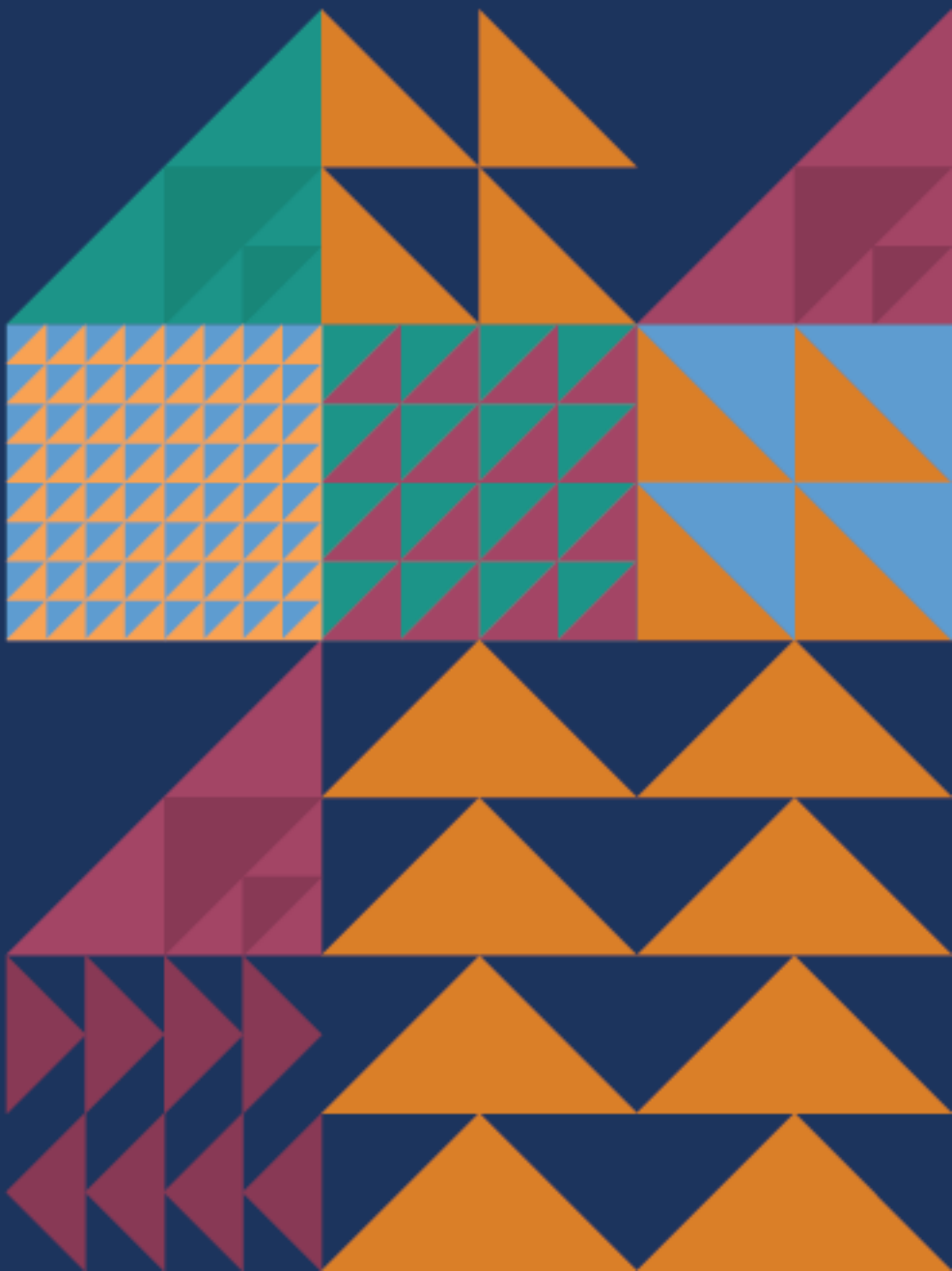
MHSOAC
Mental Health Services
Oversight & Accountability Commission

STATEGIC PLAN

EARLY PSYCHOSIS CARE IN CALIFORNIA

DRAFT
JULY 2024



PURPOSE

Draft as of 20th July 2024

This document provides initial preliminary content for the MHSOAC's Early Psychosis Intervention (EPI) Strategic Plan. It guides a discussion with MHSOAC about the structure and initial content to be included in the Strategic Plan.

This document has been created at the request of MHSOAC. All information is based on inputs from MHSOAC.

The approaches and considerations included in this document are preliminary and may be further developed based on additional inputs from MHSOAC.

Table of Contents

Key terms glossary

Term	Definition
Coordinated Specialty Care	A multicomponent, evidence-based, early intervention service for individuals experiencing a first episode of psychosis (FEP)[1]
Clinical High Risk/ Prodrome	The early symptoms of an illness which may indicate that an individual may be at a higher risk of developing a psychotic disorder[2]
Early Psychosis/ First - Episode Psychosis	The initial period of up to five years following the emergence of psychotic symptoms[3]
Early Psychosis Intervention	An evidenced-based specialized approach to providing services to individuals affected by first episode psychosis. It is aimed at early recognition of psychosis, the provision of timely comprehensive treatments that are stage and age-appropriate, family/caregiver inclusive and with a client-centered strengths-based approach[4]
Duration of Untreated Psychosis (DUP)	The time from manifestation of the first psychotic symptom to initiation of adequate antipsychotic drug treatment[5]
Psychosis	A collection of symptoms that affect the mind, where there has been some loss of contact with reality. During an episode of psychosis, a person's thoughts and perceptions are disrupted and they may have difficulty recognizing what is real and what is not[6]
Serious Mental Illness (SMI)	Mental, behavioral, or emotional disorder resulting in serious functional impairment that substantially interferes with or limits one or more major life activities[7]

[1] Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care
[2] Yale PRIME Clinic
[3] Lundin et al, Identification of Psychosis Risk and Diagnosis of First-Episode Psychosis: Advice for Clinicians, March 2021
[4] BC Early Psychosis Intervention Program: Early Psychosis Intervention
[5] JAMA: Association Between Duration of Untreated Psychosis and Outcome in Cohorts of First-Episode Patients A Systematic Review
[6] NIMH: Understanding Psychosis
[7] NIMH

1. Executive Summary

Reasons to Scale Early Psychosis Intervention (EPI)

Approximately **1 in 33 people** will experience a psychotic episode in their lifetimes.[8] Psychosis touches many lives deeply, shaking the foundations of reality for those experiencing symptoms and reshaping their lives and that of their loved ones. In California alone, 21,000 people experience their first episodes of psychosis every year.

According to the National Institute of Mental Health, psychosis represents a collection of symptoms that suggest a loss of contact with reality—reflecting a profound disruption in a person's ability to perceive the world accurately. Every experience with psychosis is unique and the effects vary, with research only able to capture some impacts, including:

- **Unemployment:** Approximately one-quarter of people with serious mental illness are unemployed, according to a study by Guhne et al.[9]
- **Criminal and legal system:** A 2017 study found that 37% of patients experiencing first-episode psychosis were incarcerated at some point during their pathway to clinical care[10], often delaying access to treatment[11.] The costs of incarceration in California (~$70,000 per year) far exceed the cost of treatment for mental health treatment (~$22,000).[12]
- **Homelessness:** Research shows that approximately ~20% of people who are experiencing homelessness are affected by psychosis13, as compared to 4% of the general population[14]
- **Chronic disease burden**: individuals with psychotic disorders are 3.5x more likely to die due to cardio-vascular disease, tobacco use, and substance use[15]
- **Hospitalization**: people with psychotic disorders often have higher utilization of the healthcare system, including higher rates of emergency department visits. These additional healthcare cost costs amounted to $62.3B in 2019 for those affected by schizophrenia.[16]

[8] NIMH Recovery After an Initial Schizophrenia Episode (RAISE)
[9] Guhne et al, Employment status and desire for work in severe mental illness: results from an observational, cross-sectional study, *Apr 2021*
[10] Wasser et al, First-Episode Psychosis and the Criminal Justice System: Using a Sequential Intercept Framework to Highlight Risks and Opportunities, *Sep 2017*
[11] Wasser et al, First-Episode Psychosis and the Criminal Justice System: Using a Sequential Intercept Framework to Highlight Risks and Opportunities, *Sep 2017*
[12] Stanford Justice Advocacy Project: The Prevalence And Severity Of Mental Illness Among California Prisoners On The Rise
[13] Ayano et al, The prevalence of schizophrenia and other psychotic disorders among homeless people: a systematic review and meta-analysis, *Nov 2019*
[14] Calabrese: Psychosis
[15] Simons et al. Mortality Rates After the First Diagnosis of Psychotic Disorder in Adolescents and Young Adults
[16] Kadakia et. al. The Economic Burden of Schizophrenia in the United States, 2019

- **Death:** individuals with psychotic disorders have shorter life expectancy by an average of 10-15 years[2] and exhibit a 15x-30x increase in mortality due to suicide[17]

Family, friends, and communities also experience the impact of psychosis in their roles as caregivers. Beyond the physical and emotional tension, caregivers experience an economic impact due to missed work days and lost income.

The initial phase of psychosis, known as early psychosis or first episode psychosis (FEP), marks a critical time in the lives of those experiencing these symptoms as early identification and access to evidence-based care is critical; receiving timely and effective treatment can significantly change both short- and long-term outcomes, offering hope for a healthy, fulfilling life.

Early Psychosis Intervention (EPI) programs like Coordinated Specialty Care (CSC) provide evidence-based care for individuals experiencing psychosis and their families. CSC not only provides symptom relief but also includes supports that help individuals reclaim their lives and pursue their goals without being defined by their condition. CSC improves symptoms of schizophrenia and psychosis over 24 months[5] and fosters stronger, more supportive communities that are informed, compassionate, and proactive. Through individual, group, and family treatment; medication management; supported education & employment; case management; community outreach; and peer & family partners, CSC cultivates environments to uplift those experiencing psychosis and equip their families, friends, and community members to support long-term recovery and resilience. CSC also provides positive impacts on the community and social systems:

- **Reduced hospitalization**: Reduces average inpatient days by 33% and average number of ED visits per year by 36%[18]
- **Reduced Unemployment:** Reduces the likelihood of being unemployed by ~42%[19]
- **Stable housing:** Reduces the need for homelessness services amongst the FEP population by 48%[20]
- **Reduced criminal justice system involvement:** Reduces risk of committing first crime by 76%[21]
- **Reduced caregiver burden:** Reduces average cost of lost productivity due to caregiving duties by 28% and lowers average incremental healthcare costs through improved health outcomes for caregivers by 29%[22]

[17] Simons et al. Mortality Rates After the First Diagnosis of Psychotic Disorder in Adolescents and Young Adults
[18] Rosenheck et al
[19] Dickerson et al,
[20] Tsiachristas et al
[21] Pollard et al.
[22] McDonell et al.

Currently, MHSOAC estimates that only 10% of Californians in need have access to Coordinated Specialty Care, with many facing barriers to timely, equitable and affordable care. The State's mission is to expand access to 90% of Californians over the next three years.[23] The State has a pivotal opportunity to guarantee that individuals experiencing psychosis, along with their families, receive equitable, high-quality, and targeted early psychosis care that is appropriately and fully funded. This is vital in addressing mental health needs comprehensively and compassionately across the state.

Impact of Scaling EPI

Expanding access to EPI from an estimated 10% to 90% of Californians in need—an expansion from 2,100 to 19,000 individuals receiving care annually—**could transform lives and livelihoods.** Outside of individual impacts on clinical and non-clinical outcomes, there would also be positive benefits on friends, families, and communities.

In California, scaling CSC may generate $858M in annual system cost savings and productivity gains in year five.[24] These savings arise from shifting costs and reduced expenses related to unemployment, homelessness, and incarceration associated with untreated psychosis:

- ~$900M increase in healthcare costs driven by realigning care from inpatient settings to CSC and ongoing outpatient care for 9x the number of clients
- ~$865M in caregiver savings from recovered earnings and healthcare costs for caregivers
- ~$457M in employment savings from recovered earnings and Supplemental Security Income (SSI) / Social Security Disability Insurance (SSDI) payments
- ~$355M in criminal justice savings from reduced criminal justice interactions
- ~$15M in housing savings from reduced homelessness and the need for supportive housing

Key Solutions to Scale EPI

MHSOAC, in collaboration with advisors, has developed a plan for scaling EPI to ensure that 90% of individuals in need have access to care within their first year of symptoms. The plan includes both strategic objectives required to realize the vision and foundational levers that are critical enablers necessary to expand access to EPI successfully:

[23] Based on input from Tara Niendam, Executive Director, UC Davis Early Psychosis Programs (EDAPT and SacEDAPT Clinics) Total programs in CA = 43; Clients per program – average 50-75 (assume 60)
[24] See Chapter 4 Opportunity for additional details and model assumptions

Our vision is to ensure Californians experiencing psychosis and their families have equitable access to high-quality, appropriate, holistic early psychosis care.

Strategic Objectives

- **Awareness:** Enhance statewide awareness and understanding of early psychosis symptoms and resources to reduce stigma and elevate expectations for quality EPI. Educate community influencers like teachers and physicians about psychosis, destigmatize related conditions, and highlight the effectiveness of EPI through comprehensive resource centers, integration of psychosis education into wider health campaigns, and development of communication strategies to boost engagement in psychosis care across healthcare, housing, criminal justice, and social service systems.
- **Access:** Address key challenges to access, including varying levels of service convenience, coverage disparities between public and private insurance, and inconsistent eligibility and intake processes. Define access standards for different community types, establish community-led working groups, address capacity and infrastructure barriers, and refine diagnostic and referral guidelines.
- **Quality:** Ensure services adhere to a stringent level of care, with the CSC model promoted as the standard, to improve the fidelity of intervention models. Provide continuous enhancement of care quality, including leading ongoing trainings for providers, standardizing treatment protocols, and conducting rigorous program evaluation.
- **Equity:** Ensure full and equitable access to high-quality treatment, focusing on vulnerable communities accessing EPI less frequently. The focus of work is cultural and language competency of care through improving workforce diversity, co-designing EPI programs with communities, and establishing and tracking measurable goals around equity metrics.

Foundational Levers

- **Sustainable funding:** Secure sustainable funding and optimize resource allocation to support the expansion and maintenance of EPI programs statewide, to provide timely access to individuals in need regardless of a patient's insurance type. Develop consensus among funding partners, secure programmatic funding to ensure 100% coverage for all CSC components, and advocate for policy changes to increase financial support for EPI programs.
- **Workforce & capabilities:** Address California’s significant workforce shortages in trained clinicians and prescribers by recruiting new members, optimizing the use of existing staff, and enhancing capabilities through state-wide CSC-specific training

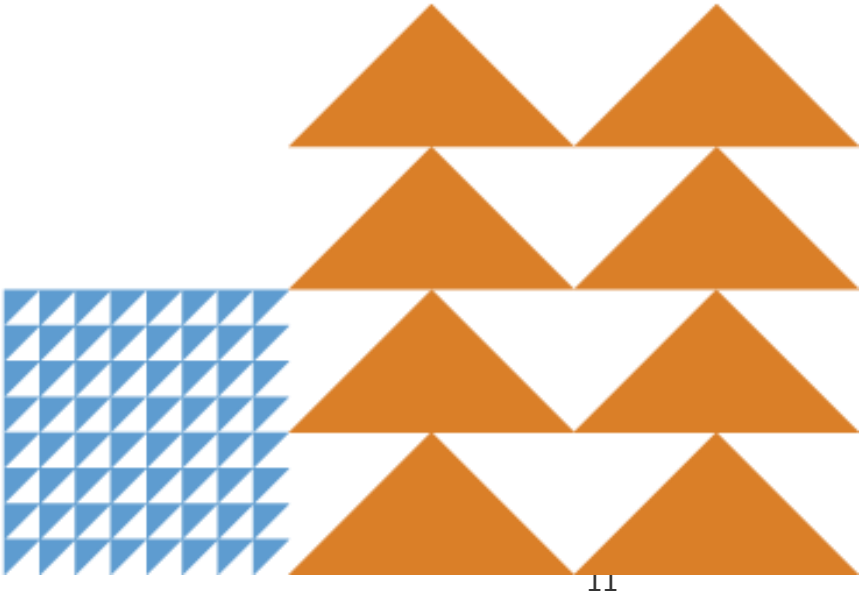
programs. Conduct a comprehensive assessment of workforce supply and demand, develop and implement recruitment and retention strategies, and expand training opportunities to build a capable, diverse workforce prepared to meet the needs of those with early psychosis, regardless of where they live.

- **Accountability:** Establish governance structures to ensure responsibility, measure progress, and facilitate continuous improvement in access, cost, quality, and outcomes of EPI. Refine and implement strategic goals, align efforts across partners, and develop incentives and structures to ensure consistent and accountable care delivery across California.
- **Infrastructure:** Improve the availability and distribution of EPI programs throughout California—including closing the gap for counties without an EPI program—through cutting-edge physical and digital infrastructures and revised public policy. Scale care models, particularly in underserved areas, by identifying infrastructure needs, developing strategic partnerships, and leveraging technology to optimize care delivery and access for individuals experiencing early psychosis.
- **Ecosystem engagement:** Establish an integrated care delivery model for individuals experiencing psychosis and their families, involving a wide range of partners from healthcare, education, housing, and criminal justice systems. Increase awareness and coordination among partners by improving training, sharing information for better care coordination, and strengthening partnerships to ensure seamless and timely care delivery.

Next Steps

If this strategic plan is supported by the public, the governor and legislature, execution will involve forming workstreams to support implementation, such as integrated coordination, performance management, communication strategies, and change management to foster ecosystem-wide transformation. Implementation involves a phased approach over three years. The first phase includes forming workgroups and conducting analysis to further understand current state, align on innovative solutions and design initiatives to execute these solutions. During this phase, working groups will also establish necessary partnerships with public, private and social sector organizations to implement solutions. Subsequently, the focus will be on developing partnerships before piloting initiatives and refining efforts based on data analytics. The work will be dynamic and regularly incorporate feedback from stakeholders with the aim of widespread access to high-quality early psychosis care in California by the end of the third year of implementation.

2. The need to scale Early Psychosis Intervention in California



It is estimated that each year, over 130,000 individuals in the United States, including nearly 21,000 Californians, experience their first episodes of psychosis.[25]

Early psychosis, also known as first-episode psychosis (FEP), is defined[26] as the initial period of up to five years following the emergence of psychotic symptoms. Early identification and access to evidence-based care is critical, as treatment within this period can improve short- and long-term health outcomes for people with schizophrenia and other psychotic disorders.[27] Studies estimate that approximately **1 in 33 people** will experience a psychotic episode in their lifetimes.[28]

According to the National Institute of Mental Health, psychosis represents a collection of symptoms that suggest a loss of contact with reality. When experiencing a psychotic episode, individuals may struggle to recognize what is real and what is not. Psychosis may also result in reduced levels of self-care, educational and professional challenges, disruptions in family and community connections, and an increased risk of harming oneself or others. Psychosis often signals the onset of psychotic disorders like schizophrenia.[29]

Psychosis may be a symptom of a mental illness, such as schizophrenia, bipolar disorder, or severe depression. However, a person can experience psychosis and never be diagnosed with schizophrenia or any other disorder. Individuals affected by schizophrenia have additional symptoms beyond psychosis.
Source: NIMH

Individuals with psychotic disorders face significant **health challenges and higher mortality rates.** Research indicates that the life expectancy of people with psychosis is shorter by an average of 10-15 years, driven largely by accidental injury, self-harm, suicide or unintentional overdose.[30] The lifetime suicide rate for individuals with psychotic disorders is 5.6%, with highest risk following initial contact with mental health services.[31] Comparatively, the age-adjusted suicide risk in the US is 14.1 per 100,000 population.[32]

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[25] Estimated by applying the observed rate in the Medicaid population (Radigan et al) to the Medicaid and uninsured populations and the observed rate in a sample size with 85% commercially insured population to the commercially insured populations. Methodology based on input from Tara Niendam, Executive Director, UC Davis Early Psychosis Programs (EDAPT and SacEDAPT Clinics)
[26] Lundin et al, Identification of Psychosis Risk and Diagnosis of First-Episode Psychosis: Advice for Clinicians, March 2021
[27] Yale School of Medicine- What is Psychosis
[28] NIMH Recovery After an Initial Schizophrenia Episode (RAISE)
[29] NIMH: Understanding Psychosis
[30] Simon: Mortality Rates After the First Diagnosis of Psychotic Disorder in Adolescents and Young Adults
[31] Nordentoft: Suicidal behavior and mortality in first-episode psychosis
[32] U.S. Centers for Disease Control and Prevention

There are also significant economic and healthcare costs associated with psychosis. The estimated excess economic burden of schizophrenia in the US in 2019 was $343.2 billion, of which, only $62.3 billion was in direct health care costs (18.2%). Caregiving ($112.3 billion), premature mortality ($77.9 billion), and unemployment ($54.2 billion) are other significant drivers of economic costs.[33]

The impact of psychosis extends to **employment and education.** People with a serious mental illness (SMI) (defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment that substantially interferes with or limits one or more major life activities[34]) are often excluded from employment even though studies show that such individuals with SMI can succeed in mainstream employment with effective supports.[35] A study in 2021 estimated that ~25% of people with serious mental illness are unemployed,[36] compared to a 4 - 6% unemployment rate in the general population.[37]

Psychosis also can affect **housing security.** A 2019 study found that approximately 20% of individuals experiencing **homelessness** are affected by psychosis,[38] as compared to less than 4% in the general population.[39] Similarly, research published in 2022, found the risk of homelessness is ~5 times higher among veterans with schizophrenia compared to those without.[40]

In the **criminal justice and legal system,** the figures are similarly concerning. A study in 2017 found that 37% of individuals experiencing first-episode psychosis (FEP) were incarcerated at some point along their pathway to clinical care. These individuals experienced longer delays to treatment and more severe positive symptoms, and they averaged having more than two episodes of incarceration, mostly for nonviolent, petty crimes.[41] A 2016 study by the Department of Correctional Health Care Services found that approximately 30% of California Prisoners received treatment for a serious mental disorder. Mental health treatment is more effective and less expensive than incarceration, with the average annual cost of incarcerating a state prisoner in California at over $70,000, not including mental healthcare costs, while the cost of treating a person with mental illness in the community is approximately $22,000.[42]

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[33] Kadakia et. al. The Economic Burden of Schizophrenia in the United States, 2019

[34] NIMH

[35] Prior: An enhanced individual placement and support (IPS) intervention based on the Model of Human Occupation (MOHO); a prospective cohort study, 2020

[36] Guhne et al, Employment status and desire for work in severe mental illness: results from an observational, cross-sectional study, *Apr 2021*

[37] U.S. Bureau of Labor Statistics range for unemployment in 2021

[38] Ayano et al, The prevalence of schizophrenia and other psychotic disorders among homeless people: a systematic review and meta-analysis, *Nov 2019*

[39] Calabrese: Psychosis

[40] Lin et al, Unemployment, homelessness, and other societal outcomes in patients with schizophrenia: a real-world retrospective cohort study of the United States Veterans Health Administration database, *July 2022*

[41] Wasser et al, First-Episode Psychosis and the Criminal Justice System: Using a Sequential Intercept Framework to Highlight Risks and Opportunities, *Sep 2017*

[42] Stanford Justice Advocacy Project: The Prevalence And Severity Of Mental Illness Among California Prisoners On The Rise

The impact of psychosis extends beyond individuals and systems to **caregivers.** Family members and other caregivers for people with psychosis report higher levels of emotional or physical tension relative to caregivers for individuals without psychotic disorders. The time needed to care for an individual experiencing psychosis may also impinge on workplace attendance, income, professional aspirations, and personal health.[43]

These challenges underscore the need to make effective evidence-based interventions that can improve outcomes in early psychosis care widely available at the individual, community, and societal levels.[44]

There are treatment models that have been demonstrated to be effective in alleviating symptoms and mitigating the impacts of early psychosis. The Substance Abuse and Mental Health Services Administration (SAMHSA) identifies **Coordinated Specialty Care (CSC)** as the standard of care for early psychosis.[46] CSC. CSC is a multi-modal, team- and community-based, collaborative treatment methodology. It comprises six primary components: psychotherapy, medication management, service coordination (e.g., case management), family education and support, supported education and employment, and peer support services.[47]

Coordinated Specialty Care (CSC) has been associated with positive outcomes for participants, including mitigation of symptoms and improvements in occupational and social functioning.[48] Select impacts are highlighted in Exhibit 1 (featured below).

