSP is reduced (though in some cases waivers have been issued allowing for small increases).

There are layers of supervision within each service which appear to provide strong, if not always very structured, quality assurance.

Service providers will have, for example: weekly supervisions of a Case Manager with a Team Leader; monthly peer reviews between Case Managers; monthly reviews with a supervisor sampling 20% of cases, and; a quality team reviewing case notes. Though the emphasis of the latter is likely to be on compliance with MediCal requirements, i.e. whether the records will be acceptable for billing.

PERFORMANCE REPORTING AND PERFORMANCE MANAGEMENT

The reporting on performance varies between counties in frequency and detail, and in who completes the report and what happens to it.

In some cases, an annual report is produced by a business office unit, entirely separate from the County's FSP contract management team. This report is comprehensive, based on data taken from the IT system(s) and also self-reported by providers, though it is again at a high level with simple summary scores. This report is not used in the ongoing performance management of service providers but will be referred to when new contracts are tendered. COVID had an impact on reporting, with some performance measures being removed because they were no longer relevant or practical.

In one County we visited, there is a monthly performance review with all providers, undertaken by a Monitor from the behavioral health team.

This is a large County, with the resources to manage this. Each month, they review individual cases. They also look at the 'outcomes' data of incarceration and hospitalization, and try to understand any variance or trends. They undertake regular service user satisfaction surveys. This County appears to have high FSP performance and falling rates of homelessness as well.

This level of engagement and active performance management appears to be the exception rather than standard practice, partly driven by the allocation of funds to counties.

In some smaller counties it is simply not possible because the County Contract Managers are responsible for huge numbers of FSPs along with other contracts. A small County, co-located with their single Adult FSP, almost share day-to-day caseload management and are able to rely on a trust-based relationship, but are stretched too thin for systematic performance management. It is not clear the extent to which the allocation of funds to counties is informed by an operating model that takes into consideration spans of control and the value of proactive performance management.

SERVICE CONTENT – STANDARDIZATION VERSUS PERSONALIZATION

There is some (but relatively little) variation in the flexibility that providers have to implement their FSP.

There is also a State-driven move towards full fidelity Assertive Community Treatment (ACT) or near-fidelity. On the whole, the different FSPs visited appear to be a rather homogenous service, with some variance in use of peers and client recovery funds or 'flex funds' (such as for clothes or to assist with housing) and additional resources available (such as supported accommodation options). There is no data comparing the use of 'flex funds' across providers and its link to outcomes.

The lack of variation and flexibility is a consequence of:

- A push towards common professional standards, in service content and in service staffing;
- A focus on process (exacerbated by the MediCal billing) away from the person and outcomes that matter to each individual;
- An emphasis, in line with the focus on process, on contract compliance as opposed to performance management of outcomes;
- A lack of meaningful data and of transparent reporting (including open comparison of providers), which drives policy makers/contractors at State level to revert to standardization for the sense of control it gives them.

The nature and content of Child FSPs and Adult FSPs[6] is clearly very different.

This is reflected in part by the difference in the average duration of time that a service user participates. A child will typically attend for between 12 and 18 months. An adult, on the other hand, may be on an FSP for many years. The next step for children beyond the FSP may be clearer, with more options existing in the system.

Families are an integral part of a Child FSP but the same families may feel excluded by an Adult FSP.

The family is an essential part of the solution for a child. Therapy may be needed by the whole family. The Child FSP looks to understand and address the role of the family relationship. In contrast, on an Adult FSP, the adult service user must obviously control access and information. The FSPs have to manage this carefully, but still need to engage with the community around the service user. Re-building family relationships may actually be an important outcome (that may be neglected).

[6] There are a wide range of different FSPs in addition to Child and Adult, varying by County, but including, Older Adult, Forensic or Criminal Adult, and Transition from Youth to Adult.

Some providers have deployed an Employment Advisor to sit within the team of Case Managers.	The Individual Placement and Support (IPS) model has proved highly effective in other places in enabling service users to maintain or to access employment. The staff in this role on the FSPs do not have outcomes targets and there are no outcomes payments to the service providers for employment. There is no data available on whether the model is working.
Some counties have purposefully contracted with small, local service providers, alongside some of the larger pan-State providers.	They have done this in an attempt to increase localization and diversity, as well as to encourage services that reflect the population being served (such as in its ethnicity).

HOUSING

The shortage of affordable housing is a challenge in all areas, with counties using 'housing dollars' to address this, with varying success.	It is managed differently in different counties, with some allocating a housing budget to providers from MHSA funds. This allocation is enough in some areas and inadequate in others. There has been no comparison made across counties to identify and share best practice. We did not come across any rent guarantee or landlord insurance schemes, which have proved effective in other countries.
Most of the providers and counties reported that their single biggest limit on performance was difficulty in recruiting staff.	This is addressed below in the section on workforce.

CHALLENGES AND POSSIBLE RESPONSES IN DETAIL

FSP PERFORMANCE – STABILITY OR INDEPENDENCE, STANDARDIZATION OR FLEXIBILITY	
The definition of performance or success as reduced homelessness, hospitalization and incarceration is an over-simplified measure.	It does not provide any insights into what it is that the FSPs deliver that actually improve an individual's wellbeing. It may be that simply providing accommodation and supporting/monitoring the taking of medication are sufficient to achieve these impacts. Defining success in this way pays no attention to the individual service user experience.
The stated 'outcomes' of reduced incarceration etc. are actually 'impacts' rather than 'outcomes', and this weakens performance management.	There are considerable cost savings (direct to the County purse) and positive social impacts from reducing justice involvement and incarceration. However, whilst it is important to measure these impacts and to understand the fiscal return, focusing the service on them does not reinforce, and potentially de-emphasizes, the experience/journey of each individual service user. Rather than tracking and reporting on each individual's experience, and reinforcing accountability for this, current reporting steps back to take a more global view. However, if each individual achieved goals around stability and independence (and this was tracked and reported), then the three big impacts would be achieved as a consequence.
On the whole, the culture of the service is derived from the 'medical model' that shapes it.	I.e. with the ***deficits*** of service users carefully assessed in order to determine, first, their eligibility and, then, their treatment. With success measured in terms of a reduction in negative outcomes, it is hard for the service to think about the positive ***addition*** of things to someone's life. One provider talked about identifying and addressing "functional impairments". The Adult FSPs in particular are all about treatment and not about recovery. There is no room for an asset-based approach, which would focus on each individual's assets (i.e. strengths and potential), help them to define goals and work towards them, and target actual achievement as outcomes.
The definition of success in terms of (just) these three impacts limit the service scope, so that service users are not moved towards wellbeing/independence.	The fact that once an adult has joined an FSP, they may still be participating many years later, is possibly indicative of the nature of that individual's mental and social condition and their level of need. It is also a reflection of the function currently fulfilled by these Adult FSPs, i.e. maintaining service users in a state of stability, without seeking progression. This is partly addressed in some areas by Wrap Around FSPs, though these are still about maintenance as opposed to recovery onwards.

There is limited long-term goal setting with service users on adult FSPs, and 'purpose' is missing from the service mix.	In addressing service user needs in terms of 'people, place and purpose' the FSP itself may fulfil the need for *people,* with staff and other service users becoming the kin. Most FSPs address the immediate need for *place,* with the majority of service users supported to secure accommodation in some way, and with the FSP premises offering a safe base; but there is little or, at best, an inadequate focus on *purpose,* with no emphasis on service users defining and achieving a personal mission (such as a job).
Once an individual is stabilized, a lighter touch level of ongoing support/maintenance might be sufficient, but no such provision is available.	With no follow-on provision in place, the FSP holds onto the individual. The position of FSPs within the system, and questions regarding the balance of supply and demand are considered below in the next section.
The outcomes that the program is targeted to achieve are defined and imposed top-down, with little or no consultation with service providers, service users, families or communities.	It is part and parcel of the service culture, but if we were working towards independence, then the service user should be given agency over the process. This may well mean challenging the received wisdom of the service, which views the service user as 'in need' and requiring the control of the professional 'expert'. It would also mean challenging the learned helplessness of a person who has had to sink through multiple layers of 'help' before arriving at the FSP in the first place.
High 'productivity' on an FSP should surely be defined as the achievement of as many meaningful outcomes as possible for as many people as possible.	The claims for billable minutes would be better called 'financial drawdown' or simply 'income'. It is essential to maintain the financial viability of the program, but it must be balanced against the desired service culture.
The need to capture the activities which will draw down MediCal money creates a real tension in the heart of the service.	The provider, and in many places the Case Manager, is managed against their ability to claim these dollars. They are given targets that they have to achieve. Towards the end of the week or the month, there is an incentive to engage the service user in something that is billable, even if it is not exactly what they need. To date, there has been no push to reduce the time spent travelling, for example, by reducing the number of home visits. But this may change as the actual financial picture emerges.

