PROGRAMS IN DEVELOPMENT

You noted that you are in the process of planning or starting your early psychosis program. We would like to ask you some questions about what populations you plan to serve and program components you plan to use.

1) Will your program be a stand-alone program or integrated within other established clinical services? *[single answer checkbox]*
   a) Stand-alone/independent program (e.g. own site, staff, management, oversight)
   b) Stand-alone/independent program (e.g. own site) associated with established program/agency (e.g. provide oversight, support)
   c) Integrated within another program (e.g. shared space, staff, management)
   d) Other (describe)
   e) Uncertain

2) When do you plan to start <u>serving</u> clients in your community (i.e. actively enroll and provide treatment)? (month, year)

3) Does your program plan to serve first-episode psychosis (FEP) clients, high-risk clients, or both)? *[single answer checkbox]*
   a) First-episode psychosis clients only (experience recent onset of psychotic-level hallucinations, delusions, disorganized speech/behavior; meet criteria for DSM Schizophrenia Spectrum Disorders or another DSM disorder with psychotic features; experience positive symptoms at a score of 6 on the SIPS)
   b) Clinical high risk or prodromal clients only (experience attenuated/subthreshold hallucinations, delusions, disorganized speech; meet criteria for a clinical high risk diagnosis according to the SIPS or CAARMS)
   c) Both first-episode and clinical high-risk/prodromal clients
   d) Other (please describe) *[text box]*
   e) Uncertain

   3-1) *[If 3a or 3c is selected]* What duration of first-episode psychosis onset do you plan to serve (in months)? *[text box]*

   3-2) *[If 3b or 3c is selected]* Please clarify what types of clinical high risk clients you plan to serve. Please check all that apply. *[multi-answer checkboxes]*
      a) Recent onset but brief psychosis (e.g., fully psychotic symptoms of recent onset and brief duration; e.g. BIPS on the SIPS)
      b) Attenuated/subthreshold symptoms of psychosis (e.g. APS on the SIPS)
      c) Genetic risk (family history and/or schizotypal personality disorder) plus deterioration (GRDS on the SIPS)
      d) Other (please describe) *[text box]*
      e) Uncertain

4) What DSM-IV diagnoses does your program plan to serve? Please check all that apply. *[FEPS Domain 30] [multi-answer checkboxes]*
   a) Schizophrenia Spectrum Diagnoses – e.g. Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder
   b) Other Psychotic Spectrum Disorders – e.g. Psychosis NOS, Brief Psychotic Disorder, Delusional Disorder
   c) Mood Disorders <u>with</u> Psychotic features – e.g. Major Depressive Disorder, Bipolar Disorder
   d) Mood Disorders <u>without</u> Psychotic features – e.g. Major Depressive Disorder, Bipolar Disorder
   e) Other (please describe) *[text box]*
   f) Uncertain

5) What age range(s) does your program plan to serve? *[FEPS Domain 30]*
   a) Lowest age accepted: *[text box]*
   b) Highest age accepted: *[text box]*
   c) All ages served *[single answer checkbox]*
   d) Uncertain *[single answer checkbox]*

6) What exclusion criteria are you considering using for your program? Please check all that apply. *[multi-answer checkboxes]*
   a) Axis II diagnosis (e.g. personality disorders)
   b) Intellectual disability (i.e. IQ under 70)
   c) Substance use disorder (of any kind)
   d) Substance dependence only
   e) Substance-induced psychotic disorder
   f) Not county resident (where program is located)
   g) No specific exclusion criteria (we serve everyone)
   h) Other (please describe) *[text box]*
   i) Uncertain

7) On average, how many clients do you hope to <u>evaluate for eligibility</u> (e.g. intake evaluations) by your program per month? *[text box]*

8) On average, how many clients do you hope to <u>engage in ongoing treatment</u> (e.g. therapy, groups, med management) with your program per month? *[text box]*

9) On average, what is the <u>target</u> amount of time your program plans to serves each client? *[FEPS Domain 26] [single answer checkbox]*
   a) 1 year or less
   b) Up to 2 years
   c) Up to 3 years
   d) Up to 4 years
   e) More than 4 years (e.g. no limit)

f) Other (please describe) *[text box]*
g) Uncertain

10) Do you plan to serve the following types of clients? Please check all that apply. *[multi-answer checkboxes]*
   a) Uninsured clients
   b) Undocumented clients
   c) Uncertain

11) Are you considering using a particular early psychosis treatment model?
   a) PREP
   b) PIER
   c) EDAPT
   d) EASA
   e) RAISE
   f) Other (please describe)
   g) Uncertain