The American Psychiatric Association (APA) in its 2020 updated practice guidelines for the treatment of schizophrenia, recommends Coordinated Specialty Care program for patients experiencing a first episode of psychosis. [45]
Source: American Psychiatric Association

[43] Cham et al, Caregiver Burden among Caregivers of Patients with Mental Illness: A Systematic Review and Meta-Analysis, Dec 2022
[44] Hirschtritt et al, Reimbursement for a Broader Array of Services in Coordinated Specialty Care for Early Psychosis, Mar 2024
[45] APA: New Practice Guidelines on Treatment of Patients with Schizophrenia
[46] SAMHSA: Coordinated Specialty Care for First Episode Psychosis
[47] SAMHSA: Coordinated Specialty Care for First Episode Psychosis
[48] SAMSHA: Evidence-Based Resource Guide Series Overview

Potential impact of CSC on program participants

Sector	Select examples of observed impact (based on empirical studies) on participants
Healthcare	On average, reduces **inpatient days** by 33% and average number of **ED visits** per year by 36%[1] Improves **symptoms of schizophrenia and psychosis** (based on measures of both PANSS[2]/CDI[3])[4] observed over 24 months[5]
Employment and education	Reduces likelihood of being **unemployed** by ~42% (represents reduction from 50% to 29%)[6]. Increases appropriate access to **social security support** where needed by 37%[1] Improves **education and employment rates** increased by 2x (from 40% to 80% in six months)[7]
Housing	Reduces **need for homelessness services** amongst the FEP population by 48%[8] Reduces average per person cost of providing supportive housing to program participants[8]
Criminal justice	Participants **experience a 76% reduction in the risk of committing a first crime** and are significantly less likely to be convicted of any crime when enrolled in CSC[9]
Caregiving	Reduces average cost of **lost productivity** due to caregiving duties by 28%[10] Reduces average **incremental healthcare costs** through improved health outcomes for caregivers by 29%[10]

Exhibit 1: Overview of select patient outcomes from CSC as identified in the literature

Sources 1. Rosenheck et al ; 2. Positive and Negative Syndrome Scale ;3. Clinical Global Impressions; 4. Kane et al.; 5. Dixon LB et al.; 6. Dickerson et al, 7. Nossel et. al. .; 8. Tsiachristas et al; 9. Pollard et al.; 10. McDonell et al.

Despite the impact of Coordinated Specialty Care, it is estimated that in California, only 10% of individuals in need have access to Coordinated Specialty Care[49]

[49] Based on input from Tara Niendam, Executive Director, UC Davis Early Psychosis Programs (EDAPT and SacEDAPT Clinics) Total programs in CA = ~43; Client per program – average 50-75

Access to high-quality, timely CSC can transform the care journey for individuals experiencing early psychosis.

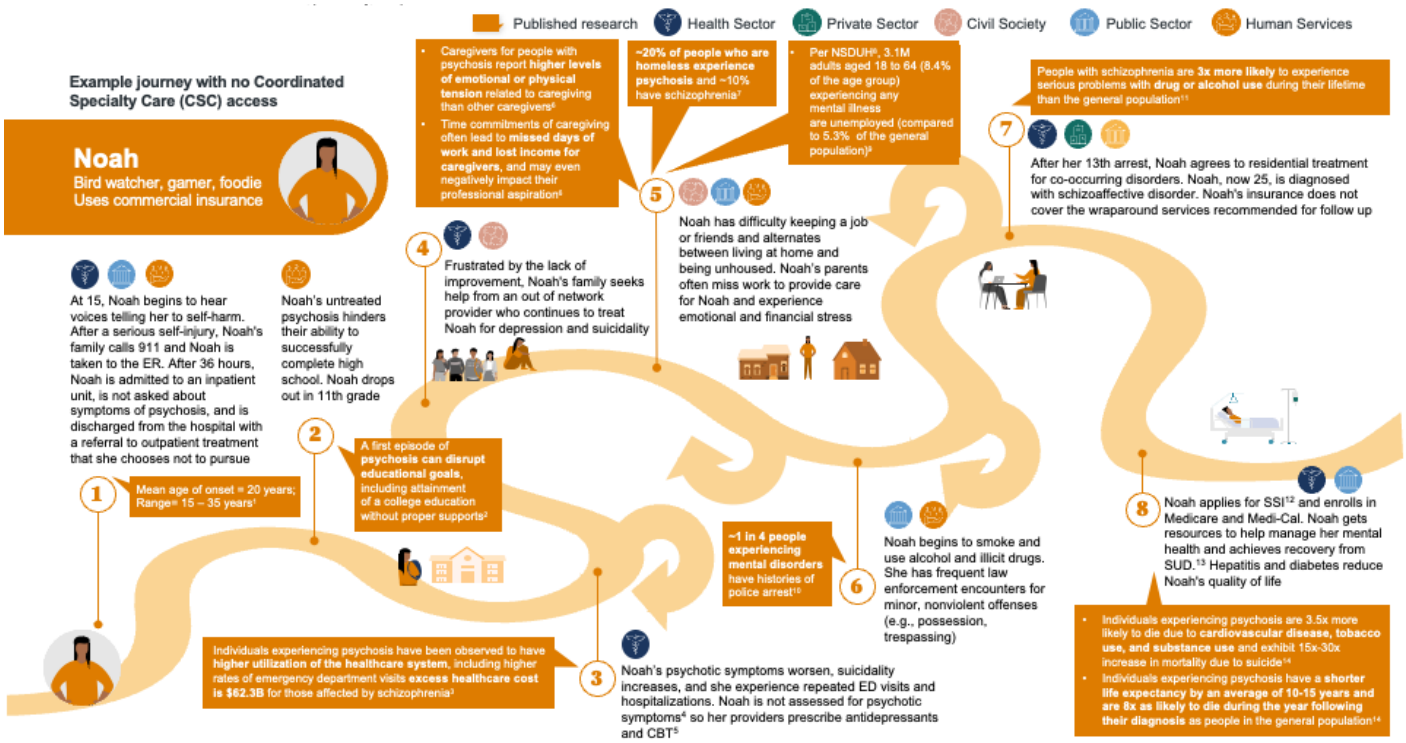


Exhibit 2: Illustrative care journey of an individual experiencing psychosis without access to Coordinated Specialty Care

Sources

1. Heinssen ; 2. Shinn et. al. ; 3. Kadakia et. al. ; 4. MHSOAC ; 5. CBT= Cognitive Behavioral Therapy; 6. Cham et. al. ; Gupta et. Al.; 7. Ayano et .al.; 8. NSDUH= National Survey on Drug Use and Health; 9. NSDUH; Guhne et al; BLS; 10. Livingston; 11. Khokar et. al. ; 12.SSI =Supplemental Security Income; 13. SUD= Substance Use Disorder; 14. Simon et. al.

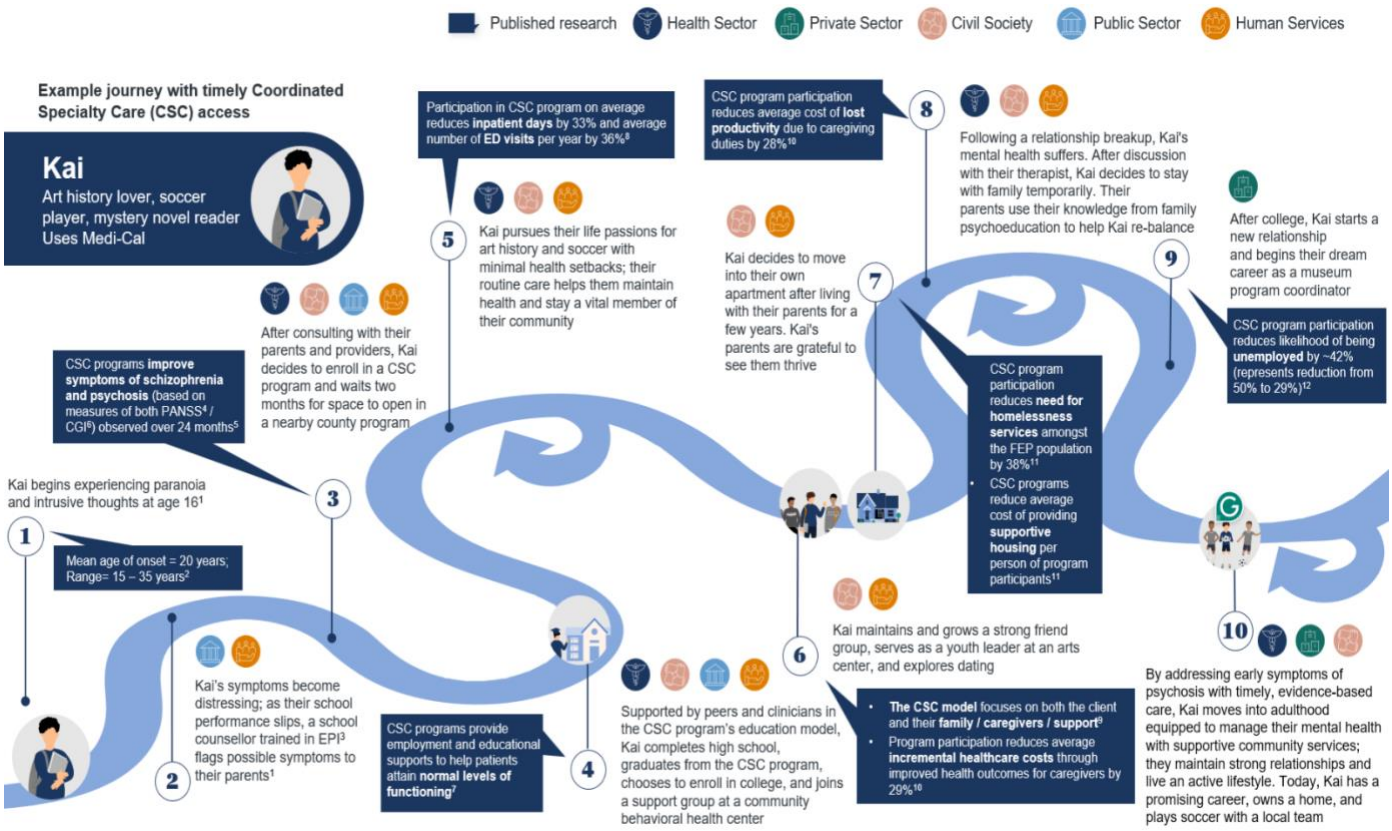


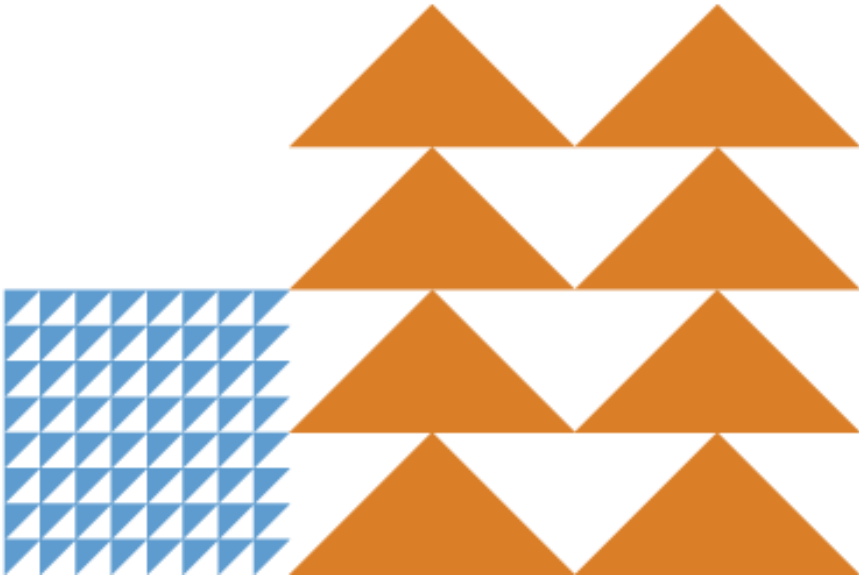
Exhibit 3: Illustrative care journey of an individual experiencing psychosis with access to Coordinated Specialty Care

Sources

1. MHSOAC; 2. Heinssen ; 3. EPI= Psychosis Intervention; 4. PANSS= Positive and Negative Syndrome Scale; 5. CGI= Clinical Global Impressions; 6. Positive and Negative Syndrome Scale; Clinical Global Impressions; Kane et. al. Dixon LB et. al. ; 7. Global assessment of functioning; 8. Rosenheck et. al.; 9. NAMI ; 10. McDonnell et. al. ; 11. Tsiachristas et. al; 12. Dickerson et. al.

There is an opportunity for California to ensure equitable access to high-quality and appropriate early psychosis care for individuals experiencing psychosis and their families.

3. Overview of the current state of early psychosis care in California



California has been a pioneer in expanding access to evidence-based care for early psychosis.[50]

3.1 Efforts in expanding early psychosis care

The Mental Health Services Oversight and Accountability Commission, an independent state agency, was created in 2004 by the Mental Health Services Act. The first of its kind in the U.S., the MHSOAC oversees and allocates funds to 59 local mental health departments across California's 58 counties. For each county, approximately 20% of MHSA annual revenues is earmarked to support prevention and early intervention programs and services,[52] which has helped to facilitate the rapid development of early psychosis programs across California.

Proposition 1, an effort to rebuild California's behavioral health system, expands access to funding for BH reforms through a two-bill package – The Behavioral Health Services Act (BHSA) provides funds through a stream of income tax revenue of ~$3.4B, and the Behavioral Health Infrastructure Bond Act (BHIBA) draws from a $6.4B general obligation bond to provide resources for supportive housing and behavioral health treatment.51 This reform provides a critical opportunity to make high-quality and appropriate Early Psychosis Intervention available statewide.

[50] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[51] Based on FY23-24 projected expenditures from Mental Health Services Act Expenditure Report – Governor's Budget
[52] MHSOAC, Well and Thriving Prevention and Early Intervention in California, *Jan 2023*

Select milestones are shown in the figure below:

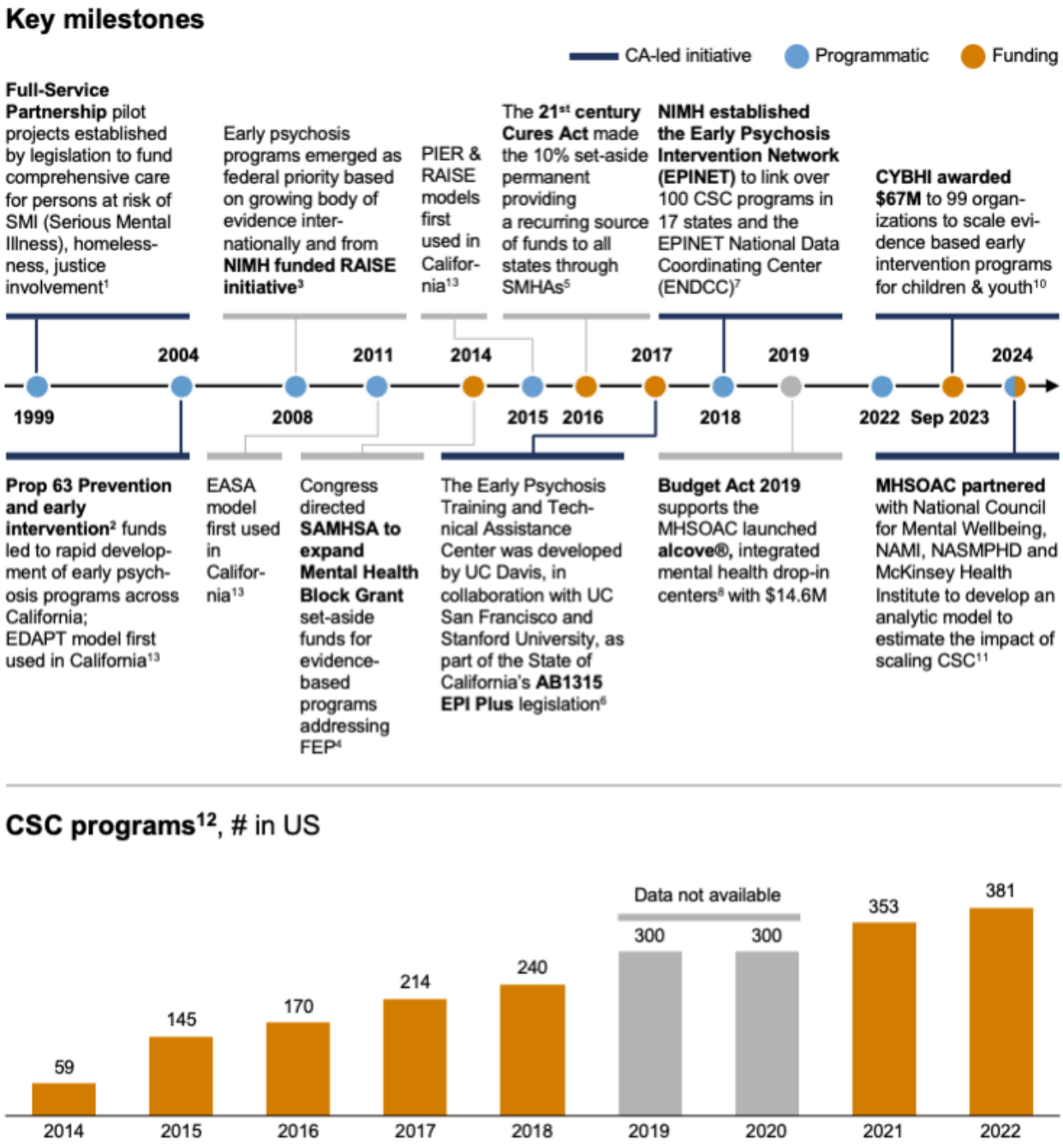


Exhibit 4: Timeline of select investment milestones in Early Psychosis Intervention (EPI) care within California

Sources

1. MHSOAC Report to the legislature on FSP, 2. MHSOAC, 3. NIMH RAISE, 4. SAMHSA, "Coordinated Specialty Care for FEP: Costs and Financing Strategies," Aug. 2023, 5. NIH Cures ACT , 6. MHSOAC EPI Plus 7. EPINET 8. MHSOAC allcove 9. Psychiatry Online, Psychiatric News. Mark Moran, 10. CYBHI 11. MHSOAC. 12. # of active CSC programs in 2022 as per SAMHSA 13. Niendam et al.

The MHSOAC (also known as the Commission) supports numerous initiatives to improve access to care for prevention and early intervention, including programs and partnerships intended to strengthen psychosis care delivery and improve public understanding of psychosis.[53] Example Commission activities and efforts include:

- Assembly Bill 1315 established the **EPI+ program** through which the Commission has made investments to support components of existing CSC programming, including care delivery, technical assistance, and data collection/evaluation strategy, and the formation of a multi-site learning collaborative.[54] Many CSC programs are operated at the county level using a variety of funds, including Medi-Cal and MHSA. [55]
- The commission supports **Full-Service Partnerships** (FSPs) that are county-level programs established under the Mental Health Services Act (MHSA). These programs support prevention and early intervention services delivered at the community level, with many services covered by Medi-Cal. FSPs are supported by the Commission through occasional funding for evaluation. Since the MHSA was passed in 2004, numerous statewide evaluations have provided quantified evidence demonstrating the success of FSPs, as indicated by fewer emergency department visits, a reduction in emergency mental health services, and decreased involvement with the criminal justice system.[56] The Commission recently approved a study to evaluate the effectiveness of a "whatever it takes" approach to recovery and management of psychosis and other mental or behavioral health needs through FSPs.[57]

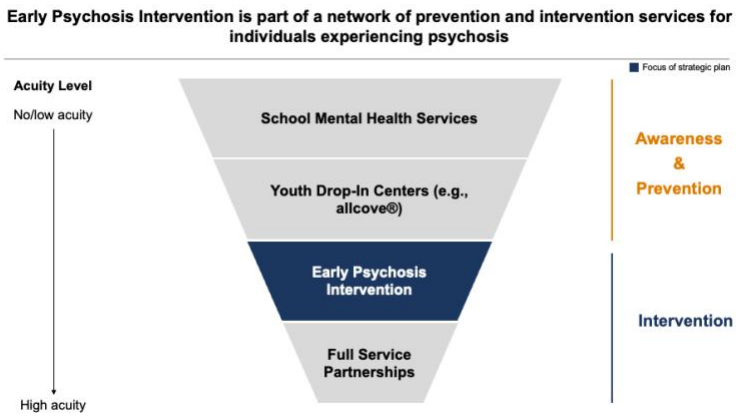


Exhibit 5: Intervention and prevention services for early psychosis

Source: Early Psychosis Intervention (EPI) Advisory Group

- The Commission has invested in strategies to support **school mental health services** for children and youth. **In 2024, DHCS partnered with MHSOAC and** awarded $67M to 99 organizations across 30 counties to expand early intervention programs for children, youth, and young adults, including coordinated specialty care.[58]

[53] MHSOAC publicly listed initiatives
[54] EPI Plus program
[55] Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017
[56] Report to the Legislature on Full-Service Partnerships, MHSOAC, January 2023
[57] MHSOAC Report to the Legislature on Full Service Partnerships
[58] DHCS news release

- The introduction of BH-CONNECT is expected to expand coverage for evidenced practices including Coordinated Specialty Care for First-Episode Psychosis[59]

3.2 Expanded CSC model

CSC is a team-based, collaborative, multidimensional approach to treatment that emphasizes the use of evidence-based interventions, shared decision-making, voluntary participation, and program fidelity.

There are six core elements of care that are part of CSC[60]:

1. **Psychotherapy** can be individual- or group-based and is typically based on cognitive-behavioral treatment (CBT) principles and emphasizes resilience training, symptom management, and coping skills
2. **Medication management** involves catering dosage and drug type to a client's specific needs and monitoring for psychopathology, side effects, and attitudes towards medication
3. **Supported education and employment (SEE)** typically involves sessions with an SEE specialist who acts as a coach to help clients plan life goals and return to education or the workforce to achieve those goals
4. **Family support and education** involves educating family about psychosis, alongside coping and communications skills to best engage with loved ones
5. **Service coordination** includes collaborative communication between providers (e.g., using phone, videoconference, electronic health records; between team leads, physicians, nurses, SEE specialists) to discuss topics such as progression of care, medication needs, and the client's treatment/life goals; individual case management is also used to coordinate catered support and services
6. **Peer support** provides CSC-FEP program participants with a sponsor with shared lived experiences related to FEP or other factors (e.g., demographics, substance use), who provides mentorship and healthy coping skill

[59] The California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BHCONNECT) Section 1115 Demonstration

[60] Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care

In addition to these core elements, the California CSC model focuses on the client and their family, caregivers, and/or other supporters at the center of the care team, incorporating an assertive case management approach. This approach includes peers and family partners, community outreach and education, and weekly team meetings to improve client outcomes.