	Anecdotally, on programs (such as some Assisted Outpatient Treatment), where there was no requirement to capture billable activities, the outcomes were very strong. This included reductions in hospitalization and incarceration. It also delivered the more immediate, individual outcomes such as people being reunited with families and moving back home. Service providers want to have this flexibility and do 'whatever it takes' but the behavior of a contracted provider will/must follow the contract.
Where 'flex funds' are available, the counties generally exert a high level of control over all expenditure.	The FSP provider must, typically, secure approval each time they want to spend over $1,000 for adults and maybe $500 for children. This level of control reflects the nature of the contracting, and the contractual relationship, and the fact they are basically still managed as budget-reimbursement. It weakens the accountability of the service providers and their ability to genuinely flex the service around the needs of the individual.
Contractually setting caseload sizes may provide a level of quality assurance but constrains service delivery.	With fixed caseload sizes and targets for billable minutes, the service providers are forced into a particular level of contact per service user. This limits their flexibility to increase or decrease this in line with service user need.

PERFORMANCE TRACKING AND REPORTING

To ensure continuing funding for FSPs, the story has to be told.	Legislators and voters have little or no visibility of what the FSPs deliver, quantitatively and qualitatively. The data that service providers collect and report to the State is limited, and it is not used for anything. It is important to get behind the population-level percentages that are currently reported (e.g. in terms of reduced hospitalization), which fail to bring the service alive. Some counties collect the powerful case studies of the lives that the FSP saves, but these are not always communicated widely.
There is no comparison made, at least publicly, of the performance of different providers, which significantly hinders the performance of FSPs everywhere.	Most providers and County staff cannot identify/name who are the best or worst performers, either in their County or across the State. Even within some providers who deliver across multiple counties, they do not report this and can only anecdotally identify the best/worst performing contracts.
Reporting the performance of all contracts/providers is still relevant and important even with significant differences in local contexts.	Within their age bands, the FSP contracts target the same groups. They share the same overall objectives (though these should be refined). Without transparent reporting of data, there is no true accountability in the system – to the taxpayers, to the communities or to the service users.
Reporting and comparing performance across providers drives higher performance.	It is a powerful motivator. It identifies failing providers, who can be supported to improve or, ultimately, removed from the system. It rewards the providers who perform exceptionally.
Without collecting the data on what works, it is impossible to replicate success across the system.	If all that providers are required/incentivized to do is to record billable activities, it significantly limits any potential learning and inhibits any search for continuous improvement. One of the reasons that one County has ceased requiring providers to report on meaningful activity, is because the providers failed to fill in the forms capturing this activity. There is insufficient incentive for frontline staff to report on this, given all the other things they must report – which are generally linked to so-called 'productivity' and payments.

QUALITY ASSURANCE

The layers of supervision within the service provide a degree of assurance that the level of care is appropriate, but this is not applied systematically.	Counties, in the first instance, should assure the providers' internal quality assurance systems and, then, based on any risks identified in that, undertake direct assurance of the services themselves.
The ad hoc quality assurance (QA) that is typically undertaken may be insufficient to mitigate the perverse incentives driven by the billing culture.	This relates to the QA undertaken by providers, as well as the monitoring undertaken by the County. In both cases, there is a lack of systematic tracking and reviewing of all individual progress, with, for example, 'exception reports' highlighting service users who have not been engaged within the last month.
Counties periodically, typically, undertake and report an analysis of FSP data, but this is in isolation of delivery.	It is a remote evaluation exercise. The analysis is not used in performance reviews with the providers. It is not used to drive continuous improvement.

IT SYSTEMS

Most providers are, at least, double-keying, i.e. entering data into at least two different systems.	Many are actually entering data into three systems, and will often employ teams of administrators to do so. This is going to impact on cost-efficiency, data quality and staff motivation.
There is a lack of consistency in the functionality of the IT systems used by service providers.	Some providers (a small number) have systems which assist staff with case management, such as highlighting service users who are due appointments or who are behind on their medication.
The transition to a new data/case management system, adopted by nearly half of the counties, has not been entirely smooth.	Reporting functionality was not immediately available to track provider spend and Medi-Cal 'productivity'.

INTRODUCING OUTCOMES CONTRACTS

The incentive-based payments trialed by some counties have not been utilized/spent and have failed to change service provider behavior in a positive way.

In one County, only around 10% of the allocated funds have actually been paid out.

Some of the FSP contracts are to be renewed at the end of the current year and there is an opportunity to revisit their terms, but most are mid-cycle and perhaps there is already enough change in the FSP world.

It would be possible to introduce a payment model in which a proportion (c.50%) of the payments are tied to billable activities (to ensure the County is able to bring in the funds), and the remainder is linked to a mix of impact (i.e. reduced hospitalization and incarceration) and individual outcomes defined with/by service users.

Pilot outcomes programs, contracted in parallel with the existing FSPs, could provide the learning to inform the next evolution of FSPs, as well as for the wider system.

Piloting outcomes contracting would be an opportunity to build the capacity of counties and providers in the model, with its much higher levels of data generation and with the mobilization of stronger performance management. Suggestions for the scope of some of these pilots are set out below, and the 'contracting framework' for a fully worked-up example is described in detail at the end of this report.

These pilot programs could, either, focus on ***purpose*** to compliment the care-based focus of the FSPs, or, explore the spaces for delivery pre- and post- FSPs. There are further suggestions in the following section to address the artificial segmentation of the system with more holistic programs targeting place or families or early intervention.

BUILDING PROVIDER CAPACITY AND THE MARKET

There is limited evidence of counties (or the State) fulfilling the vital role of market stewardship.

The performance of a County's commissioned services depends on the wellbeing of the service providers. The County must invest in building the skills and resources and motivation of their market. This can be achieved through:

- Setting informed, stretching (and deliverable) targets against which performance is fairly and transparently measured;
- Expressing these targets in terms of outcomes (not just impacts) that align the interests of the County, the service provider and the service user;
- Putting in place a performance management system that is focused on driving (and supporting) continuous improvement;
- Facilitating regular opportunities for the sharing of best practice between providers;
- Strengthening the County's communications around FSPs, to tell more clearly the story in terms of the numbers and the personal lives touched.

In order to facilitate high performance, there must be comparison and sharing across the whole State.

Suggestions are set out below for the role that the State can play in market stewardship.

The homogeneity of providers limits learning and inhibits innovation.

It is partly (possibly largely) a result of the way these services are contracted, with pressure to standardize. It will also be a result of how the market has evolved over the last 20 years, and fossilized in places. To challenge this, counties can release control over content through a shift to focus on individual outcomes (as discussed above). They can also look for ways to attract new market entrants.

There are a number of things which determine the attractiveness of contracting opportunities to new market entrants.

A new entrant will evaluate risk, through looking at:

- The size of the market, i.e. how big is the market opportunity beyond this one contract;
- Contract length, i.e. can I cover all my mobilization costs;
- Contract size, i.e. is there a critical mass, is there scale to deliver something meaningful, is there room for overheads and surplus;
- Existing evidence base of cost and performance, i.e. what is the risk of service failure;

- The procurement track record and contract management capability of the County, i.e. do they have a reputation for stability and professionalism;
- The level of control versus autonomy to deliver, i.e. will I be allowed to take the decisions I need to.

Contracting with very small service providers has advantages and disadvantages.

