Early Psychosis Care in California: Current Landscape & Future Directions

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Objectives

1. Describe current implementation of EP services across California
   - Treatment standards for individuals with early psychosis (EP, affective and nonaffective) and clinical high risk (CHR)

2. Describe EPI-CAL network and its plan to create common data elements
   - Discuss plan to expand EPI-CAL to include more counties

3. Discuss need for state-level approach to EP training and technical assistance
   - Opportunity in Sonoma County with Kaiser HP

EP Care Standards

- "Standard community treatment" = therapy (individual, group and family), medication management, and case management
- EP programs = team-based approach with rapid access; comprehensive assessment; individual & group psychotherapy; family psychoeducation & support; case management; integrated medication management, and supported education and employment to improve role functioning (Heinssen, Goldstein, Azrin, 2014)
  - Coordinated Specialty Care (CSC)

Testing the Coordinated Speciality Care Model in the Community

- Studies in Europe and Australia showed improved outcomes in schizophrenia with team-based care
- Recovery After an Initial Schizophrenia Episode (RAISE) research initiative – started by NIMH in 2009
- RAISE Early Treatment Program vs usual care in the community
  - Included individuals with diagnoses of schizophrenia, schizoaffective disorder, schizophreniform disorder, brief psychotic disorder and psychosis NOS
    - Excluded mood disorders with psychotic features and clinical high risk
  - Randomized 34 clinics in 21 states

Comprehensive Versus Usual Community Care for First-Episode Psychosis: 2-Year Outcomes From the NIMH RAISE Early Treatment Program

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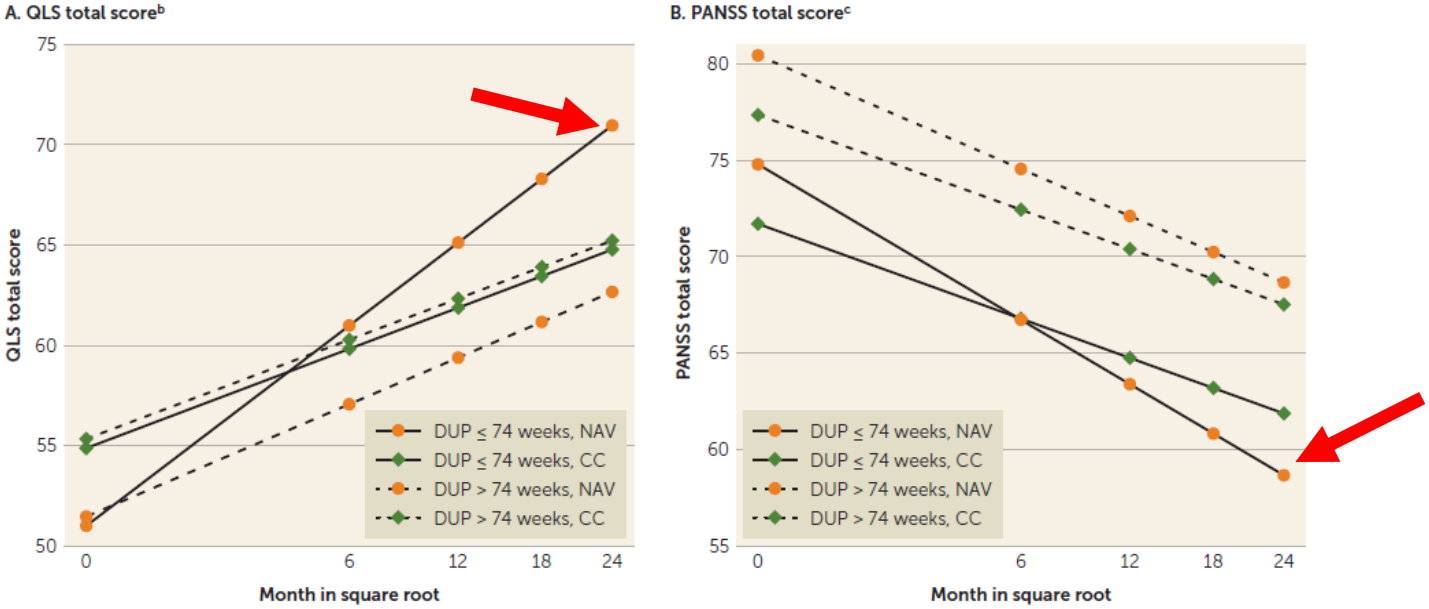
RAISE-ETP NAVIGATE

- Results demonstrated support for community-based use of CSC Model
- Recipients of NAVIGATE showed:
  - Longer treatment participation
  - Greater reduction in clinical symptoms
  - Greater improvement in quality of life and participation in work/school
- HOWEVER, treatment effects were moderated by Duration of Untreated Psychosis (DUP) → Median = <u>74 weeks (18.5 mths)</u>



Treatment Standards for CHR

- Most trials have focused on preventing psychosis onset

- Meta analysis by van der Gaag et al., (2013) examined 10 studies:
  - Antipsychotics have some effect BUT notable side effects led to high rates of dropout. No differences found from control group.
  - Omega 3 fatty acids → more recent studies have not replicated
  - CBT showed strongest results → and its helpful for those individuals who were less likely to develop psychosis

- Review of EBP intervention in CHR (Thompson et al 2015)
  - 9 RCTs of CBT – small but significant delay in preventing psychosis onset
  - Family Focused Therapy (Miklowitz et al., 2014): Family psychoeducation and support;
  - Combination treatments:
    - McFarlane et al., (2014) → Risk-based allocation design; integrated treatment (individual, family, meds, SEE) reduced symptoms and improved functioning. Not an RCT.
    - Integrated Psychological Intervention (Bechdolf et al., 2007, 2012): CBT, skills therapy group, cognitive remediation, multifamily psychoeducational group

