U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

EARLY INTERVENTION FINANCING AND RESOURCES:

FINAL REPORT

December 2012

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This report was prepared under contract #HHSP23320095655WC between HHS's ASPE/DALTCP and Westat. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/office_specific/daltcp.cfm or contact the ASPE Project Officer, Kirsten Beronio, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. Her e-mail address is: Kirsten.Beronio@hhs.gov.

EARLY INTERVENTION FINANCING AND RESOURCES: Final Report

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TABLE OF CONTENTS

LIST OF TABLES

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EXECUTIVE SUMMARY

Background and Motivation

The objective of this project is to study the implementation of coordinated specialty care services in NAVIGATE, the active treatment intervention in the National Institute of Mental Health's (NIMH's) Recovery After an Initial Schizophrenia Episode (RAISE) Early Treatment Program (ETP). The focus of this project is on the important issues of financing coordinated specialty care services for first-episode psychosis within communities. The report discusses some of the implications of the Affordable Care Act (ACA) for these financing concerns. ASPE expects to disseminate the practical lessons of the RAISE initiative, so that early psychosis services can be implemented throughout the United States in the event that their effectiveness has been established by the RAISE study.

RAISE is intended to transform behavioral health services, as recommended by the President's New Freedom Commission on Mental Health (2003). Schizophrenia, with its associated disabling symptoms and poor prognosis, has long challenged the mental health service system to provide humane and effective services. Recently, the finding that outcomes in schizophrenia may not be uniformly negative over time has sparked a new emphasis on "recovery" and with it a more hopeful expectation that with proper treatment, individuals with schizophrenia can function in their communities, by participating in work, school, and social relationships. (New Freedom Commission on Mental Health, 2003) Furthermore, this degree of social inclusion and symptomatic recovery is thought to be more likely if treatment occurs early in the course of the illness. (McCoy, Patton, and Goldman, 2010)

The RAISE initiative is a test of the practical implementation of an integrated set of evidence-based services delivered early in the course of psychosis, the hallmark of the onset of schizophrenia. There is a strong evidence base for many services in clinical use for treating psychosis, but they are not routinely available in practice. Medications, family psycho-education, skills training, and supported employment all have been demonstrated to be effective in treating psychosis and schizophrenia.

The RAISE study will assess the effectiveness of a menu of evidence-based services when marshaled together in real-world, community settings early in the course of schizophrenia, when psychotic symptoms first appear. NAVIGATE is a multi-component intervention delivered in a team approach. The components include Individual Resilience Training, supported employment and education (SEE), family psycho-education, and individualized medication management. NAVIGATE participants are individuals aged 15-40 years old who have a first psychotic episode of any duration, so long as they have taken antipsychotic medication for a cumulative period of no longer than six months. The specific set of eligible diagnostic categories is determined

using the SCID in a centralized assessment process. Individuals with schizophrenia, schizo-affective disorder, schizophreniform disorder, brief psychotic disorder, and psychotic disorder, not otherwise specified may be included, and those whose psychosis is deemed secondary to a general medical condition, such as significant head trauma or a neurological disorder, are excluded from NAVIGATE and the ETP study.

Interventions are offered to prospective patients within a shared decision-making framework. Thus, participants do not necessary receive every NAVIGATE service, but only those selected to facilitate personal recovery goals. The hypothesis is that early team-based treatment with evidence-based services can prevent disability and improve long-term functional outcomes in people with first-episode schizophrenia.

From the beginning of the RAISE initiative, the project has focused on implementing first-episode services in real-world community settings, rather than academic medical centers. NIMH hoped that a practical clinical trial of the magnitude, visibility, and scientific rigor of RAISE ETP would lead to the rapid implementation of evidence-based, first-episode services throughout the United States, should the RAISE ETP intervention prove effective. Other countries, such as the United Kingdom, Canada, and Australia, have implemented such services on a widespread basis, but they have been neither implemented nor evaluated extensively in the United States. Those other countries all have universal health insurance and cover the services, even some non-traditional supportive services, within their public mental health systems. Policymakers in the United States may need to see evidence of the effectiveness of first-episode services when delivered in typical community settings in the United States prior to supporting their wide-scale adoption. To speed the likely implementation of first-episode psychosis treatment services, the original RAISE request for proposal required that the proposed RAISE study sites use mainstream and readily available funding mechanisms in ecologically valid service systems and their community clinics and mental health centers. The project was launched prior to the passage of the ACA, and some provisions of the health reform law have implications for first-episode services.

One of the main financing challenges of RAISE is related to the historic link of Medicaid eligibility to Supplemental Security Income (SSI) disability status, prior to health care reform. It is expected that most of the early psychosis patients will not qualify for SSI, as they are not expected to be significantly disabled at this early phase of their psychotic illness, and so they are not likely to be on Medicaid. (Some individuals in the early stages of psychosis may have qualified for SSI on the basis of a general medical condition or a disabling mental disorder prior to a first psychotic episode. Some individuals in the midst of a first psychotic illness long enough to qualify for SSI could be eligible for the ETP, if they did not receive antipsychotic medication for more than six cumulative months.) The SSI disability requirement for eligibility for Medicaid will become less of an issue in 2014, when implementation of health care reform will increase Medicaid enrollment of non-disabled individuals through the so-called Medicaid expansion. Meanwhile, some participants in NAVIGATE will be able to remain on their parents' health insurance for longer because of the ACA; others will

have more opportunities for private insurance coverage without fear of being disqualified based on psychosis as a pre-existing condition.

Methodology

The main research questions of this project concern the financing of the multi-element intervention for first-episode psychosis. Overarching questions focus on embedding these services within the context of usual treatment settings in the United States, including community mental health centers and outpatient clinics. Financing is a key element of successful implementation, as reflected in the findings of the earlier ASPE studies on financing the services in the RAISE intervention (Patton, Ratner and Salkever, 2010) and RAISE-related services such as supported employment (Karakus, Frey, Goldman, Fields and Drake, 2011).

The study employed a range of qualitative research techniques, including document review, key informant interviews, and case study methodology. After discussions about what might be learned from visits to the sites, Westat researchers suggested sites that varied in terms of geography, payer mix, and organizational auspices. At that point, NIMH staff identified five sites for case studies. They were sites that had been able to implement the NAVIGATE services and participate in the research components of the randomized controlled trial. The sites were diverse in their geographic location and in their approaches to implementing NAVIGATE.

Once site selection was complete, the focus of the site visits and other qualitative analysis (taken from interviews, discussions and document reviews) was on the financing of the components and their combination into a team approach to early intervention services.

The main focus of the site visit interviews was on the ability to finance the intervention, which is a combination of services. Some are typically covered by traditional health insurance (e.g., medications, medication visits to a physician, family therapy, individual therapy), and others are non-traditional services such as SEE, which often are not covered by health insurance. Even Medicaid, the health insurance program with the benefit structure most likely to cover NAVIGATE services, does not cover all components of these non-traditional services.

Policy Implications and Lessons Learned

Site visits were completed to NAVIGATE projects in five locations: Denver, CO; Denville, NJ; Eugene, OR; Lansing, MI; and Springfield, MO. Detailed reports are presented in the full report.

The following observations emanate from the site visits and conversations with RAISE investigators and staff:

Each site has developed a creative solution to financing NAVIGATE services. As expected, each site used health insurance to pay for each of the NAVIGATE services for insured participants, other than SEE, which was only partly covered for those individuals who were Medicaid beneficiaries. For participants who were uninsured, the sites used other public resources to cover all NAVIGATE services. These tactics will generalize to locations with some of the same characteristics for behavioral health care financing. While the tactics are somewhat idiosyncratic, they do offer lessons for other future sites who wish to offer early intervention services to emulate.

Some specific observations:

- The site at the Mental Health Center of Denver has a capitated Medicaid arrangement to pay for all behavioral health services, which the site uses to pay for the full range of RAISE NAVIGATE services and treatments. This arrangement began in the 1990's throughout the State of Colorado, and it covers all Medicaid mental health services, not just those for treating first-episode psychosis.

- The PeaceHealth site in Eugene, OR is affiliated directly with a Federally Qualified Health Center (FQHC). The revenues for any behavioral health encounter at the FQHC are generous enough that the costs of care are covered and even permit a cross-subsidy for individuals whose coverage does not include the full cost of their care and treatment.

- The St. Clare's Health System site in Denville, NJ has sufficient funds from state and local behavioral health services grants and annual contracts to cover the costs of NAVIGATE services.

- The Burrell Center in Springfield, MO also funds the NAVIGATE services with state behavioral health funds through a contract with the Department of Mental Health. For those who qualify, Medicaid funds were matched to state funds in a Purchase-of-Service arrangement that covers some services, such as supported employment, which has very limited availability in Missouri.

- The site at the three-county Community Mental Health Authority in Lansing, MI uses Medicaid to pay for many of the behavioral health services for those who are qualified, and many of the participants remain on their parents' health insurance, which is now easier and lasts up to age 26 because of the ACA provisions. Many of the services are not covered by private insurance plans, and even Medicaid does not cover all services, so the site uses state and local behavioral health funds for "bad debt" to cover some services. Michigan also has an evidence-based practices implementation initiative, which covers supported employment services.

Other future sites wishing to offer services to individuals during a first episode of psychosis could use these tactics, where available, to supplement insurance payments for more traditional medically-oriented services such as medications, medical management visits, and psychotherapy. Implementing such financing tactics might require some technical assistance to community sites to learn to take advantage of local opportunities. It might also be enhanced by technical assistance to states to develop some of these options, such as Medicaid state plan amendments using Section 1915(i), use of FQHCs, or use managed care contracts with capitated financing and/or flexible benefits options.