Some counties have purposefully sought out small, very local providers, in an attempt to better reflect the communities being served. They can potentially reach parts of the community that otherwise remain excluded. They can bring diversity and innovation. However, others commented on the 'momma and pop' nature of some providers. Small providers, by their nature, are more vulnerable to staff turnover. Their premises may be less secure for staff and service users. They have less overhead to cover things like knowledge management. With limited or no reserves, they do not have the cashflow to work with payments linked to outcomes.

There may be scope in some places to consider a 'prime contractor' model.

Some counties already have service providers who subcontract to other providers. In a pure prime contractor model, the prime is not a service provider themselves. They are contracted/paid largely on the basis of outcomes, by the service contracting body. They carry the performance risk in the system. They subcontract to networks of local providers – possibly bringing in non-traditional providers – and manage performance across this network. They may or may not use performance-based payments with their providers (in some cases, they are required simply to reimburse budgets). Sometimes it is called the 'service integrator' model because, in addressing the complex needs of the service users, the prime operates above the usual silos and knits together disparate services around each individual.

SUPPLY AND DEMAND

Our key takeaways regarding supply and demand are that the FSPs are a vital resource for those people in the system who have the very highest levels of need. They are required to demonstrate this need through repeated hospitalization and incarceration. They are likely to be homeless. They will have a serious mental illness. However, we do not know exactly how FSPs map against the actual levels of need in the community. We also note that mental health fluctuates and level of need is not static. Access to FSPs could be more straightforward, and there are people pre- and post-FSPs for whom there are limited services. There is scope for impact (and further cost savings) through closer collaboration with the justice system, particularly jails. MediCal does not cover some activities which can aid recovery, and focusing on billing alone must not preclude these. There may be a need for improved cross-working between homelessness and mental health departments, and a greater emphasis on proactive outreach. If service provider accountability is increased through changes to contracts and performance management, how also can County accountability be increased?

In relation to where FSPs sit within the overall mental health and homelessness system, we offer the following ***observations,*** with further detail on all of these following.

On eligibility, access and levels of need:

- Eligibility is tightly defined, targeting those with the most serious illness, costing the most in terms of hospitalization and incarceration;
- It's a "fail first" system, with someone having to reach the bottom before being eligible;
- It is not clear if FSP capacity actually matches the demand;
- Low staffing numbers are limiting capacity and exacerbating waiting lists (in some places);
- The counties act as gatekeeper with all referrals either going through or at least being approved by them;
- Service users all have to participate on a voluntary basis;
- In at least one County, there is a high drop-out rate from Adult FSPs in the first year;
- Some counties are trialing new community-based services to improve accessibility.

On outreach and collaboration:

- Proactive outreach on the streets can be part of early intervention and pre-empt crisis;
- Engaging with jails is important but varies greatly across the counties;

- Care Courts have mixed reputations (with some questioning whether they interfere with people's rights) but appear a strong model of collaboration that could be scaled;
- If asked, communities may select different, "non-traditional" measures of success.

Alongside these observations, we offer the following ***challenges and possible responses.***

On eligibility and access:

- Accessing an FSP can be a traumatic process for the service user and those around them, including their family;
- There is very little awareness of FSPs amongst the general public;
- There is a lack of data on the level and nature of mental illness in the homeless population;
- The FSPs target the most socially excluded people (who are likely to cost the most in, for example, hospitalization and incarceration);
- Early intervention can be very cost-effective, possibly more so;
- A single gatekeeper to the services can be a bottleneck;
- FSPs cannot bill for (many) activities in hospital and jail, which limits the service responsiveness;
- There may be a lack of understanding of and sensitivity to ethnic and cultural differences (including tribal groups);
- Someone who is socially excluded may not be willing or able to 'volunteer' for a program like this.

On a continuum of care:

- Services across the continuum are organized according to level of need but mental health needs/illnesses fluctuate;
- Identifying the group of people one or two steps above eligibility for an FSP is problematic;
- Once stabilized on an Adult FSP, there is limited or no step-down provision;
- Some important interventions are not billable through MediCal;
- Focusing on billable activities limits community engagement.

On homelessness:

- Homelessness and mental illness are conflated in the way FSPs are perceived and described, but not in how services are delivered and paid for;
- They are not experienced in silos by the mentally ill person on the street;
- Most engagement with homeless people and communities is reactive rather than proactive;
- The siloed nature of these services, with limited data sharing, limits performance.

On County accountability:

- There is no measurement or reporting of counties' performance on FSPs;
- Counties are not held to account for FSP performance.

OBSERVATIONS IN DETAIL

ELIGIBILITY, ACCESS AND LEVELS OF NEED

Eligibility for FSP participation is closely defined, with strict criteria that must be met.	The program is targeted at the people viewed to be costing the system most, in terms of hospitalization and incarceration, with the most serious mental illnesses (often also with a history of substance use). In effect, the individual must prove that they are difficult and sick enough to require a high level of care.
The counties are described as having a "fail first" system.	Someone has to fail substantially, fall right through the system, in order to access an FSP.
Once the individual has failed sufficiently, that is where they get stuck.	One County commented that if they are not on the FSP, then they are on the street. They are connected to support and services through the FSP, which otherwise they would not have.
Some counties state that the need for FSPs is fully met by the contracted capacity.	It is suggested in at least some counties that if the staffing was up to allocation across all providers, then the FSP capacity would meet the required demand, but it is not clear what evidence supports this.
Some counties report large waiting lists.	There is limited or no data on how many people are waiting for how long. There is no comparative data on this.
The counties are the gatekeeper for the program.	They manage the eligibility and approve each individual's start.
Participation on an FSP must be voluntary.	Service users have to want to join the program. This was emphasized by a number of providers and county teams as an important characteristic. There is no data to help understand what this means for the extent to which FSPs address the total addressable population, i.e. what proportion of people who would otherwise be eligible are excluded because they choose not to or are perceived as not being willing.

One County reported a high number of drop-outs during the first year of their FSP.

The programs may be 'cherry picking', with the 'harder' cases choosing to leave because the service is not flexible enough to accommodate their personal needs. It could be for a number of reasons, including the requirement for voluntary participation or the potential cultural inappropriacy of the service for certain groups. It is not clear if this is true of all providers and all FSPs, or just a subset. This would be picked up and challenged, and data would be available, if there were systematic monthly performance reviews of all contracts.

The Community Outreach Recovery Empowerment (CORE) programs in Sacramento may be a strong model to improve access.

Wellness centers were transformed into CORE centers, where people seeking mental health services can self-refer. The idea is to streamline the access process and help people in their own neighborhood.

OUTREACH AND COLLABORATION

In at least one County, there is an Outreach Engagement Team of 60 people, which is funded by and reports to the Behavioral Health Department.

This proactive engagement with people on the streets is funded as part of Prevention and Early Intervention. The County is split up into regions, with different teams responsible for particular places, and the communities encamped there. The teams refer the people on to whatever services are appropriate, and available, including FSPs (with one provider joining the Outreach Team on occasion). As this is still a ratio of around 1:130 outreach worker to homeless people, it does not allow for a very personal relationship to be built. Outreach activity is not billable through MediCal.

Engagement with jails varies between counties, and there are limitations on the services that can be provided and/or funded in jails for a number of reasons.

Under CalAIM it will be possible to claim for some interventions in jail, up to 90 days pre-release. A high proportion of people are only in jail for a week or less, which can make it hard to connect, making 'warm hand offs' difficult. As many as 50% of referrals to an FSP may come directly from jail.

The Care Courts appear to be a strong example of inter-sectoral collaboration, with a strong emphasis on individual needs.

It is an example of services coming together around the person. It also appears to be built on the notion of a 'compact', with the individual being given access to certain rights and resources, in return for accepting a number of conditions and requirements. The Care Courts are a model that could be scaled up. Though some view them as eroding trust because of where they sit in the system.

There are disincentives for FSPs to engage with people who are locked-up in hospital, with no billing allowed for in-hospital engagement.

Incarceration for someone with a serious mental illness may mean being locked up in hospital.

In one county, we heard about a "culturally responsive and congruent" program in four county-run clinics designed in consultation with local Black American communities.

This included activities like art therapy. It was said to focus on things like social connectedness and employment, as opposed to "traditional measures".