Treatment Standards for CHR

- Many studies ongoing in this area, but data supports use of multiple evidence based components to meet individual needs
  - Careful medication treatment for threshold symptoms only
  - CBT and/or family focused treatments that emphasize functioning and recovery

- New focus on stepped care interventions → lower intensity interventions first, then step up treatment for non-responders

Treatment Standards for Mood Disorders

- Major Depression: RCT showed CBT+fluoxetine better than CBT or fluoxetine alone for severely depressed youth (March et al, 2004)
  - Antidepressant + antipsychotic or ECT in acute phase of psychotic depression (Rothschild, 2013)
  - ACT+Behavioral Activation (ADAPT) pilot trial in psychotic depression (Gaudiano et al., 2015)

- Bipolar Disorder: medication (McClellan et al., 2007), CBT and family-focused therapy and psychoeducation (review by Young & Fristad, 2015).

Summary of Treatment Standards

- CSC is appropriate and effective for individuals with schizophrenia spectrum diagnoses who are early in the course of illness
  - Data suggests that combination of treatments may also work for CHR

- Impact of CSC has not been tested in:
  - Individuals with mood disorders with psychotic features

US Implementation of EP Care

- Prop 63 PEI dollars had already led to rapid development of early psychosis (EP) programs across California
  - CA Programs focused on EP (with and without mood disorders) as well as individuals at clinical high risk for psychosis (CHR)

- After RAISE, CSC for early psychosis spread quickly (in US and CA) with the support of SAMHSA Block Grant funding

The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services

Tara A. Niendam, Ph.D., Angela Sardo, B.A., Mark Savill, Ph.D., Pooja Patel, B.S., Guibo Xing, Ph.D., Rachel L. Loewy, Ph.D., Carolyn S. Dewa, M.P.H., Ph.D., Joy Melnikow, M.D., M.P.H.

- Surveyed 30 programs in 24 counties between Oct 2016-May 2016
  - 41% had active programs
  - 21% were developing programs
  - 38% had no program
- Obtained data from 29 programs

Diversity of CA Programs

- 76% serve first episode psychosis (FEP) AND clinical high risk (CHR)
  - 17% serve FEP only
  - 7% serve CHR only (but SAMHSA Block grant funds have been used to include FEP)

- 86% serve any psychosis spectrum disorder, including schizophrenia spectrum
  - 72% serve mood disorder with psychosis
  - 21% serve mood disorders without psychosis

- Duration of psychosis ranges from 1 year (29%) to indefinite

- 55% serve clients for up to 2 years
  - Range is wide: 17% serve for up to 1 year while 27% go up to 3-4 years or indefinitely

Variability in Treatment Approaches

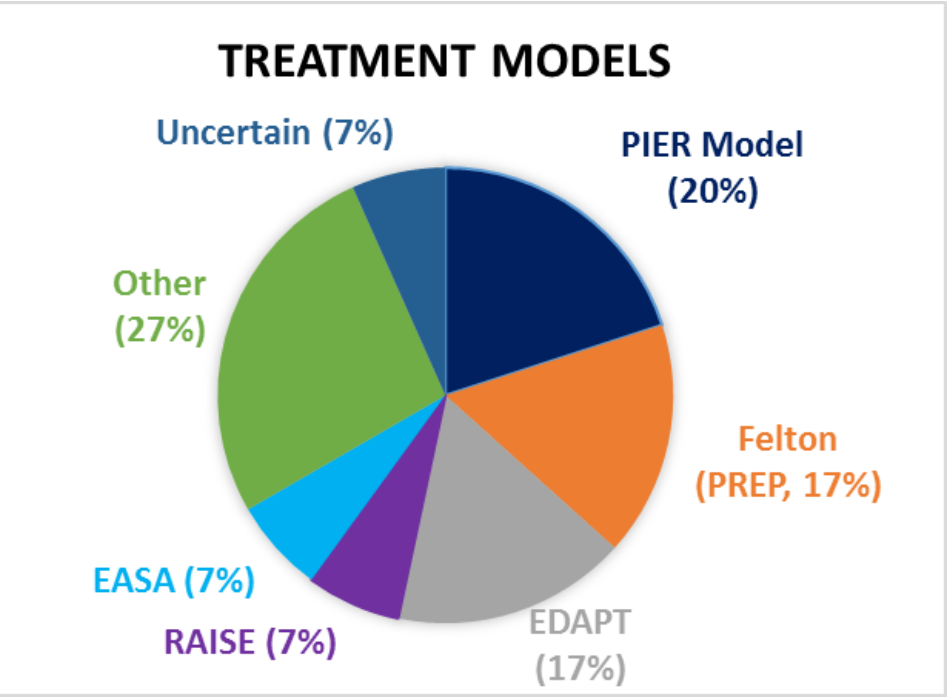
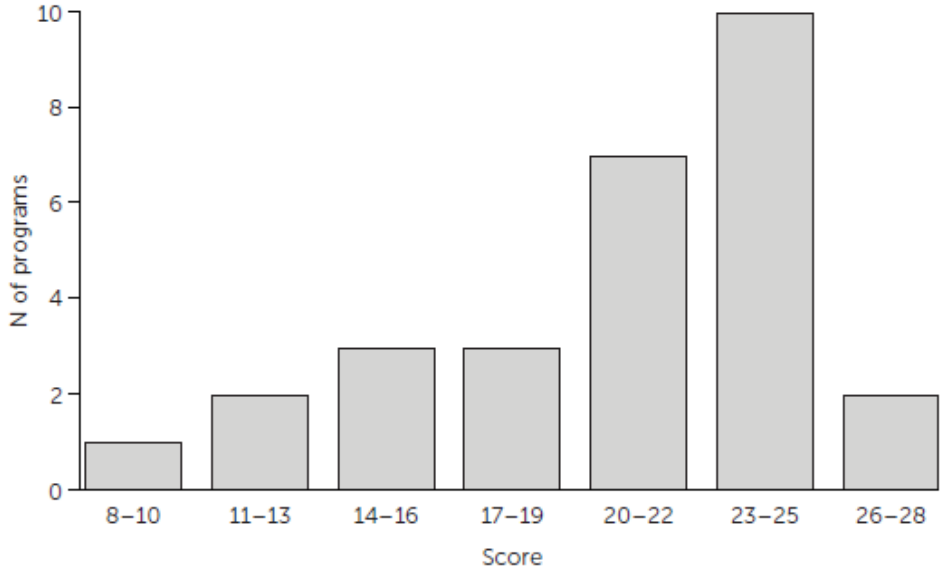


