Virginia Department of Behavioral Health & Developmental Services

Early Impacts of the Coordinated Specialty Care (CSC) Program

April 2019

DBHDS Vision: A Life of Possibilities for All Virginians

1220 BANK STREET • P.O. BOX 1797 • RICHMOND, VIRGINIA 23218-1797
PHONE: (804) 786-3921 • FAX: (804) 371-6638 • WEB SITE: WWW.DBHDS.VIRGINIA.GOV

Early Impacts of the Coordinated Specialty Care (CSC) Program

Table of Contents

Introduction: Overview of the Coordinated Specialty Care (CSC) Program

Coordinated Specialty Care (CSC) is a team-based, collaborative, recovery-oriented early intervention program for young adults experiencing First-Episode Psychosis (FEP). The approach involves the young person, treatment team members, and when appropriate, family members as active participants. CSC components emphasize outreach to identify and engage young people into youth-specific treatment, including low-dosage medications, cognitive and behavioral skills training, supported employment and supported education, case management, and family psychoeducation. CSC also emphasizes shared decision-making as a means to address the unique needs, preferences, and recovery goals of young people with FEP.

Early intervention programs, like CSC, are designed to bridge existing services for individuals experiencing FEP and eliminate gaps between child/adolescent and adult behavioral health programs. Such services are an emerging practice in behavioral healthcare, and several models, including CSC, have been shown to be promising practices in recent research.

In July 2014, the Virginia Department of Behavioral Health and Developmental Services (DBHDS) released a Request for Proposals (RFP) to our Community Services Board (CSB) system to solicit applications for funding to develop and implement evidence-supported early intervention and treatment models designed to address the behavioral health needs of young adults, including those experiencing FEP. We identified eight CSBs to implement CSC programming, beginning in 2015, including Alexandria CSB, Fairfax-Falls Church CSB, Henrico Area Mental Health and Developmental Services, Highlands CSB, Loudoun County CSB, Prince William County CSB, Rappahannock-Rapidan CSB, and Western Tidewater CSB.

This report documents the first three years of data submitted by those eight CSBs – 2015-2018. Each CSB submits data to DBHDS for all of their CSC clients on a quarterly basis.

Reach of the CSC Program since Inception

Over the first three years of its programming, the eight CSBs employing CSC have reached about 364 unique individuals. The average number of participants served by each CSB is 46 individuals since the inception of the programming. Figure 1, below, demonstrates that Henrico, Prince William, and Highlands CSBs served the most individuals with 63, 62, and 51 clients respectively in the past three years.

