EPINET
Early Psychosis Intervention Network

EPINET Program Level Core Assessment Battery (PL-CAB)

Overview

The EPINET Program Level Core Assessment Battery (PL-CAB) was developed to collect information about the 100+ early psychosis programs involved in EPINET. It is intended to be administered annually.

The information collected by the PL-CAB may help improve treatment. For example, the PL-CAB collects information on topics such as the number of clinicians working with clients, program funding and services, program enrollment criteria, and the treatment model being used within clinics. This information can be combined with client outcome data to help researchers examine whether program factors make a difference in the outcomes of clients. This information may also help policy-makers made data-informed decisions regarding program characteristics that may lead to positive treatment results.

1. What is the name and address of your program?

Name: _____

Street Address: _____

City: _____

State: _____

Zip: _____

2. Please provide contact information for the primary person completing this survey.

First Name: _____

Last Name: _____

Position: _____

Email: _____

Phone number: _____

Program Background

3. Which model, if any, does your CSC program follow?

Select all that apply.

- ☐ OnTrack
- ☐ NAVIGATE
- ☐ EASA
- ☐ FIRST
- ☐ PREP
- ☐ STEP
- ☐ EDAPT
- ☐ EPICENTER
- ☐ Other (Specify: _____)

4. Do you have more than one CSC Team at your clinic? If yes, how many?

- ○ Only one CSC team
- ○ 2-3 CSC teams
- ○ 4-5 CSC teams
- ○ More than 5 CSC teams

5. How many clients are currently enrolled in your CSC program?

_____

6. What is the maximum client capacity of your CSC program?

_____

7. What is the typical length of time that clients are served through your CSC program?

Select one.

- ○ Less than 1 year
- ○ 12-18 months
- ○ 19-24 months
- ○ 25-36 months
- ○ 37-42 months
- ○ 43-60 months
- ○ More than 5 years
- ○ Other (Specify: _____)

8. **What is the <u>maximum</u> length of time that clients can receive services within your CSC program?**

   Select one.

   ○ Less than 1 year
   ○ 12-18 months
   ○ 19-24 months
   ○ 25-36 months
   ○ 37-42 months
   ○ 43-60 months
   ○ No set time limit

9. **What catchment area does your program serve? (e.g., Hamilton County, Washington County+Bristol City, state of New Mexico, etc.)**

   _____

10. **Please estimate the distance the *majority* of your patients travel to receive Coordinated Specialty Care (CSC) services (e.g., 30 miles, 15 miles, 8 miles).**

    ○ Less than a mile
    ○ 1-10 miles
    ○ 11-20 miles
    ○ 21-50 miles
    ○ More than 50 miles

11. **When did your program first start enrolling clients with first episode psychosis?**

    Month: _____ Year: _____

Program Funding

12. How is your program currently funded?

Select all that apply.

- ☐ Mental Health Block Grant (MHBG) Set Aside for Early Psychosis funds
- ☐ Other state funds
- ☐ County (or equivalent) funding
- ☐ Grants
- ☐ Medicaid
- ☐ Any other non-Medicaid insurer, third party payer or health plan
- ☐ Client self-pay
- ☐ Other (Specify: _____)

ONLY ASK Q13 IF "Mental Health Block Grant (MHBG) Set Aside" IS SELECTED IN Q12.

13. Approximately what percent of your program is supported through MHBG funding?

_____

ONLY ASK Q14 IF "Medicaid" IS SELECTED IN Q12.

14. What percent of your clients are Medicaid beneficiaries?

_____

Community Resources and Referrals

15. Are there any other coordinated specialty care programs serving early psychosis clients in your same catchment area?

- ○ Yes
- ○ No → ***Skip to Q17***

16. If yes, please list up to five program names as well the address for each:

Program name	Address

17. Approximately what percent of referrals to your CSC program come from each of the following?

Percentages should total 100%

_____ Psychiatric inpatient facilities
_____ Outpatient mental health clinics within the agency
_____ Outpatient mental health clinics outside the agency
_____ Emergency departments
_____ Private practice psychiatrists, counselors, therapists
_____ Primary care practitioners
_____ Courts/correctional facilities
_____ Colleges, high schools, or other educational institutions
_____ Centralized phone lines for referrals
_____ Consumer, professional, or family organizations
_____ Self-referrals
_____ Family referral
_____ Other (Specify: _____)
= 100%

Agency Characteristics

18. Is your CSC program a sub-unit of a larger agency or organization?

- ○ Yes
- ○ No → ***Skip to Q20***

19. What type of agency or organization oversees your clinic/program?

Select all that apply.