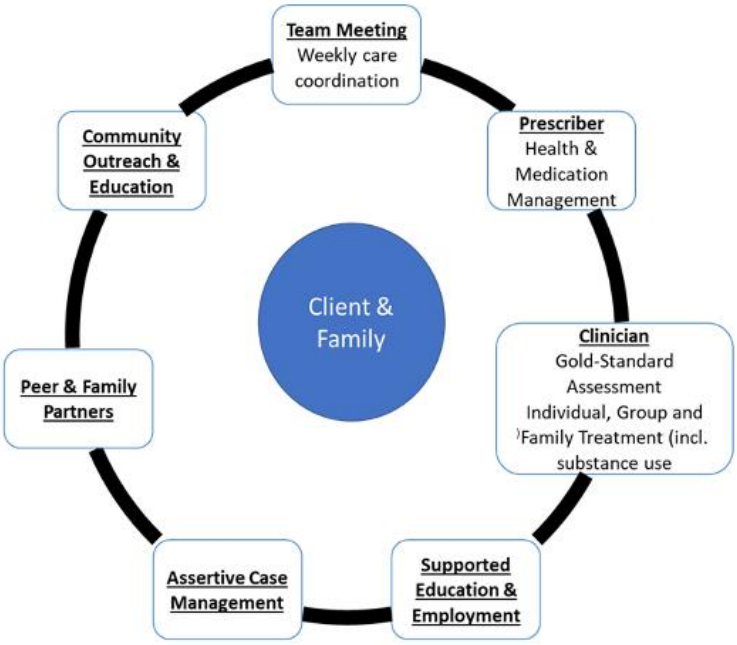


Exhibit 6: Expanded CSC model followed in California

Sources
EPICAL TTA CSC Model presented in collaboration with UC Davis, Stanford University and UCSF, MHSOAC

3.3 Funding for EPI programs

Financing for existing early psychosis programs in California comes from program-based sources at the national, state, and county levels (e.g., SAMHSA Mental Health Block Grant, CA Mental Health Services Act funding), and claims-based reimbursements. According to the California Early Psychosis Assessment Survey (CEPAS) of 28 CSC programs, state funding appears to be the most common source of nonclaims-based program funding, with 54% of programs reporting receipt of programmatic state funding. Around twice as many early psychosis programs receive reimbursement from Medicaid (Medi-Cal in California) compared

to programs receiving reimbursement from commercial insurance plans (43% and 21%, respectively).[61]

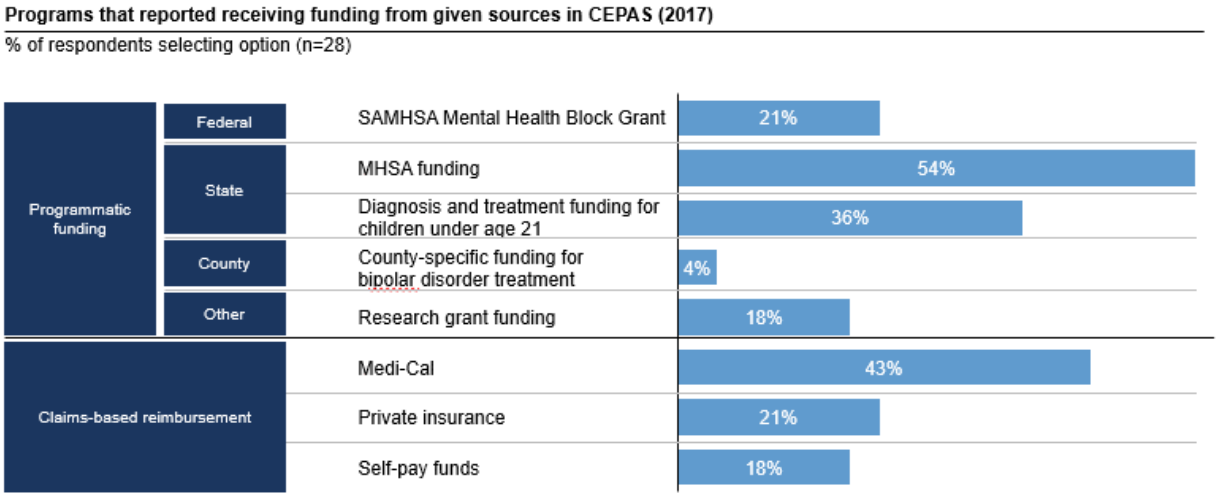


Exhibit 7: Programmatic funding and claim-based reimbursement sources for CSC programs

Sources
Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017, discussions with experts

3.4 Access to programs across geographies

California counties have developed a range of locally designed behavioral health programs to serve California's diverse population[62],[63]. The realignment of health and social services programs in 1991 restructured California's public behavioral health system, allowing counties to become responsible for program design and delivery within statewide standards for eligibility and services.

There is a need for additional Early Psychosis Intervention (EPI) Programs. In order to serve all residents experiencing early psychosis in California each year, EPICAL estimates the state will

[61] Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017
[62] The California County Platform Chapter 6 Health Services, *March 2023*
[63] County Behavioral Health Director Association

need 277 facilities providing EPI services that have the capacity to support 75 clients each.[64] Currently, there are 43 EPI programs in California.[65]

In order to serve all residents experiencing early psychosis in California each year, EPICAL estimates the state will need 277 facilities providing EPI services that have the capacity to support 75 clients each.[66] Currently, there are 43 EPI programs in California.[67]

As a result, the implementation of early psychosis intervention programs in California varies across counties. This variation is observed in performance against access metrics, with 13% of state residents living in counties without an Early Psychosis Intervention (EPI) program.[68] There are also differences between counties in treatment models and fidelity to CSC program components. In 2017, across the 58 California counties, 24 counties representing 76% of the states population and 41% of counties reported having at least one active program for treatment of early psychosis. Only five counties reported having multiple programs active. Another 21% counties had programs in development, while the remaining 38% reported no programs for early psychosis. [69]

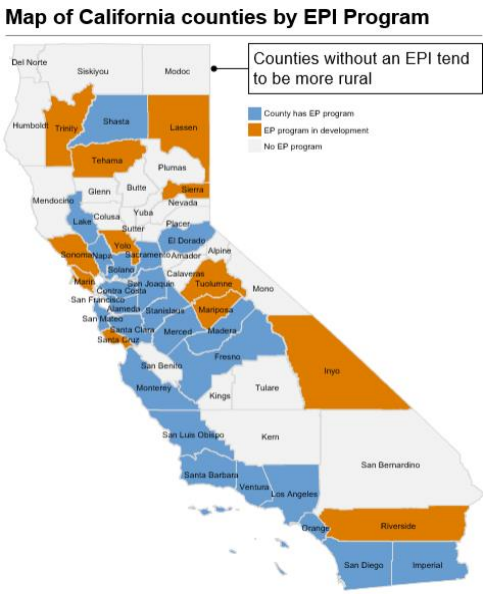


Exhibit 8: Map of California Countries by EPI Program

Sources
Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017

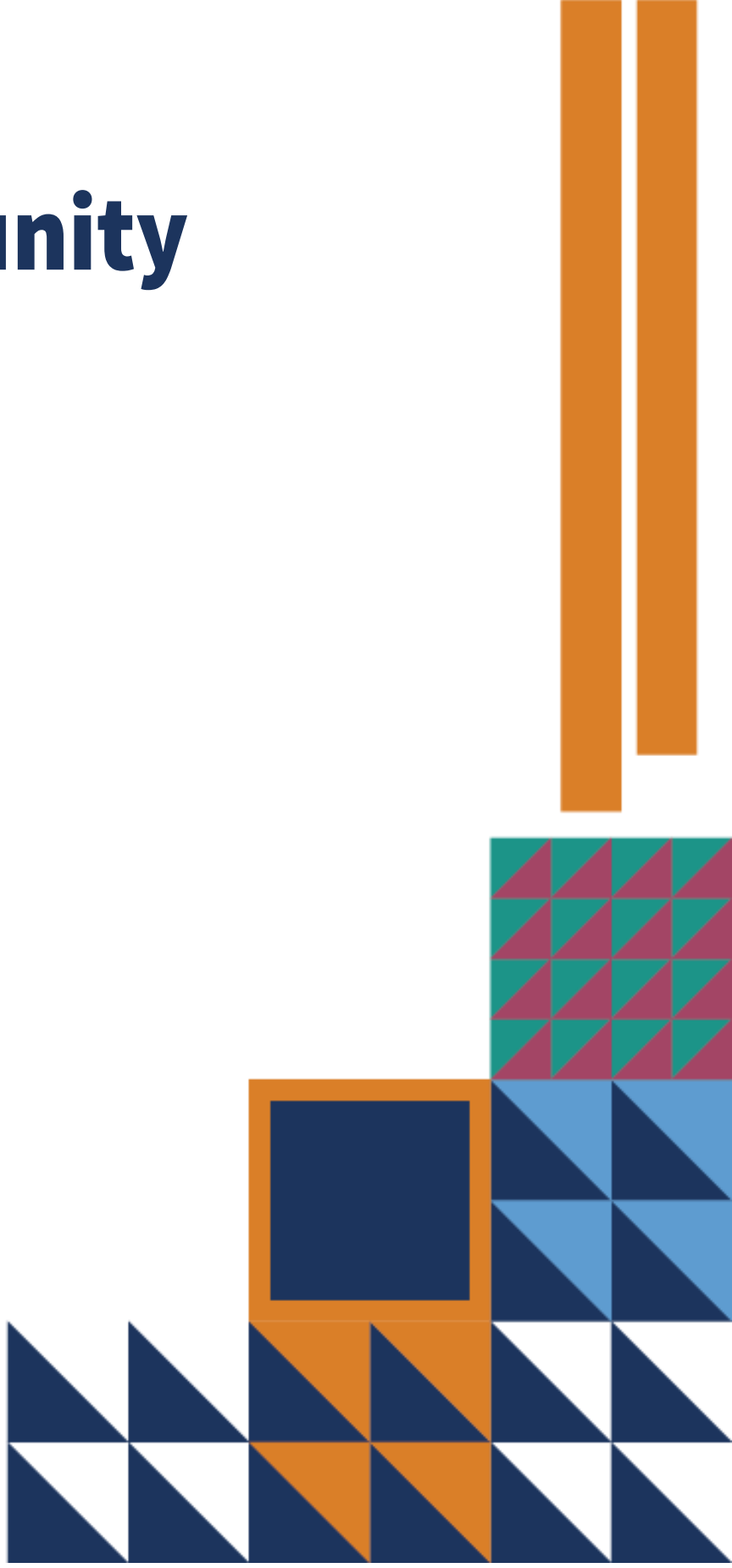
Many counties are working to address workforce gaps to expand access. While all U.S. states are working towards building a sufficient CSC-trained workforce to meet population needs, California faces a critical lack of CSC-trained staff. The state would need an estimated 5000

[64] EPI-CAL calculator estimating the number of EPI programs needed; the Incidence of early psychosis in California is 21,000 individuals. Assuming the average # of clients served by each EPI program is 75, the number of programs needed to serve 100% of annual incidence is 277
[65] Interview with Executive Director of EPI-CAL, 17th April 2024
[66] EPI-CAL calculator estimating the number of EPI programs needed; the Incidence of early psychosis in California is 21,000 individuals. Assuming the average # of clients served by each EPI program is 75, the number of programs needed to serve 100% of annual incidence is 277
[67] Interview with Executive Director of EPI-CAL, 17th April 2024
[68] Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017
[69] Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017.

more CSC personnel to meet its needs[70]. Further, only 50% of CSC programs in California have staff training specifically in CSC, compared to 85% across the US.[71]

[70] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[71] California 2022 Uniform Reporting System Mental Health Data report SAMHSA

4. Opportunity



In early 2024, the MHSOAC partnered with the National Alliance on Mental Illness (NAMI), the National Association of State Mental Health Program Directors (NASMHPD), the National Council for Mental Wellbeing, and the McKinsey Health Institute (MHI) to develop a National Early Psychosis Intervention Impact Model to estimate the effect of expanding access to Coordinated Specialty Care (CSC). Through interviews with 19 psychosis and CSC subject matter experts[72], and review of dozens of academic research papers, articles and policy briefs, the collaboration produced an analytic model. This model estimates the direct system cost savings and indirect productivity gains of expanding CSC access across several impact categories (i.e., healthcare, housing, employment and education, criminal and legal system involvement) and to caregiving family members, based on published research on the outcome evaluations of CSC[73]. The analyses have been further refined to detail the impact of expanded access to CSC in California.

Scaling access to EPI programs from the estimated 10% today to 90% would provide access to CSC for an additional 135,000 individuals in California experiencing psychosis. Further, 11,500 caregivers will be able to continue to pursue their careers and to spend time with their loved ones and friends in a non-caregiving capacity

Moreover, preliminary estimates suggest that expanding access to CSC from addressing 10%[74] of estimated need (i.e., the current estimated level of access in California) to 90%[75] of estimated need will generate measurable cost savings for the system.

If a plan to expand access from 10% to 90% for individuals with needs is implemented in a strategic manner, the state is likely to generate $12B of overall value for the entire ecosystem, compared to a system addressing only 10% of the need over a 10-year period

Increasing CSC access from 10% to 90% provides services to an additional ~17,000 individuals a year (from approximately 2,100 to 19,000). It also generates an estimated $858 million in annual system cost savings and productivity gains by year 5.[76]

[72] Subject matter interviews conducted between January – February 2024. Additional information included in Chapter 6.1 Approach
[73] Detailed list of references can be found throughout this document and specifically in this chapter
[74] Based on input from Tara Niendam, Executive Director, UC Davis Early Psychosis Programs (EDAPT and SacEDAPT Clinics) Total programs in CA = ~43; Client per program – average 50-75
[75] The Kennedy Forum
[76] California Early Psychosis Intervention Impact Model

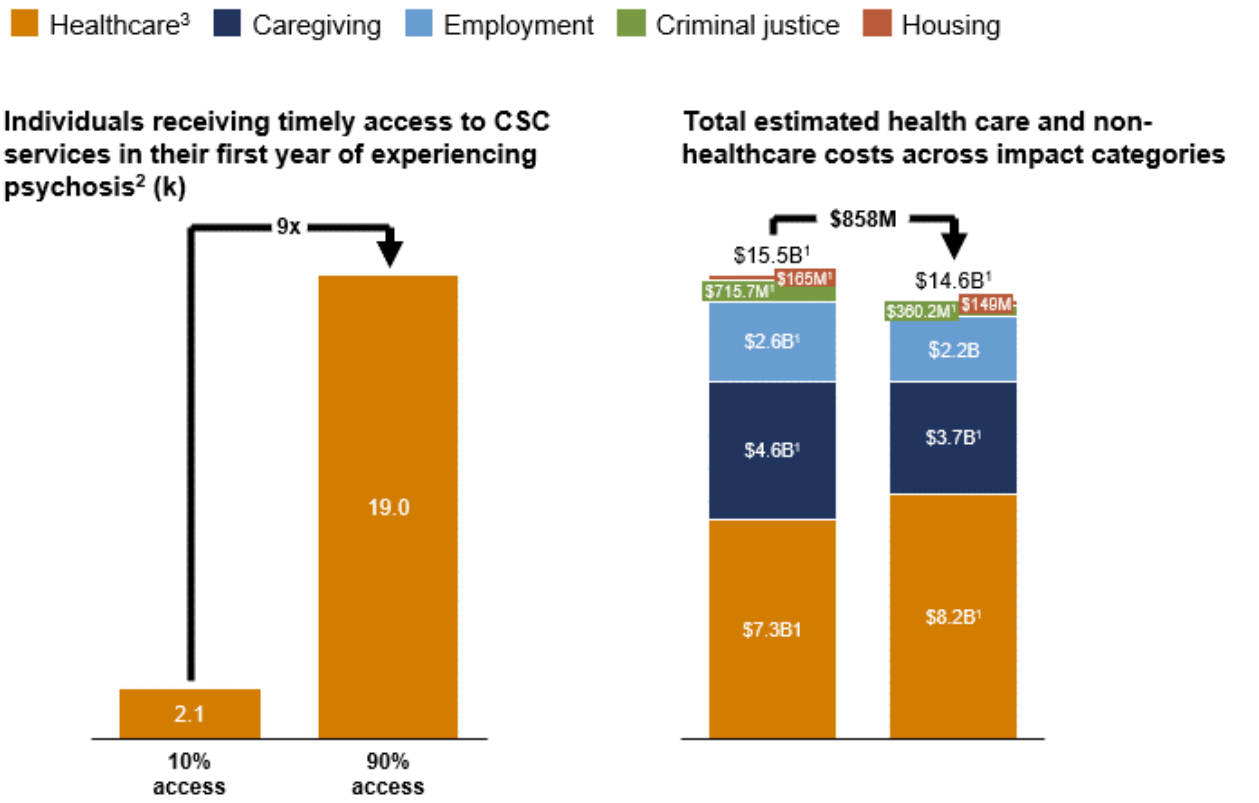


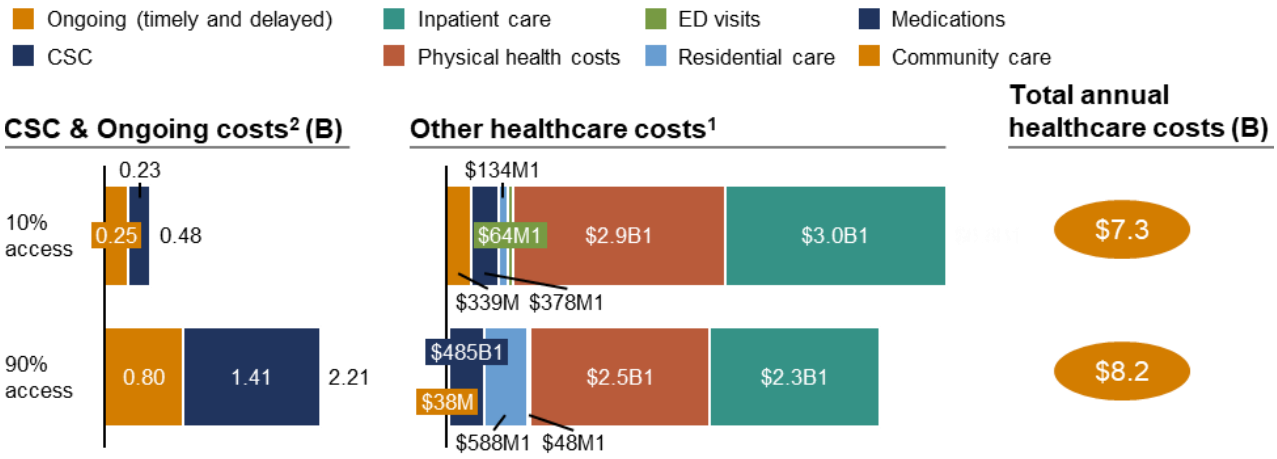
Exhibit 9: Preliminary high-level estimates of the impact of increasing access to CSC from 10% to 90% in California

Sources

1. Annual impact is based on an estimated CA incidence of approximately 21K per year for first-episode psychosis based on Radigan et al. (2019) for Medi-Cal and uninsured populations, and Simon et al. (2017) for the 19-34 aged population with commercial insurance. First presentation with psychotic symptoms in a population-based sample and accounts for a 5-year period in which individuals are either in community care for 5 years compared to receiving CSC for 2 years and ongoing care for 3 years.
2. Number of individuals receiving timely access in their first year and delayed access in their second year (6.7%) of experiencing psychosis per the 10% and 90% access rate. Incidence is calculated based on input from Tara Niendam, Executive Director, UC Davis Early Psychosis Programs (EDAPT and SacEDAPT Clinics). Age range from the Radigan paper has been expanded to assume the same incidence rate for individuals between 19-34 years with Medi-Cal and for the uninsured population.
3. Healthcare is inclusive of inpatient and residential care, outpatient visits, ED visits, medications, and physical health. Individuals not receiving CSC are assumed to receive community care, estimated at 37 visits per year and $102 per visit (adjusted to 2024 USD) based on data from the NIMH RAISE-ETP study. For individuals receiving CSC, outpatient care is estimated at the cost of a team to deliver CSC or ongoing care.

In year 5, healthcare costs increase from $7.3B to $8.2B as a result of expanding access to CSC from 10% to 90%. Approximately $0.9B in healthcare costs would shift from inpatient settings to CSC and ongoing outpatient care

Difference in healthcare costs[1] at 90% vs 10% of CSC access[2] ($B), by healthcare category[5]



Overall, annual **healthcare costs** increase from ~**$7.3B to ~$8.2B** with:

- Annual costs of providing CSC ongoing care increasing by ~**$1.7B**
- Annual costs of other healthcare services (e.g., inpatient, residential care, ED, physical) decreasing by ~**$0.9B**

The average per person healthcare costs for those receiving access to CSC decreased by **~10% from ~$61k to ~$55k**[7]

Exhibit 10: Preliminary estimates of impact on healthcare costs from expanding CSC access from 10% to 90% of estimated need

Sources

1. Healthcare is inclusive of inpatient and residential care, outpatient visits, ED visits, medications, and physical health. Individuals not receiving CSC are considered to receive community care, estimated at 37 visits per year and $102 per visit (adjusted to 2024 USD) based on data from the NIMH RAISE-ETP study. For individuals receiving CSC, outpatient care is estimated at the cost of a team to deliver CSC or ongoing care.
2. Representing percent of individuals receiving timely access in their first year and delayed access in their second year of experiencing psychosis
3. Costs are based on the salaries (adjusted to 2024 USD) of a team to deliver CSC or ongoing care as estimated in Humensky et. al. (2013). Interactive tool to estimate costs and resources for FEP initiative in NY.
4. Annual impact is based on an estimated CA incidence of approximately 21K per year for first-episode psychosis based on Radigan et. al. for Medi-Cal and uninsured populations, and Simon et. al. for the 19-34 aged population with commercial insurance. First presentation with psychotic symptoms in a population-based sample and accounts for a 5-year period in which individuals are either in community care or in CSC and ongoing care for 2 and 3 years, respectively
5. Medication and residential care costs are indirect cost increases – annual cost increases as a result of increasing access.
6. Calculated by dividing the total healthcare cost of providing CSC by total people receiving CSC care for 10% and 90% access respectively. Does not account for community care.

Increasing access to CSC is estimated to generate $1.7B in non-healthcare cost savings[31] in year 5 (Exhibit 10). The net savings are estimated to be around $858M a, with $2.4B in direct annual costs and $3.3B in direct and indirect savings across the full ecosystem.

