Mental Health Services
Oversight & Accountability Commission

Early Psychosis Intervention (EPI) Strategic plan

Hand-out materials

July 25, 2024

Purpose

DRAFT AS OF 5/11/2024 **NON-EXHAUSTIVE**

The purpose of this document is to outline the emerging Early Psychosis Intervention 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.

DRAFT, AS OF JULY 11, 2024

Table of contents

Context for the effort

DRAFT as of July 11, 2024

The Mental Health Services Oversight and Accountability Commission (MHSOAC or the Commission) recognizes opportunities for early intervention and recovery that can prevent premature death or injury, contribute to improved family connectedness, and improve quality of life for the over 20,000 individuals that experience first-episode psychosis each year

The Commission also recognizes three priority downstream challenges for persons who experience psychosis without early prevention and intervention: 1) criminal justice involvement, 2) hospitalization, and 3) homelessness

With the passing of Prop 1, California has an opportunity to strengthen its behavioral healthcare system by bolstering access to early psychosis intervention (EPI). To do so, the Commission has developed:

- **A landscape analysis** of California's EPI programs
- **An economic analysis** of the impact of scaling EPI in California
- **A strategic plan** to scale EPI over a 3-year horizon

Source: MHSOAC

Process for the development, refinement and implementation of the EPI strategic plan

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Current stage

MHSOAC will develop & refine the strategic plan for early psychosis intervention through an iterative process, seeking continual input from a broad range of experts to build consensus, encourage alignment and drive a public narrative

1 Consultations with Subject Matter Experts

MHSOAC sought technical inputs from subject matter experts including people with lived experience, clinicians, and researchers to help draft **the strategic plan and identify options for scaling EPI access**

2 Input and feedback from across the ecosystem

MHSOAC speaks to **partners** to refine the strategic plan and build consensus

3 Public engagement and refinement

MHSOAC will share the refined plan in a public hearing to ensure Californians are aware of the initiative and can share feedback to improve the approach

4 MHSOAC review and adoption

MHSOAC to revise and **review the strategic plan and decide if the plan will be adopted**

5 Implementation

Commission will work with the **governor, legislature, and other partners** to implement in an advisory role

Source: MHSOAC

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DRAFT, AS OF JULY 11, 2024

Table of contents

Early psychosis: A brief overview

DRAFT as of July 11, 2024

What is early psychosis?

NAMI defines early psychosis, or first-episode psychosis as the early period (up to five years) after the onset of psychotic symptoms due to a serious mental illness (SMI) and unrelated to substance use, brain injury, or other non-SMI medical issues. **People experiencing early psychosis can see a wide range of symptoms**, including hallucinations and delusions.[1]

Early psychosis represents a stage of psychosis in which a psychotic disorder is likely to respond best to treatment[2]

When does early psychosis typically occur?

For those who experience early psychosis, peak onset of symptoms typically occurs between 15-25 years old, which can alter young people's development at a pivotal stage in their lives[4]

For those pre-disposed to early psychosis, exposure to traumatic events or adverse childhood experiences, as well as substance use, could trigger a psychotic episode; this is especially the case among youth[5]

While early psychosis can signal the onset of a psychotic disorder such as schizophrenia, anybody could experience a first episode of psychosis without necessarily having a condition such as schizophrenia; approximately 3 in 100 people will experience a psychotic episode in their lifetimes[3]

Source: 1. Lundin et al, Identification of Psychosis Risk and Diagnosis of First-Episode Psychosis: Advice for Clinicians, March 2021, SAMHSA, "Coordinated Specialty Care for FEP: Costs and Financing Strategies," Aug. 2023 2 3 Boonstra et al 4 Heinssen 5 Linszen et al

Potential impact of psychosis on individuals' lives and livelihoods

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- Impact for individuals experiencing psychosis
- Impact on caregivers

Health Care

Employment

Housing

Criminal Justice

Caregiving

Source: 1. Simon, Stewart, et al 2. Simon et al 3. Kadakia et al, 4. NSDUH , 5. Guhne et al 6 BLS 7 Ayano et al, 8 Lin et al 9 Wasser, Pollard, et al , 10 Arizona State University research 11 Cham et al 11 Gupta et al, 12. Wasser et al.; 13. Stanford Justice Advocacy Project

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The CSC model provides a holistic intervention model for treating early psychosis

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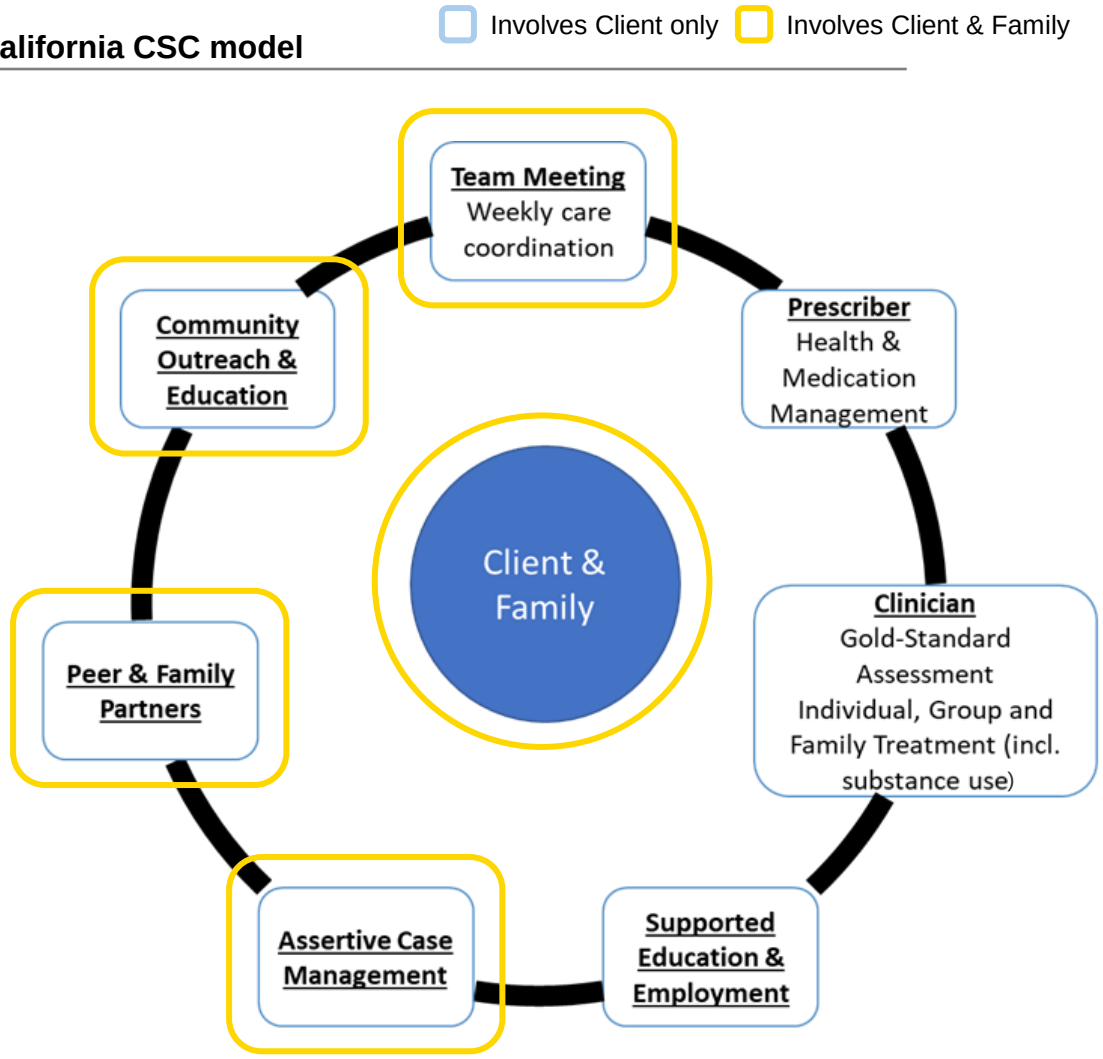
California CSC model



