EPI-CAL TTA Orientation

Presented by the EPI-CAL Training and Technical Assistance Center (TTA)

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Learning Objectives

1. Understand the origin, structure, and mission of **EPI-CAL**
2. Understand the psychosis continuum and how it relates to **EPI-CAL**, including **EP, FEP**, and **CHRp**
3. Understand the purpose of the EPI-CAL Training and Technical Assistance Center (**TTA**)
4. Understand the different grants and funding streams participating in EPI-CAL **TTA**
5. Understand the Coordinated Specialty Care (**CSC**) model
6. Understand the rationale for **TTA** based on psychosis incidence and the current landscape of EP care in California
7. Understand what services the **TTA** provides and what is expected of EP programs participating in TTA

What is EPI-CAL?

EPI-CAL is **California Early Psychosis Intervention**

Our goals are to support provision of high-quality Early Psychosis care to all Californians and to promote recovery and better outcomes through a learning health care network approach.

EPI-CAL is a county and provider-driven initiative

Our leadership is actively engaged and providing clinical services in community mental health settings

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Before we talk more about EPI-CAL, let’s briefly talk about psychosis

What is psychosis?

Key symptoms of psychosis include:

Hallucinations: sensory experiences that are not related to what is happening around you

Delusions: thoughts or beliefs that are held with conviction in the face of contradictory evidence

Thought Disorder: difficulty communicating or behaving in a linear and goal-directed manner

These experiences cause significant distress or functional impairment

Early Psychosis (EP), **First Episode Psychosis** (FEP), **and CHRp** (Clinical High Risk)

In California, we understand psychosis as a continuum

“Early Psychosis”

We use the term "**early psychosis**" (EP) to represent the continuum of psychosis from **clinical high risk** (CHR) to individuals who have experienced threshold or **first episode psychosis** (FEP)

Other states and other agencies may treat FEP differently.

Let’s look at the psychosis continuum

Psychosis continuum

"Early Psychosis"

Fully Psychotic

- Significant Distress
- Frequent (weekly, daily)
- Convinced it is real
- Effects behavior
- Impairs functioning

Attenuated/Subthreshold Psychosis

- Increasing frequency (weekly→ daily)
- Increasing distress
- Seems real (b/c it keeps happening), but not convinced
- Starting to affect behavior or impact functioning

Within Cultural Norms

- Increasing frequency (weekly)
- Some distress, bothers them
- Able to question reality
- Little effect on behavior

- No Distress
- Infrequent/rare
- No effect behavior/functioning
- Consistent with cultural beliefs

UNDERSTANDING PSYCHOSIS

Tara Niendam, Ph.D.
Executive Director
UC Davis Early Psychosis Programs

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Epidemiology

- Found in 2% of population world wide
  - Approximately 272 per 100,000 new cases per year (Medi-caid data, Radigan et al 2019)→ 4191 NEW individuals per year in Sacramento County (2018 census est. 1,540,975)
- More common in men than women
- Mean age of onset = 20
  - Range = 15 – 35 years
  - Men earlier than women (17 vs 22 yrs)
  - Early onset (before puberty) is uncommon but does exist.

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Epidemiology

HOWEVER… psychotic-like symptoms are common

- 28% of individuals endorsed psychosis-screening questions in national comorbidity survey
- 20.9% of individuals presenting for treatment at urban primary care centers report one or more psychotic symptoms, most commonly auditory hallucinations

→ Indicative of psychosis spectrum ranging from normal to illness…

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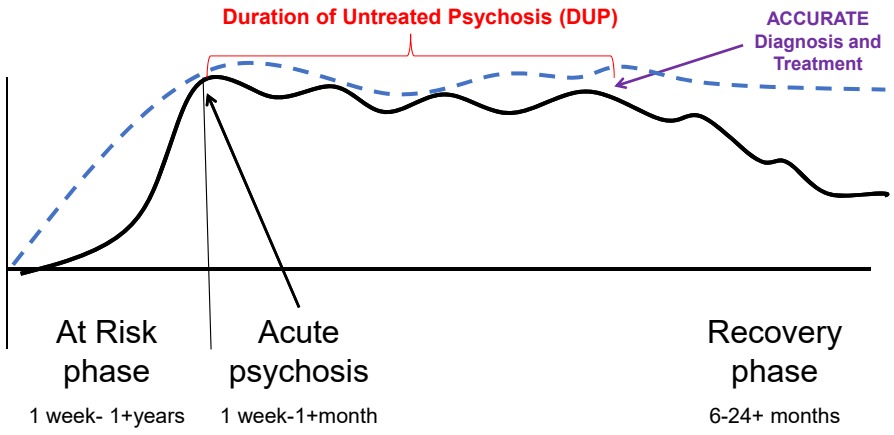
Kendler et al. 1996; Olfson et al. 2002; van Os et al. 2009

Symptoms Start Before Diagnosis

Positive symptoms = Hallucinations, Delusions, Thought Disorder

Negative symptoms = Lack of motivation, interest in pleasurable activities, flat affect, paucity of speech



Course of Illness & Prognosis

- Average delay between symptom onset and starting treatment = 18.5 months (Kane et al., 2015)
  - Duration of Untreated Psychosis (DUP) → single best predictor of long term outcome
- "Early" Psychosis = first 5 years after onset of symptoms.
  - "Critical period" during which treatment has its biggest impact
  - Often focus on MAINTAINING functioning, rather than recovering functioning that was lost

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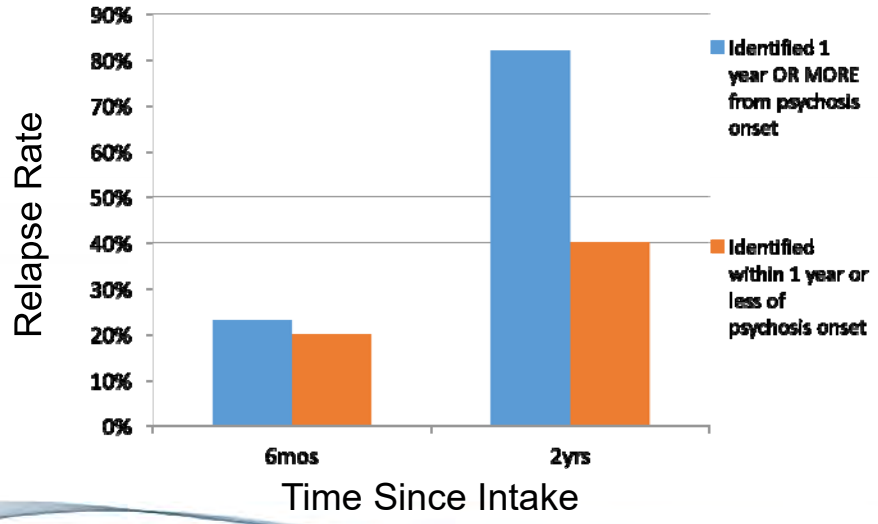
Relapse Rates Increase with DUP



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Adapted From: Crow et al., British J Psychiatry, 1986

Course of Illness & Prognosis

- Early functioning tends to be best predictor of later functioning
- High rates of disability – 20+% of Social Security benefits are used to care for individuals with SZ
- 25-50% of individuals with SZ will attempt suicide, 10% complete
  - Most common during early phase of illness
- **Recovery is possible!**
  - Not just about controlling symptoms (typically with meds)
  - Focus on hope, wellness, independence, citizenship, and pursuit of meaningful goals and roles (Ahmed et al., 2016)
  - Associated with engagement from family and support persons in treatment model

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When Do Early Signs of Psychosis Occur?

- Early warning signs (subthreshold symptoms = “at risk phase”) can appear 1-3 years prior to full psychosis
  - Likely association with brain maturation
- Psychotic Symptoms exist on a continuum from subthreshold to fully psychotic
  - Early signs present as changes in thoughts, experiences, behavior and functioning
  - Perceptual abnormalities, unusual beliefs, uncharacteristic behaviors

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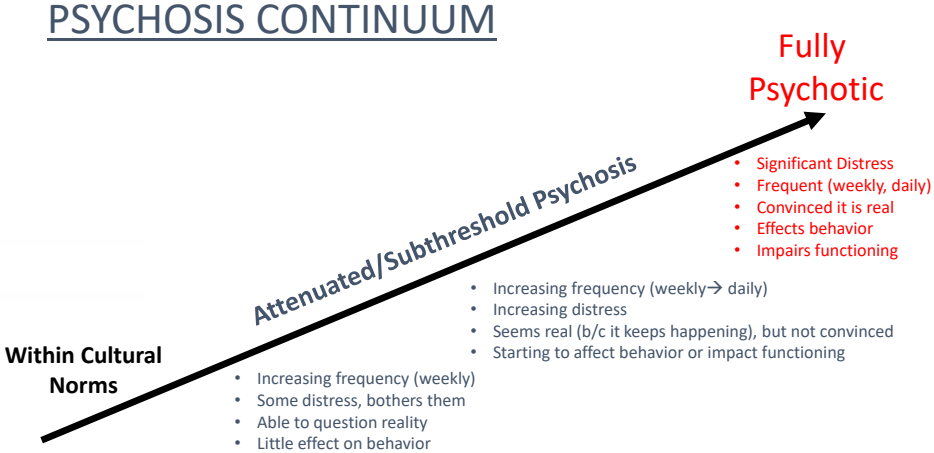
PSYCHOSIS CONTINUUM