FIGURE 1. Distribution of preliminary scores on the First-Episode Psychosis Services Fidelity Scale (FEPS-FE) among 28 county programs for treatment of early psychosis[a]



[a] Score was based on the number of FEPS-FE components endorsed by the program.

Questions on CSC Implementation in California?

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Summary of EP Landscape in CA

- Implementation of care in CA has proceeded county by county, with very little consistency
  - A third of current programs aren't using a clear model
  - Programs may lack ongoing supervision, training and support

- Treatment of wider psychosis spectrum (Mood disorders, CHR) is unique to CA
  - Need to ensure that we are providing evidence based treatments and use data to expand our knowledge of what works.

EPI-CAL Learning Healthcare Network

- Innovation project funding from 5 counties, with support from One Mind
- NIMH Grant will add 2 counties, 4 UC programs and Stanford – enable participation in national evaluation with 3 other networks

Proposed Learning Healthcare Network for CA Mental Health programs

Consumer level

Consumer (and family) enter data on relevant survey tools (in threshold languages) in app-based platform at baseline and then regular follow up

Provider level

Clinician and/or MD can visualize responses on web-based portal for the individual over the course of treatment and share that data with the consumer during session.

Clinic level

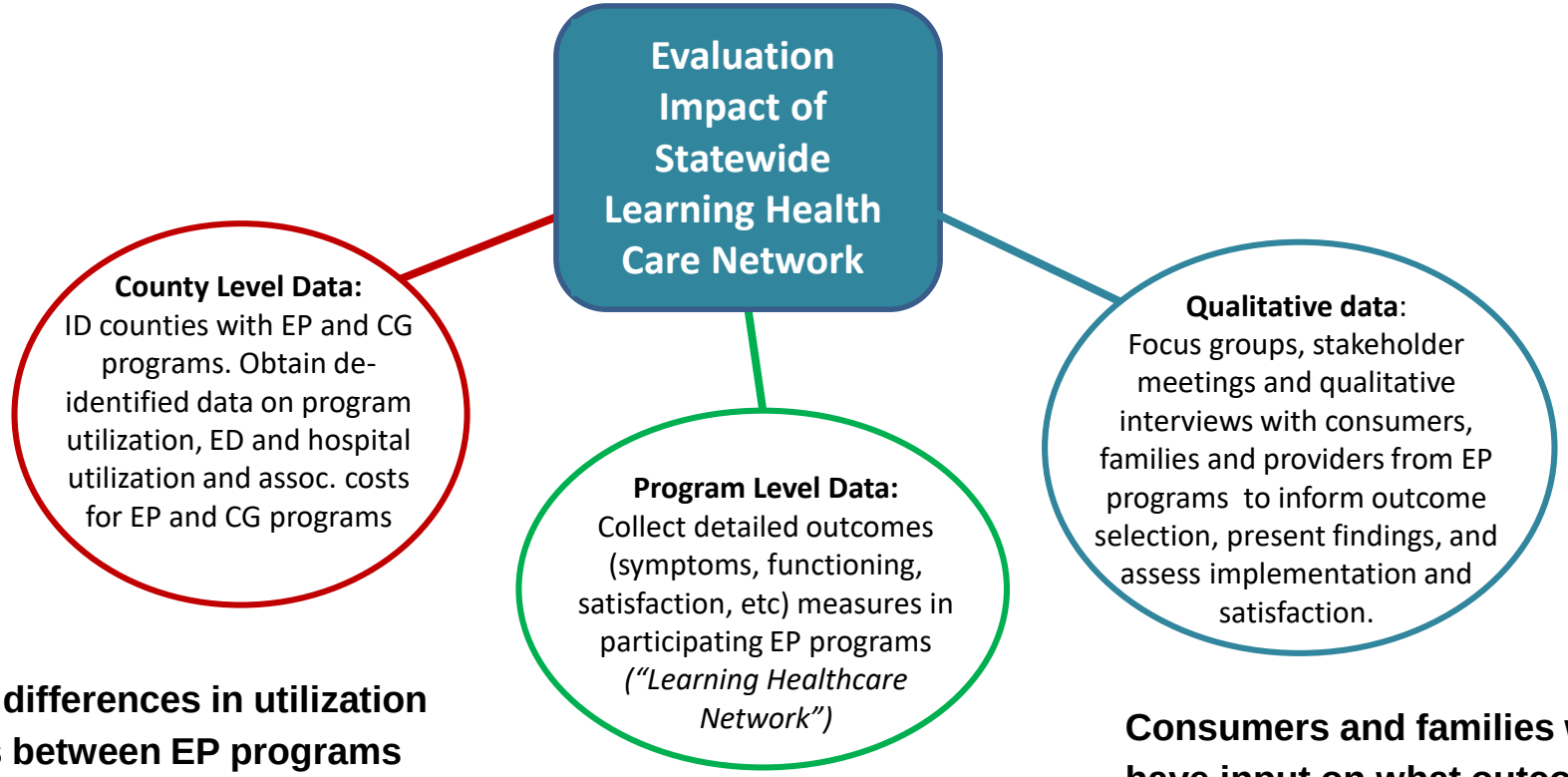
Program management can visualize summary of responses on portal for:
- All consumers in clinic
-In relation to other CA programs