Select examples of observed impact of CSC on participants

- On average, CSC **reduces inpatient days by 33%** and average number of **ED visits per year by 36%**[1]
- Reduces likelihood of being **unemployed by ~42%** (from 50% to 29%)[2]
- Improves **education and employment rates** increased **by 2x** (from 40% to 80% in six months) [3]
- Reduces need for **homelessness services** amongst the FEP population **by 48%**[4]
- 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[5]

1. Rosenheck et al; 2. Dickerson et al, 3. Nossel et. al..; 4. Tsiachristas et al; 5. Pollard et al.
Sources: MHSOAC, Based on empirical studies

California has invested in scaling EPI care

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Programmatic Funding

Key milestones

1999 — **Full-Service Partnership** pilot projects established by legislation to fund comprehensive care for persons at risk of SMI (Serious Mental Illness), homelessness, justice involvement[1]

2004 — **Prop 63 Prevention and early intervention**[2] funds led to rapid development of early psychosis programs across California; EDAPT model first used in California[3]

2017 — The Early Psychosis Training and Technical Assistance Center was developed by UC Davis, in collaboration with UC San Francisco and Stanford University, as part of the State of California's **AB1315 EPI Plus** legislation[4]

2018 — **NIMH established the Early Psychosis Intervention Network (EPINET)** to link over 100 CSC programs in 17 states and the EPINET National Data Coordinating Center (ENDCC)[5]

Sep 2023 — **CYBHI awarded $67M** to 99 organizations to scale evidence based early intervention programs for children & youth[6]

Dec 2023 — **MHSOAC partnered** with National Council for Mental Wellbeing, NAMI, NASMPHD and McKinsey Health Institute to develop a national analytic model to estimate the impact of scaling CSC[7]

Mar 2024 — **MHSOAC** begins to develop a strategic plan to expand access to EPI

1. MHSOAC Report to legislature on FSP, 2. MHSOAC, 3. Niendam et al. 4. MHSOAC EPI Plus 5. EPINET 6. CYBHI 7 MHSOAC. 12. # of active CSC programs in 2022 as per SAMHSA.

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Estimates indicate that 1 in 10 Californians in need have access to CSC

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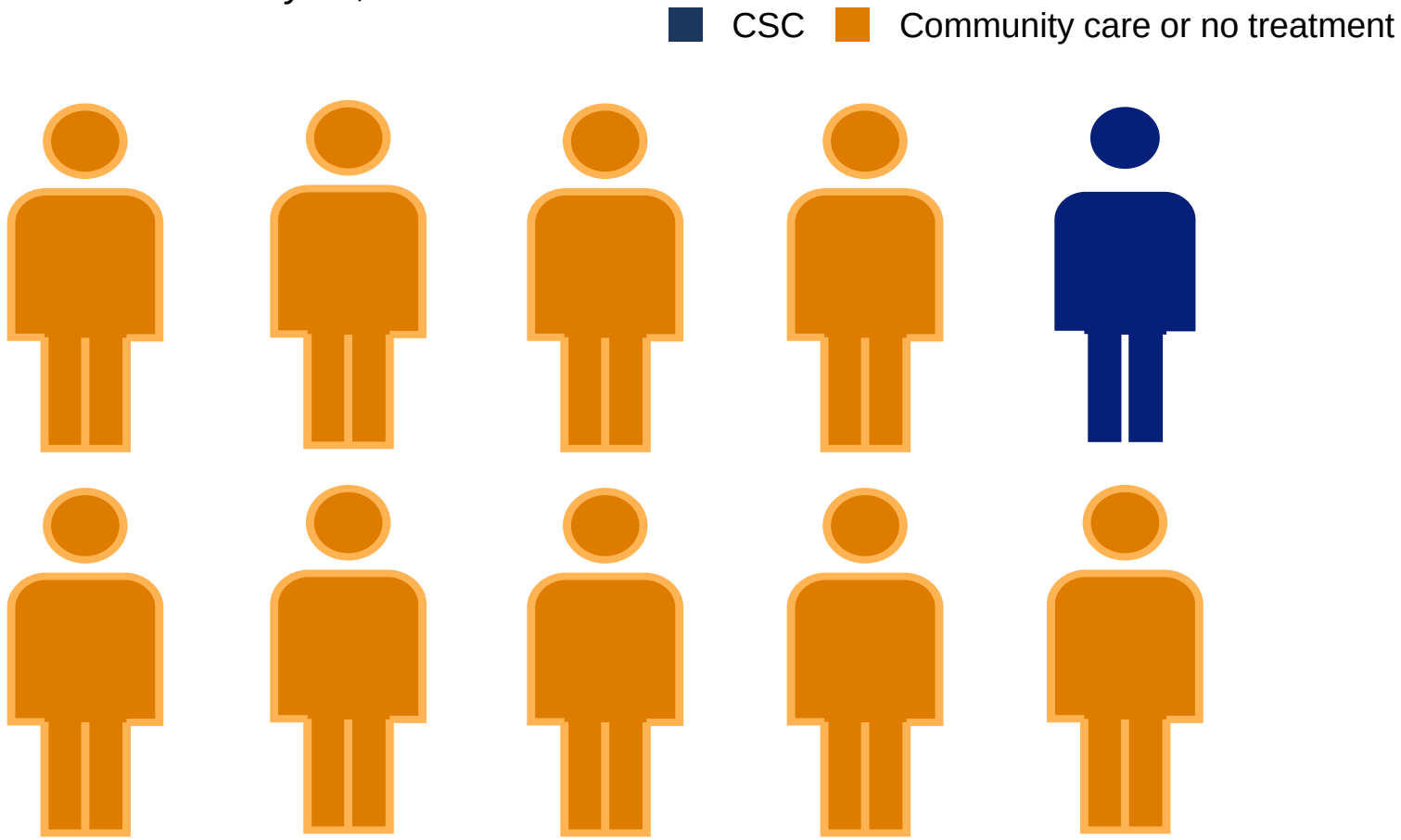

But many face barriers to access:

- Insufficient insurance coverage[1, 2]
- Availability of CSC facilities[3, 4, 5]
- Inconsistent screening, diagnosis, and care coordination[6, 1,]

1. Early Psychosis Intervention (EPI) Advisory Group; 2. Hirschtritt et al.; 3.Niendam et al.; 4. 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; 5. Interview with Executive Director of EPI-CAL, 17th April 2024; 6. Peralta et al.