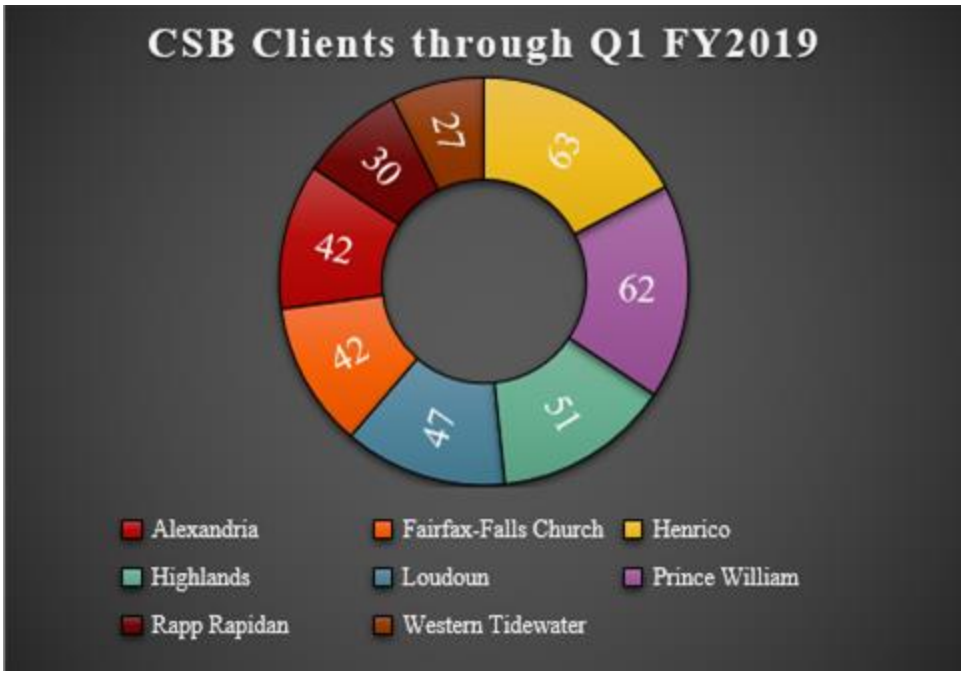

Figure 1

While the preferred age at admission ranges from 16-25 there are some cases where CSBs admit younger teenagers and a small number of adults over the age of 25 (See Figure 2, below). Still, the preferred age range of 16-25 makes up the large majority of clients admitted into the program representing 88 percent of individuals served. The average age at admission is 21 years old.

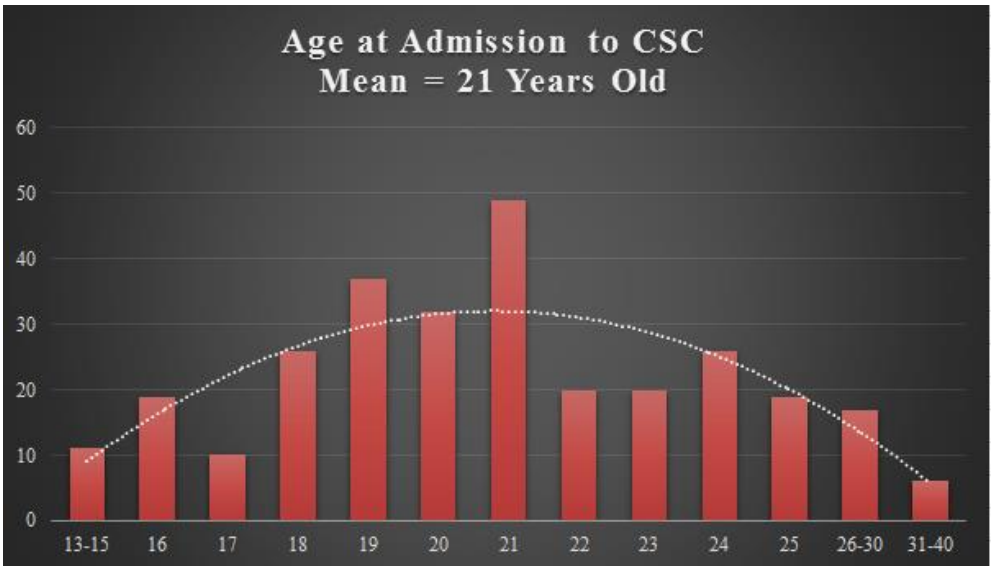

Figure 2

Typically, clients who are discharged from the CSC program complete their treatment within the first year, and nearly two-thirds of all clients already discharged (See Figure 3, below). The median duration for CSC programming treatment is nine months, which controls for some outliers in the population. Only 12.5 percent of the discharged clients were in the program for

over two years. The eight CSBs reported the same number of discharged individuals (they each reported 34 individuals) have ended treatment because of the treatment being "complete" and "incomplete." A significant proportion, 24 percent, of those discharged are marked as "other" for reason of discharge, which suggests that further reporting categories need to be offered in this reporting item.