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- Increasing frequency (weekly→ daily)
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- Increasing frequency (weekly)
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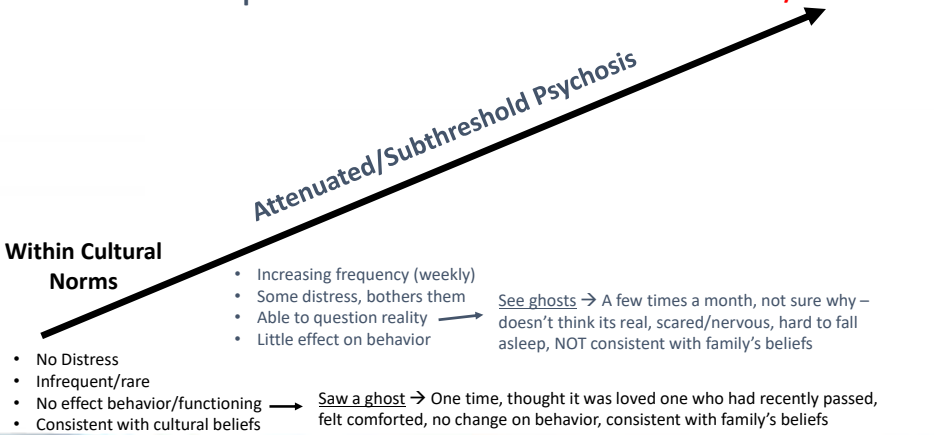
PSYCHOSIS CONTINUUM
An Example = Ghosts



- Increasing frequency (weekly)
- Some distress, bothers them
- Able to question reality
- Little effect on behavior

<u>See ghosts</u> → A few times a month, not sure why – doesn't think its real, scared/nervous, hard to fall asleep, NOT consistent with family's beliefs

- No Distress
- Infrequent/rare
- No effect behavior/functioning
- Consistent with cultural beliefs

<u>Saw a ghost</u> → One time, thought it was loved one who had recently passed, felt comforted, no change on behavior, consistent with family's beliefs

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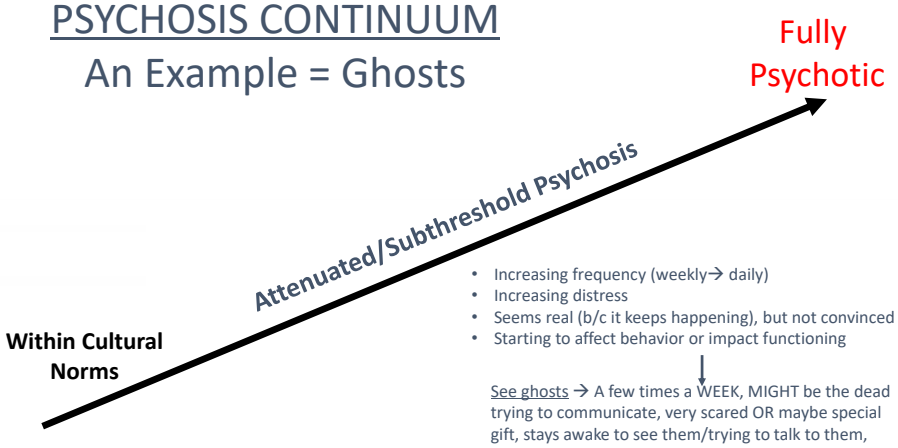
PSYCHOSIS CONTINUUM
An Example = Ghosts



- Increasing frequency (weekly→ daily)
- Increasing distress
- Seems real (b/c it keeps happening), but not convinced
- Starting to affect behavior or impact functioning

See ghosts → A few times a WEEK, MIGHT be the dead trying to communicate, very scared OR maybe special gift, stays awake to see them/trying to talk to them, NOT consistent with family's beliefs

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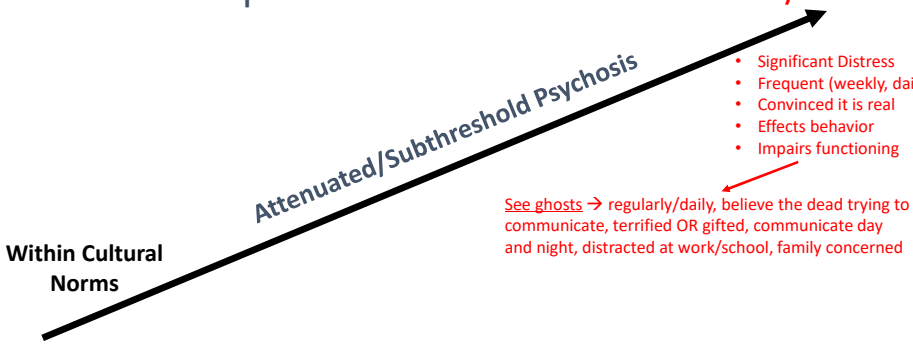
PSYCHOSIS CONTINUUM
An Example = Ghosts



- Significant Distress
- Frequent (weekly, daily)
- Convinced it is real
- Effects behavior
- Impairs functioning

See ghosts → regularly/daily, believe the dead trying to communicate, terrified OR gifted, communicate day and night, distracted at work/school, family concerned

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Important Issues to Consider:

- Developmental norms
  - Metacognition (thinking about their thinking) is hard for young children → need to be concrete in your questions, look at effect on behavior
  - Some behaviors are normal for younger children but not adolescents (e.g. imaginary friends)
- Cultural or familial context of the experience
  - e.g. belief in ghosts by the family, or religious experiences
- Environmental factors
  - e.g. bullying at school, unsafe neighborhood
  - Do symptoms occur outside of these contexts, like at the grocery?

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What Else Might I See?

Psychosis-spectrum symptoms often appear alongside a variety of COMMON NON-SPECIFIC clinical issues:

- A significant deterioration in the ability to cope with life events and stressors
  - –Decrease in work or school performance
  - –Decreased concentration and motivation
- Withdrawal from family and friends
- Decrease in personal hygiene

CAREFUL ASSESSMENT IS NEEDED!

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The full “Understanding Psychosis: Early Intervention and Treatment” video is available here:

https://www.youtube.com/watch?v=u1f4pm_6t8Y

A brief history of EPI-CAL:

a timeline

About EPI-CAL

Based on an average incidence of psychotic illness of 272 per 100,000 people each year, **approximately 107,000 California residents are estimated to experience a first psychotic episode each year**.

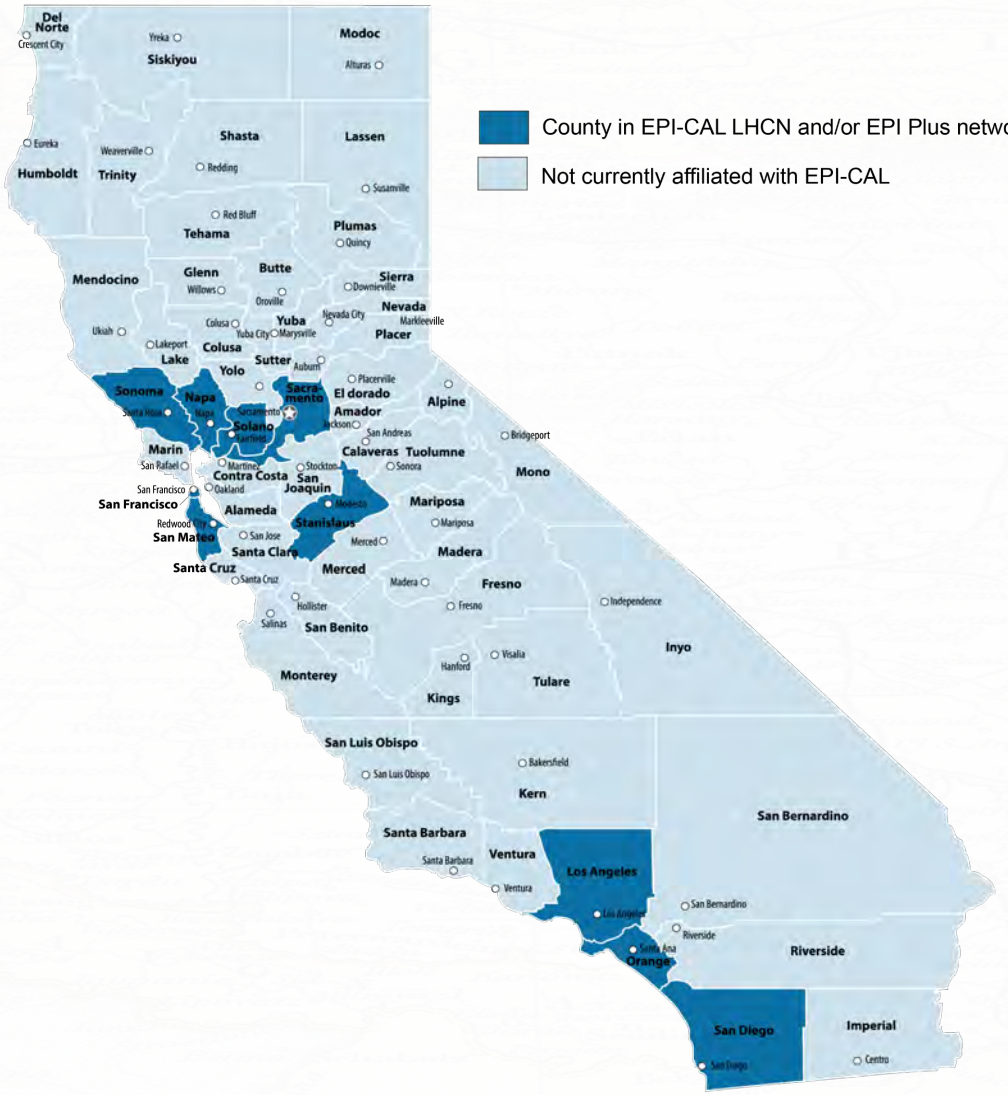
Although California currently has active programs providing Early Psychosis (EP) services across multiple counties, these **programs offer different services, follow different treatment models, and measure treatment impact differently**.