CHALLENGES AND POSSIBLE RESPONSES IN DETAIL

ELIGIBILITY AND ACCESS

We met with a group of people from the National Alliance on Mental Illness (NAMI). They were all the parents of people now on Adult FSPs. They also all told an incredibly moving story about the extreme difficulty that they had to, (a) find out about the FSPs in the first place, and (b) get access for their (adult) child. In most cases, they had been forced to have their own child repeatedly arrested. This was in a County with (at least anecdotally) high-performing FSPs, managed closely by a highly capable County team.

These parents spoke highly of the level of care now provided by the FSPs to their adult children. But there is no support for the parents themselves to cope with the deep trauma that they continue to experience.

Potential service users, and their families and other community members, are generally unaware of FSPs.	The systems appear from the outside to be opaque and highly complex, with little or no general public awareness of FSPs or other services. The segmentation of the 'continuum of care' by intensity, creates further complexity which inhibits effective access.
There is no clear data on the level and nature of mental health in the homeless population.	By virtue of their life on the street, all of this group will be experiencing daily trauma. They will live constantly with high levels of stress (with all the concomitant physical impact of this). The percentage with serious mental illness is almost certainly not matched by the number of places on an FSP.
The system targets those who are most socially excluded by virtue of their mental illness, because these are deemed to be the most costly to other services.	This group is incurring the high costs of hospitalization and incarceration. Stabilizing them (e.g. ensuring that they take their medication) appears quickly to relieve this pressure on services and this cost. But, this is achieved with an expensive, high-intensity response, with very small caseloads and large, professionally trained teams including clinical staff. Currently, on an Adult FSP, they are also likely to remain on that expensive program for many years.

Targeting people who are closer to 'home' and social *inclusion,* such as those newly arrived on the street, would potentially deliver a greater return on investment.	Someone who is recently homeless is likely to have a simpler set of needs than someone who has spent years there. Their body and mind will not yet have deteriorated as a result of that existence. They may appear to be less costly to the County/State, in the short-term, because they are not as often in out of hospital/jail, but they are at high risk of becoming as expensive, in the long-term. And as soon as they hit the street, they are already a social cost. At the same time, addressing their needs, such as helping them to reconnect with their family or to find a job, could be achieved much more quickly, and much more cheaply. Early intervention programs tend to be targeted at children not newly homeless adults (or families).
As gatekeepers for the FSPs, the counties may make entrance harder and disincentivize providers from seeking out new service users.	Having a single gatekeeper can create a bottleneck, when there are actually a wide number of touchpoints through which a service user could be identified. There is a lack of incentive for the service providers to keep pushing for higher volumes, which would incentivize them to challenge the silos in which these touchpoints operate.
There are lines drawn around FSP eligibility and participation, which don't reflect the nature of the targeted population, notably around hospitals and jails.	FSPs are not able (or cannot claim the time) to visit a service user in hospital or jail. There is, at least, a disincentive to do so. They cannot, for example, go into hospital to maintain care and possibly speed release, and ensure release means moving into a safe, stable place.
There was no reference in any of our discussions to the different experience of different ethnic groups, either in relation to mental health or to FSP performance.	There is data showing the disproportionate numbers of some ethnic groups on the street and suffering from serious mental illness. There is also data on the ethnicity of FSP service users (though with big gaps in that data). Do all ethnic groups manage to access FSPs in the same proportions? Are there any barriers, real or perceived, for any groups? Once on the program, do all groups progress in the same way and is there parity of outcomes?
We have been unable to ascertain the intersection of FSPs and tribal communities.	It is not clear the extent to which tribal groups are at particular risk of homelessness and serious mental illness, whether they have access to appropriate FSPs, and what outcomes they achieve.
Emphasizing the voluntary nature of the FSP may limit its reach and fails to account for the nature of social exclusion.	One provider talked about "harm reduction" as opposed to "treatment" because of the need to not impose on the service users.

A CONTINUUM OF CARE?

The way the system is organized, does not reflect the nature of people's lives (particularly if living on the street) or the nature of mental health.	Attempts are made to deliver a continuum of care that is segmented according to level of need and/or intensity of service (and as residential and non-residential). The FSPs are targeted at those who are ***most*** in need. However, this does necessarily reflect the true nature of need, or of mental health more generally, which fluctuates. The organization of services needs more closely to reflect this natural fluctuation, including the possible movement in and out of residential care (without this creating a gap in provision). Is there a better way to segment services, possibly by place or by priority group (e.g. homeless families) or outcome (e.g. employment)? Or is there a way to allow movement between services, without creating gaps that people fall through?
It is extremely hard to define the group of people whose level of need is one or two levels up from an FSP, or to define how the response to their needs would be different.	If we wanted to implement a Pre-FSP program, how would we delineate this group? The needs of this group, and their desired outcomes, would probably look very similar to the FSP group.
On the whole, there is no clear next step for most Adult FSP service users to progress on to as they are stabilized.	There is no coherent Post-FSP provision. There is also limited incentive for the service providers to transition service users onto lighter-touch support, whilst keeping them on the FSP.
Some of the service constraints are obviously imposed by MediCal rules.	If a young person has an eating disorder, the FSP can provide (and claim for) family therapy, but MediCal will not cover the cost of a dietician and there is no registered MediCal facility should the young person need residential care.
The focus on billable activities mitigates against community engagement, which an outcomes-based model might encourage.	In many places, particularly where the provision sits within a small, close community, the members of that community may have a role to play in supporting the service user to secure and sustain independence. If this was the function and goal of the FSP, then the provider would be incentivized to reach out for community support. Though this would not be billable under MediCal.

HOMELESSNESS	
The homeless and mental health population are conflated in the program objectives.	But the services deployed in response to these are largely separate and siloed. FSPs view themselves as a mental health, not a homeless, service. One provider reported that people try to access their program in order to secure housing and are told that it is a mental health program (which may provide housing on a short-term basis).
This separation fails to account for the holistic nature of life experience.	The system looks to separate homelessness and mental health in the way they are funded and delivered. For the individual, their homelessness and their mental health are intertwined.
Different counties deploy different teams to engage with homeless communities, but this is largely reactive.	In most instances/places, there is an emphasis on reactive responses to homelessness (and mental health) through, for example, crisis helplines, with some good practice shifting this away from the police. Behavioral Health in some counties also deploy assertive outreach or engagement teams.
Homelessness services generally sit in another department and have separate oversight.	(Notwithstanding the example above of a team of 60 outreach workers) there is fragmentation and duplication of these services, with no data sharing and with, as a consequence, weakened accountability.

COUNTY ACCOUNTABILITY	
There is a lack of clarity over exactly what counties are accountable for in terms of FSP spend and impact.	This may be related to the lack of clarity over whether the programs are about reducing hospitalization and incarceration or about improving individuals' wellbeing (and enabling their independence) – which may come to the same thing but ultimately shape different services.
There is no mechanism to hold counties to account for FSP spend and impact.	If there were transparent comparative data on FSP performance, the counties would be better equipped (and incentivized) to intervene when providers underperform. If a County consistently underperforms, then in what way are they held accountable? A potential mechanism might be as follows: 1. a performance improvement plan is agreed and the County is given the opportunity to remedy the situation; 2. continuing failure results in a further level of actions including a change in the management staffing and structure; 3. further failure and responsibility for FSP contracting and direct delivery is removed from the County and given to a neighboring County demonstrating high performance; 4. ultimately, the State may take over direct management.
A large proportion of the FSP target population also have a substance use disorder and this report has not considered the relationship between FSPs and substance abuse services.	This will have to be explored in the light of proposed changes to MHSA legislation.

WORKFORCE/STAFFING

Our key takeaways regarding workforce and staffing are that the staff working on FSPs are the heart of the performance of these programs. They are, on the whole, highly professional and committed. They entered the profession with a desire to make a real, positive difference. They tackle some of society's most difficult challenges. However, service providers are struggling to recruit and to retain staff. Some providers are doing better than others, but there is no systematic sharing of best practice. Many providers also do not appear to understand the basic link between investing in staff and hitting their contract cap in earnings. Outcomes contracting would reinforce this link, with better quality and more motivated staff delivering higher outcomes (and income). Some of the current service culture and system changes are driving down motivation and increasing stress levels. The State and counties, in consultation with stakeholders, must consider a strategic response to address this.