These lessons would best generalize to sites that also have a small number of participants and would like to add first-episode clients to existing staff caseloads. Some of the RAISE NAVIGATE sites have a small number of early psychosis patients (fewer than ten), and the small numbers make it possible to cross-subsidize the care of these participants from a variety of funding sources. This tactic would work for other sites that admitted a small number of clients but would be more difficult for sites that had more clients and wished to form a specific team to serve primarily first-episode clients, primarily because of the start-up costs and the costs of caring for a large number of participants with limited resources or insurance. This will change to some extent with full implementation of the ACA, although not all NAVIGATE services will be covered in exchange insurance plans (e.g., supported employment) nor in some state Medicaid plans.

The provisions of the ACA already in place have assisted individuals experiencing a first episode of psychosis by permitting some to remain on parents' insurance plans until age 26 years and not lose eligibility for private insurance because of a pre-existing condition. The ACA Medicaid expansion will also provide coverage for many individuals who no longer have to wait until they qualify for SSI before becoming eligible for Medicaid. It is particularly important for promoting recovery from a psychotic illness to provide the types of intensive therapies more often available through Medicaid early in the progression of these diseases in light of some indications of lasting ill effects of these conditions and expected positive effects of early intervention.

<u>Some policy lessons:</u>

- The sites have been very creative in using available financial resources above-and-beyond what is provided by the NIMH contract for supported employment. (Each of the RAISE sites receives funds from the NIMH RAISE contract to support five hours of time per week for an employment specialist.)

- Sites were encouraged to file claims with public and private health insurance in cases where a participant had such coverage and when the service was covered by the insurance plan, as the site might ordinarily do for their clients who are not part of RAISE. Of course, some of the participants have no insurance, and some of the key services are not covered by insurance or only partially covered, such

as supported employment and supported education, as well as case management and non-face-to-face meetings of staff team members.

- Medicaid is the health insurance financing mechanism that is most likely to cover RAISE NAVIGATE services. However, there is considerable variation from state-to-state in terms of behavioral health benefits. Furthermore, many of the participants would not currently qualify for Medicaid unless they were low-income parents themselves, dependent children in low-income families or disabled -- or the state offers a state-only Medicaid program for individuals who are “medically indigent”. Most individuals who qualify for first-episode services are too early in the course of their psychotic illness and thus lack the substantial functional impairments necessary to qualify for SSI (and thus Medicaid) on the basis of disability, unless they have impairments other than psychosis that would disable them.

- The Medicaid expansion of the ACA will change that eligibility limitation dramatically. Many individuals with first episode of psychosis, who are not disabled, will be able to qualify for Medicaid without qualifying for SSI. Medicaid has a benefit package in many states that is more likely to cover relevant behavioral health services when compared with typical insurance plans. The new expansion population will not necessarily receive the regular Medicaid benefits since states can base the benefit package on various benchmarks including the largest health maintenance organization and state employee benefits. However, some states may opt to offer the regular Medicaid benefits to the expansion population for administrative simplicity and some of the individuals in the expansion group may qualify for regular Medicaid as individuals with disabilities or special needs. In addition, Centers for Medicare and Medicaid Services has indicated that states can develop special benefit packages for targeted groups among the expansion population. This points to continued need for state, local and/or federal Substance Abuse and Mental Health Services Administration block grant funds to cover early intervention services. The ACA also permits states to include early intervention services, such as case management, assertive community treatment, and psychosocial rehabilitation, under the so-called Medicaid 1915(i) provisions, which do not require a waiver and instead may be established with a state Medicaid plan amendment. The 1915(i) benefits can also be targeted to specific subpopulations (e.g., those with first-episode psychosis and/or the expansion population). An important objective of treatment and services in first-episode psychosis is to prevent disability, and disability status under the SSI program will no longer be required to become eligible for Medicaid. This is particularly important for promoting recovery from a psychotic illness by encouraging affected individuals to participate in supported employment and work and not to apply for SSI prematurely, which might discourage a working and productive life.

- The ACA has been helpful already in that some of the participants are able to pay for some services by remaining on their parents' health insurance up to age 26. They also will not be disqualified from obtaining private insurance due to a pre-existing condition, which happened frequently to individuals with a history of psychosis before the ACA.

1. BACKGROUND AND MOTIVATION

The objective of this project is to study the implementation of coordinated specialty care services in NAVIGATE, the active treatment intervention in the National Institute of Mental Health's (NIMH's) Recovery After an Initial Schizophrenia Episode (RAISE) Early Treatment Program (ETP). The focus of this project is on the important issues of financing coordinated specialty care services for first-episode psychosis within communities. The report discusses some of the implications of the Affordable Care Act (ACA) for these financing concerns. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) expects to disseminate the practical lessons of the RAISE initiative, so that early psychosis services can be implemented throughout the United States in the event that their effectiveness has been established by the RAISE study.

RAISE is intended to transform behavioral health services, as recommended by the President's New Freedom Commission on Mental Health (2003). Schizophrenia, with its associated disabling symptoms and poor prognosis, has long challenged the mental health service system to provide humane and effective services. Recently, the finding that outcomes in schizophrenia may not be uniformly negative over time has sparked a new emphasis on "recovery" and with it a more hopeful expectation that with proper treatment, individuals with schizophrenia can function in their communities, by participating in work, school, and social relationships. (New Freedom Commission on Mental Health, 2003) Furthermore, this degree of social inclusion and symptomatic recovery is thought to be more likely if treatment occurs early in the course of the illness. (McCoy, Patton, and Goldman, 2010)

The RAISE study will assess the effectiveness of a menu of evidence-based services when marshaled together in real-world, community settings early in the course of schizophrenia, when psychotic symptoms first appear. NAVIGATE is a multi-component intervention delivered in a team approach. The components include Individual Resilience Training (IRT), supported employment and education (SEE), family psycho-education, and individualized medication management.

NAVIGATE participants are individuals aged 15-40 years old who have a first psychotic episode of any duration, so long as they have taken antipsychotic medication for a cumulative period of no longer than six months. The specific set of eligible diagnostic categories is determined using the SCID in a centralized assessment process. Individuals with schizophrenia, schizo-affective disorder, schizophreniform disorder, brief psychotic disorder, and psychotic disorder, not otherwise specified may be included, and those whose psychosis is deemed secondary to a general medical condition, such as significant head trauma or a neurological disorder, are excluded from NAVIGATE and the ETP study.

Interventions are offered to prospective patients within a shared decision-making framework. Thus, participants do not necessary receive every NAVIGATE service, but only those selected to facilitate personal recovery goals. The hypothesis is that early team-based treatment with evidence-based services can prevent disability and improve long-term functional outcomes in people with first-episode schizophrenia.

From the beginning of the RAISE initiative, the project has focused on implementing first-episode services in real-world community settings, rather than academic medical centers. NIMH hoped that a practical clinical trial of the magnitude, visibility, and scientific rigor of RAISE ETP would lead to the rapid implementation of evidence-based, first-episode services throughout the United States, should the RAISE ETP intervention prove effective. Other countries, such as the United Kingdom, Canada, and Australia, have implemented such services on a widespread basis, but they have been neither implemented nor evaluated extensively in the United States. Those other countries all have universal health insurance and cover the services, even some non-traditional supportive services, within their public mental health systems. Policymakers in the United States may need to see evidence of the effectiveness of first-episode services when delivered in typical community settings in the United States prior to supporting their wide-scale adoption. To speed the likely implementation of first-episode psychosis treatment services, the original RAISE request for proposal required that the proposed RAISE study sites use mainstream and readily available funding mechanisms in ecologically valid service systems and their community clinics and mental health centers. The project was launched prior to the passage of the ACA, and some provisions of the health reform law have implications for first-episode services.

One of the main financing challenges of RAISE is related to the historic link of Medicaid eligibility to Supplemental Security Income (SSI) disability status, prior to health care reform. It is expected that most of the early psychosis patients will not qualify for SSI, as they are not expected to be significantly disabled at this early phase of their psychotic illness, and so they are not likely to be on Medicaid. (Some individuals in the early stages of psychosis may have qualified for SSI on the basis of a general medical condition or a disabling mental disorder prior to a first psychotic episode. Some individuals in the midst of a first psychotic illness long enough to qualify for SSI could be eligible for the ETP, if they did not receive antipsychotic medication for more than six cumulative months.) The SSI disability requirement for eligibility for Medicaid will change in 2014, when implementation of health care reform will increase Medicaid enrollments of non-disabled individuals through the so-called Medicaid expansion. Meanwhile, some participants in NAVIGATE will be able to remain on parents' health insurance for longer because of the ACA; others will have more opportunities for private insurance coverage without fear of being disqualified based on psychosis as a pre-existing condition.

Shortly after NIMH initiated RAISE, ASPE awarded Westat with two Task Orders related to important policy questions facing the full implementation of first-episode psychosis services. One of the projects focused on supported employment, and the other on financing RAISE services more broadly.

In 2010, Westat was awarded the study that generated the report “Evaluation of the Financing Mechanisms of the Connection and NAVIGATE Programs (in RAISE),” as a first step in addressing the questions about financing first-episode psychosis services in the United States. This study documented the diverse approaches to funding services planned for the RAISE sites. The NAVIGATE teams, composed of clinicians already engaged in service delivery to a mix of patients, were to be funded primarily with available insurance and other mostly public resources. It was expected that insurance funds would be supplemented by resources from the NIMH-funded ETP to pay for non-traditional services, such as supported employment, and from locally available resources for individuals lacking health insurance. (Patton, Ratner and Salkever, 2010)

What was clear from the initial ASPE study of RAISE financing was how diverse and site-specific many of the NAVIGATE funding strategies would need to be if they were to be successful. Following the passage of health reform, the problem of serving uninsured service users in the future became less of a concern. The strategies for funding by the ETP with insurance are more likely to generalize to other real-world community mental health settings in a reformed health care system. NAVIGATE sites, however, still have highly specific and idiosyncratic approaches for financing some of their services, such as SEE, as well as some other recovery and case management services. This latest project investigated the diverse financing strategies in the NAVIGATE sites to inform other similar settings across the United States.