For this reason, EPI-CAL was created.

2017:

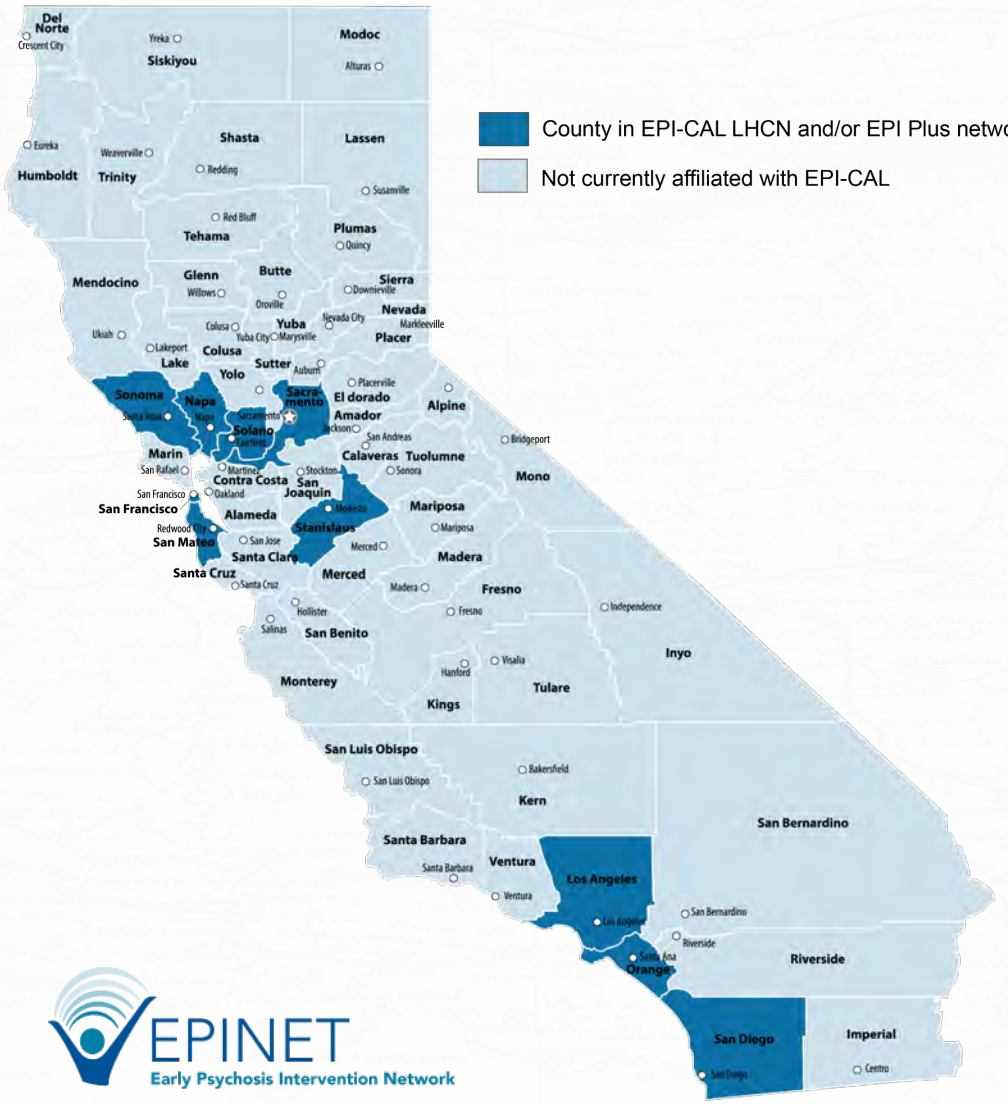
AB1315 legislation creates EPI Plus grant

- Governor Jerry Brown approves CA AB 1315, mandating MHSOAC to create/oversee committee to expand provision of high-quality, EB EP and mood disorder detection and intervention services in CA
- MHSOAC established Early Psychosis Intervention Plus committee (including psychotic conditions PLUS mood disorders) and the **EPI Plus** grant, which provided $ to counties looking to improve existing EP programs or create new ones



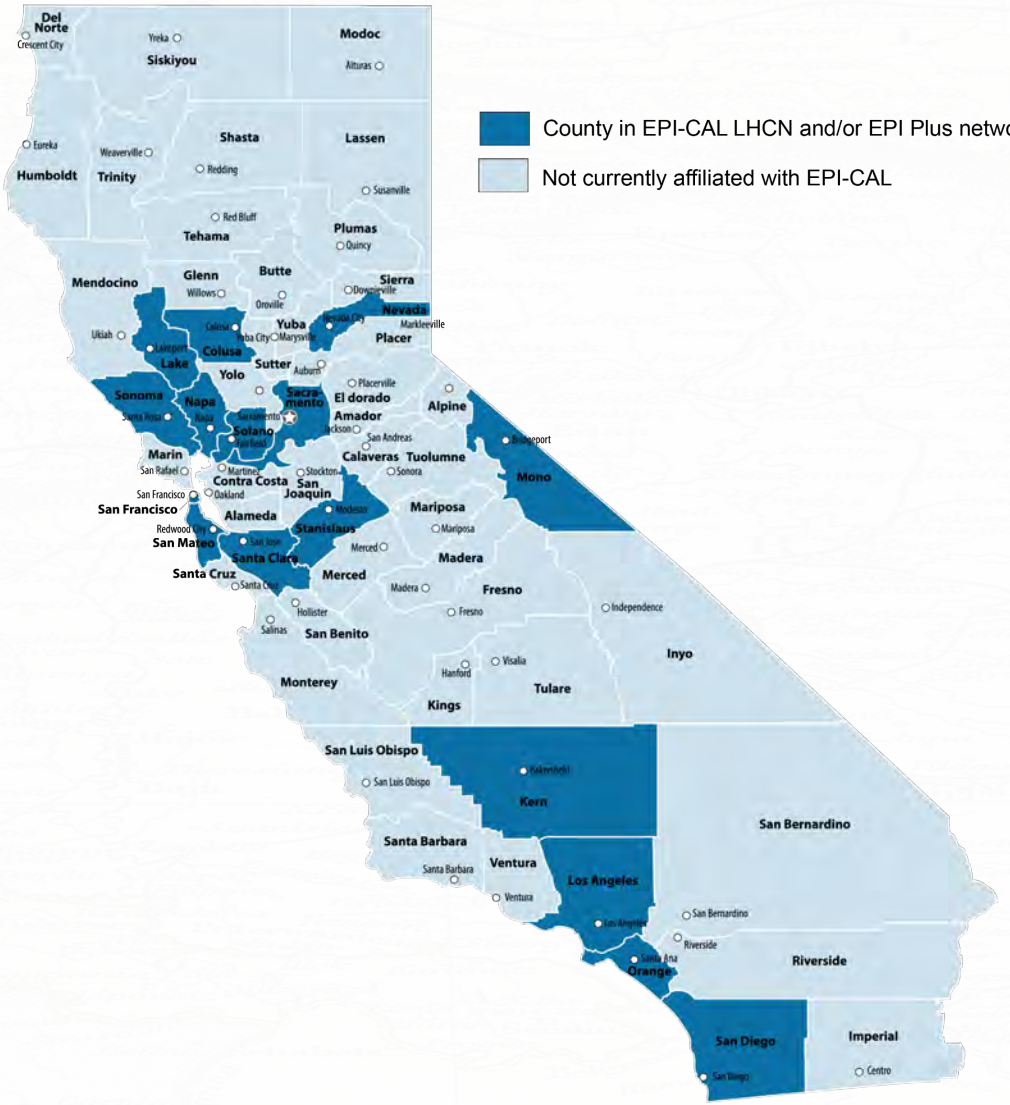
2018:
EPI-CAL is born

- EPI-CAL started as a collaboration between California counties (Los Angeles, San Diego, Orange, Solano, and Napa) and One Mind to develop a Learning Health Care Network for the EP programs of those counties.