DRAFT, AS OF JULY 11, 2024

Table of contents

High-level summary of preliminary findings of initial EPI model

DRAFT as of July 11, 2024

PRELIMINARY

Expanding access from 10% to 90%[1] of individuals with needs will have significant impact…

Estimated impact over a 10-year span

135K+ **individuals experiencing psychosis** and their families p**ositively impacted**

~$12B **overall value generated for the entire ecosystem[4]** compared to a system addressing only 10% of need

Estimated impact in year 5

17K+ **additional individuals provided access that year** (9x the number of individuals with access when there is 10% access) while reducing overall system costs[2]

~$0.9B **in annual Healthcare costs[2] shifted from inpatient settings to CSC** and ongoing outpatient care

~$1.7B **In annual non-healthcare cost savings[3]** generated

~$858M **in annual net savings** with ~**$2.4B** in direct annual costs and ~**$3.3B** direct and indirect savings across the full ecosystem

1. Representing percent of individuals receiving timely access in their first year and delayed access in their second year of experiencing psychosis
2. 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.
3. 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 / year and $102 / 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.
4. 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. 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.

Over a 10-year span, a system that addresses 90% of need could generate ~$12B in savings[1]

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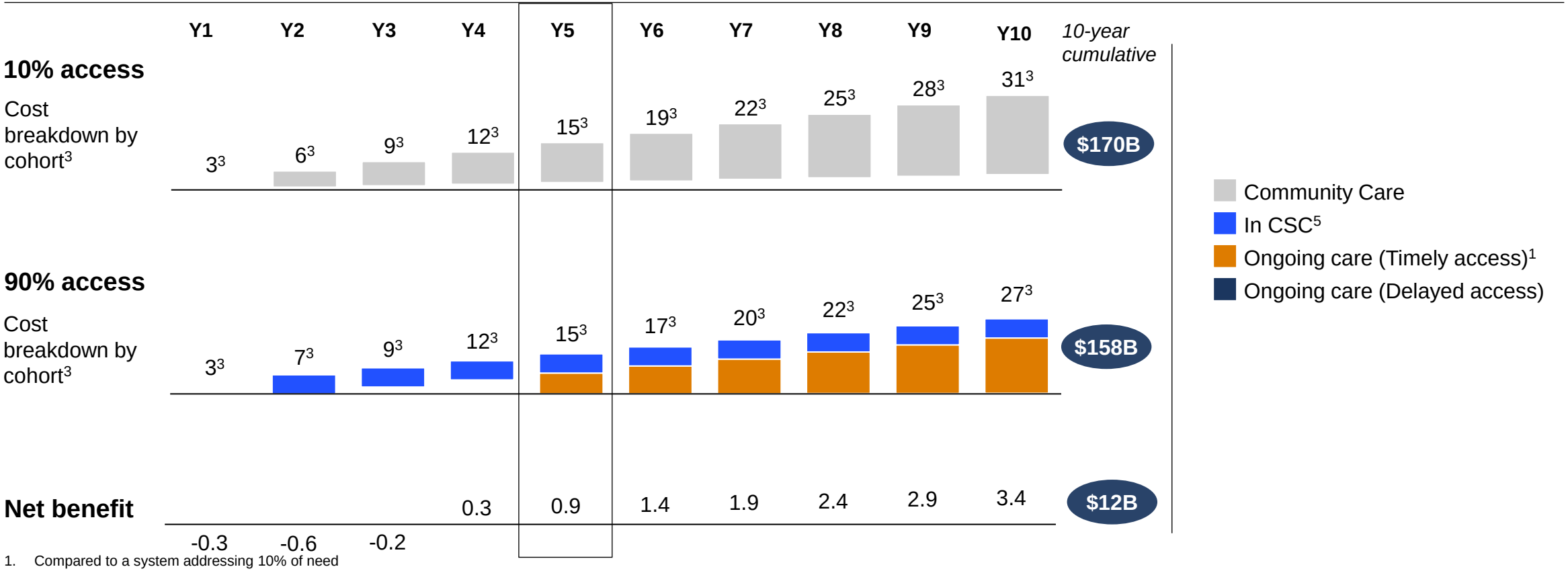
PRELIMINARY

Deep dive to follow

Difference in total system costs between 10% and 90% access[1,2] over 10 years ($B)[3,4]



1. Compared to a system addressing 10% of need
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
5. Representing percent of individuals receiving timely access in their first year and delayed access in their second year of experiencing psychosis

Source: Secher et al (2014) Ten Year Follow-up of the OPUS Trial

Table of contents

For discussion: Draft dimensions of the EPI strategic plan

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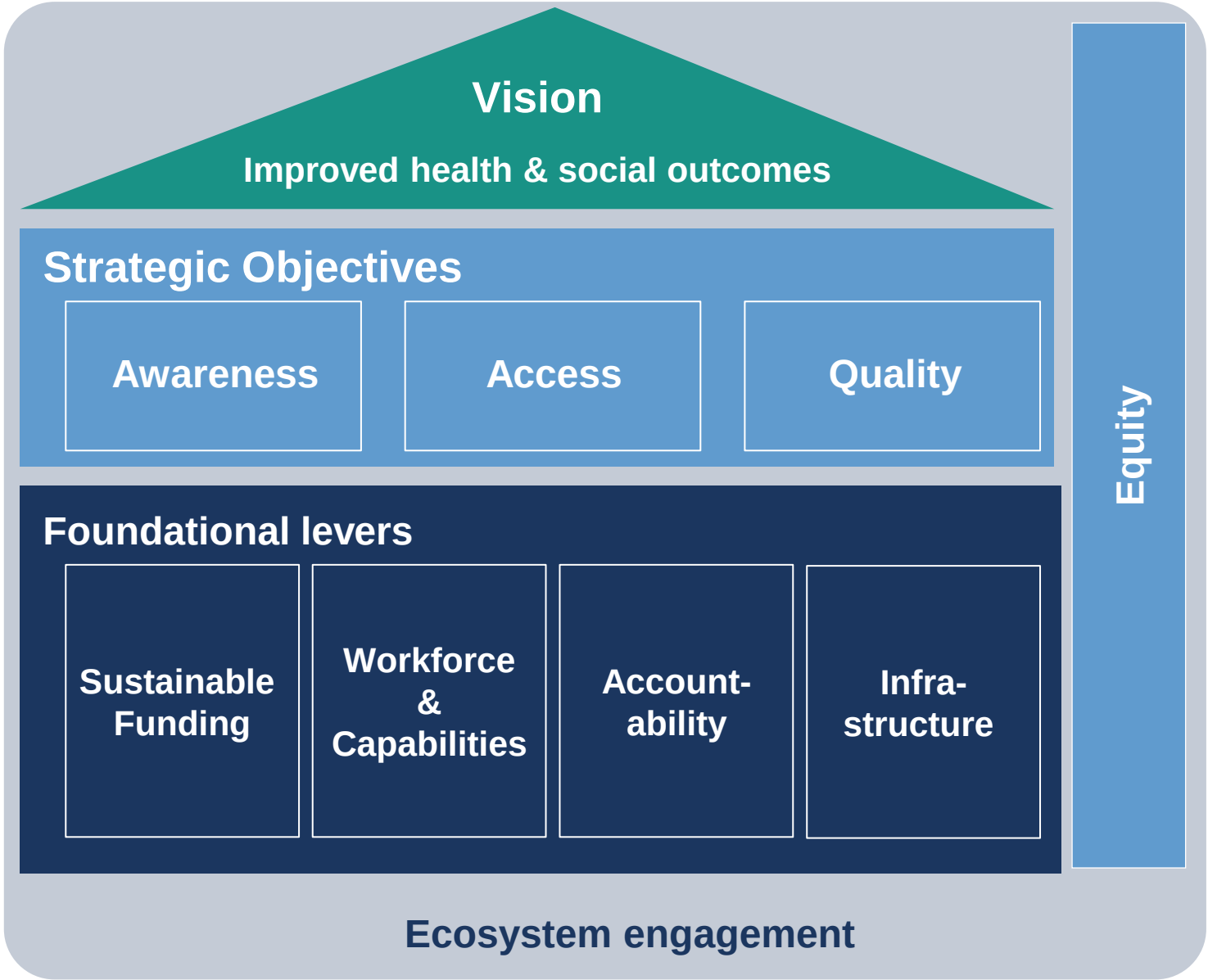