DRAFT, AS OF APRIL 18, 2024 PRELIMINARY

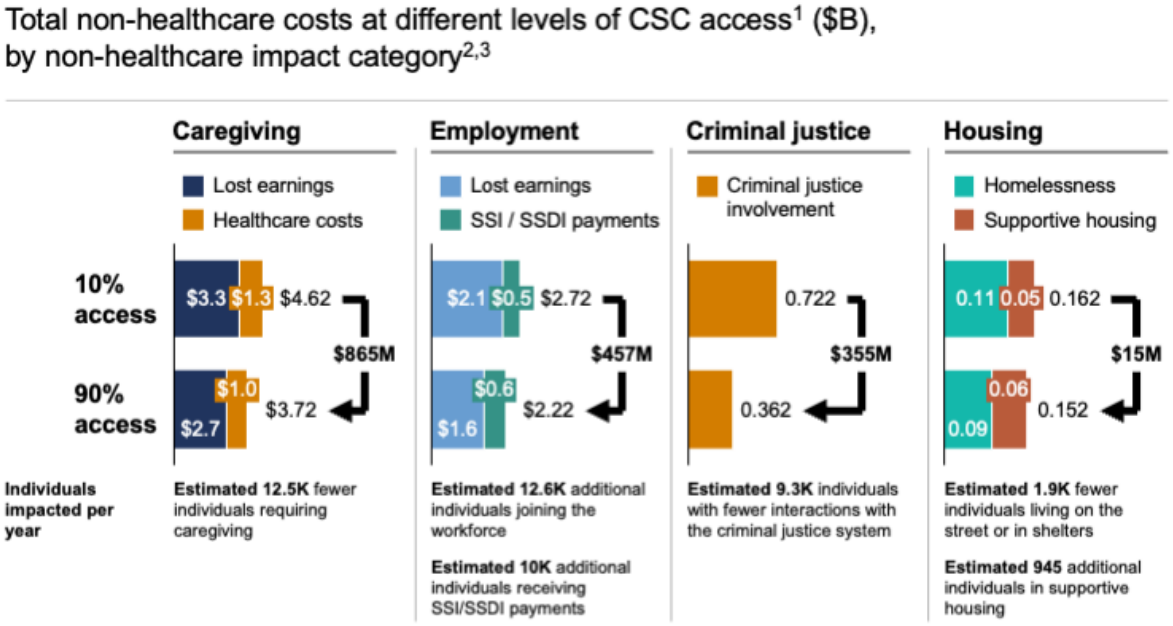


Exhibit 11: Increasing timely access from 10% to 90% is estimated to generate $1.7B in potential non-healthcare cost savings per year

Sources

1. Individuals not receiving CSC are considered to receive community care, estimated at 37 visits per year and $102 per visit (adjusted to 2024 USD) based on data from the NIMH RAISE-ETP study.
2. Annual impact is based on an estimated CA incidence of approximately 21K per year for first-episode psychosis based on Radigan et al. for Medi-Cal and uninsured populations, and Simon et. al. for the 19-34 aged population with commercial insurance. First presentation with psychotic symptoms in a population-based sample and accounts for a 5-year period in which individuals are either in community care or in CSC and ongoing care for 2 and 3 years, respectively

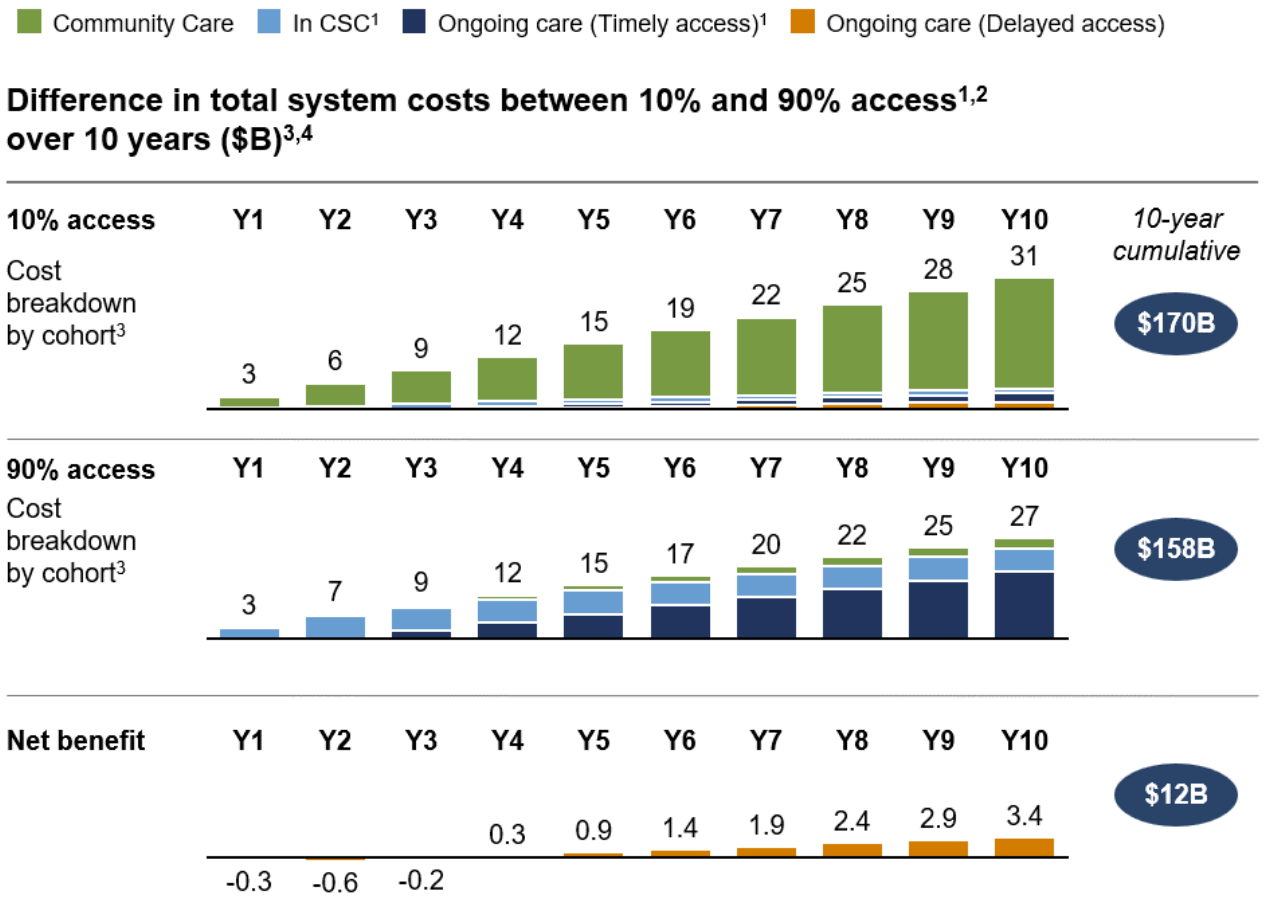


Exhibit 12: Over a 10-year span, a system that addresses 90% of need may generate an estimated $12B in savings for California compared to a system addressing only 10% of need

Sources

1. Representing percent of individuals receiving timely access in their first year and delayed access in their second year of experiencing psychosis
2. Individuals not receiving CSC are considered to receive community care, estimated at 37 visits / year and $102 / visit (adjusted to 2024 USD) based on data from the NIMH RAISE-ETP study.
3. Costs are based on the salaries (adjusted to 2024 USD) of a team to deliver CSC or ongoing care as estimated in Humensky et. al. (2013). Interactive tool to estimate costs and resources for FEP initiative in NY.
4. Annual impact is based on an estimated CA incidence of approximately 21K / year for first-episode psychosis based on Radigan et. al. for Medi-Cal and uninsured population and Simon et. al. for 19-34 aged population that has commercial insurance. First presentation with psychotic symptoms in a population - based sample and accounts for a 5-year period in which individuals are either in community care or in CSC and ongoing care for 2 and 3 years, respectively

This expansion would positively impact over 135,000 individuals experiencing psychosis and their families, demonstrating the substantial long-term benefits of investing in early psychosis care (Exhibit 13).

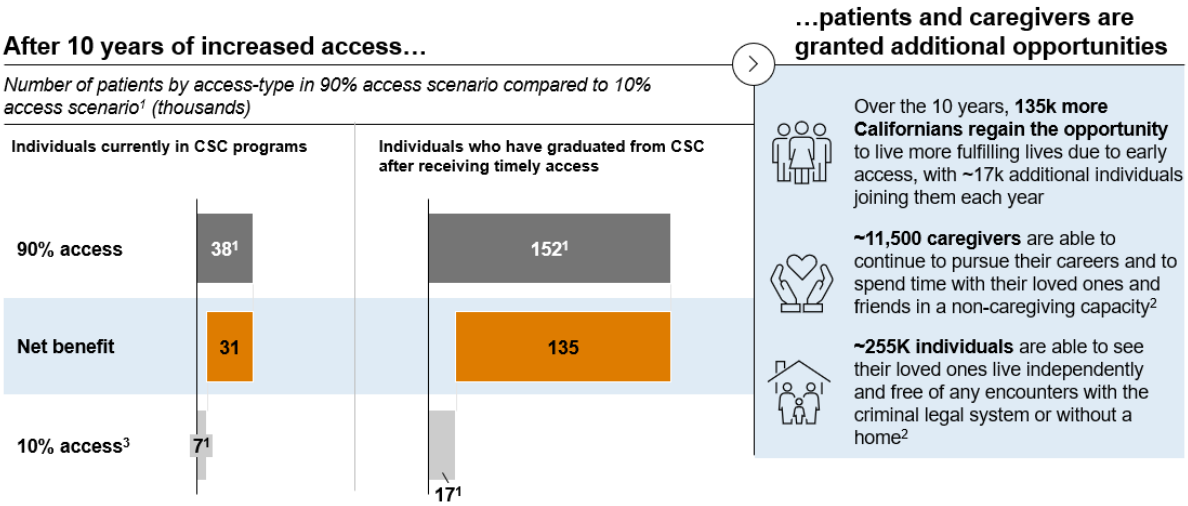


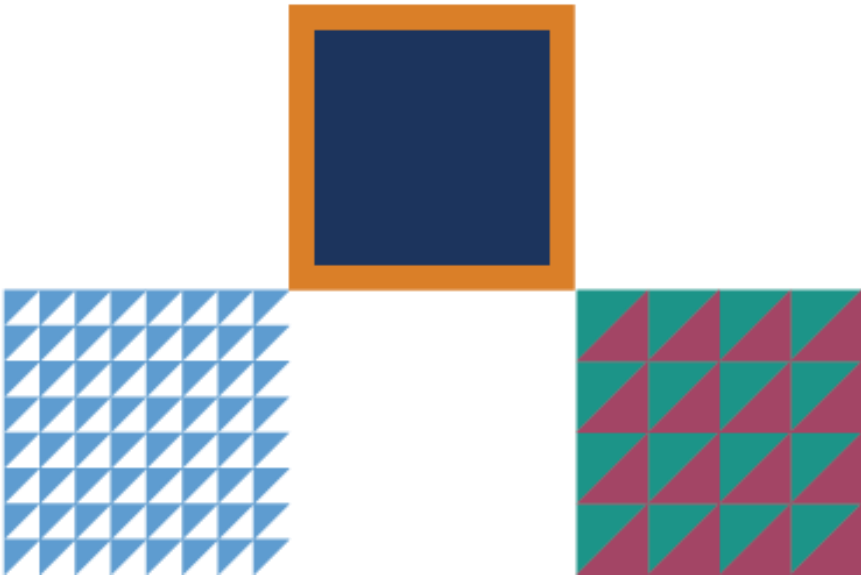
Exhibit 13: Expanded access in California reaches over 135k individuals experiencing psychosis and their families over a 10-year span

Sources

1. Representing percent of individuals receiving timely access in their first year and delayed access in their second year of experiencing psychosis
2. Based on a fixed assumption of 10% of individuals experiencing psychosis require caregivers
3. Based on the 2022 US Census estimate that the average persons per California household is 2.89; Assumes 1.89 persons per household are granted additional years with loved ones in a non-caregiving capacity Note that timely and delayed access is based on when an individual is identified as having early psychosis. Individuals may have wide variability in duration of untreated psychosis (DUP) at the time of identification. However, based on available data in empirical research, a conservative approach to mapping outcomes was taken. Where DUP is provided, shorter DUP outcomes were mapped to the timely access group and long DUP outcomes were mapped to the delayed access group. For referenced studies that did not provide DUP, outcomes were assumed to align with the timely access group

All estimates are based on published research on CSC and its impact on early psychosis, using research published between 2013-2024. Estimates of the potential system impact of expanding access to CSC may not include the impact of more recent care delivery innovations that may be deployed but were not captured in our research due to the availability of published research and data. There are components of the system impacted by the expansion of early intervention that are not included in the model due to a lack of published research, such as the impact on state hospitals, for which we might expect CSC to have downstream impacts. The real-world impact of scaling CSC in California will depend on model design and investment decisions, including those laid out in this strategic plan.

5. Potential path forward to scale early intervention



This Early Psychosis Intervention (EPI) strategic plan was formulated through an iterative process, seeking input from a broad range of experts to build consensus, encourage alignment across key partners, and engage California residents. MHSOAC sought technical inputs from subject matter experts, including people with lived experience, to inform key components of the strategic plan. These components will be shared with a broad range of ecosystem partners including individuals with lived experience, national leaders, state, and county administrations focused on health, education, housing, and criminal and legal systems, private sector health care providers and payors, CSC programs, researchers, community-based organizations, non-profits and philanthropic organizations for input. We will ensure that all Californians have the opportunity to engage in and refine the strategic plan through a public hearing prior to the Commission's review and adoption of the plan.

Process for developing and refining the EPI strategic plan

Exhibit 14: Distribution process for the draft EPI strategic plan

This draft describes the **overall vision** for the early psychosis intervention and the **strategic objectives** required to realize this vision. These cover awareness, access, quality, and equity. The plan also discusses **foundational levers** that are critical enablers necessary to expand access to EPI successfully. These levers include sustainable funding, workforce and capabilities, accountability mechanisms, infrastructure, and ecosystem engagement.

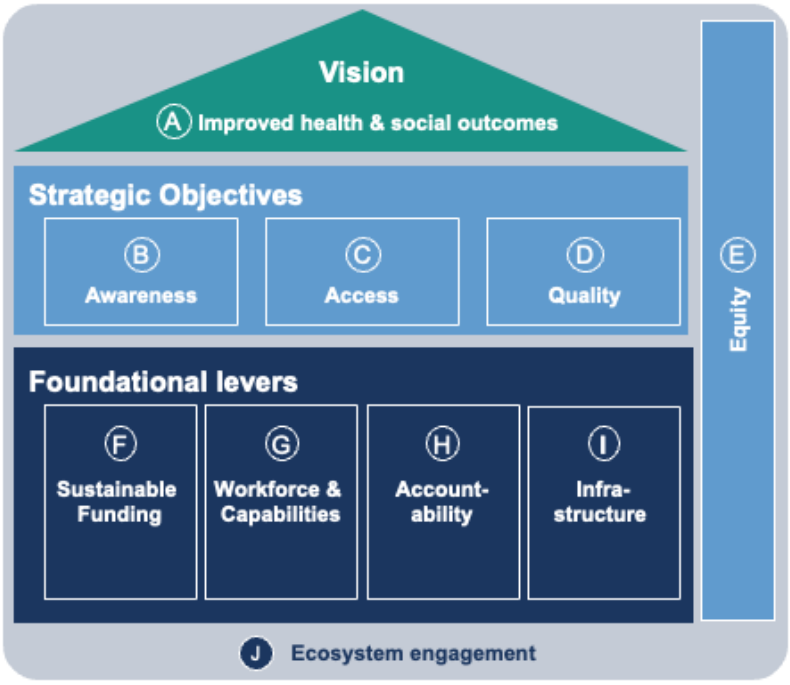


Exhibit 15: Overview of the strategic plan for early psychosis intervention in California

5.1 EPI Vision[77]

The primary goal is to ensure Californians experiencing early psychosis and their families have equitable access to high-quality, appropriate, holistic care.

To this end, the State may consider:

- Building on its pioneering focus on behavioral health.[78]
- Creating alignment across public and private sectors to expand access.
- Promoting fidelity across formats of care using a comprehensive learning health agenda and training for providers.
- Bolstering a population-based approach for indicated adults and adolescents with needs.
- Using widespread public education to destigmatize, identify, and address psychosis early on.

[77] Discussions with MHSOAC
[78] MHSOAC

- Engaging diverse perspectives and center community voices in learning, design, and implementation.

The plan targets measurable and specific goals over a three-year time horizon that could include elements such as:

- Increase access to timely, affordable, high-quality EPI services and reduce time to treatment
- Right-size the need for high acuity and high-cost downstream resources (e.g., state hospital inpatient psychiatric beds)
- Address some drivers of social needs (e.g., housing, education, and employment);
- Enhance the State's capacity and capabilities to provide high-quality EPI services by expanding the behavioral health workforce.

Progress against the targeted goals should be evaluated through outcome measures such as access to coordinated specialty care, client experience and outcomes, improvements in stable housing, career attainment and retention, reduced involvement with criminal and legal systems.

DRAFT, AS OF APRIL 23, 2024

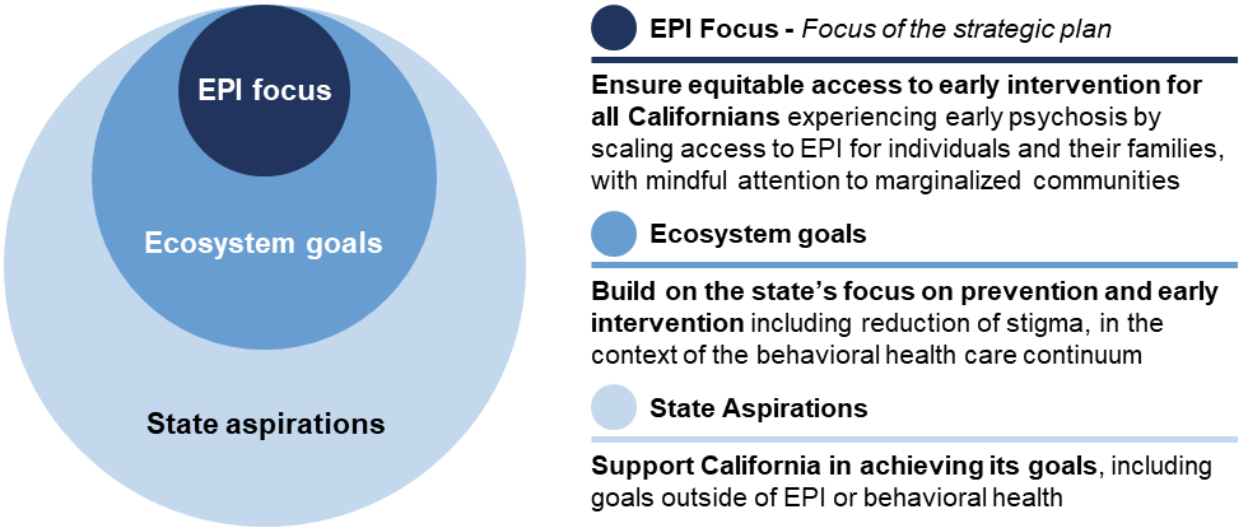


Exhibit 16: The focus of the strategic plan for EPI is situated within broader ecosystem goals and state aspirations

Sources
Discussions between MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group

5.2 Strategic Objectives

In order to achieve the vision and scale impact, the State will need to elevate awareness and education about early symptoms of psychosis and available resources, tackle barriers to psychosis treatment access, and improve the quality of evidence-based care, all while maintaining a focus on equity.

In the following sections, the Plan will examine how California is performing against the strategic objectives in the current state, potential goals that the State may aspire towards, key milestones for achieving progress, and possible next steps to inform the solutions that California considers. In order to achieve the State's goal of 90% access and minimize the duration of untreated psychosis (DUP), each component will be essential.

5.2.1 Awareness

This plan defines awareness as statewide **understanding and familiarity** with the symptoms and available resources and care for early onset of psychosis. Awareness may be built through educational approaches that **minimize stigma around psychosis and psychosis treatment** and **strengthen public expectation** of access to high-quality EPI services Awareness also includes ensuring that individuals experiencing psychosis have information on treatment effectiveness and potential impacts on their lives and well-being.[79]

Key objectives/goals[34]

The key goals of the plan regarding awareness are:

- **Improving awareness** of symptoms of early psychosis, particularly among individuals who may play a role in identifying these signs and connecting individuals to care (e.g., teachers and primary care physicians) through intentional and educational approaches informed by research and best practices including integrating screenings where appropriate.

[79] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

  - **Enhance familiarity** with psychosis assessments and care resources for individuals and their loved ones.
  - **Destigmatize psychosis** and related conditions among the general population through education
  - **Destigmatize care-seeking behavior** with a particular focus on vulnerable population segments.
  - **Educate Californians on the effectiveness of EPI** for short- and long-term recovery.
- Establish and strengthen expectations of access to high-quality EPI services through publicized targets (e.g., 90-90-90 treatment targets set by UNAIDS5)

Current state of awareness

Lack of awareness may result in high levels of stigmatization; studies have found that 55% of individuals on the schizophrenia spectrum experience stigma.[80] In California specifically, experts report that stigma and lack of awareness continues to be a challenge to providing the needed care.[81]

California has invested in improving awareness and reducing stigma associated with seeking mental health care through multiple initiatives spearheaded by MHSOAC, CDPH, DHCS, CYBHI, and other agencies; a few key initiatives include:

- **allcove®, an integrated mental health youth drop-in center**,[82] seeks to offer destigmatizing and accessible services for youth ages 12 to 25. Beyond treatment for moderate mental health challenges, allcove® provides linkages to services. Originally launched in 2018 by Santa Clara County, allcove® became a state-wide effort through the Budget Act of 2019**.**
- **The Workplace mental health project**,[83] launched in 2018 through Senate Bill 1113, enabled the development of five voluntary standards that employers may adopt to support mental health awareness. These include leadership and organizational commitment; positive workplace culture and climate; access to services; crisis preparation, response and recovery; and measurement, evaluation and continuous quality improvement.

[80] C. Simonsen et al, Perceived and experienced stigma in first-episode psychosis: A 1-year follow-up study, Comprehensive Psychiatry (2019)
[81] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[82] allcove®
[83] Workplace mental health

- **CYBHI Public Education & Change Campaigns**[84] is a youth-co-designed statewide campaign to reduce mental health stigma and boost help-seeking behavior. Launched in 2022, the 100M effort will span 4 years and work towards culturally appropriate solutions that are grounded in community empowerment strategies. **The CYBHI ACEs & Toxic Stress Public Awareness and Healing-Centered Campaign,**[85] spearheaded by CA-OSG with $24 million funding, is a dynamic statewide initiative spanning 2023-2024. By convening diverse partners, the campaign aims to enhance public understanding of Adverse Childhood Experiences (ACEs) and toxic stress, including how toxic stress is a treatable health condition.

Next steps

MHSOAC proposes the following next steps for consideration:

- Improve public awareness:
  - **Creating one-stop resource centers** for psychosis care-seekers and families to access content on early psychosis symptoms and pathways to access care[86]
  - **Create educational materials** that feature **scientists and doctors** who can speak with authority on the effectiveness and impact of EPI
  - Build an EPI **champion/ambassador program** where individuals who have gone through EPI programs themselves share their lived experiences and knowledge with the community

Tailor communications to **specific population groups including channel usage and culturally relevant messaging,** leaning on community partners to help inform and implement population-specific communication approaches that address stigmatization and other barriers that limit care seeking.

  - **Build partnerships with existing behavioral health awareness campaigns** to create or enhance psychosis-specific programming (e.g., integrating psychosis education into other awareness programs such as ACE)[87]
  - Ensure individuals working within crisis responses systems (e.g., 988 mobile crisis units, emergency room clinicians) are aware of early psychosis symptoms and treatment avenues

- Establish and strengthen public expectations:

[84] CDPH Public education and change campaigns
[85] CYBHI ACEs and toxic stress public awareness campaigns
[86] Interview with Lead Investigator of social and cultural determinants of psychosis risk, City College of New York, 28 Mar 2024
[87] Interview with Director, Stanford Center for Youth Mental Health and Wellbeing, 20 March 2024

- **Enhance transparency and strengthen public engagement** by making current access, coverage, and equity measures for EPI publicly accessible; implement regular reporting and tracking of KPIs to strengthen and foster accountability.
- Develop **a public communications strategy with awareness campaigns that facilitate a call to action by Californians** to catalyze engagement from key ecosystem partners in pursuit of the goal of achieving access to CSC for 90% of individuals within the 1st year of onset of psychosis.
- **Enhance school mental health curriculum and public awareness campaigns** to explain the benefits of CSC and showcase its comparative advantage in terms of prevention and control outputs

Potential Milestones/Progress Measures

Prospective milestones towards achieving awareness objectives include the following:[88]

- Align with advisory group and partners on the timeline and sequencing for awareness building based on EPI system readiness
- Review landscape of behavioral health awareness programs in California and identify potential partnerships and/or learnings to support awareness building for early psychosis intervention.
- Convene a workgroup with a charter to design a public engagement strategy including target metrics for awareness (e.g., awareness and stigma as measured through annual surveys, average duration of untreated psychosis) and approaches to build awareness among vulnerable populations.
- Determine community organizations to potentially partner with on tailoring messaging for specific populations or engaging in awareness efforts directly within the community.
- Engage a team of critical ecosystem partners to implement and refresh awareness strategies.