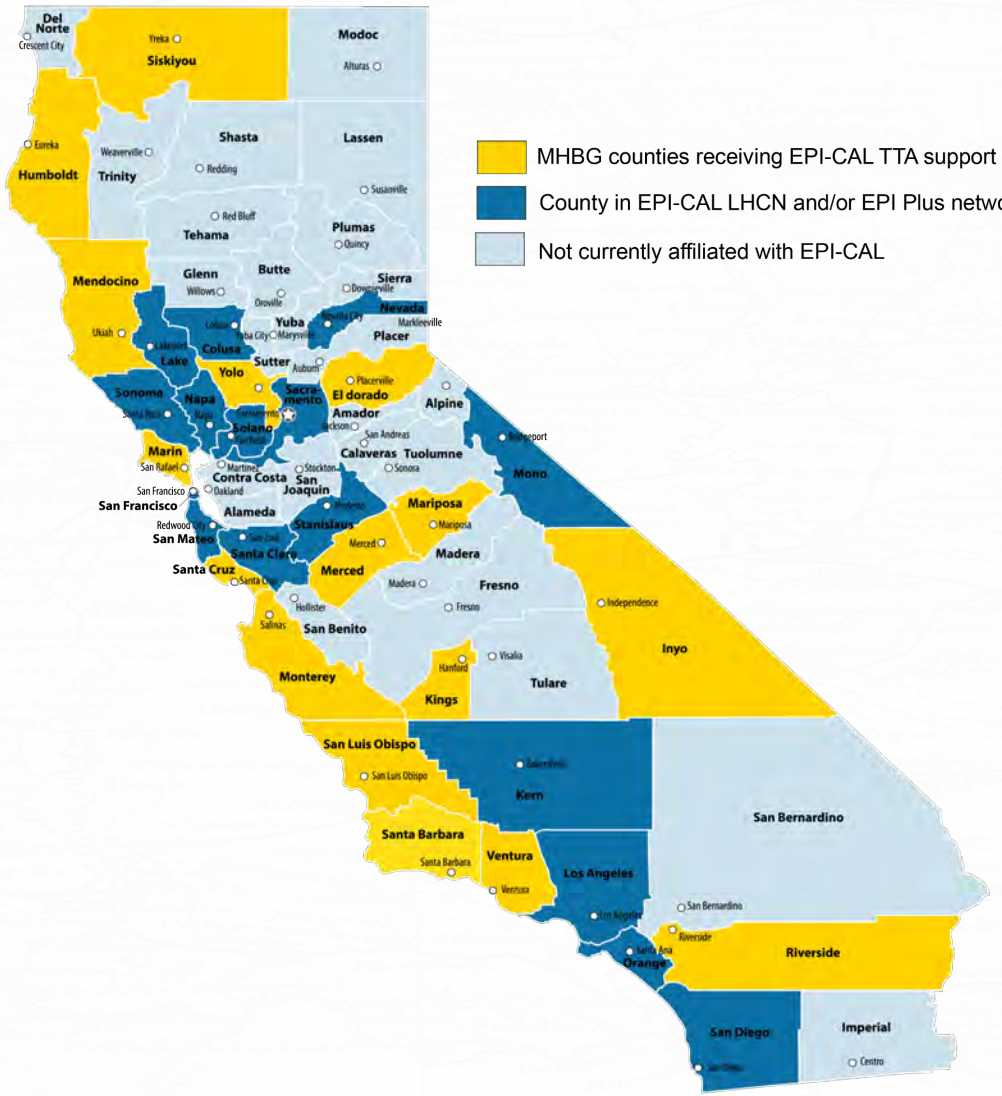
2018:
EPI-CAL is born

- A grant from NIH brought the California **Learning Health Care Network (LHCN)** into the national network of EP programs, EPINET. This grant also made it possible to add additional county and university EP programs into the LHCN.



2021:

TTA Project begins when MHSOAC investment through EPI Plus grant adds counties to EPI-CAL TTA

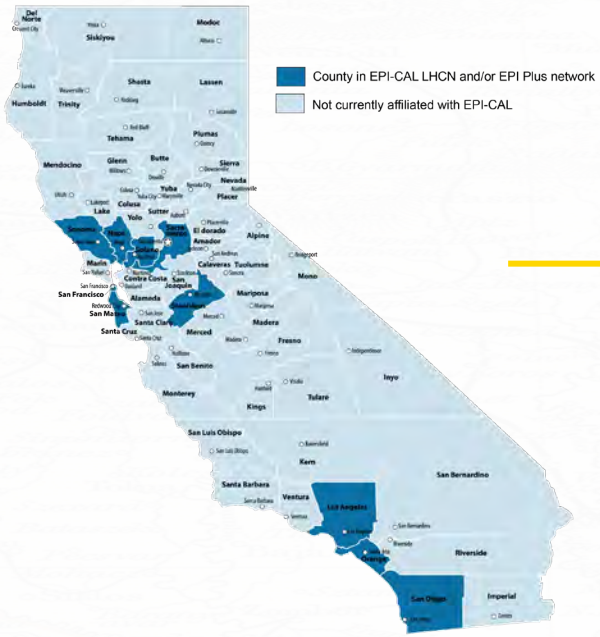


2022:

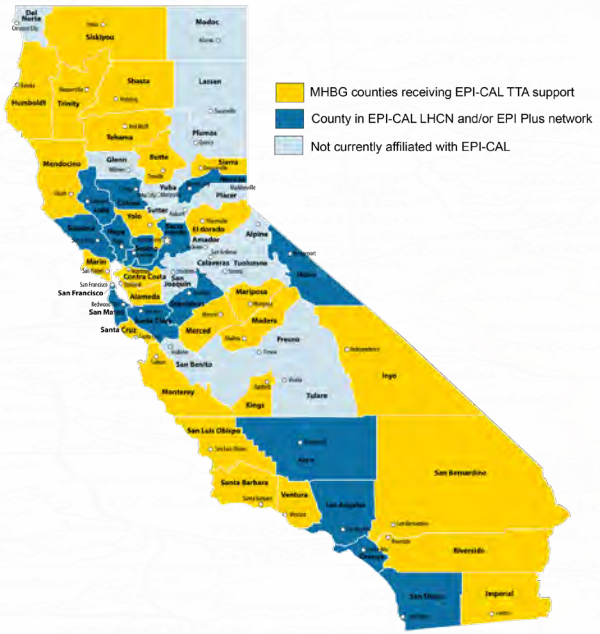
DHCS investment through MHBG supplemental grants (ARPA, CRRSAA) adds 22 counties to EPI-CAL TTA

2023:

Continued DHCS investment adds 11 counties to both EPI-CAL LHCN and TTA through MHBG Prime funding



2019



2023

36 counties are now participating in EPI-CAL!

EPI-CAL structure

California Early Psychosis Intervention Program

TTA

Training and Technical Assistance Center

Provides training and technical assistance to support implementation and sustainability of EP programs across California, support provision of high-quality EP care to all Californians and to promote recovery and better outcomes through a learning healthcare network approach.

LHCN

Learning Health Care Network

Harmonize outcomes data collection, standardize practice and support knowledge-sharing to improve the quality of EP services and measure the impact of treatment

The EPI-CAL program is comprised of two different initiatives: **LHCN** and **TTA**

TTA

Training and Technical Assistance Center

Provides training and technical assistance to support implementation and sustainability of EP programs across California, support provision of high-quality EP care to all Californians and to promote recovery and better outcomes through a learning healthcare network approach.