12) What types of support staff and direct clinical service providers and staff do you plan to employ in your program? *[multi-answer checkboxes]*
   a) Program Director
   b) Program Manager
   c) Physician/Psychiatrist
   d) Nurse practitioners
   e) Clinical Supervisor
   f) Licensed clinicians (e.g., LCSW, LMFT, psychologist)
   g) Masters-level professionals (e.g., MFT, MSW)
   h) Supported Education/Employment Specialist
   i) Community Support Specialist
   j) Consumer/Peer Advocate
   k) Family Advocate
   l) Case managers (e.g. no clinical training or degree required, provide support for linkage, daily skills, etc.)
   m) Clerical support/Clinic Coordinator
   n) Other (please describe) *[text box]*
   o) Uncertain

13) On average, how many clients do you plan to provide with <u>ongoing treatment</u> from your program per month (i.e. monthly "census" of clients active in treatment)? *[text box]*

14) Is your program planning to collect information on the following domains? If so, please indicate how often this data will be collected (e.g. intake and every 6 months after). *[FEPS Domain 3 for items noted in intake assessment, FEPS Domain 14 for items completed annually] [multi-answer checkboxes for domains and intake/6 months/annual time points, text boxes for other time points]*

a) Client characteristics (e.g. sex, gender, age, race/ethnicity, zip code, etc.)
b) Diagnosis (via SIPS, SCID, MINI, etc.)
c) Symptom severity scores (e.g., SANS, SAPS, BPRS, CGI)
d) Physical health (e.g. comorbid medical diagnosis/Axis III)
e) Metabolic parameters (weight, labs with glucose, lipids)
f) Vitals (e.g. blood pressure, weight, height)
g) Family history of mental health conditions
h) Cognitive measures (e.g. IQ scores)
i) Psychosocial data (e.g. CANS/ANSA, GAF, Global Functioning Scales: Social and Role)
j) Premorbid functioning (e.g. PAS)
k) Medication data (e.g. medications prescribed, dosage, duration of supply)
l) Medication side effects (e.g. AIMS, Barnes)
m) Substance use data (e.g. substances used, frequency, impact)
n) Hospitalization (dates, duration, reason)
o) ER or Crisis utilization (dates, duration, reason)
p) Legal involvement (e.g. arrests, incarcerations)
q) Risk assessment (e.g. suicidal ideation/attempts, danger to others, etc.)
r) Self-report of impact of care received (e.g. DHCS Adult MHSIP Consumer Survey – Adult/Youth Version, etc.)
s) Satisfaction with treatment (e.g. CSQ)
t) Other (please describe) *[text box]*
u) Uncertain

15) Will your program be required to use any of these specific data collection measures? *[multi-answer checkboxes]*
a) ANSA
b) CANS
c) DHCS Adult MHSIP Consumer Survey – Adult Version
d) DHCS Adult MHSIP Consumer Survey – Child Version
e) Uncertain

16) Did you collect any data as part of your process of planning and developing your program? (e.g. number of individuals with particular diagnoses receiving services in your county, feedback from stakeholder supporting need for your program, etc.). If so, please describe. *[text box]*
a) Yes (please describe) *[text box]*
b) No
c) Uncertain

17) Will your program use paper or electronic client records? *[single answer checkbox]*
a) Paper only
b) Electronic only
c) Both

d) Uncertain

17-1) *[If 17b or 17c is selected]* Will your electronic medical record system part of the county-wide system, or will it be a clinic-specific system? *[single answer checkbox]*
   a) County system
   b) Clinic system
   c) Uncertain

18) What percentage of your <u>annual funding</u> will come from the following sources? *[multi-answer checkboxes with text boxes]*
   a) MHSA
   b) Medi-Cal/EPSDT
   c) SAMHSA
   d) 26.5 funds
   e) Private insurance, including Kaiser
   f) Self-pay or sliding scale
   g) Research grants
   h) Donors
   i) Other (please describe) *[text box]*
   j) Uncertain

   18-1) *[If 18a is selected]* Which MHSA funding stream(s) will be used to support your program? *[multi-answer checkboxes]*
      a) Prevention and Early Intervention (PEI)
      b) Community Supports and Services (CSS)
      c) Innovation Programs (INN)
      d) Capital Facilities and Technology (CFT)
      e) Workforce Education & Training (WET)
      f) Uncertain