[88] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

5.2.2 Access

Access is defined as the adequate supply of affordable, timely, and evidence-based care across geographies and sub-populations.[89] The implications of providing access may vary based on geography (e.g., urban vs. rural vs. suburban settings) and population-based factors (e.g., children and youth vs. adults).

Current state of access

An estimated 10% of Californians experiencing psychosis are currently able to access effective early intervention services.[90] This Plan evaluates the current state through four lenses of access: timeliness, convenience, coverage, and eligibility. Workforce and infrastructure, which are key access enablers, are discussed in later sections of the strategic plan (4.3.2 and 4.3.4, respectively).

Timeliness

The California Department of Managed Health Care (DMHC) requires health plans to provide timely access to care. In the context of non-urgent mental health appointments, including for early psychosis, health plan members have the right to appointments within 10-15 business days and within 48-96 hours for urgent care.[91] However, experts report that many clients do not receive an appointment within the target time frame, especially in cases where the initial point of care is for stabilizing services (e.g., emergency departments and crisis care centers).[92] Per the 2022 DMHC Timely Access Report, the mean wait time for urgent appointments with a psychiatrist was 109 hours, exceeding the 48-96 our threshold. [93]

Convenience of access

In California, convenient access to EPI programs varies across counties; as on 2017, 59% of counties did not have an active EPI program, and less than half of the counties without active programs are in the process of developing a program. [94] Lack of convenient access may be particularly pronounced in vulnerable places within California.[95] Additionally, even in counties with EPI programs, there may be insufficient capacity and/or infrastructure to meet community needs.[96]

[89] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[90] EPI-CAL estimates; Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group)
[91] DMHC
[92] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[93] DMHC 2022 Timely Access Report
[94] Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017
[95] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[96] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

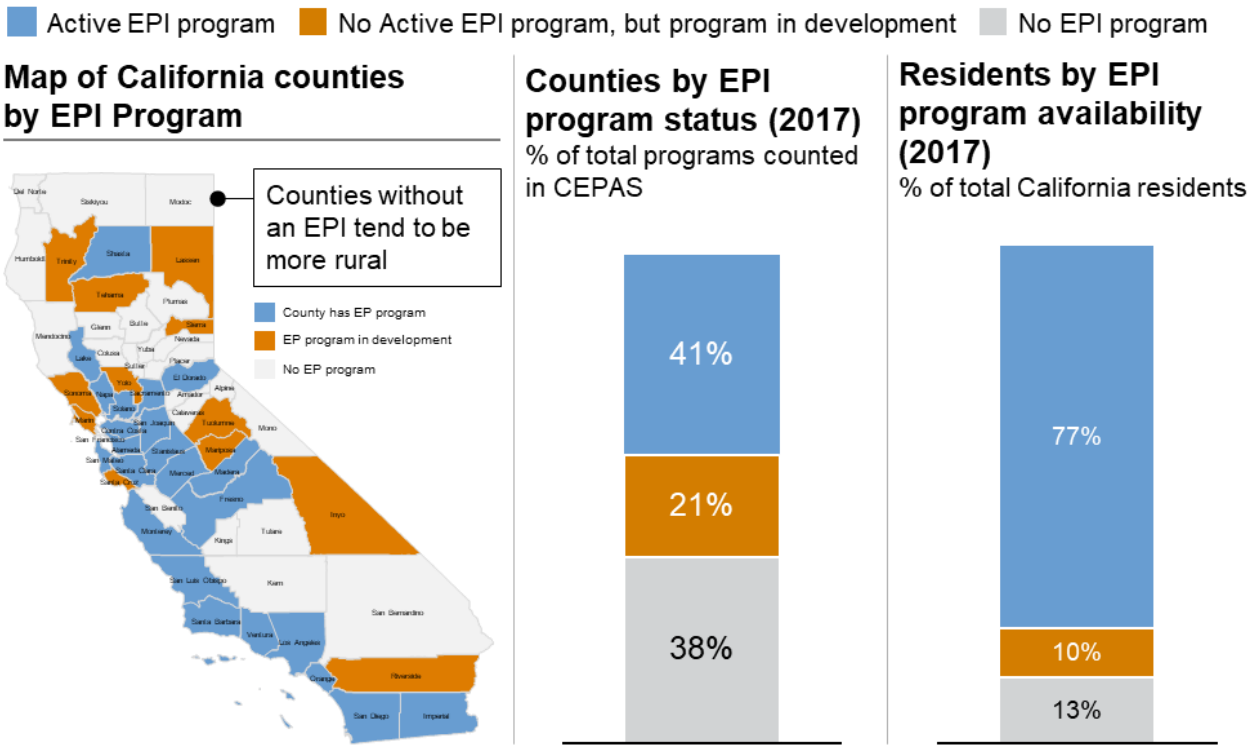


Exhibit 17: Landscape of active and developing EPI programs within California

Sources

California Early Psychosis Assessment Survey (CEPAS); U.S. Census Bureau Data: Annual estimates of Resident Population: April 1, 2010 to July, 2019

Note – This visual is not meant to assess sufficiency of EPI treatment offerings by county as needs vary based on population density and the CSC standard of care.

Coverage

In the current state, there are differences **between counties' CSC reimbursement model (Medi-Cal) and that of private health plans**. Medi-Cal often covers the suite of CSC services.[98] In contrast, private insurance usually only reimburses specific clinical services such as psychotherapy and medication management.[99] Private health plans rarely reimburse non-clinical components of CSC care (e.g., peer-support programs, supportive education and employment) despite the robust evidence base demonstrating the effectiveness of these interventions in improving health and social outcomes for people with early psychosis.[100] In California, 53.9% of the population is covered by private insurance, 26.8% by Medi-Cal, 12.0% by Medicare, and 0.8% by the military; 6.5% of Californians are uninsured.[101]

"A robust international body of literature demonstrates the effectiveness of a multimodal, recovery-oriented, and team-based treatment model—referred to as coordinated specialty care (CSC) in the United States—for addressing the complex needs of individuals with early psychosis. However, CSC remains out of reach for many individuals who would benefit from it. One major barrier to access in the United States is financial restrictions: CSC programs often struggle to receive compensation for nonbillable but essential patient-specific services (such as occupational and educational guidance, peer support, and community outreach), and patients with commercial insurance may need to pay for some or all CSC services out of pocket." Hirschtritt et. al (2024) [97]

On the federal level, there have been efforts to ensure coverage for mental health services. In 2008, the Mental Health Parity and Addiction Act called for mental health benefits covered by insurance to be provided at the same level as physical health care benefits. Mental Health Parity has been strengthened by executive and legislative actions, most recently through an executive rule in 2023; however, many still struggle to afford the care they need.[102]

California is advancing mental health legislation that encourages more participation in the delivery of mental health services for plans and providers. The State enacted the Senate Bill (SB) 855[103] in 2020. SB 855 requires health insurance to cover medically necessary

[97] Hirschtritt et. al. Reimbursement for a Broader Array of Services in Coordinated Specialty Care for Early Psychosis
[98] CMS approves payment for Coordinated Specialty Care of First-Episode Psychosis
[99] NAMI – Coverage of Coordinated Specialty Care for early of First-Episode Psychosis, SAMHSA, Coordinated Specialty Care for First Episode Psychosis: Cost and Financing Strategies
[100] Reimbursement for a Broader Array of Services in Coordinated Specialty Care for Early Psychosis by Hirschtritt et. al. 2024
[101] KFF
[102] The White House: FACT SHEET: Biden-Harris Administration Takes Action to Make it Easier to Access In-Network Mental Health Care (July 25.2023)
[103] Senate Bill 855

mental health and substance-use disorder care. All benefits that are medically necessary to prevent, diagnose, or treat mental health conditions and substance use disorders must be covered, including visits to a mental health care provider, **intensive outpatient treatment, residential treatment, hospital stays,** and prescription drugs if covered by policy.[104] An additional requirement is that networks include coverage for sufficient providers and facilities within a reasonable distance to provide timely care or arrange care from out-of-network providers or facilities.[105]

While Medi-Cal (California's Medicaid program) has historically covered many CSC components, it has not defined CSC as a distinct benefit or provided bundled reimbursement. California's Department of Healthcare Services (DHCS) proposed **Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH- CONNECT)** may change this. One of the goals of BH-Connect is "improved availability in Medi-Cal of high-quality community-based behavioral health services, evidenced-based practices (EBPs_, and community-defined evidence practices, including CSC for first-episode psychosis". By defining CSC as a county-optional Medi-Cal benefit and offering bundled payments to county BH plans, California aims to support delivery of the comprehensive Early Psychosis Intervention.[106]

Eligibility and Intake

California currently does not have a consistent standard for CSC eligibility and intake, in part reflecting the complexity of consistently and accurately diagnosing early psychosis. Studies have shown that the diagnostic stability (the degree to which a diagnosis remains the same during subsequent assessments) of psychotic disorders is 47.7%.[107] This is indicative of both the complexity of accurate psychosis assessment and potential opportunities to improve consistency in screening and diagnosis for psychosis. Experts also suggest expansion of eligibility criteria for accessing EPI programs like CSC.[108] In California, eligibility criteria vary across EPI programs. Most EPI programs under the stewardship of EPI-Cal extend treatment to a broader continuum of psychotic disorders, including individuals at Clinically High Risk (CHR) for psychosis and individuals affected by mood disorders.[109] However, as of 2017, 17%

[104] California Department of Insurance
[105] California Department of Insurance
[106] The California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BHCONNECT) Section 1115 Demonstration
[107] Peralta et al, Long-term diagnostic stability, predictors of diagnostic change, and time until diagnostic change of first-episode psychosis: a 21-year follow-up study, Nov 2021
[108] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[109] Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017

of EPI programs in California do not serve individuals at CHR and 7% of programs do not treat people whose primary diagnosis is a mood disorder.[110]

Key objectives/goals

The goal for access is to ensure that 90% of individuals within the 1st year of onset of psychosis have **timely, affordable, appropriate,** and **convenient** access to CSC programs that are designed to inspire trust. [111] In the long term, the State may seek to ensure access within a shorter timeframe, recognizing that the World Health Organization recommends specialized treatment no more than 90 days after the start of psychosis symptoms.[112]

Next steps[113]

MHSOAC proposes the following next steps for consideration:

- **Timeliness:** To improve the timeliness of access, California could establish a workgroup to collect data to identify root causes for access barriers and establish incremental and long-term targets related to the average duration of untreated psychosis (DUP), average wait times for enrollment into CSC programs, and other metrics of timely access
- **Coverage:** To work towards ensuring all individuals experiencing early psychosis have access to CSC, regardless of their insurance coverage, California could consider exploring strategic optimization of service-based reimbursements and programmatic funding sources, explored in some more detail in Chapter 4.3.1.
- **Convenience:** California could explore the following steps to improve convenience:
  - Survey care seekers, their families, and community members to understand care experiences, timelines, and convenience challenges and identify solution to address access barriers outside of the health system (e.g., transportation for treatment)
  - Establish county-level archetypes and corresponding care models for convenient access based on factors such as population density, existing infrastructure, and the presence of vulnerable places and communities.[114] Develop criteria for determining when to deploy a given model (e.g., hub and spoke, regional models, virtual care elaborated in chapter 4.3.4)

[110] Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017
[111] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[112] J Bertolote et al, Early intervention and recovery for young people with early psychosis: consensus statement
[113] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[114] CDPH definitions of vulnerable communities and vulnerable places

  - Explore and build out telehealth offerings related to EPI.
  - Build partnerships with trusted community-based organizations to enable more culturally competent programs that create an environment of safety and accessibility (described further in chapter 4.2.4. Equity.)

- **Eligibility and intake:**
  - Standardize psychosis diagnosis and intake processes (e.g., refining clinical guidelines, providing enhanced clinician and provider training for individuals who may screen or identify psychosis, such as primary care providers, school mental health providers, and healthcare providers in correctional settings).
  - Improve access to screening for individuals in child welfare homes and youth involved with the criminal/ legal systems due to the strong linkage between trauma exposure and psychosis.[115]
  - Strengthen care referral networks through partnerships with health systems, health plans, criminal/legal system facilities, housing services providers, and community- and faith-based organizations to connect patients with EPI screening and treatment services.
  - Explore universal screening for select settings (e.g., within the criminal justice and behavioral health systems)
  - Develop protocols and training for individuals without a healthcare background who may play a role in the identification of psychosis symptoms.
  - Strenthen linkages between EPI and the crisis care continuum system (e.g., 988) to ensure individuals in crisis experiencing pyschosis receive the proper care and referrals include mobile supports when needed
  - Establish Centers of Excellence to offer training and technical assistance EPI program to ensure model fidelity, improve outcomes for clients, dissiminate community-defined care practices and strengthen culturally- sensitive care[116].

Potential milestones/progress Measures[117]

- Establish access standards in the context of urban, suburban, and rural communities.
- Establish community-led working groups to
  - Evaluate EPI access barriers across counties and population groups within California (e.g., capacity, coverage, infrastructure)

[115] Morrison et al, Relationships between trauma and psychosis: an exploration of cognitive and dissociative factors, September 2005
[116] BH-CONNECT 2023
[117] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

  - Build out an iterative timeline for addressing access barriers and meeting goals.
  - Identify and implement solutions with relevant partners in private, public and social sectors.
- Refine and reinforce guidelines for psychosis diagnosis and referral.
- Track and report on impact. Potential metrics could include:
  - **Timeliness:** average duration of untreated psychosis (DUP), average wait time for the first appointment, % of individuals within the first year of onset of psychosis receiving CSC
  - **Coverage:** the # of individuals with private insurance with fully covered CSC treatment, out-of-pocket expense for clients using self-pay funding
  - **Convenience:** # of community partners engaged in EPI program design, self-reported ease of access for EPI programs for clients through surveys
  - **Eligibility and intake:** % of diagnosed individuals referred to EPI, % of clinicians reporting using the same clinical guidelines for early psychosis diagnosis.

5.2.3 Quality[118]

Quality is defined as the approach for ensuring that Early Psychosis Intervention (EPI) services increase the likelihood of desired outcomes, foster a positive client experience, and are consistent with learnings and individual community needs.[119]

Current state of quality

The American Psychiatric Association (APA) proposes Coordinated Specialty Care (CSC) as the **established standard of care** for early psychosis intervention.[120]

However, nationally and within California, the interpretation of Coordinated Specialty Care varies with multiple treatment models deployed.[121] Within California, **different treatment models are in use for EPI** including the Portland Identification and Early Referral (PIER)

[118] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[119] Institute of Medicine definition cited in Dimensions of Quality in Mental Health Care
[120] Keepers et al, The American Psychiatric Association Practice Guideline for the Treatment of Patients With Schizophrenia, Sep 2020
[121] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

model, the Felton Institute Prevention and Recovery in Early Psychosis (Felton) model, the Early Diagnosis and Preventative Treatment (EDAPT) model, the Early Assessment and Support Alliance (EASA) model, and the Recovery After an Initial Schizophrenia Episode (RAISE) model. The California Early Psychosis Assessment identified the PIER model as the most commonly used approach for CSC (20% of programs that responded to the survey cited using this model), followed by Felton and EDAPT models (17% of programs). Approximately 27% of programs reported utilizing other models that incorporated different components of CSC with modifications. [122]

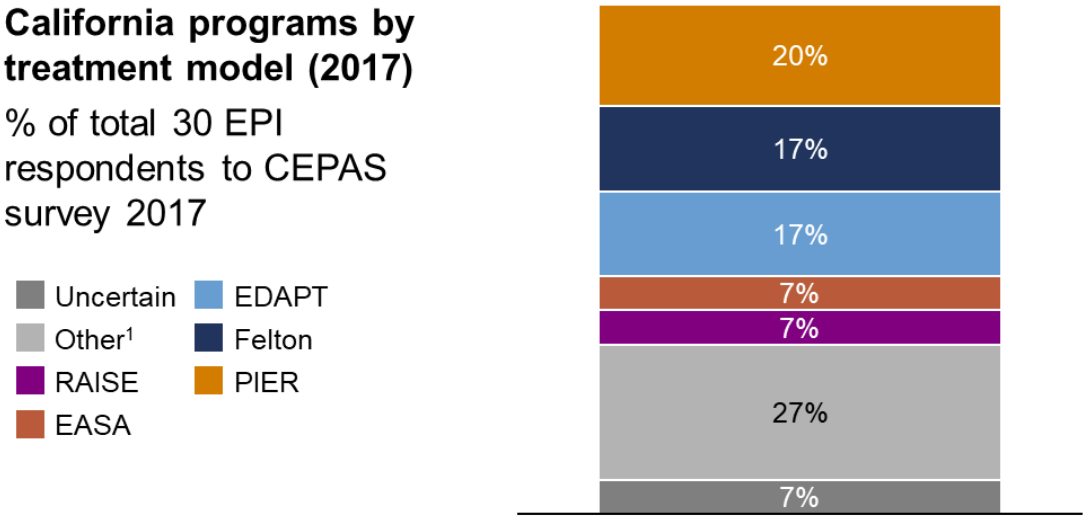


Exhibit 18: California CSC programs vary in the specific type of CSC they offer

Sources
The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services, Tara Niendam et al,
1 Other models that include various CSC components. For example, Los Angeles reported using the University of California, Los Angeles, Center for the Assessment and Prevention of Prodromal States model; Contra Costa County reported using the PIER model with adaptations; and Madera County reported using a "peer supportive service" within a full-service partnership to support linkage to medications and therapy.

Across CSC models, fidelity is a critical component of quality. The First Episode Psychosis Services Fidelity Scale (FEPS-FS) is based on a list of 35 essential components identified by systematic reviews and an international consensus process. It has been used in California as part of EPI-CAL fidelity assessments. In California, CSC **programs have varied in fidelity** to the 35-point FEPS-FS scale across models, indicating differences in adherence to evidence-based practices.[123]

[122] The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services, Tara Niendam et al,
[123] Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017

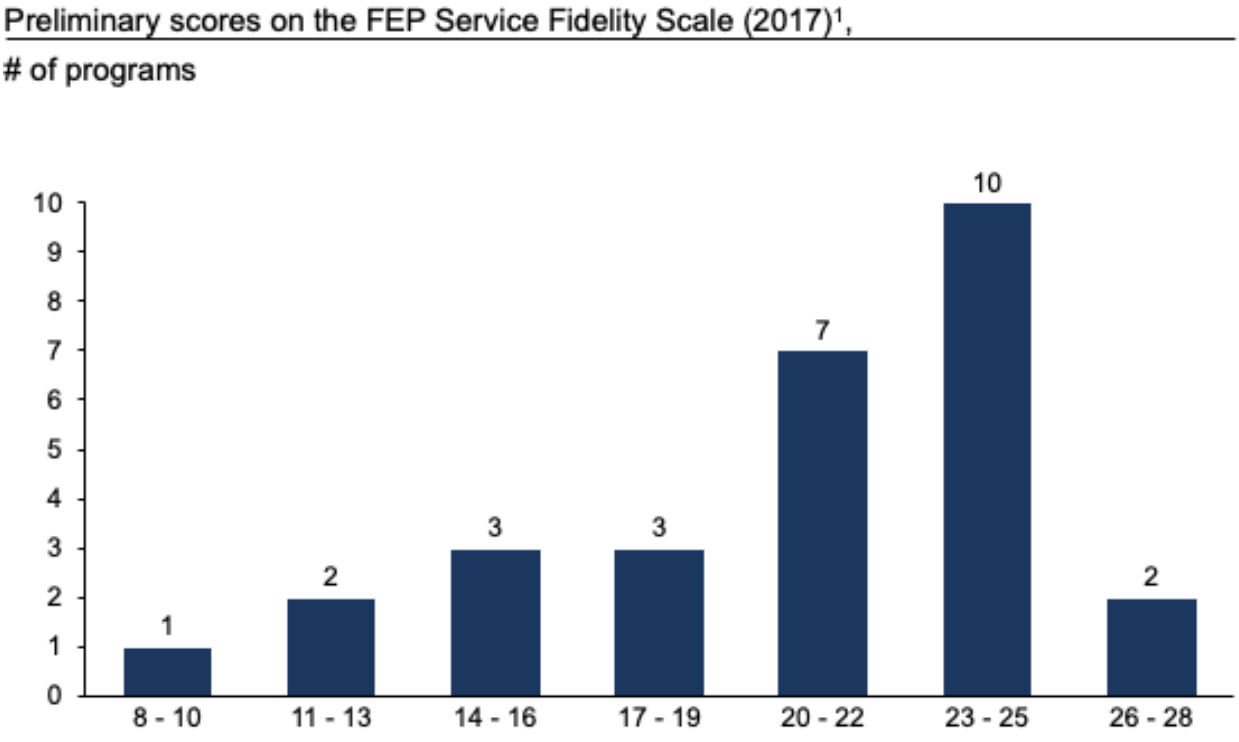


Exhibit 19: California CSC programs vary in fidelity

Sources
The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services, Tara Niendam et al., 2017

Furthermore, **programs also have varied design dimensions,** such as the duration of the care plan, eligibility criteria for care seeking, and data collection and maintenance practices.[124]

Despite variations in care delivery, **a slightly higher percentage of participants in California CSC programs reported general satisfaction** regarding the quality and appropriateness of their programs compared to the national average. According to a SAMHSA survey, 90.9% of participants in California CSC programs reported general satisfaction with care, while the national average was 89.2%.[125]

However, most Californians do not have access to CSC care currently, and other treatment programs may not be meeting the same level of care. Moreover, as CSC programs scale, there will be questions on how to maintain program quality and ensure fidelity.[126]

[124] Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017
[125] SAMHSA, 2022 Unified reporting summary
[126] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

To monitor and improve quality, the National Institute of Mental Health (NIMH) established the EPINET National Data Coordinating Center (ENDCC), with **EPI-CAL serving as California's regional hub for EPINET.**[127] EPI-CAL aims to improve the quality of services and measure the impact of treatment through initiatives such as the Learning Healthcare Network (LHCN), which supports the standardization of practices and knowledge sharing between programs.[128] Additionally, EPI-CAL Training and Technical Assistance (TTA) provides training to support the implementation and sustainability of county-led EPI programs.[129]

Key objectives/goals[130]

The key goals of the plan with regard to quality are to:

- Promote a clearly defined CSC model as the **standard of care for treatment of early psychosis.**
- **Improve fidelity to the CSC model** for EPI programs in California. Set clear standards with tailored approaches integrated, that evolves overtime to address culture, age and geographic needs.
- Continuously improve the CSC model and care delivery to **enhance experience and outcomes** for individuals with early psychosis.

Next steps[131]

MHSOAC proposes the following next steps for consideration:

- Promote a **standard of care for treatment of early psychosis**.
  - **Consider aligning on a single CSC program model** for California and promote **the implementation of all CSC components for EPI,** including non-clinical components (e.g., Supportive Education and Employment)
- Research and pilot standards of care for **step-down services** (e.g., community-based services) to be provided after receiving care from CSC as well as **coordination between CSC programs, primary care providers and other parts of the care continuum for psychosis** (e.g., Full Service Partnerships) to ensure integrated mental health and physical health care for clients to ensure integrated mental health and physical health care for clients
- **Improve fidelity to the CSC model**

[127] EPINET National data coordinating center
[128] EPI-CAL
[129] EPI-CAL TTA Orientation
[130] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[131] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

  - **Align on approach and tools for measuring fidelity**: Identify metrics to measure both fidelity and establish defined targets.
  - **Review EPI programs against fidelity scores**: Review EPI programs against fidelity scores to facilitate targeted interventions for improving adherence to modalities such as Early Diagnosis and Preventative Treatment (EDAPT), PIER, and FELTON; tailor assessments to promote and ensure cultural and contextual appropriateness.