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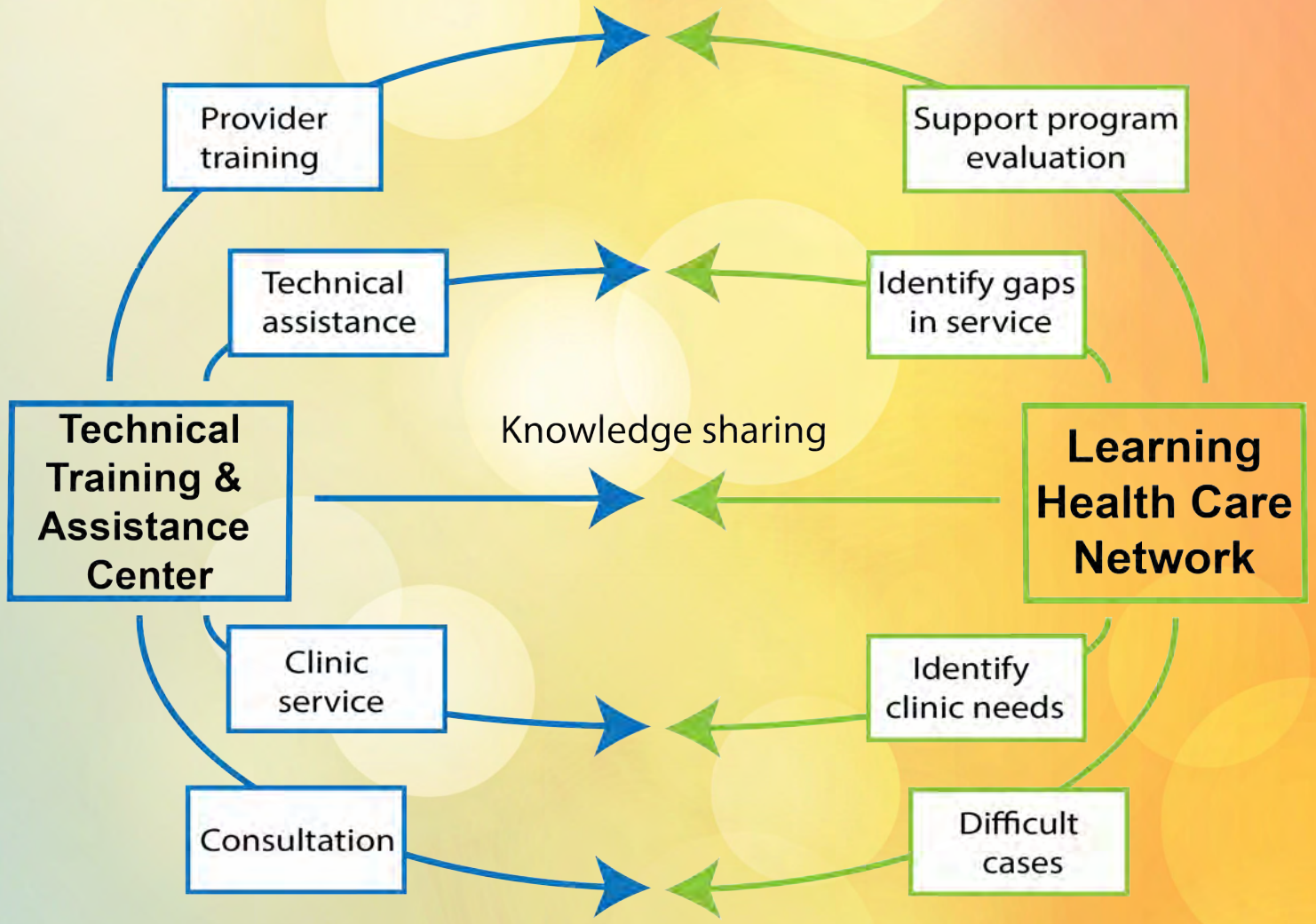
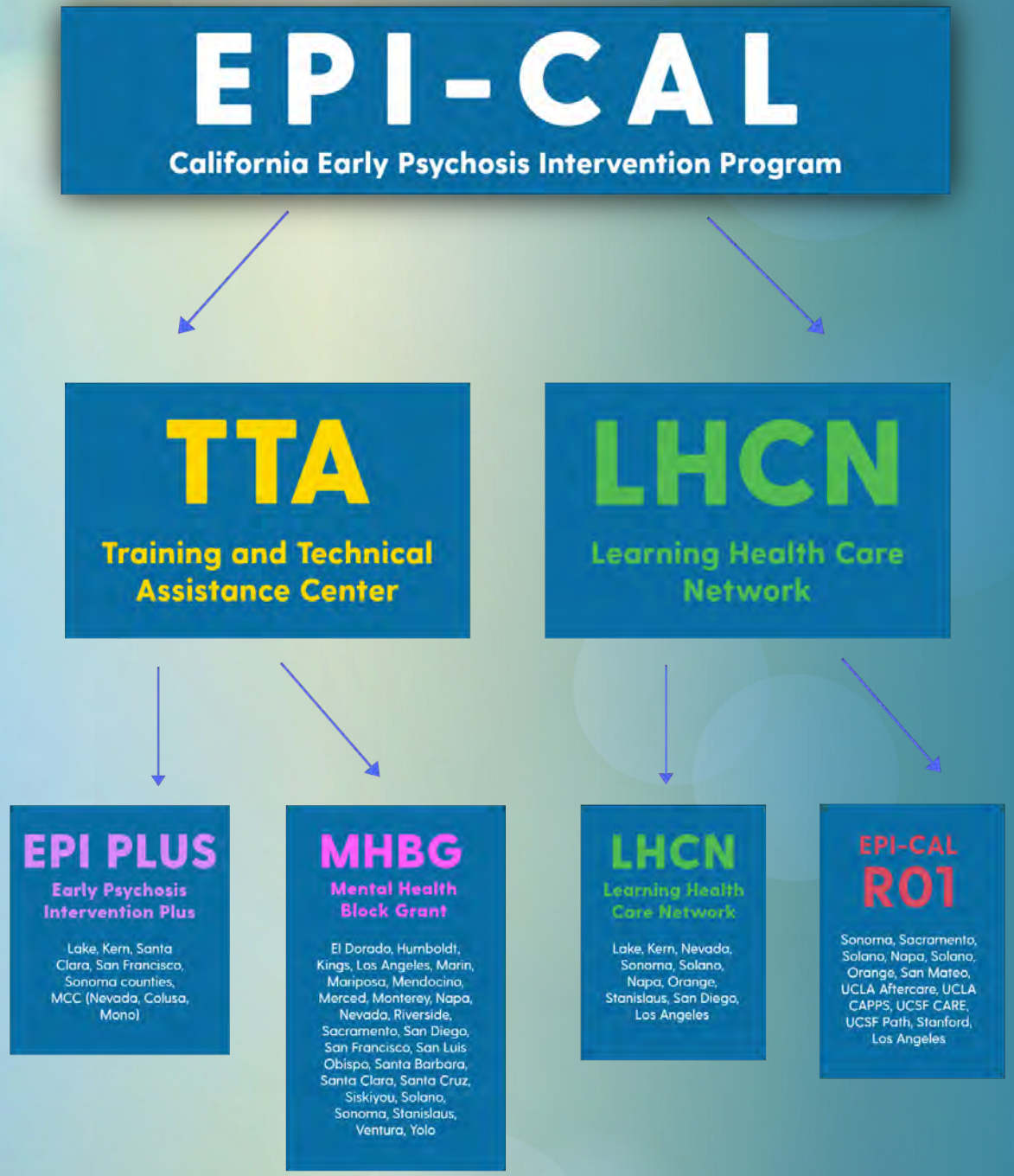




Counties/programs participate in **TTA** and/or **LHCN** through different funding mechanisms. Some counties are associated with more than one funding mechanism.

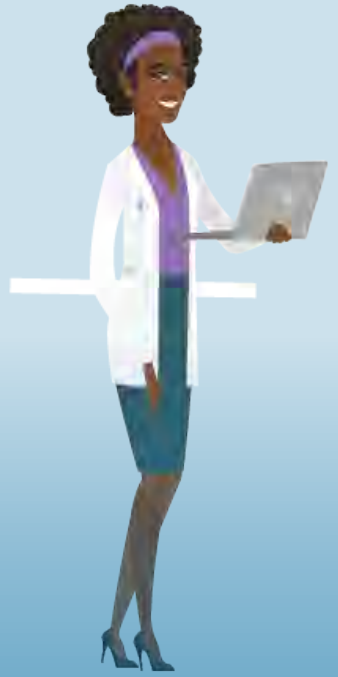
About the LHCN
(Learning Health Care Network)

The goal of the **Learning Health Care Network** is to increase the quality of EP services, including measurable outcomes.