2. METHODOLOGY

The main research questions of the Early Intervention Financing and Resources project concern the financing of the multi-element intervention for first-episode psychosis. Overarching questions focus on embedding these services within the context of usual treatment settings in the United States, including community mental health centers (CMHCs) and outpatient clinics. Financing is a key element of successful implementation, as reflected in the findings of the earlier ASPE studies on financing RAISE (Patton, Ratner and Salkever, 2010) and RAISE-related services such as supported employment (Karakus, Frey, Goldman, Fields and Drake, 2011). These questions on services implementation and financing were included in our interview guide for use with NIMH and central study personnel, as well as in the discussion guides for the interviews with site personnel, and in the site visit protocols that were developed.

The study employed a range of qualitative research techniques, including document review, key informant interviews, and case study methodology. Only a site visit and case study approach was deemed to be adequate to capture the variability of the approaches to implementation of RAISE services presented by this demonstration program.

It was important to select sites carefully but also recognize and acknowledge the problem of generalizing from what might be a series of idiosyncratic sites. After discussions about what might be learned from visits to the sites, Westat suggested sites that varied in terms of geography, payer mix, and organizational auspices. Then the NIMH recommended five sites for case studies. They were sites that had been able to implement the NAVIGATE services and participate in the study. The sites were diverse in their geographic location and in their approaches to implementing NAVIGATE.

Once site selection was complete, the focus of the site visits and other qualitative analysis (taken from interviews, discussions and document reviews) was on the implementation of the components and their combination into a team approach to early intervention services. The main focus of the site visit interviews was on the ability to finance the intervention, which is a combination of services. Some are typically covered by traditional health insurance (e.g., medications, medication visits to a physician, family therapy, individual therapy), and others are non-traditional services, such as SEE, which often are not covered by health insurance. Even Medicaid, the health insurance program with the benefit structure most likely to cover NAVIGATE services, does not cover all components of these non-traditional services.

The most fine-grained analysis in the case studies examined each component of the multi-element service package to understand the ability of the sites to implement and finance the services.

The study explored how the lessons learned from NAVIGATE may be applicable to other sites to further national dissemination and implementation of RAISE early psychosis services in the United States.

Site Visit Approach and the Discussion Guides

In all cases, the data collected and analyzed were intended to provide informed perspectives on the implementation and financing of the interventions and illuminate important barriers and barrier-resolution strategies. The project used a case study approach to obtain information on how sites are using different federal and local sources of funding to finance these services.

One-day site visits included interviews with identified key staff or a designee who was viewed as more appropriate:

- The RAISE NAVIGATE program Director; and
- The Director of the agency sponsoring the NAVIGATE Clinical Team.

The site visit protocols were customized for each key informant category. Each interviewee was asked to discuss issues in seven topical areas during the interviews:

1. A site-specific description of defining characteristics of the treatment site, including an assessment of supports or barriers to implementation encountered in the site's community or catchment area.

2. A description of the site-specific outreach, referral, recruitment and retention processes utilized with first-episode clients, including the training and implementation costs associated with adding -- and maintaining -- first-episode client interventions.

3. A description of policy barriers encountered by the site and how such barriers are addressed and resolved.

4. A description of the existing insurance coverage for new, first-episode clients (e.g., remain on parents' insurance, indigent, Medicaid), including any realized or anticipated impacts to clients' coverage associated with the ACA.

5. A description of the non-insurance funding sources (e.g., General Relief Fund, county or state monies, the RAISE contract) specific to the site that are used to provide services that are not typically funded by insurance, such as supported education or supported employment services and family psychosocial education.

6. A description of how or whether the treatment site develops or maintains partnerships in support of early intervention services, and if so, how partners were identified and cultivated.

7. A description of key structural and procedural components related to the scalability of first-episode services and whether successful (versus struggling) treatment sites can articulate specific factors that are associated with this success (e.g., client mix, staffing, financial mechanisms, size of catchment area, outreach, education, training, fidelity monitoring, and referral requirements).

Table 2.1 presents an overview Site Plan for a one-day visit to the RAISE NAVIGATE programs and the interview protocols developed for key informants are in Appendix 2.

TABLE 2.1. RAISE NAVIGATE Site Visit Overview Plan

	Agency Administrator or Designee -- -- -- -- -- Key Informants with Knowledge of Funding and Implementation	**RAISE NAVIGATE Project Director or Designee -- -- -- -- -- Key Staff with Knowledge of Funding and Implementation**
Purpose and content of interviews	To provide informed perspective and information about RAISE NAVIGATE implementation processes, activities and delivery of services. – How first-episode outreach, referral, treatment, and retention services are funded, coordinated and delivered – Nature of relationships with providers and other stakeholders partners – Professional development processes (how training needs are determined and funded) – Existing and anticipated funding resources for first-episode services – Identification of program components necessary to provide effective interventions – Identification of structural and procedural components that facilitate effective first-episode services (e.g., size of catchment area, financial mechanisms, etc.)	To provide informed perspective and information about RAISE NAVIGATE implementation processes, activities and delivery of services. – Comprehensive description of program components, from intake to follow-along or program exit – How each component is funded and coordinated – Information about professional development training, including note of training gaps or continuing issues (e.g., accommodations for staff turnover and staff training on staggered schedules) – Perspectives on policy barriers to achieving implementation – Perspectives on other structural (e.g., size of catchment area, client mix) or procedural barriers (e.g., staffing patterns, referral requirements) to successful implementation of first-episode services – Thoughts on first-episode program sustainability (e.g., necessary components, anticipated funding sources)
Duration	1.0-2.0 hours	1.0-2.0 hours
Type of interview	In-person, semi-structured format	In-person, semi-structured format

3. CASE STUDIES

This section presents information gathered during the case study visits to the five selected NAVIGATE programs across the county. We conducted site visits to the following sites during May and June 2012.

- Mental Health Center of Denver, Denver, CO
- Burell Center, Springfield, MO
- Community Mental Health Authority of Clinton, Eaton, and Ingham -- East Lansing, MI
- PeaceHealth, Eugene, OR
- Saint Clare's Behavioral Health, Denville, NJ

The site visit descriptions present some of the key findings on scalability and financing of NAVIGATE first-episode psychosis services.

Mental Health Center of Denver, Denver, CO

Mental Health Center of Denver is a non-profit, 501(c)(3), community mental health organization providing comprehensive outpatient mental health and substance abuse treatment. It is a primary treatment center in Denver and surrounding areas, providing primary health care along with mental health services since its founding in 1989. The Center employs over 500 professional staff, treats more than 15,000 individuals at 35 sites working with over 100 community partners.

The initial motivation to become a part of the RAISE study was the recognition of the need for clinical capacity building to treat individuals with first-episode psychosis. The site was also in the forefront of many major national studies and developed "value-building networks" through such studies. The study recruitment includes referrals through Denver Health (primary safety net hospital), and other acute care treatment sites (Porter, Highland Behavioral, and West Pines, Mental Health Access Team), local providers, local newsletters and other advertisements. There were also attempts to partner with local college and educational institutions for referrals.

The biggest reported challenge in NAVIGATE service delivery was meeting the unexpected level of need for case management services. The Center was prepared to provide all of the specialized services essential to the NAVIGATE program, but they did not realize the high level of case management that would be needed for the participants. Such case management included accompanying clients to appointments, assisting them with acquiring benefits, locating housing arrangements, helping clients to negotiate family issues, and providing general emotional support. This proved to be a major drain on available resources.

Financing of Services

The Center has a capitated reimbursement arrangement with Medicaid. This arrangement has been in place since the 1990's, when Colorado obtained a waiver to use a capitation model to finance its behavioral health services. To some extent, salaries of some project staff (e.g., 12 hours of project director time, five hours per week for supported employment specialist) are also covered by the RAISE contract. However, overall the study team acknowledges that the RAISE ETP services are underfunded. Some needed services, such as job development, job coaching, planning and coordination, and supported education are rarely reimbursable by traditional government or private insurance sources (Table 3.1).

There were 14 individuals enrolled in the study with two of them having only private insurance, four on Medicaid, and the rest receiving services through state General Fund. For those on Medicaid, the Mental Health Center of Denver has a capitated arrangement to pay for all behavioral health services, which the site uses to pay for the full range of RAISE NAVIGATE services and treatments. While staff members agree that dependence on public benefits such as Medicaid cannot be the ultimate goal, they see Medicaid as an important source of financing, mainly due to high cost of medications and the flexibility of the benefits under the capitation arrangement. For some privately insured patients, the Center is able to arrange special extra-contractual benefits and a case rate. Also, there is a big focus on supported employment with this study, and they were able to get some funding from the Department of Vocational Rehabilitation for supported employment services. (The Medicaid capitation could not be used to pay for supported employment.)

The Center engages with many partners in blending and braiding of resources to provide mental health services. ("Blending and braiding" is a metaphor for combining resources in a way that each component of the pooled resources is recognizable, that is the resources are not fungible but can be used in concert.) These partners include the Council on Substance Abuse and Mental Health, Colorado Behavioral Health Care Council, local National Alliance on Mental Illness chapter, Mental Health America of Colorado, and Colorado Coalition for the Homeless. In addition, they also work closely with Colorado Access (Medicaid), Denver Health, and Denver Public Schools. The state General Fund provides almost one-quarter of the Center revenues.