- Continuously improve the CSC model and care delivery to **enhance experience and outcomes** for individuals with early psychosis.
  - **Identify service-user-driven quality metrics** that can assess outcomes (e.g., patient experience, clinical outcomes, and broader ecosystem impact) and establish goals for each metric in collaboration with clients and ecosystem partners. These goals may need to account for various deployment models (e.g., peer-led or virtual) of EPI while promoting shared ownership and accountability.
  - **Consider incentive mechanisms for EPI linked** to fidelity goals, outcome goals, and client experience goals (e.g., align reimbursements to quality outcomes or establish shared savings program to incentivize quality outcomes).
  - **Ensure technical assistance and training programs** to consider the needs of vulnerable places (e.g., hyper-rural, hyper-urban settings) and provide additional resourcing where needed to meet quality standards. Training programs could be connected or established through a **Center of Excellence.**
  - **Examine models of data infrastructure management implemented** in other states (e.g., Massachusetts, Georgia, Nebraska, Tennessee, Oklahoma) to inform metrics and mechanisms that may form the basis of a robust data system for EPI programs in California.

Potential milestones/ progress measures[132]

A few prospective milestones in the process of working toward the quality goals are:

- Establish an evidence-based standard of care and continuous quality improvement strategy through a workgroup of relevant ecosystem partners.
- Collect and review evidence on quality outcomes.
- Identify metrics across dimensions of quality. The Institute of Medicine outlines six dimensions of quality[133] that may be used to inform metrics:

[132] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[133] Institute of Medicine definition cited in Dimensions of Quality in Mental Health Care

  - Effectiveness: providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit
  - Client-centeredness: providing care that is respectful of and responsive to individual client preferences and needs. Ensuring that client values guide all clinical decisions.
  - Timeliness: reducing waits and sometimes harmful delays for both those who receive and those who give care
  - Safety: avoiding injuries to patients from the care that is intended to help them
  - Efficiency: avoiding waste, including waste of equipment, supplies, ideas, energy and human resources
  - Equity: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status
- Build a mechanism to manage, measure, monitor, and improve quality, including:
  - EPI program reporting requirements.
  - Data validation mechanisms.
  - Centralized monitoring capacity (establish quality metric working group).
  - Launch impact tracking with potential metrics such as:
    - Improvements in quality outcomes.
    - Increases in fidelity scores for EPI programs.

5.2.4 Equity

The plan defines equity as ensuring full and equitable access to high-quality early psychosis care resources focusing on vulnerable communities.[134]

Current state of equity for EPI in California

California has established **key definitions and operating bodies** within the health equity space that can serve as the foundation for this plan's equity approach. The California Department of Public Health (CDPH) defines **health equity** as efforts to ensure that all people

[134] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

have full and equal access to opportunities that enable them to lead healthy lives.[135] CDPH established the Office of Health Equity (OHE) to lead efforts focused on reducing health and mental health disparities experienced by **vulnerable communities** in California. According to CDPH, vulnerable communities include but are not limited to racial or ethnic groups; low-income individuals and families; individuals who are incarcerated or have been incarcerated; individuals with disabilities; children, youth, and young adults; seniors; women; immigrants and refugees; individuals who are limited English proficient; and LGBTQ+ communities; or combinations of these populations.[136]

Workforce diversity is also critical for ensuring culturally competent and equitable care. According to the 2021 California Behavioral Health Workforce Assessment, there is cultural and racial diversity in the California behavioral health workforce on aggregate: ~60% of behavioral health workers are people of color, which reflects the diversity of California's population. However, the highest-paid professions in behavioral health—counselors, psychologists, physicians, and psychiatrists—are disproportionately white. Additionally, while approximately one-third of physicians in the state speak Spanish, that statistic does not necessarily indicate that client language needs are being met.[137]

Within behavioral health care, California has driven efforts aimed at **identifying and addressing health disparities.** In 2015, CDPH published the "California Statewide Plan to Promote Health and Mental Health Equity" which included demographic analyses of mental health disparities and a discussion on the root causes and consequences of state health inequities.[138] In 2017, Assembly Bill 470 led the Department of Health Care Services (DHCS) to improve reporting for specialty mental health services at the county and statewide levels.[139] As a result, DHCS now provides publicly available data on disparities in mental health utilization, access, and outcomes.[140]

Several **initiatives are underway to advance equity** in mental health care access and delivery. The Community Mental Health Equity Project (CMHEP) is a cross-departmental effort focused on reducing disparities in behavioral health care through allocating grants to community organizations.[141] Another effort is the California Reducing Disparities Project, which CDPH founded in 2009 to address mental health equity for key population groups.[142]

From a **regulatory and oversight standpoint,** AB 133 authorized the Department of Managed Health Care (DMHC) to establish health equity and quality measures for behavioral

[135] California Department of Public Health Office of Health Equity
[136] California Department of Public Health Office of Health Equity
[137] CDPH Demographic Report on Health and Mental Health Equity in California
[138] CDPH Portrait of Promise: the California Statewide Plan to Promote Health and Mental Health Equity
[139] CPEHN, Existing Disparities in California's system of specialty mental health care, May 2019
[140] DHCS Adults Age 21 and Over Mental Health Services Demographic Dashboards (AB470)
[141] DHCS, Community mental health equity project
[142] The California Reducing Disparities Project

health plans to address long-standing health inequities and ensure the equitable delivery of high-quality health care services.[143] On the county level, DHCS has oversight and monitoring responsibilities of county Mental Health Plans' cultural competence and quality improvement programs.[144]

There is limited historical data on equity in EPI programs, however, experts report similar equity trends to what is seen in California's Behavioral Health system more broadly. In terms of access, experts note specific populations that are accessing EPI services less frequently, potentially due to cultural or language barriers. Additionally, many California leaders have stressed the importance of improving cultural competency and workforce diversity to better meet the needs of vulnerable populations.[145]

Key objectives/goals[146]

In order to fulfill the vision of this plan with regard to equity, key goals of the plan are:

- **Reduce barriers** to receiving appropriate and timely care for vulnerable populations by **co-designing EPI programs with communities** to ensure culturally competent, contextually appropriate, and holistic solutions for individuals with early psychosis and their families.
- **Improve tracking and establish measurable goals around equity metrics.**
- Address the needs of California's diverse population by **developing a more diverse healthcare** workforce.

Next steps[147]

MHSOAC proposes the following next steps for consideration:

- **Reduce barriers to access:**
  - Assess key barriers to access for vulnerable communities (e.g., trust in institutions, concerns of confidentiality) through direct engagement and partnership.
  - Identify trusted community partners to co-create solutions to access barriers (e.g., churches, schools, community colleges)[148]

[143] 2022 Health equity and quality committee recommendations report
[144] CDPH Community Mental Health Project
[145] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[146] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[147] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[148] Program for residency, community engagement and peer support training (PRECEPT) Connecting Psychiatrists to Community Resources in Harlem, NYC

  - Invest additional funding for awareness efforts designed for vulnerable populations in partnership with community organizations.
  - Build out specialized care options for individual population groups as needed (e.g., children and youth)
  - Address realized or perceived gaps in funding for EPI services, particularly among those who are low-income and/or uninsured
  - Partner with community organizations to ensure cultural competency is central to CSC model design and delivery.
  - Explore public-private partnerships that facilitate equitable access
- **Track and set measurable goals around equity metrics:**
  - Collaborate with communities to set measurable equity goals (e.g., parity in access and outcome metrics, increases in the percentage of vulnerable communities with access)
  - Establish data collection and analysis approaches that can inform decision-making in partnerships with community coalitions.

Potential milestones/ progress measures[149]

Prospective milestones in the State's process of working towards EPI equity goals could include:

- Align on a definition for equity in the context of scaling early psychosis care in California.
- Create a working group to identify priority populations and asses the key barriers (e.g., linguistic barriers, lack of trust).
- Review and evaluate community partnership models.
- Determine community organizations for potential partnerships.
- Establish platforms and processes to strategically partner with diverse and traditionally underserved population groups.
- Set up structures to continuously assess and iterate on equity strategies.

[149] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

5.3 Foundational Levers

To achieve the strategic objectives of improved awareness and access to high-quality early psychosis care with a focus on equity the following building blocks need to be in place.

5.3.1 Sustainable Funding

The plan defines sustainable funding as the 'scaling strategy' and fiscal model to ensure high-quality, timely access to early psychosis care regardless of insurance type[150].

Current state of funding

Government funds are the most common source of CSC-FEP funding, with each source typically funding specific components of care. Some of the key funding sources in California are listed below:

	Funding sources	Current State
Programmatic funding	**Federal**	• **MHBG** Grant and 10% set aside funding for FEP[1]
	State and county	• Assembly Bill 1315 established the EPI Plus program[3] • The Budget Act of 2019 provided MHSOAC with $19.5M in one time MHSA funds to support expansion of programs[4] • Prop 1 authorized $6.38 billion in bonds to build mental health treatment facilities for those with mental health and substance use challenges and for providing housing for the homeless[5] • In Feb 2020 MHSOAC approved allocation of $15.6M to support existing programs and $3.9M to contract UC Davis to provide training and technical assistance to grantees; awarded 5 EPI Plus program grants totaling $10M, $1M for public awareness and increasing workforce development and retention, $600K for research on early barriers to accessing care[4] • **DHCS** in partnership with MHSOAC awarded $67M to 99 organizations across 30 counties to expand EPI programs funded through CYBHI in March 2024[6]
	Other sources (e.g., foundations)	18% programs receive philanthropic funding[7]
Service-based reimbursement	**Medicaid**	• Centers for Medicare and Medicaid Services approved new billing codes enabling Medicaid to cover previously non-reimbursable CSC components such as peer support • 43% of programs accepts Medi-Cal[7] • Experts estimate receiving only 30-40% compensation for CSC service costs[8]
	Private insurance	• Only 21% program accept private insurance coverage[8] • Pilot program with small cohorts of commercially insured populations are underway with Kaiser Permanente Northern California patients[8]

Exhibit 20: Programmatic funding and service-based reimbursement sources for CSC

Sources
1. SAMHSA, "Coordinated Specialty Care for FEP: Costs and Financing Strategies," Aug. 2023, 2. EPINET 3. EPI Plus, 4. MHSOAC 5. Prop 1 6. DHCS, 7 CEPAS 8. Hirschtritt et al mention commercially insured population is excluded from coverage through Medical and eligibility criteria could have more room for evolution.

[150] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

A few barriers regarding funding for early psychosis care are:

- Design challenges across the healthcare system billing processes that may be focused on covering services by clinical providers and not the other components of EPI interventions such as education and housing supports[151]
- Most **commercial health plans do not provide coverage for several CSC components,** for example Supported Education and Employment or case management and peer support, only reimbursing direct clinical care[152]
- **Perceived lack of incentives** for commercial plans to invest in early intervention as individuals may not remain on the same plan for several years[153].
- **Opportunity for improving the authorization process** to EPI programs to increase claims approval rates: Since the Coordinated Specialty Care programs are often out of network for commercial health plans, there may be instances where patients with commercial insurance seek care from programs not contracted with plans without authorization from plans, leading to claims denials.[154]
- **County-led CSC programs** face challenges in navigating the funding system.
  - Many county-led EPI programs may have challenges navigating complex **billing processes** to receive appropriate payment for reimbursable services from Medi-Cal with insufficient technical assistance to address these challenges[155]
  - **Competing priorities and budget constraints among counties** that are trying to navigate budget challenges, build residential facilities, and plan for upcoming changes related to SB43[156].

These funding challenges have an impact on care delivery:

- **Discontinuity of care** for individuals on commercial plans – in addition to challenges getting authorization for the CSC programs, when individuals change or lose insurance coverage, there is a disruption in care delivery that may impact patient outcomes[157.]

[151] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[152] Powell et. al. Implementing Coordinated Specialty Care for First Episode Psychosis: A Review of Barriers and Solutions (2020)
[153] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[154] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[155] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[156] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[157] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

- **Inability to access all components of CSC:** Reportedly, seven county-run programs in California have not adopted the peer-support service component in their treatment. Experts believe that challenges in achieving coverage for providing these services from health plans are potentially one reason why the adoption and provision of this CSC component are not uniform for all counties.[159]

To address financial barriers in accessing CSC care, the Centers for Medicare and Medicaid Services (CMS) introduced two billing codes specifically for CSC in 2023. These codes aim to streamline billing processes and ensure reimbursement for a broader range of CSC services. By allowing programs to bill for team-based care rather than individual services, the new codes will enhance financial viability, improve service coverage, and encourage innovation within CSC programs.
However, while the introduction of team-based billing codes represents a significant step forward for CSC funding, further actions are needed to address remaining barriers and ensure equitable access to high-quality early psychosis care. [158]

Key objectives/goals[160]

This plan lays out the following goals with regard to sustainable funding:

- Coverage for EPI services: Refine reimbursement models and rates to fully cover the cost of EPI for Californians with early psychosis regardless of insurance coverage.
- Funding for scaling to 90% access: Quantify and secure funding required to scale high-quality and equitable access to EPI.
- Innovative funding models to address future demand: Incentivize public and private investments in setting up and delivering EPI to meet future demand.

Next steps[161]

MHSOAC proposes the following next steps for consideration:

- **Establish approaches for covering the cost of care:**
  - Examine the barriers to accepting Med-Cal reimbursement by EPI service providers[162]

[158] Reimbursement for a broader array of services in CSC for early Psychosis (Matthew et. Al.)
[159] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[160] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[161] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[162] DHCS

- Identify the key billing challenges like the multiplicity of HCPCS billing codes and draft the steps needed to transition from a fee-for-service payment model[163]
- Develop an approach for providing information to commercial plans about individuals seeking treatment for early psychosis to validate insurance status sooner and fast-tracking authorization, where appropriate.
- Design and deploy additional training to support EPI program administrators in navigating billing and reimbursements.

- **Secure funding for scaling to 90% access:**
  - Conduct landscape analysis of reliable funding streams in partnerships with departments/agencies with an interest in expanded access to EPI.
  - Explore using a regional fund allocation while piloting the hub and spoke and regional care models (described in Chapter 4.3.4) to better resource areas with low population density.
  - Consider allocating EPI funding at the state level instead of the county level, similar to the California Children's Services Program[164] to explore the impact of improved participation in CSC model of care.
  - Explore learnings from other states, including Illinois, which required coverage of some components of CSC by all insurers[165].
  - Collaborate with other programs with aligned objectives (e.g., CalAIM[166] Care Court[167], BH-CONNECT[168], BHSA[169]) to design and fund key initiatives to enhance coordination and optimize funding allocated to each program.
- **Identify innovative funding models:**
  - Investigate incentive models to encourage private investment in programmatic funding for EPI programs such as bundled rates for team-based care and collaboration with private insurance providers to improve the commercial viability of private investment in CSC care.
  - Explore enhancing network adequacy standards for EPI to better address network needs to deliver high-quality EPI services and incentivize improved coverage from commercial health plans.

[163] Hirschitritt et al, Reimbursement for a Broader Array of Services in Coordinated Specialty Care for Early Psychosis, March 2024
[164] California's Children Services Program
[165] SAMHSA Coordinated Specialty Care for First Episode Psychosis: Cost and Financing Strategies
[166] California Health Care Foundation: CalAIM in Focus
[167] Fact Sheet: CARE Court
[168] BH-CONNECT
[169] BHSA

- Identify and evaluate the impact of initiatives (e.g., patient assistance programs/ drug costs, co-pay assistance to reduce out-of-pocket expenses) on the total affordability of EPI service.

Potential milestones/ progress measures[170]

To achieve 100% coverage for all components of CSC through service-based reimbursement and improve the proportion of programmatic funds used for enhancing infrastructure, therefore reducing the proportion used for subsidizing service delivery, California may need to **develop workgroups** to identify critical barriers and develop consensus amongst key funding partners on potential next steps in addressing them to achieve the following milestones:

- **Align on needs and sources:**
  - Estimate funding needs for programmatic and service-based reimbursement.
  - Identify funding sources across federal, state, county, and philanthropic entities.
  - Convene key funding partners to align on funding allocations for EPI.
- **Identify challenges in service-based reimbursements:**
  - Identify key challenges to the reimbursement model.
  - Establish workgroups to refine the reimbursement model and address challenges.
- **Implement solutions:**
  - Secure and disperse programmatic funding.
  - Design and implement initiatives to improve the reimbursement model.
- **Track impact:** Potential metrics include:
  - % of programs that accept Medi-Cal and commercial insurance
  - % of CSC care delivery cost covered by claims-based reimbursement

[170] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

5.3.2 Workforce Supply & Capabilities

Achieving the objectives outlined in the EPI strategic plan requires sufficient capacity of staff trained in evidence-based care for individuals experiencing early psychosis. MHSOAC believes it is critical to approach workforce considerations through the lens of reducing disparities in access across populations and regions.[171]

Current state of Workforce Supply & Capabilities in California

Throughout California, there are workforce shortages across behavioral health roles (e.g., case managers, physicians, psychiatrists, psychologists, nurses, community workers, and peer & family support members). For EPI specifically, experts report significant gaps in the availability of trained clinicians and prescribers, particularly child psychiatrists.[172] Workforce deficits vary by region. For example, while the California-wide average is 11.0 psychiatrists, the Greater Bay area has 16.7 psychiatrists per 100k population compared to San Joaquin Valley, which has 5.2 per 100k population. There are also workforce disparities based on race: Black and Latino Californians are underrepresented among psychiatrists and psychologists relative to the general population, and Latinos are also underrepresented among counselors and clinical social workers (discussed in more detail in section 4.2.4 on Equity).[173]

Workforce deficits in behavioral health are projected to continue. According to research from UCSF, if current trends persist, in 2028, California will have **50% fewer psychiatrists and 28% fewer psychologists, LMFTs, LPCCs, and LCSWs combined** than will be needed to meet population needs.[174]

Growing workforce constraints and disparities within EPI and behavioral healthcare more broadly may be attributed to several potential drivers.

One such driver within the behavioral health field is the age distribution of providers: ~40% of psychiatrists and psychologists in the state are **over 60 years old and are likely to retire or reduce working hours in the next decade**.[175]

Additionally, California may not be realizing the full potential of **peer specialists and team leads within the state.**[176] Centers for Medicare & Medicaid Services (CMS) instructs that "peer support providers must complete training and certification as defined by the State" without dictating any further guidance or stipulations regarding peer certification.[177] SAMHSA's National Model Standards for Peer Support Certification recommend that "in lieu of any

[171] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[172] Based on input from Tara Niendam, Executive Director, UC Davis Early Psychosis Programs (EDAPT and SacEDAPT Clinics)
[173] Healthcare Center at UCSF: An Overview of California's Behavioral Health Workforce Presentation (2022)
[174] Coffman et al, Research Report on California's Current and Future Behavioral Health Workforce (2018)
[175] Healthcare Center at UCSF: California's Current and Future Behavioral Health Workforce (2018)
[176] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[177] CMS Center for Medicaid and State Operations SMDL#07-011, August 15, 2007

formal educational requirements, prospective certified peer workers should be able to demonstrate literacy and fluency in the language in which they will be providing services, either through required examinations or other application requirements."[178] However, in California, Medi-Cal Peer Support Specialists must have a high school diploma, GED, or equivalent degree for certification.[179] This may limit the pool of individuals who are eligible to apply for peer support provider certifications and may impose additional recruitment barriers for some individuals, including those from marginalized communities.[180]

An additional recruitment challenge for expanding the peer workforce is **funding constraints** from both public and private insurance to reimburse peer-led support services (discussed in detail in 4.3.1).[181]

Outside of recruiting difficulties, there are also challenges with workforce retention. Behavioral health professionals may experience burnout and high turnover rates due to the demanding nature of the work and limited resources.[182] In the case of CSC, experts report that challenges retaining the workforce are exacerbated by few clinicians trained to deliver CSC care, which results in high case volumes for those trained. These workforce constraints may have an impact on care delivery. Many EPI programs utilize **telehealth or rely more heavily on nurses or physician assistants** for elements of care delivery. Additionally, to serve diverse communities in their preferred languages, some providers may rely on **interpreting services** to enable care for individuals in languages other than English.[183]

CSC programs are largely funded and run by the public sector and face further challenges in addition to those impacting the broader behavioral health landscape:

- Funding models have historically not reimbursed for some components of the CSC model (e.g., community outreach and education) or only partially reimbursed.[184] This may lead to limitations for CSC providers in reliably retaining their workforce.[185]
- In the **public sector for behavioral health services**, wages may not be competitive with private sector alternatives, which can impact the number of available workers at all skill levels including **master's and PhD level practitioners**.[186]

Another aspect of the workforce is **training & skill development.** The number of EPI programs in California with staff trained specifically in CSC components is 35% lower than the

[178] SAMHSA's National Model Standards for Peer Support Certification, 2023
[179] California Department of Health Services "Medi-Cal Peer Support Services Specialist Program - Frequently Asked Questions"
[180] SAMHSA's National Model Standards for Peer Support Certification, 2023
[181] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[182] SAMSHA: Addressing Burnout in the Behavioral Health Workforce Through Organizational Strategies
[183] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[184] Powell et. al. Implementing Coordinated Specialty Care for First Episode Psychosis: A Review of Barriers and Solutions (2020);
[185] Meadows Mental Health Policy Institute, 2020; Powell et al., 2021
[186] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

national average (CA: 50%, US: 85%).[187] Additionally, there are an insufficient number of mental health providers that have the combined specialized competencies needed for CSC, creating a significant training burden on CSC program leaders.[188] Moreover, specialized education in EPI is often less accessible within counseling and social work disciplines.[189]

California is making significant investments to bridge behavioral health workforce supply gaps and build capabilities.[190] In 2019, the Office of Statewide Health Planning and Development launched a five-year plan for growing and training the behavioral health workforce.[191] Building on its progress, in 2023, California announced it is investing $5.1B and proposing an additional $2.4B investment through reforms to the Mental Health Services Act to train and support 65,000 health care workers over the next five years.[192] **Specifically for EPI programs**, MHSOAC invested $1M in 2020-21 in workforce development and retention efforts. In 2020, MHSOAC also awarded $3.9M to the University of California, Davis, the leaders of EPI-CAL, to provide training and technical assistance to CSC programs across four years.[193]

Key objectives/goals

The workforce objectives of the EPI strategic plan are:[194]

- **Increase interest in and prestige of early psychosis intervention careers** to expand workforce timeline
- **Increase supply:** Recruit new individuals into the EPI workforce to achieve 90% access to CSC services for all Californians and align incentives to reduce attrition of clinicians (for all specialists and non-specialists) in CSC programs.
- **Enable more efficient use of existing workforce:** Efficiently deploy existing workforce to ensure optimized use of their capacity to ensure deployment of all components of CSC.
- **Improve capabilities across the workforce:** Ensure availability of CSC-specific state-wide training programs to meet or exceed the national average level of 85% of staff trained specifically in CSC components (as compared to the current 50% for California)

[187] California 2022 Uniform Reporting System Mental Health Data Report SAMHSA
[188] Pollard, J. M., & Hoge, M. A. (2017). Workforce development in coordinated specialty care programs. National Association of State Mental Health Program Directors, Confronting the Dialectic Between Quality and Access in Early Psychosis Care in the United States: Finding the Synthesis by Leveraging Psychological Expertise, Wood et. al., 2023
[189] Kourgiantakis, T., Sewell, K. M., McNeil, S., Lee, E., Logan, J., Kuehl, D., McCormick, M., Adamson, K., & Kirvan, A. (2022). Social work education and training in mental health, addictions, and suicide: A scoping review; Confronting the Dialectic Between Quality and Access in Early Psychosis Care in the United States: Finding the Synthesis by Leveraging Psychological Expertise, Wood et. al., 2023
[190] Workforce for a Healthy California
[191] OSHPD 2020-2025 Mental Health Services Act Workforce Education and Training Five-Year Plan
[192] CA MH Movement
[193] MHSOAC Investments
[194] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

- **Optimize use of available funding sources** (e.g., Prop 1) for workforce education and recruitment
- **Measure and monitor workforce supply and demand** to identify and address critical capacity constraints

Next steps[195]

MHSOAC proposes the following next steps for consideration:

Supply of diverse workforce:

- **Conduct landscape assessment** of demand for EPI workforce capacity and potential supply sources from educational institutions; identify where additional support to expand supply is needed. Identify programs and schools for expanding recruitment efforts and roles to extend the capacity of the current workforce.
- **Increase recruitment efforts to attract** the needed workforce based on capacity and capability requirements (e.g., explore new recruitment channels, revamp compensation and benefits, set up job fairs and other career events to promote EPI program opportunities, establish deeper partnerships with training programs and academic institutions, recruit from non-traditional sources, provide incentives for working in EPI).
- **Identify solutions to optimize the efficiency of the current workforce** and enhance their capacity to provide CSC (e.g., implement flexible staffing models to allow for redistribution of resources based on fluctuating demand; expand the use of mobile outreach teams to provide EPI services to different locations; implement task-shifting models to help with detection, referral, and providing basic services).
- Develop incentives for graduate programs and other learning institutions to **partner with CSC programs** to pair students with job opportunities.
- **Expand peer-led workforce:**
  - **Consider** broadening **eligibility criteria for peer support specialist certifications** to expand the pipeline of potential providers.
  - **Recruit CSC graduates** to train as peer support specialists.
  - **Consider** broadening **eligibility criteria for peer support specialist certifications** to expand the pipeline of potential providers.
  - **Provide additional training on CSC model delivery** for individuals with lived experience and their communities.