If contracts across the State are running at 70% of capacity – with 30% underspend across the system as a result – and the single biggest cause is difficulty to recruit and retain staff, then something different has to be tried.

In relation to the challenges faced by FSPs regarding the workforce, we offer the following ***observations:***

- Most providers are struggling to recruit staff, with up to 50% gaps in staffing in some places;
- Turnover varies between locations and between providers;
- There are examples of good practice in recruitment and retention;
- Some recruitment systems have been very bureaucratic and burdensome;
- The workforce does not match the service user demographic;
- Stress levels are high, so sickness levels are too;
- Peer workers add a lot of value;
- The performance management of staff varies between providers;
- There is budget available to fund education and training.

Alongside these observations, we offer the following ***challenges and possible responses:***

- Some providers are coping better but there is no sharing of this best practice;
- Most providers lack business models to give them a sensitivity analysis of the business impact of low staffing, and the value of investing in this;

- The drivers of stress include a lack of perceived control, burdensome admin and the emphasis on billing;
- Targeting billable minutes may squeeze out things like staff training and team meetings;
- Staff management and development will focus on the contracted targets, i.e. maximizing billing, as opposed to meeting service user needs;
- Contracting and paying for outcomes (personal, service user level outcomes) would incentivize providers to invest in staff;
- As 'market stewards', the State and the counties need to develop a strategic response to the workforce challenges.

These observations and challenges are set out in further detail below, along with some ideas for counties and State to consider. The development of a joint strategic plan is suggested.

OBSERVATIONS IN DETAIL

Most (but not all) of the service providers are struggling to recruit the full headcount of staff needed to service their contracted volume of service users.	It was reported that the vacancy rates are highest on the most intensive services, with up to 50% of positions unfilled on stabilization services (i.e. short-term assistance for people leaving hospital).
The turnover rate varies between providers and between locations.	Some point to the extra challenges of rurality and others to the very high costs of city living. The biggest variance appears to be between providers, reflecting different organization cultures and employment practices.
The service providers with the lowest turnover use a number of different strategies.	They look to over-recruit throughout the year. They may use an external recruitment company, which is incentivized/ rewarded to fill positions (unlike their internal HR services). They also look at the staffing model itself and shift to use accredited peers more or paid interns (many of whom progress to permanent positions).
The time taken to recruit has been as high as 250 days in some places.	There is a lack of incentive to be efficient in some parts of the recruitment system. This further deters candidates from applying. There is also a long time taken between job offer and job start.
The demographics of the workforce do not match that of the service users.	In one County, they introduced additional criteria to address this, including a requirement for lived experience. This may have reduced the pool further if it was not accompanied by proactive attempts to change the nature of the recruitment process (and possibly the nature of the employment itself) to be more inclusive of different populations.
There are reports of high levels of stress across the workforce, which is likely to be a driver of high levels of sickness and turnover.	Staff clearly experienced stress adapting and continuing services during COVID. Transitioning away from COVID brought further stress. The introduction of CalAIM is adding pressure to the frontline, along with new IT systems, new paperwork and probably legislative change. As staff leave, this adds pressure to those that remain.

The use of peers appears to be growing and this strengthens the service considerably.	The peers are more likely to match the service user demographic. Service users may open up more with peers, and can draw on their personal experience. The peers may help to ensure services are centered on users. Models such as the Club Houses appear able to deliver strong outcomes.
There is considerable variation in the capacity and commitment of providers to performance manage staff.	Performance management of staff appears to be left to supervision by many providers. A lack of performance management may be the result of: • a lack of positive outcomes measures across the service as a whole (it is much harder to manage against the negative measures such as not being hospitalized); • concern over turnover and not wanting to lose more staff; • lack of capacity/expertise at the team leader and lower management levels, or; • the lack of a performance culture across the system.
The Workforce Education and Training (WET) budget includes providing funding for educational loan repayments, undergraduate scholarships and post graduate stipends.	This is centrally administered. It removes some of the financial barriers for participation in training. However, it does not necessarily proactively look to increase the volumes of trainees.

CHALLENGES AND POSSIBLE RESPONSES IN DETAIL

Some providers appear to be tackling the recruitment challenges better than others, but there is no sharing of best practice.	Sharing comparative performance data, including ability to maintain headcount, would highlight the outliers.
No providers, or counties, have undertaken a sensitivity analysis showing the relationship between the cost of a member of staff and the income they can generate.	This would enable the setting of salary levels to be more informed and could challenge the persisting low headcount and reduced capacity.
The lack of performance management of staff limits service performance.	Performance management is about setting clear goals and objectives, and managing against these. It gives staff clarity over their role and reward/recognition improves motivation. It helps to identify the development needs of staff and can help inform, for example, in-service training.
Stress is significantly increased by a sense of lack of control.	The more the program is homogenized, and 'whatever it takes' is squeezed out, the more staff will experience stress. This will be exacerbated by a growing emphasis on replicating billable activities and maintaining records according to strict templates.
Stress is significantly decreased by a sense of delivering a meaningful purpose.	Adult FSP teams in particular do not currently measure or focus in any way on identifying and delivering purpose. They are focused on reducing hospitalization and incarceration, not helping someone to identify a dream and achieve it. The key events that are recorded are, for example, someone being arrested, not someone meeting up with their family or starting a job. What key events do the member of staff or the entire team celebrate?
Providers report a tension between maintaining activities like staff training and team meetings, and maximizing billable activities.	Many providers will simply conform to the culture created by the contract and will not recognize the long-term return from investing in staff development. They will disinvest in staff training and the meetings that build teams and support motivation.

Staff development will focus on what is needed to make the contract successful.

Staff right now are being trained on how to complete paperwork and how to maximize billing. Training is not fueling the motivations that brought these staff to this sector in the first place. It is not investing in building skills that they value.

Service providers cannot be mandated to deliver better staff management, but can be incentivized to invest in order to achieve higher performance.

If there is a culture of performance across the system, driven by the tracking, reporting and rewarding of meaningful, positive outcomes, then providers will look for ways to deliver more. They will naturally look at how to develop their most important resource, through hiring better and employing better. This can be facilitated by the counties/State, in their role as 'market steward'.

There has been a limited strategic response to workforce stress and to the need to maintain high motivation.

In the role of 'market steward', what steps can State and counties take to address the workforce challenge which is so constraining current FSP performance? Responses might include:

- Bringing providers (and other stakeholders) together to share best practice and agree an action plan;
- Review and revise the way performance is defined, measured, reported and reviewed. If needed, the contracts can continue to maximize billing as well as focus on individual, purposeful outcomes;
- Pilot the programs proposed in this Report, to create opportunities in the system for variation and innovation, and for purpose-driven services;
- Through the pilots, bring in new market entrants with different staffing models;
- Review and revise the staffing models that are contractually required, and consider a greater use of peers;
- Specifically address the inability to bill for staff training time (though a shift to outcomes payments is by far the best way to incentivize investment in staff);
- Review the sign-offs required, for example, for flex funds, to increase the sense of autonomy and empowerment among the staff;
- Undertake a mapping exercise of data flow and look to rationalize data entry;
- Explore whether there are ways to capture billable minutes behind the scenes, freeing up frontline staff to focus service users. What examples are there of best practice in physical health services?

- Consider how to stimulate the supply of labor, with recruitment targeted at non-traditional populations, through new performance-based contracts with recruiters;
- Contract an organization to grow the numbers and skills of peers (from youth to old age), with the contract performance measured/paid on the basis of peer volunteers engaged, peers trained and subsequent peer-on-peer interactions (if remotely, then monitored by a combination of AI and human coordinators).

APPENDIX II:
THE 11 CHARACTERISTICS OF HIGH-PERFORMING CONTRACTS

High-performing contracts will address these 11 questions as follows:

1 ***What does success look like?*** There is a strong, clearly articulated definition of high performance that all stakeholders buy into and understand, including service users, who are heavily involved in shaping the definition. Success aligns the interests and incentives of all stakeholders and covers both programmatic and financial objectives as well as individual outcomes. The definition of success is agreed upon at the start. On a program addressing mental illness and/or addiction, consideration is given to all three domains of People, Place and Purpose (see below).