- ☐ Community Mental Health Center (CMHC)
- ☐ Other mental health agency
- ☐ Hospital
- ☐ University
- ☐ Other (Specify: _____)

20. What is the approximate racial composition of the client population at your broader agency?

Please enter an estimated percentage for each category listed below, to sum to 100%. If you do not know or cannot access this information, use the "unsure" option.

_____ Black or African-American
_____ White
_____ Asian
_____ American Indian or Alaskan Native
_____ Native Hawaiian or Pacific Islander
_____ Two or more of the above
_____ Unsure
= 100%

21. Is your program part of a Certified Community Behavioral Health Center (CCBHC)?

- ○ Yes
- ○ No

22. Which of the following best characterizes the relationship between your CSC program and the larger agency?

Select one.

- ○ Program in larger agency, similar rules and structures as other programs
- ○ Program in larger agency, independent rules and structures from other programs
- ○ Free standing program
- ○ Other (Specify: _____)

23. Which of the following best describes the physical location of your program?

Select one.

- ○ Free-standing building, house or structure
- ○ Clearly designated separate area of a larger building with a separate entrance
- ○ Program is located in a larger building and may have separate space (e.g., a designated floor or area of a floor); no separate entrance and exit
- ○ Program boundaries are not distinguishable from a larger building/agency

Program Services

24. Please indicate what treatment services and supports your CSC program provides, and whether these are offered at the clinic, through telehealth, and/or within the community, or not provided for at least 7 of the past 12 months.

	Provided at clinic	Provided via telehealth	Provided within the community	Not provided for at least 7 of the past 12 months
Alumni program	☐	☐	☐	☐
Case management	☐	☐	☐	☐
Cognitive Adaption Training	☐	☐	☐	☐
Cognitive remediation	☐	☐	☐	☐
Community outreach	☐	☐	☐	☐
Crisis intervention services	☐	☐	☐	☐
Family education or family support	☐	☐	☐	☐
Family peer support services	☐	☐	☐	☐
Health and wellness services	☐	☐	☐	☐
Housing support and services	☐	☐	☐	☐
Individual Cognitive-Behavioral Psychotherapy	☐	☐	☐	☐
Individual Resiliency Training	☐	☐	☐	☐
Neuropsychological assessment	☐	☐	☐	☐
Occupational therapy	☐	☐	☐	☐
Peer support services	☐	☐	☐	☐
Pharmacotherapy	☐	☐	☐	☐
Primary care coordination	☐	☐	☐	☐
Psychoeducation	☐	☐	☐	☐
Recreational groups	☐	☐	☐	☐
Smoking cessation services	☐	☐	☐	☐
Supported education services	☐	☐	☐	☐
Supported employment services	☐	☐	☐	☐
Substance use services, including co-occurring substance use services	☐	☐	☐	☐
Weight loss support and services	☐	☐	☐	☐

Fidelity

25. Does your CSC program use a fidelity tool to measure how closely the program reflects a specific model?

- ○ Yes
- ○ No → ***Skip to Q28***

26. Which tool(s) do you use?

Select all that apply.

- ☐ OnTrackNY
- ☐ NAVIGATE
- ☐ Early Assessment and Alliance (EASA) fidelity tool
- ☐ First Episode Psychosis Services Fidelity Scale (FEPS-FS)
- ☐ Other (Specify: _____)

27. How often is a fidelity assessment completed for your CSC program?

Select one.

- ☐ Monthly
- ☐ Quarterly
- ☐ Annually
- ☐ Other (Specify: _____)

Program Eligibility

28. What is the age range of clients eligible to enroll in your CSC program?

Minimum age: _____ (Please enter 0 if there is no minimum age)

Maximum age: _____ (Please enter 0 if there is no maximum age)

29. Is duration of untreated psychosis (DUP) a criteria for program eligibility?

- ○ Yes
- ○ No → ***Skip to Q31***

30. What is the maximum length of DUP allowed (in months)?

_____

31. Does your CSC program accept clients who are Clinical High Risk for psychosis?

- ○ Yes
- ○ No

32. Does your CSC program <u>exclude</u> individuals who have used an antipsychotic medication for a certain amount of time before enrolling in your program?

- ○ Yes
- ○ No → ***Skip to Q34***

33. What is the maximum number of months a person can use an antipsychotic and still be eligible for your CSC program?

_____

34. Does your program have an exclusion criterion for client minimum IQ?

- ○ Yes
- ○ No → ***Skip to Q36***

35. What is this minimum IQ?

_____

36. Are clients who only have substance-induced psychosis and no other type of psychotic disorder eligible for your CSC program?