Source: MHSOAC

DRAFT EPI strategic plan's vision

DRAFT AS OF 7/10/2024

The desired future state is to ***ensure Californians experiencing psychosis and their families have equitable access to high-quality, appropriate, holistic early psychosis care***

To this end, the State may consider:

- Building on its pioneering focus on behavioral health
- 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
- Engaging diverse perspectives and centering 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 care 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., education and employment, housing)
- Enhance the State's capacity and capabilities to provide high-quality EPI services by expanding the behavioral health workforce

Source: Discussion with MHSOAC and Advisory Group on April 29, 2024

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To support successful execution four potential Implementation Support workstreams have been identified

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Integrated coordination

Establish a central team to coordinate among ecosystem partners their initiatives to ensure successful and timely implementation of the plan

Performance management

Identify metrics and track progress to promote accountability across initiatives and partners and measuring impact

Change management

Identify and deploy change champions and sponsors across ecosystem partners to promote adoption and implementation of the strategic plan

Communications plan

Develop and roll out coordinated communication and engagement strategies to ensure clarity, consistency, and alignment in messaging and provide regular updates on progress

Source: MHSOAC

Potential EPI Plan Implementation actions to be initiated over 3 years

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EPI Plan Activities

Year 1

Workgroups: Convene workgroup(s) to define goals and design strategies and 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 accordingly.

Year 2

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.

Year 3

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.

Source: MHSOAC

Next steps for the Commission

DRAFT as of July 12, 2024

1. **Provide feedback on EPI Strategic Plan** to continue to refine the document

2. **Help disseminate the plan** to ecosystem partners gather additional input

Both written feedback and/or live discussions are welcomed

Any questions?

Appendix

Published research | Health Sector | Private Sector | Civil Society | Public Sector | Human Services

Example journey with no Coordinated Specialty Care (CSC) access

Noah

Bird watcher, gamer, foodie
Uses commercial insurance

At 15, Noah begins to hear voices telling her to self-harm. After a serious self-injury, Noah's family calls 911 and Noah is taken to the ER. After 36 hours, Noah is admitted to an inpatient unit, is not asked about symptoms of psychosis, and is discharged from the hospital with a referral to outpatient treatment that she chooses not to pursue

Noah's untreated psychosis hinders her ability to successfully complete high school. Noah drops out in 11th grade

1 Mean age of onset 20 years; Range 15 35 years[1]

2 A first episode of **psychosis can disrupt educational goals**, including attainment of a college education without proper supports[2]

3 Noah's symptoms worsen, suicidality increases, and she experience repeated ED visits and hospitalizations. Noah is not assessed for psychotic symptoms[4] so her providers prescribe antidepressants and CBT[5]

Individuals experiencing psychosis have been observed to have **higher utilization of the healthcare system**, including higher rates of emergency department visits **excess healthcare cost is $62.3B** for those affected by schizophrenia[3]

4 Frustrated by the lack of improvement, Noah's family seeks help from an out of network provider who continues to treat Noah for depression and suicidality

- Caregivers for people with psychosis report **higher levels of emotional or physical tension** related to caregiving than other caregivers[6]
- Time commitments of caregiving often lead to **missed days of work and lost income for caregivers**, and may even negatively impact their professional aspiration[6]

~20% of people who are homeless experience psychosis and ~10% have schizophrenia[7]

- Per NSDUH[8], 3.1M adults aged 18 to 64 (8.4% of the age group) experiencing any mental illness are unemployed (compared to 5.3% of the general population)[9]

5 Noah has difficulty keeping a job or friends and alternates between living at home and being unhoused. Noah's parents often miss work to provide care for Noah and experience emotional and financial stress

~1 in 4 people experiencing mental disorders have histories of police arrest[10]

6 Noah begins to smoke and use alcohol and illicit drugs. She has frequent law enforcement encounters for minor, nonviolent offenses (e.g., possession, trespassing)

People with schizophrenia are **3x more likely** to experience serious problems with **drug or alcohol use** during their lifetime than the general population[11]

7 After her 13th arrest, Noah agrees to residential treatment for co-occurring disorders. Noah, now 25, is diagnosed with schizoaffective disorder. Noah's insurance does not cover the wraparound services recommended for follow up

8 Noah applies for SSI[12] and enrolls in Medicare and Medi-Cal. Noah gets resources to help manage her mental health and achieves recovery from SUD.[13] Hepatitis and diabetes reduce Noah's quality of life

- Individuals experiencing psychosis are 3.5x more likely to die due to **cardiovascular disease, tobacco use, and substance use** and exhibit 15x 30x increase in mortality due to suicide[14]
- Individuals experiencing psychosis have a **shorter life expectancy by an average of 10 15 years and are 8x as likely to die during the year following their diagnosis** as people in the general population[14]

Source: 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.

