ASPE
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

OFFICE OF BEHAVIORAL HEALTH, DISABILITY, AND AGING POLICY

The Coordinated Specialty Care Transition Study: Final Report

Prepared for
the Office of the Assistant Secretary for Planning and Evaluation (ASPE)
at the U.S. Department of Health & Human Services

by
Westat

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THE COORDINATED SPECIALTY CARE TRANSITION STUDY: FINAL REPORT

Authors

Tamara C. Daley
Preethy George
Abram Rosenblatt
Westat

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ACRONYMS

The following acronyms are mentioned in this report and/or appendices.

ACT	Assertive Community Treatment
ADAMH	Alcohol, Drug and Mental Health board
ASPE	Office of the Assistant Secretary for Planning and Evaluation
BEAM	Bipolar Early Assessment and Management
BeST	Best Practices in Schizophrenia Treatment center
BHSN	Behavioral Health Safety Net
BOOST	Better Outcomes through Ongoing Specialized Treatment
BPRS	Brief Psychiatric Rating Scale
C-SSRS	Columbia Suicide Severity Rating Scale
CADI	Community Access for Disability Inclusion
CBH	Community Behavioral Health
CBT	Cognitive Behavioral Therapy
CBTp	Cognitive Behavioral Therapy for Psychosis
CCBHC	Certified Community Behavioral Health Clinic
CfE	EASA Center for Excellence
CHR	Clinical High Risk
CMH	Community Mental Health
CMHC	Community Mental Health Center
COVID-19	Novel Coronavirus
CPT	Current Procedural Terminology
CSC	Coordinated Specialty Care
CTI	Critical Time Intervention
CTT	Continuous Treatment Team
DBT	Dialectical Behavior Therapy
DLA-20	Daily Living Activities-20 scale
DUP	Duration of Untreated Psychosis
EASA	Early Assessment and Support Alliance
EIP	Early Intervention in Psychosis
EPIC-NOLA	Early Psychosis Intervention Clinic-New Orleans
EPICENTER	Ohio Early Psychosis Intervention Center
EPINET	Early Psychosis Intervention Network
ESMI	Early Serious Mental Illness
STCH	Early Treatment and Cognitive Health
ETP	Early Treatment Program
FEP	First Episode of Psychosis
FEPI	First Episode Psychosis Initiative
FTE	Full-Time Equivalent

GAF	Global Assessment of Functioning
HCBS	Home and Community-Based Services
HHS	U.S. Department of Health and Human Services
HOPE	Healing and Opportunities with Psychotic Experiences program
IEP	Individualized Education Program
IOP	Intensive Outpatient Program
IPS	Individual Placement and Support
IQ	Intelligence Quotient
IRT	Individual Resiliency Training
LAI	Long-Acting Injectable
LGE	Local Government Entity
MCO	Managed Care Organization
MHBG	Mental Health Block Grant
MHC	Mental Health Cooperative
MHSA	Mental Health Services Act
MMHPI	Meadows Mental Health Policy Institute
NASMHPD	National Association of State Mental Health Program Directors
NIMH	National Institute of Mental Health
NRI	NASMHPD Research Institute
OBH	Louisiana Office of Behavioral Health
OHA	Oregon Health Authority
OhioMHAS	Ohio Department of Mental Health and Addiction Services
OMH	New York Office of Mental Health
OMHSAS	Pennsylvania Office of Mental Health and Substance Abuse Services
OSU	Ohio State University
OT	Occupational Therapy
PACT	Program for Assertive Community Treatment
PANSS	Positive and Negative Syndrome Scale
PATH	Program for Assistance in Transition from Homelessness
PEACE	Philadelphia Psychosis Education, Assessment, Care and Empowerment program
PEI	Prevention and Early Intervention
PEIC	Pennsylvania Early Intervention Center
PHP	Partial Hospitalization Program
PQ-B	Prodromal Questionnaire-Brief version
PROS	Personalized Recovery Oriented Services
PTSD	Post Traumatic Stress Disorder
RAISE	Recovery After an Initial Schizophrenia Episode
RFP	Request for Proposal

SAMHSA	Substance Abuse and Mental Health Services Administration
SCIT	Social Cognition and Interaction Training
SEE	Supported Employment and Education
SIPS	Structured Interview of Psychosis-risk Syndromes
SMHA	State Mental Health Authorities
SMI	Serious Mental Illness
SSI	Supplemental Security Income
STEP	Specialized Treatment Early in Psychosis
TAY	Transition Age Youth
TDMHSAS	Tennessee Department of Mental Health and Substance Abuse Services
THL	Tennessee Health Link
TIP	Transition to Independence
YAT	Young Adult in Transition

EXECUTIVE SUMMARY

Introduction & Background

Early intervention in psychosis (EIP) is well-supported by empirical evidence. Typically called Coordinated Specialty Care (CSC) in the United States, CSC is a team-based intervention that combines well-established evidence-based treatments. These components include assertive case management, psychotherapy, supported employment and education (SEE) services, family education and support, and low doses of antipsychotic medications, delivered within a shared decision-making framework (Heinssen, Goldstein & Azrin, 2014). CSC programs are commonly 2-3 years in length. After attending a CSC program, clients often receive services in a regular outpatient setting within the same clinic or are referred routine services in the community (Jones et al., 2020).

The current study, supported by the Office of the Assistant Secretary for Planning and Evaluation (ASPE), examines the landscape of existing approaches to continuity of care services that are available to CSC clients after participation in a CSC program, and how services may be better integrated into larger systems. The study combines an environmental scan with a set of nine case studies. Based on interviews with nearly 90 respondents, these case study sites highlight variability in how continuity of care services are provided and integrated with other systems and programs, how services are funded, and challenges and opportunities in continuity of care.

Findings

There are three main factors that shape how a CSC program manages transitions and that contribute to decisions about continuity of care. First, programs vary in their program length, and the degree to which program length is flexible. Second, programs differ in whether they have step-down processes and the nature of those processes. Some sites have created step-down services that are distinct from their CSC program, whereas others decrease the intensity and frequency of services as part of the program itself. Some programs have both, and some have neither. Lastly, CSC programs vary in the location of placement following transition and whether clients can be accommodated within the same organization, or need to be referred to services in the broader community.

The reality in many areas of the United States is that routine services are not always readily available or are not a good match for client needs. Many community-based providers do not have specialized training to work with young adults with psychosis. Primary care providers can be reluctant to take on clients with a history of psychosis, whom they view as requiring a higher level of care than a typical patient. Options for care are also limited by what insurance a provider accepts. Regardless of insurance type, available care is often not tailored to the particular needs of young adults as

opposed to older individuals, and the mismatch between the nature of care in the community and the more intense, supportive approach of CSC can add challenges to the success of a transition.

As a result, CSC programs have developed two primary ways to provide continuity of care. First, some programs extend the length of the "core" set of CSC services to three or more years. While an extended length program runs counter to the original conceptualization of CSC as a time-limited intervention, most respondents in this study favored a program length of three to five years, or allowing length to vary according to each individual clients' needs. This was true among sites that both have and do not have this structure already in place. CSC team members noted advantages of a longer program length, such as being able to support clients through developmental transitions, provide psychotherapy at the clients' pace, and ensure care with little disruption.

A second way programs support continuity of care is through step-down services, which are generally less intense and involve reduced frequency or a change in the type of services provided. Step-down programs vary across multiple dimensions, such as the population served, whether the services are a continuation of the CSC program or reflect a shift in focus, whether the step-down can accommodate all CSC clients and whether it has the capability to provide more intense services if needed, the length of time of step-down services, and whether clients work with the same staff or not. Structural and fiscal factors, such as funding agency or age restrictions, shape much of the variability around these dimensions. One commonality across the step-down programs in the current study is that services for the step-down take place in the same location as the core CSC program. Respondents consistently lauded the many clinical and logistical benefits of this co-location.

CSC programs that are well integrated into larger systems tend to have greater options to serve their clients following graduation. Programs located in large hospitals or community mental health centers (CMHCs), for example, may be able to provide medication management and therapy through outpatient clinics. Another example of integration with a program are sites that use Transition Age Youth (TAY) programs as a post-discharge placement. In the two case study sites that took this approach, the TAY programs were the preferred referral option primarily because services match the developmental stage of most clients in the program.

This study found that most CSC programs use a similar combination of funding sources to support as they do for their full CSC services, and therefore navigate similar constraints. Reimbursement through Medicaid and private insurance, supplemented with state and Mental Health Block Grant (MHBG) set-aside funds is common. Reimbursements often do not cover certain services--such as SEE, case management and peer support--yet these are the very services that often are most relevant to individuals once they have stabilized and are in a step-down setting.

A last finding of this study is related to context. This study took place during five months of COVID-19, with data collected between May and September 2020. Sites with step-down programs that focused on community-based and in-person activities--such as learning to navigate neighborhood resources, public transportation, job support, and use of drop-in centers --reported significant disruption. Due to COVID-19, some sites initially elected to wait to transition clients out of the program until services could resume in-person. However, the use of telehealth has generally been effective for interactions that are not dependent on in-person contact, and sites in this study report a desire to continue to have telehealth as an option for service delivery.

Policy Opportunities

The findings from this study suggest several areas where policies may increase opportunities and quality of post-transition services. First, in some cases, the reticence of community providers to accept clients with first episode of psychosis (FEP) is due to concerns about having the appropriate skills and training. Outreach activities are already a component of CSC, intended to increase referrals into the program. With targeted funding through state, county or other sources, CSC programs are well-positioned to expand this outreach in a way that also builds expertise among selected organizations. These trained providers then can serve as a referral network. Staff shortages and high caseloads in CSC programs can be addressed through either additional funding or partnerships with educational institutions. Programs can partner with medical schools and other mechanisms through which CSC can serve as internship and psychiatry placements.

Across sites, Medicaid remains a critically important source of support for continuity of care for individuals with psychosis. Medicaid could be even more effective if consistently extended to several key services, such as SEE and peer support services. Respondents in multiple sites described interest in negotiating with the State Medicaid authority and private insurance companies to support a case rate model and/or a tiered model of reimbursement, both of which have clear relevance toward fully supporting step-down and extended length models.

Summary and Conclusion

The purpose of the current study was to examine the landscape of existing approaches to continuity of services after completion of a CSC program in the United States. Using a combination of data from an environmental scan and nine case study sites, we described how services are structured and sustained, how teams facilitate transitions and what challenges they face, and how organizations and states can support transition processes. Despite challenges that this study describes, there remains considerable cause for optimism, as these challenges emerge out of the extraordinary growth of early intervention programs for psychosis and of CSC specifically. As more CSC programs mature to serve ever-growing numbers of clients, the strategies for providing effective continuity of care illustrated by this study will continue to grow. Services research can document and inform the impacts of those approaches and help guide the development

of service delivery through a learning health care approach. There is much to learn from the partnerships between clients, providers, researchers, and policy makers. Ultimately the questions to address regarding continuity of care are, at their core, born of the original successes of CSC.

I. INTRODUCTION & BACKGROUND

Early intervention in psychosis (EIP) is well-supported by empirical evidence; it is, as one expert in the field declared, “obvious, effective, overdue” (McGorry, 2015). Such services substantially improve outcomes for individuals experiencing a FEP (e.g., Correll et al., 2018; Kane et al., 2016; Nordentoft et al., 2014; Dixon et al., 2018). In the United States, EIP services are frequently referred to as Coordinated Specialty Care (CSC). As typically implemented, CSC is a team-based intervention for FEP that combines well-established evidence-based treatments, including assertive case management, psychotherapy, SEE services, family education and support, and low doses of antipsychotic medications, delivered within a shared decision-making framework (Heinssen, Goldstein & Azrin, 2014). These services are also coordinated with primary health care and when appropriate, treatment involves the individual’s close friends and family members. CSC services provide a high degree of structure and support, yet are also flexible and individualized to clients’ specific needs.

The growth of CSC programs across the United States has been swift, and implementation of the framework is highly variable. Even programs adhering to the same model (e.g., NAVIGATE, OnTrack, EASA) can look different in practice, depending on the clinical setting, staffing patterns, and community factors (Rosenblatt et al., 2018). The program population can also shape the nature of services; for example, if the primary referral source for a program is an inpatient hospital setting, clients may enter with more pronounced symptoms, depending on whether they have begun antipsychotic medication. If a common referral source is a college or university, clients may be in a narrow age bracket of 18-22. In addition to the nature of referrals and outreach in a given community, many other factors also shape who comes through the front door of a CSC program, such as whether there are other programs available in the community and eligibility parameters. Overall, CSC programs often describe their populations as having a high degree of clinical heterogeneity, and this is even more the case when the program serves both clients with and without non-affective psychosis.

Over the past five years, considerable research has focused on understanding and improving the effectiveness of the core components of CSC programs. As CSC programs mature and an increasingly number of clients “graduate,” there is also a growing interest in what happens to clients next? In many programs, clients transition from CSC to a regular outpatient setting within the same organization. Even programs that have the capacity to do this, however, also still refer some clients to settings in the community (Jones et al., 2020). Such community referrals are consistent with an early National Institute of Mental Health (NIMH) definition of CSC programs, in which scientists described CSC as a model in which clients receive services for a period of 2-3 years, and then transition into other (“routine”) services and programs, namely:

> The team provides a critical time intervention[1] rather than a source of services for people well along in their recovery. Clients transition from the team to *routine* services [emphasis added] as soon as clinically appropriate. The team follows up with discharged clients and with post-discharge providers as appropriate to help assure a smooth transition to routine community services (Heinssen et al., 2014).

The reality in many communities in the United States, however, is that "routine service" providers are not always readily available or are ill-equipped to address the range of needs of recent CSC graduates (Jones, 2016; Pollard & Hoge, 2018). For example, program staff members report that many community-based psychiatrists and therapists are unwilling to work with young adults with psychosis, and finding professionals who can work with clients on Clozapine is especially difficult (Daley, Chansky & Rosenblatt, 2020). It may also be difficult to find SEE services outside of a CSC program. Reflecting this, Goldman (2020) notes that the CSC model brings together a suite of well-established evidence-based services, the equivalent of which is often not found in the broader community.

The Current Study

Most CSC programs face some degree of challenge in finding post-discharge placements for their graduates (Jones et al., 2020) and relatively little is known about key aspects of transitions and continuity of care. Against this backdrop, ASPE initiated the current study to understand the landscape of existing approaches to continuity of care services after discharge across CSC programs in the United States, and identify larger health care system integration efforts that can be used to support these services. The study combines an environmental scan with a set of nine case studies. The scan, completed in May 2020, covers a range of transition-related topics through a synthesis of multiple data sources (see Appendix A). The current report draws on this synthesis and has a particular focus on programs that have taken innovative approaches in this area, either through extending the length of services, implementing "step-down" services, or some other approach.

The study has three major objectives and six research questions.

[1] Critical Time Intervention (CTI) was designed as a short-term intervention for people adjusting to a "critical time" of transition in their lives, originally used with people experiencing homelessness (e.g., Susser et al., 1997). It is an evidenced-based practice that has been applied across many populations, including with individuals with psychosis, for example, when exiting hospital services (e.g., Dixon et al., 2009)..

EXHIBIT I-1. CSC Transitions Study Objectives and Research Questions
Objective 1: Describe the range of existing approaches to continuity of services after discharge from CSC programs 1. What is the purpose, structure, and outcomes of post-discharge programs? 2. How are CSC post-discharge services in the United States sustained?
Objective 2: Describe the opportunities and challenges in implementing different approaches to continuity of services 3. What transition-related practices have been most effective in helping facilitate transitions and maintaining or increasing positive outcomes? 4. What aspects of the transition process pose the most challenges to CSC programs?
Objective 3: Identify ways CSC programs can integrate more effectively into the existing continuum of care for people with psychosis 5. How does integration within an organization support transition processes? 6. What role do states play in supporting transition processes?

EXHIBIT I-2. Report Terminology
Continuity of care is used in health care to refer to the concept that services received over time should be cohesive and connected (e.g., Bachrach, 1981; Haggerty et al., 2003; Sparbel & Anderson, 2000; Holland & Harris, 2007). For individuals with psychosis, the term often describes services following a hospitalization (e.g., Puntis, Rugkåsa & Burns, 2016; Holmes et al., 2005). In the current study, we refer to continuity of care as services either designed to continue treatment for clients following completion of a CSC program or accommodations in the program itself, such as extending the length of service. **Graduation** in the context of the current study is the act of completing a program to the mutual satisfaction and agreement of both the client and CSC team. In many cases, this means that a client has stayed for the maximum amount of time allowed by a program. Alternatively, a client may graduate because they needed less time in the program, and assuming that the team and client both agree that the client is ready to move on, we also refer to this as a graduation. **Planned discharge** is the term we use to describe the administrative process of formally removing a client from service at an organization or program. A planned discharge can occur at any stage of care, including before the program has been completed, such as if a client moves to another area and cannot continue to receive services. In some organizations, a client may be discharged from the CSC program yet remain an open case at the organization, while in other sites, a client may move to another level of service or program without any change in status because services are considered all part of the CSC program. **Premature discharge and disengagement** are terms used to refer to the situation when a client discontinues services with a CSC program, yet the team felt that services were still indicated. In many cases, this may involve a client simply not showing up, and eventually, receiving a discharge on the basis of administrative reasons. In the United States, data suggests that disengagement is a significant issue, as we discuss in Section 2. This report does not directly examine premature discharge and disengagement. **Extended length** models in the current study are programs that, by design, are more than three years in length. We use this definition since the majority of CSC programs are two to two and a half years. **Step-down services** refer to practices that are intended to provide a less intense experience than CSC, commonly through a reduction in frequency or intensity of services. In some cases, step-down programs are able to serve individuals at the same level as the full CSC model for a period of time, if needed. Throughout this report, we use the term step-down to encompass a broad set of approaches that are designed to provide support to individuals who have been engaged in a CSC program.

The terminology associated with continuity of care in the context of early intervention is generally straightforward; in Exhibit I-2, we provide a brief explanation of terms as they appear in the current report.

II. KEY FINDINGS

A central goal of this study is to identify approaches used in the United States to provide services to individuals following treatment in a CSC program. In this section we first present a schema to describe overall patterns of service and transitions, which we developed through a review of approximately 50 CSC programs in the United States that responded to a survey conducted by the National Association of State Mental Health Program Directors (NASMHPD) and the NASMHPD Research Institute (NRI). This schema provides a broad picture of how programs *generally* approach services and continuity of care. We then provide data from the nine case studies to highlight both shared and variable aspects of extended length and step-down models, program length and its relationship to continuity of care, as well as funding mechanisms used to support various types of services. This section also covers key transition practices and challenges, and integration of CSC programs within larger organizations and systems.

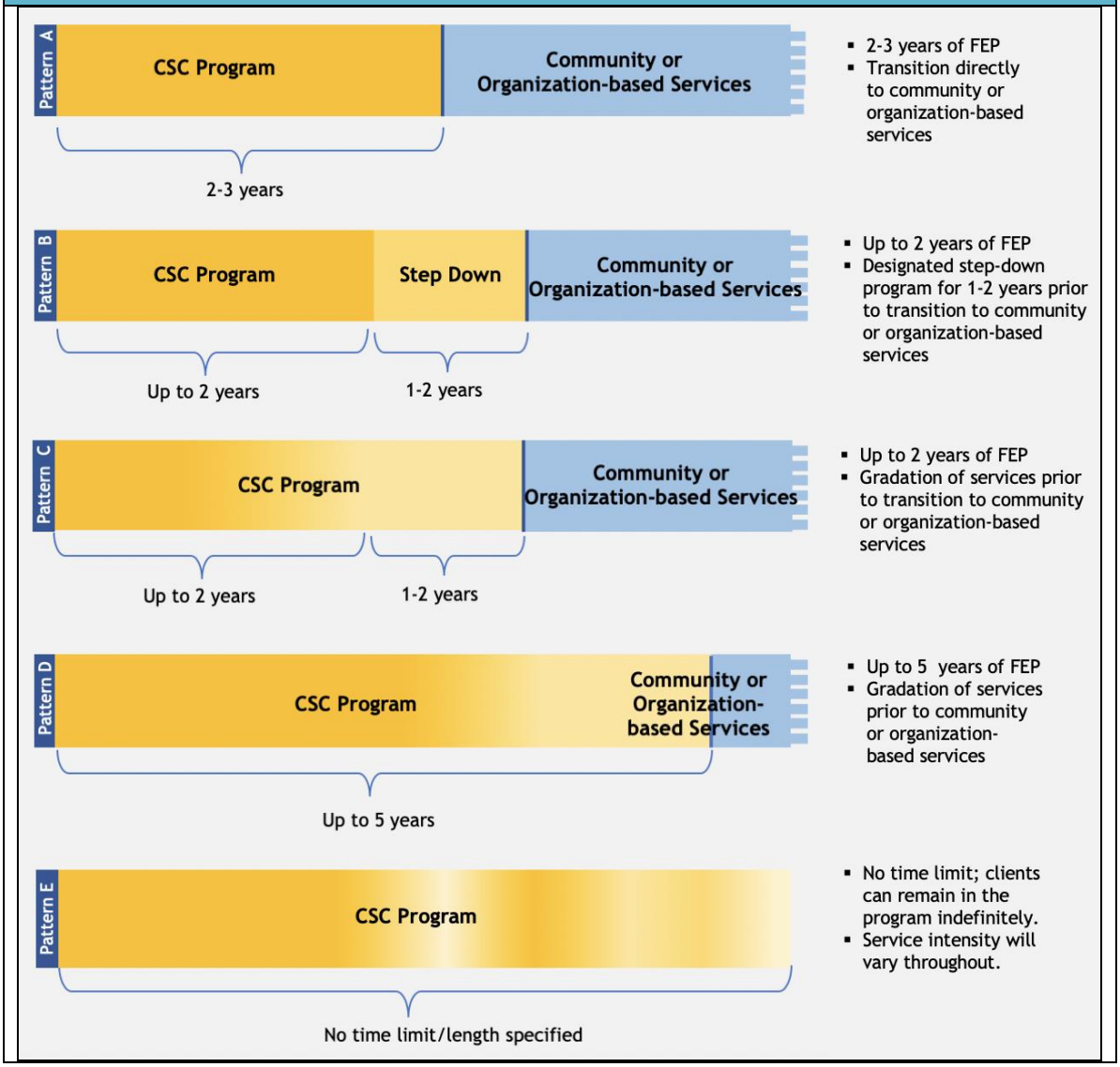
A. Approaches to Continuity of Care

General Framework of Planned Transition Patterns

The trajectories of clients attending a CSC program generally vary based on three main factors: (1) the duration of the CSC program; (2) the nature of step-down/transitional services available (i.e., none, a formal step-down program, or step-down/transitional practices that occur as part of the CSC program); and (3) whether the placement following the transition is within the broader community or the same organization that provided the CSC services. In each of these patterns, the services following a CSC program may be either of lower *or* higher intensity than the program itself. Within these patterns, there are still additional variations, such as the degree to which a program is flexible about its duration of services (e.g., allowing a client to stay an extra month vs. an extra year) and the time point within CSC services that the team initiates a step-down approach (e.g., within the first six months, only six months before the anticipated graduation). These overall patterns appear in Exhibit II-1 and the descriptions below provide detail.

Pattern A is one in which a client receives focused CSC services for approximately two years (though sometimes longer, which could be a few months up to three years), followed by a referral for services either within the same or outside the organization. CSC team members discuss relapse prevention and implement other preparatory strategies, and aid in making a transition, such as through a warm handoff where the CSC clinician might accompany the client to a follow-up session or otherwise help establish a new connection.

EXHIBIT II-1. Patterns of Service and Transitions



Pattern B reflects programs that have developed or defined a program that is distinct from their CSC services, and which the team considers a step-down in some respect. The length of the CSC program is variable. The services received in the step-down program can be either a reduction in frequency or intensity, or they can also be a different set of services, and often last between one to two years. After participating in the step-down program, the team discharges clients to receive services either in the same organization or within the community.

Pattern C contrasts with B in that the team incorporates step-down services into the CSC program, which tends to be 2-3 years in length. Clients may receive services less frequently or may receive fewer services overall, for example, shifting from therapy, medication management, SEE, and case management to just medication management and case management. After a transitional period, the team formally discharges the

client from the CSC program to receive services either in the same organization or at some other location in the community.

Pattern D describes programs in which participation in the CSC program is longer, up to five years. With services spread out over a longer time, there are periods where clients may have limited contact with the program and may come back if needed within that window. There may be a natural decrease of services with an eventual transition to services either at the same organization or in the community.

Pattern E reflects programs in which clients can remain indefinitely. The intensity of services within the CSC program will vary according to the clients' needs, but there is no stated maximum time that a client can stay enrolled.

B. Case Studies

EXHIBIT II-2. Basic Characteristics of Case Study Sites[a]

Program	Location	Date CSC program started	Approximate program census	Type of program setting	Clinic serves adults only or both children and adults	Age range served	Clinical team size	EPINET Site?
EPICENTER	Columbus, OH	2015	107	University	Both	15-35	24	N
EPIC-NOLA	New Orleans, LA	2015	156	University	Adult	12-35	10	Y
PEACE	Philadelphia, PA	2015	115	CMHC	Adult	15-30	13	Y
ETCH	East Lansing, MI	2014	51	Other[b]	Adult	15-30	9	Y
ETP and OnTrack NY at Zucker Hillside	Glen Oaks, NY	2013	75	Hospital	Both	16-30	10	Y
Felton (re)MIND®	San Mateo, CA	2012	45	CMHC	Both	14-35	10	Y
Deschutes EASA	Bend, OR	2008	35	CMHC	Both	12-29	13	N
OnTrackTN FEPI	Nashville, TN	2016	21	CMHC	Both	15-30	6	N
HOPE	Minneapolis, MN	2017	50	Hospital	Both	15-40	9	Y

a. Presented data collected through September 2020.
b. ETCH is freestanding program and operates as an outpatient clinic contracted by a community mental health entity.

The case study approach allows us to understand patterns of continuity of care more deeply. In order to choose the sites, we used survey data from the NRI/NASMHPD CSC Program Survey, information from the MHBG Ten Percent Set Aside Study as well as soliciting potential programs for inclusion from other sources (see Appendix A). The nine CSC programs reflect different patterns of service and transition (i.e., "A" through "E" in Exhibit II-1). We conducted interviews with a total of 88 individuals representing program teams, organizations, intermediary units and state agencies, and a small number of parents and participants (see Appendix B for topics). As shown in Exhibit II-2, these sites are physically and administratively located in different settings, serve clients

between 12-40 years, and include programs that have operated for between three and 12 years. Program and staff size vary. Six of the nine sites are part of the NIMH Early Psychosis Intervention Network (EPINET; https://nationalepinet.org).

Exhibit II-3 provides an overview of the characteristics of each case study site that relate to transitions and continuity of care. Each site appears using the typology (A-E) above.

EXHIBIT II-3. Case Study Continuity of Care Characteristics[a]

			Primary study selection characteristic		
Program (Step-down name)	**Program length**	**Pattern**	**Extended program length**	**Step-down services**	**Other**
EPICENTER	Up to 5 years, with clients able to leave and return anytime in that window	D	◆		
EPIC-NOLA	No defined program length	E	◆		
PEACE *Step Up*	Typically 2½ years with flexibility	B		◆	
ETCH *NAV2GO*	Typically 2-5 years	B		◆	
ETP *BOOST*	Typically 2½ years with flexibility	B[b]		◆	
Felton (re)MIND® San Mateo *(re)Mind Alumni*	Typically 2 years	B		◆	
Deschutes EASA *YAT*	Generally follow a 2-year guideline but flexible based on needs	B		◆	
OnTrackTN FEPI	2 years and must apply to state for an extension	A			◆
HOPE	Typically 1-3 years	C			◆

a. Presented data collected through September 2020.
b. Clients transition from OnTrackNY to the ETP for 5-6 years, and then to BOOST, which currently does not have a limit on how long clients can stay.

Extended Length Models

Overview

CSC programs in the United States are often two to three years in length. We therefore define programs that serve clients for more than three years as "extended length." We selected two sites that are, by design, more than three years in length, **EPICENTER** in Columbus Ohio and **EPIC-NOLA** in New Orleans, Lousiana.

EPICENTER is based at the Ohio State University Wexner Medical Center. The program provides a menu of services that clients can access for up to five years. The program includes cognitive behavioral therapy, family psychoeducation, metacognitive remediation therapy, and medication management. The team outsources SEE if a client wants to work on those goals, and there is not a dedicated case manager as part of the team. During the five-year period, clients can receive as many or few services as they like, and they can also stop using services at any time and still re-engage within the five years. The intensity of services is generally higher in the first 18-24 months of

treatment, often followed by less frequent contact with prescribers and other staff members. The team individualizes the degree to which this tapering occurs to the client.

EPIC-NOLA is affiliated with the medical school at Tulane University. The program does not specify length of service; the clinical approach is to provide care until the client chooses otherwise, or until the team feels that the services provided are not appropriate. EPIC-NOLA has a strong focus on individualized psychotherapy in conjunction with medication management. The team does not have a specific case management or SEE position; the primary therapist provides these activities. The team has a full-time nurse and part-time wellness coach, and a peer specialist position. Intensity of services varies over time, based on client needs. EPIC-NOLA has an explicitly psychodynamic orientation.

Rationale for Approach

The rationale for developing an extended length model differs between these two programs. Within the first two years of the original EPICENTER program (located at the University of Arizona), the EPICENTER team observed that a longer period of intervention seemed necessary for clients to be successful, and at the same time, the OPUS study released data suggesting that a longer length of treatment may be important to sustain gains (Bertelson et al., 2008). EPICENTER thus transitioned to a five-year model. In EPIC-NOLA, there were two major drivers of creating a program with an extended length model. First, New Orleans has very limited behavioral health services; discharging a client almost certainly means that they stop all treatment or receive sub-optimal treatment. Second, the client population is primarily low-income and African American. High levels of trauma combined with high stigma about mental health are prevalent specifically among this community in New Orleans, leading to cultural mistrust of service providers and systems. Respondents described many services in the city as taking a “put out the fire” approach to treatment, where only immediate needs are met. As a result, many families have an expectation of a negative experience with services. Engagement with clients and families is therefore a challenge from the beginning of treatment, and the program team felt that setting a time limit at the start of treatment would only exacerbate this problem. In addition, several clinicians noted that clients are not typically able to address underlying trauma until the therapist establishes a strong relationship with the client, which itself can take one to two years.

Commonality and Variability

While the impetus for a longer program length differs between EPICENTER and EPIC-NOLA, there are commonalities in other respects that are helpful to identify. In both states, there is local control over behavioral health services. Ohio is state-governed, but county-led; county-level entities called the Alcohol, Drug and Mental Health (ADAMH) boards manage behavioral health. ADAMH board funds can support non-reimbursable aspects of CSC programs, such as peer support and parent psychoeducation. Louisiana’s behavioral health is organized through ten Local Government Entities, referred to as Human Services Districts or Human Services Authorities. This arrangement means that most funding comes through the legislature and the state has

relatively little control over local programs for first-episode psychosis. Local control likely allows these two programs to have more flexibility.

There are also similarities in the program operation and structure. As expected in lengthier programs, the census is large in both: EPICENTER has 107 clients enrolled and EPIC-NOLA has 156. Both programs accept clients with a relatively longer duration of untreated psychosis (DUP); in EPICENTER, DUP is up to five years since their first onset of either hallucinations or delusions and in EPIC-NOLA, it is up to three years. This long DUP criterion is another factor that contributes to higher program census, since it broadens the eligible population. Both sites are linked administratively with universities. This allows the programs to use psychiatry residents and fellows to provide medication management to their large client population. Neither program has a dedicated SEE position.

The context of these two programs is quite different, however. The State of Ohio has a well-developed network of 17 CSC programs; in Louisiana, there are just four FEP programs and apart from EPIC-NOLA, these are in a very early stage of development. Both EPICENTER and EPIC-NOLA do, however, provide technical assistance to newer programs in their respective states. While both have a university affiliation, EPICENTER is highly integrated into the OSU health system both physically and structurally, and works closely with two campus counseling centers; EPIC-NOLA is in a building off the Tulane campus and operates as an outpatient clinic. The programs also serve very different populations. EPICENTER draws from central Ohio and client demographics match the area, which is approximately 62 percent White. The percent of clients on Medicaid fluctuates between 40 percent and 60 percent. Among EPIC-NOLA participants, 73 percent are Black and about 70 percent are Medicaid-insured. Lastly, EPIC-NOLA uses MHBG funds to subsidize all team members' salaries to cover non-billable services and fully fund the nurse position and the intake coordinator positions, whereas EPICENTER is not eligible to receive MHBG funds because the program does not meet the state definition of a CMHC.

Perceived Advantages

Staff members in both programs emphasized three overarching benefits of a longer model. First, a flexible program length is consistent with the clinical heterogeneity of the population they see in their programs. Client and staff perception of what will be most beneficial drives length of time in the program; someone who needs just a year and someone who needs four years are both easily accommodated. Second, an extended length approach allows staff members to provide support through multiple developmental transitions, for example, graduation from high school, and entry into college or the workforce. Third, transitions are an inherently difficult time. Clients can often get "lost" between systems and drop out of services, and may be reluctant to start over with a new therapist to whom they must retell their story, and establish trust. Since an extended length model extends or may eliminate these major transitions while the client remains with the same clinician, this aspect reduces drop outs and there are not problems or set-backs caused by a rupture in the client-therapist relationship.

Team members in these programs identified additional advantages for clients and families. At the time of entry into the program, clients are often in or just emerging from crisis. The priority at that time is to establish rapport. For clients with underlying trauma issues, this is especially important, since having more time in therapy allows trauma issues to surface at a natural juncture. Consistent with this, one clinician asserted that true psychotherapy is only possible after someone has stabilized, is asymptomatic, and trusts the clinician. When team members describe the program to families as up to five years (or more) in length, it signals that this program differs from inpatient hospitalization settings and previous clinics, which treat clients for much shorter time periods; clients and families then feel less anxious and this helps build the therapeutic relationship. In addition, when clients know they can come and go with services according to their needs, such as in the EPICENTER model, they feel a greater sense of self-determination. Lastly, having more time allows clinicians to meet the client at their point of need, which if done effectively, will lead to greater trust; there is no rush to push ahead with treatment that is not in sync with the client's pace. As described by clinicians in EPICENTER and EPIC-NOLA, clients do not feel pressure to perform or to meet certain milestones, and care can truly be more client-centered.

Respondents also identified major advantages of an extended length model for team members. With a longer relationship, clinicians know the clients so well that they can readily discern between someone experiencing symptoms and someone having a bad day; they can also recognize subtle changes and intervene early to prevent a client from worsening. Team members felt their job is easier because they provide treatment without the shadow of program or organization restrictions influencing clinical decisions. Respondents noted the challenge of working with this population, but feel they experience less burnout because in this model, they can "provide the care that they were trained to provide," without being "hamstrung" by program or organization policy that determines when a client must be discharged.

Step-Down Services

Overview

Among the patterns described in Exhibit II-1, all the approaches except for "A" incorporate some aspects of step-down services. This includes the two extended length models we describe above, which both reduce the intensity of services to meet the needs of their clients over time. In our study, we have five programs that have *explicit* step-down programs (i.e., there is a point at which the program determines that the client is ready to graduate and some or all clients have the opportunity to receive additional services that are associated with the program). These five step-down programs are located at **PEACE, ETCH, Early Treatment Program (ETP) at Zucker Hillside, Deschutes EASA**, and **Felton (re)MIND®**. More detail about each of these appears in the individual reports, in Appendix C.

At PEACE, the step-down program, called "Step Up" is a two-year pilot project that the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) funds. Clients can choose to transition out of Step Up at any point, or stay for the full two

years. The overall goal of Step Up is to help clients develop the skills they need to navigate the adult system within their own communities. The program centers around occupational services with an explicit focus on helping clients learn how to navigate the mental health system and other services and programs that they may need following their time in Step Up. This contrasts with the core PEACE program, which has a primary therapeutic modality of recovery-oriented trauma therapy. PEACE services include all the standard components of CSC (i.e., psychotherapy, case management, medication management, SEE, and family psychoeducation). As noted in Exhibit II-4, Step Up serves about 17 percent of PEACE graduates.

The NAV2GO program at ETCH provides selected clients with a bridge between the CSC team-based program and community-based services. In ETCH, services include all the standard components of CSC models such as medication management, individual therapy, SEE, family psychoeducation and support, and case management. As with other NAVIGATE programs, ETCH provides Individual Resiliency Training with Cognitive Behavioral Therapy for psychosis (CBTp). ETCH also has a peer as part of the team and offers groups, such as those with a mindfulness, music, and exercise focus. Services in NAV2GO reflect a shift away from standard CSC services toward "realizing clients' values of what makes their lives meaningful." Namely, the program was designed to focus on community and cultivating a sense of belonging and connection outside of the program itself. Currently, about 28 percent of graduates are entering NAV2GO.

Zucker Hillside has two early intervention programs; one is an OnTrackNY site, in which clients receive psychotherapy, medication management, case management, SEE, and family psychoeducation. In addition, clinicians in OnTrack frequently see clients in the community and offer peer support. The other is the ETP, which has been in place for a decade, and predates the OnTrackNY program. Currently, ETP serves as a step-down program for clients in OnTrackNY. ETP also accepts clients who were not eligible for OnTrackNY due to having a longer DUP or being outside the age range. ETP does not have a dedicated SEE position like OnTrackNY. In 2019, the ETP team started BOOST to serve as a step-down program for individuals from ETP. BOOST continues the specialized care of ETP. The team also started BOOST to serve individuals who did not fit the entry criteria of ETP, due to their age or having a longer DUP. At the current time, BOOST can serve clients of all ages for an unlimited amount of time.