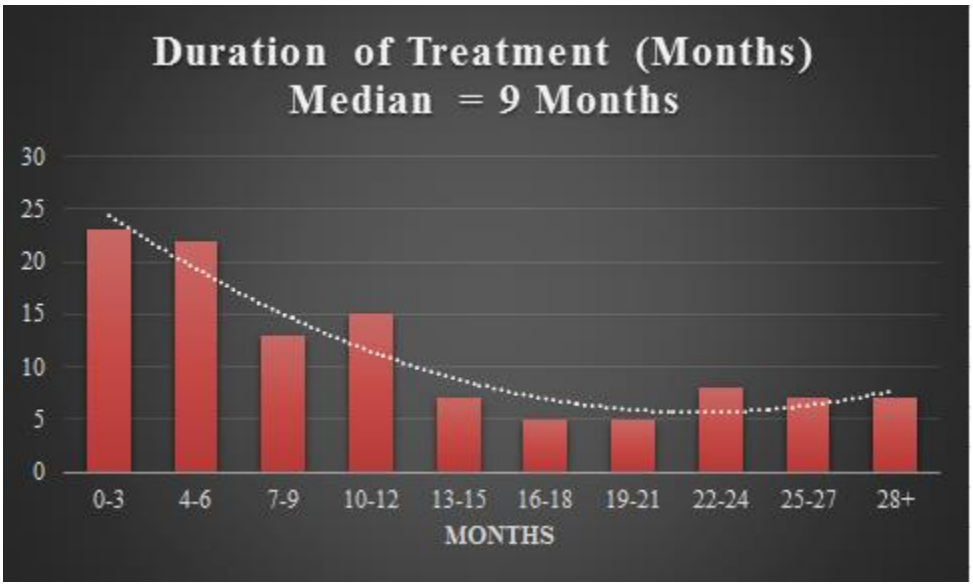

Figure 3

Demonstrated Impact of CSC

Time-Lapse Between First Episode Psychosis (FEP) and Admission to CSC

A critical element of the CSC model is to significantly reduce the time before an individual begins receiving specialized treatment after First Episode Psychosis (FEP), also known as the Duration of Untreated Psychosis (DUP). The body of research supporting the CSC program demonstrates that immediate access to specialty care after FEP correlates with a multitude of positive indicators such as reduction in rates of remission, improvement of social supports, greater involvement in school and work, and more.

The data reveals that almost half, 46 percent of all clients served through the CSC program, are admitted within six months of an individual's FEP (See Figure 4, below). Furthermore, the median value for the date between onset and admission to the CSC is eight months. The target established by proponents of the CSC model is to enroll clients within two years of onset. Figure 4 demonstrates that 83 percent of all clients in the program are admitted within two years of date of onset, indicating that the eight CSBs are performing well in this metric.