Published research | Health Sector | Private Sector | Civil Society | Public Sector | Human Services

Example journey with timely Coordinated Specialty Care (CSC) access

Kai

Art history lover, soccer player, mystery novel reader
Uses Medi Cal

Kai begins experiencing paranoia and intrusive thoughts at age 16[1]

1

Mean age of onset 20 years; Range 15 35 years[2]

2

Kai's symptoms become distressing; as their school performance slips, a school counsellor trained in EPI[3] flags possible symptoms to their parents[1]

After consulting with their parents and providers, Kai decides to enroll in a CSC program and waits two months for space to open in a nearby county program

3

CSC programs **improve symptoms of schizophrenia and psychosis** (based on measures of both PANSS[4] / CGI[6]) observed over 24 months[5]

4

CSC programs provide employment and educational supports to help patients attain **normal levels of functioning**[7]

5

Kai pursues their life passions for art history and soccer with minimal health setbacks; their routine care helps them maintain health and stay a vital member of their community

Participation in CSC program on average reduces **inpatient days** by 33% and average number of **ED visits** per year by 36%[8]

6

Supported by peers and clinicians in the CSC program's education model, Kai completes high school, graduates from the CSC program, chooses to enroll in college, and joins a support group at a community behavioral health center

Kai maintains and grows a strong friend group, serves as a youth leader at an arts center, and explores dating

- **The CSC model** focuses on both the client and their **family / caregivers / support**[9]
- Program participation reduces average **incremental healthcare costs** through improved health outcomes for caregivers by 29%[10]

7

Kai decides to move into their own apartment after living with their parents for a few years. Kai's parents are grateful to see them thrive

CSC program participation reduces average cost of **lost productivity** due to caregiving duties by 28%[10]

8

Following a relationship breakup, Kai's mental health suffers. After discussion with their therapist, Kai decides to stay with family temporarily. Their parents use their knowledge from family psychoeducation to help Kai re-balance

- CSC program participation reduces **need for homelessness services** amongst the FEP population by 38%[11]
- CSC programs reduce average cost of providing **supportive housing** per person of program participants[11]

9

After college, Kai starts a new relationship and begins their dream career as a museum program coordinator

CSC program participation reduces likelihood of being **unemployed** by ~42% (represents reduction from 50% to 29%)[12]

10

By addressing early symptoms of psychosis with timely, evidence-based care, Kai moves into adulthood equipped to manage their mental health with supportive community services; they maintain strong relationships and live an active lifestyle. Today, Kai has a promising career, owns a home, and plays soccer with a local team

Source1. 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.

Potential impact of psychosis on individuals' lives and livelihoods

DRAFT as of July 11, 2024

NON-EXHAUSTIVE

Dimension	Impact of psychosis
Healthcare	• Individuals with psychotic disorders have **shorter life expectancy by an average of 10-15 years**[1] and are **8x as likely to die during the year following their diagnosis**[2] as people in the general population • According to a study by G. Simon et al, individuals with psychotic disorders are 3.5x more likely to die due to **cardio-vascular disease, tobacco use and substance use** and exhibit 15x-30x increase in mortality due to suicide[2] • According to a study by A. Kadaika et al, people with psychotic disorders have been observed to have **higher utilization of the healthcare system**, including higher rates of emergency department visits[3;] **excess healthcare cost is $62.3B** for those affected by schizophrenia[3]
Employ-ment	• A study by U. Guhne et al found that about one quarter of people with SMI are unemployed; per NSDUH data, **3.1M adults** aged 18 to 64 (8.4% of the age group) experiencing any mental illness are **unemployed** (compared to 5.3% unemployment rate of the general population)[4,5,6]
Housing	• A study by G. Ayano reported that **~20%** of people who are **homeless** experience psychosis and ~10% have schizophrenia[7] • According to a study by D. Lin, the **risk of experiencing homelessness is 4.5-5.4x** higher amongst veterans with schizophrenia versus without[8]
Criminal justice	• A study by T. Wasser and J. Pollard found that **37% of patients experiencing FEP were incarcerated** at some point during their **pathway to clinical care**[9] • A study by the California Department of Correctional Health Care Services found that approximately 30% of California Prisoners received treatment for a serious mental disorder.[12] The average annual cost of incarcerating a state prisoner in California at over $70,000while the cost of treating a person with mental illness in the community is approximately $22,000.[13]
Caregiving	• Per a study by C. Cham, caregivers for people with psychosis report **higher levels of emotional or physical tension** related to caregiving than other caregivers[11] • According to a study by S. Gupta, time commitments of caregiving often lead to **missed days of work and lost income for caregivers**, and may even negatively impact their professional aspirations[12]

1. Simon, Stewart, et al 2. Simon et al 3. Kadakia et al, 4. NSDUH , 5. Guhne et al 6 BLS 7 Ayano et al, 8 Lin et al 9 Wasser, Pollard, et al , 10 Arizona State University research 11 Cham et al 11 Gupta et al, 12. Wasser et al.: 13. Stanford Justice Advocacy Project

When access is expanded from 10% to 90% of estimated need, healthcare costs shift from inpatient settings to CSC and ongoing outpatient care

DRAFT as of July 11, 2024

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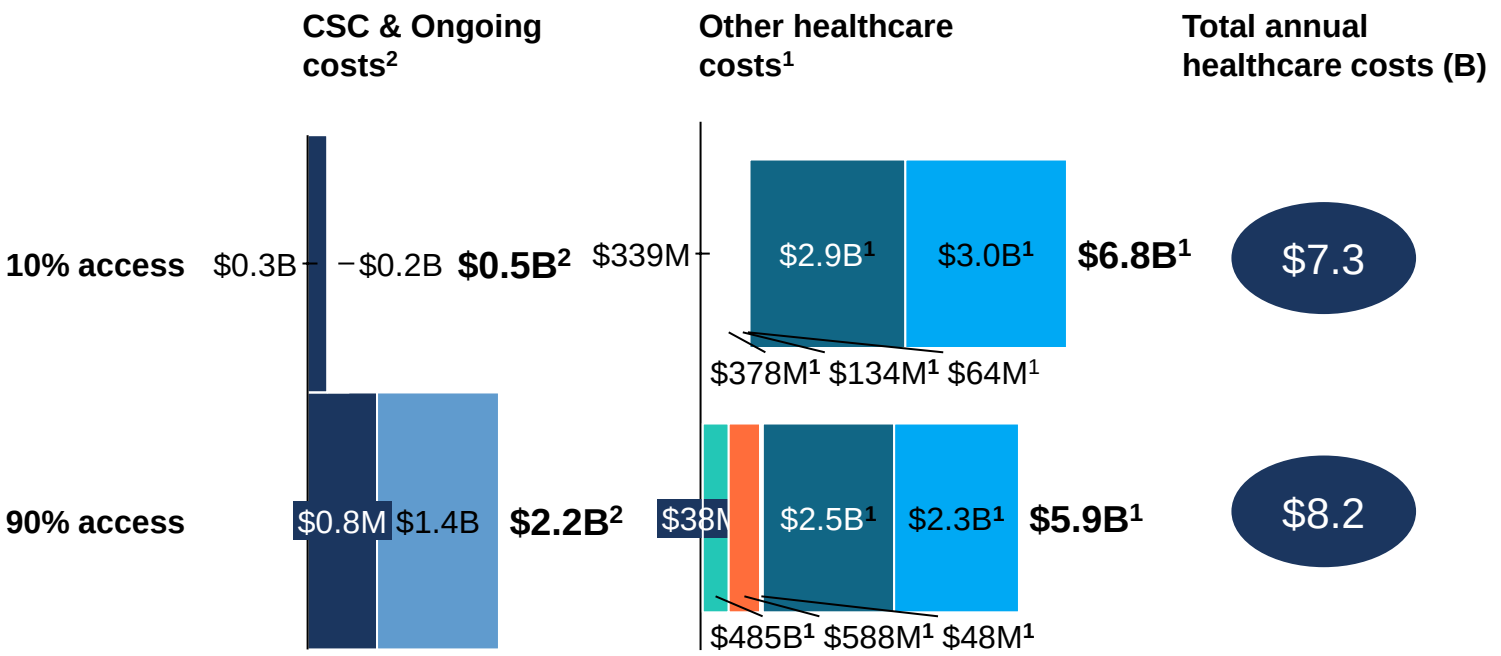
CSC
Ongoing (timely and delayed)
Inpatient care
Physical health costs
ED visits
Residential care
Medications
Community care