The Felton (re)MIND® Alumni program serves selected clients who participated in the (re)MIND® CSC program for non-affective psychosis. The Alumni program also accepts clients with affective psychosis, from a program called BEAM. The Alumni program is for clients who are engaged with multiple team members and express a desire for continued services. A client can also graduate and return later and enter the Alumni program if they decide they want additional services, so long as this occurs within the four-year window that the funding source, the Prevention and Early Intervention (PEI) initiative of the California Mental Health Services Act (MHSA), allows. The Alumni services are largely an extension of the core CSC program (i.e., psychotherapy, case management, medication management, SEE, and family psychoeducation) at a lower

frequency of therapy and medication support services, and the higher frequency of SEE, and peer/family support services. Felton (re)MIND® Alumni also has a stronger focus than reMIND® on helping clients practice personal responsibility, self-sufficiency, and overall independence. Approximately 30 percent of Felton (re)MIND® clients enter the Alumni program.

EXHIBIT II-4. Approximate Percent of Graduates who Participate in the Step-down Program[a]	
Program	**Percent**
ETP/BOOST	100
Deschutes EASA/YAT	42
Felton/(re)MIND® Alumni	30
ETCH/NAV2GO	28
PEACE/Step Up	17
a. Presented data collected through September 2020.	

Deschutes EASA operates the Young Adult in Transition (YAT) program, an intensive outpatient program that is available to individuals between the ages of 14 and 26. The EASA team designed YAT with EASA clients in mind, as an "EASA-lite." In addition to graduates from EASA, YAT serves young adults who do not qualify for EASA, for example, those who have had a diagnosis of schizophrenia spectrum disorder for more than a year. YAT serves youth with other mental health conditions and those who have limited natural supports, including youth experiencing homelessness. Approximately 42 percent of EASA clients transition into YAT.

Rationale for Approach

In slightly different ways, four of the five programs initiated a step-down option to address a gap in services. Following graduation of the initial cohort of PEACE clients, the team quickly saw that many in this group were becoming re-hospitalized. Clients did not enjoy or connect with their new programs, and were not engaging with services. PEACE team members felt that this lack of engagement was at least in part due to the absence of high-quality care in the community following the CSC program, which was "not supportive, at best" and provided poor care at worst. Staff members working in programs within the broader organization also did not have specific training in working with young adults with psychosis. The ETP team at Zucker Hillside observed something similar within their site; clients received services from the large, general outpatient clinic at the hospital, but these services were not geared toward individuals with psychosis. The ETP team started BOOST both to provide recovery-oriented services that extend the gains made through the work with ETP, and also to serve individuals who do not fit the entry criteria of ETP due to their age or having a longer DUP.

At ETCH, the team observed that after the full NAVIGATE program, many young people and their families were reluctant to leave the intensive support of the CSC team and transition to services in the community. The program lead was also aware of the OPUS study suggesting that clients often do not maintain gains when programs withdraw supports. In recognition of these two factors, the ETCH team developed NAV2GO. In Deschutes EASA, the team saw that younger clients were struggling after discharge; clients found that entering adult programs within the organization serving older

individuals with schizophrenia was disheartening, by suggesting the potential course of their illness. The Oregon Health Authority issued a request for proposals to launch four "youth hub" programs to support young adults in transition, and the EASA team used this funding opportunity to launch the YAT program specifically to serve young adults.

EXHIBIT II-5. Variation in Implementation of Step-Down Programs[a]

Characteristic of Step-Down Program	PEACE	EASA Deschutes	Felton (re)MIND®	ETCH	ETP
	Step Up	***YAT***	***Alumni***	***NAV2GO***	***BOOST***
Serves clients in the same location *vs.* a different setting	Same	Same	Same	Same	Same
Major shift in focus during step-down *vs.* extension of CSC	Shift in focus	Extension	Extension[d]	Shift in focus	Extension
Selective in who can attend step-down *vs.* admits all clients	Selective	All (within age range)	Selective	Selective	All (within age range)
Step-down can serve clients at the same level as the full CSC if needed *vs.* only at a lower level	Lower only	Same level if needed	Same level if needed	Same level if needed	Lower only
Step-down serves CSC population only *vs.* also serves others	Only CSC	Others also	Others also	Only CSC	Others also
Step-down serves all ages *vs.* limited age group	All ages	Up to age 25	All ages	All ages	Age 18+
Time limit to step-down services *vs.* unspecified length of services	Limit (time-based, 2 years)[b]	Limit (age-based)	Limit (time-based, 2 years)[e]	No limit defined[f]	No limit defined
Staff members are same or different					
Prescriber/Licensed Medical Provider	Same	Different	Same	Same	Different
Therapist	Different	Same[c]	Same	Different	Likely different
Case Manager	Same	Different	Not a position	Not a position	Not a position
SEE Specialist	Same	Different	Same	Different	Not a position
Peer Support Specialist	Same	Same	Same	Same	Not a position

a. Presented data collected through September 2020.
b. Some flexibility in length of step-down.
c. Could be same or different, depending on needs of the client.
d. Shift from primarily psychotherapy/medication management to primarily SEE and peer/family support, but the program will feel like an extension of services for existing clients.
e. The total amount of time in CSC plus the alumni program cannot be greater than 4 years, so the length in 1 could be longer than 2 years and less than 2 years in the other.
f. Typically around 18 months.

The origin of the Felton (re)MIND® Alumni program includes a perceived gap in routine community care. However, there is another element as well: prior to starting the alumni program, clients who had graduated could receive "booster" sessions if they were struggling to adjust to care in the community or were generally successful but wanted to be able to touch base with their previous clinician. Slowly, the program began extending components of the CSC model during these boosters, such as allowing the family support specialist to continue work with families. What began as a case-by-case follow-

up process organically developed into a more formalized program that is offered more broadly.

Commonality and Variability
One of the major advantages of including multiple step-down programs in this study is that we can highlight the diverse ways that programs implement the same concept. As illustrated in Exhibit II-5, these five programs vary across many dimensions. What is important about the variation is not just what they do, but *why* they do it. For CSC programs that have not yet established step-down services, what contextual factors are salient to understand in choosing an approach to care? What choices do these programs believe are most central to their work, and most important to the success of their clients? Below, we expand on three elements that programs often emphasized during our interviews.

Program co-location. All five step-down programs are physically in the same building as the CSC program, and sometimes even within the same hall or wing within the building. Respondents repeatedly mentioned this element as one of the keys to success in ensuring that clients continue their services. Even the OnTrackTN First Episode Psychosis Initiative (FEPI) program, which we discuss in more detail below, cited the significance of having the organization's TAY program (which is unrelated to the CSC program), located in the same hallway. One of the challenges that staff members mentioned about transitions to outside providers is that they suspect the client simply does not show up, which may be for a variety of reasons. As one clinician noted about the co-location of programs, "they're coming to the same physical location where they were coming before, and for some people, going someplace new would be a huge impediment." With the step-down program located in the same space, the team can at least remove the barrier of logistic navigation. Going beyond that, clients have the comfort of a familiar setting. For staff members, shared space means that the teams get to know one another, if they do not work as part of both programs already. Staff members talked about the ease of consultation, communication, and coordination because of this structure.

Shift in focus. While program staff members typically emphasized the importance of step-down programs to help maintain the gains that clients had achieved while in the program, two of the programs explicitly discussed how the step-down program is intended to do something different. This shift is especially pronounced for clients moving from PEACE to Step Up. PEACE team members noted that behavioral health services in Philadelphia are both variable in quality and are complex to negotiate. However, it is not practical for clients to travel across the city to receive services from a single program, like PEACE. The explicit focus of Step Up is to bridge the two systems; the program uses occupational therapy services and helps clients learn how to navigate the mental health system and other services and programs that they will need following their time in Step Up. A key goal of Step Up is to help clients become skilled system navigators.

ETCH is an example of another shift in focus. While the CSC program closely follows the NAVIGATE model, when it came to designing a new program, the Program Director shifted the focus to values, with program services shaped around questions such as, “what's important to you? What makes your life meaningful? How do you want to show up in the world?” While there are many opportunities for clients to attend groups as part of ETCH and NAV2GO, the program “manufactures” these. The clinician in the step-down, therefore, helps clients cultivate a sense of belonging and connection *outside* the program, and restore or create experiences in the clients’ own community.

Selection process for entry. Some programs are designed to accommodate everyone graduating from the program, whereas others focus on serving clients with a particular level of functioning. In Deschutes EASA, the YAT program is open to everyone up to age 25 and can provide services at the same level as EASA, if needed. Although the age cap limits who can enter the program, the capability to provide an equivalent level of care as the CSC program allows more flexibility in who may receive services. Similarly, BOOST can serve everyone coming out of the ETP, as well as individuals who did not qualify for ETP.

In the other three programs, teams described a decision-making process, usually centered on a team meeting, which the team uses to determine which clients could or should enter the step-down. ETCH looks for individuals who are stable symptomatically, have not been recently hospitalized, are confident about leaving the program, and at the same time, are open to continued services. In Felton, the Alumni program is generally available to everyone, but the client must be engaged, want to receive services, and be working with more team members than just the therapist. For transitions into Step Up, the PEACE team identifies individuals who are stable enough to be able to reduce the intensity of services and really benefit from the shift in focus, yet not so independent or high functioning that they could achieve the same progress on their own. In addition, a PEACE team member noted that they are working towards being able to identify criteria around who makes a good candidate, noting:

> We're not just retaining people who are otherwise disengaged just to keep them on census, just because we want to keep eyes on them. This should really be a space for folks to be doing some concrete work and to help make the transition out, essentially. Give them a year where they can really work on whatever sort of skills or resource development or whatever it is, so that they are able to then maintain recovery in the community outside of PEACE. Just knowing really who fits the bill and then being pretty strict about that.

Perceived Advantages

Many of the perceived advantages of a step-down program are the same as an extended length model, such as being able to provide high-quality care over a longer period with minimal interruption to services, and ensuring that clients do not drop out of services or get lost. Respondents often noted how the transition between CSC services and the step-down could be “nearly seamless” and avoids clients potentially “feeling abandoned or feeling resentful about termination of care.” Even if a client must change

providers, they retain a sense of community and connection. One respondent explained that:

> A lot of clients have very tight peer relationships. A lot of them have pretty strong connections to some of our staff and just being able to retain that element for an additional year and not to face losing that, I think is really powerful for folks. Those have been really sustaining relationships and to have to step away from that I think can be really frightening, and there's a real sense of loss there.

In fact, many respondents identified a variation of this notion of safety and security. Clients feel a sense of safety and trust that "even if they're not feeling 100 percent confident," the program will be there to help them, "a little bit like training wheels" that allows the client to "try out their wings." The step-down serves "kind of like a try-out to see how they function and see what their needs continue to be" but in a way that "they don't feel like they're just dumped out there and left hanging. Like there's a safety net, a person that is there for them."

As noted above, many of these advantages are the same whether the program is an extended length model or has a formal or separate step-down component. One aspect that differs is that a step-down can provide a clear marker for clients that they have achieved some success. As one respondent noted, keeping somebody in the program because they didn't have a suitable referral "left a sense of stagnant uncertainty about 'what now?'" In contrast, the step-down reaffirms that things are moving in the direction away from that degree of service, and "it just sends a stronger message."

When asked about advantages of a step-down for staff members, there were two clear emotional benefits: first, being able to see clients progress through the program and graduate to a lower level of service is "refreshing," increases job satisfaction, and "it shows the work we are doing pays off." Staff members appreciate being able to see the "fruits of the labor" when they see the success in their clients, and:

> It's rewarding to have a participant that you've been working with for two years transition, or graduate from one service and transition to a place where they don't necessarily need as much support. I think that is something that maybe reinvigorates therapists.

At the same time, staff members can appreciate this in part because they do not feel anxiety themselves. Having the step-down brings peace of mind, makes it "much less stressful, much less painful," because "even though I might not be working with them anymore, somebody I respect and trust is working with them." Knowing their client will be well-cared for allows staff members to approach the transition in a more relaxed manner. Respondents also cited the logistic advantages of being able to easily move a client from one program to another, with a high degree of coordination among team members and the convenience of shared resources.

Other Approaches to Continuity of Care

We included two additional programs in this study to illustrate other approaches to continuity of care. The HOPE program in Minneapolis is located within Hennepin Healthcare. There is no specific step-down option; HOPE takes an approach common among many CSC programs by working clients through built-in step-down in services within the program, depicted as Pattern "C" in Exhibit II-1. The program informally views clients as falling into three different groups: those in the engagement phase, the active treatment phase, and the transition phase. This third group are clients who are moving toward discharge and receive a reduced frequency of appointments. If clients need more support after stepping down, they will step back up. Programs that *do* have step-down programs also incorporate this internal step-down process is into the latter part of their structure. The HOPE approach to transitions is rooted in the NAVIGATE model, which details a structured process for team review and a checklist of factors for consideration. However, the HOPE team came to their approach based on clinical experience. A respondent from HOPE described their model as the following:

> I think collectively, we've just come to that step-down, taper-down approach as that just makes sense clinically. And at the same time, because of regular monitoring of that client, if that taper-down means to reverse and ramp up, then it's available to do that. It doesn't have to be a continuous stair-step down, down, down.

HOPE team members emphasized the person-centered and individualized nature of their process. There are no standards or milestones that the client must meet; the transition is based on how they view their own progress and recovery. As described by one respondent:

> We say, 'If we taper-down and you're not ready for it, it's okay that you say you're not ready and we can move up again'…so it becomes more person-centered, it's not so regimented. Staff and clients have realized that, so both sides can really say 'I wonder if we need to make some changes here.'

One staff member pointed out that when clients have fewer sessions with team members, they begin to rely on their natural supports more, at least in an ideal situation. For staff members, having this flexibility provides "freedom and creativity" to work with somebody, bringing their individual skills and talents to each client as opposed to "pushing through a model for the sake of fidelity." Team members described their work as a partnership with the client, and in that partnership, find greater satisfaction. Staff members also pointed out that from a practical standpoint, having a group of clients they see less frequently opens clinicians' availability to see new clients and helps minimize the program's waitlist.

OnTrackTN FEPI in Nashville is located within a large behavioral health organization, Mental Health Cooperative (MHC). The FEPI program follows the OnTrack model, but adheres to a fairly strict two-year program length, which is determined by the state. What distinguishes the FEPI program from the other case study sites is the unusually

large number of post-transition options available to clients within the organization. After two years in FEPI, clients may transfer to one of more than a dozen services within MHC, including two TAY programs. Except for the Program for Assertive Community Treatment team, the other options all provide a lower level of services than the FEPI.

In contrast to the step-down programs described above, the MHC programs all operate independent of the FEPI. However, there are still some linkages. Staff members on the FEPI team have previously worked in some of these other programs, and are able to bring that knowledge to the transition process. Staff members in the TAY and Healthy Transitions programs receive the same transition age training and all work in a team-based approach. For clients who move into these programs, the programs “feel” similar, although by having less intense support, clients can build longer-term independence through the process. Youth who transfer into these two programs can continue to see the same prescriber in some cases. The TAY and FEPI programs are physically in the same hallway. The team leads of all MHC programs meet and exchange information, including potential upcoming transfers. This communication was touted as a key, with one respondent explaining:

> We've seen some really great transitions occur because of our ability to have those in-house conversations. To have relationships built across teams, across providers, to really make that as smooth a process as possible. And to put the individual and family at ease with being served by somebody new and starting a new relationship, which is hard for everybody. I feel like the good communication and alignment that we've been able to achieve on an internal level has really made for better outcomes when it comes to transitions; folks don't just fall off the map.

Given the wide range of options for post-transition services within the organization, team members generally did not feel anxiety as clients approached the two-year mark of service, even if they felt that a longer length of time might be beneficial.

C. Program Length

Program length is central to understanding approaches to continuity of care, and throughout the descriptions of the case studies above, figures in how programs choose to operate. In EPICENTER and EPIC-NOLA, a hallmark characteristic is their length. Each of the programs that developed step-down services found a way to combine core CSC services with additional services, essentially result in extending program length from four years (in Felton (re)MIND®) to as much as a decade in the case of OnTrackNY-ETP-BOOST.

The decision to extend program length through one mechanism or other mirrors data from Europe and Asia that suggest that longer programs provide clients more time to solidify gains. Some respondents we interviewed were aware of these and other studies, and used them as a basis for suggesting that a longer program length is beneficial, such as the influence of the OPUS study in Denmark (Bertelsen et al., 2008)

on decisions by EPICENTER and ETCH. We asked case study respondents what might be an "ideal" length of time for a CSC program, if funding and policies were not a factor. Roughly **three-quarters of respondents** either favored a time period of approximately 3-5 years, or reported that the program should tie length to client need; examples of their rationale appear in Exhibit II-6.

EXHIBIT II-6. Example Reasons for a Longer Program Length

Three to five years

- I think around that 3 year mark is when we were starting to see success. Because we did have some people stay or past that ideal 2-year mark, but I think appropriately given all of the different services provided, I think 3 years, on average, would be an appropriate length of time.
- The optimal would probably be 3½…that's when it really everything came together, and I understood what was going on. Not that the 2 years that passed were not worth it, but they were just almost like a starting point.
- I'm not saying that somebody needs 4 years of the full FEP *intensive* supports, but somebody might need time before they're really making progress to transition to a different level.
- Four to 5 years gives a good sense of progress, you see growth happen. Two years feels too soon. Clients with slow progress don't make any headway…and then suddenly they have to start talking about discharge and termination.

Unlimited and Individualized

- If I had my druthers, I would love to provide people with this kind of program and evidence-based recovery-oriented approach for as long as they wanted it. Because there's no reason why this shouldn't be offered.
- People will have different optimal tenure. Some stay for shorter periods, some longer. I would like to have a more client-directed approach, not having a cutoff.
- I think it should be individualized. One of my mantras is, 'people before programs.' If we lose the person because we're trying to develop and deliver a particular structured intervention, and that doesn't have enough wiggle room to flex for the person who's actually engaging in the program, then I think we've got things backward.
- I think it should be case-specific, to be honest. I don't know if it makes sense to provide some arbitrary cutoff...in the end, I think the decision should be based on when the team and the family and the patient feel like they have gained enough mastery over their experiences, that they can then move on with a little bit less handholding.
- I don't know if there really even is a number that you can put on it. We certainly have folks that have needed more time and folks that probably would need a significant amount of intensive treatment and support. We also have folks who have needed less; it really does feel like a very individualized question.

A small group of respondents endorsed a 2-3 year period, generally with the rationale that a short duration promotes a recovery philosophy, such as:

> I'm not sure I would change it to be honest. We promote recovery, right? From the very beginning we instill hope that recovery is possible. I don't know that I would want to change that…the risk to not having a program end date is that are you going to languish in care.

> I'm a big believer that the two-year timeline is a good amount of time, because it just punctuates that this service is early intervention, this is a window in time where we can try to understand what's going on diagnostically, and then help that young person adjust to this realization that, I struggle with whatever symptoms it might be.

In addition, other respondents felt that two years is enough time to provide services, noting:

> Usually in two years, most people have gotten like a lot of really great insights and skills and stabilization. They're making progress toward goals, and that's a good, natural transition time…Most of our folks when they graduate are really just interested in maintaining medication management and they're feeling a bit 'therapied-out' after a couple of years. I would say on average two years is probably like a pretty good critical window for this kind of intensive work.

The perspectives of staff members presented above lay bare a tension that is inherent to the concept of CSC itself. On the one hand, NIMH guidance following RAISE-ETP (Heinssen et al., 2014) notes that CSC teams should offer services over a two to three-year period following psychosis onset, stemming from the critical period hypothesis (Birchwood, Todd & Jackson, 1998). Consistent with this, some respondents saw talking with clients about CSC services as transitional and time-limited to emphasize a message of recovery, "that our more intensive program is intended to be temporary. And our goal is to obviously communicate that as a message of hope." At the same time, CSC services client-centered and individualized. Given the considerable heterogeneity in clinical presentation of young adults attending CSC programs, the respondents in this study also made clear the challenge of meeting individual needs within an artificial time frame, such as two years. As one participant mused:

> What if Coordinated Specialty Care did not have a specific discharge? I think that that is a valid question to ask. If there were tiered models of care where young people could stay connected to the same psychiatrist and the same therapist at rates that match their needs, I don't see a particular benefit to transitioning into the community really aside from that there is a time cap on our program.

The discussion above focuses primarily on extending the length of time in a CSC program; also important is to consider whether and when a young adult should transition out of CSC at an *earlier* time point. Staff members talked about early transitions to allow clients to access more appropriate services, such as specialized eating disorder treatment, specialized substance use treatment, and people who need a formal, structured Dialectical Behavior Therapy (DBT) program. In EPIC-NOLA, the team regularly refers clients who need a higher level of care to Assertive Community Treatment (ACT) teams, with one respondent explaining:

> We don't keep people that are not benefiting from what we're doing. If somebody needs an ACT team, somebody needs somebody to come into the home more often than we're able to, somebody needs a different type of care, we will get them to where they need to be, not just keep people 'just because.'

Paul French, the Associate Director of the Psychosis Research Unit in the United Kingdom, echos this approach. He notes that the National Institute for Health and Care Excellence in England recently published guidelines recommending that individuals in early intervention programs receive specialized rehabilitation services as soon as they are identified to have treatment resistant symptoms of psychosis in conjunction with

impaired social and everyday functioning. Following from this, he ponders whether "the current practice of working with people for 2-3 years in EIP services does some people a misjustice and we need to consider diverting some people out of EIP sooner" (French, 2020). In the United States, researchers have not yet raised this question in a formal way, although the practices of some of the sites in this study suggest that it is an area worth further investigation.

D. Funding

Across the case study sites, Medicaid is the primary source for payment for CSC programs as well as services received following a program, whether provided as part of a step-down or in the community (see Exhibit II-7). As noted above, Medicaid has limitations with respect to which services are reimbursable, but without exception, the range of post-transition options available to clients with Medicaid is still greater than to those with private insurance; one respondent characterized Medicaid as the "gold card" for clients who need long-term services. Among the case study sites, eight of the nine are in Medicaid expansion states, which has allowed a greater number of people to receive services. For example, the state representatives in Louisiana reported that expansion has "unquestionably" allowed EPIC-NOLA to serve more clients than before, and in Oregon, the percent of FEP clients who are uninsured changed from 30 percent to less than 5 percent. Several sites noted that they will sometimes help clients get off their parents' insurance and enroll in Medicaid to have more flexibility in service options. For graduates of Felton (re)MIND®, Medicaid beneficiaries can access services in the community because there are many options in San Mateo County that are funded by the county. However, if a graduate's service needs are minimal and they only need low-frequency psychiatric appointments (e.g., with a private psychiatrist or private psychotherapist outside the county system of care), the client will face access issues since providers in private practice often do not accept Medicaid.

Some states have begun discussions about either a tiered model of reimbursement, with different rates for different levels of service or a case rate model, similar to what ACT services often use. (Private insurers could apply these same mechanisms.) Among our case study sites, respondents affiliated with HOPE, ETCH, EPICENTER, PEACE, the Zucker Hillside programs and OnTrackTN FEPI all mentioned these options either as something they strongly support; one respondent called it her "dream" to have in place. As an example, Horizon House, the organization that houses PEACE, has proposed a three-level model to their managed care organization (MCO). This model includes a top tier with a full case rate covering "regular" or full services, where team members see clients multiple times a week. The next tier, with funding at a reduced case rate, can cover clients who don't need to be seen as frequently but who need ongoing care, such as monthly visits. The last tier involves a fee-for-service structure, where reimbursement covers each visit, such as a client coming for medication checks every three months. In this model, step-down services align well with the second and third tiers of service. At the current time, the MCO has not decided whether to support this model.

EXHIBIT II-7. Overview of Case Study Program Funding[a]			
Program	**How is the program funded?**	**How are step-down or extended care costs covered?**	**Additional comments**
EPICENTER	▪ Reimbursement through Medicaid and private insurance (generally split 60%-40%) ▪ Philanthropic dollars to cover some costs	▪ Extended length model; same as CSC program funding	▪ Not eligible for MHBG funds ▪ ADAMH board supports a Clinical High Risk (CHR) program ▪ Does not see uninsured clients in the FEP program (but does in the CHR program) ▪ Reimbursement from Medicaid is at a significantly lower rate than for the same services at a CMHC
EPIC-NOLA	▪ Reimbursement through Medicaid (≈70% of clients) and private insurance (≈30% of clients) ▪ MHBG funds ▪ Early detection grant funds outreach activities ▪ Louisiana Medicaid provides psychosocial rehab codes through Community Psychiatric Support and Treatment community visits	▪ Extended length model; Same as CSC program funding	▪ Case management, treatment team meetings, coordination of care services, and nursing services are all not covered by either Medicaid or private insurance; MHBG funds are used ▪ Site has a commitment to the state to see uninsured clients ▪ Commercial insurance does not cover ACT teams
PEACE	▪ For the past year, OMHSAS is using the in lieu of provision with 1915(B) Medicaid waiver using Value Base Purchasing (case rate)	▪ Staffing paid for through the MHBG/OMHSAS ▪ Participants are funded through Medicaid reimbursement	▪ Horizon House has proposed a reduced intensity CSC model for stepped care (3 tiers) to the MCO ▪ Occupational therapy is not reimbursable as a behavioral health intervention with the MCO ▪ The goal of OMHSAS is for all steps to be sustainably funded at every tier
ETCH	▪ MHBG funds ▪ Reimbursement through Medicaid and private insurance	▪ Same as CSC program funding	▪ CSC programs in Michigan receive a 15% “fee uplift” through one private insurer for clients with a schizophrenia spectrum diagnosis, intended to cover the gap for services not funded through Current Procedural Terminology code billing
ETP & OnTrackNY Zucker Hillside	▪ State funds (including MHBG funding) ▪ Private pay ▪ Reimbursement through Medicaid and private insurance	▪ Hospital general revenue funding covers ETP and BOOST ▪ Sliding scale possible for clients without insurance or with insurance not accepted by the hospital	▪ Program has submitted grant applications to cover cost of SEES and other services ▪ Clients in the step-down programs can access some employment services through vocational rehabilitation (ACESS-VR)
Felton (re)MIND® San Mateo	▪ California MHSA PEI ▪ Reimbursement through Medicaid and private insurance ▪ MHBG funds	▪ California MHSA PEI	▪ PEI funding restricts total time in services to 4 years ▪ Providers in private practice may not accept Medicaid/Medi-Cal
Deschutes EASA	▪ State general funds ▪ Reimbursement through Medicaid ▪ Private insurance (the State requires all EASA sites to accept private insurance) ▪ CCBHC grant	▪ Initial funding for the YAT program came from Oregon Health Authority ▪ Service allocated dollars ▪ Medicaid billing	▪ Medicaid expansion has decreased the uninsured from about 30% to 5% ▪ Private insurance does not cover injectables, nor many services in EASA like case management, skills training, and peer support ▪ Private insurance copays for therapy can be a barrier for some people
OnTrackTN	▪ MHBG funds ▪ Reimbursement through Medicaid and private insurance	▪ The TAY program reimburses through Medicaid; the Healthy Transitions program is a SAMHSA grant	▪ Tennessee is not a Medicaid expansion state ▪ The organization cannot serve clients with private insurance other than through grant-funded programs

EXHIBIT II-7 (*continued*)			
Program	**How is the program funded?**	**How are step-down or extended care costs covered?**	**Additional comments**
HOPE	▪ Reimbursement through Medicaid/Medicare and private insurance ▪ MHBG funds ▪ Minnesota general funds	▪ Not applicable (no separate step-down model or extended length)	▪ A few clients who left HOPE have used a CADI Waiver to access non-CSC services
a. Presented data collected through September 2020.			

Several sites have other funding mechanisms. Deschutes County Health Services participated in the Certified Community Behavioral Health Clinic (CCBHC) demonstration starting in 2017, which we describe in more detail in relation to organization integration below. While the CCBHC funding goes well beyond services for the FEP population, program managers originally saw it as a potential program sustainability strategy in this site. One respondent noted that it "might not have panned out" as a mechanism to sustain CSC activities but the funding has allowed the program to expand services in ways that they might not have been able to otherwise. In particular, the CCBHC allows the program to increase health care integration and provide more peer support. Deschutes County has received a new CCBHC grant that further expands their work, such as allowing the department to retain more than a dozen limited time duration employees and add five new employees. Even if the EASA program does not specifically receive these funds, team members anticipate that the continued funding will enhance the overall experience for all clients at the organization, including those in EASA and YAT.

Tennessee is the only state among the case study sites that is a non-Medicaid expansion state. Respondents noted that they do not have a frame of reference to comment specifically on what their services might be lacking because of this. For clients in the OnTrack FEPI program, the organization has a high number of options for referrals following the CSC program, so the challenge may be somewhat mitigated. Tennessee Health Link (THL) is a Medicaid program and payment model created to serve members who have the highest behavioral health needs. As a non-expansion state, clients would have to qualify for THL based on other eligibility criteria, such as being a youth still on Temporary Assistance for Needy Families or be found disabled through Supplemental Security Income. The program is based on the federal health home model and started with a State Innovation Model initiative. Clients receive traditional case management, coordination of care, referrals to social supports, member and family support, transitional care, health promotion, and population health management and a therapist if they choose. Clients who do not qualify for THL may receive coverage under the Behavioral Health Safety Net (BHSN). BHSN is a state program that provides mental health services to people who have no other behavioral health coverage, have an income at or below 138 percent of the federal poverty level, and are 18 years or older. Each client on this team has access to a nurse and a medication provider. This team can only serve people meeting criteria for BHSN. However, if BHSN lapses, a client's status changes, or someone cannot renew, MHC will discharge the client from services or will transition him into a more appropriate

program. Tennessee may be exceptional as a non-expansion state that nonetheless offers relatively robust coverage for services for former CSC clients.

A final and important note on funding: Funding and program length are inextricably linked. As program length increases, program size also increases, since the turnover of clients is not rapid nor predictable. Increased program size requires additional resources for staffing. In Oregon, for example, the legislature is currently considering a recommendation to lengthen programs from two to three years across the 26 EASA sites, and would expand funding accordingly. In Ohio, the ADAMHs Board in part support EPICENTER, and this local entity supports the program as it was designed: as a five-year model. However, the state is currently looking at options for a bundled reimbursement rate for CSC services. While this would likely provide coverage for key services not currently reimbursed, a bundled rate could potentially pose a threat to implementation of a longer model, since insurers may be reluctant to provide support for an "early intervention" program of three or more years. In this respect, addressing the funding challenge could inadvertently dictate program implementation.

E. Key Transition Practices

Regardless of the model, every CSC program must address transitions at some point while working with a client. Determining when a client is ready for a different level of care is one step of implementing a transition. Across case study sites, the types of assessments, formality of the process, and the timing for these readiness reviews varied. However, all case study sites that included a transition process developed readiness assessment that were collaborative, team-based, inclusive of a variety of viewpoints, and comprehensive in reviewing many aspects of a clients' life to help gauge readiness. This includes conducting readiness assessments, weekly case planning meetings, formal transition planning meetings, and informal individual discussions. Some sites used structured checklists and other measures to inform their decision-making. For example, the EASA Deschutes site uses the EASA Transitions Checklist, which assesses seven domains six months before anticipated program completion. Respondents appreciated that this approach allows each member of the team to provide input into the areas most relevant to their work with the client and collectively assist the client with the transition process and as one clinician described, when clinicians "check all the boxes and then make sure that the person gets set up in their next level of service…nothing falls through the cracks."

Programs also include processes to assess unique aspects of a client's progress that reflect the philosophy of the program. Consistent with the NAV2GO emphasis on values and achieving life goals, clients at ETCH complete a Wellness Confidence Inventory and a tool that helps identify and clarify their personal values, selecting the top ten from a list of 34 items. This values assessment is one of the hallmarks of the program and is designed to help clients think about what qualities the want to develop in themselves, what they want their relationships to be like with others, and what are the main values they want their life to reflect. Through this process, the team can start to identify clients

who have stabilized with respect to symptoms and functioning and see if there is a shift from more basic needs to quality of life goals.

In Felton (re)MIND®, the CSC team conducts an evaluation approximately six months before they anticipate a transition to identify what supports are already in place and what needs to be put in place after graduation. The team will raise the issue of graduation with the client (and the family if appropriate) and inquire about their interest and preferences. Similarly, team members on the HOPE team discuss client progress in weekly meetings and whether clients are in the engagement, active treatment, or transition phase and moving towards graduation. In PEACE, once a client has been in the program for a year (except for rare exceptions where it may occur earlier), the team will begin talking about transitions with clients whom they feel are stable.

EXHIBIT II-8. Example Factors for Determining Transition Readiness Among Case Study Sites

Pollard & Hoge (2018) Category	Examples from Case Study Sites
Treatment progress	
Progress toward treatment goals	▪ Has met treatment goals or has clear plans for meeting goals in the future ▪ Has progressed from meeting basic needs to quality of life goals ▪ Active participation in treatment
Response to decreased CSC services	▪ Utilizing fewer services ▪ Increased time in between visits ▪ Decrease in frequency of visits
Ability to manage symptoms	▪ Has a clear prevention relapse plan ▪ Has a crisis and safety plan in place ▪ Managing symptoms
Medication adherence	▪ Has medical providers for ongoing care ▪ Participates in regular medication management
Functioning & Stability	
Clinical stability	▪ Reductions in symptoms ▪ Time since last inpatient hospitalization ▪ Number of hospitalizations
Level of functioning	▪ Strengths in employment or continuing education ▪ Improved functioning in daily living ▪ Developed coping skills when dealing with stress ▪ Sustaining life goals in education, work, and relationships
Ability to engage	▪ Social engagement
Physical health	▪ Has well care visits with primary care provider
Developmental stage	*No examples located*
Substance use	*No examples located*
External support	
Support system	▪ Has access to natural and community supports ▪ Family functioning and support system ▪ Has transportation access
Stability of the housing situation	▪ Has stable housing

Pollard and Hoge (2018) list 12 factors to consider in determining readiness for a transition. Case study site respondent descriptions include many of these factors in their process, including progress in treatment, functioning and stability, and client support. Exhibit II-8 provides examples of these factors from the case study sites.

In addition to the factors outlined in Exhibit II-8, all the case study sites described having a transition assessment process that used shared decision-making. Discussing the

goals, needs and preferences with the client and family is an integral component to assessing readiness.

Case study sites include specific practices that facilitate planned transitions and encourage personalization and flexibility for clients in the process. When asked what strategies they have found to be most effective in preparing clients for transitions, team members commonly reported five strategies: (1) discussing transitions early within the course of treatment; (2) identifying and establishing connections with receiving providers and organizations; (3) continuing contact with CSC staff; (4) involving family members in the transition process; and (5) holding graduation ceremonies to mark the transition. Exhibit II-9 presents a sample of responses.

> *Obviously we as providers are always going to have our own perspective and agenda and what we think is going to be best, but really none of that matters unless the participant shares those same beliefs. So, constantly assessing what those beliefs are and goals are is really important.*
>
> *--CSC team SEE*

Discussing Transitions Early

One way programs prepare a client is to raise the issue of transition early on in treatment. Some sites discuss transition or discharge at the intake or first session, and in doing so, clients then have an understanding that CSC treatment will not last indefinitely. In the OnTrackNY program at Zucker Hillside, OnTrackTN, ETCH, and EASA Deschutes, team members discuss transitions early to instill a sense of hope and convey that clients will progress towards recovery and may not always require a level of service as intensive as CSC. In other programs, there are reasons that programs do *not* discuss transitions early in the process; for example, in PEACE, the team typically tells them that they can access two years of intensive wraparound services and have an option to transition to a lower level of services. One clinician noted that for people who are ambivalent about treatment, telling a client “three years” can be intimidating.

Connecting with Receiving Providers

Establishing some level of connection with a receiving provider is an important transition-related practice. Programs with post-transition options within the same office, medical campus, or organization described a collaborative process with new providers that often involves discussing the client’s history, sharing treatment and service goals, escorting the client to meet the new provider, and joining the client and the new provider for an initial session or two. Programs that refer clients to external providers in the community experienced varying levels of engagement when attempting to connect. In these cases, respondents reported that they could do a warm handoff and have an initial phone call with new providers about their clients but may not be able to have an initial shared session because many insurance policies do not allow payment for similar services by two organizations. One respondent suggested that truly concurrent “hybrid” services for a period of time could be a major support to the client, but such services would require changes to reimbursement policies that at this time, are not in place.

Continuing Contact with Clients

Team members noted that having clients maintain contact with CSC providers is a useful practice to help ease the transition to a new provider. Several case study sites structure their transition programs so that the same staff in the CSC program also provide services in the step-down program as well, as highlighted in Exhibit II-5. Respondents also described other strategies for continued contact. Prior to COVID-19, the HOPE program had a monthly alumni group led by the peer specialist for people who left the program. The alumni group provided a way for the peer specialist to hear about challenges that clients were facing and then inform CSC team members if short-term assistance might be beneficial. Deschutes EASA's drop-in program offers access to computers, a place to do laundry, snacks, and general entertainment. While not currently able to operate in the same way due to COVID-19, the drop-in itself previously facilitated transitions because clients would often have familiarity with the center prior to transition, through attending specific activities and meeting staff. If a client had a challenge related to case management, CSC team members could provide assistance or connect them to external providers.