Consumer Level

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

Provider Level



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

Clinic Level

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

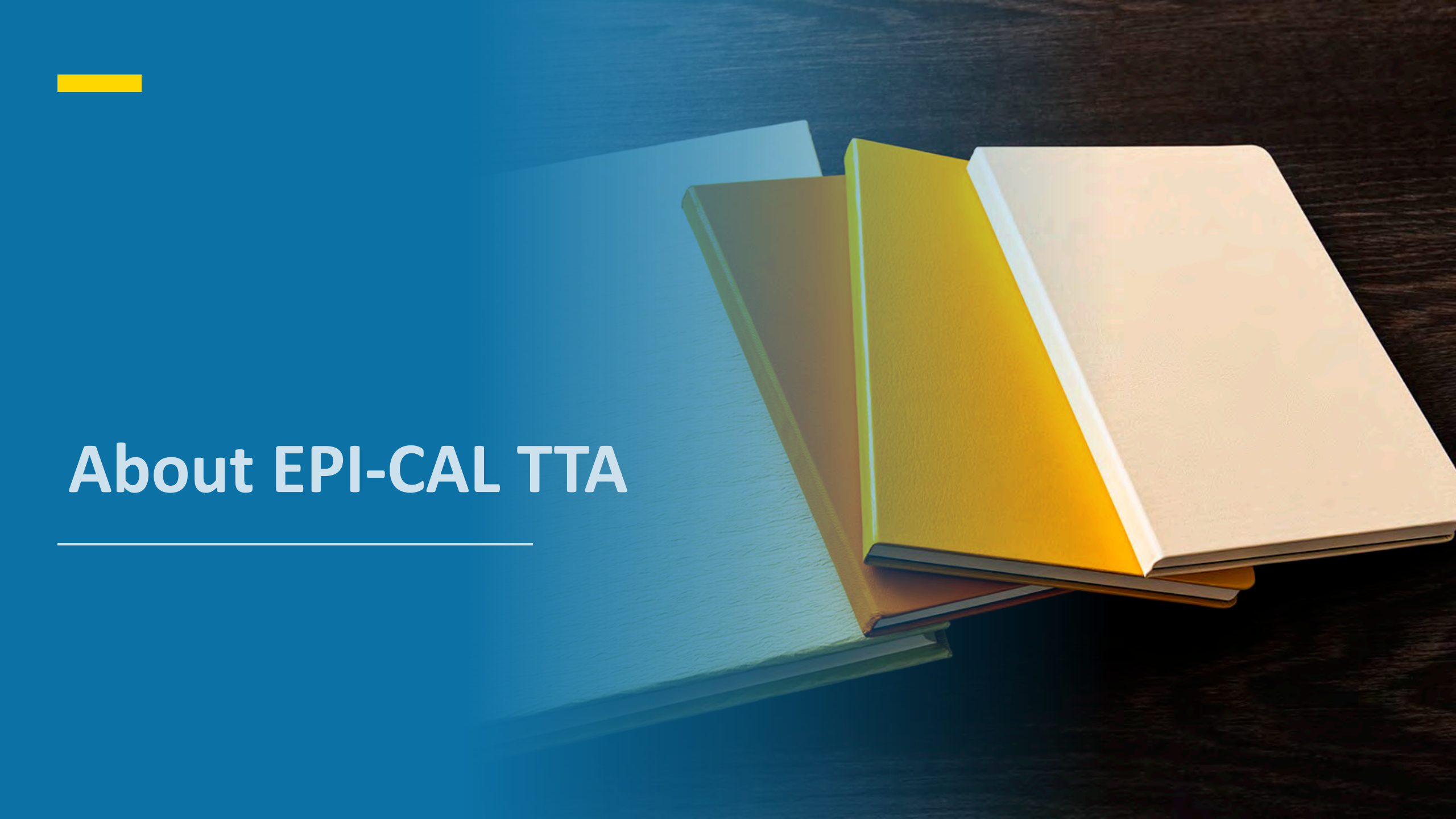
State Level

Administrator level allows access to a limited data set across all clinics on the app for county- or state-level data analysis

Proposed Learning Health Care Network for CA Mental Health Programs

Now that you understand EPI-CAL as a whole, the remainder of this presentation will focus on the EPI-CAL **TTA** (Training and Technical Assistance Center)

About EPI-CAL TTA



The **TTA** currently consists of 2 different funding streams: **EPI Plus** and **MHBG** supplemental funds. Each county/EP program is a recipient of at least one of these two grants.

TTA mission

We provide training and technical assistance to support implementation and sustainability of EP programs across California.

Our goals are to support provision of high-quality Early Psychosis care to all Californians and to promote recovery and better outcomes through a learning health care network approach.

Our team

UC DAVIS
UNIVERSITY OF CALIFORNIA

UCSF
University of California
San Francisco

Stanford
University

This program, presented by UC Davis, is a collaboration with our colleagues at UC San Francisco and Stanford University.

Your main point of contact will be TTA project manager Jessica Windhaus (**jrwindhaus@ucdavis.edu**)

Our sponsors

EPI-CAL receives funding from many different counties through the Mental Health Services Oversight and Accountability Commission(**MHSOAC**), **One Mind**, Department of Health Care Services (**DHCS**), and the National Institute of Mental Health (**NIMH**).

ONE MIND™

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

MHSOAC
Mental Health Services
Oversight & Accountability Commission

NIH National Institute of Mental Health

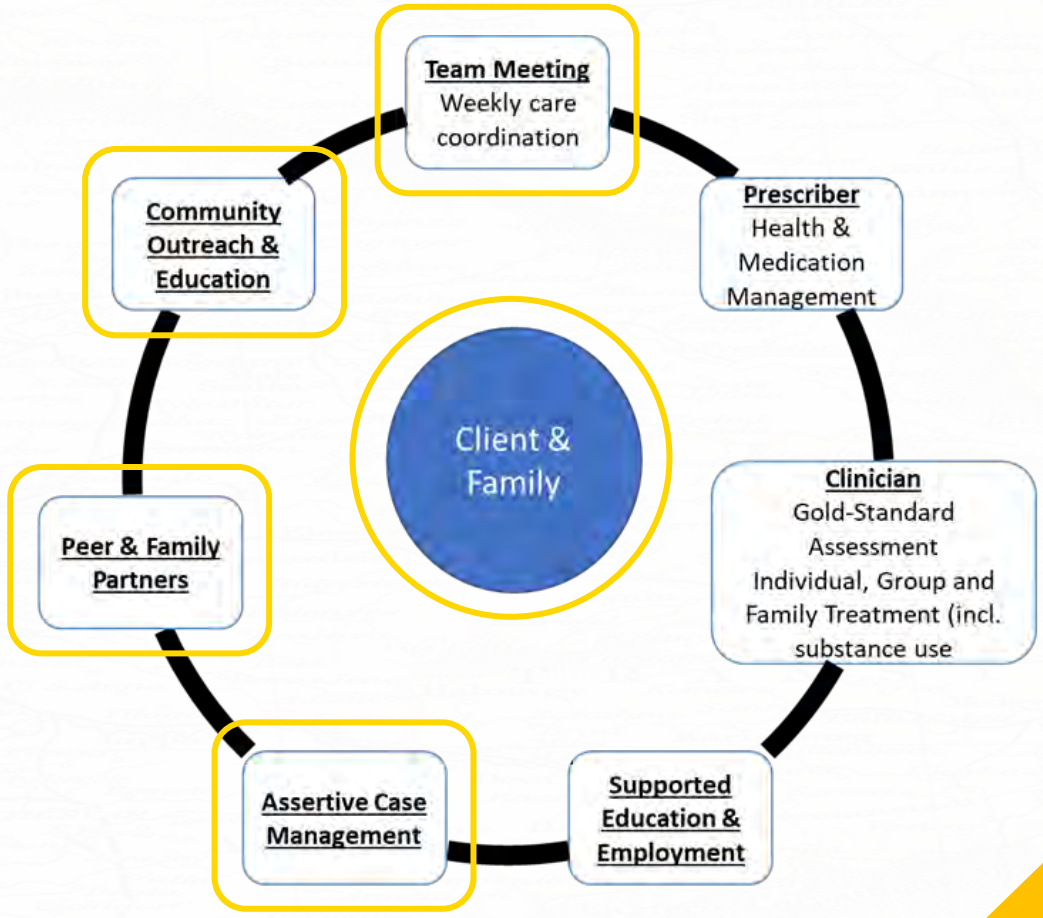
About CSC

The Coordinated Specialty Care Model

All grantees are expected to provide services consistent with the Coordinated Specialty Care (CSC) model, a team-based program providing an array of evidence-based interventions for recent onset/first episode psychosis.

Original CSC model tested by RAISE
(Heinssen, Goldstein, Azrin, 2014)

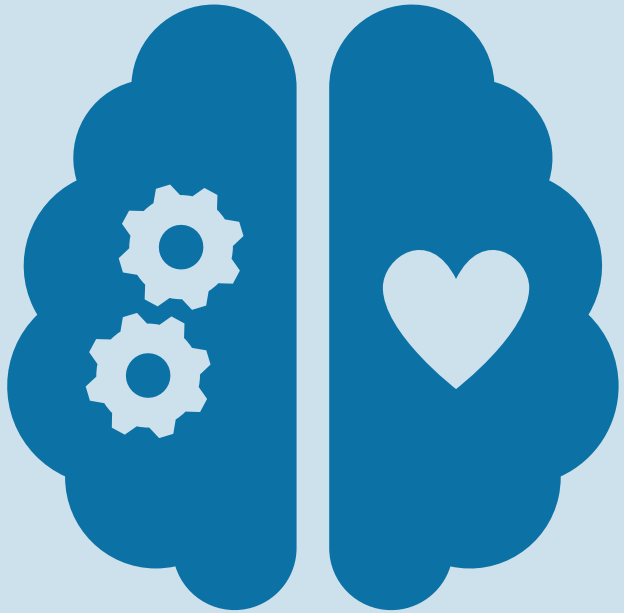
Our CSC model focuses both the client AND their **family/caregivers/support**. It also uses **assertive case management** and includes **Peers and Family Partners, community outreach and education**, and **weekly team meetings** to improve client outcomes.



EPI-CAL TTA CSC model

How is CSC different from normal community mental health care?