TABLE 3.1. Mental Health Center of Denver, Denver, CO: RAISE NAVIGATE Early Treatment Components and Funding Sources								
	In-house or Other	**Out-of-Pocket**	**Private Insurance**	**Medicaid**	**Medicare**	**Other Insurance (e.g., VA, Tricare)**	**State MH Resources**	**Local MH Resources**
Outreach and engagement	✓							
Medication		✓	✓	✓	✓	✓	✓	
Medication visits	✓		✓	✓			✓	
Alcohol and substance use treatment								
Family psycho-education	✓	✓	✓	✓	✓	✓	✓	
Family therapy	✓	✓	✓	✓	✓	✓	✓	
Other outpatient visits								
Inpatient care as needed		✓	✓	✓	✓	✓		
Supported employment	✓			✓			✓	
Job development								
Planning (e.g., treatment and/or recovery plans)								
Job coaching and other vocational supports				✓				
Supported education								
Individual resilience training				✓	✓			
Case management	✓	✓		✓			✓	
Benefits counseling (e.g., WIPA)								
Treatment and primary care coordination								
Other (e.g., occupational or psychosocial therapy, groups, etc.)								
NOTE: In-house or Other means services provided by staff directly and not billed to any payer. Out-of-pocket means services were paid for either entirely out-of-pocket or some cost-sharing was required.								

Burell Center, Springfield, MO

Missouri operates an Administrative Agent System. In this system, mental health services are accessed through 25 service areas, with each service area serving particular counties of the state. Administrative Agents and/or Affiliates (CMHCs) are responsible for providing these services. These designated centers serve as entry/exit points in each geographic area, into and out of the state mental health delivery system, offering a continuum of comprehensive mental health services.

The Burrell Center is a non-profit organization [under section 501(c)(3) of the tax code] that was established in 1977. Until 2007, Burrell was responsible for a seven county catchment area with 500,000 people. The Center can be characterized as a semi-urban hub of a rural area. After 2007, the catchment area was extended to a ten-county area in the central region of the state. The Center has grown from a handful of employees when established to its current complement of 800 employees operating with a budget of $50 million a year.

The project director of the NAVIGATE program recruits, screens for eligibility, enrolls clients, attends the weekly team meetings, and monitors case managers including the IRT clinic staff and the family clinical staff. At Burrell she is a Community Support staff supervisor, who oversees six case workers who are employed in one of the Center's residential facilities. There were no new hires, per se, for the project. Staff positions include: one prescriber; two IRT facilitators; one family clinician; one project director; and one supported employment specialist on the ACT team [about 5% of that full-time equivalent (FTE) is RAISE-funded].

Primary referral sources for the program are hospitals, emergency rooms, inpatient units, primary care providers, school personnel, walk-ins to the 24-hour acute stabilization clinic, the 24-hour crisis line, and from the ten-bed crisis stabilization unit. Since RAISE was a good match for what the Center was already doing, it was not difficult to identify and recruit clients. They have a good working relationship with the Cox hospitals group, which is a major health and hospital provider in the region, and with the staff that provide inpatient services to people on their units. The program also recruited through the 24-hour crisis line (throughout the catchment area counties) and got some responses to the pamphlets that were distributed to primary care offices. But most of the referrals for the project were coming internally from other departments. There were a few family medical center referrals (from the family care center in a Cox hospital).

The majority of the recruiting and outreach was accomplished through word-of-mouth. Most of the recruits were in their 20s and were either on SSI or eligible to apply for it. (The high level of SSI eligibility suggests that this might be an atypical case mix at this NAVIGATE site. As discussed, above, while it is possible for young adults to qualify for SSI and still meet RAISE eligibility criteria for early psychosis, it is expected to occur rarely.) There were 25 recruits referred to NAVIGATE and 18 of them enrolled in the

program, but two of them left the study later (one was mandated to a residential facility and became ineligible for the study after enrollment). The project director did most of the eligibility screening (by telephone) after people were identified or referred. Fidelity to model in terms of the clinical approach for NAVIGATE has been exemplary with relatively strong client retention. The clients consistently come to their therapy appointments and to the psychosocial/psychosocial rehabilitation offerings.

The approach to RAISE is very much in keeping with the mission of the Center (treat early, avoid larger problems, and provide needed services). The outreach work of the Center was already aggressive -- the Center worked with the mental health court, the drug court, hospital emergency rooms, responded to walk-ins and call-ins, and had good surveillance of behavioral health needs established before RAISE. An earlier grant had funded counselors in schools, and the Center stretched out that three year program to five years to study its effects.

Financing of Services

There is no federal block grant money involved in service delivery. Burrell receives an allocation from the state to serve the priority population, and they use funds as they see fit. Some mental health providers develop services that are Medicaid billable, sometimes exclusively. However, Burrell operates according to a Purchase-of-Service model in which the state has a contract with the Center for the purchase of direct human services for clients. Such contract provides more flexibility in reimbursement of services for the Center. If a service is not Medicaid billable, they use their allocated state funds to cover it. The Center actually takes a loss on many services to psychiatric clients (which include the cost of nurses and administrative support they provide to the doctors). This is part of the reason that they are working with others to attain better Medicaid reimbursement rates. Making money on some community services provides a subsidy to support workers in other less lucrative services in the Center.

About three-quarters of the funds for community mental health services come from state funds, and the majority of the remaining one-quarter comes from Medicaid and some from private insurance. Cox Health, a regional health and hospital group, provides most of the private insurance and is a big player in the state. Before the grant, CMHC services were almost solely funded by the state. Over the last years, because of initiatives started with the Center leadership and private insurance companies, there has been a notable increase in the portion of private insurance that funds services (Table 3.2). There were two study participants with private insurance initially and one is still with a private carrier. All others are on Medicaid or are eligible and have applied for Medicaid.

A reduction in state funding has had less of an impact on the Center than for other providers. The Center was able to restructure and avoid lay-offs, allowing routine job attrition and no new hiring to reduce staff in response to the reductions in budget. They try to balance revenues to stay solvent. The success was in most part due to having a visionary leadership that helped to structure the Center and funding to attain a solvent

outcome. A vice president of Burrell Center is also the Chief Executive Officer of the Missouri Coalition of CMHCs and the Coalition has been very active in advocating for additional state mental health dollars.

There is one supported employment specialist on staff and that employee works with the ACT team to some extent but lack of adequate supported employment services was described by the leadership as a notable weakness in the system. There is limited funding for supported employment in the state and there is still very little attention being paid to this area. All NAVIGATE components except supported employment (which was never fully developed) are likely to be sustained after the conclusion of RAISE ETP. Burrell sees supported employment as a critical need and they are working hard to advocate for funding. More awareness about early intervention is being stirred by the grant, and much of that is occurring through word-of-mouth. In general, they expect early intervention services will be sustained and will be offered across the board and engagement will be stressed.

There is no property tax dedicated to mental health funding and there are no state or local subsidies for behavioral health care, other than the standing budget allocation from the state Department of Mental Health. There is also a Community Medical Access program in place. Because Burrell is an Administrative Agent for mental health they also treat adult substance use disorders. The drug court also has some limited resources. Burrell has its own pharmacy and helps people who cannot otherwise afford medications.

The Center believes that it is important to establish medical homes for people with severe and persistent mental illness (SPMI). The Center sees identifying high utilizers and providing customized services as a good precursor to the fiscal (and clinical) benefits that will accrue to establishing medical homes for people with SPMI, and work in that area has served as good preparation for changes that are anticipated with the ACA.

TABLE 3.2. Burell Center, Springfield, MO: RAISE NAVIGATE Early Treatment Components and Funding Sources								
	In-house or Other	**Out-of-Pocket**	**Private Insurance**	**Medicaid**	**Medicare**	**Other Insurance (e.g., VA, Tricare)**	**State MH Resources**	**Local MH Resources**
Outreach and engagement	✓						✓	
Medication	✓	✓	✓	✓	✓	✓	✓	✓
Medication visits		✓	✓	✓	✓	✓	✓	
Alcohol and substance use treatment	✓	✓	✓	✓		✓	✓	
Family psycho-education	✓	✓					✓	
Family therapy		✓	✓	✓		✓	✓	
Other outpatient visits	✓	✓	✓	✓	✓	✓	✓	
Inpatient care as needed		✓	✓	✓	✓	✓	✓	
Supported employment	✓						✓	
Job development							✓	
Planning (e.g., treatment and/or recovery plans)				✓	✓	✓	✓	
Job coaching and other vocational supports				✓			✓	
Supported education								
Individual resilience training	✓							
Case management	✓			✓			✓	
Benefits counseling (e.g., WIPA)								
Treatment and primary care coordination	✓			✓			✓	
Other (e.g., occupational or psychosocial therapy, groups, etc.)	✓							
NOTE: In-house or Other means services provided by staff directly and not billed to any payer. Out-of-pocket means services were paid for either entirely out-of-pocket or some cost-sharing was required.								

Community Mental Health Authority, East Lansing, MI

The Community Mental Health Authority of Clinton, Eaton and Ingham Counties (the Authority) is a locally-based, public organization, created in 1964 with the purpose of serving the mental health needs of the residents of the tri-county community. Annually, the organization serves over 10,000 persons at 122 sites throughout the tri-county region with over 900 employees.

The Authority and the mental health centers that it operates did not have a particular focus on first-episode patients prior to this study. The main motivation was to develop further understanding and build capacity to address the needs of patients with first-episode psychosis. The state has a steering committee disseminating information on evidence-based practices in mental health services, such as assertive community treatment (ACT), family psycho-education, supported employment, and medication algorithms. Lead members of the RAISE study team serve on this steering committee.

The main source of referrals was the inpatient unit operated by the CMHC as well as other hospitals and providers through brochures or word-of-mouth. They had a total of 50 referrals that went through initial screening by the project manager Cathy Adams. The 26 of them were sent for further interviews for medical diagnosis and 18 participants, ages between 18 and 33, finally enrolled in the study.