[195] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

- **Grow pipeline of diverse future workforce:**
  - Increase funding for stipends and scholarships for students in behavioral health professions, social services, education or other related fields.
  - Increase funding for stipends and scholarships for students in behavioral health professions, social services, education or other related fields.
  - Increase funding for postbaccalaureate programs that focus on medical school reapplicants from underserved communities.
  - Increase psychiatry resident positions.
  - Recruit and train students from underserved areas to practice in community health centers in their home regions.
  - Expand rotations for social work, education degrees in organizations engaged in EPI services
- **Develop a more diverse workforce:**
  - Launch workforce training and development efforts within vulnerable communities (e.g., in collaboration with community colleges)
  - Identify programming for EPI workforce development, retention, and promotion to increase diversity.
  - Develop strategies to engage peers in the EPI workforce (e.g., engaging CSC graduates as peer specialists)[196]

Explore options to improve total compensation to address pay parity gaps and retain providers (e.g., funding to support EPI workforce costs, loan repayment benefits, improved healthcare coverage for employees and their families, programs to support burnout prevention, continuing education stipends).

Launch workforce training and development efforts within vulnerable communities (e.g., in collaboration with community colleges)

Capabilities/training & development:

- **Explore options to improve total compensation to address pay parity gaps** and retain providers (e.g., funding to support EPI workforce costs, loan repayment benefits, improved healthcare coverage for employees and their families, programs to support burnout prevention, continuing education stipends).

[196] Oluwoye et al, Study protocol for a multi-level cross-sectional study on the equitable reach and implementation of coordinated specialty care for early psychosis, Aug 2023

- **Partner with professional schools** to enhance curriculums for specialist and non-specialist providers in recognizing early psychosis and referring individuals to appropriate care.
- **Create a central repository for CSC curricula**, including on-the-job training and essential competencies for health professionals as well as other service provides such as social-workers, employment specialists.[197]
- **Increase and promote opportunities for future clinicians to engage in behavioral health, specifically CSC programs** (e.g., psychiatric rotations, clinical psychology internships, externships to enhance training (e.g., through grant funding, scholarships).
    - Launch workforce training and development efforts within vulnerable communities (e.g., in collaboration with community colleges)

Highlight career pathways within EPI for non-clinical roles (e.g., education specialists, social workers, peer counsellors) during education and trainings for these professions

Potential milestones/progress measures[198]

- Establish a workforce and capabilities workgroup to conduct analysis, develop and roll out a recruitment strategy based on the findings.
- Conduct a current state demand and supply assessment of EPI workforce, including analysis by region and expertise/role.
- Identify key drivers of attrition and develop a plan to address prioritized drivers.
- Identify workforce diversity needs and integrate findings into a recruiting strategy.
- Design and implement the recruitment strategy and roll-out plan.
- Develop training programs for upskilling the existing workforce and training new professionals.
- Establish KPIs to measure progress on workforce supply and capabilities and the efficiency of training programs (e.g., workforce supply and demand by region, by role, and through the lens of workforce diversity; number of appointments via telehealth vs. in person; number of family and peer partners for each region/community; performance, morale, and satisfaction before and after training programs; performance against benchmarks of standard of care).

[197] Confronting the Dialectic Between Quality and Access in Early Psychosis Care in the United States: Finding the Synthesis by Leveraging Psychological Expertise, Wood et. al., 2023

[198] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

- Implement continuous monitoring mechanisms to improve workforce supply and capabilities.

5.3.3 Accountability

This plan defines accountability as the approach to establishing or utilizing governance structures to enable responsibility and ownership, measure progress for access, cost, quality, and other related outcomes, and establish ongoing improvement processes through research initiatives.[199]

Current state of Accountability for EPI in California

Accountability structures for CSC programs are closely tied to funding sources for the various county and commercial EPI programs. County-run EPI programs are established using funds received from both state, federal and grant sources and commercial EPI programs are primarily supported through research grants, as described in Chapter 4.3.1 Sustainable Funding.

Counties generally have some discretion in the allocation of funds for mental health services[200]. Counties do not have to establish an EPI program with funding received but may utilize it for other needs[201]. As of 2017, 38% of counties do not have an EPI program.[202] Additionally, there are **challenges in coordination among different counties in delivering and funding EPI care.** County EPI Programs are able to serve individuals within their county utilizing funding dispersed via County Departments of Behavioral Health (DBH). While some counties may have reciprocity systems in place to serve individuals across counties, many individuals who seek care in counties that differ from that for which they enroll in Medi-Cal have challenges accessing EPI. This could potentially add a barrier to access to care for some individuals who are moving across counties (e.g., for education), are housed in a state child welfare system, or are in a juvenile system in a different county[203].

The counties that have EPI programs **may have different contractual obligations that may impact their approach to deploying EP**I. There are variations in contractual requirements for EPI providers contracted with DBH. For example, some programs are required to measure

[199] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[200] Example sources: Funding for Medi-Cal Mental Health Services, Mental Health Block Grant
[201] Discussions between MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group
[202] Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017
[203] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

and track the fidelity of the program, while others may not be.[204] There are limited mandatory contract components which may pose challenges to ensuring EPI programs are accountable to delivering care aligned to set standards.[205]

Both county and commercial EPI programs lack robust data-gathering mechanisms, limiting the ability to identify opportunities for improvement.[206] This is further elaborated in Infrastructure, Chapter 4.3.4.

MHSOAC's strategic plan (2024-2027)[207] includes a goal to develop a behavioral health index that will track and promote key indicators of behavioral health by county, with benchmarks from peer counties, peer states, and nations to compare with California and its counties. Additionally, California launched the **Learning Healthcare Network initiative,** for which one of the goals is to utilize a collaborative statewide evaluation to examine the impact of LHCN[208] on EPI care network and evaluate the effect of EPI programs on the consumer- and program-level outcomes.

The **Behavioral Health Services Act (BHSA),** which replaced the 2004 Mental Health Services Act, enhances oversight, transparency, and accountability at both state and local levels. The Act also creates pathways to ensure equitable access to care, advancing equity and reducing disparities for those with behavioral health needs.[209] BHSA requires that counties "establish and administer an early intervention program that is designed to prevent mental illnesses and substance use disorders from becoming severe and disabling and to reduce disparities in behavioral health." The early intervention programs should include, among other criteria, "access and linkage to care includes the scaling of, and referral to, the Early Psychosis Intervention (EPI) Plus Program […] Coordinated Specialty Care, or other similar evidence-based practices and community-defined evidence practices for early psychosis and mood disorder detection and intervention programs[210]

Key objectives/goals[211]

- **Establish governance structure & mechanism** to define roles and responsibilities in expanding access to EPI and develop accountability mechanism for all ecosystem partners.
- **Develop a monitoring & evaluation framework** to track progress against goals with KPIs that provide insight into client experience and impact across various ecosystem

[204] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[205] Discussions between MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group
[206] Discussions between MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group
[207] MHSOAC Strategic Plan
[208]
\hLearning Healthcare Network
[209] Behavioral Health Services Act - DHCS
[210] Cal. Welf. and Inst. Code § 5840
[211] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

partners and develop reporting mechanisms to communicate progress to all ecosystem partners.

- **Establish an ongoing improvement process** that utilizes learnings to identify development opportunities in EPI program design and delivery.

Next steps[212]

MHSOAC proposes the following next steps for consideration:

Governance structure & mechanism

- Align on which organization(s) will be responsible for refining and implementing the EPI strategic plan.
- Establish the purview of the leadership team(s) and their authority to design and implement the strategic plan with key partners.
- Identify existing efforts in California aligned with the strategic plan and align on partnership approaches where feasible.
- Convene ecosystem partners to determine which groups will lead each of the initiatives.
- Design incentive models and accountability structures for each implementation partner and implement infrastructure or legislative changes to ensure accountability.
- Develop mechanisms to incentivize all counties to establish or partner with existing EPI programs.
- Identify and develop mechanisms to ensure care across counties for those who need care (e.g., additional reciprocity relationships between counties)

Monitoring & evaluation framework

- Develop a process for gathering and reporting on metrics to assess implementation progress, building on the learning healthcare network [213]
- Establish KPIs to measure the impact of expanded EPI access for clients and ecosystem partners.

[212] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[213] Learning Healthcare Network

Ongoing improvement

- Develop a process to gather learnings (including insights from people with lived experience, academic research, and data) and refine program design and implementation.

Potential milestones/ progress measures[214]

To ensure accountability goals are met, the potential milestones may include:

- Identify existing accountability, monitoring & evaluation, and process improvement initiatives for early psychosis intervention.
- Identify the leadership team to implement the EPI strategic plan.
- Implement accountability initiatives.
- Establish monitoring, evaluation, and reporting framework to assess implementation progress.
- Develop and implement a process for gathering and reporting on progress metrics.

5.3.4 Infrastructure

Infrastructure is defined as the availability of facilities and technology to provide care that is accessible, equitable, and effective, including the use of telehealth where appropriate.[215]

Current state of infrastructure

California has invested in both physical and digital infrastructure for EPI.

The **physical infrastructure** includes the facilities and resources necessary for the provision of EPI services (e.g., physical clinics for providing CSC components and screening services). Currently, the availability of EPI **programs per capita** in California is trailing the national average (1 program for every **907K** Californians compared to 1 program for every **879K** residents in the US).[216] The availability of EPI facilities **varies across the counties:** 41% of counties having an active EPI program, 21% of counties are in the process of developing an

[214] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[215] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[216] Programs per capita is derived by dividing the CA population as per census, by number of programs as per EPICAL. CA has ~43 programs for a population of 38.9M; US has 381 programs for a population of 334.9M

EPI program, and 38% have no EPI programs (described further in Chapter 4.2.2).[217] Some of the rural and low-density counties cite challenges relating to low incidence rates and challenges in finding sufficiently qualified local service providers as barriers to setting up their own EPI programs.[218]

There are also physical infrastructure considerations beyond EPI programs across different levels of care. California has invested in infrastructure to support **care across the continuum of psychosis**, ranging from drop-in facilities for youth (e.g., allcove®)[219] to a buildout of crisis infrastructure through the Behavioral Health Continuum Infrastructure Program.[220]

Digital infrastructure is the technical foundation and systems that support the delivery of services. Digital infrastructure also involves the management of data, including the hardware, software, networks, and protocols, to enable the secure and efficient exchange of information between care providers, clients, payors, and other ecosystem partners. Examples of digital infrastructure include technology that enables the delivery of CSC service components like case management, technology that enhances access using telehealth, electronic health records (EHR) platforms, and centralized data systems and tools for measuring key metrics for scaling EPI programs.[221]

One key aspect of digital infrastructure is the health information and billing system. There is currently no unified approach across counties to managing **medical records and billing.** Additionally, there is limited interoperability between county programs and health plans that limits the ability of some programs to bill for CSC services and consequently limits reimbursement,[222] as discussed in Chapter 4.3.1.

Digital infrastructure may also be used to inform individual and provider-level decision making. Currently, EPI-CAL uses an EPI-focused **technology platform (mHealth)** to collect core client outcomes and metrics of data use. Data insights from this platform are available to clients and their physicians across 30 programs to support care decisions; the platform is also available in 13 languages.[223] EPI-CAL also utilizes **Beehive**, which is a data collection and visualization software platform that incorporates information about a client's recovery and wellness into their mental health care.[224]

On a systems level, there are opportunities to strengthen **data infrastructure in support of scaling EPI.** There is currently no centralized method for tracking system capacity (e.g., open

[217] Tara Niendam et al., The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017
[218] Interview with Executive Director of EPICAL, 2nd May 2024
[219] MHSOAC: allcove® Youth Drop-In Centers
[220] DCHS: Behavioral Health Continuum Infrastructure Program
[221] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[222] Interview with Executive Director of EPI-CAL, 17th April 2024
[223] EPI-CAL
[224] EPI-CAL Beehive

workforce positions, number of programs, number of clients) or metrics to assess network strength and integrity (e.g., wait times for clinic availability, the average duration of untreated psychosis). Related systems are currently managed through individual record-keeping such as excel spreadsheets.[225]

There are also opportunities to improve the digital infrastructure to facilitate **care coordination**. While there is a national database for locating care for serious mental illness,[226] the state may consider creating a publicly available state-wide EPI coordination system for accessing CSC programs and other resources.[227]

Experts point out that select vulnerable places and communities may require improved digital ecosystem readiness as a foundation for specialized EPI digital infrastructure. This includes reliable broadband, population-level digital literacy, access to suitable devices for engaging with telehealth, and digital support accessing information management systems. There may also be challenges in building capabilities for new technology adoption.[228]

Draft key objectives/goals[229]

Design and build the infrastructure needed for **delivering affordable, appropriate care to 90%** of individuals who need it with a focus on ensuring equity and a high standard of care.

Next steps[230]

MHSOAC proposes the following next steps for consideration:

- **Explore and scale multiple archetypes of care deployment models** to improve access to care in alignment with workforce improvement strategies (Chapter 4.3.3):
  - **Increase the number of EPI programs:** EPICAL estimates the need for 277 EPI care centers to cater to the annual incidence of early psychosis in California each year. A few potential steps towards achieving this target may be:
    - Identifying areas with the greatest gaps in the supply of EPI services based on community demand and prioritizing a list of locations for standing up EPI programs.
    - Designing a phased plan to develop facilities and provide resourcing in the form of equipment and service providers.

[225] Interview with Executive Director of EPI-CAL, 17th April 2024
[226] SAMHSA SMI care program locator
[227] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[228] Interview with Director Mental Health Strategic Impact Initiative, 30th April 2024
[229] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[230] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

  - **Explore new formats of extending EPI:** Collaborate with partners to understand local strengths and needs to meet demand in the context of the CSC approach; explore innovative partnerships for CSC (e.g., Hub and spoke model, multi-county collaborative or regional mobile care delivery models).
  - Identify **digital capabilities** required for expanding telehealth, omnichannel care delivery, tailored mobile applications and remote monitoring.
  - Estimate resource needs at the program and provider level relating to digital and physical infrastructure.
- **Identify resources for infrastructure development:**
  - **Establish partnerships** with other healthcare providers, supportive housing providers, community organizations, or academic institutions to accelerate infrastructure development & deployment.
  - **Explore solutions for improving interoperability of medical records and billing modules** for EPI programs specifically and mental health services broadly; this could involve building on national efforts such as the SAMSHA Behavioral Health Information Technology Initiative that is investing more than $20M over the next three years to advance interoperable exchange of behavioral health data across the care continuum.[231]
  - **Identify technical support** and funding to transition EPI programs to the same medical records and billing systems.
- **Improve care coordination and access:**
  - Develop a publicly available resource that identifies EPI programming across the state to help individuals select potential programs in their area.
- **Training for effective use of technology and digital infrastructure:**
  - Conduct needs assessments to identify training gaps in technology and digital infrastructure.
  - Collaborate with technology experts to design tailored training programs.
  - Ensure accessibility of training programs for all ecosystem partners
  - Provide digital literacy training in underserved communities.
  - Establish monitoring and evaluation mechanisms for progress tracking and refinement.

[231] SAMHSA Behavioral Health Information Technology Initiative, Feb 2024

- Draft milestones/ progress measures[232]
- Establish working groups to design and implement infrastructure initiatives.
- Identify digital and physical infrastructure gaps for the state and each county.
- Complete an infrastructure development plan and identify resource requirements.
- Identify and contact infrastructure partners.
- Deploy infrastructure development plan.
- Complete need assessment of technical training
- Establish cadence and mechanism to refresh and re-estimate infrastructure needs.

5.3.5 Ecosystem Engagement

Ecosystem engagement focuses on establishing a more integrated care delivery model for people experiencing early psychosis and their families by encouraging incentive alignment and coordination among key partners. The key ecosystem partners considered in this chapter include people with lived experience, families, community-based organizations, public and private payors and providers, state and county agencies focused on housing, education actors, and the criminal and legal systems.[233]

[232] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[233] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

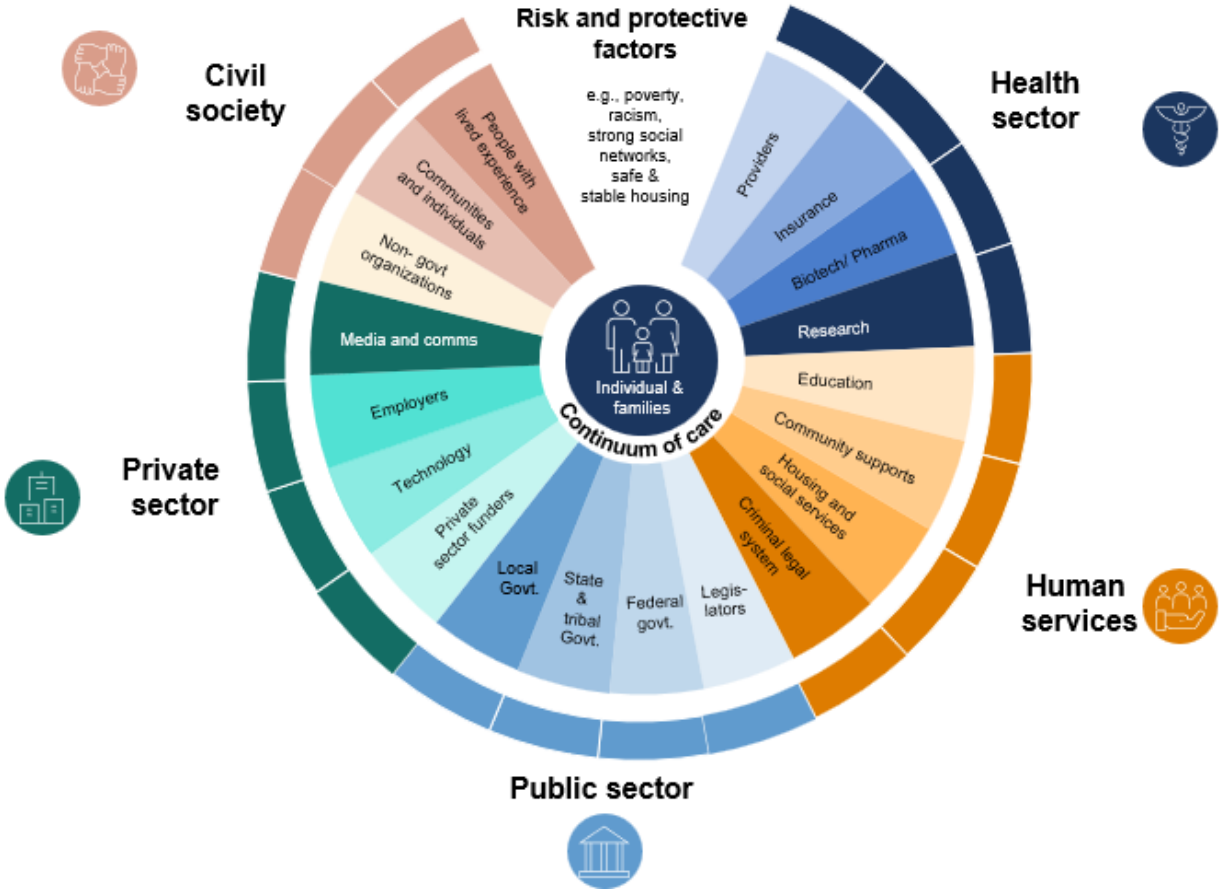


Exhibit 21: Overview of sectors and ecosystem partners

Sources
The Kennedy Forum System Mapping Tool

Current state of ecosystem engagement in California

Ecosystem partners play a crucial part in Early Psychosis Intervention (EPI). Roles include developing human capital, funding system elements, collecting and sharing relevant information, providing products / services, and developing policy.