State level

Administrator level allows access to de-identified data across all clinics on the app for analysis for analysis for county- or state-level data analysis

Evaluating EP programs and Improving Care Outcomes

Learning Questions and Outcomes



Are there differences in utilization and costs between EP programs and standard care?

How does utilization and cost relate to consumer-level outcomes within EP programs?

Do California EP programs deliver high fidelity to evidence-based care?

What are the program components associated with consumer-level short-and long-term outcomes in particular domains?

Consumers and families will have input on what outcomes are selected via focus groups and surveys.

What are the barriers and facilitators to implementing a LHCN app?

Goal of EPI-CAL

- Gather high-quality data to understand:
  - what's happening now in EP programs
  - what is promoting client recovery (and what isn't)
  - the needs and priorities of clients, families, communities
  - how data can influence collaborative care decisions in real time

- Contribute to national evaluation of CSC care through NIMH-funded EPI-NET

Progress in Year 1

- Establishing contracts with the counties
- Obtain IRB
- Identify members for Advisory and Executive Committees
- Begin site visits – introduce project, focus groups on outcomes

Adding Counties in Year 2

- Engaging with counties who are interested in joining LHCN
  - Sonoma, Stanislaus, Modoc
  - 6 more counties have expressed interest
- Estimating $200-$250K per year to join into program, county and qualitative data collection, starting in Year 2 (June 2020)
  - Data informs implementation at all levels
- After Year 5, costs will be lower because of fewer project components

Questions on EPI-CAL Network?

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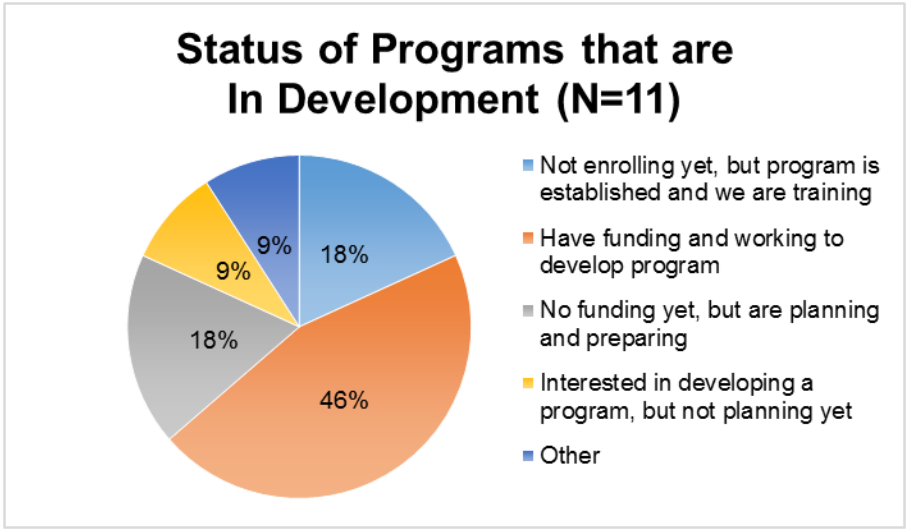
Vision for California

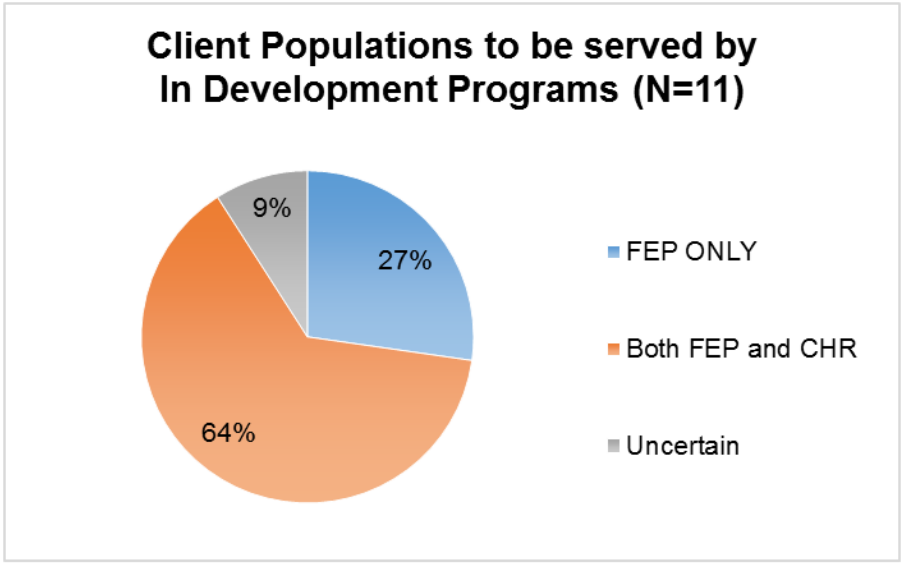
GOAL: Make high-quality EP care available to all Californians, enabling improved outcomes across the state