Financing of Services

Among the study participants, 12 came with health insurance coverage from their parents and six were uninsured. Those who were uninsured applied and obtained Medicaid coverage (either through SSI eligibility or some other eligibility status) to pay for services. The Center receives per enrollee per month capitated allocation from Medicaid. There is also some revenue that comes from state General Funds under categorical funding mainly for the uninsured. State mental health block grants are also available for evidence-based treatment services. However, for the agency overall, the capitated Medicaid payment is the main source of income both for RAISE clients and clients in general (Table 3.3).

In general, the participants had a focus of continuing their education and mostly requested supported education services to achieve their learning and recovery goals and the case managers were able to provide such support to a great extent. In terms of supported employment services, although the Center had some earlier initiatives aligned with providing supported employment services, they did not have a dedicated staff assigned to provide for these services. There were a couple of referrals to Michigan Rehabilitation Services for employment and training services.

The site is also using “presumptive eligibility” to some extent to streamline the Medicaid enrollment process. Presumptive eligibility enables patients who appear to be income eligible for Medicaid or the Children’s Health Insurance Program to receive

temporary coverage while a full determination is processed. Beginning January 1, 2014, states can allow Medicaid-participating hospitals to conduct presumptive eligibility determinations for any Medicaid-eligible populations regardless of whether the state is using presumptive eligibility in any other setting or for any other populations in the state (ACA, 2011). The study team did not think they would be able to sustain all components of the NAVIGATE treatment, particularly SEE. They saw this study as a good learning experience.

TABLE 3.3. Community Mental Health Authority, East Lansing, MI: RAISE NAVIGATE Early Treatment Components and Funding Sources								
	In-house or Other	**Out-of-Pocket**	**Private Insurance**	**Medicaid**	**Medicare**	**Other Insurance (e.g., VA, Tricare)**	**State MH Resources**	**Local MH Resources**
Outreach and engagement	✓			✓		✓	✓	✓
Medication		✓	✓	✓	✓	✓	✓	✓
Medication visits		✓	✓	✓	✓	✓	✓	✓
Alcohol and substance use treatment	✓		✓	✓	✓	✓	✓	✓
Family psycho-education				✓	✓	✓	✓	✓
Family therapy			✓	✓	✓		✓	✓
Other outpatient visits		✓	✓	✓	✓	✓	✓	✓
Inpatient care as needed		✓	✓	✓	✓	✓	✓	✓
Supported employment				✓			✓	✓
Job development	✓							
Planning (e.g., treatment and/or recovery plans)				✓			✓	✓
Job coaching and other vocational supports				✓			✓	✓
Supported education				✓				
Individual resilience training		✓	~	~	~	~	~	~
Case management				✓			✓	✓
Benefits counseling (e.g., WIPA)	✓							
Treatment and primary care coordination		✓		✓	✓	✓	✓	✓
Other (e.g., occupational or psychosocial therapy, groups, etc.)		✓	~	✓	~	~	✓	✓

NOTE: In-house or Other means services provided by staff directly and not billed to any payer. Out-of-pocket means services were paid for either entirely out-of-pocket or some cost-sharing was required.
~ Denotes possible funding if billed under therapy code.

PeaceHealth, Eugene, OR

PeaceHealth Medical Group is a non-profit treatment facility within Eugene, OR. Eugene is the third largest metro area in the state and the largest community served by PeaceHealth. They have operated the only psychiatric inpatient facility in the county for over a decade. Due to financial issues, they started a partnership with Lane County Behavioral Health Services and formed a transition team. Lane County Behavioral Health Services is a public mental health provider receiving funding mainly from state mental health grants, Medicaid, and Medicare reimbursements. In this partnership, PeaceHealth provided staff for the RAISE project and the county provided other financial funds and supports.

The idea of treating first-episode psychosis had been considered for several years by the partnership. There were prior first-episode psychosis study grants under the Early Assessment and Support Alliance supported by the Oregon Health Authority, but the site was not prepared to put in proposals at that time. However, they continued communication with the state and later learned about the potential involvement in the RAISE study. This study was seen as a good fit because of the site's success with clients with psychotic illnesses and having many required elements already in place. In addition, lack of funding for mental health services in the public system has encouraged collaboration among all parties. Having direct access to emergency rooms, hospitals, and other providers allows the site to identify and recruit participants for the study. There are 21 participants enrolled in the study, and while there were a few referrals from the University of Oregon, the majority of the referrals were from emergency rooms and hospitals.

Financing of Services

The main sources of funding for the services are state Medicaid and state General Funds. Currently, out of the 21 enrollees, 11 are on Medicaid, three have private insurance, and seven are uninsured. The RAISE study funds the project director's time and pays for four hours a week of a supported employment specialist time.

The Center has a Federally Qualified Health Center (FQHC)[1] designation which provides a higher reimbursement for Medicaid-eligible services compared to other providers. FQHCs are "safety net" providers, such as community health centers and other outpatient health programs with the main purpose of enhancing the provision of primary care services in underserved urban and rural communities. The staff interviewed during the site visit stated that the difference between enhanced rate due to

[1] FQHCs are public or tax-exempt entities which receive a direct grant from the United States under Section 330 of the Public Health Service Act, or are determined by HHS to meet the requirements for receiving such grants. This statute defined the services to be provided by FQHCs for Medicaid purposes and included special payment provisions to ensure that they would be reimbursed for 100% of their reasonable costs associated with furnishing these services (Leifer and Freedus, 2011).

FQHC status and normal Medicaid reimbursement covers the cost of other services in NAVIGATE that are generally not reimbursable (Table 3.4).

The site also acknowledges that enrolling participants in SSI to get health care benefits also creates some disincentives to obtain and maintain employment. Thus, the supported employment is considered to be an important addition to the site's services through RAISE. However, they were not able to hire a qualified staff person to provide these services. Some aspects of the supported employment were provided by the case managers (mostly reimbursable services that they can bill under Medicaid) and for some others they use referrals to other partner agencies with supported employment staff.

While the Medicaid reimbursement under FQHC status seems to be working for now, the staff was not sure how the Medicaid prospective payment system will be restructured under the ACA. There are some discussions to move from a fee-for-service system to capitated and outcome-based payment in the next years. The implications of such an arrangement on funding first-episode psychosis services are also not clear. The Governor has signed a new law that will change the funding for people covered by the Oregon Health Plan (the state's plan for individuals covered by Medicaid). This transformation will result in a greater emphasis on prevention and the integration of medical, mental health, and substance abuse care. The law calls for local communities to come together to form Coordinated Care Organizations (CCOs) to design and manage the new local health care systems for local Oregon Health Plan members. A Steering Committee has formed to lead this work in Lane County and there is some discussion to provide coverage for supported employment services under the CCO system.

Recently, the Center has obtained "innovation funding" from state Medicaid to develop a health home model of treatment. In the future, first-episode psychosis services will be offered through the health home. They hope to hire a SE specialist and provide services directly aligned with return to work (and/or education) philosophy.

TABLE 3.4. PeaceHealth, Eugene, OR: RAISE NAVIGATE Early Treatment Components and Funding Sources								
	In-house or Other	**Out-of-Pocket**	**Private Insurance**	**Medicaid**	**Medicare**	**Other Insurance (e.g., VA, Tricare)**	**State MH Resources**	**Local MH Resources**
Outreach and engagement	✓						✓	✓
Medication	✓		✓	✓	✓	✓	✓	✓
Medication visits	✓		✓	✓	✓	✓	✓	✓
Alcohol and substance use treatment	✓		✓	✓	✓		✓	✓
Family psycho-education	✓			✓		✓	✓	✓
Family therapy	✓		✓	✓	✓	✓	✓	✓
Other outpatient visits	✓			✓		✓	✓	✓
Inpatient care as needed			✓	✓	✓		✓	
Supported employment	✓			✓		✓	✓	✓
Job development	✓						✓	✓
Planning (e.g., treatment and/or recovery plans)	✓		✓	✓	✓	✓	✓	✓
Job coaching and other vocational supports	✓			✓		✓	✓	✓
Supported education	✓			✓		✓	✓	✓
Individual resilience training	✓			✓	✓	✓	✓	✓
Case management	✓			✓			✓	✓
Benefits counseling (e.g., WIPA)	✓			✓			✓	✓
Treatment and primary care coordination	✓		✓	✓			✓	✓
Other (e.g., occupational or psychosocial therapy, groups, etc.)	✓			✓		✓	✓	✓
NOTE: In-house means RAISE grant funding and PeaceHealth contribution and Other means federal WRAP payments. State MH Resources means indigent care funds. Local MH Resources means county indigent care funds.								

Saint Clare's Behavioral Health, Denville, NJ

St. Clare's Health Systems, an affiliate of Catholic Health Initiatives, operates a community mental health program that sponsors the NAVIGATE site in Denville, NJ. It also operates a hospital and other behavioral health services in the area. St. Clare's is the dominant behavioral health provider in Morris County. It has a staff of approximately 150 professionals of all specialist types, serving 2400 clients in 2009, the most recent year of complete data. They serve adults and children with the full range of behavioral problems and diagnoses. Although they did not have a first-episode psychosis service prior to RAISE and NAVIGATE, the state and St. Clare's have an emphasis on early intervention services, which includes emergency response services and medications. This emphasis on early intervention services set the groundwork for participating in RAISE.

NAVIGATE is located within the same program that supports the ACT teams at St. Clare's. The NAVIGATE program is embedded within this program area and is entirely funded by categorical mental health resources provided by the state mental health authority. Those state funds have made it possible for St. Clare's to finance NAVIGATE and participate in the RAISE study.

The catchment area for St. Clare's is suburban and not very densely populated. Recruitment was limited, and only four individuals of the 24 screened are participating in the study. Only ten people consented, and of them, three were found ineligible for the study, and three withdrew consent, deciding not to participate. The participants are considered uninsured for the purpose of the study, as St. Clare's pays for all of their services from public mental health services resources. The site did not consider it worth the effort to bill for any insured services for this small number of participants, when they were able to use public resources to cover all of the NAVIGATE services.