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

Total annual healthcare cost:



To **expand access to 90% of Californians** experiencing early psychosis:

- Annual costs of providing CSC & ongoing care increase by ~**$1.7B**
- Annual costs of other healthcare services (e.g., inpatient, residential care, ED, physical) decrease by ~**$0.9B**
- Average per person healthcare costs for those receiving access to CSC decreased by **~10% from ~$61k to ~$55k[7]**

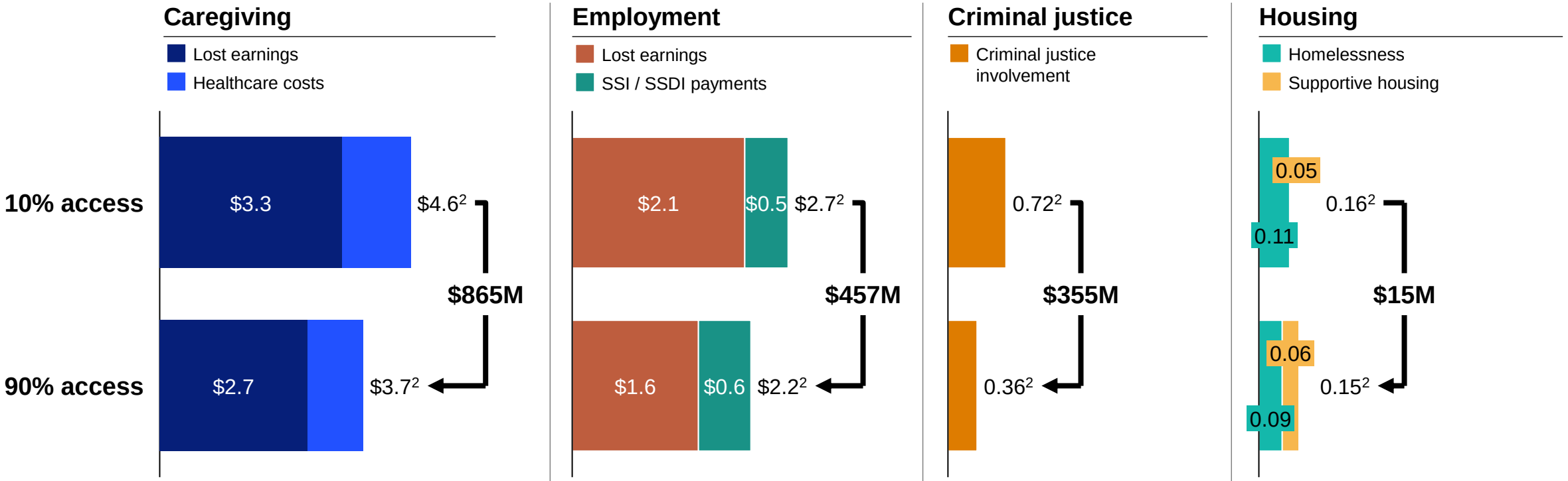
1. Healthcare is inclusive of inpatient and residential care, outpatient visits, ED visits, medications, and physical health. Individuals not receiving CSC are considered to receive community care, estimated at 37 visits / year and $102 / visit (adjusted to 2024 USD) based on data from the NIMH RAISE-ETP study. For individuals receiving CSC, outpatient care is estimated at the cost of a team to deliver CSC or ongoing care.
2. 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. Representing percent of individuals receiving timely access in their first year and delayed access in their second year of experiencing psychosis
4. 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.
5. 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
6. Medication and residential care costs are indirect costs increases – annual cost increase as a result of increasing access.
7. Calculated by dividing 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 timely access from 10% to 90% is estimated to generate ~$1.7B in potential non-healthcare cost savings in year 5

DRAFT as of July 11, 2024

PRELIMINARY

Total non-healthcare costs at different levels of Coordinated Specialty Care (CSC) access[1] ($B), by non-healthcare impact category[2,3]



Individuals impacted per year

Estimated 12.5K fewer individuals requiring caregiving

Estimated 12.6K additional individuals joining the workforce

Estimated 10K additional individuals receiving SSI/SSDI payments

Estimated 9.3K individuals with fewer interactions with the criminal justice system

Estimated 1.9K fewer individuals living on the street or in shelters

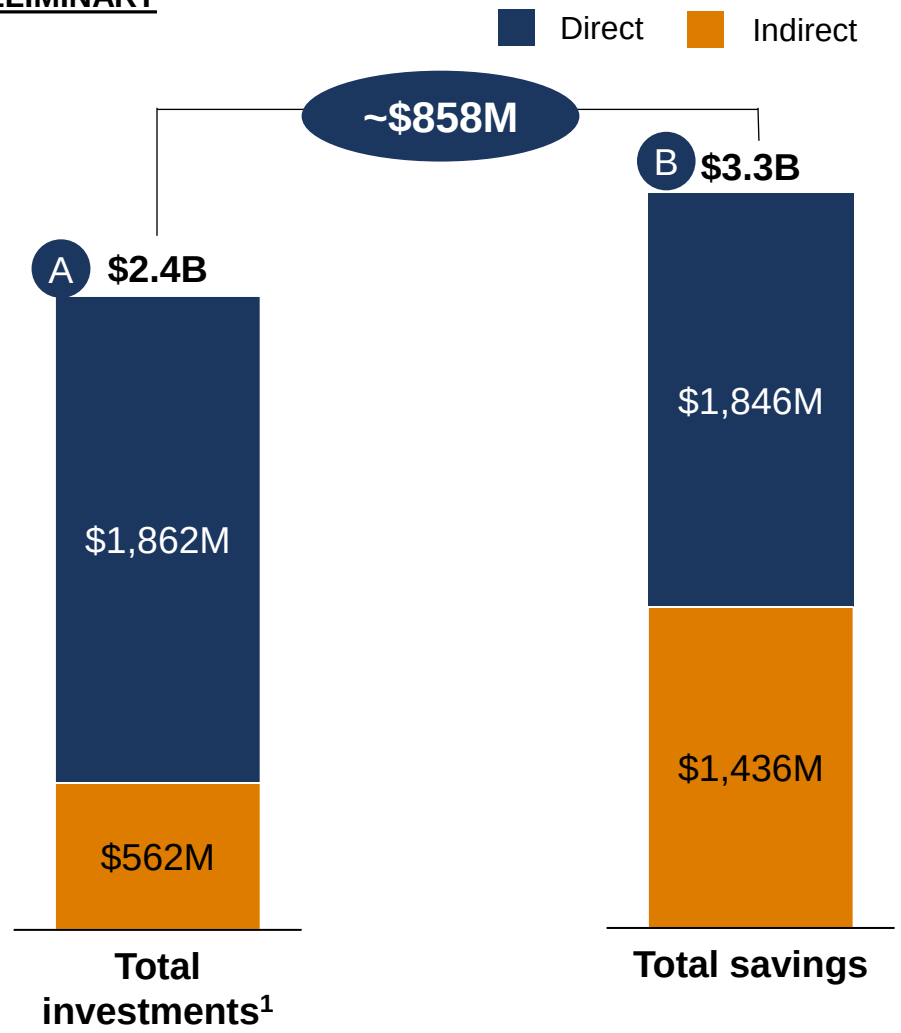
Estimated 945 additional individuals in supportive housing