- Have 30 programs in 24 counties
- 59% of counties do not have a program
  - 21% were developing programs
  - 38% had no program

We need a way to support program development and sustainability

In Development Programs





Counties surveyed Oct 2016-May 2016
Marin County
Trinity County
Mariposa
Inyo
Riverside
Santa Cruz
Sierra County
Sonoma
Tehama County
Tuolumne
Yolo

Counties without an EP Program

Counties surveyed Oct 2016-May 2016
Alpine
Amador
Butte *
Calaveras
Colusa *
Del Norte *
Glenn *
Humboldt *
Kern *
Kings *
Mendocino
Modoc *
Mono
Nevada *
Placer
Plumas *
San Benito
San Bernadino
Siskiyou
Sutter
Tulare *
Yuba

* 11 counties that completed phone interview (50%)

- Counties have small population (median population size= 65,470, IQR= 27,873 – 150,960) and low population density (median number of people per square mile = 38.5, IQR 15 – 100)

- Reasons for not implementing:
  - Not a priority for stakeholders (want broad services)/perceived lack of need
  - Accessibility issues across rural areas

- TTA Needs:
  - 3 counties had pursued training in EP care
  - 6 said they would be interested in training, if available
  - 3 noted need for technical assistance in program development
  - 2 noted need for increased financial and human resources

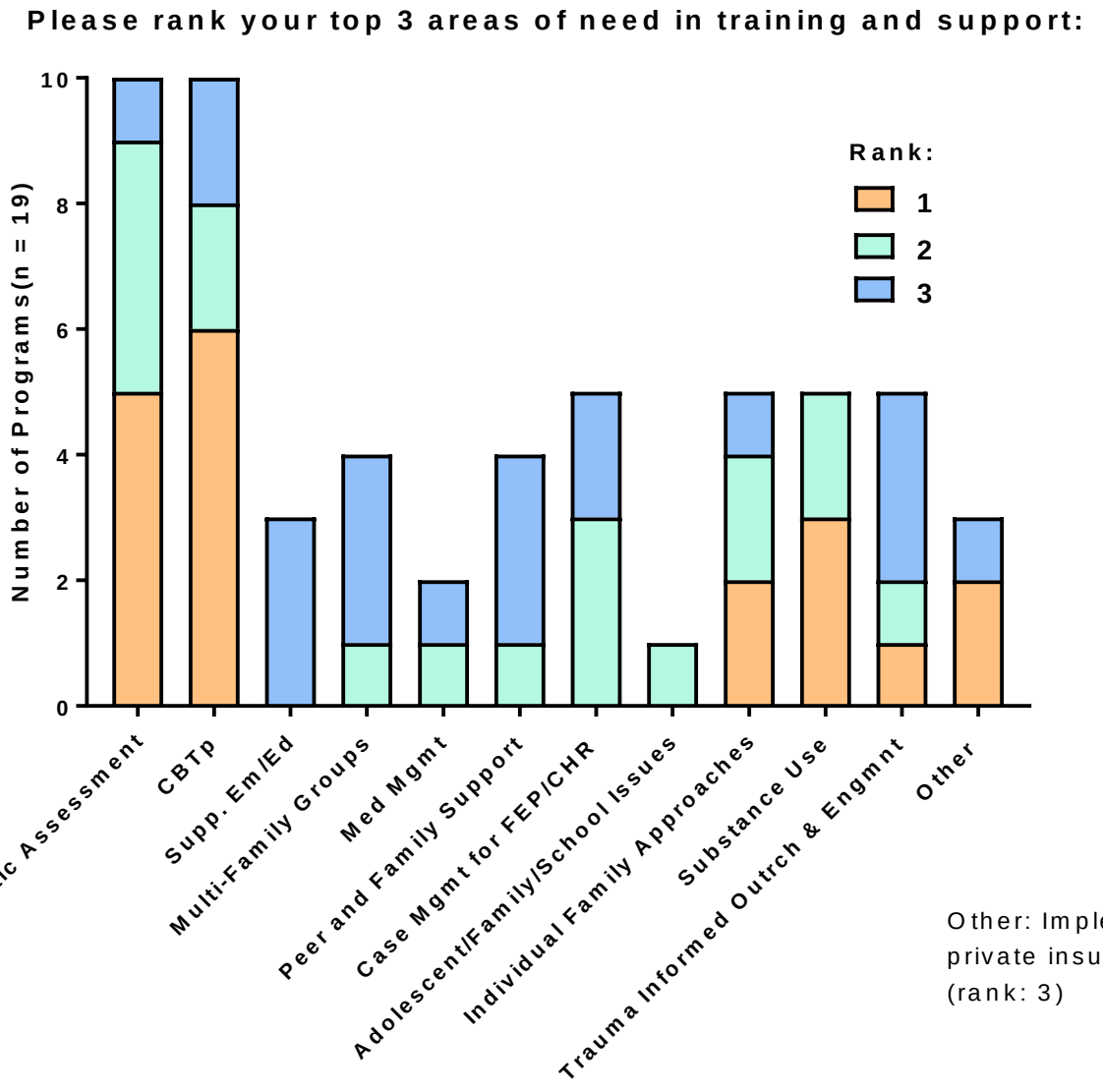
Early Psychosis Training and Technical Assistance Needs Assessment Survey