In two sites, continued contact can take the form of "booster" sessions and re-enrollment. In Felton (re)MIND®, clients can receive up to five sessions after they leave the program, even if they do not enter the Alumni component. The boosters can be any modality that they were engaged with while they were a client, except medication. Similarly, once a client has discharged from HOPE, the program therapist is able to provide a few "refreshers" for clients and families, although this cannot be ongoing therapy. HOPE also allows clients to re-enroll in the program under certain circumstances. The team makes this decision patient by patient, depending on their needs, how engaged they were before leaving the program, and their circumstances. For example, one team member explained, "if they weren't engaged and that's why they discharged, and then a few months later they were hospitalized, or their case manager calls and they're ready for services again, we usually take them right back."

Involving Family Members

Although all case study sites identified family involvement as an important aspect of CSC treatment, some sites explicitly noted that preparing families or other natural supports is a critical transition-related practice. While a client is transitioning to a new provider, families can be helpful in recognizing when their loved one is stressed, what coping strategies they have learned, and what steps are in place for both crisis management and safety planning. Site visit respondents also noted the importance of keeping family members involved to address any stress that family members experience as their loved one moves to a less intensive level of service that may have fewer or more infrequent contact with the program.

Holding Graduation Ceremonies

Three of the case study sites described having graduation ceremonies. Prior to COVID-19, programs would plan in-person ceremonies that involved staff, and depending on the preferences of the client, could also include family members, friends, organization level staff, outside providers, and other clients in the program. Overall, sites that do

these type of graduation ceremonies report that it provides a time to celebrate the client's progress, strengths, and achievements since staring CSC treatment. These ceremonies also provide staff members with an opportunity to reflect on the work they had done with their clients and see how their efforts matter. Finally, clients still in treatment have a chance to hear about a peer's progress from the beginning to the end of treatment and reflect on the possibilities of treatment for themselves. In light of COVID-19, programs have not had in-person ceremonies and some are attempting to offer online graduation ceremonies instead.

EXHIBIT II-9. Examples of Strategies to Facilitate Transitions

(1) Raising the issue of transitions early

- Even from the very beginning, we're already trying to plant the seed that our more intensive CSC program is intended to be temporary, and our goal is to obviously communicate that as a message of hope that it's temporary because they may not always need this level of intensive services and that things will move forward in a positive direction.
- One of the biggest things would be talking about the availability of the step-down program early on. Then all the while, really believe that always assessing what the participant wants and what is driving their desires and motivations for treatment and what their goals are so that we have their buy in.
- Discharge starts when you start working with somebody. So it's a process that we're always working toward and knowing that our therapy relationship should not last forever.
- We start talking about transition early on, too, and it starts by asking, 'What do you think it should look like? What does it look like for you to be ready to transition? What are the things that you think should be in place if you were to no longer be connected with the CSC program?' So it starts right there to get a person's perspective early on.
- Talking about it kind of like almost from the get go, from intake. Like, 'This is how long our program is. This is kind of what the course of the services can look like.' So, talking about it early is really important.
- I try as much as possible to give a lot of lead time to consult with my patients on, 'Hey, what do you think you need to feel ready for this transition?' Really kind of exploring that in advance of the transition and not assuming that we can just switch and it'll be fine. I really try to involve them in the conversation about what the transition looks like.

(2) Identifying and establishing connections with receiving providers and organizations

- I think we've done a lot of warm handoffs. So I'd say that's really important. Honestly, I think that's the most successful way of doing things…making sure that we're all on the same page here and helping the client feel comfortable with the new therapists.
- It's helpful when reaching out to the psychiatrist or the team lead for the ACT team, discussing the patient's history, seeing if they have capacity on the ACT team, and if this is a good match and then making a warm handoff.
- If I know that the client continues to struggle in areas that are going to impact their ability to follow through on outpatient care like poor organization, time management, transportation… those are things that I will specifically communicate to the therapist that that person is transferring to.
- Providing a warm handoff to new providers is really excellent. That always really helps things out. Reading a note is important and useful, but being able to talk about the person too I think just adds a layer to really being able to make sure that the new provider understands the person.
- I would say it's really important to do the warm handoff so not just provide resources but to ensure that somebody makes it to that resource, feels comfortable with every source and is likely to continue on with that resource.

(3) Having continued contact with members of the CSC Team

- With the Drop-In Center individuals know that they can always come back and see their team. They can come back and have a cup of coffee or play a board game or hangout. If they're struggling maybe with some case management needs, we can reach out and help support them in that way, or get them connected to their new team in a way that feels supportive.
- When people discharge or graduate we still continue to follow them for a while. So, this would be calling them or me calling them on a regular basis for at least a couple of months just to ensure that things are going okay and find out did they connect to the next level of service that they were referred.

EXHIBIT II-9 (*continued*)
(4) Family involvement ▪ My recommendation would be to include family members in the discussion as well because I know sometimes young people say, "Oh, yeah, it's fine, it's fine, it's fine," and then when the transition comes, it may be harder than they anticipated. And so, what nicer continuity can you have than if you have a family member who knows this transition's coming up, and knows what it's going to look like, and help bridge that gap until the young person gets to know their new provider well? ▪ I would say families really struggle with things stepping back. There's a lot of anxiety, both overt and covert, because I think a lot of are of the mind more is better, "More is better for the person." We need to make sure everybody's part of this larger conversation and that nobody's been missed because otherwise takes the wind out of things for people to think that their young person might be seen less. ▪ Start to include family as part of that conversation, start to think about how can family help support them, when their loved one starts to experience some anxiety or distress, how can they help them utilize some of the coping skills that they're learning about? ▪ Definitely have a conversation with the parents and the family members, whoever's involved, saying this is our thinking, this is the plan.
(5) Hold graduation ceremonies ▪ We celebrate those successes they made as a client…There are periods in someone's life where you need to celebrate the gains you made. And so I think that's kind of the approach we've taken towards it, but it's not the end. It's just another benchmark to feel good about. ▪ You see the young person that's graduated from the program experiencing that support from their community, which is lovely. I think that what that does is it also really encourages and promotes a sense of hope for they to invite other people, not just the attendees, but the individuals who are currently involved in the program. Then they have a chance to see, okay, this is a possibility for my future if I graduate. ▪ I like the fact that we have a graduation ceremony when people are ready to leave the team, because it's just a wonderful opportunity for all of us to sit at the table together and just think about the client's progress and say, wow, look how far you have come in the last year, 12 months, 18 months, 2 years.

F. Transitions in the Time of COVID-19 and the Rise of Telehealth

Many of the descriptions above reflect pre-COVID conditions, but respondents also described how services--and transitions--have changed because of COVID-19. Broadly speaking, COVID-19 put transitions on hold in some sites and lack of in-person contact disrupted key services and facilitators of transitions in every site, as other programs in the United States have reported (Meyer-Kalos et al., 2020). Respondents in Deschutes EASA, OnTrackTN FEPI, and ETCH, for example, all noted that they were holding off on transitioning clients while the team worked out the best strategy for providing support. The degree of disruption to transition processes varied across sites. Examples include the following:

- Deschutes EASA was just in the process of establishing an alumni group when COVID-19 occurred, and put plans for this on hold.
- A major facilitator for transitions in the Deschutes EASA site pre-COVID was the drop-in program, which made the transition from EASA into YAT smoother and allowed contact with a peer specialist; the program was trying some online activities at the time of our site visit, but the loss of a physical space was especially acute and consistently referenced.
- In HOPE, COVID-19 similarly affected the peer specialist position, where one role of the peer was to pick up on emerging problems that a client might have during casual contact with clients and help secure support before the problem escalated.

- Community-based work is central to the step-down program at PEACE; that aspect of the program stopped completely with COVID-19 since not only did in-person contact change to telehealth, but the clinics and organizations that the therapist and client might have visited also closed.
- Respondents from several programs noted that clients felt strongly about the loss of in-person graduation ceremonies. Team members suggested creative ways of addressing this, such as delivering food to the client and others attending the celebration and doing everything by Zoom, but some clients still wanted to wait for an in-person event instead.
- One site had to discontinue an aftercare group with families, and another site also noted that privacy issues made video parent groups generally difficult. (However, another site continued with parent groups and reported even higher attendance at the “mom’s” group post-COVID.)

However, respondents also described some positive changes since COVID-19, which may also be true for clients in step-down programs. Most consistently, providers reported a reduction in no-shows and cancellations, with one program citing 100 percent attendance with prescriber appointments that was previously “unheard of.” In general, respondents felt clients shifted to telehealth relatively easily, and that COVID-19 facilitated closer contact in some cases because:

> People who maybe had transportation issues or for one reason, or the other wouldn't come in for their appointments, they now just log onto the computer, their phone. They call a lot more frequently. I think many more clients have my cell phone than I ever would thought that I would. That stretch of nine to five, whereas it didn't serve them before, or it might have been a barrier, kind of doesn't exist or it's blurred to the point where they have greater access. I have to acknowledge that I'm also more inclined to pick up the phone on the Saturday and check on somebody than I would have been before.

Overall, respondents in this study report that the switch has been “shockingly smooth” and expressed hope that they will be able to continue to use telehealth in some capacity even after it is no longer necessary. A program director explained:

> I think we're going to continue to use telehealth as a way to engage with people that otherwise won’t engage. For some folks it actually increased the amount of time they will participate with the team. It's very interesting. They're actually more likely to do phone calls. So we're trying to think about what would be like a minimum face-to-face contact that we would want to have with people. But we're definitely contemplating all the ways we can do telehealth with folks.

Prior to COVID-19, only EPIC-NOLA had tested out telehealth services, primarily to reach families living farther away from the clinic and unable to make appointments. Now, other programs have had the ability to see that it can work. One clinician noted that “for this particular population, telehealth is a great addition to clinical care...it alleviates the angst of having to leave their home and come into a clinical setting.” There are also challenges associated with telehealth, which we note in Section III.

G. Integration Within Organizations and Programs

How Organization Integration Supports Transitions

As originally conceptualized, CSC programs lead to a transfer or discharge at some point in the trajectory of a client's treatment, followed by other community or organization-based care as needed. A transfer within clinic or hospital, albeit with different providers, may allow a client a familiar environment and the possibility for some type of informal communication between CSC providers and new clinicians. Examples of this include the transition between the OnTrackTN FEPI program and the TAY or Healthy Transitions program, and transfers between the Zucker Hillside ETP and BOOST.

Among the case study sites, Deschutes EASA stands out as a model for organizational integration. Deschutes County Health Department operates the EASA program, which falls under the auspices of the Intensive Youth Services division, along with the YAT program and the drop-in program. Layered on top of these, Deschutes follows the Wraparound model, originally designed to provide intensive care coordination to children and families, but Deschutes trained the Qualified Mental Health Associate staff in EASA so the same principles are in use for all clients. As previously noted, Deschutes is also following the CCBHC model. CCBHCs must directly provide or contract to provide nine different services, which include services that FEP clients may be likely to need, such as having access to a 24/7/365 mobile crisis team, services to address substance use, care coordination with primary care partners, integration with schools, outreach and public education, and integration with physical health care. From among these, integration with primary health care is an area that multiple respondents mentioned as a critical feature of the CCBHC model. Deschutes established a collaborative relationship with a health care provider called Mosaic, and that provider now has an office integrated within the Deschutes clinic that operates the adult programs. Not only does this mean that team members can talk to physicians in person ("as opposed to calling or emailing and leaving a message and waiting for a response") but a physician from Mosaic also attends CSC team meetings. The YAT program factors strongly into the concept of integration at Deschutes. As one team member described:

> We want to be that one-stop shopping center. We don't want families to have to know what department or line to call. We want families to call, and we want to be able to say, 'we can help.' And so this concept of why is YAT so important because we want families to know that we can help...they're not clinicians. They don't have to know whether or not what's going on is first-episode psychosis or whether or not it's related to trauma. And what we want them to know is, we might not get it right, but somewhere we are going to help you within this team. And here are all the things that we have to offer.

Being located within a hospital setting can also enhance care for clients. HOPE is located within Hennepin Health Care, and through this, clients have a “built-in structure,” so there are very few situations that necessitate an outside referral. Common referrals within the hospital include emergency care; inpatient, day treatment, and partial care; neuropsych services; a DBT program; access to a nutritionist; and primary care, among others. Similarly, EPICENTER is based within a medical center, the Ohio State Wexner Medical Center, which offers multiple layers of care across the continuum. There is a large adult psychiatric hospital on the medical campus, with a capacity for 84 adult beds, in addition to partial hospitalization and intensive outpatient programs. This allows EPICENTER to leverage the layer of continuum both ways; patients can move from the acute settings into EPICENTER and if needed, can also move from EPICENTER to a more intensive setting. The Wexner Medical Center has specialty clinics (including substance use), medication management within outpatient services (including a long-acting injectable clinic), and group and individual psychotherapy. Clients can also access primary care internally.

There are additional advantages of being located in a medical setting for clients and staff. All ambulatory and outpatient services and programs at Wexner use a standardized intake packet, which includes a brief psychosis screen. Through the shared electronic health record system, EPICENTER receives notification for any patient who fits within the EPICENTER age bracket and has a non-zero score, and can review the information to see if that person might be eligible for EPICENTER services; the team can also consult with the provider who did their intake. EPICENTER also has ties to the university outside the medical center, through a relationship with university counseling services and the psychology training clinic that the doctoral program in clinical psychology uses. Both clinics refer students to EPICENTER, and because there is a strong working relationship, this referral is direct and efficient; as one respondent noted, “It's not like they send something through a fax machine, and we have to sift through and find it. They call us. They email us. They let us know.”

State Support in Transitions

State factors can have a significant role in shaping post-CSC services both through providing guidance to CSC programs as well as by facilitating linkage to non-CSC community-based services. Some states have implemented first-episode programs statewide, and provide training, technical assistance, program development, community education, data support and monitor fidelity either directly or through contracts. States can also have an influence on CSC programs, including transition processes, because of *low* involvement. For example, states that do not set limits on CSC program length afford programs a high degree of latitude to make local decisions, although this can also mean the absence of the kind of support noted above.

Guidance on program length is one of the areas where states vary in their involvement. The State Mental Health Authority provides hard limits in nine states, and in 20 states, the state provides recommended limits, mostly of two years (see Exhibit II-10). These rules are not fixed; new staff members and evolving opinion can result in a state limit

becoming more flexible or less flexible. In Tennessee, for example, the state shifted over the past year from having a recommended limit of two years with flexibility (as indicated below) to a policy of requiring authorization to keep a client more than two years. Other states are explicit in their *lack* of guidelines; among programs included as case studies, for example, respondents in both Michigan and Louisiana (both of which organize their behavioral health services through local entities) reported that the state mental health authority wanted to see that programs were effective but leave decisions of program structure and length to local authorities. As one example of a state with flexible limits, a state respondent explained:

> We say that the average is probably two-ish years, but there's going to be a plus or a minus standard deviation for each person. There isn't necessarily a cut-and-dry limit that you will work through this in nine months or you'll work through this in two and a half years…I'm not coming in from the state level saying, 'It has to be two years.' So 365 days times two and then you're out. We don't have those numbers on the books, at this point. It is based on clinical appropriateness.

EXHIBIT II-10. Involvement of States in Setting Program Length Limits (N=45)
No set limits (N=16) AR, AZ, CT, FL, HI, IA, IN, KS, LA, MI, MO, ND, NH, NM, OK, RI
Recommended limits (N=20) AK, GA, ID, IL, KY, MA, ME, MN, MS, MT, NE, NJ, NY, OH, OR, PA, SD, TN, UT, WI
Hard limits (N=9) AL, CO, MD, NV, SC, TX, VA, WA, WV
Data source: NRI/NASMHPD State Mental Health Authority Survey Notes: No response received from CA, DE, NC, and WY. VT did not have any CSC programs at the time of the survey. In AZ, CT, FL, IN and NM the state allows the program or managing entity to set the limits.

Among case study sites, most respondents described state-level involvement in post-CSC processes to be supportive, and in some cases, essential to development of services. As one example, the OMHSAS in Pennsylvania is supporting step-down models across the state, not only in the PEACE. In FY 2019-20, OMHSAS invited all FEP programs that had been in existence for at least two years to apply for funds to support a pilot step-down program, stating that "a growing body of practice-based evidence suggests that a more gradual transition of services is required to maintain the outcomes of the FEP program" rather than the two-year, time-limited service initially studied by NIMH.[2] OMHSAS gave programs latitude to define their steps, but needed to identify what services would be provided in each step (i.e., individual therapy, medication management, case management, peer support services, etc.); how often clients would be seen in each step (i.e., a minimum of every two weeks); and the payment type for each step (i.e., fee-for-service, case rate, reduced case rate, etc.). Seven programs are currently testing step-down models. Under contract with OMHSAS, the Pennsylvania Early Intervention Center is currently evaluating these seven programs; results are forthcoming.

[2] OMHSAS Pennsylvania Department of Human Services FY20-21 FEP Renewal Application--Final.

State engagement among other case study site states also has relevance in supporting post-CSC options. We have previously noted the legislative efforts underway in Oregon to potentially expand the length of EASA programs from two to three years, which if passed, will be implemented across all 26 EASA locations. The ramifications of this change could be far-reaching; programs throughout the United States implement the EASA model. A change in Oregon legislation to allocate additional funding may be a compelling policy change to motivate similar legislation in other states. As a case in point, in Louisiana, the state FEP coordinator and others in the office of Behavioral Health are keeping a watchful eye on what research shows about program length, and noted:

> If the research shows that they need to stay in even longer, that's fine. And if that's the case, then we might have to think about how to support them to do that, with more funding, so they can hire more staff. I support anything that is backed up by research that says it's the best thing for the client.

In sum, state involvement in transition-related activities has been limited to date, with a few exceptions as noted above. States have continued to develop CSC programs, and as more and more programs mature, it is likely that states in turn will begin to develop technical assistance, guidance, and perhaps even support for step-down and related options.

III. POLICY IMPLICATIONS & OPPORTUNITIES FOR FUTURE SERVICES RESEARCH

A motivation for the current study is the need to understand how CSC programs are ensuring that clients receive appropriate services once they have completed early intervention. While the case study sites represented in the current study reflect a range of settings, populations, and service approaches, respondents were generally consistent in their identification of specific challenges. In this section, we discuss these most common challenges and the potential opportunities to address these through shifts in either policy or practice. We then discuss areas for future research and examination that can help further clarify how to improve services for individuals experiencing a FEP across all stages of their treatment and recovery.

Challenges and Opportunities: Potential Policy Levers

Lack of Appropriate Services through Routine Community Care

Challenges

Most of the programs featured in this report developed their services as a response to inadequate routine community-based options, a well-known issue for early intervention programs in the United States (Rosenblatt et al., 2018; Goldman, 2020). In the current study, respondents highlighted the difficulty in finding providers in the community that had appropriate training or experience to treat clients with early psychosis. Primary care providers are often reluctant to take on clients with psychosis, whom they view as "intense," especially if injectables are involved, since these require more monitoring than oral administration. There is a shortage of psychiatrists more generally, and some may not accept Medicaid or only take on a limited number of clients, creating a bottleneck among those that do. In addition, community-based programs may have less welcoming waiting rooms, less flexibility if clients are late or miss appointments, fewer follow-up visits, and less individualized attention and time with providers during sessions. The discrepancy between these practices and the highly accessible services provided by CSC teams can sometimes lead to client disengagement with follow-up care.

Opportunities

Targeted efforts by CSC programs to increase community linkages and partnerships may ultimately be the most efficient mechanism to meet the needs of clients leaving those specific programs. CSC team members, through outreach efforts to increase referrals, often make connections with other organizations and providers in the community, placing the team in an excellent position to know what options are potential placements. Building capacity within local community providers can then establish a pathway for clients after graduation.

Several case study sites have begun to undertake training efforts, with different mechanisms of support. EPIC NOLA uses a non-profit, Clear Answers to Louisiana Mental Health, as an outreach mechanism to educate the community about psychosis. The engagement specialist and other team members hold town hall meetings with different populations (e.g., teachers, faith leaders, police officers), go to universities, other mental health organizations and facilities, and include training to future physicians. This initiative relies on community donors to support the work. County agencies can play an important role in fostering relationships among relevant organizations to improve options for post-transition placements in the community. As one example, San Mateo County has a Youth Transition Assessment Committee, where the focus is on identifying services for transitioning youth. Felton participates in this committee, providing a connection to the larger county system of care for young adults and familiarity with those providers. With funding from the county and MHSA, Felton also has a community outreach program through which they invite providers to events, disseminate information, offer CBTp training, and encourage providers to call if they have questions about patients with psychosis.

Financing for Continuity of Care Services

Challenges

The challenges for funding step-down programs are largely the same as those for funding CSC services, which others have highlighted in detail elsewhere (e.g., Shern, 2020; Shern et al., 2017; Jackson et al., 2019; Rosenblatt & Goldman, 2019). Namely, Medicaid covers only about 50 percent of the costs of CSC programs and may not cover certain services, such as some aspects of SEE and family therapy. Private insurance also typically does not reimburse for key CSC services or other activities by the team lead that do not include face-to-face contact (Jackson et al., 2019; Smith et al., 2019). As noted above, some providers in the community do not accept Medicaid, or restrict the number of Medicaid and sliding scale clients they are willing to take. In some cases, private insurance may not cover injectables, and copays for therapist visits can pose a barrier for clients. Programs often use State general funds and MHBG set-aside funds to support the provision of these services and to cover clinician time to engage in outreach, team coordination, and other non-billable activities. One site in this study, however, was not eligible for MHBG set-aside funds because it does not meet the state definition of a CMHC. All these issues are similar for programs wishing to continue services through a step-down mechanism or extended length model.

Opportunities

In spite of gaps in coverage, Medicaid remains a critically important source of support for continuity of care for individuals with psychosis. Medicaid could be even more effective if coverage was consistently extended to several key services, namely, SEE and peer support services. Recently, states have begun focusing on changes to reimbursement through Medicaid (and private insurers) through other mechanisms. One avenue with high potential implications for post-CSC care is a tiered model of reimbursement, with different rates for different levels of service. As an example,

advocates in Pennsylvania proposed a three-level model. The top tier would be reimbursed through a full case rate covering standard CSC services, where team members see clients multiple times a week. The next tier, with funding at a reduced case rate, is proposed to cover clients who do not need to as frequent visits but who need ongoing care, such as monthly visits. The last tier involves a fee-for-service structure, where reimbursement covers each visit, such as a client coming for medication checks every three months. In this model, step-down services align well with the second and third tiers of service. The Meadows Mental Health Policy Institute (MMHPI) makes a recommendation similar to this, proposing a monthly case rate for delivery of the full model plus an encounter rate for less intensive service delivery, which includes follow-up contact as clients transition to other levels of care (Jackson et al., 2019).

A second approach is a single "bundled" payment. The MMHPI report noted above makes a strong case for this, and suggests a billing code that is consistent with a bundled rate for CSC programs. The authors note that the effectiveness of CSC services derives in part from being a coordinated, flexible package of services using a team-based model and as such, reimbursement should follow the structure of the model. Very recently, Maine was able to achieve this by negotiating a cost-based, bundled payment, calculated as the total cost for the CSC program divided by individuals served (Robbins, 2019). In June 2019, the state passed a bill with bipartisan support, in which the Maine Department of Health and Human Services was directed to pursue federal funding sources and develop a bundled rate that will be honored by private insurers.[3] In Illinois, Public Act 100-1016, the Early Mental Health and Addictions Treatment Act was passed in August 2018 and included provisions for a pay-for-performance payment model, another example of state progress in shaping Medicaid to better fit CSC services. While the Maine and Illinois examples do not directly address funding for transition services, states in our study are currently reviewing these as potential models.

At the state level, California provides an example of leveraging public sentiment and the political process to enhance behavioral health services, including both CSC and continuity of care services. Advocates in California successfully used the state's initiative process to pass Proposition 63, the MHSA, in 2004 (referenced above). This placed a 1 percent state tax on incomes over one million dollars, which has transformed mental health services in the state, including providing funding for early intervention programs such as CSC. The outreach activities by Felton described above, as well as coverage for the Alumni program, are examples of how this type of funding supports individuals with psychosis beyond the CSC program.

The use of Medicaid authorities, such as the 1915(c) Home and Community-Based Services (HCBS) waiver, the 1915(i) State Plan HCBS authority and Section 1115 demonstration waiver of the Social Security Act have been discussed elsewhere (Shern et al., 2017; Shern, 2020). The 1115 waivers provide opportunities for states to engage

[3] See https://legislature.maine.gov/legis/bills/bills_129th/billtexts/SP044601.asp.

in pilot or demonstration projects, including providing services that Medicaid does not typically cover. Illinois, New York, and Oregon are all examples of states that have used this waiver to support core CSC services. In the current study, however, we did not see any examples of this waiver used to support continuity of care services specifically.

Many states have 1915(c) HCBS waivers, which vary by state, and population served. In states where these waivers include adults with serious mental illness (SMI), such as Minnesota and Texas, some individuals graduating from a CSC program may be eligible for these services, which can be quite comprehensive. However, to meet the eligibility criteria through these waivers, an individual must an "institutional level of care criteria" which would require a level of severity that one is unlikely to see in a "graduate" of a CSC program.[4] For example, in Minnesota the Community Access for Disability Inclusion (CADI) waiver is for people who otherwise require the level of care provided in a nursing facility (a Medicaid "institution"). In Texas, an individual with a SMI must have had 15 or more emergency room visits or four arrests and two psychiatric crises during the three years before the referral. Ideally, at least, most graduates of a CSC program will not have experienced this level of crisis during their time in the program. The 1915(i) State Plan HCBS option does not require individuals to meet an "institutional level of care" to be eligible for services and therefore, may be a better option for covering supportive services for graduates of CSC programs.[5]

Staffing and Capacity

Challenges

In the current study, the primary staffing challenge that respondents identified is the tension between keeping clients for a longer period and maintaining the high staff-to-client ratios that are central to the delivery of services through CSC. This is primarily a challenge for extended length models, where it is not always possible to determine when a clinician will have an opening in their caseload to accommodate new clients. As one clinician explained, "if we're seeing people for longer, that means we have people on our caseload that we've been seeing for five years filling the slot, which means somebody else maybe is on a wait list and not getting into treatment quite as fast." The structural changes that occurred because of the pandemic (e.g., rapidly switching from in-person to online sessions, staff turnover), may have made capacity issues more pronounced, as staff shifted their responsibilities in new ways. One prescriber lamented, "Sometimes it just feels like people are slipping through the cracks. I think partially that could be a capacity issue. But it also feels like it could be just the organizational shifts that have occurred since Coronavirus that have made it difficult for everything to be well organized, and for people not to slip through."

[4] See https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c/index.html.

[5] See https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915i/index.html.

Opportunities
Capacity issues require either additional funding to hire more staff, or use of other mechanisms to fill in gaps. One administrator described this challenge as needing more well-trained clinical psychologists and psychiatrists "to give patients the best care right away when they need it, rather than having to wait to enter the program," adding, "So, more resources need to come to bear in order for us to open the gate and treat patients right away if they need it right away."

The alternative to increased funding is for programs to use less costly trainees, interns, psychiatry residents, and other programs that increase the size of the team without a commensurate increase in cost. Both EPICENTER and EPIC-NOLA do exactly this, drawing from their respective university medical centers; the EPICENTER "team" of more than 30 illustrates this approach. More broadly, clinical training programs in psychiatry, social work, psychology, and nursing all have a role to play in creating a workforce that is well-prepared to step into CSC positions. Professional organizations such as the American Psychological Association, American Psychiatric Association and National Association of Social Workers might also take the lead in offering training as part of continuing education in their respective fields. As one example, the partnership between the American Psychiatric Association and SMI Adviser (a SAMHSA-funded project to enhance clinical support) produced a conference in November 2020 on advancing early psychosis care in the United States. Offered virtually and at no cost, the conference provided continuing education credits physicians, psychologists and social workers and had well over 3000 attendees.

Disengagement

Challenges
As noted in the introduction, the focus of this study was on *planned* discharges and continuity of care following a designated period in a CSC program, rather than all discharges. However, a non-trivial number of young adults leave programs at much earlier times--including immediately following intake. The issue of premature discharge in the United States is just beginning to receive attention. Mascayano & colleagues (2020) report that the probability of discharge before one year within the OnTrackNY clinics was 32 percent. One program director in the current study noted that a third of the clients "disappeared very quickly," most commonly between the referral and the first visit (i.e., a third of individuals who were scheduled to come in were never seen). A study from 2012 estimated disengagement at one year, as defined as having no contact with CSC service providers for a period of three months or greater, at 49 percent (Kruse, 2012). A state-level evaluation, from Virginia's eight CSC programs, reports that nearly two-thirds of clients discharged within the first year, and approximately 36 percent of those discharges ended treatment "incomplete."[6] Respondents from the case study sites acknowledged that they had concerns about clients who dropped out early and that the program could not locate.

[6] See http://www.dbhds.virginia.gov/assets/doc/BH/mhs/csc-report-final.pdf.

Opportunities

These descriptions and reports raise important questions about the nature of CSC services and who is--and is not--served through them. Data on this issue are difficult to locate; programs understandably focus on the clients who are engaged in services and providing the best care possible. Based on our discussions with team members and state representatives within the case study sites, state mental health authorities generally do *not* require sites to provide detailed information about patterns of discharge, and many sites do not document this themselves. Moreover, staff may view devoting valuable (and non-billable) time to documentation as onerous. However, systematic data collection is the only way to understand whether CSC programs are serving the population in need, and if not, how changes in policies and practices can improve them to do so.

Many states already incorporate performance monitoring and quality measures; some states have comprehensive assessment protocols that cover a wide number of domains, such as in the OnTrack sites in New York and the EASA programs in Oregon. States (or intermediary organizations operating on behalf of states) could complement these assessments in two ways. First, programs could document and report a few key data elements on all clients. In EPINET, for example, clinics will indicate the primary reason for discharge from a list of options. These questions will allow analysis of whether the discharge is "premature" due to client-initiated termination or drop-out, whether clients are leaving to a different level of services, or whether discharge is for a positive reason, such because of client improvement. Second, programs can document the referrals made at the time of discharge. From these data, we could then better understand key points where CSC programs may need to strengthening, such as between referral and intake, intake and the first appointment, and within a specific number of appointments or time frame.

There is an important caveat to the process of increased data collection. States collect many behavioral health quality measures that they do not end up using, and among the reasons for underutilization are low denominators, especially for measures that focus on lower-prevalence conditions. This includes many of the adult SMI measures, depending on the level of reporting. If states do not already have dedicated data collection mechanisms for FEP programs, then this challenge may interfere with reporting and interpretation of FEP discharge data. For states that already collect data from programs, however, the addition of discharge information would be more straightforward, consisting of simply one more data element.

COVID-19 and Disruptions in Care

Challenges

The absence of in-person contact because of COVID-19 has had an impact on the ability for CSC teams to prepare for transitions and ensure that transitions proceed smoothly. Assessments, which help clinicians gauge readiness for transitions, cannot occur as frequently or easily remotely. Respondents in many sites noted that the concept of a warm handoff is "odd" since clients are not actually going anywhere

different than they were before. Common practices, such as physically walking with a client to the new space and providers, are no longer relevant. Among the case study sites, transition team meetings all switched to video platforms, but as in many settings, there is a degree of informal coordination that staff lose by not being in person, for example, staff cannot informally check in with one another on how a client is doing by dropping in or see a client as they pass through the halls. A nurse summed up her feelings about the challenge of remote care as:

> The shortfall I feel is not being able to lay my eyes on my clients' faces and their physical needs, because that's the core of nursing is touching people. You cannot touch a person anymore. You have to just build on your experience with them and what the data that you do have to kind of figure out where they are, as opposed to being able to just sit back and talk to them for a few minutes.

A small number of clients are uncomfortable with video, often for reasons linked to their symptoms, such as paranoia, and also just as a personal preference ("lot of young people like text anyways, they don't talk on a phone, they text; that's the way they do their communication"). Access is an issue for clients with older cell phones, limited data plans, and who live in rural areas that have poor internet connectivity. For some clients, getting out of their house and to the clinic is an important intervention itself. A prescriber noted that while clients generally can handle telehealth, there is a "disconnect" that he feels as compared to seeing clients in person.

Opportunities

The sites in this study, including those engaged in step-down programs, all changed to telehealth services just prior to our site visits. Temporary legislation supported this shift and allowed Medicare to provide reimbursement at the same rate for telehealth as in-person visits, permitted services to take place in the clients' home and allowed all Medicare eligible providers to provide telehealth services.[7] For the duration of the COVID-19 public health emergency, telehealth under these circumstances remains billable, including among many major private insurers. Programs are likely to shift back to providing at least some core CSC services in person, once allowed. For continuity of care, however, telehealth holds intriguing possibilities. A client who is ready to graduate is also ideally able to manage with less intensive services; switching from in person to telehealth is one way to reduce the intensity of services and give the client an opportunity to gradually transition to other care settings. In locations with limited providers in the community, telehealth holds particular promise as a mechanism that can extend the relationship that a client has with the CSC program without commensurate burden on staff. Permission from insurance providers to continue telehealth services would allow programs to test this as a planned and purposeful approach to care.

[7] See https://telehealth.hhs.gov/providers/billing-and-reimbursement/medicare-payment-policies-during-covid-19/. Also see https://www.cchpca.org/resources/covid-19-telehealth-coverage-policies.

IV. SUMMARY & CONCLUSION

The purpose of the current study was to examine the landscape of existing approaches to continuity of services after discharge in CSC programs in the United States. Using a combination of data from an environmental scan and nine case study sites, we described how services are structured and sustained, how teams facilitate transitions and what challenges they face, and how organizations and states can support transition processes. We offer the following key points as a summary of these findings.

A. Summary

Programs differ in their philosophy about the underlying purpose of a CSC program, and this relates to decisions around continuity of care. The original motivation of early intervention programs was to change the life trajectory for people with psychosis; the early stage of psychosis provides a special opportunity to get individuals "on the right track," supported by a strong recovery orientation. This is consistent with a CTI model. Some respondents in this study offered an alternative frame: CSC may or may not change the trajectory of an individual's illness, but certainly provides exceptional services during the early stage of the illness, and likely earlier than they used to occur. In this conceptualization, CSC is not early intervention with the idea of preventing ongoing illness and disability, but rather early intervention with the goal of providing needed services sooner, and over a longer period. One respondent called CSC a "nice front door experience" which can hopefully provide a positive experience with the health care system that will keep people engaged in services as long as needed. One way teams enact this perspective is through extending services beyond two years, and creating step-down services is one manifestation of this.

Most respondents favored a longer program length or length determined by client need, both among sites that do and do not already have this option. In programs that already have an extended length model, staff members offered numerous clinical reasons for a longer stay, including being able to establish rapport with clients who need more time, support clients through developmental transitions, provide psychotherapy at the clients' pace, and address underlying issues of trauma if present. Seven programs had either a longer length of program or extended length by virtue of a step-down program; in these, CSC team members also emphasized the benefit afforded to them, above all, allowing them to use their skills appropriately, work with less anxiety, and feel a high degree of job satisfaction by seeing clients' growth. Most respondents favored a program length of 3–5 years, or allowing length to vary according to each individual clients' needs. This point of view marks an important conceptual change in that it is a departure from the idea that a relatively fixed-time dose of specific services will dramatically change the trajectory of those with early psychosis.

Lack of community-based options is both a major driver in the development of post-CSC services and a significant barrier in continuity of care. A challenge for CSC programs is that even if a step-down program exists, there is still a transition that needs to occur at some stage. In some cases, the reticence of community providers to accept clients with FEP may be due to concerns about having the appropriate skills and training to meet their needs, for which outreach and collaboration from the CSC program could be effective. However, it is well beyond the scope of CSC programs to improve community-based care, and most CSC programs already struggle to cover non-reimbursable costs. Specific training in care for individuals with first-episode psychosis, perhaps coupled with incentives for working with this population, may be a way that states and intermediary organizations can increase community capacity.

CSC programs created step-down services to provide a shared goal of extending care for clients, yet step-down models vary across multiple dimensions. These factors include whether the services are a continuation or reflect a shift in focus, whether the step-down can accommodate all CSC clients and whether it has the capability to provide more intense services if needed, the population served, the length of time of step-down services, and whether clients work with the same staff or not. While the two programs that view the step-down as a shift in focus did so very intentionally, much of the variability around these other factors is more a result of structural and funding constraints. For example, the age restriction for step-down services in the Deschutes EASA program is because the step-down is a TAY program that serves that age population only; the time limit in the Felton re(MIND)® program is due to restrictions in the funding source. The one commonality across the step-down programs in the current study is that services for the step-down occur in the same location as the core CSC program, and respondents repeatedly emphasized the importance of co-location both to facilitate communication and coordination around the transition as well as a clinical benefit to clients.

Post-transition services that focus on TAY are highly valued but not widely available. A common concern among respondents in this study was that program staff in outpatient clinics do not always have skills to work with youth, and also that being in a setting with much older (and possibly more disabled) adults can be discouraging to youth. Two of the case study sites used TAY programs as a post-discharge placement. In both cases, the TAY programs also serve youth who were not part of the CSC program, and in both sites, the TAY programs are the preferred referral option primarily because services match the developmental stage of most clients in the program. If TAY program staff can receive training in psychosis, such placements may be the best option for TAY following a CSC program.