19) For each of the funding streams noted above, how will you be reimbursed for the services you provide as part of your contract? *[single answer checkbox]*
   a) Rate per unit of service (e.g. $1.21 per unit of Case management), established by contract
   b) Flat rate per client served across all service types (e.g. $1000 per client served per year – services are "bundled")
   c) Hourly rate based on service type provided (e.g. $60 per 50 min therapy session)
   d) Other (please describe) *[text box]*
   e) Uncertain

20) Does your program currently receive OR plan to receive training, technical assistance or support from an outside organization or university? *[single answer checkbox]*
   a) Yes, we are currently working with an outside organization for training
   b) Yes, we plan to work with an outside organization, but are not sure who yet

c) No, we are not current collaborating with an outside organization, BUT we would like to

d) No, we are not current collaborating with an outside organization and we do not plan to

e) Uncertain

20-1) *[If 20a is selected]* What is the name of the organization or university? What type of training do they provide? *[text box]*

20-2) *[If 20b or 20c is selected]* What type of training are you looking for? *[text box]*

21) What components of multi-disciplinary care is your program team planning to provide? *[FEPS Domain 26] [multi-answer checkboxes]*
    a) Psychiatric services (e.g. regular appointments for medication support)
    b) Nursing services
    c) Individual Psychotherapy
    d) Case management
    e) Client-focused psychoeducation or illness management training (via individual or group setting) *[FEPS Domain 10]*
    f) Treatment of comorbid substance use
    g) Supported employment *[FEPS Domain 18]*
    h) Supported education *[FEPS Domain 18]*
    i) Family/Caregiver/Support person education and support (via individual or group setting) *[FEPS Domain 11]*
    j) Occupational Therapy
    k) Social and community living skills training (e.g., social activities, using transportation, renting, banking, budgeting, meal planning)? *[FEPS Domain 20]*
    l) Other (please describe) *[text box]*

22) Do you plan to offer clients sessions of individual or group psychotherapy using any of the following approaches? *[FEPS Domain 12] [multi-answer checkboxes]*
    a) Cognitive Behavioral Therapy (CBT)for psychosis symptoms
    b) Cognitive Behavioral Therapy for OTHER symptoms (e.g. depression, anxiety)
    c) Cognitive Behavioral Therapy or Motivational Enhancement for comorbid substance use *[FEPS Domain 17]*
    d) Cognitive Behavioral Social Skills Training
    e) Dialectical Behavior Therapy (DBT)
    f) Multi Family Group (MFG)
    g) Family Focused Therapy (FFT)
    h) Trauma informed care (e.g. TF-CBT)
    i) Individual Placement and Support (IPT)
    j) Feedback Informed Treatment (FIT)
    k) Wellness Recovery Action Planning (WRAP)
    l) Mindfulness based treatment

m) Cognitive training/remediation
n) Structured intervention to prevent weight gain *[FEPS Domain 13]*
o) We do not use any of these treatments
p) Uncertain

23) What is the <u>target</u> active FEP client/provider ratio for your program? *[FEPS Domain 22]* *[single answer checkbox]*
    a) 51+ clients with FEP per provider FTE
    b) 41-50 clients with FEP per provider FTE
    c) 31-40 clients with FEP per provider FTE
    d) 21-30 clients with FEP per provider FTE
    e) 20 or fewer clients with FEP per provider FTE
    f) Uncertain

24) Are you planning to have a Masters-level (or higher) Team Leader/Supervisor? *[FEPS Domain 23] [single answer checkbox]*
    a) Yes, providing only administrative/managerial direction. No responsibility to ensure clinical supervision
    b) Yes, providing administrative direction and ensures clinical supervision by others
    c) Yes, providing administrative direction and supervision to some staff
    d) Yes, providing administrative direction and supervision to all staff
    e) Yes, providing administrative direction and supervision to all staff, in addition to providing some direct clinical services
    f) No, our program will not have a Team Leader
    g) Uncertain

25) Are you planning to have a psychiatrist who is <u>part of the team</u>? *[FEPS Domain 24] [single answer checkbox]*
    a) Yes
    b) No
    c) Uncertain

26) Are you planning for your clients with FEP have an <u>assigned</u> case manager or clinician? *[FEPS Domain 16] [single answer checkbox]*
    a) Yes
    b) No
    c) Uncertain

27) Are you planning to hold team meetings? *[FEPS Domain 27] [single answer checkbox]*
    a) Monthly team meetings
    b) Bi-weekly team meetings
    c) Weekly team meetings
    d) No team meetings
    e) Uncertain

Is there anything else about your program that is important for us to know that we have not already covered? *[text box]*