1. 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.
2. 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
3. Representing percent of individuals receiving timely access in their first year and delayed access in their second year of experiencing psychosis

Increasing access from 10% to 90% a potential investment of ~$2.4B in annual costs may realize $3.3B of benefit

DRAFT as of July 11, 2024

PRELIMINARY



A **Direct annual cost:** Investments made directly to providing Coordinated Specialty Care (CSC) and follow-on services

- Healthcare: Costs of increasing CSC & ongoing care
- Employment: Increase in appropriate SSI / SSDI payments due to increased access to resources through CSC
- Housing: Increase in appropriate use of supportive housing due to increased access to resources through CSC

Indirect annual cost: Investments made as a result of increasing access to CSC but not directly towards providing CSC and follow-on services

- Healthcare: Costs of increase in stays at residential care facilities and average cost of medication due to increase in access

B **Direct annual benefits:** Benefits directly associated with increasing access to CSC e.g.,

- Healthcare: Savings due to reduction in inpatient hospitalizations, ED visits, and medication and residential care costs
- Criminal Justice: Savings from reduction in criminal justice involvement (e.g. reduced average cost of incarceration / detention, arrest, probation, etc.)
- Housing: Savings from reduction of average cost or providing homelessness services

Indirect annual benefits: Additional benefits observed as impact of increasing access to CSC, but cannot be directly tied back to investments made to CSC, e.g.

- Caregiving: Value generation from preventing loss in productivity due to caregiving duties
- Employment: Value generation from preventing loss in productivity due to unemployment

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 / year and $102 / 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. All annual costs are calculated 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. All other costs such as criminal justice, employment, housing are 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.

Overview of strategic objectives (1/2)

DRAFT as of July 12, 2024

NOT EXHAUSTIVE

Objective	Key objectives	Example next steps	Example potential milestones
Awareness	**Improve awareness of symptoms of early psychosis**, particularly among individuals who may play a role in identifying these signs and connecting individuals to care **Establish and strengthen expectations of access to high-quality EPI services** through publicized targets	**Create one-stop resource centers** for psychosis care-seekers **Build an EPI[2] champion/ambassador program** where individuals who have gone through EPI programs themselves share their lived experiences and knowledge with the community **Build partnerships** with existing BH awareness campaigns **Develop a public communications strategy** that facilitates a call to action by Californians	**Align with advisory group and partners** on the timeline for awareness building based on EPI system readiness **Identify potential partnerships** to support awareness building **Convene a workgroup** with a charter to design a public engagement strategy
Access	**Ensure that 90% of individuals within the 1st year of onset of psychosis have timely, affordable, appropriate, and convenient access** to CSC[1] programs designed to inspire trust **Consider a shorter goal timeline to access in the long-term**, given the WHO recommends specialized treatment no more than 90 days after symptom onset	**Strengthen care referral networks** through partnerships with health systems, health plans, criminal/legal system facilities, housing services providers, and community- and faith-based organizations **Explore alternative funding sources** (e.g., service-based reimbursement or programmatic funding sources) **Establish county-level archetypes and corresponding care models** for convenient access **Strengthen community and health system partnerships** and care referral networks	**Convene community-led working groups** to evaluate access barriers, build a workplan, and identify solutions **Track and report on impact** (e.g., average Duration of Untreated Psychosis (DUP), average wait times, % of individuals receiving CSC within 1 year, # of partners engaged in program design)

1. Coordinated Specialty Care
2. Early Psychosis Intervention

Source: Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group. Additional detail captured in draft Early Psychosis Intervention Strategic Plan

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Overview of strategic objectives (2/2)

DRAFT as of July 12, 2024

NOT EXHAUSTIVE

Objective	Key objectives	Example next steps	Example potential milestones
Quality	**Promote a clearly defined CSC[1] model as the standard of care** for treatment of early psychosis **Improve fidelity to the CSC model** for EPI[2] programs in California **Continuously improve the CSC model** and care delivery to enhance experience and outcomes	**Align on a single CSC program model for CA** and promote the implementation of all CSC components for EPI (including non-clinical) **Research and pilot standards of care for step-down services** (e.g., community-based services) **Align on approach / tools to measure fidelity** **Identify quality metrics** and consider incentive mechanisms for EPI linked to fidelity, outcome, and client goals	**Establish an evidence-based standard of care and continuous quality improvement strategy** through a workgroup of relevant ecosystem partners **Identify, track, and report metrics** across dimensions of quality **Build a statewide performance management mechanism**
Equity	**Reduce barriers to care by co-designing EPI programs with communities** to ensure culturally competent, contextually appropriate, and holistic solutions **Improve tracking of equity metrics** and establish measurable goals **Develop a more diverse healthcare workforce** to better address the needs of California's diverse population	**Assess key barriers for vulnerable communities** **Identify trusted community partners** to co-create solutions to access barriers **Build out specialized care options for individual population groups** as needed **Collaborate with communities to set measurable equity goals** (e.g., parity in access and outcome metrics)	**Align on a definition for equity** in the context of scaling early psychosis care in California **Convene a working group** to identify priority populations and key barriers **Evaluate and expand community partnership models**

1. Coordinated Specialty Care
2. Early Psychosis Intervention

Source: Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group. Additional detail captured in draft Early Psychosis Intervention Strategic Plan

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Overview of foundational levers (1/3)

DRAFT as of July 12, 2024

Objective	Key objectives	Example next steps	Example potential milestones
Sustainable funding	**Refine reimbursement models and rates to fully cover the cost of EPI** for Californians with early psychosis, regardless of insurance coverage **Quantify and secure funding** required to scale high-quality and equitable access to EPI[1] **Incentivize public and private investment** in EPI programs	**Examine and address barriers** to accepting Medi-Cal reimbursement, other billing challenges **Conduct landscape analysis** of reliable funding streams alongside partners **Consider allocating funds for EPI at the state level** rather than the country level **Investigate incentive models** to encourage private investment in programmatic funding	**Develop and convene working groups** to: • Align on funding needs and potential sources • Refine the reimbursement model, where needed • Secure programmatic funding • Track impact
Workforce and capabilities	**Increase interest in EPI careers** **Recruit new individuals into the EPI workforce,** and align incentives to reduce attribution of CSC[2] clinicians **Optimize capacity** of workforce **Enhance capability** of workforce **Measure and monitor workforce supply and demand** for EPI programs	**Increase recruitment efforts** to attract the needed workforce based on capacity and capability requirements[3] **Identify solutions to optimize the efficiency of the existing workforce** and enhance their capacity to provide CSC **Expand the peer-led workforce** **Invest in growing the pipeline** for students in behavioral health professions	**Conduct a current state supply and demand assessment** of the EPI workforce, by region and by expertise/role Develop and implement a **comprehensive recruitment and retention strategy** for EPI **Establish and track KPIs[3]** to measure progress