Most CSC programs fund continuity of care services through a similar mechanism as their full CSC services, and therefore navigate similar constraints. Reimbursements through Medicaid and private insurance, supplemented with state and MHBG set-aside funds are common. Certain services--such as SEE, case management and peer support--are often not covered through reimbursements, yet these are the very services that often are most relevant to individuals once they have stabilized and may

be in a step-down setting. However, respondents reported a sense of feeling that the sustainability of continuity of care services is tenuous, and respondents in multiple sites described efforts to negotiate with the State Medicaid authority and private insurance companies, noting the potential advantage of a case rate model and/or a tiered model of reimbursement. The policy levers available for financing CSC transition services rely on successfully leveraging a patchwork of funding streams. States have the option of participating in the expansion of the ACA, obtaining federal waivers, creatively using MHBG funds, obtaining grants from federal or local sources, or allocating state general funds for these purposes.

Regardless of the post-CSC placement, CSC programs tend to use similar practices to prepare clients for transition and facilitate continuity of care. In general, preparation involves a team discussion about readiness, sometimes in conjunction with assessment data. Client and family input are central to the process. Most programs emphasize the importance of discussing transitions early, sometimes even in the first session. Program staff reach out to providers in the new program where possible, and in the sites where step-down services are co-located, these providers can also join in the treatment team meetings related to planning if they do not already attend. Many programs have some way to maintain contact with clients, including through booster and refresher sessions. Lastly, some programs use graduation ceremonies as a way to celebrate client progress, strengths, and achievements, even if the client continues to receive step-down services.

There is likely to be a subset of clients in any program who, despite early intervention, do not progress to the point that a reduction in services is feasible. Across all nine case study site programs, respondents noted that they believe some clients may need higher intensity services for the rest of their lives. For these clients, a referral to an ACT team is the most common post-CSC placement, and in some cases, this referral occurs as soon as the team feels that the client needs additional services. Respondents did not view a transition to ACT as a failure of the program or of the client. Rather, the *majority* of respondents were appreciative to have an option that would provide more intensive services, even if imperfectly, because “if that’s what the client needs, it’s what they need.” An important question implied by this finding is whether there should be greater effort to identify individuals who are not likely to benefit from CSC early on and provide supports that are better able to meet their needs.

Early discharge from CSC programs is a significant issue, but little is currently known about this topic in the United States. A recent report using OnTrackNY data estimated that approximately a third of clients who enter CSC leave before one year; the State of Virginia noted a similar level among their programs. In addition, one of the case study sites estimated that a third of clients who are scheduled for an intake do not attend. These data point to a clear need for mechanisms to better understand who is actually served through CSC services, and who is not. While the issue of continued care for individuals completing a program is important, it is equally important to spend resources to address how to better keep clients engaged in program services.

COVID-19 has interrupted normal transition practices and step-down program activities, but the use of telehealth has generally been an effective tool. Transitions are by definition a time of disruption, even when all efforts are in place to make the process run smoothly. With COVID-19, some sites elected to hold off on transitioning clients out of the program and are waiting until in-person services could resume. Sites with programs that centered on community-based and in-person activities--such as learning to navigate neighborhood resources, public transportation, job support, and using drop-in centers--reported significant disruption. Respondents found the use of telehealth generally an effective means of communication with clients, and some clients showed greater engagement through this modality. However, the effectiveness of telehealth over a longer period is not yet clear.

B. Limitations of the Current Research

There are several limitations of this study that are important to highlight.

Most of the current report focuses on case study data, which necessitates at least two important caveats. First, case studies are unique. As such, it is critical that findings from the case study data are not used to generalize but rather serve as examples. Second, there are additional CSC programs in the United States that are taking equally interesting and novel approaches to continuity of care that were not included in this study, but had been doing so for a relatively short amount of time, and we elected to focus on programs where the activity was more well-established.

This study focuses on how programs in the United States address *planned* discharges and continuity of care. A high number of individuals who enter CSC programs do not stay through the "full" treatment and discharge at an earlier point, which may not align with the recommendation of the CSC team. As noted in the sections above on policy implications and suggestions for future research, earlier discharges need to be studied in their own right, with development of a new schema to understand these patterns.

The perspectives reflected through our interviews are primarily those of CSC team members, organization representatives, and state-level policy makers. This study collected very limited data from participants, parents, and other family members. The limited interviews we were able to conduct with parents and CSC program participants were compelling and thoughtful accounts, and we strongly suggest that future work could focus more thoroughly on their experiences.

Lastly, we designed this study prior to COVID-19 and it originally involved in-person site visits. Methodologically, COVID-19 necessitated that we conduct all the interviews by video; we were not able to see the spaces that respondents described as so central to their work, such as the YAT program in Deschutes EASA, and the "cozy" space of ETCH where clients can gather. In-person interviews may have also allowed for more opportunities for casual comments than those conducted virtually, where there is the pressure and formality of a camera. More critically, the practices and experiences that

respondents described tended to reflect their practices prior to COVID-19, which is a context that may not exist again, even in a “post-COVID” world. Programs will need to revisit (and possibly reconstitute) many of the processes in place before COVID-19, and some of the recommendations that program staff members provided may no longer apply.

C. Conclusion

Early intervention programs for psychosis were originally rooted in the belief that the initial stages of psychosis presented an opportunity to fundamentally alter life trajectories and promote recovery. A complementary frame is provided by a number of respondents in this study: At least for some individuals, CSC may be an essential first step to service trajectories that extend beyond the two-year time frame provided by most CSC programs. This evolving perspective highlights the importance of continual examination and reflection of CSC implementation by obtaining multiple perspectives and looking at programs across different contexts. A fundamental approach to addressing this problem, preferred by a majority of respondents in this study, is to extend the length of stay in CSC programs to 3-5 years, either through receiving full or step-down services. Beyond this time frame, all programs acknowledged that some clients may require intensive services, such as those provided by ACT across the life span.

The complexity and opportunity of providing effective continuity of care, whether from a three to five-year frame or for a lifetime, lies at the core of the findings presented in this study. There are numerous potential lessons from the respondents in this study. Step-down services from CSC programs to less intensive options are best provided in the same location as the CSC services to facilitate communication and coordination. Youth who transition to adulthood as they graduate from CSC services may benefit most from TAY programs, though they are not widely available. Similarly, many community-based options are inadequate or not available. A patchwork of public, private, federal, and state sources fund CSC services, and funding post-transition face these same issues. There is little information about clients who discharge prematurely from CSC services. Providing financing, enhancing quality of care, establishing and maintaining a trained workforce, enabling coordinated service delivery systems, and collecting essential data to improve programs all remain challenges. For the foreseeable future, COVID-19 adds a layer of interruption while providing the opportunity to enhance telehealth services.

Despite challenges that this study describes, there remains considerable cause for optimism, as these challenges emerge out of the extraordinary growth of early intervention programs for psychosis and of CSC specifically. As more CSC programs mature to serve ever-growing numbers of clients, the strategies for providing effective continuity of care illustrated in this report will continue to grow. Services research can document and inform the impacts of those approaches and help guide the development of service delivery through a learning health care approach. There is much to learn from the partnerships between clients, providers, researchers, and policy makers. Ultimately

the questions we still need to address regarding continuity of care are, at their core, born of the original successes of CSC.

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Senior Advisor
Howard Goldman
Professor of Psychiatry
University of Maryland, School of Medicine

Advisory Panel
Lisa B. Dixon
Edna L. Edison Professor of Psychiatry
New York State Psychiatric Institute

Nev Jones
Assistant Professor, Department of Psychiatry & Behavioral Neurosciences
University of South Florida

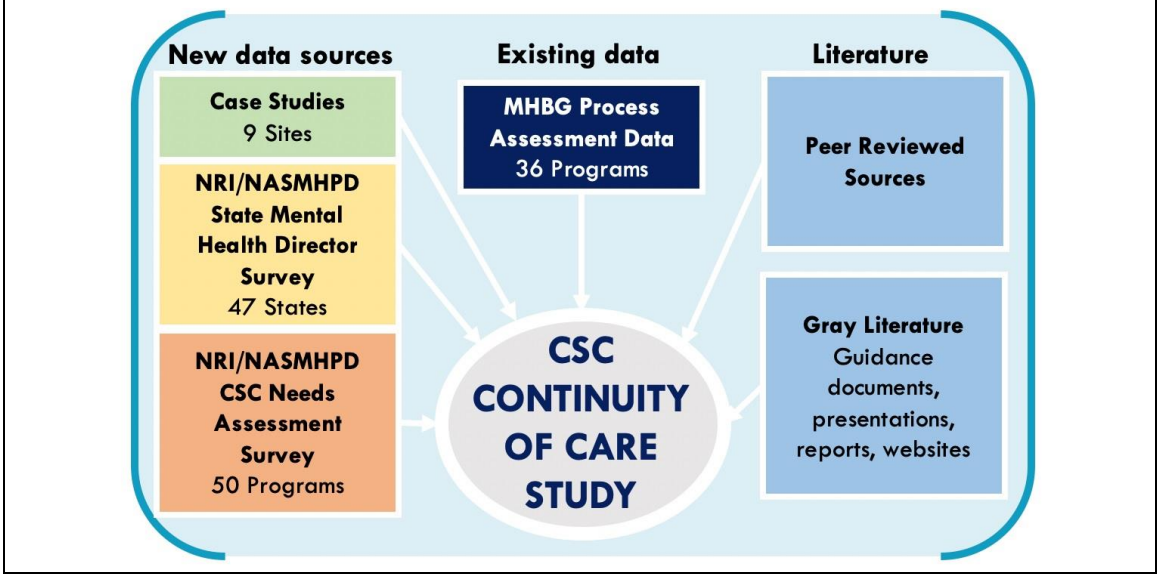
Ted Lutterman
Senior Director, Government & Commercial Research
National Association of State Mental Health Program Directors Research Institute

David Shern
NASMHPD Senior Public Health Advisor

APPENDIX A. METHODOLOGY

The CSC Continuity of Care study integrates data from multiple sources. The Environmental Scan drew from two surveys conducted by NRI/NASMHPD, interviews collected as part of the MHBG Ten Percent Set Aside Study (Rosenblatt et al., 2018), and peer and gray literature focused on transitions and related topics. The current report draws primarily on data collected through nine case studies, described in more detail below.

EXHIBIT A-1. CSC Continuity of Care Study Sources



A. Environmental Scan

1. **NRI/NASMHPD State Mental Health Director Survey**. NRI, a research organization affiliated with the National Association of State Mental Health Mental Health Program Directors, works with state agencies, the Federal Government, and other entities to define, collect, and analyze data on public behavioral health systems. In August 2019, NRI administered a survey to all State Mental Health Authorities (SMHAs), specifically focused on transitions. This survey included several items that overlap with our research questions. In total, responses from 47 states are included in this summary. Within the responses, some SMHAs provided information about individual programs within their state.

2. **NRI/NASMHPD CSC Needs Assessment Survey**. As part of a needs assessment conducted for the American Psychiatric Association, NRI administered a survey to all current CSC programs covering a range of topics. NRI included three questions with direct relevance to the CSC Transition Study.

Data collection is ongoing; in this report, we incorporate data from responses provided by 50 programs that had had either partial or completed surveys as of March 1, 2020.[1]

3. **Peer Reviewed Literature**. Studies that examine some aspect of transitions have been conducted under a wide range of circumstances, and primarily outside the United States. They also vary in methodology, depending on the purpose of the study (i.e., to obtain participant perspectives on discharge vs. to compare outcomes between groups that received different lengths of treatment). Given the limited literature base that exists, we chose to incorporate data from studies of all types of designs, and as noted above, this scan does not include a comprehensive review of peer reviewed literature. Rather, we included refereed publications to support the specific topics of focus in this scan. The initial search for relevant articles was conducted using the same set of search parameters as for general online sources, noted below. Additional sources were obtained through references within publications.

4. **Gray Literature**. As a relatively new topic and one that draws heavily on practitioner experience, the "gray" literature forms a major source of our review. These sources include organization, organization, state and other websites, guidance documents, presentations, program descriptions, unpublished or yet-to-be published papers, and other similar materials. These documents were obtained through different avenues.

5. **MHBG Process Assessment**. SAMHSA, ASPE and NIMH funded an evaluation of CSC programs from 2016-2019, called the MHBG Ten Percent Set Aside Study. This study included site visits and in-depth interviews with 36 CSC programs located across the United States (Westat, 2019). The study incorporated several questions about transitions that are relevant to the current study. Some of these were incorporated into the Final Evaluation Report, as well as included in a publication (Jones et al., 2020). For the current scan, we have analyzed MHBG data to align with the current research questions.

B. Case Studies

Site Selection and Recruitment

We used data from the Environmental Scan, input from Advisory Panel members, and recommendations from others in the field to identify possible candidate programs for the case studies. In addition, we posted on the PEPPNET Listserv to allow programs to nominate themselves if they believed their program may fit the description of offering one or more of the criteria for inclusion, noted in Exhibit A-2. In total, we invited 21 sites

[1] At the time of this report, the survey data collection was incomplete, and active follow-up was discontinued after the increase of COVID-19 activity in the United States.

to provide information about their transition and continuity of care services using a screening form. Two sites responded that their program was closing or in danger of closing, and they would not be able to participate. One site no longer had a step-down program. Six programs did not respond. We interpreted non-response as programs not being interested in the study, and did not follow up.

For the remaining 12 programs, we conducted follow-up calls to verify the information they provided and obtain additional detail that would help select the final sites. Based on the information we obtained through the screening forms and follow-up phone calls, we found that candidate programs generally offered an extended length model or step-down services. With consultation from Advisory Panel members and ASPE, we selected nine sites for inclusion.

EXHIBIT A-2. Initial Criteria for Case Study Sites
▪ Developed step-down services. ▪ Extended program length as a defining feature. ▪ Integrated post-transition services with TAY programs. ▪ Innovative use of funding for post-transition services. ▪ Well-specified transition preparation and planning processes. ▪ Strong relationships with community-based providers. ▪ Alumni and family support services for former participants.

Respondent Selection

We considered the team lead or program director the key respondent, and we asked this individual to identify all additional potential respondents who might be best positioned to help us understand aspects of transition practices and policies within the site from multiple levels and perspectives. Depending on the nature of the continuity of care services, we included representatives accordingly. For example, in the OnTrackTN FEPI program, which refers individuals to the TAY and Healthy Transitions programs, we interviewed the program coordinator of each of these programs as well. Unless there was a very specific reason not to interview someone at the state level (i.e., all CSC activity is at the county level in California; the State level individual in Michigan was new to the position) we always included one or more state-level respondents, which could include individuals engaged in both contract management as well as technical assistance and training, if those roles were separated. Exhibit A-3 provides the distribution of respondents across the nine sites.

Given the focus of this study and a limit to the number of participants who could be interviewed per site, interviews with clients, former clients, and parents were not a central component of these procedures.

EXHIBIT A-3. Summary of Case Study Respondents	
Respondent Position	**Number of Respondents**
CSC team member Team leader, clinician/therapist, SEE specialist, peer specialist, family peer specialist, case manager, psychiatrist, nurse, OT, Individual Resiliency Trainer	50
State representative or state contractor	15
Organization representative	12
Participant	5
Parent	3
Other	3
Total	88

Procedures

Using the list of respondents that the team lead suggested, we individually contacted each individual and invited them to participate in the project. Interviews with the team lead were 90 minutes each, and interviews with prescribers were scheduled for 30 minutes. All other interviews were scheduled for an hour, although did not always take the full amount of time. In total, we conducted a total of 85 interviews, all using video. All interviews were recorded and professionally transcribed. We obtained verbal informed consent to participate in the interview and for the interview to be recorded before the start of each interview.

We developed a team lead protocol, and a core set of questions for all respondents along with additional items appropriate to each respondents role (e.g., prescriber, state-level official, organization administrator). These topics appear in Appendix B.

Analysis and Reporting

All interviews were professionally transcribed and uploaded for analysis to the qualitative software program Dedoose, Version 8.3.10 (2019). Interview topics were broadly coded according to Following a directed content analysis approach (Hsieh & Shannon, 2005), we assigned each topic to a broad area for further review (see Exhibit A-4). For each site, we developed an individual Case Study report, which the sites individually reviewed for accuracy and completeness (see Appendix C). We completed these reports by synthesizing interviews from across a site, looking for areas of consistency as well as divergence among the respondents. For the purpose of summarizing and synthesizing data, we looked at both the case study reports and the original transcripts to identify key issues as well as at the individual analysis content areas identified above.

EXHIBIT A-4. Broad Analysis Content Areas
▪ Advantages/strengths of continuity of care structure. ▪ Areas for improvement of continuity of care structure. ▪ Recommendations to other programs. ▪ Contact and communication after discharge. ▪ Integration in organization. ▪ Context (population served, community). ▪ Origin of general approach. ▪ Post-discharge placements. ▪ Preparation for transitions. ▪ Program length. ▪ Program structure and philosophy. ▪ State involvement. ▪ Staffing and caseloads.

APPENDIX B. PROTOCOL TOPICS

I. Team Lead / Program Director & Team Members (excluding prescribers)

A. Respondent background

B. Program context [team lead only]

1. Eligibility for program (DUP, age, diagnosis, exclusionary criteria).
2. Gender.
3. Race.
4. Socioeconomic background.
5. Funding.

C. General approach to transitions

1. General approach.
2. Changes since COVID-19 [team lead only].

D. Program length

1. Guidelines and policies [team lead only].
2. Average time clients are expected to be in the program.
3. Ideal length of time for a CSC program to serve clients if no constraints.
4. Any changes to the program length, limits, or time that clients stay in the program post-COVID.

E. Step-down program [if applicable]

1. Services received (compared to CSC).
2. Ways the step-down program is different from CSC program.
3. Staff members involved with the step-down program.
4. How long clients receive services.
5. Whether clients can step back “up” to the CSC program.
6. Advantages of the step-down: (a) for clients; and (b) for staff members.

F. Integration within provider organization

1. Connection, if any, between CSC program and other programs within organization with respect to continuity of care.
2. Any shared staff members with other programs in the organization.
3. Impact of integration (or, lack of integration) within organization on continuity of care for clients.
4. Ways that CSC program could be better integrated with other programs within organization.

G. Preparation, practices and policies

1. Specific protocols for discharge.
2. When program starts talking about transitions with clients.
3. How post-discharge services are selected.
4. Most effective strategies in preparing clients for transitions.
5. How strategies have changed since COVID-19.

H. Post-discharge placements

1. Where clients most typically receive services after they leave.
2. All places clients receive support.
3. What happens if clients need a higher level of support.
4. Any aspect of transitions that differs for Medicaid vs. privately insured clients.
5. Any state specialized waivers for people with mental health conditions or complex medical needs that also serves the CSC population.
6. Level of communication or coordination with receiving providers.
7. Most effective strategies in working with receiving providers.
8. Whether clients can return to organization or program to receive services after they have left and what services they are eligible to receive.
9. Level of contact with providers once the client has transferred care.
10. Level of contact with clients after they leave the program.
11. Any reports from families, clients or providers about experiences after leaving CSC.
12. Ways that CSC programs can be modified to minimize the problems experienced by individuals who leave a program.

I. Data collection and monitoring

1. What information is documented at the time of discharge.
2. Whether there is collection of any data from clients after discharge.
3. What would need to happen to collect data from clients after discharge.
4. If it was feasible to do so, post-discharge information that would be of interest.

J. Medication management

1. Issues or challenges regarding medication management following discharge.
2. Successes or promising practices seen in medication management following discharge.

K. Conclusion

1. Main strengths of approach to transitions.
2. Aspects of approach to discharge and transition that could be improved.
3. Recommendations to other early psychosis programs.
4. Other comments.

II. Staff Members within Other Programs at Organization (e.g., TAY, ACT, etc.)

A. Respondent background

B. Relationship with CSC program

1. Level of interaction, communication and coordination with staff members from CSC program.
2. Length of relationship.
3. Nature of interaction with clients who are part of CSC program.
4. Effective strategies in working with providers from CSC program.
5. Advantages for clients who are now in new program.
6. Challenges in working with clients from CSC program.
7. Any changes post-COVID.

III. Family Members/Significant Others Involved

A. Respondent background

B. Connection with CSC Program/Alumni program

1. Length of time client attended program.
2. Length of time since he/she graduated or was discharged.
3. Process of transitioning out of the program.
4. Type of contact with program currently.
5. Positives about step-down program/alumni group.
6. Can you think of an example of a situation where participating in the alumni program was especially useful to you?
7. Example of how step-down program/alumni group has been especially useful.
8. Aspects of step-down program/alumni group that could be improved.
9. Any changes since COVID-19.

IV. Former Participants/Participants in Step-Down

A. Respondent background

1. Age.
2. Living arrangements.

B. Experience with step-down/alumni program

1. Length attended CSC program.
2. Length of time since graduation.
3. Process of transitioning out of the program.
4. Type of contact with program currently.
5. Positives about step-down program/alumni group.
6. Example of how step-down program/alumni group has been especially useful.
7. Aspects of step-down program/alumni group that could be improved.
8. Any changes since COVID-19.

V. State Respondents

A. Respondent background

B. State involvement in CSC program

1. State's role or involvement with CSC program.
2. Parameters or rules for how State or Block Grant funds are used by clinics.
3. Frequency of communication with program.
4. Extent of involvement in services and programming related to transitions and discharge planning.
5. State guidelines regarding program length.
6. State guidance about other aspects of the transition process.
7. Any specialized waiver to delivery services to people with mental health conditions or complex medical needs that also serves the CSC population.
8. Impact of COVID-19 on CSC and CSC-related transition age service provision and funding.
9. State-specific questions about programs, if applicable.

APPENDIX C. INDIVIDUAL CASE STUDY REPORTS

Coordinated Specialty Care (CSC) Continuity of Care Case Study Site Visit Report

EPICENTER, Columbus Ohio
August 2020

I. Overview

The Early Psychosis Intervention Center (EPICENTER) program at Ohio State University (OSU) has been in operation since 2015. Services are available to anyone in Ohio who is willing to travel to the site; there are no restrictions based on geographic location. The program serves individuals for up to five years, and during that five-year window, clients can leave and come back, receive as many services as they like, or even no services. EPICENTER also runs a CHR program. A $1.1 million federal grant from SAMHSA funds the CHR program with support from the Franklin County ADAMH Board. There is a conjoint team meeting and the same staff work in both programs, and both programs use the same team-based approach.

We selected EPICENTER for inclusion in the CSC Continuity of Care Study as an example of a program with an extended length (more than two years) approach to services.

II. State Context

In addition to EPICENTER, there are 17 community-based first-episode psychosis programs in the State of Ohio. The state contracts with two vendors for technical assistance to these programs. OSU operates a contract for four programs serving 14 counties in Ohio in addition to the EPICENTER site located at OSU, and the rest of the sites are under the Northeast Ohio Medical University and the BeST Center. The state provides funding for these community-based first-episode programs through the MHBG 10 percent set-aside. The Ohio Department of Mental Health and Addiction Services (OhioMHAS) itself does not have any regulations regarding the array of services provided through the individual programs, or guidelines regarding program length. OhioMHAS does plan to work on a fidelity scale for use with all 17 programs. There is an information system at the state level called First Episode Psychosis Information System, which collects data from each program. Within OhioMHAS, the Chief of Mental Health Treatment Services communicates monthly with all the team leaders, in which OSU and the Best Practices in Schizophrenia Treatment (BeST) Center also participate. The general direction at the state level is towards more collaboration and coordination

across the 17 community-based sites, in particular, where sites would be able to learn more directly from one another.

Ohio is state-governed, but county-led. All 88 counties have behavioral health managed through county-level boards, the ADAMH boards referenced above. A taxpayer levy, which generates approximately $70 million per year, supports the ADAMHs. ADAMH board funds can support non-reimbursable aspects of CSC programs, such as peer support and parent psychoeducation. SAMHSA awarded the state a System of Care grant for transitional age youth, which has brought some consistency to what counties do, but counties can still modify their programs to fit the needs of the county.

III. CSC Implementation

Model: EPICENTER follows its own model, also called EPICENTER. Both SAMHSA and NIMH have recognized EPICENTER as a CSC program. The program includes Cognitive Behavioral Therapy (CBT), family psychoeducation, metacognitive remediation therapy, and medication management. SEE services are outsourced if a client wants to work on those goals, and there has not to date been a dedicated case manager as part of the team, although there is currently an ongoing search for a social worker to provide case management and SEE services within EPICENTER.

Based on the program director's report, EPICENTER is one of the most studied CSC models with regard to longitudinal clinical outcomes outside of the Recovery After an Initial Schizophrenia Episode (RAISE) trials, with five different peer reviewed evaluations of the EPICENTER model of care. These studies have identified positive outcomes over the first six months of care across multiple domains, including mental health symptoms, substance use, suicidality, rates of inpatient hospitalization, and contact with the legal symptoms; increased participation in competitive work and school; and improvements in social functioning, motivation, problem-solving skills, autonomy, and neurocognitive, social cognitive, and metacognitive abilities. EPICENTER has also used their data to highlight cost-effectiveness of the model of care, primarily due to reduced utilization of inpatient hospitalization service and contact with the legal system among EPICENTER participants.

Program size: There are currently 107 clients enrolled in EPICENTER. The program can support 150+ clients with its current structure.

Population and age range served: EPICENTER serves individuals between the ages of 15 and 35. EPICENTER includes people with up to a five-year duration of illness, specifically, five years since their first onset of either hallucinations or delusions. EPICENTER refers individuals with substance-induced psychosis, medically induced psychosis, and intellectual disabilities to other programs. EPICENTER clients are generally 60-70 percent male and match the demographics of central Ohio. As EPICENTER does not receive MHBG 10 percent set-aside funds to support their

operation, EPICENTER clinicians can only serve clients with insurance. The ratio of Medicaid to privately insured is typically 60:40.

Program length: EPICENTER is a five-year program. When clients and families enter EPICENTER, staff tell them that it is a five-year program and they can use as much or as little of that time as they need. While clients have access to five years of treatment, the team typically sees heavy use of program services for 9-18 months, followed by a drop-in service use for about two-thirds of clients, such as using just medication management. The remaining third of clients either do not attend their first appointment or need longer, sustained support, beyond just medication management.

Funding/Medicaid reimbursement mechanism: EPICENTER receives support through a combination of reimbursement through Medicaid and private insurance, and the SAMHSA grant in partnership with the Franklin County ADAMH board for the CHR program as noted above. EPICENTER does not receive MHBG funds, because the program does not meet the state definition of a CMHC. In addition, the reimbursement rates from Medicaid are lower for a client receiving services from EPICENTER than a client receiving the same services at a CMHC. However, in spite of sometimes heavy use of services initially (e.g., therapy up to three times a week), most of the insurance providers and payers have not created any difficulty with reimbursement for EPICENTER services.

Data collection and monitoring: EPICENTER conducts routine outcome monitoring and repeats an assessment battery every six months. The program uses this battery to help with treatment planning, and the clinician sits down with clients after each administration to talk through the results and assess whether there are new goals should we continue.

Measures include:

- Positive and Negative Syndrome Scale (PANSS)--Symptoms
- Clinical Assessment Interview for Negative Symptoms (CAINS)--Negative symptoms
- Psychotic Symptom Rating Scales--Auditory Hallucinations Subscale--Auditory hallucinations
- Columbia Suicide Severity Rating Scale (C-SSRS)--Suicidal ideation and behavior
- World Health Organization Quality of Life Instrument-Brief (WHOQOl-BREF)--Quality of life
- COMPASS--vocational assessment, and their output links with U.S. Department of Labor so clients get a printout of jobs that that fit their expertise and interest, and what jobs would be available at the next level up, use it as a decision point to decide between school and work.
- Performance-based Skills Assessment Brief and Specific Level of Functioning scale (SLOF)--functional capacity
- Social Functional Scale (SFS)--Social functioning
- Alcohol Use Scale/Drug Use Scale (AUS/DUS)--Substance use

- The MATRICS Consensus Cognitive Battery--Cognitive functioning
- Stages of Recovery Instrument (STORI)--Recovery

Integration within organization: EPICENTER is located within the Department of Psychiatry and Behavioral Health at OSU. The Department has a standardized intake packet, which includes a brief psychosis screen they provide to everyone, regardless of the clinic or service they access. If a client endorses even one item on this screener, the clinic or provider electronically forwards the information to EPICENTER for review to see if the individual might benefit from services. Clients who are part of EPICENTER have access to all other services and clinics within the OSU health system, although they typically receive all their mental health services from the EPICENTER team. EPICENTER is located within a large, free-standing adult psychiatric hospital with capacity for 84 adult beds, located on the medical campus of OSU, and receives referrals from this unit, and can also easily facilitate a transfer back into the unit, if necessary. There is a partial hospitalization program (PHP) and intensive outpatient program (IOP) located in the same building as EPICENTER, which some EPICENTER clients have used and while doing so, “take a pause” on therapy through the program. OSU also has a PHP substance use program that some clients have used. In addition, EPICENTER works closely with two campus counseling centers, one which is the university counseling service and the other which is the training clinic for clinical psychology graduate students.

EXHIBIT OH-1. CSC Team Staff

Name		Position Name	Degrees/ Licensure	Length of Time at the Organization	% Time Working on the CSC Team
1.	Nick Breitborde	Team Leader	PhD	5 years	30
2.	Aubrey Moe	Therapist	PhD	5 years	10
3.	Heather Wastler	Therapist	PhD	11 months	5
4.	Ian McKay	Therapist	MS	1 month	20
5.	Claire Speelman	Therapist	MA	1 month	20
6.	Kaley Angers	Therapist	MA	1 year	20
7.	Briana Brownlow	Therapist	MA	1 year	20
8.	Annelise Madison	Therapist	MA	1 month	40
9.	Hossam Guirgis	Prescriber	MD	4 years, 2 months	10
10.	Sarah Hamilton	Prescriber	MD	2 months	20
11.	Craig Parris	Prescriber	APRN	1 year, 2 months	10
12.	Walter Stearns	Prescriber	MD	3 years, 2 months	10
13.	Patricia Arnold	Prescriber	MD	1 month	10
14.	Ben Foreman	Prescriber	MD	1 month	10
15.	Taylor Hendricks-Johnson	Prescriber	MD	1 month	10
16.	M. Usama Hindeyeh	Prescriber	MD	1 month	10
17.	Zak Kelm	Prescriber	MD	1 month	10
18.	Natalie Klag	Prescriber	MD	1 month	10
19.	Nadav Klein	Prescriber	MD	1 month	10
20.	Tim Kocher	Prescriber	MD	1 month	10
21.	Leslie Pillow	Prescriber	MD	1 month	10
22.	Evita Singh	Prescriber	MD	1 month	10
23.	James Xidas	Prescriber	MD	1 month	10
24.	Kristen Howard	Assessor	MA	1 year, 1 month	20
25.	Nichole Storey	Coordinator	BA	3 years, 1 month	15
26.	Angela Hughes	Coordinator	BA	2 months	75

Site staff roles and background: In addition to the staff identified in Exhibit OH-1, four new prescribers at 20 percent, a new therapist at 100 percent and a new therapist at 40 percent time were slated to start at EPICENTER shortly after the site visit took place.

EXHIBIT OH-2. List of Respondents Interviewed		
Name	**Position**	**Organization or Affiliation**
Nicholas Breitborde	Team leader, EPICENTER	Ohio State University
Aubrey Moe	Therapist, EPICENTER	Ohio State University
Heather Wastler	Therapist, EPICENTER	Ohio State University
Hossam Guirgis	Prescriber, EPICENTER	Ohio State University
Walter Stearns	Prescriber, EPICENTER	Ohio State University
Luan Phan	Professor and Chair, Department of Psychiatry and Behavioral Health	Ohio State University
Kristen Carpenter	Director of Ambulatory Services, Department of Psychiatry and Behavioral Health	Ohio State University
Vicki Montesano	Chief, Mental Health Treatment Services	Ohio Department of Mental Health and Addiction Services
Kythryn Carr Harris	Vice President of Clinical Services	ADAMH Board of Franklin County
Tammy Stage	FEP Program Director	Hopewell Health Centers

IV. Site Visit Respondents

For this case study, we included interviews with a representative from the state, county ADAMH board, another community mental health (CMH) organization, and OSU Department of Psychiatry and Behavioral Health faculty in addition to selected members of the EPICENTER team.

V. Featured Program Aspect Description

We are a 5-year program. You can use as much or as little as that time as you need. But what you have is a window, to be with us here, and to utilize our services during that time here. We anticipate that your needs and interests are going to change over time, and our goal is to be flexible, and make sure you're able to get what you need during that 5-year window. Even to the point that you may leave our program, at some point here, and then decide you want to come back. If you want to come back, all that it requires is just giving us a call, and we'll jump back into services, and by that, I mean, our menu of services becomes available to you here. And we'll, work with you on, collaboratively crafting whatever the appropriate, care plan is that you want to participate in.

--EPICENTER Director

Recovery is a journey and I think it's pretty challenging to say this journey is only going to be 2 years. This approach gives people more opportunities for growth and also it gives us this opportunity to really track people's changes over time. It just gives us more time to work on those recovery goals and shape the treatment or just switch gears if we need to. We're not as limited to just stabilizing psychotic symptoms. We can help with a wide range of things.

--EPICENTER Team member

Summary

- EPICENTER is an early intervention program that provides a menu of services for up to five years. During this time, clients can receive as much or as little as they like, and they can also discontinue receiving services and easily re-engage with services. The EPICENTER site at OSU was the first of the EPICENTER programs established in Ohio.
- The EPICENTER team has provided training and support for the model in four CMHCs serving 14 counties in Ohio. Each of these four community-based programs receive MHBG funds.
- The intensity of services in the OSU EPICENTER program is generally higher in the first 18-24 months of treatment and then often involves less frequent contact with clinicians and prescribers. The degree to which this tapering occurs is individualized to the client.

Rationale/History for Program or Practice

- Dr. Breitborde initiated an early intervention program at the University of Arizona in 2010, which he originally intended to be two years in length. During this same period, data from the OPUS study suggested that a longer length of treatment may be important to sustain gains that are achieved through treatment. Prior to any clients even reaching the two-year mark, the Arizona EPICENTER program shifted to a five-year approach. The EPICENTER program at Arizona continues to operate in this way.
- OSU recruited Dr. Breitborde in 2015 and initiated the EPICENTER program at OSU following this same model.

Funding

- In addition to the funding sources identified above, the Department of Psychiatry and Behavioral Health has used discretionary funds to support individual pilot projects within EPICENTER that are clinically relevant and research-based. An example of this is a study examining suicidality among clients who have attended EPICENTER over the years.
- The department sometimes also uses philanthropic dollars to support the salary of EPICENTER staff, trainees and faculty, as well as to support the ongoing search for a social work to provide case management and SEE.

Preparation, Practices and Policies

- As the team starts to feel that the same level of service is no longer clinically indicated, the therapist will talk with the client to get their perspective on whether the individual feels the same way. Staff emphasized shared decision-making in this process.
- If a transition occurs to a provider outside the EPICENTER team, clinicians always "bridge care" and continue to meet with clients until the intake session with the new provider.
- EPICENTER does not have strict discharge policies that require discharge after a certain amount of time. EPICENTER allows clients to receive services from providers outside OSU, for example, if someone wants to retain their psychiatrist who is based in the community.

Post-Discharge Placements

- The majority of EPICENTER discharges have not been planned, they are individuals who were connected with the program and are no longer active and are not in contact with EPICENTER.
- Among planned discharges, the majority are still connected with outpatient services at OSU, including through a psychosis clinical program, which provides just medication management. Prescribers in that program have access to past treatment through the electronic health records, and may contact the EPICENTER clinical team directly.
- Some discharges have occurred because either the client or the team feel that there is benefit to a different type of treatment, such as for eating disorders, inpatient substance abuse treatment, or a formal, structured DBT program.
- OSU does not have an ACT team. In a few instances, EPICENTER has referred a client to a CMH provider with an ACT team, but if a client needs a higher level of service, EPICENTER will refer to the OSU PHP and IOP programs.

Perceived Advantages: What Does This Allow?

- The flexibility of program length is consistent with the clinical heterogeneity of the population served. Someone may need only six months, and someone may need five years; the program can accommodate both with the current structure. As noted by one respondent:

  > *If you get better in that time and don't need treatment, go live your life. That's what we want you to be doing. If something happens, just call. We'll reconnect. We'll start working again and we can just pick up where we left off, instead of having to establish a new relationship, we already know each other. We can just pick right back up.*

- The extended length approach recognizes the "immensely critical" developmental issues (e.g., graduation from high school, entry into college or the workforce) that occur for a person aged 16, 17 or 18. A five-year relationship with the client and family allows support through this sensitive time.

- When clinicians describe the program as up to five years to clients and families, it provides more reassurance than being told, “we’re a two-year program and after that we can probably make it work.” Removing uncertainty helps build the relationship with the client and family. Providing this information also reduces clients’ anxiety.
- Transitions are especially difficult for people experiencing symptoms of psychosis, so decreasing the number of times clients have to go through transitions is beneficial and keeps people from falling through the cracks. Clients do not have to repeat their story repeatedly.
- Team members can be more effective and their job is easier because they can provide treatment without clinic or organization policy with regard to duration of care having an influence. Team members experience less burnout because in this model, they are allowed to “provide the care that they were trained to provide,” without being “hamstrung” in some way.
- Prescribers on the EPICENTER team are more comfortable and may more quickly use Clozapine than providers in the community, and sending clients to community providers could therefore destabilize their medication regimen.
- Having the program established as five years avoids administrative and bureaucratic questions about length of stay and why clients are not discharged sooner.