- CSC is a targeted, team-based intervention specifically for treating psychotic symptoms early in the course of illness to preserve functioning and prevent deterioration with the goal of improving overall life satisfaction, functioning, and outcomes
- Focuses on individuals with threshold psychosis
- Can also be used with CHRp (Clinical High Risk for Psychosis), but the ***CSC model has not been tested on this population***
- **If you decide to accept CHRp clients, this should be in addition to serving FEP, not instead of!**



Outcomes *without* CSC Care

Without good care, we can expect to see…

- Life expectancy is 10-20 years below average, increased risk for premature mortality[a]
- Related to significant medical comorbidities and high rates of substance use
- Rates of death by suicide range from 4% to 13%[b] - Most common during early phase of illness
- Rates of unemployment as high as 90%. High risk for homelessness, poverty, poor quality of life. [a,c]
- These experiences complicate treatment and recovery process!
- Annual economic burden of approximately $155.7 billion → $44,773 annual average cost per individual[a]

a. Wander, C. *Am J Manag Care*. 2020;26:S62-S68. b. Popovic D, et al. *Acta Psychiatr Scand*. 2014;130:418-426. c. Volavka J, et al. *Int J Clin Pract*. 2018;72:e13094.

Based on an average incidence of psychotic illness of 272 per 100,000 people each year, **approximately 107,000 Californians are estimated to experience a first psychotic episode each year**.

Let's look at the estimated incidence rates per county and how to staff your EP program according to the incidence rates.

psychosis incidence rates examples

Based on 2020 census

County	Total county pop.	FEP w/Medi-Cal[1]	FEP w/o Ins.[2]	Private Insured FEP[2]	**Total estimated new FEP cases per year**
Inyo	18,718	4	2	2	**8**
El Dorado	192,646	29	9	31	**69**
Los Angeles	9,721,138	2,923	958	1,698	**5,579**

1. Radigan, M., Gu, G., Frimpong, E. Y., Wang, R., Huz, S., Li, M., . . . Dixon, L. (2019). A New Method for Estimating Incidence of First Psychotic Diagnosis in a Medicaid Population. *Psychiatr Serv, 70*(8), 665-673. doi:10.1176/appi.ps.201900033
2. Simon, G. E., Coleman, K. J., Yarborough, B. J. H., Operskalski, B., Stewart, C., Hunkeler, E. M., . . . Beck, A. (2017). First Presentation With Psychotic Symptoms in a Population-Based Sample. *Psychiatr Serv, 68*(5), 456-461. doi:10.1176/appi.ps.201600257

Title	Role
Physician	Prescriber (1FTE/100 clients - 1 day/week = 20 clients). Must consider supervision of other staff (NP, nurse, etc.)
Nurse/NP	Same as above - needs supervision
Program Manager/Team Lead	1 FTE = 100 clients. Supports Admin and outreach. May also be a supervisor
Clinician	1 FTE = 1 bi-weekly intake + 16-18 cases
Case Manager	1 FTE = 40 cases
Peer	1 FTE = 50-60 cases
Family Partner	1 FTE = 50-60 cases
SEES	1 FTE = 50-60 cases
Clinic Coordinator	All referrals, daily clinic activity. Min .50 FTE, 1 FTE=50

Need to accommodate time for supervision, team meeting, administrative support for outreach and clinic coordinators

EP program staffing estimator

based on psychosis incidence rates

Staffing estimator for total incidence of 100 new cases of psychosis per year

Title	Role	#FTE for incidence
Physician	Prescriber (1FTE/100 clients - 1 day/week = 20 clients). Must consider supervision of other staff (NP, nurse, etc.)	1.0
Nurse/NP	Same as above - needs supervision	1.0
Program Manager/Team Lead	1 FTE = 100 clients. Supports Admin and outreach. May also be a supervisor	1.0
Clinician	1 FTE = 1 bi-weekly intake + 16-18 cases	6.3
Case Manager	1 FTE = 40 cases	2.5
Peer	1 FTE = 50-60 cases	1.8
Family Partner	1 FTE = 50-60 cases	1.8
SEES	1 FTE = 50-60 cases	1.8
Clinic Coordinator	All referrals, daily clinic activity. Min .50 FTE, 1 FTE=50	2.0

Need to accommodate time for supervision, team meeting, administrative support for outreach and clinic coordinators

TTA training

Our training content covers evidence-based assessment and treatment of individuals experiencing early psychosis, with a particular focus on fidelity to the CSC model

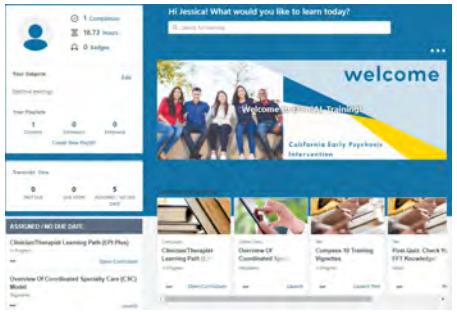
- TTA offers EP program staff a suite of trainings in CSC components
- Most are available for online/on-demand training
- We offer CME and CEU accreditation for 21 learning modules
- We have created custom learning paths for different clinic roles to suit individual need
- We provide drop-in trainings and learning collaboratives based on grantee requests and feedback

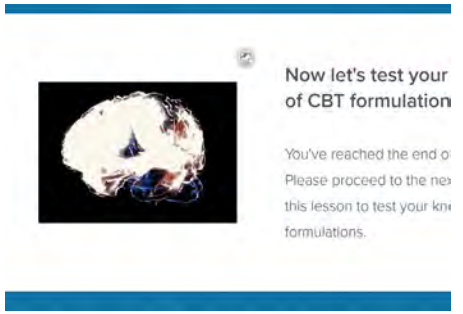
Our training modules

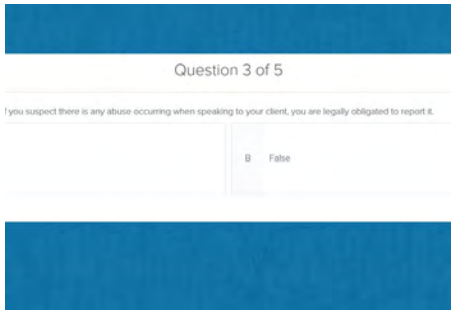
- TikTok for Mental Health Outreach
- Supported Education and Employment
- Avoiding and Responding to Burnout: Protecting our Ability to do Challenging Work
- Addressing Trauma with an Equity Lens: How Structural Inequities Impact Mental Health Care and Service Access
- Panel Discussion: Addressing Staff Retention and Turnover in EP Care
- Providing Psychoeducation in Early Psychosis Care
- Social Security, Work, and School in the Context of Psychosis
- Neurodevelopmental Considerations in the Differential Diagnosis of Psychosis Spectrum Disorders
- Overview of CBT
- CBT Informed Skills
- Formulation-Driven CBT
- PQ-B Screening
- Trauma in Early Psychosis
- Role of Families in EP Care
- Connecting with Communities/Outreach
- Compassion Fatigue and Self-Compassion
- Mini SIPS Administration Tips: Real World Implementation
- Working with Interpreters: General Guidelines for Clinical Settings
- Exploring the Impact of Cannabis Use on Psychosis Risk, Relapse, and Outcome
- Mini SIPS
- Preparing for Your First Intake Assessment
- Early Psychosis Clinic Phone Screening
- Clinical Outcomes Assessment
- Structured Clinical Interview for DSM Diagnoses (SCID)
- Understanding Medications in Psychosis
- Overview of the Coordinated Specialty Care Model
- Coordinated Specialty Care: Eligibility and Screening
- Overview of CPS and APS Reporting Guidelines in California
- Suicide Risk Assessment and Safety Planning in Early Psychosis Populations
- Understanding Psychosis: Early Identification & Treatment
- Overview of Early Psychosis Intake Assessment
- Assessment of Psychosocial Functioning in Clinical Populations
- Group Therapy
- Family Focused Therapy (FFT)
- Intro to CBT
- Positive Practices for Working with Psychosis
- Peer Support 101
- Introduction to Groups
- Assessment Feedback and Welcome Session
- Clozapine: A Guide for Clinicians
- Cultural Considerations and Working with Latinx Families