Collaboration between UCD, UCSF and Stanford

- 22 respondents from 20 programs filled out the TTA survey by 9/4/18
  - 12 county leadership; 10 EP program staff
- Of the programs represented by respondents, 12 were county run, 5 were community based organizations, and 3 were university affiliated programs.
- 59% of programs have existing funding for training and technical assistance
  - 69% of this funding is ongoing rather than one time only
  - 27% are working on getting TTA funding

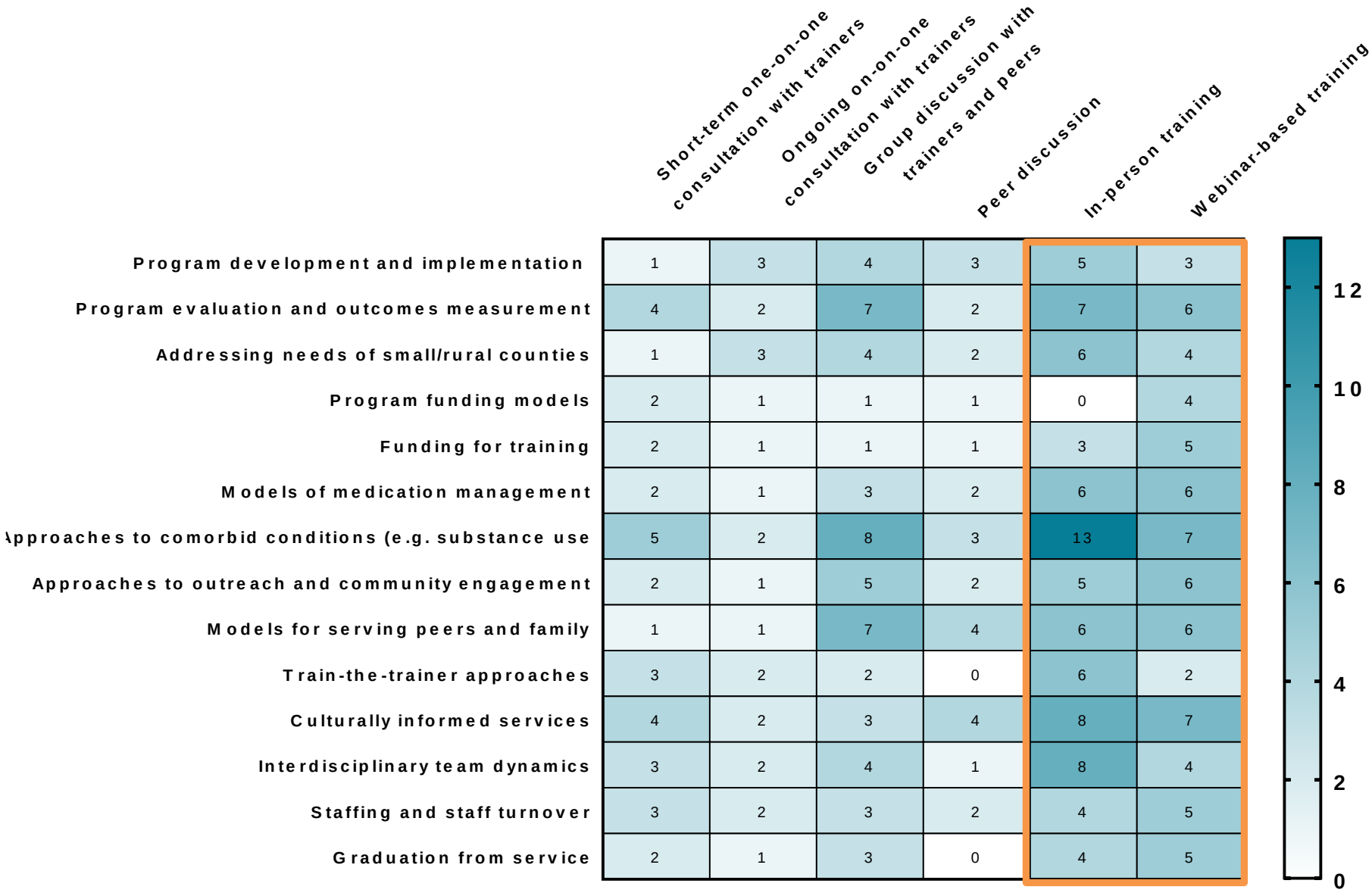
Please indicate the type of training or support your EP program or county is looking for related to clinical services and the manner in which you would prefer that training/support to be delivered.