Challenges

- There are two primary challenges of the five-year model that staff cited: First, it is not always possible to predict when a clinician will have an opening on his or her caseload, and that makes it a constant balancing act in order to accommodate new clients. There have been times when EPICENTER was unable to with a potential client immediately and referred them to the nearby CMHC that is also using the EPICENTER model, but having an “overflow” clinic might not be an option in many places. Second, the level of resources and staff to sustain a program this size is considerable, and the program relies on the flow of trainees coming through OSU.
- Because the program uses practicum students and residents to help meet staffing challenges, clients can experience a change in clinicians more frequently. However, the client would still have the familiarity of the clinic and receive services in-house rather than a completely new clinic.

Lessons Learned: Recommendations for Other Programs

- Find a champion of the model.
- Get a good feel for the reimbursement structure to make sure that a five-year model is financially feasible, since money drives the availability of the service in many CMHCs.
- Be prepared to build the staffing of your team over time in order to keep up with demand. This may be easier to do in an academic medical setting than in a CMH setting.

- To persuade higher levels of administration that a longer model is more appropriate, draw on the data from OPUS and other studies as a rationale.
- While not an issue in EPICENTER, programs need to communicate clearly that a five-year model does not mean that a client should slow down their recovery or take the full five years if they are ready and able to leave sooner.
- Start the model as a pilot by getting staff in place, getting the right training and seeking advice from those who have done it before on what are the challenges of implementation. Learn from the experience of others and "get ahead of those things."
- For a community-based organization, form a partnership with an academic center that can engage in a sustained relationship.
- One suggestion, which does not yet exist at EPICENTER, is to offer a hybrid period of care where EPICENTER and community prescribers and clinicians are providing services intermittently to wean clients off EPICENTER services and more securely transfer their care to the community, if that is needed.

Other Highlights

- The five-year model necessitates a larger team to handle the large census. As a result of having a high number of clinicians, EPICENTER operates as a small community of providers and has been able to serve as a support for one another as well as the support they provide to other programs and CMH providers.

Coordinated Specialty Care (CSC) Continuity of Care Case Study Site Visit Report

EPIC-NOLA, New Orleans, Louisiana
July 2020

I. Overview

The Early Psychosis Intervention Clinic-New Orleans (EPIC-NOLA) is a CSC program located in New Orleans, Louisiana and affiliated with Tulane University Department of Psychiatry and Behavioral Sciences. The program officially started in August 2015, initiated by Ashley Weiss, DO, MPH. Within the first ten months, the team was seeing over 20 patients, and mid-2016, with the MHBG Set-Aside funding increased to 10 percent for programs targeting first-episode psychosis, Dr. Weiss was able to secure funding for expanding EPIC-NOLA. This allowed the addition of a peer support specialist and another clinician to the team, and in addition, subsidization of the non-billable services associated with providing CSC services such as treatment team meeting and case management. When the CMH organization housing EPIC-NOLA appeared to be experiencing financial struggles, Dr. Weiss lobbied to bring the program under the administration of Tulane University Medical Group and the Department of Psychiatry, where she is faculty. The entire team transitioned to become Tulane staff or faculty.

While affiliated with Tulane, EPIC-NOLA is 3½ miles away from the campus, therefore it maintains a community-oriented atmosphere while being able to educate Tulane medical students, psychiatry residents and child and adolescent psychiatry fellows. EPIC-NOLA continues to have a contract with the State of Louisiana Office of Behavioral Health (OBH), which is managed by the Tulane Department of Psychiatry and Dr. Weiss.

We selected EPIC-NOLA for inclusion in the CSC Continuity of Care Study as an example of a program that does not have an explicit time limit for services provided to clients.

II. State Context

Louisiana's behavioral health is organized through ten Local Government Entities (LGEs), referred to as Human Services Districts or Human Services Authorities. This arrangement means that most funding comes through the legislature and the state has relatively little control over local programs for first-episode psychosis. MHBG funds pass through the OBH, and the office does have agreements with LGEs with respect to use of funds, but the contracts are for relatively small amounts of money. For example, in fiscal year 2018, the state provided MHBG funds to four LGEs, and two of these received just $21,000 each. The OBH has hosted trainings on first-episode psychosis and recently, on Social Cognition and Interaction Training (SCIT). The OBH Early

Serious Mental Illness (ESMI)/FEP Coordinator also holds monthly meetings with LGEs (which Dr. Weiss attends) and provides encouragement to LGEs to grow their programs. Currently, there are FEP programs in some state of development in four LGEs: Capital Area Human Services District, Florida Parishes Human Services Authority, Jefferson Parish Human Services Authority, and Metropolitan Human Services District, which is where EPIC-NOLA is located.

III. CSC Implementation

Model: EPIC-NOLA does not subscribe to a single specific model. A main focus of the program is providing an individualized psychotherapy approach, for instance what may start as CBT for psychosis could evolve into Eye Movement Desensitization and Reprocessing should trauma be identified as a driving force for psychosis perpetuation or exacerbation. The program has specific interest in narrative and meaning making, and the integration of CBT and psychodynamic approaches. The program started with initial training from Specialized Treatment Early in Psychosis (STEP), a CSC program located at Yale University. EPIC-NOLA also follows components of other programs, for example drawing from the family psychoeducation and prescriber aspects of NAVIGATE, and through videos from OnTrack. All team members are trained in SCIT, and in provision of the Structured Interview of Psychosis-risk Syndromes (SIPS). EPIC-NOLA adheres to the First Episode Psychosis Fidelity Scale, developed by Dr. Donald Addington, to ensure fidelity to FEP care, and this was most recently assessed with Dr. Addington in Fall 2019.

Program size: There are currently 156 clients enrolled in the program and there is no maximum program size.

Population and age range served: EPIC-NOLA officially serves individuals between 12 and 35, however they will provide consultation and potentially treatment for those outside of that range (for example, older clients with onset of delusional disorder). Clients are accepted with a DUP of up to three years. Clients are drawn from the Greater New Orleans area, and are 73 percent African American, a demographic that is similar to that of the City. The median age of clients is 22. Getting referrals has never been a challenge for the program; on average, the program receives about 12-15 referrals per month, and there was an increase to 24 referrals in May. Around 65 percent of referrals come from the inpatient psychiatric setting, with the rest coming from outpatient mental health settings, schools, and from individuals themselves. Mental health resources are scarce in New Orleans, therefore, EPIC-NOLA aims to minimize barriers to care by using simple eligibility criteria, and providing consultation with the referral if eligibility is not clear.

Program length: EPIC-NOLA has no maximum program length. Clients are considered part of the program as long as they are receiving any level of service from a team member. The Medical Director estimated that the typical length of treatment in the

program is 2½ years; there are some clients who have been with the program since its inception.

Funding/Medicaid reimbursement mechanism: EPIC-NOLA is funded through multiple sources. The client population is about 70 percent Medicaid funded, 30 percent commercial insurance. The MHBG subsidizes all team members' salaries to cover non-billable services, such as weekly treatment team meetings, daily 'huddles' to review acute issues, case management, and clinical supervision. The MHBG support also fully funds the nurse position and the intake coordinator. This support from MHBG funds has helped the program grow and meet the needs of clients who require a longer length of service. In addition, EPIC-NOLA has a grant to fund their outreach program, *Clear Answers to Louisiana Mental Health*, which aims to educate the public about psychosis, promote early detection and therefore early referral EPIC-NOLA.

The general strategy for program growth and funding is to grow incrementally so the program can be sustainable. Managed care in Louisiana has been outsourced to five private insurance companies that have individual variation. There are occasional times when an individual discussion is needed if an insurance company (whether Medicaid or private) feels that a client has had too many behavioral health visits, but the Medical Director did not identify this as a major problem. If a client is uninsured, the program will work with them and try to get them connected with Medicaid as soon as possible. One "tricky" aspect of funding for EPIC-NOLA is that team members with terminal degrees are considered faculty at Tulane, and for those individuals, there are more responsibilities for billing.

Data collection and monitoring: At entry into the program, EPIC-NOLA collects the SIPS, Pathways to Care, PANSS, and other referral characteristics such as demographics and time from referral to intake. At quarterly intervals, individual level data is collected surrounding diagnoses, service engagement and resource utilization, including number and type of visits, emergency room visits, inpatient visits, medication adherence, incarceration, danger of homelessness, and participation in work, school, volunteering. Every six months the PANSS, Service Engagement Scale, Recovery Assessment Scale are completed, along with clinical outcomes such as rate of re-hospitalization.

Integration within organization: Clients attending EPIC-NOLA have no direct contact with other staff from Tulane as part of the program (i.e., there is no direct integration of EPIC-NOLA with any clinic or aspect of Tulane). However, faculty and staff have collegial relationships with other Tulane faculty and staff in mental health, therefore, are able to provide coordination of care with ease (i.e., when an EPIC-NOLA patient is in need of hospitalization, EPIC-NOLA team members coordinate with other Tulane members working on inpatient units). Currently, under COVID-19 conditions, clients are receiving their long-acting injectables (LAIs) through a community pharmacy that is partnering with EPIC-NOLA to provide this service.

Site staff roles and background: Dr. Weiss serves as Medical Director and provides overall guidance to program implementation and development. The team divides management between two key staff, Serena Chaudry and Michael Dyer, both of whom have been with the program since its inception. Of note, roles among EPIC-NOLA team members are not rigidly defined. The clinical therapist serves as the "primary clinician" and main point of contact for clients in the EPIC-NOLA program. They have caseloads consisting of clients they are working with on an individual basis, as well as families they may be working with. They alternate running rounds of group therapy, and liaison with clients' schools and workplaces as the need arises, as well as identify opportunities in the community to further school and vocational goals. All physicians who provide medication management also identify as providing psychotherapy and family education and support, and case management if needed. The Medical Director may participate in an IEP meeting, one resident runs a music group for clients, and another runs a meditation group. Similarly, EPIC-NOLA has a full-time nurse who assists the physicians and conducts assessments, but on days when they are not in the clinic, she works with families to address questions about medication or the course of treatment, helps to facilitate referrals, coordinates with inpatient units if/when EPIC-NOLA patients are hospitalized, and other case management activities. Prior to COVID-19, she managed the long-acting injection clinic; since COVID-19, a pharmacy is handling this, so her role is to coordinate with the nurse at that clinic for EPIC-NOLA clients.

To address the growing caseload among the primary clinicians, the program is in the process of hiring a clinical therapist. The program is also in the process of hiring two part-time Peer Support positions to fill a position that has been vacant since December 2019. Lastly, at the time of our site visit, the program was increasing from two psychiatry trainees (a total of 0.4 FTE) to four trainees (a total of 0.6 FTE).

EXHIBIT LA-1. CSC Team Staff

Name		Position Name	Degrees/ Licensure	Length of Time at the Program	% Time Working on CSC
1.	Ashley Weiss	Medical Director / Attending Psychiatrist	DO, MPH	4 years, 10 months	50-60
2.	Serena Chaudhry	Clinical Director / Clinical Therapist	DSW, LCSW	4 years, 10 months	80
3.	Michael Dyer	Program Manager / Clinical Therapist	LPC	4 years, 10 months	100
4.	James Douglas Headrick	Clinical Therapist	LPC	3 years	100
5.	Grinasha Dillon	Community and Clinical Engagement Specialist		3 years, 10 months	100
6.	Akanksha Thakur	Attending Psychiatrist	MD	1 year	20
7.	Nicole Smith	Nurse	RN	1 year	100
8.	Nithya Ravindan	Child and Adolescent Fellow	DO	2 years	20
9.	Steven Stein	Senior Psychiatry Resident	MD	1 year	
10.	Brandon Nelson	Wellness Coach	BS	1 year	38

IV. Site Visit Respondents

For this case study, we focused our interviews on the EPIC-NOLA team, a state representative, and one client and one parent selected by the program.

EXHIBIT LA-2. List of Respondents Interviewed	
Position	**Organization or Affiliation**
Medical Director, EPIC-NOLA	EPIC-NOLA / Tulane
Clinical Director, EPIC-NOLA	EPIC-NOLA / Tulane
Program Manager, EPIC-NOLA	EPIC-NOLA / Tulane
Attending Psychiatrist, EPIC-NOLA	EPIC-NOLA / Tulane
Clinical Therapist, EPIC-NOLA	EPIC-NOLA / Tulane
Nurse, EPIC-NOLA	EPIC-NOLA / Tulane
Community and Clinical Engagement Specialist, EPIC-NOLA	EPIC-NOLA / Tulane
ESMI / FEP Coordinator	Louisiana Department of Health, Office of Behavioral Health
Program Manager II	Louisiana Department of Health, Office of Behavioral Health
Client, continuing services that pre-date EPIC-NOLA	N/A
Parent, son is in 3rd year of services with EPIC-NOLA	N/A

V. Featured Program Aspect Description

Our model gives us the flexibility to use an array of tools from a psychotherapeutic standpoint. We can delve to into solution-focused therapy while they're searching for jobs, use dialectical behavioral strategies and mindfulness when struggling with emotional regulation, all in the context of someone first experiencing psychosis. This allows us a real-time approach so we don't have to worry about cramming everything in during a specified time frame. We can address things as they happen in life for the young person, and that becomes meaningful for the client because we're actually working on their life rather than just a set of symptoms.

--EPIC-NOLA Team Member

Summary

- EPIC-NOLA does not discuss length of treatment at entry into the program. The clinical approach is to provide services to a client until they choose not to seek services from the clinic, or until the team feels that the services provided are not appropriate. In that sense the program does not have a defined timeframe for services; services are provided as long as needed by the patients.
- The intensity of services may vary over time, and will most likely decrease in frequency. There is no predefined time at which this will occur, and the frequency may once again increase to meet the client's needs.

Rationale/History for Program or Practice

- Dr. Weiss purposefully initiated EPIC-NOLA with an undefined program length. This is consistent with the program goal to provide good clinical care in an organic and evidence-based way that allows the clinician to follow the lead of the client. Placing emphasis on therapeutic alliance and continuity of care were guiding principles to establishment of this program.
- Dr. Weiss founded the program following her psychiatry residency and child and adolescent psychiatry fellowship at Tulane University, after working with a patient with first-episode psychosis (FEP). She began a long-term mentorship with Dr. Vinod Srihari, from the STEP clinic at Yale University. The EPIC-NOLA is based on consultation with Dr. Srihari and examination of international and national research on early psychosis intervention.
- Key team members incorporate a psychodynamic orientation into their clinical work, and place primary emphasis on establishing a strong relationship with the client.
- The context of New Orleans is also relevant to this approach. Many agencies in the City are "in-and-out," where the approach is more to put out fires. These experiences create a negative expectation of treatment for clients.
- Especially among the African American community, there is a combination of high stigma about mental health and high levels of trauma, creating a dynamic in which clients and families who are already hypervigilant and distrusting of established systems. Engagement with many clients and families is therefore a challenge from the beginning of treatment. Clinicians expressed concern that setting a time limit at the start of treatment would significantly disrupt the process of engagement.

Funding

- There is no difference in funding based on the length of treatment that a client receives; as noted, about 70 percent of clients are Medicaid funded and 30 percent have commercial insurance. Funding for the extended length is the same as funding in general.
- Medicaid covers ACT services but commercial insurance does not, which is a consideration in transitioning to that program (where needed). Some clients come off their parents' insurance and onto Medicaid because Medicaid offers more flexibility.

Preparation, Practices and Policies

- As noted, the most common trajectory is for someone to continue services through EPIC-NOLA, although with varying intensity of services.
- Among services, psychiatry is usually titrated first, going from weekly sessions or biweekly sessions to monthly sessions; clients would not go for more than three months without seeing a psychiatrist.

- Individual therapy starts weekly, except for people who may be in acute stage of a crisis and may not begin with individual therapy until they are stabilized. Weekly sessions would change to biweekly and then to once a month or as needed, based on the client's clinical need and interest.

Post-Discharge Placements

- For most clients, post-discharge placements do not apply to this program, given that clients can continue to receive services through the EPIC-NOLA team.
- Approximately one client per month transitions to a higher level of care, or a different type of care, most frequently, to one of two ACT teams located within mental health agencies in New Orleans. Others have been discharged to substance use treatment programs.

Perceived Advantages: What Does This Allow?

- At the time of entry into the program, clients are often in crisis or coming out of crisis. The priority at that time is to establish rapport; clinicians feel that talking simultaneously about an end point would be counterproductive.
- Clinicians do not feel rushed to push ahead with treatment that is not in sync with the client's pace. Clinicians meet the client at their point of need, which if done effectively, will lead to greater trust. Clients do not feel pressure to perform or to meet certain milestones; care is more client-centered.
- Not having a rigid time structure helps clients and families feel that the program is different than hospitalization and other clinics.
- Families feel comfort from knowing that their children's care will not change.
- When clients know that they can come and go with services according to their own needs, they feel a greater sense of self-determination.
- Having a longer relationship allows clinicians to recognize subtle changes and intervene early to prevent a client from worsening. Team members can more readily discern between someone experiencing symptoms vs. their personality or when they are having a bad day.
- Since the client remains with the same clinician, there are no problems or set-backs caused by a rupture in the relationship.
- Underlying trauma issues are difficult to address early in treatment, and having more time allows those issues to surface at a more natural time. True psychotherapy is only possible after someone has stabilized, is asymptomatic, and trusts the clinician.
- In New Orleans, there are limited services for individuals who have experienced a FEP. If a transition were required, there would be very few community-based providers and agencies that could assure continuity of high-quality care.

Challenges

- Clinicians have larger caseloads than ideal since there is no maximum program size, and there is a lag in hiring and training new staff.

- A long-term relationship can lead team members to lose their “fresh eyes,” and being so familiar with a person might lead to something being overlooked.

Lessons Learned: Recommendations for Other Programs

- Identify a champion within the organization who will advocate for the program and the approach.
- Start small and grow the program staff in proportion to the need. Do not try to start a program with six to eight staff from the beginning.
- Nurture relationships with community partners in order to strengthen care over time, including with hospitals, who can then serve as a safety net over time.

Other Highlights

- EPIC-NOLA team members did six trainings throughout the state on FEP. One CMH organization is working with EPIC-NOLA to help them establish their own FEP program. This involves consultation, visits, and interaction between the two teams, including through a regular book club where the teams discuss a book of relevance as well as cases. This is currently considered a pilot program and if it continues to go well, the state will provide funding (presumably through the MHBG) to cover non-billable time. This organization has more rigid time frames for services and rules around discharge, so it is unclear how long their program length will ultimately be.
- Team members describe a particularly high level of coordination, with daily staff meetings (“huddles”) and a longer meeting every Monday afternoon. Team members note that their continual contact means not only are they aware of everything going on with clients, but it allows them to take care of each other and support one another if needed.

Coordinated Specialty Care (CSC) Continuity of Care Case Study Site Visit Report

PEACE, Philadelphia, Pennsylvania
September 2020

I. Overview

Psychosis Education, Assessment, Care and Empowerment (PEACE) is a CSC program that started in January 2015. It is located within an adult-focused community organization called Horizon House that started in 1952, and which provides an array of behavioral health services, services for individuals with intellectual and developmental disabilities, and services for people experiencing homelessness. In November 2019, PEACE initiated a pilot step-down program with ten PEACE clients, called "Step Up." One of the first ten clients in Step Up came up with the name as one that is more positive than "Step-down." The goal of Step Up is to bridge the gap between services received during PEACE and those that clients will receive through community-based providers once they leave the program.

We selected PEACE for inclusion in the CSC Continuity of Care Study as an example of a step-down program.

II. State Context

There are currently nine first-episode programs operating in Pennsylvania, and five more that the Department of Human Services Office of Mental Health and Substance Abuse Services (OMHSAS) just funded. OMHSAS supports these programs through a combination of MHBG dollars as well as other state sources of funding. In general, OMHSAS asks programs to bill insurance for whatever they can and use grant funds to cover SEE, peer support, outreach, and team time that is not billable. The state is involved in the selection and launch of new program, specifies how programs can use funds, but does not impose restrictions or guidelines regarding program length.

OMHSAS contracts with the University of Pennsylvania to operate PEIC (now known as Heads Up), to provide program evaluation, fidelity monitoring, in-person annual training, and opportunities for additional training for the Pennsylvania FEP sites. As an example of annual training, PEIC has developed training in program implementation and Recovery Oriented Cognitive Therapy using trainers from the University of Pennsylvania and The Beck Institute. PEIC also provides consultation for providers in counties that do not have an FEP program and has a special focus on providing services to rural providers through telehealth.

In 2019, all FEP programs in existence for at least two years had the opportunity to apply for additional funding to support step-down services. The motivation behind this initiative is that the state has made a large investment in FEP services and heard

repeatedly from sites, especially PEACE, that clients faced challenges in continuing their care following the CSC period. OMHSAS suggested that programs use funding to have more therapy positions to allow flexibility in caseloads, but did not prescribe a particular approach or model of stepped care and what would constitute different steps. As noted above, one of the activities of PEIC is program evaluation, and all programs funded with MHBG funds provide data through REDCap. PEIC established a core assessment battery in January 2017, and is currently conducting a statewide evaluation of FEP programs that also includes the step-down aspect. Sites continue to collect the same data on clients in the step-down program as during the core CSC program. No data are collected on clients who complete the CSC program (i.e., do not prematurely discharge) and do not enter the step-down program. PEIC will complete an initial report during the fall of 2020.

III. CSC Implementation

Model: PEACE is a CSC model with a primary therapeutic modality of recovery-oriented trauma therapy. Services include all the standard components of CSC (i.e., psychotherapy, case management, medication management, supported employment, and family psychoeducation). Drawing from the PIER model, the PEACE team includes an occupational therapist (OT) who, until taking over the Step Up program, played a large role in the general model of PEACE through functional and cognitive intervention and support. In particular, the OT helps the other therapists identify whether any sensory issues that may need an intervention, or whether a cognitive assessment may help clarify and support employment and education specialists.

PEACE offers a variety of groups that individuals in both the CSC and Step Up programs can attend. Examples include a creative writing group, a girl's group that is focused on female empowerment, an anime group, an OT group where the topics change weekly (e.g., healthy eating, exercise etc.), and a sexual health identity and empowerment group. Examples of past groups include a chess club, a group that recorded an album, and a group that started an Etsy page where they make and sell their jewelry online. PEACE also has a monthly family psychoeducation group.

Program size: At the time of the site visit, PEACE had 115 clients enrolled, with a maximum program size of 125. The program is currently seeking support from Community Behavioral Health (CBH; the non-profit corporation contracted by the City of Philadelphia to provide mental health and substance abuse services for Philadelphia County Medicaid recipients), in order to expand to serve up to 200 clients.

Population and age range served: PEACE serves ages 15-30 years old, with most people falling between 18-21 years. Inclusion criteria are a DUP of 18 months or less, and the program only excludes for an IQ of less than 70 or an autism diagnosis; both affective and non-affective psychosis is included. The program only serves Medicaid clients, and the census consists primarily of African American males.

Program length: PEACE began its program as a two-year model. Over time, and with recognition that many clients need a longer period of care, the average length of stay is now approximately 2½ years, and is based on client needs. No formal process needs to occur for a client to stay longer than two years. Multiple team members reported that an individualized program length, even as long as 5-6 years, would be more helpful. One team member felt this was especially important for clients who enter the program at a younger age, such as at 15-16 years old.

Funding/Medicaid reimbursement mechanism: The state funds PEACE, and for the past year, OMHSAS is using a 1915(B) Medicaid waiver to reimburse at a case rate. Given this, PEACE has not encountered any funding challenges for the main CSC program.

Data collection and monitoring: PEACE collects a range of assessment measures, and is part of an ongoing evaluation PEIC is conducting across CSC programs in Pennsylvania. The team collects data every six months. These measures include:

- Cornblatt Role and Social Global Function--Role and social functioning
- Brief Psychiatric Rating Scale (BPRS)
- Extrapyramidal Symptom Rating Scale (ESRS)--Medication side effects
- Medical Monitoring Form
- PTSD Symptom Scale (PSS)--Post-traumatic stress symptoms
- Lehman Quality of Life Functional Assessment (LQOL)--Quality of life
- Questionnaire about the Process of Recovery (QPR)--Perception of recovery
- Systematic Clinical Outcome Routine Evaluation (SCORE-15)
- Mental Health Statistics Improvement Program Youth Services Survey (YSS)--Satisfaction with services
- Glasgow Antipsychotic Side-effect Scale (GASS)
- Beck Collection (BC)--Anxiety and depression
- Step Transition--A state-level form to document transitions

For Step Up specifically, the same measures from PEACE are continued and the OT uses the Occupational Profile at baseline to look at past and current roles, routines, and habits. In addition, she uses the following three measures at baseline and then every six months:

- Canadian Occupational Performance Measure (COPM): A semi-structured tool that looks at self-care, occupation, and leisure and has them rate their performance and their satisfaction with that area.
- Occupation Self-Assessment, short form: Looks at motivation, habits, roles, and routines. There are 21 items rated on self-perceived competence and value.
- Daily Living Activities Scale (DLA-20): Standard tool that captures clinician's perception of how the clients' illness affects daily living areas.

Integration within organization: Horizon House employs approximately 2,200 staff and has a large number of programs. These include two ACT programs, a case management program, a mobile psychiatric rehabilitation program, residential programs for people who need a community residential rehabilitation level of care, an outpatient

program with medication management, and a residential drug and alcohol facility. At times, PEACE clients have transitioned into both the ACT and day treatment program. All other programs offered by Horizon House would be a duplication of services provided by PEACE/Step Up, so clients would only interact with other programs after leaving PEACE or Step Up.

Site staff roles and background: The PEACE program operates with a program director, team leader, two prescribers, an OT, five therapists, a case manager, a SEE specialist, and a nurse. With the exception of one of the prescribers, all the members are 100 percent time dedicated to the program.

EXHIBIT PA-1. CSC Team Staff

	Name	Position Name	Degrees/ Licensure	Length of Time at the Organization	% Time Working on the CSC
1.	Ruth Marie Wenzel	Program Director	MSW / LSW	3 years, 7 months	100
2.	Guesthia Jacques	Team Leader	MSW	1 years, 4 months	100
3.	Andrea Bowen	Prescriber	MD	3 years	100
4.	Jasmine Sawhne	Prescriber	MD	2 years	33
5.	Nuriya Neumann	OT	OT	2 years, 5 months	100
6.	Ashley Park	Therapist	MSW / LCSW	2 years, 11 months	100
7.	Nina Koch	Therapist	MSW / LSW	10 months	100
8.	Robert Tynan III	Therapist	MSW / LSW	3 years, 7 months	100
9.	Ben Goldstein	Therapist	MSW / LSW	1 years, 6 months	100
10.	Anne Agre	Therapist	MSW / LSW	10 months	100
11.	Monica Williams	Care Manager	BA	7 years	100
12.	Valerie Walter	SEE Specialist	MEd	2 years, 4 months	100
13.	Candace Harrell	Nurse	RN	1 year, 2 months	100

IV. Site Visit Respondents

EXHIBIT PA-2. List of Respondents Interviewed

Name	Position	Organization or Affiliation
Marie Wenzel	Program Director	PEACE
Guesthia Jacques	Team Lead	PEACE
Ashley Park	Therapist	PEACE
Nuriya Neumann	OT	PEACE / Step Up
Elizabeth Thomas	Assistant Professor	Temple University
Christine Stutman	Regional Director of Behavioral Health	Horizon House
Marcia	Current client in Step Up	
Jill Stemple	Section Chief of Planning	OMHSAS
Kayla Sheffer	Human Services Program Specialist	OMHSAS
Laurie Madera	Human Services Program Specialist	OMHSAS
Christian Kohler	Associate Professor; Co-Investigator of PEIC; Director of Penn Psychosis Evaluation and Recovery Center	University of Pennsylvania
Monica Calkins	Associate Professor; Co-Investigator of PEIC; Associate Director of Penn Psychosis Evaluation and Recovery Center	University of Pennsylvania
Megan Westfall	Data Analyst	University of Pennsylvania

For this site visit, we interviewed representatives from the state, two different evaluation teams, and one current client in the Step Up program in addition to members of the PEACE and Step Up teams.

V. Featured Program Aspect Description

> *Step Up is a transition period between the full wraparound intense treatment team, and the harder-to-navigate system of community mental health services. It's not just a warm handoff from 1 provider to another provider, but literally, the OT will take people to several different outpatient providers in their neighborhoods or where they think they would like to go and they'll go explore and see them. We're also trying to build partnerships with these outpatient providers, where we can find some folks that we can kind of build a relationship with that we can say, 'These are the folks that we're bringing to you, these are their unique needs, this is what we know about them, this is what activates them.' So, instead of a warm handoff of being a couple of exchanges in a few visits, it's using these 2 years to really get somebody fully ready and prepared and to engage in the community, both in work and employment or work in school, but also with their treatment. It is the warmest handoff you could ever have to a community-based system.*
>
> *--Program Director, PEACE*

Summary

- The Step Up program is a two-year pilot project that OMHSAS funds. Clients can choose to transition out of Step Up at any point, or stay for the full two years.
- The program centers around occupational services with an explicit focus on helping clients learn how to navigate the mental health system and other services and programs that they may need following their time in Step Up. The goal of Step Up is to help clients develop the skills they need to navigate the adult system within their own communities.
- Step Up currently has 12 clients enrolled, and has identified additional clients to enter the program, which will bring the census to 25 participants by December 2020. If the census for PEACE increases to 200, the team hopes to expand the number of spots available for Step Up. The specific number of clients in the future will depend on how easy it is to hire staff and balance the needs of participants.

Rationale/History for Program or Practice

- The PEACE program length was set at two years when the program began ("arbitrarily, like all FEP programs") and after the first two years, held a graduation for the first 32 clients in the program.
- The team quickly saw that many in this group were becoming re-hospitalized. Clients did not enjoy or connect with their new programs, and were not engaging with services. Clients would "tank" in these settings, would stop their medications and would miss appointments. Many clients ended up coming back to PEACE.

- PEACE team members felt that this lack of engagement was at least in part due to the absence of high-quality care in the community following the CSC program, which were “not supportive, at best” and providing poor care at the worst. Clients would “fall off the radar very quickly” because community providers could not support clients the way they needed. Clients had an expectation that they were going to get the kind of engagement and support from other services that they get from PEACE.
- While some clients previously also transitioned to mental health outpatient services at Horizon House, many were not successful in part because the program structure is more rigid and did not provide the type of support (e.g., text reminders for appointments) that clients tend to need. Outpatient service staff did not have training to work with younger people. PEACE has not transitioned clients to the case management program because staff do not have training with the FEP population.

Funding

- Currently, the state funds Step Up program as a two-year pilot project. For the second year, the program receives 50 percent of the funding instead of 100 percent because OMHSAS wants programs to become fully self-funded. However, because insurance companies do not acknowledge OT as a behavioral health intervention, the program is not able to bill OT to Medicaid, which has been a challenge.
- PEACE has proposed to CBH a more structured step-down program that to also bill at a case rate, like the CSC program, but at a reduced rate.

Preparation, Practices and Policies

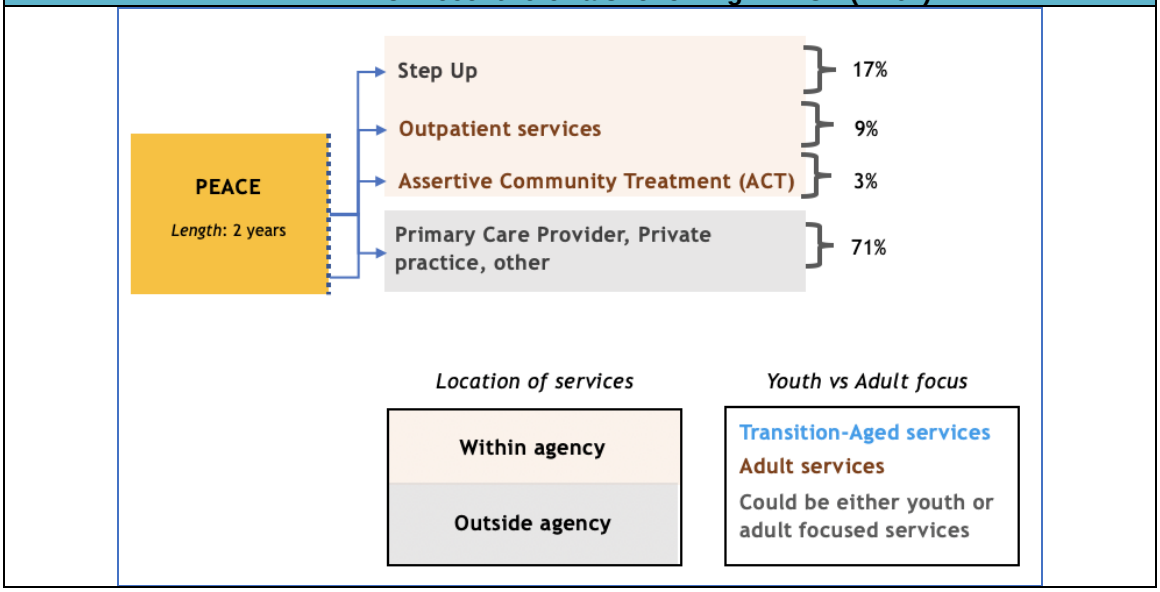
- When a client enters the program, the program typically tells them that they can access two years of intensive wraparound services and option to transition to a lower level of services. One clinician noted that for people who are ambivalent about treatment, telling a client “three years” can be intimidating.
- Once a client has been in PEACE for a year (except for rare exceptions where it may occur earlier), the team will begin talking about transitions with clients whom they feel are stable. The team weighs factors such as the client not having been hospitalized the past six months, being engaged and actively participating in community activities; feeling comfortable with his level of symptoms and medication, and feeling equipped to handle symptoms when in stressful situations in the community. Shared decision-making is central in the process, and clients can say that they do not yet feel ready to leave the program. Clients who fit this description and would still benefit from support are considered for Step Up. This process often happens a month or two in advance of a transition, but clinicians noted that it ideally would occur sooner.
- The team evaluates readiness to transition every six months.
- Clinicians will then have an orientation conversation and spend a few sessions exploring what Step Up looks like and will ask the client how much longer he

would like to receive services. The clinician will also initiate a conversation with the OT who runs Step Up if the client does not already know her.

- While a client is in Step Up, a major focus is to identify the subsequent placement. Historically, the team would examine what services are relevant and available in the clients' area, and begin there. Now, the team works to have a more intimate understanding of the providers themselves and emphasizes the importance of visiting the relevant options in person with the client. Team members encourage the client to consider aspects such as how the person at the front desk treated them, and at which organization did they feel most welcome.
- Whether transitioning from PEACE or Step Up, when transitions occur to programs outside Step Up, the team will try to have joint meetings with the new program.

Post-Discharge Placements

EXHIBIT PA-3. Recent referrals following PEACE (N=64)



- Clients do not automatically transition from PEACE to Step Up, as described above. Clients who don't need the level of support of Step Up and clients who need a higher level of support would not be offered a place in Step Up.
- Compared to the main PEACE program, Step Up involves more sessions that take place in the community. Clients in Step Up continue to meet with the physician once a month, which is less frequent than what clients receive during PEACE but which is intended to more closely match the frequency in the community. Clients still have access to the SEE, case manager, peer support and group therapy all as needed, although the OT primarily provides SEE services. Clients are encouraged to help co-facilitate groups with the OT. Individual therapy transitions to the OT as the primary clinician. In PEACE, the goal is a weekly or bi-weekly contact with the clinician; in Step Up, the minimum requirement is one monthly contact, but many clients continue to use a bi-weekly meeting.

- The OT role in Step Up is different from what a SEE would provide in that the OT administers formal structured assessments that look at cognition and functioning to understand clients' interests, and then tries to align educational and employment opportunities with both interests and strengths.
- If a client in PEACE needs a higher level of care, PEACE is likely to refer to an ACT team, a residential treatment program, or Project Transition, which is a residential program where clients can receive all their services.
- Historically, a small number of PEACE clients have transitioned to a Horizon House program called Community Integration and Recovery Center, a day treatment program that includes a young adult track within that program.
- Now with Step Up, the major focus is preparing people to transition to outpatient settings within the clients' home community or neighborhood.

Perceived Advantages: What Does This Allow?

- Having Step Up as an option provides a sense of relief, safety and connection to clients. Many clients report that they want continued support but appreciate that there are less frequent requirements for contact with the team once in Step Up.
- Allowing clients to retain their connections to staff and peers for an additional year is "very powerful" as part of their recovery. Continued access to services such as groups is very beneficial, and being able to work with the same prescriber and nurse allows for treatment continuity. The program provides a safety net in case clients' symptoms increase, since they can access more services if needed.
- Serving clients in the same office space allows clients to know what to expect and feel comfortable.
- Having Step Up co-housed with PEACE allows Step Up participants to serve as positive examples for PEACE clients.
- With an occupational focus, Step Up allows clients to build knowledge of and competence with navigating resources that are in their own communities. Because Step Up focuses on services in the client's home community, it better prepares clients to make a successful transition into community-based services. Traditionally, there would not be time or the opportunity to pursue these activities.
- Having Step Up gives clinicians a sense of hopefulness. It is rewarding to be able to see a client graduate and receive a lower level of services. Clinicians appreciate being able to provide the bridge to the community in a way that they do not have time to do during the main PEACE model, and they feel more confident in the quality of services clients receive.
- Because some aspects with Step Up change while others stay the same, Step Up allows participants to experience change but not too much change, or too quickly.

Challenges

- With such a large census in the PEACE program, Step Up does not have the capacity to serve all the people who may benefit.