For example, ecosystem partners may play a crucial role in identifying symptoms for individuals experiencing psychosis. However, there are key challenges across the ecosystem **in symptom identification, referral, and diagnosis.** These include **limited education on the symptoms of psychosis for workers in education, criminal and legal, and housing systems** and limited knowledge of referral pathways for individuals experiencing a psychotic episode.[234] This may lead to delays in referral to appropriate screening and care. **Even within healthcare, there may be a need for additional training on psychosis** diagnoses and

[234] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

treatment for early psychosis, as individuals may be incorrectly diagnosed and treated for other conditions.[235] This occurrence is not unique to California. A retroactive chart review of 78 patients referred to a specialty early psychosis consultation clinic found that of the 43 cases that had a primary diagnosis at referral of a schizophrenia spectrum disorder, the primary diagnosis in the consultation clinic was different in 22 (51%) of these 43 cases.[236]

Ecosystem partners' **contributions extend beyond the identification of symptoms; they are also often engaged in care delivery.** Both county and commercial EPI programs collaborate with state and local programs, national organizations, and community partners to coordinate services such as supportive education and employment.[237] These services are typically coordinated by individual EPI programs through relationships with county and community organizations. Such relationships are **often not established as formal partnerships and vary by program.**[238]

[235] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[236] Specialized Consultation for Suspected Recent-onset Schizophrenia: Diagnostic Clarity and the Distorting Impact of Anxiety and Reported Auditory Hallucinations, Coulter et. al
[237] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[238] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

NON-EXHAUSTIVE

✓ Partner plays a primary role ✓ Partner plays a secondary role

Roles of select ecosystem partners		People Developing the human capital needed to support progress	Funding Funding or enabling funding specific system elements	Data & information Collecting and sharing data and/or information	Products & services Developing and/or deploying products and services	Policy Developing and shifting policies
Health Sector	Insurance		✓	✓	✓	✓
	Providers	✓		✓	✓	✓
	Research			✓	✓	✓
Human Services	Education	✓		✓	✓	
	Community supports	✓		✓	✓	
	Criminal legal system			✓	✓	✓
	Housing and social services			✓	✓	
Civil Society	People with lived experience	✓	✓	✓	✓	✓
	Non-govt. organizations	✓			✓	✓
Public Sector	Local Govt.	✓	✓	✓	✓	✓
	State & tribal Govt.	✓	✓	✓	✓	✓
Private Sector	Employers	✓	✓		✓	
	Technology			✓	✓	
	Private sector funders		✓			

Exhibit 22: Illustrative roles of ecosystem partners along the care journey

There is an opportunity to enhance coordination among key ecosystem partners to achieve the goal of expanding EPI access. While there is collaboration across ecosystem partners, limitations in processes and data sharing restrict the ability to gather important information about treatment history and coordinate care delivery across provider types (i.e., crisis care, inpatient care, and CSC programs) and between systems (e.g., housing and criminal and legal systems). Effective coordination and collaboration could help ensure individuals are referred to appropriate sites of care.[239]

In California, programs such as the Mental Health Court Linkage Program (CLP) provide examples of ecosystem collaboration to support individuals with mental illnesses, including psychosis. The CLP is a joint effort between the Los Angeles County Department of

[239] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

Mental Health (LACDMH) and the Los Angeles County Superior Court. It is run by a team of 15 mental health clinicians who are stationed at 22 courts throughout the county. This program is designed to assist adults who have a mental illness or a co-occurring mental health and substance abuse disorder and are involved with the criminal and legal system. It is part of LACDMH's system of support and services that are available throughout the criminal justice process, from arrest to release. The program follows the "no wrong door" philosophy by using the courtroom as a point of entry for services. The program's goals are to improve coordination and collaboration between the criminal and legal systems and mental health systems, increase access to mental health services and support, and improve continuity of care.[240] Services provided include individual needs assessments; information to individuals and the Court on available treatment options; development of diversion, alternative sentencing, and post-release plans that take into account best-fit treatment alternatives and Court stipulations; linkage of individuals to treatment programs; and expedition of mental health referrals. [241]

Expanded access to CSC will have an impact on partners in healthcare, education, criminal and legal systems, child welfare, and housing systems. In healthcare, CSC reduces average inpatient days by 33% and the average number of ED visits per year by 36%.[242] Outside of direct health impacts, CSC reduces the likelihood of being unemployed by approximately 42%[243]. The CSC model also reduces the need for homelessness services amongst the FEP population by 48% and reduces the average cost per person of providing supportive housing to program participants.[244]

In the criminal and legal system, participation in CSC programs for Early Psychosis Intervention reduces involvement in the criminal justice system. Participants experience a 76% reduction in the risk of committing a first crime and are significantly less likely to be convicted of any crime when enrolled in CSC.[245]

Key objectives/goals[246]

Potential objectives/goals to be considered for ecosystem engagement are as follows:

[240] Los Angeles Department of Mental Health – Metal Health Court Linkage Program
[241] Los Angeles Department of Mental Health – Metal Health Court Linkage Program
[183] Cost-Effectiveness of Comprehensive, Integrated Care for First Episode Psychosis in the NIMH RAISE Early Treatment Program, Rosenheck et al. Cost-Effectiveness of Comprehensive, Integrated Care for First Episode Psychosis in the NIMH RAISE Early Treatment Program, Rosenheck et al.
[243] Predictors of occupational status six months after hospitalization in persons with a recent onset of psychosis, Dickerson et. al.
[244] Tsiachristas et al. "Economic impact of early intervention in psychosis services: results from a longitudinal retrospective controlled study in England"
[245] Pollard, Jessica M et al. "Analysis of Early Intervention Services on Adult Judicial Outcomes." JAMA psychiatry vol. 77,8 (2020). Based on the difference between % of individuals with convictions for any offense after enrolling in the STEP program (5%) and the % of individuals with convictions for any offense receiving usual treatment (19%)
[246] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

Enhanced integrated care delivery network: ensure coordination among ecosystem partners to enable timely and seamless access to all components of the Coordinated Specialty Care model for clients and their families.

Next steps[247]

MHSOAC proposes the following next steps for consideration:

- Improve **awareness, education, and training for early psychosis**
  - Communicate the impact of early identification and treatment of early psychosis for ecosystem partners to align incentives.
  - Provide training on symptom identification and referral pathways for state, county, and community ecosystem partners (e.g., law enforcement, K-12 educators, supportive housing workforce)
  - Provide additional training for medical students and residents on psychosis diagnosis and treatment.
- Enable **improved information sharing for care coordination**
  - Expand the use of psychiatric advanced directives to provide information on the care needs and preferences of individuals with psychosis and coordinate care delivery across partners (i.e., crisis care, Full-Service Partnerships, CSC programs, and inpatient care)
  - Explore resources for enabling interoperability of EHR systems and other data-sharing platforms across health systems, health plans, criminal and legal systems, and other partners to enable data-sharing.
  - Establish coordination mechanisms to refer patients for diagnosis and treatment (e.g., centralized referral portals)
- **Establish stronger alliances among ecosystem partners for CSC care delivery**
  - Expand the use of programs deploying the "no wrong door" philosophy[248] to screen and refer individuals for psychosis in partnership with criminal and legal, housing, and other supportive services.
  - Consider establishing state-wide or county-wide partnerships for housing, education, employment, and other client needs where appropriate.

[247] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[248] No Wrong Door

Potential milestones/ progress measures[249]

- To drive alignment among ecosystem partners and ensure the development of a more integrated care delivery network, the following milestones could help guide execution:
- Convene key ecosystem partners to highlight shared benefits of expanded access to EPI.
- Identify initiatives to deploy better care delivery and size additional resourcing needs.
- Identify and deploy digital resources and operating model changes.
- Initiate impact tracking.

[249] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

6. Implementation plan

MHSOAC has prepared an initial draft of a high-level implementation approach for the rollout of the strategic plan. The implementation plan **will undergo further enhancement as the strategic plan is refined through input from ecosystem partners, public engagement and additional guidance from the Governor, Legislature and other stakeholders. The approach will also need to be tailored based on the entity responsible for spearheading implementation** if the plan is adopted.

To support the successful executions of milestones across our Strategic Objectives and Foundational Levers, **four Implementation Support workstreams have been identified.** These workstreams will focus on coordinating across key partners to implement initiatives, identifying and tracking key metrics to monitor the performance of the overall plan, developing and implementing a robust communications plan, and overseeing change management efforts to drive transformational change in the ecosystem.

- **Integrated coordination:** This workstream will establish a dedicated central team to coordinate among ecosystem partners and across initiatives to ensure successful and timely implementation of the plan.
- **Performance management:** To promote accountability during the implementation of the strategic plan, this workstream will identify metrics and track progress. The dedicated central team will be responsible for developing an integrated process for collecting and reporting on implementation progress across initiatives and partners and measuring impact.
- **Communication plan:** This workstream will develop and roll out coordinated communication and engagement strategies to ensure clarity, consistency, and alignment in messaging with California agencies, ecosystem partners, and other interested parties. Additionally, it will provide regular updates on progress.
- **Change management:** This workstream will support identifying change champions and sponsors across ecosystem partners to promote adoption and implementation of the strategic plan.

This chapter outlines key themes and milestones over a 3-year time horizon, with an initial perspective on where additional funding may be required to ensure the timely execution of our key goals across each element of the strategic plan as outlined in Chapters 4.2 and 4.3[250]. The multi-year time horizon allows for appropriate sequencing of milestones to account for interdependencies across teams and milestones. It also ensures sustainable impact over time, with each milestone achieved serving as a building block for subsequent successful milestones. By the end of year 3, the expectation is that 90% of Californians with needs will have access to equitable, high-quality, and appropriate early psychosis care in California.[251]

[250] Objectives and milestones developed based on input from the Early Psychosis Intervention (EPI) Advisory Group
[251] Discussions with MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group

Over the course of **Year 1**, implementation begins with forming workgroups, conducting landscape analyses and opportunity identification, and developing initial strategies and partnerships:

- **Workgroups:** Convene workgroup(s) to define goals and design innovative strategies across Strategic Objectives and Foundational Levers, as well as align on roles and responsibilities.
- **Landscape analyses:** Review behavioral health landscape, including identifying gaps, estimating infrastructure, funding, and other requirements to fill those gaps, and outlining barriers to impact.
- **Strategies and partnerships:** Develop strategies for working with populations MHSOAC has identified as areas of focus and source partnerships across public, private, and social sector organizations.

Within **Year 2**, work progresses to establishing and rolling out pilots, prioritized by estimated level of impact, followed by aligning on performance indicators to ultimately begin tracking success:

- **Pilots:** Act on planned initiatives and pilot approaches, from engagement to funding, based on prioritization. Appropriately utilize embedded community partnerships and facilitate necessary training.
- **Performance indicators:** Define and implement measurements of success while simultaneously gathering pilot participant and partnership feedback to determine adjustments needed to pilots.

By **Year 3**, as pilots are well underway, the emphasis of work is on continued data analytics and consequent effort refinement for maximum impact:

- **Data analytics:** Continuously collect performance data in service of improving awareness, access, quality, and equity of care.
- **Effort refinements:** Based on analytics, redirect resourcing and refine goals to ensure adherence to the priority needs of target populations.

For specific milestones by year, see exhibits.

May require additional funding

	Year 1	Year 2	Year 3
Awareness	• Convene a workgroup to **design awareness goals** and **public engagement strategy** • **Review landscape** of behavioral health awareness programs in CA and opportunities of psychosis specific partnerships • Develop **engagement strategies for populations** MHSOAC has deemed as areas of focus and **partner with key** Behavioral health **campaigns** • Develop a public **communications strategy** that facilitates a call to action by Californians for key ecosystem partners necessary to meet 90% access goals	Establish **one stop resource center** for care-seekers and family to access content on EP symptoms and ways to access care • Prioritize **channels** and **culturally competent** narratives for reduction of stigma Roll out planned initiatives in **partnership with key community partners**	• Identify **mechanisms to measure awareness** and continuously monitor metrics like engagement of priority population in programs, reduction in DUP etc. • Periodically **review effectiveness** of public narrative and establish process of refreshing it
Access	• Establish a workgroup to **identify barriers** and define progressive **goals** across dimensions of access: timeliness, affordability, convenience, standardization of intake • Establish approach for measuring **client satisfaction** with access	**Start pilots** of approaches on improving timeliness, affordability and convenience of access • Develop an approach towards **standardization** of psychosis diagnosis and **intake** into the EPI programs **Roll out mechanism** (e.g., surveys) to measure client's satisfaction with ease of access	**Continuously measure** access across the dimensions of timeliness, affordability, convenience and standardization of intake with established mechanism of initiating steps for improvement on metrics like average duration of untreated psychosis, average wait time for intake, client satisfaction with ease of access

Exhibit 23: Milestones related to improving Awareness and Access

Sources
Discussions with MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group

May require additional funding

	Year 1	Year 2	Year 3
Quality	• Establish alignment among stakeholder partners on the **standard of care** across 7 dimensions of quality • **Identify gaps in fidelity** to expanded CSC model and prioritize mechanisms for improving fidelity • **Estimate infrastructure requirement** for reporting and analyzing quality metrics • Define **mechanisms of self reporting**, cadence of assessments and technical assistance to support improvement	Set up a **center of excellence and** working team and technical assistance team to track quality across the state **Evaluate EPI programs** against fidelity scale **Commission in research** to assess and improve quality	**Automate mechanism to track quality** of care with transparent visibility for all ecosystem partners and the public • Continuously **re-evaluate goals and plan** for improving quality
Equity	• Align with experts the definition of equity in the context of scaling early psychosis care and **specific goals for reducing barriers to access** • Define approach to **integrating diverse cultural, linguistic and developmental needs** into the EPI program design and delivery • **Identify** diverse or marginalized populations and **communities to brainstorm solutions**	• Align on approach for establishing a **diverse skilled workforce** equipped to meet the diverse needs of vulnerable communities	Establish **data collection and analytics strategy** that can help decision making in partnerships with community

Exhibit 24: Milestones for enhancing Quality and Equity

Sources
Discussions with MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group

May require additional funding

	Year 1	Year 2	Year 3
Sustainable funding	• **Identify key challenges to existing service-based reimbursement** models • **Estimate and align on funding needs** for programmatic and service-based reimbursement • **Identify funding sources** across federal, state, county and philanthropic entities • Convene key funding partners to **align on funding allocations** for EPI program	• **Secure and disperse programmatic funding** • **Design and implement initiatives** to improve reimbursement model • **Track funding progress and impact** across initiatives	• Disseminate **additional programmatic funding** • **Enforce billing** using refined reimbursement models decided across payors • Continue tracking and reporting progress
Workforce & capabilities	• Conduct **demand and supply assessment** of BH workforce; identify workforce need by region, expertise / role, and diversity Identify and prioritize **key drivers of attrition** • Develop and roll-out **recruitment strategy for key roles based on need by county** (e.g., psychiatrists and clinicians that includes expanding recruitment efforts and optimizing efficiency of current workforce)	**Roll out recruitment strategy for remaining roles -** expand recruitment efforts and optimize efficiency of current workforce **Develop and deploy training and onboarding** programs • **Establish KPIs** to track progress	Continue deploying recruitment and training initiatives Set up **continuous monitoring mechanisms** to track demand and supply and measure progress across other key metrics

Exhibit 25: Milestones related to Sustainable Funding and Workforce & Capabilities

Sources Discussions with MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group

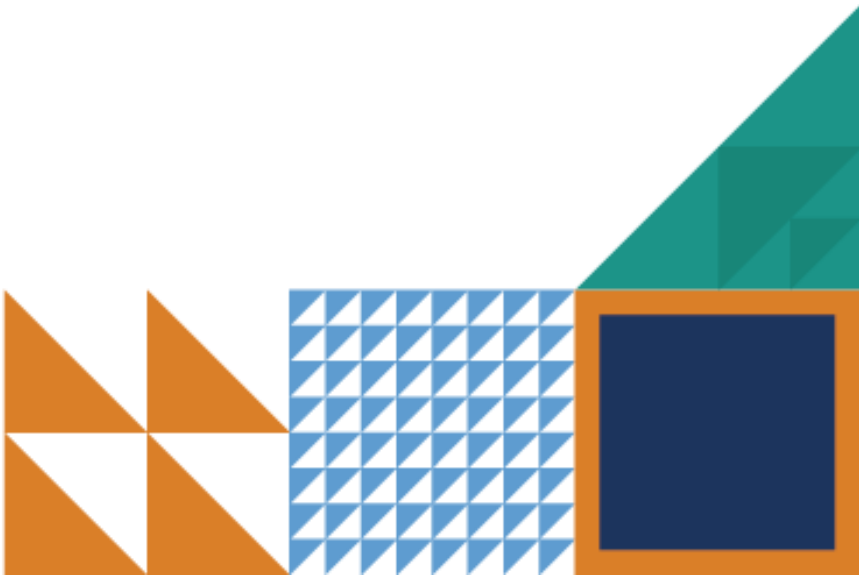
May require additional funding

	Year 1	Year 2	Year 3
Accountability	• Establish **governance structure and mechanism and** identify the leadership team • Get appropriate advice to guide decisions on **legal and administrative scope** • Design **incentive models and accountability structures for key partners / entities** Develop and deploy **monitoring and evaluation and reporting framework** to measure progress across initiatives • Establish **process to commission and utilize research to improve EPI programs**	Track progress and **evaluate effectiveness** of current governance structure, adjust as needed **Deploy incentive models** and refine as needed **Solicit feedback from EPI programs** and incorporate changes into CSC programs	Monitor **effectiveness of the accountability measures** on ongoing basis and adjust strategy as needed • Continue to solicit feedback from EPI programs to measure improvement
Infrastructure	• Identify key **digital and physical infrastructure gaps** by county • Create **infrastructure development plan**, identify resource requirement Identify **infrastructure partners and establish contracts** • Assess the **need for technical training** and develop or contract out training programs	Deploy **infrastructure development plan** and begin setting up digital and physical infrastructure Begin **technical training** where needed Run pilots and set up expansion plans	• Track supply and demand and establish cadence and mechanism to **re-estimate infrastructure needs** **Continue deploying infrastructure** as per the plan
Ecosystem Engagement	• Convene **key ecosystem partners and define roles and responsibilities** • Develop **mechanisms or incentive models** to deploy better care delivery and improve payment systems • Evaluate and align on **potential reimbursement models** • **Evaluate and align on possible operating model** solutions • Develop **communication strategy and influential engagement plan** to engage private health plans	• **Convene key partners to make decisions** on reimbursement models and operating models Continue to deploy incentive models to **deploy better care delivery** • Work closely with all ecosystem partners to **establish the new reimbursement model and operating model**	Continue **deployment and roll-out of the reimbursement** model and operating model • Refine models based on feedback

Exhibit 26: Milestones related to Accountability, Infrastructure and Ecosystem Engagement

Sources Discussions with MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group

7. Appendix



7.1 Approach

The approach to drafting this strategic plan for expanding early psychosis care in California involved the following:

7.1.1 Syndicating quantitative estimates based on perspectives from national leaders and experts.

Through interviews and synthesis of existing research, a model was developed to demonstrate the potential impact of scaling CSC, looking at both the potential economic savings as well as the impact on quality of life. The impact was estimated across two-time horizons: a near -term view and a lifespan view.

A National Impact Model on Early Psychosis was developed, incorporating expert opinions, partnerships with leading organizations, and a thorough review of academic literature. The process involved interviews of over 19 subject matter experts from various organizations, including national, state government agencies and universities. Partnerships were established with leaders of the National Council of Mental Wellbeing, the National Association of State Mental Health Program Directors (NAMHPD), the National Alliance on Mental Illness (NAMI), and the McKinsey Health Institute (MHI). Additionally, dozens of academic research papers and articles, as well as more than ten policy briefs, were reviewed to gather relevant information.

Expert	Organization and roles	Interview date
Richard Frank	*Director, Center on Health Policy,* Brookings Institution	Jan 21
Steve Adelsheim	*Director,* Stanford Center for Youth Mental Health and Wellbeing	Jan 22
Lisa Dixon	*Director, Division Behavioral Health Services and Policy Research*, Columbia University	Jan 23
Robert Heinssen	*Senior Advisor*, NIMH, RAISE, EPINET	Jan 23
Tamara Sale	*Director EASA Center for Excellence,* OHSU	Jan 26
Vinod Srihari	*Director of STEP Program,* STEP program Yale University	Jan 29
David Shern	*Senior Public Health Advisor,* NASMHPD; *Moderator* PEPPNET Financing Workgroup	Jan 31
Patrick McGorry	*Director Orygen Youth Health, Chair Youth Mental Health,* University of Melbourne	Feb 1
Robert Rosenheck	*Director Division of Mental Health Services and Outcomes Research,* Yale, NIMH RAISE	Feb 1
Tara Niendam	*Executive Director* UC Davis, SacEDAPT Clinics; *Principal Investigator,* EPI-CAL	Feb 8
Keris Myrick	*Co-Director Mental Health Strategic Impact Initiative,* Mental Health America; Inseparable	Feb 8
Carolyn Dewa	*Director Behavioural Health Center of Excellence,* UC Davis	Feb 14
Brandon Staglin	*President, One* Mind	Feb 14
Debra Pinals	*Medical Director Behaviorial Health and Forensic Programs,* University of Michigan	Feb 16
Oladunni Oluwoye	*Co-director Washington State Center for Excellence in Early Psychosis*, Washington State University	Feb 22
Iruma Bello	*Director of OnTrackNY*, Behavioral Health Services and Policy Research, Columbia University	Feb 22
Ken Duckworth	*Chief Medical Officer*, NAMI	Mar 4
Jessica Banthin	*Senior Fellow & CBO expert*, Urban Institute	Mar 8
Deidre Anglin	*Lead Investigator of social and cultural determinants of psychosis risk*, City College of New York	Mar 28

Exhibit 27: Interviews with subject matter experts

In building the model, the first step involved estimating the early psychosis incidence rate among the population by age and insurance type (e.g., Medicaid, commercial, uninsured). The second step was to determine the level of access and estimate the proportion of individuals experiencing psychosis who receive access to Coordinated Specialty Care (CSC) either in a timely manner, in a delayed manner, or do not receive CSC and rely on community care for support. The third step was to estimate the costs of scaling CSC and the benefits of receiving CSC across various dimensions of an individual's life, such as healthcare, education and employment, housing, criminal justice, and caregivers and family members.

It's important to note that the initial model accounts for impact areas and estimates that have been empirically studied and reported in published literature. However, there are other known areas of CSC's impact that are not included in the model, such as productivity loss due to premature mortality. This comprehensive approach to building the economic model provides a robust business case for investing in upstream care for psychosis, demonstrating its potential cost-effectiveness compared to more expensive downstream care like the need for more psychiatric beds.

Preliminary insights from the national impact model

Increasing the availability of CSC has the potential to improve the lives and livelihoods of individuals experiencing first-episode psychosis and to generate system impact. As access to CSC increases, more individuals receive services early in their psychosis journey, and overall

system costs decrease. For example, increasing access across the nation to CSC from 25% to 90% of individuals in need could generate $21K per year in healthcare and social impact per individual who receives CSC early in their psychosis journey, translating to $5.7B per year in national system impact.

The California specific impact model was built using the same methodology but with California specific estimates to help articulate the economic case for investment in upstream care for psychosis.

7.1.2 Series of consultative meetings and discussions with subject matter experts

An Advisory Group of Subject Matter Experts (SMEs) was formed to facilitate the discussion and development of the Early Psychosis Incidence (EPI) Strategic Plan. This group comprised a diverse range of stakeholders, such as state leaders, MHSOAC commissioners, healthcare partners, DHCS, DMH, DSH, local implementers, county leaders, public safety, EPI programs, ecosystem partners, commercial healthcare payors, healthcare providers, employers, communities and individuals, individuals with lived experience, family members, justice-involved individuals, tribal communities, children and youth, and national leaders. The group worked together to review the findings of the impact model, develop a landscape analysis of California, and share inputs for a strategic roadmap for the expansion of early psychosis care outlined in this plan.

Advisory group members

NOT EXHAUSTIVE

Category	Group	Name
Communities and Individuals	Individuals with lived experience	Brandon Staglin
	Individuals with lived experience	Claire Conway
	Individuals with lived experience	Keris Myrick
	Family members	Gladys Mitchell
	Children and Youth	Radha
	Tribal communities	Virgil Moorehead
Ecosystem Stakeholders	Payors - CalPERs	Julia Logan
	CHA	Paul Rains
Local Implementors	County Leaders	Supervisor Ellenberg
	Rural	Phebe Bell
	Public Safety	Sheriff Bill Brown
	EPI Programs	Ann Boynton
	EPI Programs	Steve Adelsheim
	EPI Programs	Kerry Ahern
	EPI Programs	Tara Niendam

Category	Group	Name
National Leaders	National Council for Wellbeing	Chuck Ingoglia
	NAMI	Daniel H. Gillison, Jr.
	NAMI	Darcy Gruttadaro
	NASMHPD	Brian Hepburn
	NIMH	Robert Heinssen
	Brookings Institute	Richard Frank
State Leaders	Healthcare - Dept Managed Care	Amanda Levy
	Healthcare - DSH	Ambarin Faizi
	Healthcare- Cal HSS	Stephanie Welch
	MHSOAC Commissioners	Jay Robinson
	MHSOAC Commissioners	Mark Bontrager
	Healthcare - CBHA	Le Ondra Clark Harvey
	Healthcare - DHCS	Paula Wilhelm
	Healthcare - Cal HSS	Sohil Sud

Exhibit 28: Early Psychosis Intervention Advisory Group members