Early Psychosis Training and Technical Assistance Needs Assessment Survey

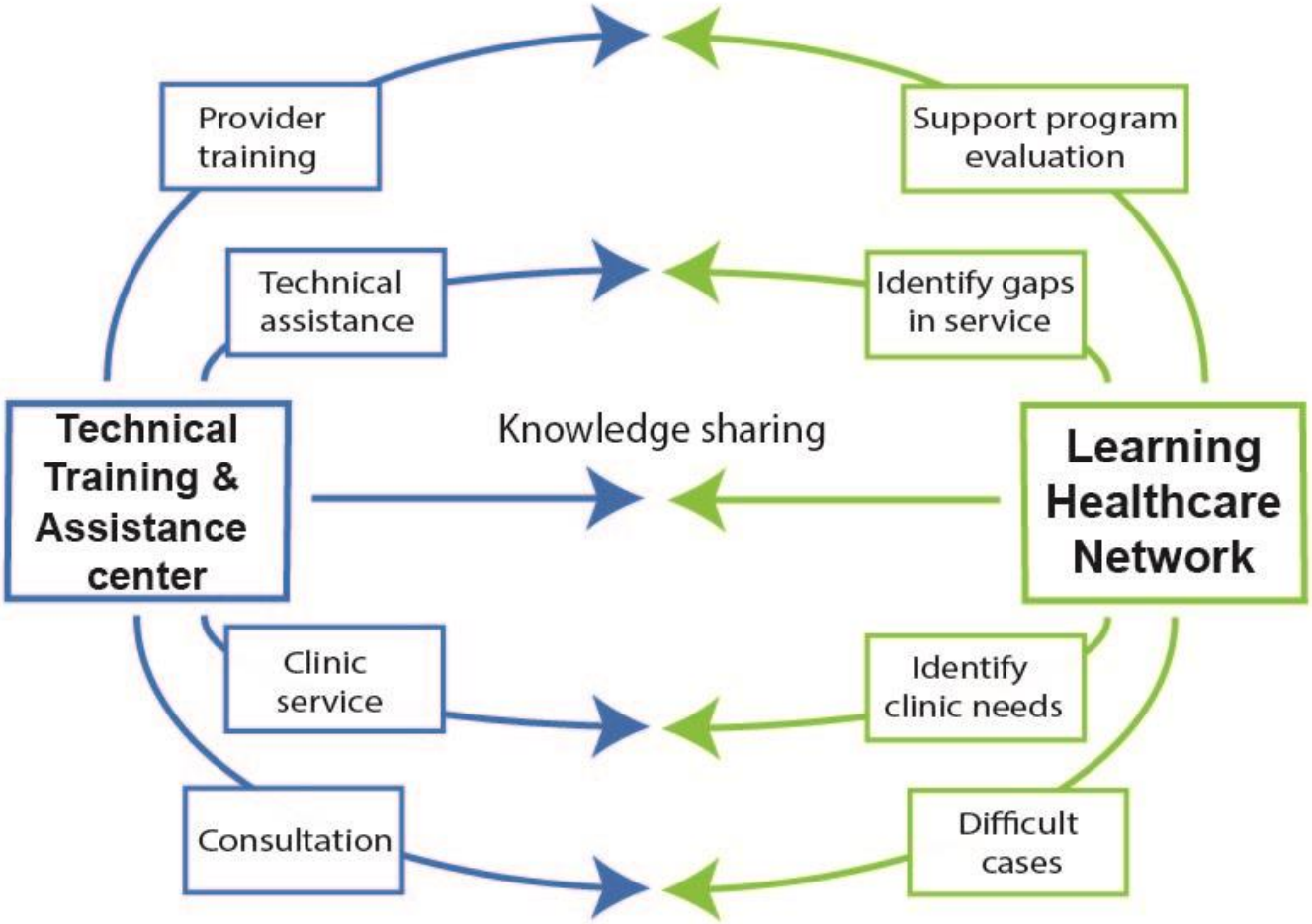


Other: Implementation (rank: 1), Billing private insurance (rank: 1), Team wellness (rank: 3)

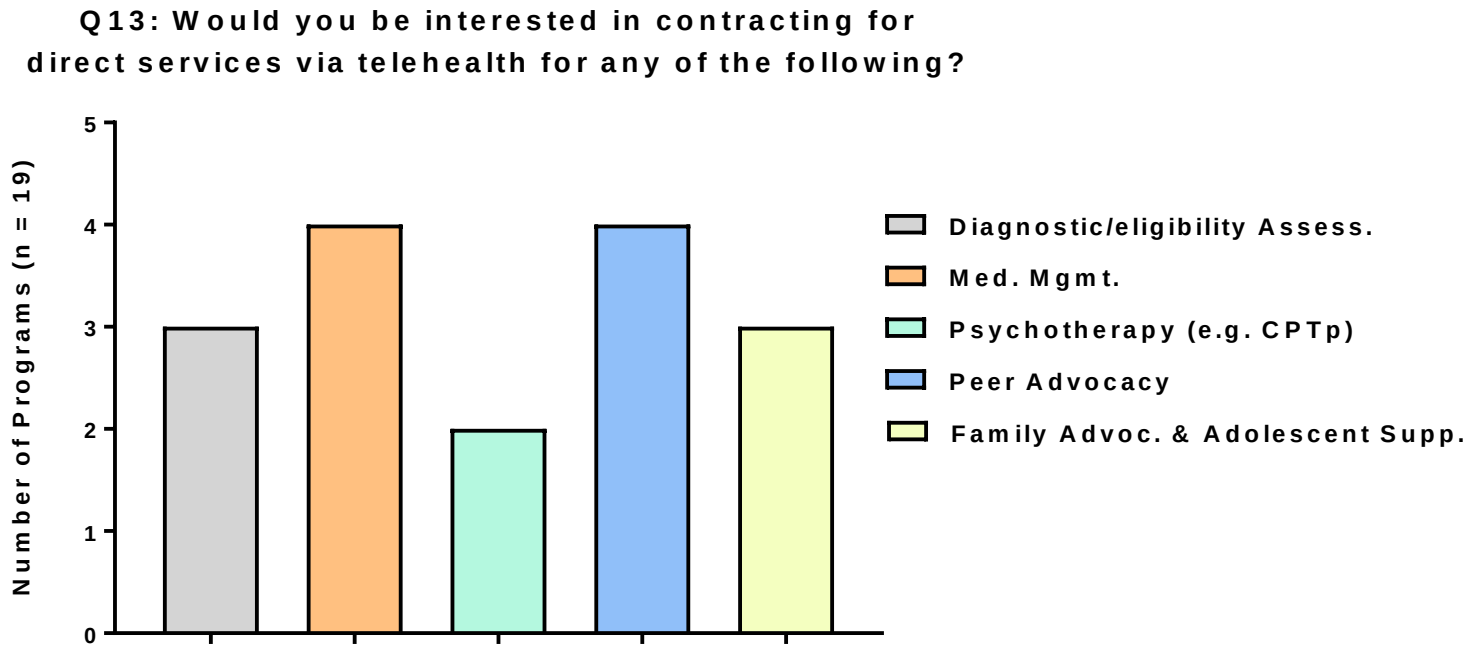
Please indicate the type of training or support your EP program or county is looking for related to program development and/or management and the manner in which you would prefer that training/support to be delivered.