- The additional time spent receiving services means that clients remain attached and want to stay with Step Up even longer. Even with the continuity between programs, some clients get “cold feet” about making the transition because it is a step away from PEACE. To address this, clinicians use reflection to celebrate that the client has formed a strong relationship, and at the same time, look for ways to identify therapists and CMH providers who may be able to provide similar connections.
- Team members are working on how they can improve the transition between the therapist and the Step Up clinician, since that person will change between programs.
- Family engagement is a large part of PEACE, and there has been much less in Step Up.
- The heavy demand on OT time as part of Step Up means that the PEACE program has lost the level of involvement the OT provided when just part of PEACE.
- The quality of outpatient programs in different areas of the city remains poor, and even with the support and connections that Step Up works to provide, that effort cannot necessarily compensate for deeply rooted organization or program issues.

Lessons Learned: Recommendations for Other Programs

- Emphasize in-vivo experiences in the community, both as a way to prepare clients for what they will actually experience and to increase connections between the community and the program.
- Incorporate client perspectives in the design and operation of the step-down program, and incorporate continuous assessment and reassessment with clients to get their feedback on how the program is going.
- Talk to existing programs to get specifics about hurdles and challenges they have experienced.
- Be thoughtful about how staff select clients to participate in the step-down program and consider whether the program is the right fit for each individual client. Identify criteria around who makes a good candidate for the program; don’t just include people to be able to “keep eyes” on them, rather, people should be in the program when they are motivated and have goals and areas where the program can help them.
- Make decisions about transitions collectively as a team, and always include client input on whether they feel prepared to transition.
- Have a personal relationship with the outpatient provider who can help curate a very individualized transition experience for the client.

Other Highlights

- For the OT, providing services via telehealth because of COVID-19 has been much more challenging because an important aspect of work is based in the community and involves physically visiting different community programs, which is not currently possible. The OT will at least try to do in person meetings with clients who are not doing as well.

Coordinated Specialty Care (CSC) Continuity of Care Case Study Site Visit Report

ETCH/NAV2GO, Lansing, Michigan
August 2020

I. Overview

Early Treatment and Cognitive Health (ETCH) is a CSC program that officially started in October 2014 and serves the greater Lansing, Michigan area. ETCH operates as a subcontractor to Network 180, which is a CMH authority in Kent County that connects individuals and their families to services for mental illness, substance use disorders or developmental disabilities. In May 2019, ETCH initiated the NAV2GO program with 10 participants. The goal of NAV2GO is to provide clients with a bridge between the CSC team-based program and community-based services.

We selected ETCH for inclusion in the CSC Continuity of Care Study as an example of a step-down program.

II. State Context

ETCH is one of four first-episode psychosis programs in the State of Michigan. ETCH was initiated by Catherine Adams, the clinical director. In 2010, Ms. Adams' clinical site was one of the three sites in Michigan selected to be included in the RAISE ETP study. In 2014, after the RAISE study ended, the state had access to MHBG funds. Network 180, which serves as the CMH authority for Kent County, initiated an Request for Proposal (RFP) process to create new CSC programs. The three RAISE study sites (including ETCH) were subsequently funded as subcontractors to Network 180 to provide CSC services. One additional CSC program was funded later with MHBG funds. Of the four first-episode psychosis programs in the state, ETCH is the only one that provides a step-down program.

The federal MHBG funds are directed to the Michigan Department of Health and Human Services, which in turn are dispersed to Network 180, which acts as an intermediary fiduciary organization between the state and the CSC sites. Network 180 disperses MHBG funds to the four CSC programs in Michigan and handles the administrative operations of early psychosis programming across the state (e.g., managing procurement processes for CSC sites, overseeing program budgets and contracts).

The State of Michigan also contracts with the NAVIGATE program to provide training and technical assistance to early psychosis programs in the state, based on a train-the-trainer model. Catherine Adams is the lead trainer and consultant for the State of Michigan, and other members of the ETCH team are also certified NAVIGATE trainers. They provide the other CSC programs across the state with training on specific CSC

team roles, manage credentialing and certification of staff at different sites, and do fidelity monitoring and consultation.

III. CSC Implementation

Model: All the Michigan programs use the NAVIGATE model. Services include all the standard components of CSC models such as medication management, individual therapy, SEE, family psychoeducation and support, and case management. As with other NAVIGATE programs, ETCH provides Individual Resiliency Training (IRT) with CBTp. ETCH also has a peer as part of the team and offers groups, such as those with a mindfulness, music, and exercise focus.

Program size: At the time of the visit, there were 51 clients enrolled in ETCH with a maximum program size of 57.

Population and age range served: ETCH serves young adults, ages 15-30 with schizophrenia spectrum diagnoses. The program serves clients in the greater Lansing Michigan area. Currently, the clients served are 81 percent male and 19 percent female and approximately 61 percent White. Exclusion criteria include clients with substance-induced psychosis. DUP must be 18 months or less.

Program length: ETCH does not have a defined program length, but clients typically stay in ETCH for 2-5 years.

Funding/Medicaid reimbursement mechanism: Approximately 75-80 percent of young people served by ETCH have private insurance. This is in contrast to the other three CSC programs in the state, all which have much higher enrollments of Medicaid-insured clients. There are no differences in the services offered through ETCH and NAV2GO based on whether a client has Medicaid or private insurance.

Michigan expanded Medicaid in 2014, however, it was unclear what impact that had on CSC programming. Since expansion, some families elected to enroll their young person in the state Medicaid program (Healthy Michigan). Possible reasons given for this move to Medicaid were because copays for some medications were very high with private insurance and some self-employed families who purchased their own insurance had very high deductibles. Staff at ETCH are paneled with a variety of private insurance providers and are able to bill for Current Procedural Terminology (CPT) coded services, such as therapy and medication management. Additionally, they have negotiated fee “uplifts” with Blue Care Network in Michigan, which allows them to reimburse an additional 15 percent on billable services such as individual therapy, family therapy and medication management for anyone who has a schizophrenia spectrum diagnosis. On a typical case, that amounts to approximately an additional $350-$650 per case, per year. Medicaid and private insurance do not pay for peer support service, supported employment, or supported education, and so the MHBG funds are used to cover those services. The Michigan NAMI chapter has begun a coordinated effort to lobby the state

to pass legislation to require funding of first-episode psychosis services by Medicaid and insurance providers and have advocated for bundled rates to help establish sustainability beyond MHBG funding.

Data collection and monitoring: ETCH collects a range of assessment measures quarterly. These include:

- Columbia Suicide Severity Rating Scale (C-SSRS)
- Questionnaire about the Process of Recovery (QPR)
- Selected items from the Service Utilization and Resources Form for Schizophrenia (SURF)--specifically, inpatient days and emergency room visits
- Work, school, and legal involvement.

As part of their preparations for transition, clients complete a Wellness Confidence Inventory and a tool that helps identify and clarify their personal values, selecting the top ten from a list of 34 items. This values assessment is one of the hallmarks of this program and is designed to help clients think about questions such as 'what do you want your life to stand for?' 'What qualities do you want to cultivate as a person?' 'How do you want to be in your relationships with others?'

Integration within organization: ETCH is a freestanding program and operates as an outpatient clinic contracted by a CMH entity, as noted above. Clients do not generally receive services from other agencies while they are in ETCH.

Site staff roles and background: The ETCH program operates with a Clinical Director, three IRT clinicians, a NAV2GO clinician, a SEE specialist, two prescribers and a peer. Staff range in commitment to the CSC team range from 10 percent to 100 percent.

EXHIBIT MI-1. CSC Team Staff

Name		Position Name	Degrees/ Licensure	Length of Time at the Organization	% Time Working on CSC
1.	Catherine Adams	Clinical Director	MSW	5 years, 8 months	90
2.	Neeshan Mehretu	NAV2GO Clinician	MSW	4 years, 1 month	80
3.	Raelyn Elliott-Remes	IRT Clinician	MSW	5 years, 8 months	10
4.	Lauren Sullivan	IRT Clinician	MSW	5 years, 2 months	75
5.	Scott Palazzolo	IRT Clinician	MSW	3 years, 5 months	75
6.	Oliver Westervelt	SEE Specialist		1 year, 8 months	100
7.	Jacob Halmich	Peer	BA	7 months	25
8.	Dale D'Mello	Prescriber	MD	5 years, 8 months	5
9.	Adrienne Westphal	Prescriber	DO	1 year, 8 months	5

IV. Site Visit Respondents

For this case study, we focused our interviews with members of the ETCH team, representatives from the fiduciary organization, and a client selected by the program.

EXHIBIT MI-2. List of Respondents Interviewed		
Name	**Position**	**Organization or Affiliation**
Catherine Adams	Team lead	ETCH
Neeshan Mehretu	Clinician	ETCH
Scott Palazzolo	IRT	ETCH
Raelyn Elliott-Remes	IRT	ETCH
Oliver Westervelt	SEE	ETCH
Eric Achtyes	Medical Director	Network 180
Kari Kempema	Program Coordinator	Network 180
Dale D'Mello	Prescriber	Michigan State University
"Calvin"	Participant in ETCH	

V. Featured Program Aspect Description

We created NAV2GO because there were so many of our clients who were not ready to go out into the community, but they were at a point where we felt like they had passed that crisis point of needing more intense services. And so NAV2GO was this bridge to keeping them within our program with many of the supports and the relationships that had been formed there, and allowing them to maintain that, but starting to bridge out into the community and intentionally preparing for that next step.

The step-down program focuses on values in terms of thinking what's important to you? What makes you makes your life meaningful? How do you want to show up in the world? The emphasis is switched to that.

--ETCH team members

Summary

- ETCH includes two programs, a CSC program (following NAVIGATE) and the step-down, NAV2GO. Started in May 2019, NAV2GO serves as a step-down program for selected clients from the full NAVIGATE program. Services in NAV2GO are focused on realizing client's values for what makes their lives meaningful, rather than focusing only on specific goals. Additionally, the program was designed to focus on community and cultivating a sense of belonging and connection outside of the program itself. At the time of the visit, there were 13 clients in NAV2GO.
- Clients do not automatically transition from the full NAVIGATE program to NAV2GO; the team meets regularly to review the ETCH caseload and identifies individuals who might be candidates for transition. The team consults with the client to make informed decision about their preferences for transitioning to a different level of care. Clients who need a higher level of support are not considered good candidates for NAV2GO.
- NAV2GO and the NAVIGATE program operate in the same office suite. As such, clients have familiarity with the NAV2GO clinician before the transition. In NAV2GO, the services are delivered less frequently than services in the full NAVIGATE model (e.g., monthly in NAV2GO versus weekly in the NAVIGATE program); however, the frequency of services can increase depending on the

client's needs. For example, if a client started out with monthly sessions with the NAV2GO therapist, but is going to be moving to a new location or starting a new job, they can increase the frequency of their sessions to help during the transition. Instead of meeting with the full CSC team, individuals in NAV2GO meet with one clinician and an ETCH prescriber. Participants also have access to peer support if desired.

- There is no formal discharge from the full NAVIGATE program to enter NAV2GO because NAV2GO is seen as an extension or arm of the full NAVIGATE program
- At this time, there is no defined timeframe or time limit for NAV2GO participation.

Rationale/History for Program or Practice

- The team noticed that after the full NAVIGATE program, it was challenging for many young people and their families to leave the intensive support of the CSC team and transition to services in the community. At the same time, research from international studies suggested that gains are not typically sustained when intensive supports of early intervention are withdrawn.
- In recognition of this widespread issue, Cathy Adams spearheaded the design of the NAV2GO program to help clients strengthen the positive outcomes they had achieved and build a bridge to services in the community. They consulted with other CSC programs, such as EASA, OnTrackNY, and NAVIGATE about strategies for addressing transitions, worked as a team to identify signs of readiness and planning for phases of care for clients, presented their step-down model at the state level and at national conferences to obtain feedback, and developed a unique program specific to their clients' needs.

Funding

- NAV2GO is funded in the same way that the full NAVIGATE model is funded. The program is able to use MHBG funds because NAV2GO is not considered a separate program, but rather a part of the NAVIGATE model.
- There are no immediate funding barriers to supporting NAV2GO.

Preparation, Practices and Policies

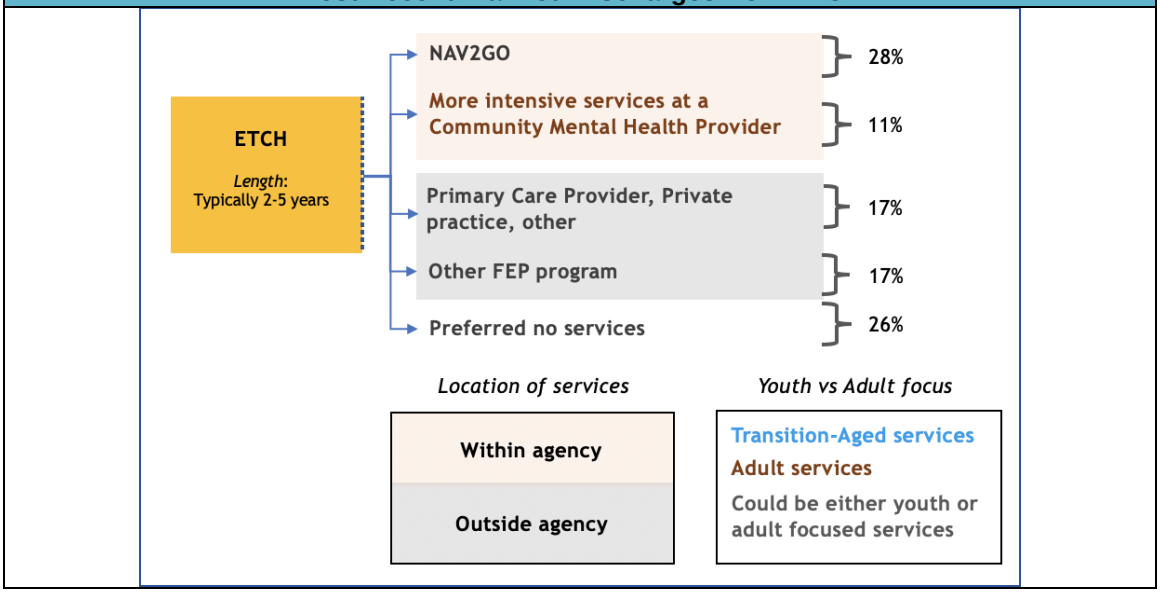
- Clients are prepared from the very beginning of the NAVIGATE program about discharge and transition. The goal is to instill a sense of hope early on that the services will end, the client will improve and will eventually no longer need services.
- When a client has been in the program for 18 months, the team has more deliberate conversations more specifically about the process of transition with clients whom they see as stable.
- ETCH developed a set of transition guidelines to help guide the transition process. This form, which draws from NAVIGATE as well as from other programs, includes nine items, such as whether the client and family express readiness to transition. The team assesses how many hospitalizations clients

have had, the time between hospitalizations, clients' initial goals, and how those goals have changed over time. The team looks to see if there is a shift from more basic needs to quality of life goals. They also review a confidence rating scale completed by the client and gauge which clients require less frequent visits with members of the team. Through this process, the team can start to identify clients who have stabilized with respect to symptoms and functioning and who may benefit from the step-down program. Shared decision-making is central in the process, and clients can say that they do not yet feel ready to leave the program.

- The communication process between the ETCH team and the NAV2GO clinician is seamless because the NAV2GO clinician attends all the team meetings when clients' case files are discussed.
- When preparing for transition, clinicians will have an orientation conversation and discuss how transition to NAV2GO will unfold.
- Clients will complete a wellness confidence tool to assess areas that they might want to address in NAV2GO. Clients then work with the SEE specialist to create a portfolio that includes their resume, a list of job experiences specific to their academic pursuits, and an inventory of their employment goals. Clients also receive an individualized study skills tip sheet, if that would be useful to their next steps. Having these resources allows them to come to the NAV2GO clinician with some clarity about educational and employment next steps.
- If a client goes to NAV2GO but then requires a higher level of services, they can enroll back in the full NAVIGATE program.
- Respondents noted that if the client agrees, it is useful to involve the family in preparation for the transition so that everyone is prepared for the stepped down level of care.

Post-Discharge Placements

EXHIBIT MI-3. Post-Discharge Placements among Most Recent Planned Discharges from ETCH



- Respondents noted that there are services in the community that clients can access after discharge; however, the fit between what clients need and what the community can provide is sometimes at odds. For example, ETCH team members noted the lack of community clinicians with experience and confidence to work with individuals with schizophrenia spectrum disorders. If a client wants to continue with medication management but not therapy, many group practices in the community require individuals to continue with a therapist to be connected to psychiatry. Hence, clients are again faced with the challenge of finding therapists who are equipped to serve individuals with psychosis.
- The CMH system in Michigan operates services, such as therapy and residential treatment, group homes (i.e., a medically fragile group home and high intensity homes for people with significant severity of illness). Respondents doubted that care in these residential facilities would be specialized enough or adequate to serve their clients.
- CMH also operates a clubhouse model called Charter House, which has peer services and case management.
- Apart from transitioning into NAV2GO, the team refers individuals and families to specialized substance use facilities, NAMI for family services, CMH programs, and the Counseling and Psychiatry Services program through Michigan State University.

Perceived Advantages: What Does This Allow?

- The team reported that the step-down approach allows clients to have a “safety net” to strengthen their skills and confidence to ease the transition from the program.
- Respondents reported that the step-down program’s shift to promoting values, congruent living, natural supports and civic engagement respects the whole person and are positive areas to address with clients as they prepare to launch from the program and become more independent.
- As people move to NAV2GO, more slots are available for individuals to access the full NAVIGATE program. This allows clients more time and flexibility to transition out of the program when they feel ready.
- Serving clients in the same office space allows clients to become familiar with the step-down clinician and feel more comfortable with the transition.
- The NAV2GO clinician has prior experience at ETCH as a SEE specialist and an IRT clinician. This same clinician also has experience working with families. As such, the NAV2GO clinician “wears different hats” and provides employment, education, case management, and IRT services.
- Providing services to clients in the step-down program and seeing their successes can instill hope in clinicians as they have an opportunity to see how far their clients can progress. They can see that the work that they are doing with clients is making a difference.

Challenges

- Respondents noted that their biggest barrier is finding community providers for clients once they leave the program. There is some reluctance among community-based therapists to take on clients with schizophrenia spectrum disorders. The team has established working relationships with selected providers; however, the reticence to take on CSC graduates remains. Possible reasons include lack of training in working with clients with similar diagnostic profiles and uncertainty about the level of risk and liability for that risk.
- Another challenge across the state is access to psychiatric resources. When clients leave the program, they still often require periodic oversight of medications, and many primary care physicians do not want to manage antipsychotic medication use. There are also some limitations in the availability of locations where people can get medication injections; however, there are some local pharmacies that have recently offered that service.
- Although funding is currently not a challenge for ETCH/NAV2GO, the program is looking for ways to remain sustainable. As case management, supported employment and supported education are not reimbursable though insurance, respondents noted it would take legislation to allow for those services to continue and to be funded appropriately if MHBG funding were unavailable at some point.

Lessons Learned: Recommendations for Other Programs

- Preparing clients and families for transition early in the treatment process allows for sufficient time to plan for discharge.
- Having continuity in treatment providers from the program to step down is useful in terms of building rapport and trust with clients.
- Team members providing step-down services should have clear and frequent communication with the CSC team so that the transition is smooth.
- Developing partnerships with community-based agencies, hospitals or universities is useful so that when clients are ready to discharge, they have resources available to them if they choose to pursue additional services.
- When designing a transitional phase to a CSC program, it is useful to have a framework for timing when staff should raise the topic of transition with clients, families, and community partners. The timing of those conversations should be thoughtfully planned to help ease the transition, rather than arbitrarily determined.
- Doing community outreach and describing the program to other providers in the community is critical to help build a referral base for clients once they leave the program.
- Collecting data that can show meaningful outcomes can be a compelling way to bolster support for the program and improve sustainability.

Other Highlights

- The impact of COVID-19 has been mixed.
    - Since March 2020, the ETCH team has moved to using tele-health, with injections as the only in-person activity. Providers reported that staff and clients have learned to adapt and that client engagement has not diminished. Some clients have reportedly become more engaged using telehealth. During some weeks, there has been 100 percent attendance for psychiatric appointments, for example. Many ETCH clients have access to the Internet and can connect to sessions remotely without any difficulties.
    - Many of the employment opportunities that were unavailable at the beginning of the pandemic are now available for clients to pursue.
    - One challenge with COVID-19 is obtaining vital signs. Approximately 40-50 percent of clients are on LAIs, and those clients will get their vital signs checked when they come in for injections; however, vital signs are not available for those who do not get injections.
    - NAV2GO program was operating a peer group for people in the NAV2GO program; however, it's been put on hold since COVID-19.
    - Medicaid and many private insurance companies have opened up billing codes to allow for telehealth.
    - Some clients were preparing to discharge from the program prior to shelter in place rules; however, due some feelings of stress and isolation associated with the pandemic, they have chosen to remain in the program for a while longer.
- Respondents noted that post-discharge data that would be useful to collect from their clients six-months after the program or longer would include information about: employment, education, relationship status, relapse, coping skills, service satisfaction, the ability to communicate with current providers, family perceptions about transition, quality of life, social connectedness, suicidality, medication status, and direct feedback on their experience in NAV2GO.

Coordinated Specialty Care (CSC) Continuity of Care Case Study Site Visit Report

OnTrackNY/Early Treatment Program, Glen Oaks, NY
August 2020

I. Overview

The OnTrackNY at Zucker Hillside Hospital, in Queens, New York is one of 23 OnTrackNY CSC programs in the State of New York. The OnTrack program operates within an early intervention initiative called the Early Treatment Program (ETP). ETP serves a broader population than OnTrackNY and can also serve as a step down for OnTrackNY clients, since it is generally less intense in frequency of services. Zucker Hillside now has a third program, called Better Outcomes through Ongoing Specialized Treatment (BOOST), which is designed to serve both as a step down from ETP and to treat people who did not fit the criteria for ETP. We highlight the difference between all three programs in Section V.

We selected OnTrackNY at Zucker Hillside for inclusion in the CSC Continuity of Care Study as an example of a program with a step-down program.

II. State Context

There are 23 OnTrack programs currently operating in New York. The New York Office of Mental Health (OMH) funds OnTrack Central (within the Center for Practice Innovations) to serve as an intermediary between the state and the 23 CSC programs. OnTrack Central supports implementation of the OnTrackNY model through training and technical assistance. OnTrack Central does not support training or technical assistance for a specific step-down approach. As such, CSC programs across the state vary in terms of how they address transitions. Similarly, the availability of services and resources in the community after clients leave the CSC program also varies across state.

CSC programs in the State of New York are supported through a variety of sources (e.g., state dollars, MHBG dollars, federal grants, insurance), and each site varies by how they are funded.

III. CSC Implementation

Model: The OnTrack Zucker Hillside program follows all the components of the OnTrackNY model. Clients receive psychotherapy, medication management, case management, SEE, and family psychoeducation. In addition, clinicians in OnTrack frequently see clients in the community and offer peer support.

Program size: OnTrackNY Zucker Hillside currently has 75 clients enrolled, which is also the maximum program size.

Population and age range served: OnTrackNY Zucker Hillside serves clients between the ages of 16-30. Clients cannot have a DUP of greater than one year; other OnTrackNY programs allow a DUP of up to two years. Most OnTrackNY Zucker Hillside clients come from Nassau County and Queens, but there is no geographic restriction for services and clients may travel from farther areas if other programs are full, or they prefer Zucker Hillside. Socioeconomically, the Zucker Hillside site generally sees working class and middle class families, but also has clients at both economic extremes. The site has a "fair amount" of people coming in with private insurance.

Program length: OnTrackNY is a two-year program with flexibility; clients can stay longer than two years if the team believes it would be beneficial. On average, clients tend to stay two and a half years. Staff noted that a program length of three years seemed like it may more realistically reflect the length of time that most clients need to solidify gains and be ready to benefit from a transition.

Funding/Medicaid reimbursement mechanism: As noted, OnTrackNY receives support through reimbursement for private insurance and Medicaid, and through OnTrackNY state funding. MHBG funding is part of the state funding. Zucker Hillside accepts all but one type of insurance, United Healthcare. While a client is in OnTrackNY, they will receive a fee waiver for that period of service if they do not have an insurance provider that can be billed.

Data collection and monitoring: Data can be analyzed across OnTrack, ETP and BOOST, however, data are not currently integrated between programs in such a way that team members can easily look at for clients if they attended a program at Zucker Hillside prior to ETP/OnTrack. OnTrackNY has an extensive assessment battery used across all sites in the state. Standardized assessments for OnTrackNY clients include baseline, quarterly and discharge forms created by OnTrackNY Central.

All OnTrackNY and ETP participants who are willing to participate receive the following assessments at baseline, with some measures repeated. At this point BOOST participants are not receiving assessments.

- Test of Premorbid Functioning (TOPF)
- Wechsler Abbreviated Scale of Intelligence--Second Edition (WASI-II)
- Repeatable Battery for the Assessment of Neuropsychological Status (RBANS)
- Conners' Continuous Performance Test--3rd Edition (Conners CPT-3)
- Trail Making Test Part A and B (TMT-A & B)
- Wisconsin Card Sorting Task-64 card version (WCST-64)
- Controlled Oral Word Association Test (COWAT) Letter Fluency
- Brief Psychiatric Rating Scale (BPRS)
- The Scale for the Assessment of Negative Symptoms (SANS)
- Quality of Life Scale (QLS)

- Calgary Depression Scale for Schizophrenia (CDSS)
- Global Assessment of Functioning (GAF)
- Quality of Life (QOL)

Integration within organization: Clients attending any of the early intervention programs have access to Zucker Hillside services, which include a range of services, such as a Clozapine clinic, a program for young adults with substance use, an Obsessive Compulsive Disorder program, and a DBT program. OnTrack receives referrals from the Zucker Hillside inpatient unit and the PHP and the community.

Site staff roles and background: The OnTrackNY program at Zucker Hillside includes four clinicians (several part-time with OnTrackNY), a prescriber, two SEE specialists, and a peer specialist, in addition to the Program Director and the Team Leader, who also sees clients. The program does not have a designated case manager as a separate role, it is covered within other rolls like primary clinician and supported education and employment specialist. The clinic includes a position of Resource Associate, who work across all the centers. If a client did not have a primary clinician, the Resource Associate could potentially assist with administrative needs, such as procuring transportation or assisting with housing.

EXHIBIT NY-1. CSC Team Staff

Name		Position Name	Degrees/ Licensure	Length of Time at the Organization	% Time Working on CSC
1.	Kristin Candan	Team Leader / Primary Clinician	PhD / MBA	11 years, 9 months	90
2.	Michael Birnbaum	Director	MD	7 years	10
3.	Lauren Hanna	Psychiatrist	MD	4 years	90
4.	Kristen Risola	Primary Clinician	PhD	5 years	100
5.	Gracy Thomas	Primary Clinician	LCSW	15+ years	50
6.	Megan Brennan	Primary Clinician	LMHC	10 years	60
7.	Brianna Cheney	Outreach and Recruitment Specialist / Primary Clinician	PhD	3 years	100
8.	Danny Sosa	Peer Specialist		3 years	80
9.	Connie Seltenreich	Supported Education / Employment Specialist	MA	10+ years	100
10.	Tina Brady	Supported Education / Employment Specialist	LCSW	5+ years	50

IV. Site Visit Respondents

For the site visit, we included six team members whose work cuts across OnTrackNY, ETP and BOOST, as well as the program director and a representative from OnTrackNY Central.

EXHIBIT NY-2. List of Respondents Interviewed		
Name	**Position**	**Organization or Affiliation**
Michael Birnbaum	Director	Zucker Hillside
Kristin Candan	Team Leader	Zucker Hillside
Gracy Thomas	Primary Clinician	Zucker Hillside
Danny Sosa	Peer Specialist	Zucker Hillside
Nathan Frishberg	BOOST Manager	Zucker Hillside
Lauren Hanna	Psychiatrist	Zucker Hillside
Brianna Cheney	Outreach and Recruitment Specialist / Primary Clinician	Zucker Hillside
Lisa Dixon	OnTrackNY Central	New York State Psychiatric Institute

V. Featured Program Aspect Description

I'd like to think we're giving a high-quality compassion based service to people and now that gets to continue for 15, 20 years as opposed to seven…, I think staying at a place where you feel comfortable and you got well--or you didn't get well--but people are still working with you and trying to help you get well, as opposed to starting fresh, is a real value.

--OnTrackNY Team Member

Summary

EXHIBIT NY-3. Comparison of OnTrackNY with Step-Down Programs			
	OnTrackNY	**ETP**	**BOOST**
Maximum program size	75		TBD
Age range	16-30	16-35	18-40
DUP requirement	≤ 1 year	≤ 2 years	None
Services directly through program			
Individual therapy	Yes	Yes	Yes
Group therapy	Yes	Yes	Yes
Medication management	Yes	Yes	Yes
Neuropsychology assessments	Yes	Yes	No
Case management	Yes	Yes	No
Cognitive remediation	Yes	Yes	No
Family therapy / psychoeducation	Yes	Less frequent	Less frequent
Supported employment and education	Yes	No	No
Visits in the community	Yes	No	No
Providers		Compared to OnTrackNY: • Can potentially have same therapist, likely to be different • Different prescriber	Compared to ETP: • Can potentially have same therapist, likely to be different • Different prescriber

- Zucker Hillside has two programs that provide step-down options, ETP and BOOST. Both these programs also serve clients that do not meet criteria for OnTrackNY. ETP will also serve clients who meet OnTrackNY criteria, but cannot join because of capacity issues. For a client who has been in OnTrackNY, BOOST serves as a step down from the ETP step-down. For those who entered ETP, BOOST will be the first step-down.
- To date, ETP has generally absorbed the vast majority of clients when they complete OnTrackNY. BOOST was initiated in September 2019 with a population of clients who had been in ETP for a longer period of time, in addition to clients who fell outside the age range of ETP. BOOST currently has 50 clients, with expansion to 80 clients by next year.
- Although the SEE specialist can provide brief consultation to clients in ETP, neither ETP nor BOOST can provide SEE support to clients because it is a non-reimbursable service. Clients may receive employment support through the Personalized Recovery Oriented Services (PROS) program.

Rationale/History for Program or Practice

- Approximately nine years ago, Zucker Hillside had an existing early intervention program called START. In July 2013, START became the ETP under the OnTrackNY grant. Clients who met the narrower criteria of OnTrackNY became part of that program, while others continued to receive services through the ETP.
- In 2019, the ETP team started BOOST to serve as a step-down program for individuals from ETP. BOOST continues the specialized care of ETP, in contrast to participants going to the large general outpatient clinic at Zucker Hillside. The team also started BOOST to serve individuals who did not fit the entry criteria of ETP, due to their age or having a longer DUP.
- The early psychosis team at Zucker Hillside intends BOOST to be a long-term treatment option that is integrated within an outpatient clinic setting. By offering this recovery-oriented model over the long term, the hope is to extend the gains of CSC.
- The BOOST focus is less on symptom reduction and more on quality of life, what brings meaning to people's lives, and on functional outcomes. The BOOST focus is "how do you get back to doing the things that matter to you, that are part of your identity, that are part of your fulfillment and maximizing those outcomes over the long term."

Funding

- Program costs in ETP and BOOST are covered through Medicaid and all private insurance providers (except United Healthcare).
- Clients with United Healthcare negotiate with the hospital for an out-of-pocket session fee, or pay full cost.

Preparation, Practices and Policies

- When clients enter OnTrackNY, they are told that it is a two-year program. The team also tells clients that there is another program in the same building that they can continue to attend after the two years, if they still want services.
- Within OnTrackNY, a few months before the two-year mark, the clinician will bring up the topic of transitions with the client and his family. At the same time, the team will tell the ETP providers that they have a client they would like to transfer into the ETP program.
- In moving from ETP to boost, the most significant factor is length of time in the program. When the team knows that there is space in BOOST, they will discuss who among the people who have been in ETP the longest are ready to transition. The clinician will talk with the client and emphasize that even though a transition will take place at some point, the client will help design what that transition looks like.

Post-Discharge Placements

- The “overwhelming number” of people discharged from OnTrackNY go into the broader ETP program. The main reason a client would not transition to ETP is if they move
- If a client has not progressed with the supported education and employment support, one additional support to provide more structure is the PROS program. PROS is run by the OMH and focuses on occupational and functional skills, and can serve as a social outlet since clients can attend up to five days in a week.
- OnTrackNY Zucker Hillside does *not* typically discharge clients to a higher level of care.
- Family groups (currently conducted by Zoom) are available to families in all three programs.

Perceived Advantages: What Does This Allow?

- The current set of programs allows for continuity of care for potentially ten or more years, with services all provided by clinicians who have training in first-episode psychosis and through a team-based framework. By covering this longer time span, the team is able to support clients through key milestones and with minimal disruptions to care.
- All the programs are located in the same area of the hospital grounds. When moving from program to program, clients will be in the same waiting area, and will still see their former clinician from time to time, or can stop by the office to say hello. The co-location minimizes the sense of transition and makes it easier for the doctors to make lab requisitions and other coordination of care needs. Having a centralized location for clients to obtain medications and see different providers helps clients remain engaged in treatment.

- Having a trusted program to follow OnTrackNY and ETP, rather than having to look for clinicians and prescribers in the community who are qualified to provide care, alleviates stress for clinicians.
- BOOST offers therapists a more manageable caseload where clinicians can devote time to each case. Having a program with a specialized focus allows clinicians to feel competent in the cases they see and able to access support from team members if needed.

Challenges

- In general, clients have to transition clinicians and prescribers when they move from one program to the next.
- There are no dedicated case managers and no nurses involved in the programs, which are two positions that team members reported could add value to the current services.

Lessons Learned: Recommendations for Other Programs

- In finding a champion, look for "qualified, enthusiastic non-rigid people who are willing to take chances and try something and adjust to what works" in order to get a step-down program started.
- Have the step-down program run by someone who is closely affiliated with and has been involved with the first-episode program.
- Understanding the CSC model and philosophy is critical to a successful transition program because it helps to see ways to support the next phase of treatment. For example, as clients mature, a transition program may address clients' goals to achieve more independence (e.g., moving out, living on their own, living with roommates, keeping a job for an extended period of time, maintaining a household).
- Involve peer specialists in aspects of transition and step down if possible.
- Allow flexibility in terms of how long clients can access transition services.
- Help clients develop skills to advocate for themselves in order to prepare for the treatment experience in the community.
- Consider incorporating case management services in the step-down component, since this can be a critical service for clients who do not have family support to help navigate aspects of care.

Other Highlights

- The OnTrackNY program was already closed to new admissions when all services became remote due to COVID-19. The team initially slowed ETP enrollment to account for the smaller number of intake slots, but is now closer to regular flow. During COVID-19, many youth groups have been able to thrive online, and the team plans to continue the parent group by Zoom as long as it is reimbursable through telehealth because it has been less of a burden on families to participate that way than in person.

Coordinated Specialty Care (CSC) Continuity of Care Case Study Site Visit Report

Felton (re)MIND® San Mateo County, California
August 2020

I. Overview

Felton (re)MIND® San Mateo is a CSC program established in 2012 in San Mateo County, California. It is one of five Felton Institute early psychosis sites in Northern and Central California Coast counties. The (re)MIND® early psychosis programs are all operated by Felton Institute, which provides a variety of social and behavioral health services to children, youth, families, adults and seniors. In July 2018, Felton (re)MIND® San Mateo was funded to pilot an alumni services program--Felton (re)MIND Alumni®--designed to serve as a bridge between the CSC program and services that participants could receive in the community. The San Mateo (re)MIND® site is the only Felton early psychosis program that offers alumni services.

We selected Felton (re)MIND® San Mateo for inclusion in the CSC Continuity of Care Study as an example of a step-down program.

II. State Context

Mental health services in California are administered and provided by the California Department of Health Care Services, Mental Health Services Division. In 2004, voters passed the California MHSA. The MHSA is funded by a one percent income tax on personal income in excess of $1 million per year. It is designed to expand California's behavioral health system to serve individuals with, and at risk of, serious mental health issues. Twenty percent of MHSA funding is earmarked for PEI strategies, which is how the early psychosis programs are classified. San Mateo County Department of Behavioral Health and Recovery Services is the organization that contracts with Felton to provide services. The County allocates the funding for the San Mateo early psychosis program and oversees administrative aspects of the program, such as census, waitlists, staffing and timelines.

Felton program leadership meet quarterly with the County of San Mateo through their Steering Committee Meetings. Felton also is involved in San Mateo County committees, such as the youth transition assessment committee, which alerts them to clients who may be experiencing first-episode psychosis. There was a recent transition in leadership at the county because the Medical Director who introduced the Felton Institute to San Mateo County passed away earlier this year. The new medical director has not yet had involvement with the program or attended the steering committee meetings; however, there are plans for that process to begin in the near future.

III. CSC Implementation

Model: The site uses the Felton Early Psychosis Model. Services include standard components of CSC, including psychotherapy, case management, medication management, supported employment, supported education, and family psychoeducation. The program delivers CBTp and offers peer support, family peer support and multifamily groups. If a client enrolls in the (re)MIND® program and is already taking medication, clients have the option of keeping their existing prescriber. Of the clients that enter the program with medication, approximately half choose to stay with their existing prescribers and the other half transfer medication management to the CSC team prescriber.

Program size: The San Mateo site currently has 45 clients with a maximum size of 80 clients.

Population and age range served: The program serves clients with schizophrenia spectrum disorders who are ages 14-35, with the majority of clients falling between 16-25 years. Inclusion criteria include a DUP of two years. The (re)MIND® program also includes people who are CHR. In a given year, no more than ten individuals will be in the CHR category. The (re)MIND® program does not include individuals with affective psychosis. The San Mateo site offers an affiliated program called Bipolar Early Assessment and Management (BEAM), which is a CSC program for individuals with affective psychosis. Though the clinical interventions provided in the two programs are similar, the (re)MIND® and BEAM programs are separate for administrative funding and evaluation reasons.