The NAVIGATE program, and the community program in which it is embedded, is surrounded by a service system operated by St. Clare's, delivering a wide range of non-NAVIGATE services. The non-NAVIGATE, other behavioral health programs, include hospital and partial hospital services, outpatient services, and supported housing services. These services are financed entirely with state funds, while any other behavioral health services are financed through a $650,000 grant from the local Morris County Mental Health Administration.

St. Clare's provides all of the services listed in the NAVIGATE service matrix in one form or another, as needed, to NAVIGATE participants, funded by state mental health authority resources. The larger program of "enhanced outpatient and support services" is also funded in this manner with an $8.5 million grant from the State of New Jersey and serves 100-120 clients. Supported education and supported employment (SEE) services are included in this package of services, which includes some support from the state Division of Vocational Rehabilitation services.

Unlike any of the other sites, New Jersey discussed some training activities that they had initiated in response to questions concerning training in evidence-based practices, such as those included in the NAVIGATE intervention. The only training resources mentioned by the other sites were those provided by the central RAISE project itself. The state behavioral health agency also provides financial support for training practitioners and programs in evidence-based practices, including ACT and SEE. In addition, the state funds training in Illness Management and Recovery, which has some similarity to IRT. Prior to site involvement in RAISE, training was provided both by the University of Medicine and Dentistry of New Jersey and by out-of-state trainers from Dartmouth and Boston University. With respect to SEE, staff members have been trained in both Individual Placement and Support and Choose-Get-Keep approaches. During RAISE, of course, the training in the various NAVIGATE service elements has been provided by the RAISE study team.

The NAVIGATE team is currently comprised of four FTE staff members. Their salaries are covered by the state behavioral health agency grant, and they serve many more clients in addition to the four NAVIGATE participants. The NIMH grant supplement for SEE covers the cost of SEE services not covered by the state grant.

TABLE 3.5. St. Clare's Behavioral Health, Denville, NJ: RAISE NAVIGATE Early Treatment Components and Funding Sources								
	In-house or Other	**Out-of-Pocket**	**Private Insurance**	**Medicaid**	**Medicare**	**Other Insurance (e.g., VA, Tricare)**	**State MH Resources**	**Local MH Resources**
Outreach and engagement	✓						✓	
Medication		✓					✓	✓
Medication visits		✓					✓	✓
Alcohol and substance use treatment							✓	✓
Family psycho-education							✓	
Family therapy							✓	✓
Other outpatient visits		✓					✓	✓
Inpatient care as needed							✓	✓
Supported employment							✓	
Job development	✓						✓	
Planning (e.g., treatment and/or recovery plans)							✓	
Job coaching and other vocational supports							✓	
Supported education							✓	
Individual resilience training								
Case management							✓	✓
Benefits counseling (e.g., WIPA)							✓	✓
Treatment and primary care coordination							✓	✓
Other (e.g., occupational or psychosocial therapy, groups, etc.)							✓	✓

4. POLICY IMPLICATIONS AND LESSSONS LEARNED

The following observations emanate from the site visits and conversations with RAISE investigators and staff:

Each site has developed a creative solution to financing NAVIGATE services. As expected, each site used health insurance to pay for each of the NAVIGATE services for insured participants, other than SEE, which was only partly covered for those individuals who were Medicaid beneficiaries. For participants who were uninsured, the sites used other public resources to cover all NAVIGATE services. These tactics will generalize to locations with some of the same characteristics for behavioral health care financing. While the tactics are somewhat idiosyncratic, they do offer lessons for other future sites who wish to offer early intervention services to emulate.

Some specific observations:

- The site at the Mental Health Center of Denver has a capitated Medicaid arrangement to pay for all behavioral health services, which the site uses to pay for the full range of RAISE NAVIGATE services and treatments. This arrangement began in the 1990's throughout the State of Colorado, and covers all Medicaid mental health services, not just those for treating first-episode psychosis.

- The PeaceHealth site in Eugene, OR is affiliated directly with an FQHC. The revenues for any behavioral health encounter at the FQHC are generous enough that the costs of care are covered and even permit a cross-subsidy for individuals whose coverage does not include the full cost of their care and treatment.

- The St. Clare's Health System site in Denville, NJ has sufficient funds from state and local behavioral health services grants and annual contracts to cover the costs of NAVIGATE services.

- The Burrell Center in Springfield, MO also funds the NAVIGATE services with state behavioral health funds through a contract with the Department of Mental Health. For those who qualify, Medicaid funds were matched to state funds in a Purchase-of-Service arrangement that covers some services, such as supported employment, which has very limited availability in Missouri.

- The site at the three-county Community Mental Health Authority in Lansing, MI uses Medicaid to pay for many of the behavioral health services for those who are qualified, and many of the participants remain on their parents' health insurance, which is easier and lasts up to age 26 because of the ACA provisions.

Many of the services are not covered by private insurance plans, and even Medicaid does not cover all services, so the site uses state and local behavioral health funds for "bad debt" to cover some services. Michigan also has an evidence-based practices implementation initiative, which covers supported employment services.

- The Michigan site also took advantage of "presumptive eligibility" for Medicaid. Beginning January 1, 2014, states can allow Medicaid-participating hospitals to conduct presumptive eligibility determinations for any Medicaid-eligible populations regardless of whether the state is using presumptive eligibility in any other setting or for any other populations in the state (ACA, 2011). Until online applications are sufficiently linked to state and federal databases so that individuals or families will no longer need to document their income, citizenship, and other information, presumptive eligibility seems to be a "best practice", particularly for patients who need immediate care and support services such as, people with first-episode psychosis (Sebastian, 2011).

Other future sites wishing to offer services to individuals during a first episode of psychosis could use these tactics, where available, to supplement insurance payments for more traditional medically-oriented services such as medications, medical management visits, and psychotherapy. Tactics include capitation financing arrangements, affiliation with a FQHC, or Medicaid coverage of innovative home and community-based behavioral health services. Implementing such financing tactics might require some technical assistance to community sites to learn to take advantage of local opportunities. It might also be enhanced by technical assistance to states to develop some of these options, such as Medicaid state plan amendments (SPAs) using Section 1915(i), use of FQHCs, or use of managed care contracts with capitated financing and/or flexible benefits options.

These lessons would best generalize to sites that also have a small number of participants and would like to add first-episode clients to existing staff caseloads. Some RAISE NAVIGATE sites have a small number of early psychosis patients (fewer than ten), and the small numbers makes it possible to cross-subsidize the care of these participants from a variety of funding sources. This tactic would work for other sites that admitted a small number of clients but would be more difficult for sites that had more clients and wished to form a specific team to serve primarily first-episode clients, primarily because of the start-up costs and the costs of caring for a large number of participants with limited resources or insurance. This will change to some extent with full implementation of the ACA, although not all NAVIGATE services will be covered in exchange insurance plans (e.g., supported employment) nor in some state Medicaid plans.

The provisions of the ACA already in place have assisted individuals experiencing a first episode of psychosis by permitting some to remain on parents' insurance plans until age 26 years and not lose eligibility for private insurance because of a pre-existing condition. The ACA Medicaid expansion will also provide coverage for many individuals

who no longer have to wait until they qualify for SSI before becoming eligible for Medicaid. It is particularly important for promoting recovery from a psychotic illness to provide the types of intensive therapies more often available through Medicaid early in the progression of these diseases in light of some indications of lasting ill effects of these conditions and expected positive effects of early intervention.

Some policy lessons:

- The sites have been very creative in using available financial resources above-and-beyond what is provided by the NIMH contract for supported employment. (Each of the RAISE sites receives funds from the NIMH RAISE contract to support five hours of time per week for an employment specialist.)

- Sites were encouraged to file claims with public and private health insurance in cases where a participant had such coverage and when the service was covered by the insurance plan, as the site might ordinarily do for their clients who are not part of RAISE. Of course, some of the participants have no insurance, and some of the key services are not covered by insurance or only partially covered, such as supported employment and supported education, as well as case management and non-face-to-face meetings of staff team members.

- Medicaid is the health insurance financing mechanism that is most likely to cover RAISE NAVIGATE services. However, there is considerable variation from state-to-state in terms of behavioral health benefits. Furthermore, many of the participants would not currently qualify for Medicaid unless they were low-income parents themselves, dependent children in low-income families, or disabled -- or the state offers a state-only Medicaid program for individuals who are “medically indigent”. Most individuals who qualify for first-episode services are too early in the course of their psychotic illness and thus lack the substantial functional impairments necessary to qualify for SSI (and thus Medicaid) on the basis of disability, unless they have impairments other than psychosis that would disable them.

- The Medicaid expansion of the ACA will change that eligibility limitation dramatically. Many individuals with first episode of psychosis, who are not disabled, will be able to qualify for Medicaid without qualifying for SSI. Medicaid has a benefit package in many states that is more likely to cover relevant behavioral health services when compared with typical insurance plans. The new expansion population will not necessarily receive the regular Medicaid benefits since states can base the benefit package on various benchmarks including the largest health maintenance organization and state employee benefits. However, some states may opt to offer the regular Medicaid benefits to the expansion population for administrative simplicity and some of the individuals in the expansion group may qualify for regular Medicaid as individuals with disabilities or special needs. In addition, the Centers for Medicare and Medicaid Services has indicated that states can develop special benefit packages for

targeted groups among the expansion population. This points to continued need for state, local and/or federal Substance Abuse and Mental Health Services Administration block grant funds to cover early intervention services. The ACA also permits states to include early intervention services, such as case management, ACT, and psychosocial rehabilitation, under the so-called Medicaid 1915(i) provisions, which do not require a waiver and instead may be established with a Medicaid SPA. The 1915(i) benefits can also be targeted to specific subpopulations (e.g., those with first-episode psychosis and/or the expansion population). An important objective of treatment and services in first-episode psychosis is to prevent disability, and disability status under the SSI program will no longer be required to become eligible for Medicaid. This is particularly important for promoting recovery from a psychotic illness by encouraging affected individuals to participate in supported employment and work and not to apply for SSI prematurely, which might discourage a working and productive life.