2 ***What is being purchased?*** Payments to Service Providers are tied to highly relevant and easy-to-understand deliverables that reflect high performance. These might be inputs, outputs, outcomes, or possibly even impact[7], but the emphasis should be outcomes. Deliverables are measurable, verifiable, limited in number (between four and eight is optimal) and assessed at the individual service user level. Deliverables are designed to create a culture of high-quality service that drives frontline behavior and are instrumental in guiding the performance management of staff. In addition to deliverables that trigger payment, there needs to be minimum service standards that are not tied to payment but are built into and required by the contract (such as maximum response times or minimum levels and frequency of contact with service users). In some contexts, there will need to be a separate 'verifier' who independently checks that deliverables have been achieved in order to trigger payment.

3 ***At what price?*** The pricing attached to deliverables must be programmatically informed and relevant, incentivize performance and drive efficiencies. Pricing is derived from an analysis of the inputs/expenditure required to achieve the targeted level of performance. The cheapest offer from service providers is not necessarily the best when the primary objective is a service that maximizes outcomes. The question is not, 'how cheaply can you do this?', but 'how many high-quality outcomes can you deliver for the money that is available?'

4 ***How much is paid when?*** The payment schedule balances the need for working capital with incentivizing performance. Payments are tied as far as possible to outcomes but the County and the provider understand the cashflow implications and ensure this is addressed in some way. The optimal balance of outcomes versus budget reimbursement or input payments is with 2/3 of payments linked to outcomes. All payments to providers are scheduled and efficiently administered (with monthly invoicing and payments made within 20 working days).

[7] For example, an input is someone receiving training, an output is someone gaining a qualification, an outcome is someone securing and sustaining employment, and an impact is a reduction in % of unemployment.

5 ***When and how are (potential and actual) service users, peers and advocates involved in program design, delivery and oversight?*** Service users and peers are involved in the design of the program and throughout delivery. Giving service users the ability to select some or all of the payment triggers can help to put ownership in their hands and empower them. Users, families and peer advocates will also be given a seat on any performance review board or committee. There are regular satisfaction surveys.

6 ***How is the target group defined and who controls referrals of service users onto the program?*** Careful delineation of the targeted population and definition of eligibility criteria mitigate 'deadweight' (people who could have achieved the outcome by themselves, without the program) and 'creaming' (i.e. providers choosing 'easy' people to work with). These criteria are kept under review and may be varied on occasion to ensure high referral numbers. Volumes are a key performance driver and the service provider controls or at least can influence the flow of service users, for example, being able to undertake outreach to secure new clients. A high performing contract incentivizes the service provider to deliver as many outcomes for as many people as possible, who could otherwise not have progressed.

7 ***How is frontline activity and performance recorded and facilitated?*** All activity delivered on the frontline is recorded and can be analyzed, quantitatively and qualitatively, at different levels (e.g. at individual staff, team, office or contract level). A good IT system for capturing frontline activity enhances service quality and facilitates efficiencies day-to-day (e.g. with accessible case management tools, diary reminders, template letters or automated text messaging). Consideration is given to how the IT system (or app) impacts the workload and motivation of staff; double data entry into different systems is avoided.

8 ***What is the performance management structure/system?*** There is a systematic review of performance. There are monthly performance reviews by a Performance Board where the provider presents to the contract manager and other relevant parties as indicated. Performance is tracked at an individual service user level, and includes 'exception reporting', i.e. who has not been seen in the last month and for what reasons. The objective is to seek continuous performance improvement, asking each month, 'what do we need to be doing more of?' as well as 'what do we need to be doing differently?'. Performance is reported transparently with regular publication on a website. There is regular (e.g. monthly) performance comparison between providers.

9 ***What are the consequences of under-delivery or other disagreements/violations?*** The contractual terms are clear on 'step-in rights' when performance standards are not met, e.g. the provider is required first to draw up an improvement plan and then implement changes as agreed. There may be adjustments to the payments, referrals may be stopped for a period of time, the provider might have to change their managers, or, ultimately, the contract may be terminated. Service failure might result from failing to meet performance targets or failing to meet quality minimum standards.

10 ***What assurance model oversees performance?*** Service providers have in place a robust, systematic audit and assurance process to verify the deliverables/outcomes that are claimed including the quality of the service received by each service user. The County audits the provider's systems and undertakes additional auditing as indicated, based on the evaluation of risk.

11 ***How does the service contracting body (i.e. County Director) fulfill the role of market steward?*** The performance of the program depends on the wellbeing of the service providers – on them being able to perform at their best, with the right resources and with high levels of motivation. The State and County think about how to build the service providers' capability, investing in capacity building activities and bringing providers together to share best practice. This is underpinned by transparent reporting of performance across all providers – the focus always remains maximizing outcomes for service users.

APPENDIX III:
OUTCOME DOMAINS (I.E. DELIVERING ON 'PEOPLE, PLACE AND PURPOSE')

Being part of a community, or simply having community in life, is a requirement for, and core indicator of, overall health and wellbeing. In general, human beings with strong community flourish while those without it languish. At HBGI, we use three life domains[8]: ***People, Place*** and ***Purpose,*** to define community.

These domains can be used to assess and track the trajectory of an individual client's progress as they receive care interventions in the pursuit of recovery from mental illness and/or addiction.

Metrics of relevance in each of the three domains include the following.

People, or 'someone to love', provided, for example, through peer support, family reunification or socialization programs. This might be measured in terms of:

1. Capacity to care for and be cared for by others, including family/kin;
2. Contact with, and connection to, family of origin and or equivalent kin;
3. Current and ongoing fellowship/support from friends and/or colleagues.

Place, or 'somewhere to live', such as housing, a clubhouse or peer respite programs. This might be measured in terms of access to:

1. A dignified, safe, secure and comfortable living environment (housing);
2. A space for convening or center of gravity for social and recreational activity;
3. A calm and easily accessible sanctuary (e.g. for relaxation mindfulness/meditation).

Purpose, or 'something to do', which might include developing hobbies, education/training, volunteering (including providing peer support), or employment programs:

1. A sense that there is meaning in the activities of life (a personal mission);
2. A pattern of activities that reflect, and/or stances that represent, mission;
3. A job and/or vocation that empowers both livelihood and independence.

The precise outcomes measures (and/or payment triggers) for each one will depend on the context and should be agreed in consultation with all stakeholders – and should meet the criteria set out on the 11 Characteristics (notably being measurable and verifiable). As noted elsewhere in this report, performance can be significantly enhanced through a shift of control to service users, giving them the ability to define (or select from a list of options) their own expression/measures of People, Place and Purpose outcomes.

[8] Based on the work of Dr Jonathan Sherin, co-author of this report.

APPENDIX IV:
AN ANALYSIS OF THE ADULT FULL SERVICE PARTNERSHIP (FSP) CONTRACTS

There is clearly variation in FSPs between counties and between contracts. The following analysis describes the prevalent characteristics observed during preparation of this Report (with a focus on Adult FSPs) against the 11 characteristics of high-performing contracts and the domains of people, place and purpose.

Target Model	FSP Observations	Recommendations
1. What does success look like?		
Clear definition of high performance understood by, and aligning the interests of, all stakeholders.	Success stated mainly in terms of impact, namely high-level reductions in homelessness, hospitalization and incarceration. Missing individual service user outcomes (notably around Purpose). Emphasis on a 'medical model' and identifying what's wrong with service users. Treatment rather than recovery.	Continue to track impact on homelessness, hospitalization and incarceration. Agree new outcome-level targets, at the service user level, and new monthly reporting. Pilot new contracts with 'success' defined clearly in terms of outcomes, including around Purpose.
2. What is being purchased?		
Payments attached to (4 to 8) relevant, measurable, verifiable deliverables, focusing on the individuals, creating the right culture, driving frontline performance. With minimum quality standards established alongside.	Mainly a pre-agreed budget, with key specified staffing numbers to manage a maximum caseload size/contract volume. A largely homogeneous service, becoming more so with a push towards fidelity or near-fidelity ACT. Provider payments moving towards a link with MediCal billing, with providers targeted to maximize this.	Introduce a blended payment model with 50% of the payments to providers partly linked to MediCal billing and partly to individual service user outcomes. Define minimum service standards but leave providers room to innovate to achieve outcomes.