The catchment area for the Felton (re)MIND® program is San Mateo County, California; however, clients in the alumni services program can be outside of San Mateo County. Among re(MIND)® clients, 53 percent are male. The racial/ethnic background of participants is quite diverse: The three largest groups represented are Mexican/Chicano (29 percent), White/Caucasian or European (22 percent), and Filipino (12 percent). The program provides services to clients in both English and Spanish. The program can serve individuals with either Medicaid (known as MediCal in California), private insurance, or uninsured. Of all Felton early psychosis programs, the San Mateo site serves comparatively more individuals with commercial insurance.

Program length: The program is designed to last two years; however, clients can stay in the program an extra six months if they are part of the multifamily group or if clinically indicated. One specific provision of PEI services funded by the MHSA is that services cannot be extended over four years. As such, clients can receive a maximum total of four years of service in the San Mateo program.

Funding/Medicaid reimbursement mechanism: The program is funded through California's MHSA PEI dollars. The dollars are dispersed through the County of San Mateo, which bills services to Medicaid and private insurance providers.

Data collection and monitoring: Clients entering the Felton (re)MIND® program are assessed with the Structured Clinical Interview for DSM-5 Disorders and the SIPS. Other assessments include:

- Adult Needs and Strengths Assessment (ANSA)--Mental health
- Prodromal Questionnaire-Brief version (PQ-B)--Prodromal symptoms
- Modified Colorado Symptom Index (CSI)--Symptoms
- Brief Psychiatric Rating Scale (BPRS)--Symptoms
- Lehman's Quality of Life Global Rating Scale--Quality of life
- Mental Illness Research Education and Clinical Center version of the GAF scale (MIRECC-GAF) Symptom, Social and Occupational Functioning Scales

Integration within organization: Felton Institute, formerly Family Service Agency of San Francisco, is a non-profit social services and behavioral health provider in the larger San Francisco Bay Area. The (re)MIND®, BEAM, BEAM UP®, and (re)MIND® Alumni programs are a part of the Early Psychosis Division of Felton Institute. In addition to the Early Psychosis division, Felton Institute's core services divisions consists of adult services, children, youth, family services, seniors services: justice services, and training and research. While in (re)MIND® clients do not typically access services from other programs within Felton Institute.

Team members emphasized the integration of the CSC program into the existing system of care. In San Mateo County, Felton spent a considerable amount of time doing public presentations, joining various leadership groups, and getting connected to the various systems of care within the county. Staff members at Felton do community education about early psychosis for providers, hold trainings on CBTp, invite community providers to graduation ceremonies, and try to be a resource of information about early psychosis. Felton became known as a partner throughout the county and when clients transition, they are able to make use of the service relationships that were already in place.

EXHIBIT CA-1. CSC Team Staff

Name		Position Name	Degrees/ Licensure	Length of Time Working at Organization	% Time Working on CSC
1.	Adriana Furuzawa	Early Psychosis Division Director	MA	7 years, 5 months	30
2.	Bruce Adams	Associate Director	MS	6 years, 6 months	100
3.	Emily Mann	Clinical Team Leader	MA	3 years, 5 months	100
4.	David Johnson	Bilingual Staff Therapist	MA	4 years, 5 months	100
5.	Tato Torres	Bilingual Staff Therapist	PhD	5 months	100
6.	Monet Burpee	SEE Specialist	BA	7 years, 5 months	100
7.	Philip Hershon	Peer Support Specialist	BA	3 years, 9 months	100
8.	Michael Krechevsky	Family Support Specialist	BA	3 years, 6 months	100
9.	Jennifer Brewer	Psychiatrist	MD	3 years, 10 months	10
10.	Reva Longacre	Psychiatric Nurse Practitioner	PMHNP	4 years, 5 months	50
11.	Rosalind Picou	Quality & Performance Manager		5 years	25

Site staff roles and background: The San Mateo Felton staff include the Early Psychosis Division Director, the Associate Director, two prescribers, three clinicians, a SEE specialist, a peer support specialist, a family support specialist, a senior evaluation

manager, and an office manager. With the exception of the psychiatrist and the senior evaluation manager, all staff members have 100 percent time at the San Mateo program.

IV. Site Visit Respondents

EXHIBIT CA-2. List of Respondents Interviewed		
Name	**Position**	**Organization or Affiliation**
Adriana Furuzawa	Early Psychosis Division Director	Felton Institute
Bruce Adams	Associate Director	Felton Institute
Emily Mann	Clinical Team Leader	Felton Institute
David Johnson	Bilingual Staff Therapist	Felton Institute
Monet Burpee	SEE Specialist	Felton Institute
Reva Longacre	Psychiatric Nurse Practitioner	Felton Institute
Philip Hershon	Peer Support Specialist	Felton Institute
Michael Krechevsky	Family Support Specialist	Felton Institute
Rod Cooper	Office Manager	Felton Institute
Doug Fong	Clinical Services Manager II	San Mateo County Behavioral Health and Recovery Services

V. Featured Program Aspect Description

I was really glad when we added our alumni care into the program. It makes so much sense. Our participants have put in so much work in their recovery over the 2 years when they are in the core program. But even then, 2 years is not enough. It can take half that time for clinicians to build the rapport with the person and then to really get into the work. The vast majority of folks come in with pretty significant histories of trauma. Getting to dive into those things definitely takes time and rapport building with the clinician. Sometimes it really feels like when a person is ready on paper for graduation that's really when people are in the throes of some really great work. So, with the step-down model and with alumni care, we can continue that work. And the disruption of care does not occur, which can be such a set-back for the participant, as they have to find a new therapist, a new med provider, tell their story all over again. Also whoever they transition to, they are not going to be experts like we are. It's a great opportunity for us to continue that work. Sometimes it feels we're like, "Okay go now. Go fly." When really the resources out there can be less than satisfactory. So, we get to continue to hold people and I just think it's really important.

--CSC Team Member

Summary

- Felton (re)MIND® Alumni began in 2019 as a step-down program for clients in the (re)MIND® program. Not all Felton (re)MIND® clients are served through alumni services; it is intended for clients who are engaged with multiple team members (i.e., not only the therapist) and express a desire for continued services. Approximately 30 percent of (re)MIND® clients transition into alumni services.

Clients with affective psychosis in the BEAM program are also eligible to participate in (re)MIND® Alumni.

- Clients in Felton (re)MIND® Alumni are technically still enrolled in (re)MIND® and the program includes the same components as (re)MIND® provided by the same clinicians. The primary difference is the lower frequency of therapy and medication support services, and the higher frequency of SEE, and peer/family support services.
- Felton (re)MIND® Alumni has a stronger focus than reMIND® on helping clients practice personal responsibility, self-sufficiency and overall independence. Clients may receive fewer prompts or reminders for appointments to allow them opportunities to manage those tasks for themselves. Clinicians will tailor the level of reminders and support to a client's needs. Within a four year period, a client can increase the level of services if needed.

Rationale/History for Program or Practice

- Staff members observed that clients became accustomed to a certain level of coordinated care after going through (re)MIND®. Clients expected an approach to medication management specific to early psychosis care. Some clients who left the program struggled to remain engaged in treatment in the community.
- Staff also observed that prior to the development of (re)MIND® Alumni, families struggled when their loved one graduated. For example, the team found the need to extend multifamily groups for six months post-graduation because families wanted that continued level of support.
- The Felton (re)MIND® Alumni program was proposed as a way to extend care for an additional two years and continue to be that bridge for young people and their families. The program also allows staff to track how clients are doing after graduation.

Funding

- Felton leadership worked closely with the County of San Mateo Department of Behavioral Health and Recovery Services to identify funding. The (re)MIND® Alumni program is funded through MHSA's PEI.
- The (re)MIND® program also bills for clients who have either Medicaid (Medi-Cal) or private insurance, and this is extended to (re)MIND® Alumni clients.

Preparation, Practices and Policies

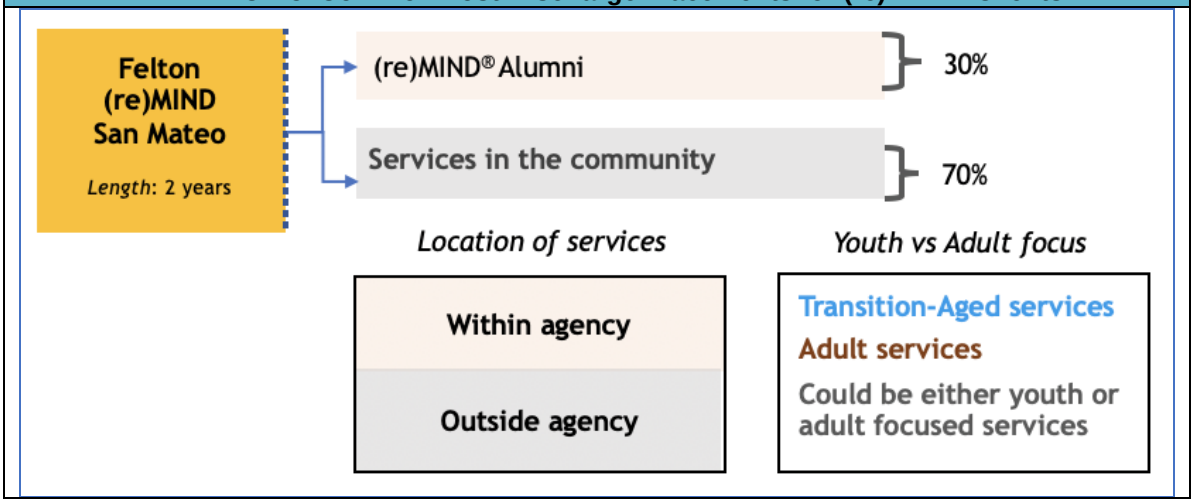
- When clients first come into the CSC program, the team conveys that this is a time-limited intervention and over time, the client may not need this intensive level of service.
- The staff have weekly case conferences in which the team discusses the phases of treatment, including whether clients may be ready for discharge.
- Staff also have discharge planning meetings to identify what is in place for clients and what support needs to be put in place after they graduate. Staff members

also discuss clients' behavioral health needs, identify possible resources post-discharge (e.g., individual therapy in the community, group therapy, medication management, support groups), and discuss how the client is planning to manage their symptoms.
    - Approximately six months before a client transitions from the program, the care team will raise graduation with the client (and the family when appropriate) and inquire about their interest and preferences.
    - Approximately three months before discharge, clinicians work with clients to develop a wellness plan and identify options, including whether they want to continue with (re)MIND® Alumni.
    - Approximately two months before discharge, clinicians will work with clients to call and identify treatment providers if they are choosing to leave the program.
- When a client graduates (and is *not* entering (re)MIND® Alumni), the team holds a graduation party to mark the event as a milestone. Families, staff members and others may attend, and individuals who have completed the program may speak to those who are graduating. Staff speak about the progress the client has made.
- Team members prepare survival kits, resources, and medication refills to help support the client after discharge.
- Team members try, if they are able, to meet the new provider with the client and do a warm handoff.

Post-Discharge Placements

Exhibit CA-3 provides an estimate of post-discharge placements for clients graduating from Felton (re)MIND®.

EXHIBIT CA-3. Common Post-Discharge Placements for (re)MIND® Clients



- In Alumni Services, individual therapy sessions tend to occur less frequently than in (re)MIND® with the rationale that most clients at this stage of treatment have developed more mastery in skills through CBTp. Therapy may occur once or twice a month in Alumni Services, compared to weekly in (re)MIND®; medication

management appointments may be once every 4-6 weeks as compared to every two weeks in (re)MIND®.

- If a client leaves the Felton program and then wants to return four years after their initial enrollment date, staff would have to request authorization from San Mateo County to allow the client to re-enroll in the program. If four years has passed since their initial enrollment date, the CSC team will typically discuss the case with an ACT team and do a warm handoff to that program
- For clients who do not enter (re)MIND®:
    - Clients 18-24 years have access to a county based Transitional Age Youth (TAY) program called Youth to Adult Committee, which has a peer partner, a family partner, a medication provider, and a therapist.
    - Clients of all ages are referred to community psychiatry for medication management. Clients may also go through their health plans to identify a prescriber.
    - Some clients may access residential treatment, transitional housing services or supported independent living services.
    - Clients who are not on medication and transitioning to college are connected with resources such as the student affairs office in the college to ensure they have counseling or other supports.
- If a client discharges from the program, the client can access up to six booster sessions with each CSC provider, except the prescriber.

Perceived Advantages: What Does This Allow?

- Having the alumni services program has allowed the transition at the two year mark to become much smoother. If a client received services for two years but still requires more support, they could graduate if that was clinically indicated and have the option to move to less intensive services in the alumni program with the same therapist, prescriber, SEE specialist, peer and family peer specialist.
- The alumni services program allows clients the opportunity to maintain the gains they achieved in the (re)MIND® program, and in doing so instills a feeling of hope for clients and their families.
- Having the alumni services program allows staff to see the progress that their clients are making. It reinforces job satisfaction because it allows staff to witness that the work that they are doing with clients is making a difference.
- Stress from important milestones, such as attending college, may contribute to distress or relapse, and having a step-down program during those critical times can provide clients with a safety net.
- Respondents noted that for medication management, the program provides a unique opportunity to help a person form a different type of relationship with medication as one part of the recovery plan. Team members have a chance to discuss all the aspects of recovery with clients, and that there may be points in time when medication takes up more of the recovery picture; however, respondents noted that the goal for this population is to shrink the role medication plays as a person is able to engage in education and employment and learn skills in therapy. In other treatment settings, medication is often at the

forefront because of how advanced the illness is; however, respondents noted that it does not have to be like that with their clients for the entire time they are in the program.
- Moving more clients into (re)MIND® Alumni frees up more time for clinicians to take on other clients in the program.

Challenges

- The impact of (re)MIND® Alumni services is still unclear. This uncertainty creates challenges in advocating for continuous funding.
- Defining the right mix of step-down services can be a challenge. The (re)MIND® Alumni program was designed to provide more access to psychosocial rehabilitation services (peer support, family support, SEE specialist) while transitioning clients to community resources for psychotherapy and medication support, with the intention of promoting the development of a community safety net that former CSC participants can access as needed. However, barriers to accessing these services do exist due to provider shortage and gaps in insurance coverage.
- It can be challenging to identify providers outside of the public behavioral health system of care that take private insurance and who accept clients with a schizophrenia diagnosis. Finding a private insurance provider can be a lengthy process because often insurance companies do not categorize providers by their expertise or specialty within psychiatry. Clients and families get a very long list of providers that then the family is tasked with calling. Then time and time again they are told that the providers do not work with people with psychosis. This process of rejection can be discouraging for clients and their families.
- Medication management providers in private practice are difficult to access because they often work in more solitary environments, rather than working as part of a team with others who can support clients with therapy and case management.
- Clients with Medi-Cal have more provider options at the county level than individuals who have private insurance, as there is more of a collaborative approach to care and services include peer support and case management as part of treatment.
- Respondents noted that it is difficult to find adequate treatment options for young people who have both early psychosis and a substance use disorder. Service systems are often siloed and it can be difficult to get specialized treatment for substance use if someone has a schizophrenia diagnosis.

Lessons Learned: Recommendations for Other Programs

- Discuss the process of transition early on in the treatment process, using shared decision-making.
- If a client has less need for medication management or therapy, they may still be engaged in supported employment or education and can work to achieve those types of goals while in a step-down program.

- When developing an aftercare or step-down program, it is important to identify the components of the program that clients are engaged in, determine whether those components would also be part of the continuation of care, and plan if the existing services should be altered in some way. Also, it is useful to determine whether new components that are not a part of CSC should be included in the continuation of care.
- Identifying a way to serve clients outside the county is useful with a step-down program because it provides a client with support if they have moved to a new area.
- Having peer support can be therapeutic for clients because they can talk to each other about what they are facing, without a sense of shame, as they are often going through similar experiences.
- Treating co-occurring disorders and substance use disorders at the same time is a best practice and the Comprehensive Coordinated Integrated System of Care model provides information about that approach.

Other Highlights

- Since the pandemic began, therapists have had shorter, more frequent sessions with clients per week. Some clients have adapted to online meetings and it has helped clients who live farther from the clinic; however, virtual meetings are a challenge for some clients with paranoia about technology and family members who do not have reliable Internet connectivity. Parent support groups have ceased since the pandemic because it is difficult to maintain privacy; however, family members are reaching out for more individual support sessions.
- Respondents noted that it would be useful to collect post-discharge data on clients' social connectedness, employment and education outcomes, quality of life, hospitalization, use of medication and relapse.

Coordinated Specialty Care (CSC) Continuity of Care Case Study Site Visit Report

Deschutes EASA, Bend, Oregon
August 2020

I. Overview

The Deschutes EASA program began in 2008, and was one of the first sites launched by the Oregon Health Authority (OHA) as part of a statewide initiative to provide universal access to early psychosis intervention. Deschutes County Health Services operates the program, and in addition to Deschutes, also serves two other rural counties. The Young Adult in Transition (YAT) program is a state-funded initiative that provides an extension of EASA services for young adults who are under 25 years old. As discussed in more detail in Section V, the YAT program also serves youth who are not part of EASA.

We selected Deschutes EASA for inclusion in the CSC Continuity of Care Study as an example of a program with a step-down program. Deschutes County has other components of interest; it participated in the federal CCBHC program, the county has implemented Wraparound services, and the organization has also received a Substance Abuse Mental Health Services Systems of Care expansion grant.

II. State Context

Oregon has a long history with first-episode psychosis programs, predating the RAISE study and most other locations in the United States. EASA started as a five-county program, and currently has 26 sites across the state. Most have a catchment area of a single county; the Deschutes site is one of two that cover multiple counties.

The OHA contracts directly with all the EASA sites. OHA also contracts with the EASA Center for Excellence (CfE), located at Oregon Health and Science University to provide training and technical assistance. EASA CfE developed a set of practice guidelines that all EASA sites use as the basis of their services. The CfE has a monthly call with local directors and holds regular clinical consultation calls. Through the EASA CfE, nurses, OTs, and prescribers each have their own monthly phone calls that draw from across EASA sites. EASA CfE also conducts fidelity assessments, maintains a centralized website, collects and analyzes data from sites, has a listserv, and hosts conferences. The CfE has a training process in place any time a new staff joins an EASA team. EASA also has a state-level Young Adult Leadership Council, which provides an avenue for EASA graduates to help guide and support EASA's work. The Council meets monthly.

In July 2010, Oregon became part of the Systems of Care Wraparound Initiative, which provides intensive care coordination to develop a flexible, comprehensive and

individualized care plan for high-need children and families. In 2016, Oregon was one of eight states that received a CCBHC planning grant. CCBHCs must directly provide or contract to provide eleven different services.

III. CSC Implementation

Model: Deschutes EASA follows the EASA model, which has clearly articulated practice guidelines. The EASA model identifies five phases of care, including two that specifically relate to transitions and post-transition work: *Transition* and *Post-graduation*. In Deschutes, there is no dedicated SEE specialist; the case manager plays this role but he does not have formal training in SEE. The team refers clients who need more extensive services to the workforce office, which is a state funded vocational rehab program. The Deschutes EASA team also includes an OT, who completes assessments with clients and communicates with other team members to discuss environments that may help people be more successful.

Program size: At the time of the site visit, there were 35 clients enrolled, and the program has a maximum size of 45 clients.

Population and age range served: Deschutes EASA serves individuals residing in Deschutes, Crook or Jefferson counties, between the ages of 12-29. Because it is a two year program, clients cannot be older than 27 at entry. Most clients tend to be between 18-20 years old, and approximately two thirds are male. While the Latinx or Latino population in Central Oregon is only about 8 percent, at one point, the EASA census included a third Latinx/Latino clients. Socioeconomically, EASA serves the full range of incomes.

Program length: When originally started in 2008, program length within the EASA model was 3-5 years. A few years after implementation, the CfE observed there was not enough focus on transitions and clients and clinicians were not well prepared. The CfE then defined a transitional process and reduced the program duration to two years as a way to reinforce that EASA is a transitional program. Currently, the Oregon state legislature is discussing whether to extend the program length. EASA Deschutes generally follows the two-year guideline, but the team will make extensions based on clinical need.

Funding/Medicaid reimbursement mechanism: All EASA sites receive some amount of state general funds and MHBG funding, all accept Medicaid, and all are required to accept private insurance. There are no restrictions on services based on ability to pay, the county absorbs the expenses for uninsured. Medicaid expansion in Oregon has resulted in less than 5 percent of EASA clients at the state level being uninsured.

Data collection and monitoring: As with all EASA sites in Oregon, Deschutes collects and sends data to EASA central quarterly. The EASA data elements include a wide range of domains, covering the client's living situation, legal involvement, substance

use, education and employment, service use, and hospitalizations. The team completes assessment for clinical high-risk (CHR) clients using the SIPS and the PQ-B.

The OT conducts assessments at baseline, and repeats selected measures:

- Adult/Adolescent Sensory Profile--Sensory processing patterns and effects on functional performance (baseline only)
- Canadian Occupational Performance Measure (COPM)--Perception of occupational performance (repeated)
- Self-evaluation of living skills--(repeated)
- Executive functioning--(may repeat)
- Allen Cognitive Level (ACL)--Level of occupational functioning (repeated)

There are data that the OHA requires for participants in the YAT program, but these two systems have historically not been in alignment. With a new System of Care expansion grant through SAMHSA, Deschutes is going to reevaluate how to think about data in the two programs.

Integration within organization: The EASA program falls under the auspices of the Intensive Youth Services division of the county, which also includes the YAT program, Wraparound services, and a drop-in program referred to as The Drop. We describe the relationship between EASA and YAT in detail as a featured program aspect in Section V. **Wraparound services** overlap with EASA in that the wraparound care coordinator, along with the EASA coordinator, will facilitate coordination meetings, especially if a client needs a higher level of care and he is 18 or younger. EASA providers have all received training in the wraparound framework, so the same approach to coordination occurs for all clients, not just for those 18 and under. **The Drop** serves youth between the ages of 14-29. While the actual physical Drop is not currently open due to COVID-19, under normal circumstances it offers access to computers, a place to do laundry, snacks, and general entertainment. A program to address substance use also operates at the Drop. In addition, the partner Federally Qualified Health Center, Mosaic Medical, provides services once a week through a mobile van program. Dental services are also available.

As part of being a CCBHC, the team collects data on all EASA clients using the core CCBHC metrics. The CCBHC family partner at Deschutes primarily works with Wraparound services but has worked with a few EASA families to help them engage in services. As a CCBHC, EASA clients have also gained more coordinated services with a primary care provider, and this provider attends clinical meetings for YAT and EASA.

Site staff roles and background: The EASA team has three therapists, two case managers, a nurse, an OT, a psychiatrist, and a peer support specialist. There are also multiple people in supervisory and management roles. Most of the staff listed in Exhibit OR-1 also have a role with the YAT.

EXHIBIT OR-1. CSC Team Staff					
Name		Position Name	Degrees/ Licensure	Length of Time Working at the Organization	% Time Working on CSC
1.	Elizabeth Renteria	Program Manager / Clinical Manager	LCSW	8 years, 6 months	33
2.	Wil Berry	Medical Director	MD	4 years, 11 months	20
3.	Shannon Brister	Program Supervisor	BA	14 years, 5 months	33
4.	Suzanne Garliepp	Clinical Supervisor	LCSW	10 years, 6 months	33
5.	Lindsey Tischart	Therapist	LPC	7 years, 6 months	100
6.	Bob Estabrook	Therapist	LPCI	1 year, 2 months	100
7.	Robert Meringolo	Therapist	LPCI	4 years, 7 months	33
8.	Zackary Madison	Case Manager	BA	3 years, 6 months	100
9.	Dustin Fanning Painter	Case Manager	CADC	4 years, 3 months	33
10.	Siobhan Watson	Nurse	RN	3 years, 11 months	50
11.	Heather Welker	OT	OT	1 year, 1 month	50
12.	Bri Kiso	Peer Specialist	BA	3 years, 2 months	33

IV. Site Visit Respondents

We focused our interviews on Deschutes County staff who have a role in both EASA and the Youth in Transition program. In addition, we interviewed the Director of the EASA CfE, which works with EASA programs not only across Oregon but nationwide.

EXHIBIT OR-2. List of Respondents Interviewed		
Name	Position	Organization or Affiliation
Elizabeth Renteria-Holden	Program Manager, Comprehensive Care for Youths and Families / EASA Clinical Lead	Deschutes County
Shannon Brister	Program Supervisor, Intensive Youth Services	Deschutes County
Robert Meringolo	Therapist (EASA / YAT)	Deschutes County
Zackary Madison	Case Manager (EASA / YAT)	Deschutes County
Bri Kiso	Peer Specialist (EASA / YAT)	Deschutes County
Heather Welker	OT, Intensive Youth Services	Deschutes County
Siobhan Watson	Nurse, Intensive Youth Services	Deschutes County
Tamara Sale	Director	EASA Center for Excellence

V. Featured Program Aspect Description

We rely heavily on relationship and a youth-centric developmental approach. It's the old social work adage, just start where the client is. Don't build a system and expect the client to come to you. You build a system around their individual needs and their plan around them. I think we can do that and take into consideration what has worked for them, what they want, even how they want their transitions to go. We prepare for a healthy goodbye, or healthy hello. We can really take that into consideration.

--EASA Team Member

Summary

- The Young Adult in Transition (YAT) program is an IOP that is available to individuals between the ages of 14 and 26 who graduate from EASA. The EASA team designed YAT with EASA clients in mind, as an "EASA-lite." In addition to graduates from EASA, YAT serves young adults who do not qualify for EASA, for example, those who have had a diagnosis of schizophrenia spectrum disorder for more than a year. YAT serves youth with other mental health conditions and/or who have limited natural supports, including youth experiencing homelessness. Individuals can stay in YAT as long as they meet the age criteria. The size of the YAT program is 70, which is double the size of EASA.
- Service intensity in YAT can increase to be at the same level that a client would receive in EASA, if needed. A client does not return to EASA once they have aged out of the program.

Rationale/History for Program or Practice

- Approximately three years after EASA began in Deschutes, the OHA issued a RFP to launch four "youth hub" programs to support young adults in transition. At that time, the EASA team already saw the need for a step down for younger EASA clients because there were no options that were developmentally appropriate for youth. Clients who entered adult programs were discouraged and turned off when they saw older individuals with schizophrenia who had not received early intervention.
- Deschutes County applied for and received the grant, and launched the YAT program in 2012. The Deschutes EASA team intentionally designed YAT as a step down for young adults who attended EASA, as well as a program for people who did not meet the narrow diagnostic and other criteria for EASA.

Funding

- The YAT program receives support through a combination of funding from OHA and Medicaid billing.

Preparation, Practices and Policies

- Clients and families know from the beginning of services that Deschutes EASA is a two- year program and that it has different phases embedded within that time.
- EASA team members identified client and family voice and involvement as the most critical component in transition planning.
- The EASA model supports transitions through a transition checklist. The checklist and processes involve specifying a wellness/relapse prevention plan, a crisis/safety plan, identifying medical staff, identifying whether the client wants ongoing counseling and medication, medication coordination, treatment goals. The lead therapist generally has responsibility to complete the transition checklist

and will start the process at least 6 months in advance. Team members consistently identified the checklist as helpful.

- The team also uses the EASA and OT assessments to help make decisions about transitions.
- In preparation of the transition, the peer support specialist focuses on helping clients "end relationships in a healthy way."
- The case manager is trained in wraparound care coordination, and the team also uses that framework to support transitions. The case manager will coordinate a treatment team meeting between the old and new team. This meeting allows the client to decide whether he feels that the new therapist will be a good fit; the team does not just assume it will be the assigned therapist and that "it's a done deal." There is still an opportunity to change.
- Each client has a graduation celebration when they leave EASA that includes the family, all the therapists, and anyone else they want to include. The program views the ceremony as a way to mark progress and celebrate gains, rather than to imply that treatment is complete--since the majority of clients continue in either YAT or adult intensive services.
- The nurse has a high level of contact with clients and since she works across both programs, she will even go to a client's home and take them to their therapist to make sure the transition actually takes place. Since the nurse also works in the adult clinic at times, she knows the nurses in that department and can help communicate about individuals who have intense medication needs and are in that program.
- The team keeps cases open for several weeks even after the transition in case there is a need for the client to come back.
- The Drop itself is a program that itself facilitates transitions because clients will often have familiarity with the center prior to transition, through attending specific activities or even just being there for a cup of coffee or to talk. The Drop also has a common area where clients can interact with agencies providing community resources.

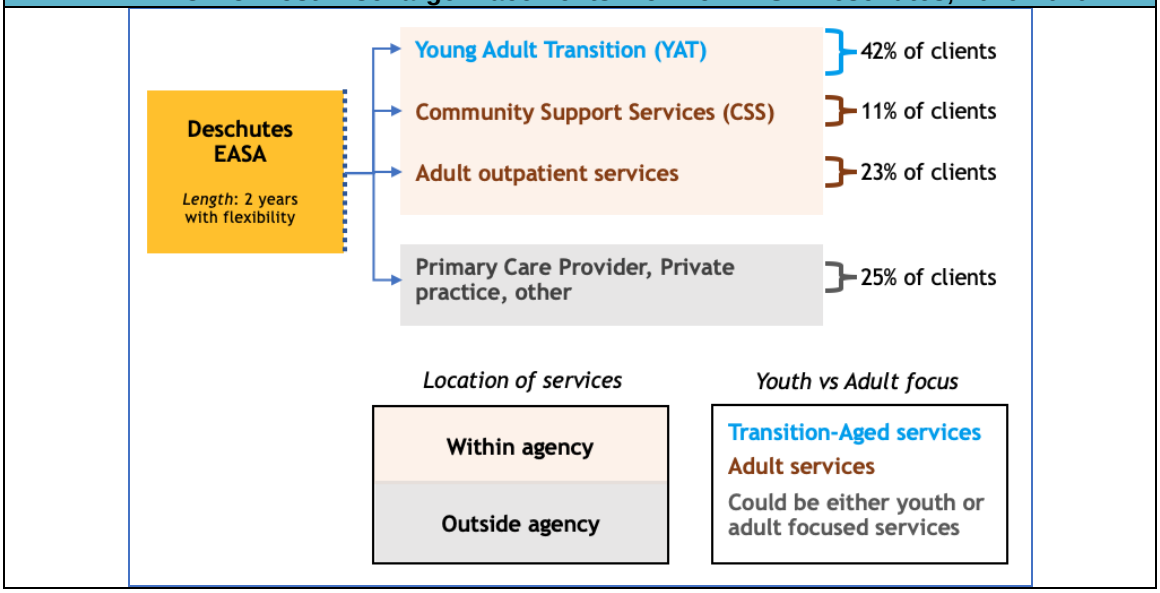
Post-Discharge Placements

- The EASA team views YAT as the first choice placement for clients who need continued care. The transition to YAT is essentially seamless; YAT is in the same building as EASA and the same person oversees both programs. Like EASA, it uses a team-based approach, and the same nurse, OT, therapist and peer from EASA are all still available and provide services to individuals in YAT. The EASA case manager also works on the YAT team and can continue to see clients once in YAT if they are in the middle of working on a specific goal.
- The main difference in services between EASA and YAT is that the level of contact in YAT is less. In YAT, there is typically three to four contacts with providers per week as compared to 5-6 in EASA. The higher caseload in YAT means that team members cannot do the type of outreach that occurs in EASA, which may also contribute to less engagement with services. Another difference in the programs is that EASA incorporates a high level of family involvement, and

because the YAT population does not always have family supports, YAT emphasizes this less.

- Clients who need continued support but are too old for YAT services will go to Community Support Services (CSS) or the adult outpatient program, all within the County agency. CSS is located in walking distance from EASA, and there is a high level of collaboration between all three programs and EASA.
- Deschutes County has an ACT program but the program has not typically accepted clients from EASA.
- Clients who do *not* need as high a level of support transition either to adult outpatient or child and family services within Deschutes County, or to community-based providers (often, the practitioner who referred them to EASA originally). However, referrals to the community has, at times, resulted in "bounce back" when the community provider contacts EASA and asks if the client can return.
- Up until COVID-19, Deschutes EASA facilitated an aftercare group for families that family members generally led and which met twice a month. The group served as a place for emotional support, with EASA staff providing information as needed.

EXHIBIT OR-3. Post-Discharge Placements Flow for EASA Deschutes, 2019-2020



Perceived Advantages: What Does This Allow?

- Having a youth-focused program is helpful to younger clients who are difficult to engage. They would likely not feel comfortable in a program with older clients.
- The YAT structure allows for whatever intensity of services the client might need, including services at the same intensity as in EASA. This helps the client transition to a lower level of care on their own timetable.
- Since many EASA clients lack family support, the YAT program is a good fit since it provides a high level of continued care and support.

- Services for the YAT and EASA are in the same building, and the YAT team can easily consult with the case manager and others, if needed. Team members all know each other and it is easy to coordinate treatment team meetings. Without YAT, team members noted that communication would be difficult.
- Having team members who go between the programs provides clients with a familiar face and staff believe it helps clients adjust and follow through more consistently.
- In some cases, clients have started in the YAT program and staff have identified them for services through EASA because of the presence of psychotic symptoms.
- Team members report a high level of job satisfaction because they can work with a client "from start to finish" and see progress. One team member noted that this creates a great work environment.

Challenges

- Initially, some participants in YAT felt isolated because the program includes youth who have not experienced psychosis. To address this, the staff set-aside a specific time for people with psychosis to attend.
- Due to organization policy, a client cannot receive *only* medication management through Deschutes County. As a result, a client who does not want to receive therapy after graduation but still wants to take medication must receive services from an outside provider, and loses the continuity of care that would otherwise be possible.
- There have been internal (organization) challenges to admit EASA clients into ACT services. This eliminates a potential post-discharge placement option for older clients who need continued care.
- OHA is not evaluating the YAT and other youth hubs, so there are not clear data to assess outcomes.

Lessons Learned: Recommendations for Other Programs

- Conceptualize services more in terms of systems of care rather than individual programs. Doing so means that there is a need to be proactive about relapse prevention, and engage in partnerships with community programs and agencies that can provide different aspects of the needed support. Build these relationships intentionally over time as part of the transition. Bring child serving and adult serving agencies together to discuss how to support families and young adults struggling with mental illness.
- Conduct coordination meetings using wraparound principles. Members can use these meetings to review client strengths, introduce clients to the new team, provide encouragement, and ease client anxiety. Plan for multiple meetings.
- Start transition discussions with the client early, and develop everything in collaboration with the youth.
- Have very strong relationships with the receiving provider, and provide opportunities staff from different programs to get to know each other. Make sure

a system of communication is in place before the transition and establish an expectation of strong communication with whomever the provider may be. Communicate with the next treatment team as early as possible.

- As much as possible, try to provide clarity around diagnosis at the time of transition. Clients often diagnostically fall into a gray area, but because they have participated in an early intervention program, they may think that they have schizophrenia and identify as “sick.” In some cases, the diagnosis may not be clear and explaining this to the client at discharge may help them better understand their illness.
- Have one person on the team check in with the new therapist for a couple of months after the transition to ensure that the client remains engaged.

Other Highlights

- With COVID-19, the Drop has not been open, and the virtual Drop does not have the same level of participation. It is more difficult for staff to connect as well because they relied a lot on in person communication since everyone was in a shared office space.
- Within Deschutes, a Youth Advisory Council serves as a mechanism for youth to advise and provide information about the system of care, which includes the EASA program. It meets regularly at the Drop for members to talk about services and what they would like to see done differently; the Youth Advisory Council is not only for EASA clients, but all young adults receiving services from Deschutes.

Coordinated Specialty Care (CSC) Continuity of Care Case Study Site Visit Report

OnTrackTN, Nashville, Tennessee
July 2020

I. Overview

The OnTrackTN Nashville FEPI program serves Davidson County, Tennessee. FEPI is operated by the Mental Health Cooperative (MHC), a behavioral health care organization that serves adults, adolescents and children and which has been in operation since 1993. MHC itself operates in 42 counties through its services in nine offices. MHC applied to the state to initiate the MHC FEPI program in response to a RFP, and the program began in September 2016. At the time that MHC began operating FEPI in Nashville, a program in Paris, Tennessee was already up and running through Carey Counseling, and MHC staff members shadowed the Carey program and received one-on-one consultation from them as part of their training. The program also received consultation from OnTrack Central. FEPI provides medication management, individual therapy, SEE, family psychoeducation and support, and case management. FEPI also runs a rap group, operated by the program's full-time peer support specialist, as well as a DBT skills group.

We selected the OnTrackTN Nashville FEPI program for inclusion in the CSC Continuity of Care Study as an example of a program that has a wide array of post-transition options available to clients after completion of the CSC program.

II. State Context

FEPI Nashville is one of five CSC programs that operates in the State of Tennessee as part of the FEPI. The five programs serve eleven counties, and the MHBG Ten Percent Set Aside funds provide support to all but one program. The state provides oversight and technical assistance through a two-pronged approach; the Director of Youth and Young Adult Initiatives within the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS), Division of Mental Health Services oversees program budgets and contracts, coordinates training and technical assistance, and monitors the sites. TDMHSAS also has a contract with the Center of Excellence at Vanderbilt University, under which the Youth and Young Adult Statewide Trainer and Consultant provides training and technical assistance, meet with sites regularly and to work with them to address specific areas of need. The Vanderbilt technical assistance provider meets both with the whole team as well as with individual team members, including meeting with the team lead at least once a month. TDMHSAS ensures that programs follow the MHBG requirements with respect to allowable use of funds and clearly specify the roles and credentials of the CSC team. We note that Vanderbilt University Department of Psychiatry operates its own first-episode program, however,

this program uses the NAVIGATE model and is not part of the TDMHSAS statewide initiative.