- The ACA has been helpful already in that some of the participants are able to pay for some services by remaining on their parents' health insurance up to age 26. They also will not be disqualified from obtaining private insurance due to a pre-existing condition, which happened frequently to individuals with a history of psychosis before the ACA.

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APPENDIX 1. MEDICAID 1915(i) HOME AND COMMUNITY-BASED SERVICES OPTION

The 1915(i) home and community-based services (HCBS) state plan option presents a vehicle for states that are interested in supporting individuals with serious mental illness in attaining and sustaining competitive work. Differences in the design of the 1915(i), such as using needs-based rather than institutional level of care eligibility criteria, make it easier for states to develop services for persons with serious mental illness than under 1915(c). While the ability to offer HCBS including SEE and prevocational services via a state plan option as opposed to a 1915(c) waiver or 1115 demonstration program, has been available to states since enabling legislation as part of the Deficit Reduction Act (DRA) was enacted in 2005, few states have taken advantage of this option. This was in part due the capping of financial eligibility at 150% of the federal poverty level (FPL). Although 1915(c) waivers allow states to enroll individuals with incomes higher than 150% of the FPL, states could not use the 1915(i) for persons with incomes greater than 150% of the FPL. Also individuals with disabilities eligible for Medicaid under "Buy-In" programs with incomes greater than 150% of FPL were not able to take advantage of services such as supported employment available under 1915(i). States were also limited to a more restricted range of services than was allowed under the 1915(c) waiver program.

Section 2402 of the ACA modifies the original legislation and makes major changes and improvements to how states may amend their state plans using the 1915(i) option; including changing the issues described above that made the 1915(i) option less attractive to states. These changes became effective October 1, 2010. Modifications to the 1915(i) state plan option as part of the ACA include:[1]

- Permits states to propose additional HCBS beyond those that are defined in statute in order to design benefit packages that are customized to a particular population. For example, states are now able to cover psychosocial rehabilitation, case management and community transition services that were previously not permitted under the former regulations governing 1915(i).

- Under 1915(i) individuals up to 150% FPL do not have to meet institutional level of care in order to be eligible for the waiver; states develop criteria based on need. This allows states to offer HCBS to individuals whose needs are substantial, but not serious enough to meet institutional level of care.

- Offers states the option of expanding eligibility to 300% of the SSI federal benefit rate (FBR) for those individuals who would otherwise be eligible for HCBS under 1915(c), (d), or (e) waiver or an 1115 demonstration program. This is a significant change from the prior iteration of 1915(i) as it allows states to create a new

[1] For more information please refer to State Medicaid Director Letter #10-013 from August 6, 2010.

optional eligibility category, allowing them to extend the services available as part 1915(i) to more individuals than previously allowed.

- Services offered under 1915(i) must be offered statewide.

- States are now permitted to target 1915(i) benefits to certain populations (effectively waiving the comparability requirement) to allow them to design different benefit packages for different target populations. For example, states could design a benefit package to meet the needs of individuals with SPMI.

- States are no longer allowed to limit the number of individuals who can receive services offered as part a state's 1915(i) services, SPA or create waiting lists. This important change to 1915(i) will allow more individuals to take advantage of HCBS that can assist persons in gaining and sustaining employment.

If states elect to pursue the 1915(i), it is an opportunity to provide individuals with mental illness a more comprehensive array of HCBS that could support them in attaining and sustaining competitive employment. There is no cost-neutrality requirement in the 1915(i) state plan option nor do individuals up to 150% FPL have to meet institutional level of care criteria; these functional differences in the structure of 1915(i) reduce historical barriers to states covering HCBS for individuals with serious mental illness.

TABLE A1. Comparison of 1915(i) under DRA and the ACA

	1915(i) under DRA	1915(i) as Amended by ACA
Geography	Could limit to certain geographic areas or political subdivisions.	Must be available statewide.
Financial eligibility	Up to 150% of FPL.	Up to 300% of SSI FBR as long as the person meets criteria for an existing 1915(c) waiver or 1115 demonstration.
Non-financial eligibility	States develop needs-based criteria.	States develop needs-based criteria can tighten needs-based criteria but must continue to offer services to eligible persons served under the former standards.
Targeting criteria	Not allowed to target benefits to certain populations.	Can target to certain populations and can have more than one benefit by target group.
Services	States not permitted to propose "other services" as available under 1915(c).	States permitted to propose all services available under 1915(c) including "other services".
Number served	Could place caps on the number served and maintain waiting lists.	Must be available to all eligible Medicaid beneficiaries without limitation.

APPENDIX 2. CASE STUDY INTERVIEW PROTOCOLS

Interview with Agency Administrator or Administrative Designee

INTERVIEWER: [PARAPHRASE AS NEEDED]: My name is [INSERT NAME] and this is [INSERT NAME]. We both work for Westat, a private research company in Rockville, Maryland. Westat is collecting information on the RAISE NAVIGATE programs, which is being sponsored by NIMH. The site visit study is being sponsored by ASPE within the HHS.

As the agency administrator for the organization sponsoring the RAISE NAVIGATE program, you are a vital source of information. The broad focus of our interviews is to obtain your perspectives on the challenges you have encountered during implementation. We are particularly interested in how your site addresses these issues:

- Fidelity to the RAISE NAVIGATE service package
- Funding for different components of the services package
- How funds are combined and accessed to support the overall model, and
- Perceived conflicts between service requirements and funding options, and any other barriers to successful implementation of first-episode services.

Before we begin, we'd like your permission to record our conversation to make sure we capture all of your comments. The recordings will only be used by Westat and will be disposed of after the study ends. Do we have your permission for this? [PAUSE] Do you have any other questions? [PAUSE] Thank you. Let's begin.

A. Overview of the RAISE NAVIGATE program

1. I'd like to start off by having you describe your experiences with the project thus far.

   - What were your objectives for the RAISE NAVIGATE project at the beginning? In what ways, if at all, have your objectives changed since then? Explain.

   - Describe how you have provided education and training for RAISE project staff & providers.

   - What changes, if any, have been made to your original implementation plan and why?

2. We'd like to ask you some information about the past calendar or fiscal year. Which time period is applicable for the RAISE NAVIGATE program, a calendar year (1/1/10 to 12/31/10) or a fiscal year (e.g., 9/1/10 to 8/31/11)?
   _____ (Specify)

Funding and Billing

3. Which of the following were typical sources of funding for your agency during the past year? (Select all that apply.)

___Federal Grant or Contract
___Private Foundation Grant
___State or County Grant or Contract
___ Special Program/Study (similar to but other than RAISE NAVIGATE)
___Medicare
___Medicaid
___Private Insurance
___Other Insurance (e.g., state or county)
___Client payment for services (**FAMILY**)
___Client payment, Sliding scale
___Ticket to Work, subcontract work
___School Contracts, donations
___Agency fundraising, donations, or endowments (Please specify)
_____

4. Were any special or ear-marked funds used to meet the needs of RAISE NAVIGATE clients compared to the funding typically used for your traditional clients? Please describe.

B. Program Components and Activities

Now we'd like to focus on the primary activities and how services are delivered to RAISE NAVIGATE clients. We'd like to capture all the components of the program that are being offered and then discuss how each of the components is funded. *[Hand informant a laminated chart of components.]* Using this chart as a reference point, let's establish which components are available to RAISE NAVIGATE clients through your site. Then we'll talk about the provider (i.e., your site or another organization) and the funding source for each of the services that are available.

TABLE 1. RAISE NAVIGATE Early Treatment Components and Funding Sources									
	In-house or Other*	**Out-of-Pocket**	**Private Insurance**	**Medicaid**	**Medicare**	**Other Insurance**	**State MH Resources**	**Local MH Resources**	**Bad Debt**
Outreach and engagement									
Medication									
Medication visits									
Alcohol and substance use treatment									
Family psycho-education									
Family therapy									
Other outpatient visits									
Inpatient care as needed									
Supported employment									
Job development									
Planning (e.g., treatment and/or recovery plans)									
Job coaching and other vocational supports									
Supported education									
Individual resilience training									
Case management									
Benefits counseling (e.g., WIPA)									
Treatment and primary care coordination									
Other (e.g., occupational or psychosocial therapy, groups, etc.)									
* Include grant-funded sources here and specify whether grant is federal, state, or local.									

Outreach and Intake, Engagement, Referrals, and Service Coordination

1. How does intake into RAISE NAVIGATE services occur? Where do most referrals for RAISE enrollees come from? Please describe.

    - Use checklist for probes, as needed:
        - Local hospitals?
        - Local universities?
        - School-based clinics?
        - High school guidance counselors or other staff?
        - Community or school-based police or security guards?
        - Pediatricians?
        - Adolescent health care facilities?
        - Individual or family “walk-ins” or “call-ins”?

    - Please walk us through the referral process for RAISE NAVIGATE (e.g., method of referral, typical time to start of services) and highlight any problematic aspect of it (e.g., fee-for-service, transportation issues, referral paperwork, privacy and information-sharing issues, etc.).

    - Are there any difficulties associated with the process you have in place, or are you considering changes in the process? If so, please describe.

2. Are there funding challenges associated with adding, and also maintaining, the first-episode intervention program at your site? If so, are these challenges likely to continue into the future?

3. For some agencies, the type of outreach associated with the RAISE package of interventions is a “new” model of community engagement than usually associated with community mental health practice. How have staff and community partners reacted to this approach?

    - From your perspective, have you observed factors that facilitate this kind of outreach?

    - Have you encountered barriers to developing this kind of outreach?