Target Model	FSP Observations	Recommendations
3. At what price?		
Pricing recognizes commercial reality of delivery, considers the link between inputs/costs and outcomes/income, and incentivizes high performance.	Very high variation in FSP cost from County to County. Possibly fossilized business models with costs becoming fixed over time. Variation in procurement practice but generally a mix of technical and cost evaluation, sometimes with past performance.	Look to compete future contracts on performance rather than price. State the budget available and ask bidders to state the number of outcomes they will achieve within this budget – that sets the price per outcome. Require bidders to submit fully costed plans showing the cost of all inputs and the rationale behind their performance offer.
4. How much is paid when?		
The selected payment triggers take into consideration provider cashflow. Payments to providers are administered efficiently.	Flat monthly budget reimbursement (i.e. annual overall program cost is divided by 12), moving towards link with MediCal billing and monthly variance. Flex funds appear to be utilized well in some places though no data on this (and strictly controlled by the counties). Small incentive payments have been trialed in some places without success.	Monthly submission of invoices based on the month's performance (e.g. outcomes achieved). If cashflow is a concern, pay the first six months anticipated earnings upfront and then readjust in the light of actual performance. Verify a sample of all outcomes claimed and clawback funds if there is no evidence. Build the flex funds into the overall contract value and give control to the providers to maximize their outcomes. Providers to record all spend.

Target Model	FSP Observations	Recommendations
5. When and how are (potential and actual) service users, peers and advocates involved in program design, delivery and oversight?		
Wide stakeholder engagement from the outset, including lived experience. Service users given clear sense of ownership.	Service specification is very top down. Families/advocates are closely involved in Child FSPs but much less, if at all, in Adult FSPs. There is increasing, valuable use of peers. Limited program oversight overall.	Service users to select their own desired outcomes across People, Place and Purpose. Service users, families, peers and advocates to be consulted in drawing up the lists from which the outcomes are selected. Families to be surveyed following a service user's start on an FSP regarding their experiences accessing the service. Monthly Performance Board to include service users, peers and possibly advocates, as relevant in that setting.
6. How is the target group defined and who controls referrals of service users onto the program?		
Referrals are not a blocker. Providers are incentivized to seek high volumes. Eligibility criteria mitigate 'deadweight' and 'creaming'. Eligibility criteria kept under review.	The counties generally act as the gatekeeper. This can cause bottlenecks. People must really 'fail' in order to access the program. It is not clear if there is the right match of supply/spaces and demand/service users at present. Spaces are awarded to those who have failed the most loudly. Major constraint on being able to make referrals at the moment is lack of staffing in the providers. There are waiting lists of service users in some locations. There is little public awareness of FSPs.	Widen referral routes and incentivize service providers to go out to engage potential new service users (including onto the street and into jails). Review the forms used to screen referrals to ensure they aren't overly bureaucratic. Extend Care Court collaboration. Move to outcomes-based payments, with the potential for over-performance, to incentivize providers to look for higher volumes. Pilot a Follow-On program with lighter-touch support, possibly with an emphasis on peers, to create space on the FSP. Pilot place-based programs to take the services beyond FSPs. Review communications activities to raise public awareness.

Target Model	FSP Observations	Recommendations
7. How is frontline activity and performance recorded and facilitated?		
Activity is tracked, recorded and reported. IT/case management systems help not hinder staff performance.	Variation between counties and providers, with some good practice (though it is the exception). An emphasis on accurate recording of activity according to MediCal requirements - with reporting on billing 'productivity'. Double or triple entry into IT systems. Staff stress/motivation a concern.	Review all IT system use. Map data flows. Consider impact on staff and time taken to enter data (in multiple systems). Review case management tools available to case managers. Look for examples of good practice in physical health programs with systems recording billable activities in the background. In the workforce strategy, plan for ways to address staff stress. Build provider capacity in stress management. Shifting focus to recovery outcomes will reinforce the positive purpose of the program.
8. What is the performance management structure/system?		
Monthly performance reports published and reviewed. A systematic search for continuous improvement.	Occasional high-level reports on the three impacts (percentage reductions in homelessness, hospitalization and incarceration). No link back to individual progress on the program. Some monitoring reports produced in isolation from delivery. No transparent reporting of performance. No comparison across contracts/providers. In a small number of cases, there are monthly performance reviews. Most providers do not even undertake this internally.	Continue the high-level reporting. In addition, introduce: • Monthly reporting. • The production of a monthly Performance Pack, which is reviewed by a Performance Board. Membership of the Board to include operational leaders from the provider and possibly peers, advocates and service users. The County Monitor (or equivalent Contract Manager) to attend at least quarterly. • Consolidated performance reporting across all providers – monthly in the County and quarterly in the State.

Target Model	FSP Observations	Recommendations
9. What are the consequences of under-delivery or other disagreements/violations?		
Clear 'step-in rights' in the event of underperformance.	On occasion, action plans are requested. Terminations are very rare and largely due to financial failure.	Monthly Performance Boards to capture agreed actions, looking each month for continuous improvement. Review service provider contracts and add clarity on 'step-in rights' for minor and major performance failures.
10. What assurance model oversees performance?		
Providers have quality assurance systems in place. The service contracting body audits these and possible assures directly based on risk.	Reliance on layers of supervision. Some evidence of wider quality assurance systems in larger providers.	Providers to review their internal systems. Providers to present this review to the County and, together, decide the strengths and weaknesses. County to consider how to audit this assurance system and if/how to undertake direct inspections or observations. County thereafter to conduct a periodic risk analysis and determine their audit regime in response. Focusing on personal outcomes will strengthen the personal responsiveness of the FSP.
11. How does the service contracting body fulfill the role of market steward?		
The service contracting body invests in supporting and growing the service providers, with capacity building and best practice sharing.	Little or no sharing of best practice across/between service providers. No systematic engagement across the sector. The Association of not-for-profits is about to open to for-profits too. No sharing of lessons between in-house and contracted provision.	County to convene an initial meeting of all providers. Share an overview of the County services and the FSP contracts and performance. Present the service improvement plan. Brainstorm ways to support, collectively, provider development (always with a focus on performance). Continue with at least twice-yearly best practice sharing days. State to echo this, with State-wide engagement and an annual conference (convened in partnership with the provider Association(s)).

Target Model	FSP Observations	Recommendations
People		
Service users are meaningfully connected with others, such as peers, families or other social networks.	Close involvement of families in Child FSPs. Possible active disengagement with families in Adult FSPs. Increasing use of peers. Adult FSPs likely to run a range of group activities and appear to build positive/supportive connections between service users.	Agree desired outcome(s) with service user regarding social connections outside the FSP. Track progress against this. Consider how to establish (and fund) family support in parallel with the FSP.
Place		
Service users have somewhere safe, secure and stable to live.	Sourcing good housing options is a challenge in all areas. However, high proportion of service users secure accommodation. Club Houses and peer respite programs used well where they exist.	Look for best practice on homeless programs elsewhere. What innovative models have been used to create space and also to finance it? Explore the use of rent guarantees and landlord insurance schemes. Consider the use of Impact Bonds with private finance paying for property development against a guaranteed income stream of rent underwritten by the County. Consider the potential for cooperative construction projects, with the service users building their own future accommodation. Consider re-purposing disused office space, possibly in partnership with Club House organizations to ensure community spaces and activities are integrated.
Purpose		
Service users are connected to activity that gives meaning and independence, such as employment.	Child FSP service users move on after 12 to 18 months (maximum). Adult FSP users appear to become stuck on their FSP, possible reinforcing their dependency. An emphasis on keeping them safe and stable. There is little evidence of purposeful goal setting. Some employment advisors being embedded in teams now.	Pilot a program in parallel with FSPs that pays the provider to support people into work (possibly training and supported employment too). When recontracting FSPs, split the provider payments between billable activity and outcomes. Look as far as possible for the measurable, verifiable outcomes to be selected by the service user.