The Medicaid authority in Tennessee is called TennCare. Tennessee is not a Medicaid expansion state. Respondents in the case study noted that they did not have a frame of reference to comment on what they might be lacking because of this. Under TennCare, peer support services are reimbursable but at a very low rate. The state is in the process of creating a certification for young adult peers, and having a peer position is something that TDMHSAS encourages FEPI sites to include. In addition, SEE is also challenging to reimburse and programs generally use MHBG funds to support it. Staff at TDMHSAS who are involved with first-episode psychosis programming have been following the movement towards a bundled rate for services that is taking place elsewhere, and would like to see the same occur in Tennessee.

All OnTrackTN programs have a two-year time limit, which is based on the OnTrack model and reinforced through guidance from the state. The state currently has an extension form that can be submitted to request that a client receive services for longer than two years. This form asks the clinician to provide the length of time of the request (not to exceed six months), why the treatment team recommends the extension, what is the anticipated outcome of the extension, and plans for discharging the participant after/if the extension is approved. State representatives noted that it comes up “quite frequently” that sites want to extend the length of stay, particularly since COVID-19. Previously, under different leadership at the state, there was somewhat more flexibility and clients were staying longer.

III. CSC Implementation

Model: All OnTrackTN programs follow the OnTrack model.

Program size: There are currently 21 clients enrolled in the Nashville FEPI program and a maximum program size of 30.

Population and age range served: FEPI Nashville serves individuals who are between 15 and 30, and primarily sees clients in the age range of 18-24. Clients must live in Davidson County. DUP must be less than two years. Currently, the clients served are primarily African American and all but two clients are male. Exclusion criteria include clients with substance-induced psychosis or psychosis due to a traumatic brain injury, IQ below 70, and psychosis that is better explained by autism.

Program length: Consistent with other programs in the state, OnTrackTN Nashville has a two year time limit, and staff tell this information to clients when they first begin the program. Around January of this year, the state leadership worked with FEPI to transition a group of clients who had been in the program for more than two years to other services, mostly within the organization.

Funding/Medicaid reimbursement mechanism: FEPI Nashville receives support through MHBG funds. The majority of clients receive TennCare; there are also clients who receive BHSN, which is a state program that provides mental health services to people who have no other behavioral health coverage, have an income at or below 138 percent of the federal poverty level, and are 18 years or older. A small number of clients also have private insurance.

Data collection and monitoring: Currently, there are different data requirements for clients in FEPI and those in other MHC programs, which means that it would not be straightforward to track outcomes of clients after they leave FEPI, even if they remain within the organization. In addition to client demographics, medications and service delivery information, specific data elements at baseline and every three months include:

- Mental Illness Research, Education, and Clinical Center version of the GAF Scale (MIRREC GAF)--General functioning
- Substance Abuse Treatment Scale (SATS)--Substance use
- Abnormal Involuntary Movement Scale (AIMS)--Medication side effects
- PTSD questionnaire--Trauma
- Columbia Suicide Severity Rating Scale (C-SSRS)
- Adverse Childhood Experiences (ACEs) questionnaire (at initial assessment only)

Every six months the program completes a treatment plan review, crisis plan review, DLA-20 review and an assessment using the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences. Once the client has been in services for six months, staff ideally collect client satisfaction surveys every three months. The therapist conducts additional assessment measures for dissociation, delusional thought content, depression, anxiety and other symptoms on a case-by-case basis.

Integration within organization: We selected FEPI because there are a particularly high number of post-discharge placement options for clients once they leave the program, and consistent with this, the program is very integrated within the larger organization, MHC. In addition to the various programs described in the next section, clients who are age 16 and over can receive primary health services through the organization. There are emergency psychiatric services through the Crisis Treatment Center, where clients can stay for a night or two while they stabilize, and the Crisis Stabilization Unit, which is a seven-bed unit where clients may stay for 3-4 days. Nursing care is available 24/7 for both of these. There is also a 14-bed intensive intervention center located next door to MHC. Lastly, the representative payee office is also located within MHC, so clients who receive Supplemental Security Income (SSI) and have the organization as their payee can easily access this office.

Site staff roles and background: The FEPI team includes five full-time members and a psychiatrist and nurse both at 15 percent time.

EXHIBIT TN-1. CSC Team Staff					
Name		Position Name	Degrees/ Licensure	Length of Time Working at Organization	% Time Working on CSC
1.	Kaylee Wilson	Team Lead	LMSW	6 years, 11 months	100
2.	Madison Anderson	Care Manager	BA	2 years, 10 months	100
3.	Travina Wynn	SEE Specialist	MSW	5 years	100
4.	Abby Graham	Therapist	Med / NCC	11 months	100
5.	Ashley Pace	Peer Specialist	CPRS / WRAP	1 year, 3 months	100
6.	David Patzer	Prescriber	MD	9 years	15
7.	Melissa Fulton	Nurse	RN	2 years	15

IV. Site Visit Respondents

For this case study, we focused our interviews on the FEPI team, state representatives, and supervisors from other programs within the organization.

EXHIBIT TN-2. List of Respondents Interviewed		
Name	Position	Organization or Affiliation
Kaylee Wilson	FEPI Team Leader	Mental Health Cooperative
Abby Graham	FEPI Therapist	Mental Health Cooperative
Kendall Elsass	Program Manager, Child and Youth Special Programs	Mental Health Cooperative
Kris Schonewill	Supervisor, Healthy Transitions	Mental Health Cooperative
Lacie Rice	Supervisor, TAY Program	Mental Health Cooperative
Tiffanie Whitaker	Statewide IPS Trainer and former SEE on FEPI Team	Tennessee Department of Mental Health and Substance Abuse Service
Jessica Mullins	Director of Youth and Young Adult Initiatives	Tennessee Department of Mental Health and Substance Abuse Service
Krystal Fortney	Youth and Young Adult Statewide Trainer and Consultant	Vanderbilt University Center of Excellence and Children in State Custody

V. Featured Program Aspect Description

I think we've seen some really great transitions occur because of our ability to have those in-house conversations, to have relationships built across teams, across providers, to really make that as smooth a process as possible. And to put the individual and family at ease about being served by somebody new and starting a new relationship...the good communication and alignment that we've been able to achieve on an internal level has made for better outcomes when it comes to transitions. So folks don't just fall off the map.

--MHC Employee

Summary

- FEPI Nashville has a clearly defined two year time limit for services within the program. Under the current policy, the program may request an extension from the state of no more than six months if there are extenuating circumstances, such as housing instability or other life events that would make a transition ill-advised.
- Within MHC, clients can enter more than a dozen different potential programs following discharge from FEPI.

Rationale/History for Program or Practice

- The FEPI Nashville program follows state policies with respect to program limits, which stem from the OnTrack model.
- In general, MHC establishes programs based on needs observed over the course of the agencies' operation. For example, MHC established PATH due to a large homeless population the organization serves, and needing particular modalities/ treatment structure to support individuals experiencing chronic homelessness. MHC developed the Transitional program with the Transition to Independence (TIP) model of care because individuals within that age group required specific support that children and adults teams were not providing.

Funding

- Client insurance is a factor in making post-discharge referrals and placements from FEPI Nashville to other programs. Within MHC, Healthy Transitions (like FEPI) is grant-funded and has no limitations based on client insurance. However, MHC does not accept private insurance; an individual with private insurance who is outside the age range of Healthy Transitions would not be able to transition to a program within the organization. The TAY program requires TennCare (and does not serve clients who are uninsured or have Behavioral Safety Net).
- Outside MHC, Vanderbilt *only* accepts individuals with private insurance; this would be an option for these individuals. Two non-profits in the community, Launch Pad and Oasis, are grant-funded and do not have limitations based on insurance; the Park Center requires TennCare.

Preparation, Practices and Policies

- At intake, the team tells clients that FEPI is a two-year program, and a welcome packet that includes a visual depicting the three phases of treatment reinforces this information.
- Meetings take place between the whole treatment team, client, and family every six months. Three months before the transition, the team holds a meeting to specifically talk about potential placements.
- Between three and six months before the transition, the team starts to titrate the services that the client receives, for example, moving from therapy every week to

every other week or even once a month. The services can also increase if needed, but during the last three months, the team will try to remain with a reduced frequency of services and troubleshoot other ways to address challenges besides increasing the frequency of services.

- If clients sign a consent and agree, FEPI will provide a transfer form that outlines the client's work in the program, needs, upcoming appointments, and any relevant psychological evaluation information. This transition plan also includes specific information about education and employment services.
- FEPI will arrange a three way call with the client and current and future care managers. Pre-COVID, these visits would have either taken place on the date of a med management appointment or even in the client's home. The warm handoff usually happens through just one appointment.
- For programs within the organization, FEPI will typically work with the receiving providers for between 2-4 weeks before the transition. In addition to acquainting the new program with the client's particular profile, they will discuss who may be the best specific care manager, for example, a male or female, someone who is good working with difficult parents, someone older or younger. This level of discussion is particularly feasible for transitions into the TAY program, for which the supervisor's office is next door to FEPI.

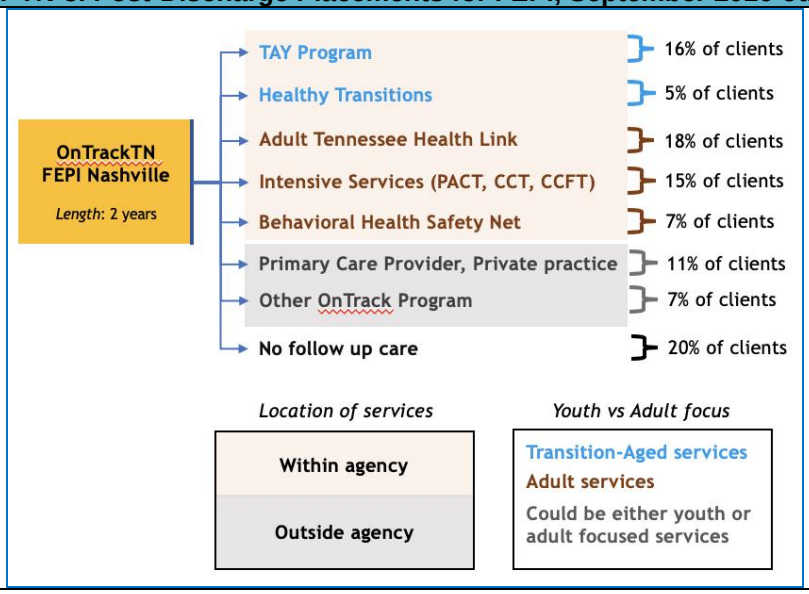
Post-Discharge Placements

- As noted above, there are many different potential post-discharge placements or treatment routes within the same organization, MHC, which appear on the right.
- After discharge, clients do not generally have contact with FEPI providers. If they are in one of the therapeutic groups, they are allowed to continue the group until a natural break point. There are not alumni groups or other specific activities for former FEPI clients.
- At times, a client may have difficulty letting go of the FEPI providers, and will continue to contact them or use the FEPI crisis line. FEPI handles this as a "teachable moment" and communicates with the client but primarily through coordinating with the new care manager to talk through the situation.

EXHIBIT TN-3. Programs that Serve as Post-Discharge Placements for FEPI Clients
▪ Behavioral Health Safety Net (BHSN) ▪ Adult Tennessee Health Link (THL) ▪ Kid Tennessee Health Link (THL) ▪ Medication-Assisted Treatment (MAT) ▪ Transitional Age Youth (TAY) ▪ Healthy Transitions (HT) ▪ Kids intensive--CTT ▪ Comprehensive Child and Family Treatment (CCFT) ▪ Program for Assertive Community Treatment (PACT) ▪ Continuous Treatment Team (CTT) ▪ Medication management only ▪ Therapy Only ▪ MHC-FACT ▪ Program for Assistance in Transition from Homelessness (PATH)

Post-discharge placements from FEPI for September 2016-July 2020 appear below.

EXHIBIT TN-3. Post-Discharge Placements for FEPI, September 2016-July 2020



Programs Specifically for Transitional Aged Youth

Transition Age Youth Program (TAY)

Age: 18-24

Level of intensity compared to FEPI: Lower

TAY serves individuals who are 18 through 24. The program has been at the organization for more than seven years, and staff within this program train in the TIP model. Staff consider the TAY program an appropriate placement for a client who is experiencing life transitions, such as working on completing high school, moving into college, or starting in the workforce with minimal work experience. Clients receive services a minimum of twice a month, but more typically, every week for the first few months. Services will depend on goals, and the program will engage in case management activities like reminding clients about appointments, making sure they have transportation, and coordinating with school or college if that's applicable. Clients also have access to a psychiatrist and in some cases, it will be the same physician they saw while in FEPI.

Healthy Transitions

Age: 16-25

Level of intensity compared to FEPI: Lower

This is a grant-funded program that also serves young adults, ages 16-25 and just began working with clients in January. A supervisor, Individual Placement and Support (IPS) position, peer support specialist, a case manager, and an outreach specialist form the Healthy Transitions team. All staff are training in the TIP model. The IPS specialist from Healthy Transitions collaborates with the IPS specialist from FEPI to meet regularly and talk about job leads. Clients working with a SEE will need to change to the new SEE but can keep their prescriber from FEPI team. Compared to the Traditional Health Link team, a case manager within the Healthy Transitions

program would likely have half the caseload, so Healthy Transitions provides a higher level of services. Healthy Transitions can accept clients with any type of insurance, as well as those with none at all. Healthy Transitions also has funds to provide selected support related to treatment goals such as an interview outfit or help with a rent deposit.

Adult, Non-Intensive Services

Tennessee Health Link (THL)

Age: 18 and above

Level of intensity compared to FEPI: Lower

THL is a TennCare (Medicaid) program and payment model created to serve TennCare members who have the highest behavioral health needs and improve care coordination. The program is based on the federal health home model and started with a State Innovation Model initiative. Clients receive traditional case management, coordination of care, referrals to social supports, member and family support, transitional care, health promotion, and population health management and a therapist if they choose. There is a primary care provider within the organization for clients who are 16 and above, so they can also receive primary health care services at MHC. Transition practices from FEPI to THL are less structured than from FEPI to other programs, the preparation may not involve a face-to-face meeting between the old and new care managers in the presence of the client. Through THL, clients receive a minimum of one care management visit per week and medication management.

Behavioral Health Safety Net (BHSN)

Age: 18 and above

Level of intensity compared to FEPI: Lower (similar to THL)

BHSN shares consumer needs by operating as a team of care management individuals. Caseloads are larger in this program and clients often come into the office to meet with a care manager, instead of the care manager doing outreach into the community. Each client on this team has access to a nurse and a medication provider. This team can only serve people meeting criteria for BHSN. If BHSN lapses, a client's status changes, or someone cannot renew, MHC will discharge the client from services or will transition him into a more appropriate program.

Adult, Intensive Services

Continuous Treatment Team (CTT)

Age: 18 and above (a separate program also exists for under 18)

Level of intensity compared to FEPI: Lower, and lower than PACT

CTT is a step "up" from THL with respect to intensity of services. Clients see a case manager at minimum four times per month (i.e., 1-2 times per week. Medication deliveries might occur weekly or monthly). A medical provider follows clients, providing contact at least once a month, and therapy is based on client preference.

Comprehensive Child and Family Treatment (CCFT)
Age: Up to 18
Level of intensity compared to FEPI: Lower than FEPI.
Clients see a case manager a minimum of ten times per month, which averages 2-3 times per week. Medication management appointments monthly, and therapy as determined by the client and therapist.

Program for Assertive Community Treatment (PACT)
Age: 18 and above
Level of intensity compared to FEPI: Higher (and higher than CTT)
PACT is a team-based program offering daily interactions with consumers who are experiencing acute symptoms of mental illness and would benefit from a high level of support to maintain independence in the community. The MHC PACT program began in 2001. The program sees each client at least twice per week and up to every day including weekends and holidays. The PACT mental health specialists focus on a side-by-side philosophy, assisting with: following prescribed medication schedules, attending clinic, lab, and therapy appointments, engaging with primary care providers or physical health specialists, budgeting, gaining employment, and other items to promote independence. The team consists of seven mental health specialists, a team lead, a supervisor, two registered nurses, and an advanced nurse practitioner. Ideal staff-to-client ratio is 10:1.

Perceived Advantages: What Does This Allow?

- Having such a wide array of programs, and ones that offer different levels of care, gives staff and clients many choices when planning for discharge.
- Since programs are located within the same organization, clients feel a sense of familiarity and comfort with the new program, even if the specific program and care providers have changed.
- Depending on the program that the client enters after discharge, a client may be able to continue to work with the same prescriber.
- Since providers do generally change, this provides the client experience handling change while still in a familiar environment.
- Programs within MHC share an electronic health record system and staff in the receiving program can use that to review the client's history.
- Staff in the TAY and Healthy Transitions programs receive the same TIP model training and all work in a team-based approach. For clients who move into these programs, the programs "feel" similar, although by having less intense support, clients are able to build longer-term independence through the process.
- Since programs are in the same building (and some even closely located to the FEPI offices), clients can still say hello to staff from the FEPI program, and know that case managers and others from the two teams are working together in their best interest.

Challenges

- Clients are attached to the providers in FEPI, and sometimes have difficulty letting go after two years. They may continue to reach out to FEPI staff rather than the new team and require redirection.
- Team members do not feel that the two year period always allows enough time for the client to meet goals before they have to start talking about transitions.

Lessons Learned: Recommendations for Other Programs

- Begin conversations about discharge right at the beginning of treatment and include them throughout treatment, at regular intervals.
- Have frequent and open discussions around the therapeutic relationship and aim for the client to use the team as a source of empowerment and guard against learned helplessness.
- Take a team-based approach in other programs, not just the CSC program. This both enhances the quality of care but also makes transitions between teams easier.
- Maintain good relationships and communication with all the other providers within the organization, as well as with higher-level managers to make sure that everyone is aware of the CSC program and also as a way to keep up on post-discharge options. At MHC, this occurs in part through a regular meeting among program supervisors, as well as through regular email communication.

Other Highlights

- Since there are other programs at MHC that serve a similar age population, there have been times when a client enters the TAY program and the team is able to identify him as more appropriate for the FEPI program and transfer *in* to FEPI.
- Overall, COVID-19 does not seem to have unduly disrupted services for FEPI clients. Clients have generally switched to remote services without difficulty. However, the team generally feels that now is not the right time to transition people out of the FEPI program, so they have made requests to keep clients longer than two years.
- In April 2020, MHC opened “FEPI House,” a transitional housing option for participants and graduates of the FEPI program who need transitional housing or are homeless. The Peer Support Specialist was the team member who advocated for this house.
- FEPI staff frequently use community resources as adjunct services for clients enrolled in the program. Team members mentioned the Park Center as an organization with an IOP as well as an Emerging Adults program for those 18-24; the Oasis Center, which offers more than 20 programs for youth and young

adults; Launch Pad, which provides shelter options for youth; Rogers Behavioral Health, another organization in the community that also offers IOP; Vanderbilt Psychiatric Hospital, which offers a PHP for both adolescents and adults, a young adult IOP program, and a substance abuse/co-occurring disorders outpatient program.

Coordinated Specialty Care (CSC) Continuity of Care Case Study Site Visit Report

Healing and Opportunities with Psychotic Experiences Program (HOPE), Minneapolis, Minnesota
September 2020

I. Overview

HOPE is a CSC program that began enrolling clients in February 2017 in Minneapolis, Minnesota. It is located within a larger hospital health system called Hennepin Healthcare. HOPE has a step-down approach that involves gradually tapering off services to clients depending on their preferences, levels of functioning, and treatment goals. The program is flexible in that it also allows clients to return to more frequent or more intensive services if needed. The step down is designed to ease the transition between services received during HOPE's CSC program and those that clients will receive with other providers once they leave the program, while helping to build clients' independence and self-sufficiency.

We selected HOPE for inclusion in the CSC Continuity of Care Study as an example of a step-down program.

II. State Context

In 2016, the State of Minnesota issued an RFP for CSC programs with funding from the MHBG Ten Percent Set Aside. The state funded two additional CSC programs in addition to HOPE, one at the University of Minnesota through the MHealth health care system and the other at the Human Development Center in Duluth, Minnesota. HOPE and the University of Minnesota program are both in the Twin Cities area. The state coordinates, manages, and distributes funding to the three programs. HOPE's approach to taper services towards the end of treatment and have a flexible approach to program length is consistent with how other programs in the state address transitions. The state does not issue regulations on program length; across the programs, the average is about two years. The state also leaves other decisions up to the individual sites, and views the current programs as pilot programs.

The state monitors the CSC programs through regular phone calls and site visits to assess areas such as client engagement, recruitment, numbers of new clients, numbers of clients who discharge, and other deliverables related to the contract. The state has allowed the programs some flexibility in terms of how their agencies use MHBG funding. Programs often use MHBG funding for staff salaries because many components of the intervention are not billable services; however, the money can also be allocated to other expenses, such as bus cards or transportation for clients, support group activities, or trainings for outreach and engagement. Legislation requires that case managers, peer specialists and family peer specialists can only be billable services at a higher level of

care. As the state designates CSC as an outpatient level of care, it is not high enough on the continuum to have those services included in the billing structure.

III. CSC Implementation

Model: The HOPE program uses the NAVIGATE model. Services include all the standard components of CSC such as medication management, individual therapy, SEE, family psychoeducation and support, and case management. The program provides family peer support, peer support groups, and individual meetings between peers and clients/families. Clients are not required to participate in all treatment components; rather, they can work with the team to determine which aspects of the program are relevant to their needs and goals.

Program size: At the time of the visit, there were 50 clients enrolled in HOPE, and 50 is also the maximum program size. HOPE informally views clients as falling into three groups: (1) individuals who have recently been referred or have been in the program but who require more involvement to keep them engaged; (2) "active" clients who are typically attending weekly or biweekly therapy, SEE, medication management, and family sessions; and (3) "alumni status" clients who are moving toward discharge and receive check ins about once a month to sustain that progress. Approximately 30-35 clients are typically in the active group.

Population and age range served: The HOPE program serves clients ages 15-40 with schizophrenia spectrum diagnoses. Inclusion criteria are a DUP of two years or less and fewer than 12 cumulative months of antipsychotic medication. The program excludes for an IQ of less than 70, an autism diagnosis, substance-induced psychosis, and affective psychosis. The program serves clients in the Twin Cities (seven county) area. Currently, of the 50 clients in the program, 16 are African or African American, ten are Latino or Latina, five are Native American, and five are Asian. Clients come from a wide range in client socioeconomic backgrounds. Approximately 85-90 percent of clients live at home with their families.

Program length: HOPE does not have a defined program length. Clients typically stay in HOPE for 1-3 years, with an average length of 18 months. The program offers a flexible approach. If clients graduate from the program, they can still return to the program if the team determines that the program can best fit their needs.

Funding/Medicaid reimbursement mechanism: The program can bill medication management, individual therapy, family therapy and family psychoeducation, and psychological assessment through insurance. Non-billable care includes the SEE component, case management, and all peer support services. MHBG and additional state funds cover non-billable services. Psychiatrists on the team work out of their respective psychiatry clinics. The advantage of that arrangement is that the program does not have to cover the psychiatrists' time; however, the program does not receive any of the psychiatrists' billing revenue because that goes to the psychiatry clinics. Two

staff members on the team have billing revenue for the program--the full-time IRT clinician and half of the Team Director's time for providing clinical work.

If MHBG funds were not available, the sustainability of the program is questionable. Partners at the Minnesota Department of Human Services are working to find some legislative strategies to encourage insurance companies to cover these costs, possibly through a fee-for-service model. Clients can have either private insurance or Medicaid. The majority of clients are insured or insurance eligible. For individuals who are not eligible for insurance or if the cost is prohibitive, they can access charity care through the health care organization.

Data collection and monitoring: At intake, discharge, and six-month intervals in between, the HOPE team collects the following data:

- Demographic factors and background information, including client living situation, sources of income, employment, education, social supports, relationship status, and substance use.
- A Health Screening Form
- Colorado Symptom Index (CSI)
- Illness Management and Recovery Scale (IMRS)
- Mental Illness Research Education and Clinical Center version of the GAF scale (MIRECC-GAF)
- Camberwell Assessment of Need Short Appraisal Schedule (CANSAS)
- Patient Health Questionnaire (PHQ-9)
- General Anxiety Disorder Scale (GAD-7)
- CAGE-AID Substance Abuse Screening Tool (for adults)
- CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) Substance Abuse Screening Tool (for adolescents)
- Child and Adolescent Service Intensity Instrument (for adolescents)

A discharge template is completed for the medical record that includes admission date, discharge date, initial diagnosis, discharge diagnosis, a synopsis on each of the areas of service that were provide and the work completed, and disposition status.

Respondents reported that ideally, data collected on clients post-discharge would include: quality of life, life satisfaction, level of stability, level of care, employment outcomes, functioning, hospitalization rates, school engagement, dropout rates, legal involvement, incarceration rates, homelessness, housing status, application for SSI and Social Security Disability Insurance and client perceptions of the step-down process in the HOPE program.

Integration within organization: HOPE resides within Hennepin Healthcare and HOPE clients are automatically part of the Hennepin Healthcare system. Psychiatrists that are working with clients in the HOPE program are simultaneously working within psychiatry clinics in the Hennepin Healthcare system. Through Hennepin Healthcare, clients can access primary care, nutritionists, counseling for substance use, outpatient

therapy, inpatient psychiatry, partial hospitalization, crisis residence and a 90-day Intensive Residential Treatment Services program.

Site staff roles and background: The HOPE program operates with a Team Director, an IRT clinician, a SEE specialist, a case manager, a peer specialist, a family peer specialist, two psychiatrists, a nurse, a patient services coordinator, and a research coordinator. The peer specialist recently left and the team is seeking to fill that role. Staff commitment to the CSC team ranges from 5 percent to 100 percent.

EXHIBIT MN-1. CSC Team Staff

Name		Position Name	Degrees/ Licensure	Length of Time Working with Organization	% Time Working on CSC
1.	Marielle Demarais	Team Director / Family Clinician	PhD / LP	4 years, 10 months	100
2.	Laurel Bieschke	IRT Clinician	MSSW / LICSW	5 months	100
3.	Clare Moser	SEE Specialist	BA	4 years, 9 months	100
4.	Lindley Braaten	Case Manager	BA	4 years, 8 months	100
5.	Robert Lindberg	Peer Specialist	GED / AAS	1 year, 8 months	70
6.	Nancy Howe	Family Peer Specialist	BA	1 year, 8 months	20
7.	Stamatis Zeris	Psychiatrist (Adult)	MD	4 years, 10 months	10
8.	John Wermager	Psychiatrist (Adolescent)	MD	4 years, 10 months	5
9.	Connie Dwyer	Nurse	BSN	4 years, 10 months	5

IV. Site Visit Respondents

Interviews for the case study focused on key team members of HOPE, a representative from Hennepin Healthcare and from the state Department of Human Services, as well as two parents and participant of the program.

EXHIBIT MN-2. List of Respondents Interviewed

Name	Position	Organization or Affiliation
Marielle Demarais	Team Leader / Family Clinician	HOPE / Hennepin Healthcare
Laurel Bieschke	IRT Therapist	HOPE / Hennepin Healthcare
Nancy Howe	Family Peer Specialist	HOPE / Hennepin Healthcare
Clare Moser	SEE Specialist	HOPE / Hennepin Healthcare
Lindley Braaten	Case Manager	Hennepin Healthcare
Amy Mensch	Nurse Manager	Hennepin Healthcare
Monica Peterson	DHS Liaison	Minnesota Department of Human Services
Alison & Mark	Parents	
James	Participant	

V. Featured Program Aspect Description

> *The idea of recovery is very individualized and so we reflect that in how we help people step-down. There's some movement back and forth I would say in both directions but most often people are moving from engagement to active treatment to transition and that's solely based on what the person is wanting. Usually as part of that step-down they're meeting with us less frequently, so they are already building that distance and reflecting their independence and their ability to manage a lot of things on their own. The approach is very person-centered and based on how they are viewing their own progress and their own recovery with our input but very person-centered in that way. Which I think helps so that people are feeling successful."*
>
> *--CSC Team Member*

Summary

- HOPE has an internal step-down process embedded within their program. The program follows NAVIGATE guidelines and processes regarding discussion of transitions.
- At a time mutually agreed upon with the client, some services offered less frequently and others ramped up to meet the needs of the client and their goals.
- The course of treatment and step-down aspect will vary by client. A common course of care may involve the following:
    - Intensive services for the first six months of the program, with weekly to bi-weekly sessions with members of the team.
    - After six months, the frequency of sessions may change depending on the specific program component. For example, family sessions may occur once a month, therapy sessions may occur on a bi-weekly basis, and the SEE may start to see clients more often (e.g., a couple of sessions a week) as clients expand their readiness for employment and educational opportunities. This rate of involvement may last for another 6-12 months.
    - As clients achieve more stability in different aspects of their lives, by the last six months, members of the team may be meeting with the client on a monthly basis.

Rationale/History for Program or Practice

- The approach to transitions is a person-centered. The team does not have a standard that someone has to meet for the program to consider him or her successful. Rather, the team bases the approach to transitions on how clients view their own progress and their own recovery.
- The program is future-oriented and has a positive wellness perspective. A primary goal is to help clients function in all aspects of life that are important to them.

Funding

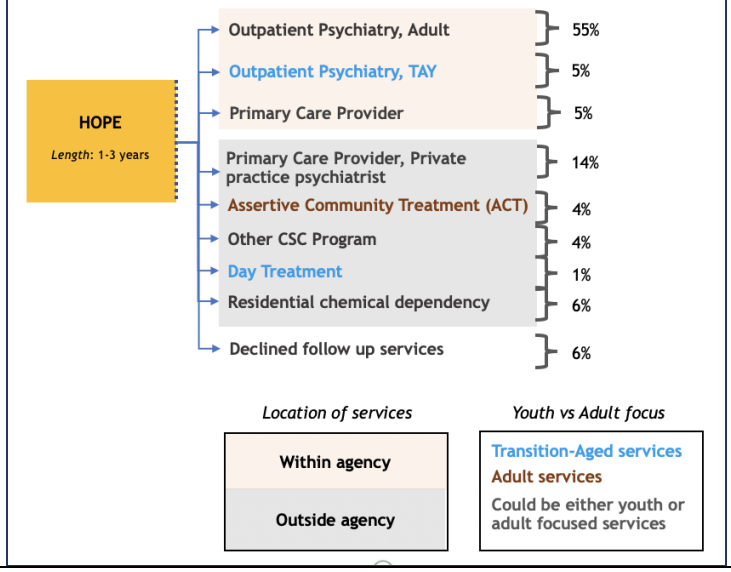
- Step-down services are within the core CSC program and funded the same way (i.e., through insurance or MHBG funding), depending on the services utilized.
- Some clients who leave the HOPE program may use a CADI Waiver to access services. The CADI program is funded by the Minnesota Department of Human Services and it provides HCBS to children and adults with disabilities who require the level of care provided in a nursing facility. These services are an alternative to institutionalization. They help a person live as independently as possible in community settings and promote optimal health, independence, safety and community integration. Clients can use this program to access a range of services, such as independent housing and case management.

Preparation, Practices and Policies

- From the first team meeting, staff members discuss discharge planning with the client. They emphasize that the program is not a lifelong solution; rather, the program will be a support to help clients become independent and meet challenges on their own.
- Team members discuss client progress in weekly meetings and whether clients are in the engagement, active treatment, or transition phase and moving towards graduation. The IRT usually plays the most active role in guiding the transition process.
- Every six months, the full team has a formal treatment-planning meeting with the client and the family, when appropriate, and the team discusses discharge.
- When clients start to reduce the frequency of their visits to monthly sessions, staff members will work with the client to determine how much longer the client would like to remain in the program as well as what resources may help to have in place after graduation. The HOPE team encourages clients to have a say in how long they want to remain in the program and what the process of transition will look like for them.
- Approximately six months prior to transition, each member of the team will meet with the client to discuss what his or her unique needs are after graduation. Each CSC team member will gather resources and put referrals or recommendations in place (e.g., the IRT therapist may assist the client identify another therapist for a specialized need, the peer support partner may accompany them to a community support program, the SEE may accompany them on a college tour).
- When a client discharges from HOPE, the program holds a graduation party with whomever the client wants to invite as well as the whole team. The celebration is an opportunity to mark all the progress that the client has made.
- If a client is moving to a more intense program, the team does not discharge them until they are fully established and the team feels confident that the transition is complete.

Post-Discharge Placements

EXHIBIT MN-3. Recent Post-Discharge Placements from HOPE



- Because Hennepin Healthcare houses the HOPE program, most people obtain services through Hennepin Healthcare after discharge. Most commonly, participants engage in medication management services through the outpatient psychiatry clinics.
- The HOPE clinic is physically located across the hallway from the general psychiatry and therapy clinics, so staff members can walk clients across the hall to establish care with therapy or with psychiatry. The child psychiatry department is in a different building connected by a skyway. Having resources within the same organization allows a clients' transition to be seamless.
- Most clients do *not* continue with therapy services immediately after the HOPE program.
- For those who do seek out therapy outside Hennepin Healthcare, clients can access clinical services in the community, such as DBT groups, services on gender identity and sexuality through the University of Minnesota, and ACT teams if indicated. Individuals can access case management services post-discharge outside the organization through Hennepin County mental health services, Vail Place, Catholic Charities, the Wilder Foundation, and a number of other agencies around the Twin Cities that do county-funded case management. A client could also access Individualized Placement Services (IPS) and housing services in the community or adult drop-in centers for support.
- Until COVID-19, the program had a monthly alumni group led by the peer specialist for people who left the program. COVID-19 has made the group more difficult to run because of logistical challenges. Similarly, the program used to host a quarterly social event for friends and families; however, since COVID-19 it has been a challenge to maintain.

- The alumni group allowed the peer specialist to hear about specific issues that clients were facing and pull in a CSC team member if needed to provide short-term assistance. For example, if a client lost their health insurance, the case manager can assist in helping the client apply for medical assistance or reinstate with their health insurance. If a client is starting school and needs resources about how to request accommodations, the SEE could provide the client with the contact information for the accommodations office. A clinician could provide 1-2 therapy refresher sessions. If a client requires more in-depth treatment, then the program could link the client to resources in Hennepin Healthcare or in the community.
- The family support specialist can remain in touch with families who need support after their young person graduates from the program.
- Clients may use the CADI waiver to access independent housing services or home based services. In this case, the client receives a county case manager with the CADI program, and the county case manager would do a yearly assessment to determine if the client still meets criteria for the program.

Perceived Advantages: What Does This Allow?

- The flexible program length helps clients realize their individualized treatment goals without time pressure.
- Having collaborative discussions about transition and discharge with the client, the team, and the family (when applicable) early on and throughout the treatment process allows staff members to set clients up with beneficial resources and referrals.
- The HOPE program operates within a health care system that provides many services to clients post-discharge, in particular, medication management and therapy. New providers can easily access information about treatment received while in the program; the CSC team can walk a client down the hallway to see a new provider. That level of integration can provide a seamless transition for the client. It also places less burden on the clinician to sift through referral sources in the community that may not adequately address the needs of clients with early psychosis.
- As clients taper the frequency of services near graduation, team members have more time available to see new clients in the program.
- Because participants can choose to remain with the same prescriber from HOPE after they leave the program, they feel more confident having their medication addressed by someone they already know and trust.

Challenges

- The team was trying to get the alumni monthly support group up and running; however, since COVID-19, it has been difficult to maintain that group virtually.
- Sustainability in the absence of MHBG funds would be a challenge given that many of the core services of the program are not billable through insurance.

- If clients are seeking more culturally specific services, they will need to go out into the community to access them. As such, the team is working to identify what those services are and how to develop connections with providers outside of the Hennepin Healthcare system who can provide those culturally specific services.
- Due to organization policies about privacy, team members that provided non-billable services could not use Zoom for sessions and could only use the phone, until recently. Use of video conferencing has helped the substance of their sessions significantly.

Lessons Learned: Recommendations for Other Programs

- Work with consultants and others who have implemented a similar process to learn from their experiences.
- The transition should be a collaborative decision-making process with the client.
- Having flexibility in the length of time that a client can attend the program is helpful so that the process of transition is not a one size fits all process. The team should customize the transition to the unique needs and preferences of the client.
- If HOPE refers a client to another program, it is important to do a warm handoff and maintain connections with the client until the client establishes a relationship with the new treatment provider.
- Having a dedicated case manager as member of the team can be very useful in helping to identify resources and set up plans for transition. Having someone dedicated to that case management role helps families navigate the mental health system and frees up more time for the therapist to address clinical aspects of care.
- The team should address transition from the very beginning of treatment.
- Having a peer led support group process for clients and families can be useful and important.

Other Highlights

- Approximately eight clients were planning to graduate in the spring; however, many decided to delay transition because of heightened levels of stress due to COVID-19 and the killing of George Floyd.
- Minneapolis is home to a large number of immigrant and refugee communities. Since beliefs about mental health (and especially symptoms of psychosis) vary across cultures and even within families among different members, the family psychoeducation component of HOPE is particularly important.