- ○ Yes
- ○ No

37. Does your CSC program exclude clients with psychosis due to a medical condition?

- ○ Yes
- ○ No

38. Does your CSC program exclude clients with affective psychosis?

- ○ Yes
- ○ No

39. Does your program have any other exclusion criteria? (e.g., needing a certain type of insurance; needing a primary care provider etc.) Please describe.

_____

_____

_____

_____

Team Composition and Staffing

40. What is the total number of team members who are engaged in <u>providing direct services</u> to clients as part of your early intervention program.

Include yourself if you also provide direct services. Also include each team member who is at least 10% FTE or greater. For example, if you have 5 direct services team members at 100% time and 1 team member at 25% time, the total number would be 6.)

_____

41. Among those staff members providing direct services, what is the total number of full time equivalent (FTE) staff members who provide services to clients in your CSC program?

For example, if you have five team members at 100% time and one team member at 25% time, the total FTE would be 5.25.

_____

42. Do you currently have any trainees/students who provide services to clients as part of your program?

- ○ Yes
- ○ No

Team Staffing Detail

Below is a set of eight questions about each current member of your CSC team. After answering the set of questions for one team member, you will be asked if you have an another team member to add. This set of questions should be completed for <u>every</u> member of your CSC team who is engaged with your team (10% FTE or greater). In addition to the core members of your team, this may include individuals such as peer support specialists, outreach coordinators, nurses, prescribers, and interns or trainees.

43. Team member initials or ID:

_____

We need this identifier only to ask about each team member during subsequent follow-up surveys. It is fine to use fictitious initials or a random ID but please keep track of which identifier is being used for which team member for future reference.

44. What is the <u>primary</u> position of team member {INITIALS PREFILL}?

If this team member plays more than one role, please indicate the primary position and in the next question, you can indicate multiple roles.

- ☐ Team Lead
- ☐ Clinician
- ☐ Prescriber
- ☐ Case Manager
- ☐ Peer Specialist
- ☐ Family Peer Specialist
- ☐ Supported Education and Employment Specialist
- ☐ Nurse
- ☐ Outreach and Recruitment Coordinator

45. What roles/services does team member {INITIALS PREFILL} provide?

Select all that apply.

- ☐ Team leadership
- ☐ Supervision
- ☐ Psychotherapy
- ☐ Pharmacotherapy/Medication Management
- ☐ Case Management
- ☐ Peer Support
- ☐ Family education and support
- ☐ Supported Education and Employment Services
- ☐ Health/Nursing
- ☐ Occupational therapy
- ☐ Administrative support/Clinic coordinator
- ☐ Outreach and Recruitment
- ☐ Other (Specify: _____)

46. What is the highest degree(s) that team member{INITIALS PREFILL} has?
Select one.

- ○ HS Diploma/GED
- ○ BA/BS
- ○ MA/MS/MSW/MFT
- ○ PsyD
- ○ PhD
- ○ DO
- ○ MD
- ○ Other (Specify: _____)

47. What date did team member {INITIALS PREFILL} start working at your agency?

Month: _____ Year: _____

48. What date did team member {INITIALS PREFILL} start working on the CSC team?

Month: _____ Year: _____

49. What FTE is team member {INITIALS PREFILL}?
Enter a decimal value greater than 0 and less than or equal to 1

_____

50. What percent of this team member's time is devoted to the CSC team?

_____

51. Currently, how many clients does this team member provide services to?
Enter '0' if this does not apply.

_____

52. Do you have another team member to add?

- ○ Yes
- ○ No

[REPEAT FOR AS MANY TEAM MEMBERS AS NEEDED]

Cultural and Related Areas of Training and Services

53. Do any team members in your CSC program offer services in a language other than English?

- ○ Yes
- ○ No → *Skip to Q55*

54. If so, please indicate which language(s) below.

Check all that apply.

- ☐ Spanish/Spanish Creole
- ☐ African Languages
- ☐ Arabic
- ☐ Armenian
- ☐ Cambodian
- ☐ Cantonese
- ☐ Farsi
- ☐ French/French Creole
- ☐ Hebrew
- ☐ Hmong
- ☐ Indic (e.g., Hindi, Urdu, Sindhi)
- ☐ Italian
- ☐ Korean
- ☐ Mandarin
- ☐ Other Indo-European
- ☐ Polish
- ☐ Portuguese/Portuguese Creole
- ☐ Russian
- ☐ Tagalog
- ☐ Vietnamese
- ☐ Yiddish
- ☐ Other Asian languages
- ☐ Sign Language
- ☐ Other (Specify: _____)

55. Apart from bilingual services provided by team members, does your program offer live translation for languages other than English?