APPENDIX V:
THE FRAMEWORK FOR A PARALLEL PURPOSE-LED OUTCOMES CONTRACT

The following table takes the same 11 Characteristics, and sets out the answers for an outcomes contract that might run in parallel with an Adult FSP, focused on Purpose through (training and) employment. This is by way of example, with many of the details in practice to be agreed in consultation with the relevant stakeholders.

Purpose-led outcomes contract – focus on employment

1. What does success look like?

The overall objective is sustained employment for as many people as possible. Success is people engaged in activity that they perceive to be purposeful. This may mean participating in education, training or supported employment and progressing to full employment, or going straight into work. It might mean establishing an Intermediate Labor Market to create supported employment opportunities (such as recycling furniture), as long as there is a clear progression to full employment.

2. What is being purchased?

At least 65% of the payments to the providers are linked to job entry and sustained employment. The employment must be sustained for at least three months (13 weeks) and it could include two different jobs during that time (with no more than a two-week break between them).

The total contract value is split 10/10/15/30/35:

- ***10%*** for enrolments, with agreement on a job goal (possibly short-term and long-term goals, which may be revised later) and completion of an Action Plan;
- ***10%*** for completion of education or training (with certification);
- ***15%*** for completion of up to three months of voluntary work or supported employment;
- ***30%*** for starting a formal job (with a letter of appointment or work contract as evidence);
- ***35%*** for sustained employment (with pay slips or other evidence of ongoing work). The employment must be in a 'good' job, the detail to be defined (e.g. in terms of minimum number of hours per week, salary, travel distance to work from home, match with job goals, in a safe environment). If someone moves straight to work without training and/or supported employment, these payments can be rolled up and added to the job start payment.

3. At what price?

The budget is capped at $10m per provider, to be split 10/10/15/30/35 as described above. Potential providers submit bids setting out their technical proposal and saying how many enrolments, training completions, supported employment completions, job starts and sustained employments they can achieve. If their bid is successful, this determines the unit price that they are paid for each of these deliverables.

Bids are evaluated 80% on technical offer and 20% on price. Once mobilized, the provider can over-perform on the job starts and sustained employment outcomes/payments (not on the training or supported employment), and claim up to $3m over the $10m (i.e. 30% over their base targets).

4. How much is paid when?

Service providers submit an invoice at the end of each month detailing the individuals and the deliverables achieved. They must submit evidence to support each claim (e.g. copy of identification at enrolment, certificate after training, work contract or letter of appointment, etc.). The County audits this claim and then pays the invoice within 20 working days.

In order to allow providers to bid and participate who do not have large reserves or the ability to borrow, the County may consider paying an upfront 'mobilization allowance'. This will cover the early cash gap ahead of the earnings from the outcomes. The provider 'repays' this upfront money once they start to deliver outcomes (i.e. it is deducted from invoices).

5. When and how are (potential and actual) service users, peers and advocates involved in program design, delivery and oversight?

As an outcomes contract with a strong focus on jobs and sustained employment, the service provider must listen to each individual participant and build the service around their individual needs – or they won't be able to achieve any outcomes. The service is highly localized, around the individual and their community.

The monthly Performance Board includes representation from participants and/or peers and advocates.

6. How is the target group defined and who controls referrals of service users onto the program?

Participants must be unemployed. They may be attending an FSP but not necessarily. They have a diagnosed mental illness or addiction. The service provider is responsible for establishing referral channels and for achieving their contracted volume.

7. How is frontline activity and performance recorded and facilitated?

Service providers use a case management system to record (and report) all activity with participants and to support the work of their case managers. It is possible to report activity (including outcomes) by individual and by cohort, in the month and cumulatively. The strength of their system is evaluated as part of their bid.

8. What is the performance management structure/system?

The contract has payments weighted on outcomes to incentivize performance. Service providers submit a weekly report of all activity. On a monthly basis they present an analysis to the Performance Board. The Board is chaired by a County representative. There is a minimum of two providers to mitigate the risk of one failing and to allow for comparison of performance.

9. What are the consequences of under-delivery or other disagreements/violations?

The service providers are only paid if they deliver the outcomes. Targets are derived from the bid for enrolments, training, supported employment, jobs and sustained employment. If these targets are being missed and the Performance Board is concerned, then, in the first instance, a Performance Improvement Plan is agreed. If targets continue to be missed, then a formal Improvement Notice is served. Finally, the contract may be terminated and the service transferred to another provider.

10. What assurance model oversees performance?

The service provider implements their own quality assurance system, which is in turn assured by the County. Summary Quality Assurance reports are included in the monthly Performance Pack. The quality of the outcomes is also controlled by definition of minimum standards (e.g. hours of work, salary, etc.).

11. How does the service contracting body fulfill the role of market steward?

During procurement, the County runs a series of briefing events, which include capacity building for all interested providers on: outcomes contracting; building an outcomes contract operating budget; mobilizing outcomes contracts, and; strengthening performance management.

On a quarterly basis the County convenes a meeting of all service providers. Performance across the service is reviewed and key lessons from the Performance Boards are shared.

APPENDIX VI:
A NOTE ON TECHNICAL ASSISTANCE

If the State and/or counties decide to implement any of the recommendations set out in this Report, they will look to bring in Technical Assistance (TA) to support this. Their own resources are stretched thin and there are already a number of other initiatives underway. The TA should be looking to enhance performance – increasing efficiency and effectiveness - without putting pressure on existing delivery.

The specific opportunities for TA support include:

- Revision of the payment terms and performance measures for existing FSP contracts;
- Amendments to existing, or new, contracts to pilot an FSP Follow-On;
- Piloting a purpose-led outcomes contract to run in parallel with the FSPs;
- Piloting an outcomes contract focused on reducing jail re-entry;
- Piloting an outcomes contract targeting particular homeless communities with special consideration of homeless encampments;
- Agreeing upon new performance measures with the FSP providers and implementing new performance management and performance reporting (e.g. the production of monthly reporting 'packs');
- Introducing monthly performance 'boards' to review progress and drive continuous improvement;
- Introducing new transparent comparative performance reporting across contracts and providers within a given County and between jurisdictions.

All counties have specific challenges. Counties may review this Report and identify different approaches to address the recommendations here in terms of amended or new contracts or ways of working, that would benefit from TA.

It is recommended that the TA commissioned to support the implementation of any recommendations set out in this Report should be able to evidence the following experience:

- Considerable senior leadership in the design, mobilization, direct delivery, contracting and oversight of services targeting the most vulnerable populations, in multiple countries and contexts, including for people with physical and mental health conditions, addictions, unemployment and homelessness, with an emphasis on experience in contracting and monitoring services on the basis of performance and outcomes;
- Considerable senior leadership in the design, mobilization, direct delivery, contracting and oversight of behavioral health services at a County level in California, with a focus on serious mental illness and addictions covering hospitals, clinics, jails, prisons, juvenile halls, foster care, veterans and homeless people (including services which have been contracted through extended networks of providers);
- Senior level collaboration across private, philanthropic, public, not-for-profit and academic sectors in multiple country contexts, including California. Working with stakeholders at international, national, state and local government levels, including engagement with significant policy and cultural influencers (with an impact on clinical as well as community-based practice).

The TA should focus on:

- Working with local stakeholders, including service users, in order to understand needs and to design empowering services that give control to each service user;
- Designing and deploying data systems to track and drive the performance of frontline services across health and human service systems, with a focus on mental health and addiction services as well as at-risk populations;
- Designing, procuring and overseeing performance- and outcomes-based contracts, relevant to the local context, including developing the reformed payment models for these contracts;
- Shifting services from grant-based or budget-reimbursed contracts to performance-and outcome-based models, managing the change to secure stakeholder buy-in, minimize disruption and maximize performance;
- Managing large networks of pan-sector contracted service providers, implementing performance management systems to drive outcomes/impact, intervening to address under-performance;
- Developing and delivering culturally-appropriate capacity building programs in contract design, procurement, and contract and performance management, for contracting bodies and for service providers;
- Developing and implementing human resource strategies to build skills, capacity and motivation to grow a workforce that is able to work at its best.

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