EP Training & Technical Assistance Center



Early Psychosis Training and Technical Assistance Needs Assessment Survey



Summary & Challenges

Summary

- Counties are asking for ongoing training and technical assistance to get programs started and keep them going
- Providing support at a state level will allow us to get more done for less money
  - E.g. UCD can provide initial comprehensive training in CSC skills for approximately $2500 per person
- Some counties need direct service (e.g. psychiatry) by licensed CA providers

Challenges

- Need to respect unique needs of each county (e.g. brick-and-mortar clinic vs telehealth) and use collaborative approach to engagement
- High staff turnover = need for ongoing training and support
- Need incentives to motivate change, encourage counties to see this as a priority and invest for the long-term
- Need to engage private sector
- Need to focus on workforce development – how to engage training programs to increase baseline skill of workforce?

Proposed Steps for Development of California EP Training & Technical Assistance Network

Year 1

Track 1: Path for New Program Development

- Engage stakeholders and develop collaborations across the state to determine needs, use qualitative data analysis to inform potential solutions
  - Counties with established programs – what can they contribute to this initiative?
  - Counties hoping to build programs
  - Counties who feel like they can't start a program
  - Engage with private sector

- Review the literature – what evidence exists for various treatment components? Where do we need additional research and evaluation?

Track 2: Strengthen Active Programs

- Create collaborative to support current work
  - Linking counties/cities with similar needs to develop programs (e.g. 3 nearby counties who could collaborate on shared system)
  - Linking counties with established programs to address ongoing needs
  - Creating mentorship opportunities (e.g. established program supports nearby county with new program) or collaborative groups who are at a similar stage in development.

Collaboration between UCD, UCSF and Stanford

Proposed Steps for Development of California EP Training & Technical Assistance Network

Year 1

Track 1: Path for New Program Development

- Learn from prior large initiatives
  - Engage experts in large scale dissemination/implementation and ongoing consultation (e.g. UK implementation & training programs)
  - Visit statewide EP programs (e.g. New York, Washington, Oregon with stakeholders)
  - Talk to other states who have engaged private payers
  - Engage programs outside of psychosis (e.g. Texas statewide depression initiative)
- Identify incentives to support program development, staff recruitment/retention

Track 2: Strengthen Active Programs

- Identify potential resources to meet needs
  - Clinical services to meet needs by telehealth
  - Access to online training (e.g. CSC OnDemand)
  - In Person trainings that can be provided statewide

End of Year 1: Statewide meeting to review findings and select two priority areas for investment (e.g. new collaboratives or trainings)

Proposed Steps for Development of California EP Training & Technical Assistance Network

Year 2

- Develop statewide expectations and plan for ongoing support to maintain excellent service and program evaluation.
  - Define core vs peripheral elements of CSC
  - Use of readiness assessment (SAMHSA tool) to help counties determine next steps and level of preparedness for implementation
  - Expand EPI-CAL to gather data statewide, identify ongoing needs, inform training
  - Implement incentives to jump start program development
- Implement statewide training modules
- Develop sustainable funding model
  - Counties pay by individual for initial training, ongoing supervision & support
- Statewide meeting to review and incorporate new findings in the field

Proposed Steps for Development of California EP Training & Technical Assistance Network

Year 3+

- Implement fidelity evaluations to identify areas where ongoing training or support is needed

- Workforce enhancement and flexibility
  - Engage colleges, universities and professional programs to build workforce
  - Between-county partnerships or direct support by TTAN to help with turnover of highly skill staff
  - Support leadership development to retain best staff

- Sustainable funding
  - State provide ongoing support to rollout of changes or new initiatives

- Annual meeting to review and incorporate new findings in the field
  - What are we learning from EPI-CAL and national EPI-NET?
  - Shift training components as needed

Proposed Implementation

- EPI-CAL provides foundation for county engagement and training in the TTA
- Need financial support build infrastructure, hire staff, find space → create a state-level foundation that supports rapid achievement of TTA goals as well as EP program development and sustainability
- Engage experts around CA that can provide training and support collaboratives
- Collaboration between Sonoma County, One Mind and Kaiser Foundation provides opportunity to get initial Year 1 trainings off the ground…

EMB One Mind ASPIRe Program of Sonoma County: Introduction

- One Mind has distributed a Request for Proposals to establish a CSC program in Sonoma County

- Established funding sources – can sustain program for ~2 years:
  - Kaiser Permanente Northern California Community Benefit Programs
  - The Elizabeth Morgan Brown Memorial Fund
  - Other Philanthropic sources

- Will seek sustaining funding from:
  - Sonoma County MHSA Innovations RFP
  - Potentially AB 1315

EMB One Mind ASPIRe Program of Sonoma County: Scope

With One Mind guidance, the program will:

- Implement CSC for CHR and FEP youth.
- In addition to serving Sonoma County residents at large, the program will also contract with Kaiser Permanente (KP) to serve KP members residing in Sonoma County, as reimbursed by KP.
- Prepare to join the California Early Psychosis Learning Health Care Network (LHCN) and EPI-CAL.
- Establish a contract with the UC Davis Behavioral Health Center of Excellence for TTA.

Questions?

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