EPINET Program Level Core Assessment Battery (PL-CAB)

Overview

This survey, called the EPINET Program Level Core Assessment Battery (PL-CAB), is being administered across {NAME OF HUB} clinics and also to first episode psychosis programs within EPINET. The results of the PL-CAB will help EPINET researchers understand the diversity of EPINET clinics across the nation.

The results of the PL-CAB will only be reported in aggregate and you will not be identified as the respondent nor will your program's name be attached to your PL-CAB data in publications or presentations using the data.

The PL-CAB will be administered annually and future versions will incorporate the information you provide today. The survey will take approximately 30 minutes to complete, and you can stop and start the survey multiple times to gather information. Although only one survey will be completed for each first episode psychosis program, multiple individuals can share the responsibility for completing it.

You may see that that some questions are already answered; these are answers that your Hub has completed for you.

If you have any questions or concerns, please contact {PLEASE PROVIDE HUB CONTACT PERSON NAME, TITLE, AND EMAIL ADDRESS}.Thank you!

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

   You will not be identified as the respondent in any reports, but this will help in follow-up if we need clarification on any responses.

   First Name: _____

   Last Name: _____

   Position: _____

   Email: _____

   Phone number: _____

Program Background

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

Select all that apply.

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

3. 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

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

_____

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

_____

6. 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: _____)

7. What is the *maximum* 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

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

_____

9. 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

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

Month: _____ Year: _____

- ○ Not Applicable, we do not serve FEP clients

Program Funding

11. 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 Q12 IF "Mental Health Block Grant (MHBG) Set Aside" IS SELECTED IN Q11.

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

_____

ONLY ASK Q13 IF "Medicaid" IS SELECTED IN Q11.

13. What percent of your clients are Medicaid beneficiaries?

_____

Community Resources and Referrals

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

- ○ Yes
- ○ No

15. Please select all referral sources for your CSC program:

- ☐ 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
- ☐ Consumer, professional, or family organizations (e.g., NAMI, Mental Health America)
- ☐ Self-referral
- ☐ Family referral
- ☐ Other (Specify: _____)

Agency Characteristics

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

- ○ Yes
- ○ No → ***Skip to Q18***

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

Select all that apply.

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

18. 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

19. 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

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

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

21. 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: _____)

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

Select one.

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

Program Eligibility

23. 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)

24. Is duration of untreated psychosis (DUP) a criterion for program eligibility?

○ Yes
○ No → ***Skip to Q26***

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

_____

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

○ Yes
○ No

27. Does your CSC program *exclude* individuals who have used an antipsychotic medication for a certain amount of time before enrolling in your program?

○ Yes
○ No → ***Skip to Q29***

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

_____

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

○ Yes
○ No → ***Skip to Q31***

30. What is this minimum IQ?

_____

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

- ○ Yes
- ○ No

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

- ○ Yes
- ○ No

33. Does your CSC program *exclude* clients with affective psychosis?

- ○ Yes
- ○ No

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

CSC Team Composition and Staffing

35. What is the total number of staff who are a part of your CSC team?

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

_____

36. Among those staff members that are a part of your CSC team, what is the total number of full time equivalent (FTE) staff members?

For example, if you have 5 team members at 100% time and 1 team member at 25% time, the total FTE would be 5.25.

_____

37. In the past year, how many staff members have *left* the CSC team? _____

38. In the past year, how many staff members have *joined* the CSC team? _____

CSC Team Lead

Below is a set of questions about the Team Lead of your CSC program.

39. What date did the Team Lead start working on the CSC team?

Month: _____ Year: _____

40. What FTE is the Team Lead?

Enter a decimal value greater than 0 and less than or equal to 1

_____

41. What percent of the Team Lead's time is devoted to the CSC team?

_____

Language and Related Areas of Training and Services

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

- ○ Yes
- ○ No

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

- ○ Yes
- ○ No

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

- ○ Yes
- ○ No

Transitions and Discharge

45. Please select all settings clients are referred to 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, or other community mental health services, etc.)
- ☐ No treatment following CSC
- ☐ Unknown
- ☐ Other

46. 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

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