1. Early Psychosis Intervention; 2. Coordinated Specialty Care. 3. Key Performance Indicators

Source: Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group. Additional detail captured in draft Early Psychosis Intervention Strategic Plan

Overview of foundational levers (2/3)

DRAFT as of July 12, 2024

Objective	Key objectives	Example next steps	Example potential milestones
Account ability	**Establish a governance structure and mechanism** to define roles and responsibilities in expanding access to EPI[1] programs **Develop a monitoring and evaluation framework** to track progress against established goals **Establish an ongoing improvement process** for continuous iteration	**Align on which organizations will be responsible for refining and implementing the EPI strategic plan,** and what the roles and responsibilities of team members will be **Establish KPIs[2] to measure the impact of expanded EPI access**, and a system to track relevant metrics **Develop a process to gather learnings** from implementation and refine as needed	**Identify existing structures** for accountability, monitoring and evaluation, and process improvement **Identify the leadership team** to implement the EPI strategic plan **Establish framework** for monitoring, evaluation, and reporting
Infra structure	**Design and build the infrastructure needed to deliver care to 90% of individuals who need it,** with a focus on ensuring equity and quality of care	**Explore and scale multiple archetypes of care deployment models** (e.g., telehealth, omnichannel care delivery, remote monitoring) **Identify resources for infrastructure development** (e.g., partnerships, technical support, data interoperability, care coordination) **Ensure training for effective use of technology** (e.g., identify training gaps, design tailored training programs)	**Design a phased plan to develop facilities** and provide resourcing of equipment and clinicians **Build infrastructure to support omnichannel delivery** of EPI **Support workforce and existing programs** with appropriate technology and digital infrastructure

1. Early Psychosis Intervention; 2. Key Performance Indicators

Source: Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group. Additional detail captured in draft Early Psychosis Intervention Strategic Plan

Overview of foundational levers (3/3)

DRAFT as of July 12, 2024

Objective	Key objectives	Example next steps	Example potential milestones
Ecosystem engagement	**Enhance integrated care delivery network, by ensuring coordination among ecosystem partners** to enable timely and seamless access to all components of CSC[1] for clients and their families	**Improve awareness, education, and training for early psychosis** (e.g., provide training on symptom identification and referral pathways for clinicians and community members) **Enable improved information sharing for care coordination** (e.g., expand the use of psychiatric advanced directors to provide information on care needs and preferences, explore options to improve data sharing and interoperability) **Establish stronger alliances among ecosystem partners for CSC care delivery** (e.g., consider establishing state-wide or county-wide partnerships for housing, education, employment and other needs as appropriate)	**Convene key ecosystem partners** to highlight benefits of expanded access to EPI[2] **Identify and deploy digital resources** and operating model changes **Track impact** (e.g., number of partners engaged, level of awareness)

1. Coordinated Specialty Care; 2. Early Psychosis Intervention

Source: Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group. Additional detail captured in draft Early Psychosis Intervention Strategic Plan

PRELIMINARY NOT EXHAUSTIVE

Example Ecosystem Partners to engage on EPI Strategic plan (1/3)

DRAFT as of May 14th, 202

Oversee
(sets agenda)

State health

- Medi-Cal
- Department of Health Care Services (DHCS)[1]
- Department of State Hospitals (DSH)[1]
- California Department of Managed Health Care (DMHC)
- California Department of Public Health (CDPH)
- Emergency Medical Services Authority (EMSA)

Implement
(responsible for execution)

State health

- California Public Employees' Retirement System (CalPERS)[1]

Private sector payors e.g.,

- Aetna
- Anthem Blue Cross
- Health Net
- Humana
- UnitedHealthcare
- Kaiser

State supports

- California Association of Social Rehabilitation Agencies (CASRA)

CSC programs e.g.,

- Portland Identification and Early Referral Program (PIER)
- Early Diagnosis & Preventative Treatment Clinic (EDAPT)
- Sacramento EDAPT (SacEDAPT)

Community care programs

County education entities e.g.,

- Education Coordinating Council
- Santa Clara County Office of Education

1. Represented on Early Psychosis Intervention (EPI) Advisory Group

Source: MHSOAC

PRELIMINARY NOT EXHAUSTIVE

Example Ecosystem Partners to engage on EPI Strategic plan (2/3)

DRAFT as of May 14th, 202

Consult

(provides expertise)

Individuals with lived experience[1]

State health

- California Council of Community Behavioral Health Agencies[1]
- California Health Care Association (CHA)[1]

CSC programs

- California early psychosis intervention (EPI-CAL)[1]

Community based organizations, non-profits, philanthropic orgs

- OneMind[1]
- Two feathers[1]

National leaders

- National Alliance on Mental Illness (NAMI)[1]
- National Council for Well-being[1]
- National Institute of Mental Health (NIMH)[1]
- National Association of State Mental Health Program Directors (NASMHPD)[1]
- Brookings Institute[1]
- MHSOAC Commisioners[1]

Researchers

- UC Davis
- Stanford
- RAND Corporation

Behavioral Health Providers e.g.,

- Carelon Behavioral Health
- Didi Hirsch

Health systems e.g.,

- CommonSpirit
- Kaiser Permanente
- Sutter Health
- University of California Health

Community based organizations, non-profits, philanthropic orgs e.g.,

- County Behavioral Health Directors Association of California (CBHDA)
- California Consortium for Urban Indian Health
- Cal Voices
- Pan-Ethnic Health Network

1. Represented on Early Psychosis Intervention (EPI) Advisory Group

Source: MHSOAC

PRELIMINARY NOT EXHAUSTIVE

Example Ecosystem Partners to engage on EPI Strategic plan (3/3)

DRAFT as of May 14th, 202

Engage
(utilizes service)

Individuals with lived experience and their families[1] (willing participants identified in partnership with NAMI California, Parents Anonymous, United Parents, etc. or other state / federal lists)

State education:

- California Department of Education (CDE)

State supports

- California Dept. of Social Services (DSS)

Criminal /legal

- Dept. of Corrections and Rehabilitation (CDCR)
- Office of Youth & Community Restoration (OYCR)

County health

- Children's Hospital of Orange County, Tulare County HHSA

County Criminal/legal

- Neighborhood Legal Services (NLS)

Champion
(shares information)

National leaders

- National Center for Child Traumatic Stress
- Criminal/ legal
  - Council on Criminal Justice & Behavioral Health (CCJBH)

Community based organizations, non-profits, philanthropic orgs

- Sycamores
- Safe Passage
- Steinberg Institute
- Child Mind Institute
- National Health Law Program
- The Children's Partnership
- California Healthcare Foundation
- LA Trust for Children's Health,

1. Represented on Early Psychosis Intervention (EPI) Advisory Group

Source: MHSOAC

Advisory group members

Draft as of May 8th, 2024

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
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

Note: Advisory group members were identified by MHSOAC

Source: MHSOAC