- ○ Yes
- ○ No → *Skip to Q57*

56. What other languages are available?

Check all that apply.

- ☐ Spanish/Spanish Creole
- ☐ African Languages
- ☐ Arabic
- ☐ Armenian
- ☐ Cambodian
- ☐ Cantonese
- ☐ Farsi
- ☐ French/French Creole
- ☐ Hebrew
- ☐ Hmong
- ☐ Indic (e.g., Hindi, Urdu, Sindhi)
- ☐ Italian
- ☐ Korean
- ☐ Mandarin
- ☐ Other Indo-European
- ☐ Polish
- ☐ Portuguese/Portuguese Creole
- ☐ Russian
- ☐ Tagalog
- ☐ Vietnamese
- ☐ Yiddish
- ☐ Other Asian languages
- ☐ Sign Language
- ☐ Other (Specify: _____)

57. Do you offer materials that are translated into other languages at your clinic?

- ○ Yes
- ○ No → *Skip to next section*

58. What languages are available?

- ☐ Spanish/Spanish Creole
- ☐ African Languages
- ☐ Arabic
- ☐ Armenian
- ☐ Cambodian
- ☐ Cantonese
- ☐ Farsi
- ☐ French/French Creole
- ☐ Hebrew
- ☐ Hmong
- ☐ Indic (e.g., Hindi, Urdu, Sindhi)
- ☐ Italian
- ☐ Korean
- ☐ Mandarin
- ☐ Other Indo-European
- ☐ Polish
- ☐ Portuguese/Portuguese Creole
- ☐ Russian
- ☐ Tagalog
- ☐ Vietnamese
- ☐ Yiddish
- ☐ Other Asian languages
- ☐ Sign Language
- ☐ Other (Specify: _____)

Transitions and Discharge

59. Please estimate the percent of clients who are typically referred to each of the following settings following completion of your CSC program.

_____ General outpatient services within the same agency (must include more than just medication management)
_____ Medication management within the same agency
_____ Assertive Community Treatment (ACT) or similar program for individuals requiring a higher level of support
_____ Transition Aged Youth (TAY) or similar program for young adults
_____ Step-down program that is separate from CSC
_____ Services provided in the broader community (e.g., community-based psychiatrist, general practitioner, etc.)
_____ No treatment following CSC
_____ Unknown
_____ Other

60. Apart from general outpatient services, does your agency have a defined step-down program (i.e., following completion of your CSC program) that can serve clients at the same or lower level of intensity and/or frequency following discharge?

○ Yes
○ No → ***Skip to Q63***

61. When did your step-down first begin serving clients?

Month: _____ Year: _____

62. How long are clients permitted to stay in this step-down program (in months)?
Enter '0' if there is no limit.

Months: _____

63. Are there criteria for entry into this step-down program?

Select all that apply.

- ☐ Age
- ☐ Level of functioning: The program is designed for higher functioning individuals
- ☐ Level of functioning: The program is designed for lower functioning individuals
- ☐ Other functioning criteria
- ☐ Payment source
- ☐ Other (Specify: _____)

64. Is this program limited to Transition Aged Youth?

- ○ Yes
- ○ No

65. Do any team members work with clients in both the primary CSC and step-down program?

Select all that apply.

- ☐ Team lead
- ☐ Primary Clinician
- ☐ Prescriber
- ☐ Case Manager
- ☐ Peer Specialist
- ☐ Supported Education and Employment Specialist
- ☐ Nurse
- ☐ Other (Specify: _____)
- ☐ None of the above

66. How are these step-down services currently funded?

Select all that apply.

- ☐ Mental Health Block Grant Set Aside for Early Psychosis funds
- ☐ Other state funds
- ☐ County (or equivalent) funding
- ☐ Grants
- ☐ Medicaid
- ☐ Any other non-Medicaid insurer, third party payer or health plan
- ☐ Client self-pay
- ☐ Other (Specify: _____)

67. How does the focus of the step-down program compare to your core CSC program?
Select all that apply.

- ☐ The step-down reflects a continuation of the CSC focus, but at a lower intensity/frequency
- ☐ The step-down reflects a continuation of the CSC focus, but a reduction in the type of services provided
- ☐ The step-down reflects a change in focus as compared to the CSC program
- ☐ Other (Specify: _____)

Thank you for taking our survey. Your response is very important to us!