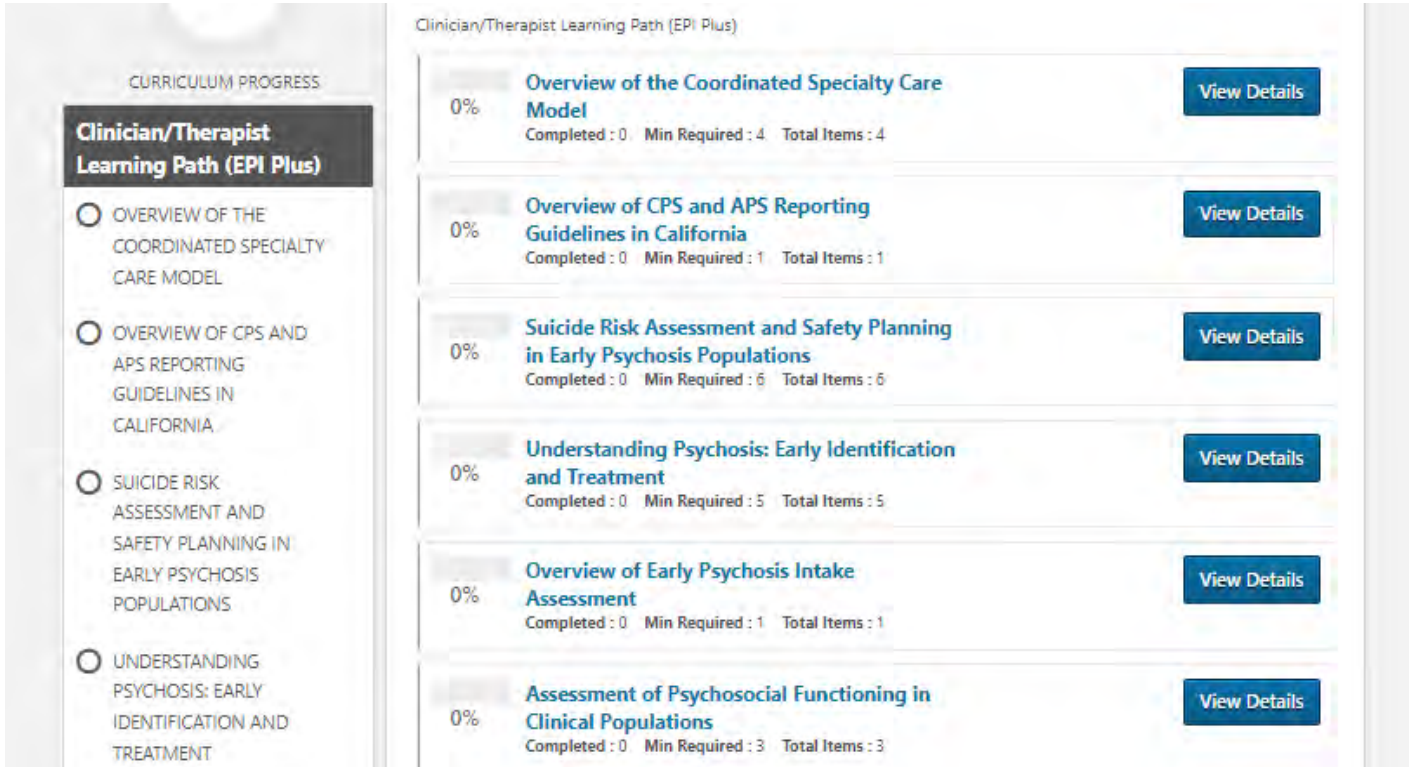
Our Learning Management System: Cornerstone

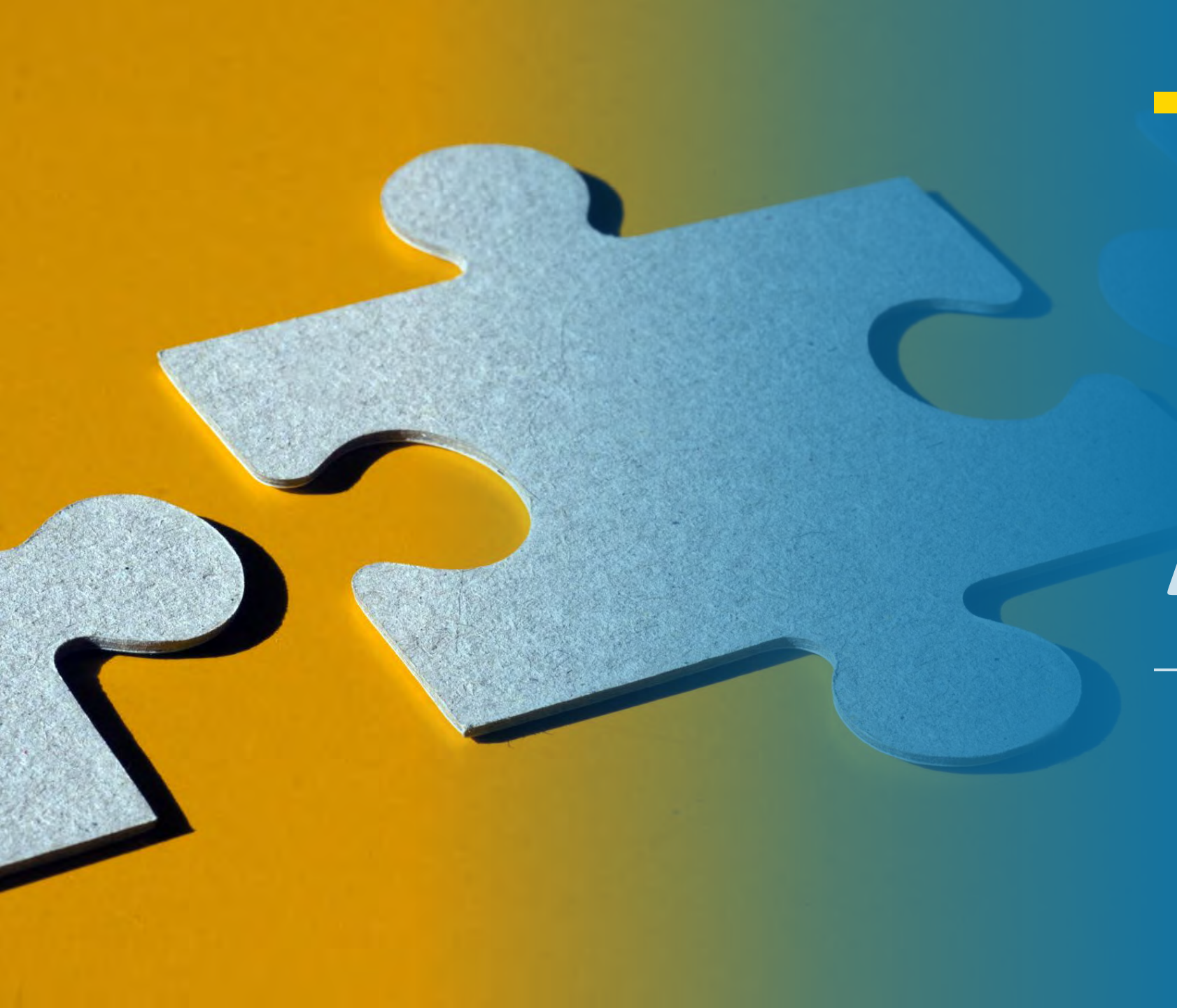
- Cornerstone is a software application for the delivery, tracking, reporting, and administration of educational courses, trainings, etc.
- Will allow you to attend live AND asynchronous/on-demand trainings
- **Cornerstone allows you to take trainings specific to your role within your clinic anytime in the order they should be taken**
- Cornerstone will track your progress in each training











Technical Assistance

Regular consultation meetings with each county EP program monitor progress towards TTA goals and assist counties with any challenges experienced within your EP program. Topics include:

- Staffing
- Training on CSC components
- Billing and documentation
- Medication management
- Eligibility and screening criteria/procedures
- Program and team structure
- Coordinated team care
- In-reach, referrals, outreach, development of targeted materials, and psychoeducation
- Enrollment
- Participation in the LHCN
- CSC fidelity and fidelity assessments
- Funding

Technical assistance:

ongoing consultation

Technical assistance:

TTA plans

- At the start of the grant period, each grantee completes self-assessments as part of the grant application to give the EPI-CAL TTA team a snapshot of each EP program's needs, strengths, weaknesses, etc.
- These assessments are then used to draft a TTA Plan
- TTA plans set annual goals towards improving fidelity to the CSC model for specific program components based on the strengths, weaknesses, and resources of EP programs.
- Plans include staffing, training, and overall goals for EP programs
- Grantees provide input on the plan goals and report progress during each consultation meeting with the EPI-CAL TTA
- Progress on TTA plan goals is reported to the sponsor

Fidelity assessment

Outcomes data collection: fidelity assessments

- Fidelity is the degree to which an activity is delivered consistent to evidence-based practice (EBP).
- TTA fidelity assessments measure how closely each program is delivering Coordinated Specialty Care in accordance with EBP, against a set of objective criteria.
- Grantee improvement on fidelity scores over time is the primary outcome metric for the TTA
- Fidelity assessments are crucial in:
  - identifying areas of strength and opportunities for growth within each program
  - informing TTA goals and the nature of support our program provides
  - identifying potential for data to support county/funder dialogue
  - evaluating the impact of the TTA on the improvements that programs achieve over time

Outcomes data collection: fidelity assessments

- For each assessment, we utilize the FEPS-FS version 1.1. (First Episode Psychosis Service – Fidelity Scale) and CHRPS, which assess fidelity to best practices delivered by a team that provides treatment and care for clients with FEP, or FEP and CHRp
- Assessments are conducted using:
  - admin data
  - patient numbers and staffing
  - health record data
  - components common to all patients
  - interviews with clinic staff
  - clinical services and staff training provided
- At the end of the assessment, we provide each clinic with a detailed report of the findings, including a summary of program strengths and possible modifications that could be made to deliver early psychosis care consistent with current best practices.
- We will provide more details on this process when it's time to schedule your program's fidelity assessment

Questions?

Reach out to Jessica Windhaus at
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Thank you