4. What is your experience with using existing staff to implement RAISE services?

    - Has this approach been balanced, or has this overburdened staff, or do staffing demands vary?

    - Would you describe the uptake of RAISE services as slow, or as expected, or in some other way?

- How has your agency's administration handled the staff shifts?

- Are there issues about staffing that need to be reconciled as funding for RAISE services comes to an end?

Employment and Job-Related Services

5. Does the state Department of Vocational Rehabilitation have any role in the RAISE NAVIGATE? For instance, has the project involved VR in (or leveraged any VR funds for) micro-enterprises or self-employment efforts among project participants?

6. Was funding for the employment-related services to RAISE NAVIGATE program clients a problem for your site? Do you anticipate that funding these services will be problematic for your site after this grant ends? Please describe the situation and your thoughts about problem resolution, if applicable.

7. Has supported employment or supported education (or a combination of the two) been the greatest priority for the RAISE population you're seeing? Please describe.

C. Professional Development: Information and Training for Staff on RAISE NAVIGATE

Now we'd like to discuss training issues & its impact for staff involved with RAISE NAVIGATE partner organizations.

1. Did you encounter any problems while providing information and training? Please describe.

2. What funding is used to cover the costs of training and professional development associated with the RAISE NAVIGATE program?

3. Do you anticipate that funding for professional development will be ongoing? If so, please describe how you believe training costs might be funded after the RAISE NAVIGATE program ends.

4. Are details about the amount, duration, and frequency of training sessions for staff compiled by your agency? If so, please describe how or if that information affects decision-making about professional training needs. (If available, may we obtain a copy of the report?)

5. What are your goals and plans for providing information and training specific to first-episode interventions in the future (e.g., does a project management team handle these issues, partners are discussing cost-sharing approaches, etc.)?

Impacts of Information and Training

6. How is the fidelity of evidence-based practices used in RAISE NAVIGATE program services assessed (e.g., motivational interviewing techniques, supported education, supported employment, Individual Resilience Training)?

D. Policy

Now we'd like your perspectives on policy changes that might address barriers you have identified in launching the RAISE NAVIGATE program and how support for first-episode programs might be strengthened here.

1. Have you encountered problems with funding RAISE NAVIGATE program services that are associated with existing policies (e.g., providing services to clients who do not meet income thresholds for Medicaid or low-income assistance available in your state)? Please describe.

2. Given your knowledge of the existing coverage used by new, first-episode clients (e.g., remain on parents' insurance, indigent, Medicaid), have you already encountered, or do you anticipate, impacts to clients' coverage associated with the Affordable Care Act (ACA)? Please elaborate.

3. Do you/your site have any policy recommendations for funding first-episode interventions, employment services, or other content areas that you might recommend for federal, state, or local levels? If so, have any of the following concerns been a focus for your agency or for RAISE NAVIGATE program partners (formal or informal)?

    - Eliminating barriers to identifying, facilitating referrals, and/or delivering first-episode interventions that are connected to adverse economic situations in your community.

    - Activities with project partners or providers to improve employment prospects for first-episode intervention clients.

E. Sustaining Program Elements

1. Please describe the components of the RAISE NAVIGATE program that you think should be sustained in the future. If not all components can be sustained, which of them are the most important? Use checklist below for probes, as needed.
    - Targeted outreach and engagement strategies
    - Supported employment (including job development and job coaching)
    - Supported education
    - Family supports (e.g., psycho-education, therapy)
    - Individual Resilience Training

- Medication visits and/or medication management assistance
- Case management
- Treatment and recovery plans
- Coordination with primary care

2. What are the plans (emerging or in place) to ensure these elements will be sustained after RAISE NAVIGATE funding ends?

3. Is sustainability of first-episode interventions an investment your agency hopes or plans to make? Please describe whether your agency thinks that programs like RAISE NAVIGATE should be sustained.

4. What funding sources (either new or existing funding streams) will be available to support program services during and after the grant period?

5. Are federal, state, and local public sector commitments contributing to the sustainability of project activities (e.g., have there been changes in policies, procedures, or relevant legislation)? Please explain.

Thank you. That concludes our interview. We appreciate your time and help with this study!

Interview Topics for RAISE NAVIGATE Project Director or Designee

[INTERVIEWER:]: Good morning and thank you for taking the time to meet with me today. My name is [INSERT NAME] and this is [INSERT NAME]. We both work for Westat, a private research company in Rockville, Maryland. Westat is collecting information on the RAISE NAVIGATE programs, which are being sponsored by NIMH. The site visit study is sponsored by ASPE in HHS.

As a provider of RAISE NAVIGATE program services, you are an important source of information about the implementation and funding sources for first-episode intervention services offered by the program. I have some specific questions I need to ask, but I am also interested in your general comments and feedback. I'd like your permission to record our conversation so that we do not miss any of your comments. These recordings will be used by Westat only, and will be disposed of after the study is complete.

May we record our talk? [PAUSE] Do you have any questions before we start? [PAUSE]

O.K. Thank you. Let's Begin.

Outreach and Intake, Engagement, Referrals, and Service Coordination

1. How does intake into RAISE NAVIGATE services occur? Where do most referrals for RAISE enrollees come from? Please describe.

    - Use checklist for probes, as needed:
        - Local hospitals?
        - Local universities?
        - School-based clinics?
        - High school guidance counselors or other staff?
        - Community or school-based police or security guards?
        - Pediatricians?
        - Adolescent health care facilities?
        - Individual or family "walk-ins" or "call-ins"?

    - Please walk us through the referral process for RAISE NAVIGATE (e.g., method of referral, typical time to start of services) and highlight any problematic aspect of it (e.g., fee-for-service, transportation issues, referral paperwork, privacy and information-sharing issues, etc.).

    - Are there any difficulties associated with the process you have in place, or are you considering changes in the process? If so, please describe.

2. Are there funding challenges associated with adding, and also maintaining, the first-episode intervention program at your site? If so, are these challenges likely to continue into the future?

3. For some agencies, the type of outreach associated with the RAISE package of interventions is a "new" model of community engagement than usually associated with community mental health practice. How have staff and community partners reacted to this approach?

    - From your perspective, have you observed factors that facilitate this kind of outreach?

    - Have you encountered barriers to developing this kind of outreach?

4. What is your experience with using existing staff to implement RAISE services?

    - Has this approach been balanced, or has this overburdened staff, or do staffing demands vary?

    - Would you describe the uptake of RAISE services as slow, or as expected, or in some other way?

    - How has your agency's administration handled the staff shifts?

    - Are there issues about staffing that need to be reconciled as funding for RAISE services comes to an end?

Employment and Job-Related Services

5. Please describe how your RAISE NAVIGATE works with the Career Centers (One Stop Offices) in this area.

    - Do any of your clients routinely receive services at the WorkSource Centers?

    - Do you have any outreach or screening staff co-located in the Career Center(s) involved with RAISE NAVIGATE?

6. Does the state Department of Vocational Rehabilitation have any role in the RAISE NAVIGATE? For instance, has the project involved VR in (or leveraged any VR funds for) micro-enterprises or self-employment efforts among project participants?

7. Was funding for the employment-related services to RAISE NAVIGATE program clients a problem for your site? Do you anticipate that funding these services will

be problematic for your site after this grant ends? Please describe the situation and your thoughts about problem resolution, if applicable.

RAISE NAVIGATE Clients Served by Your Organization

8. Are there any financial or other barriers that prevent individuals in need of first-episode interventions from receiving services in the RAISE NAVIGATE program? Please describe.

    - Do funding issues for the supports or service needs you identify present an obstacle that your program is trying to resolve? Please describe any funding issues connected to addressing the ongoing needs in the program.

Professional Development and Technical Assistance on RAISE NAVIGATE

9. Have you (personally) participated in training opportunities associated with RAISE and the NAVIGATE program interventions?

10. Have these offerings being helpful in your work with RAISE NAVIGATE clients? Has any topic or training been especially useful to you or your organization? Please describe the topical area and why it has been beneficial.

11. Are there other training areas of which you are aware that you think would better prepare you or your staff members to work more effectively with RAISE NAVIGATE clients? Are there certain topics that haven't been covered in training(s) that you'd like to see added?

12. What data are gathered to include in reports (if any) that are generated about the program? How are reports that present or analyze program operations used by your organization (e.g., to inform policy suggestions or professional development content decisions, to disseminate information about client outcomes, to monitor the fidelity of practices to models in use, etc.?). Please describe. (If available, please provide interviewers with a copy of relevant reports.)

Barriers to Reaching and Serving NAVIGATE Clients

13. What do you think are the biggest barriers (beyond the population typically served in community mental health centers) -- if any -- to outreaching, engaging, and helping people who are experiencing their first episode obtain access to appropriate interventions, treatments, or referrals?

    - Are there barriers that affect whether people come in for or agree to be screened for certain issues (e.g., mental health, substance use, cultural issues)?

    - How are those barriers being addressed now?

Perspectives on Program Impact and Sustainability

14. Please describe the components of the RAISE NAVIGATE program that you think should be sustained in the future. If not all components can be sustained, which of them are the most important? Use checklist below for probes, as needed.
    - Targeted outreach and engagement strategies
    - Supported employment (including job development and job coaching)
    - Supported education
    - Family supports (e.g., psycho-education, therapy)
    - Individual Resilience Training
    - Medication visits and/or medication management assistance
    - Case management
    - Treatment and recovery plans
    - Coordination with primary care

15. What do you see as the RAISE NAVIGATE program's biggest accomplishments? What contributed to the success?

16. What have you wanted to accomplish through RAISE NAVIGATE but been unable to achieve? Give examples. What would have made a difference?

17. Based on your knowledge of how RAISE NAVIGATE program services are currently funded, which, if any, of the program components do you believe will continue to be funded after the project ends?

Thank you. That concludes our interview. We appreciate your time and help with this study!

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