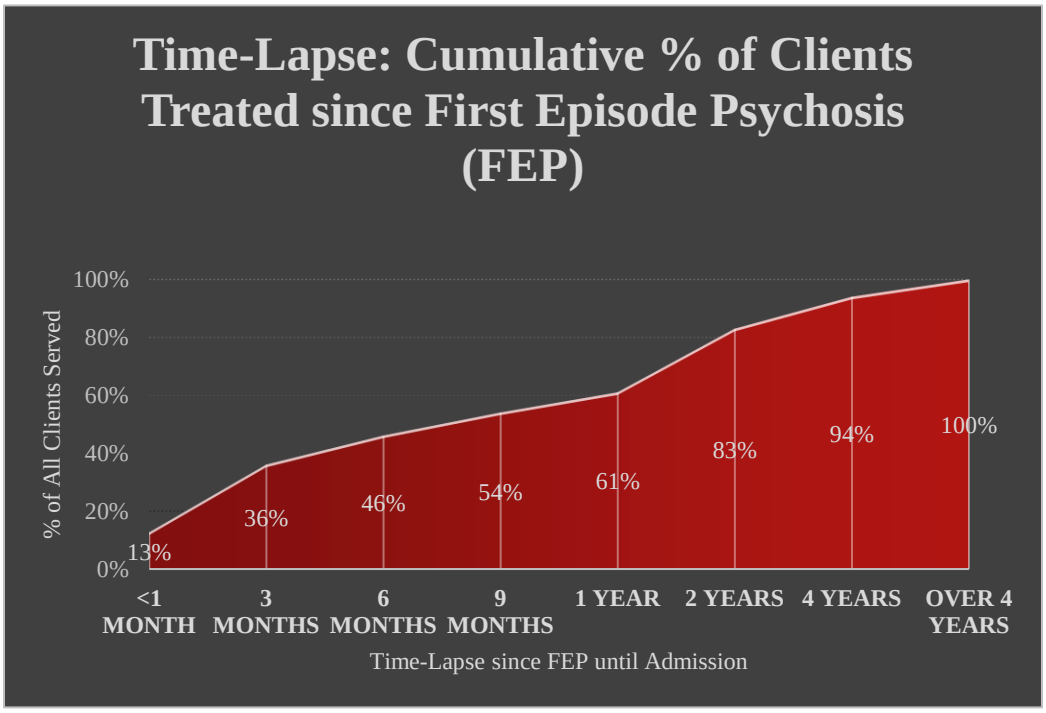

Figure 4

Illness Management and Recovery Survey

One of the tools utilized by the CSBs to measure impact is the *Illness Management and Recovery Survey*. This instrument contains indicators to chart a client's progress in furthering social connectedness and support systems, movement towards healthy behavior, and avoidance of negative interferences to recovery. The CSB practitioner administers the survey at the time of admission to the program and follows up with the survey every subsequent quarter until discharge. A unique component of this measurement tool is that both the client and practitioner complete an *Illness Management and Recovery Survey* each quarter. This elucidates any disconnect or synchronicity between how the client and practitioner assess ongoing progress.

The survey is structured so the low-end of the scale (1.0) is the best possible outcome and the high-end (5.0) indicates a disconcerting response. Figures 5 and 6 below illustrate that 1) on average, clients have more favorable responses during quarterly assessments compared to the baseline survey, and 2) that clients and practitioners are generally tracking closely across the different survey items, documenting consistent improvement – though, the practitioner tends to score his/her client higher (less favorable response) for baseline and quarterly assessments.

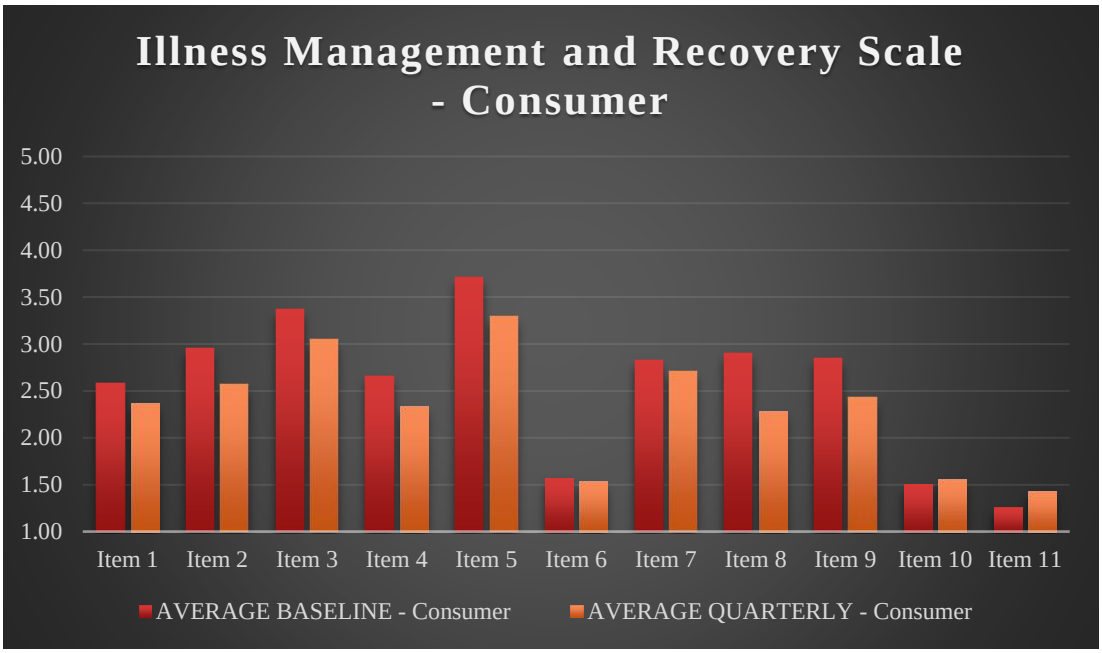

Figure 5

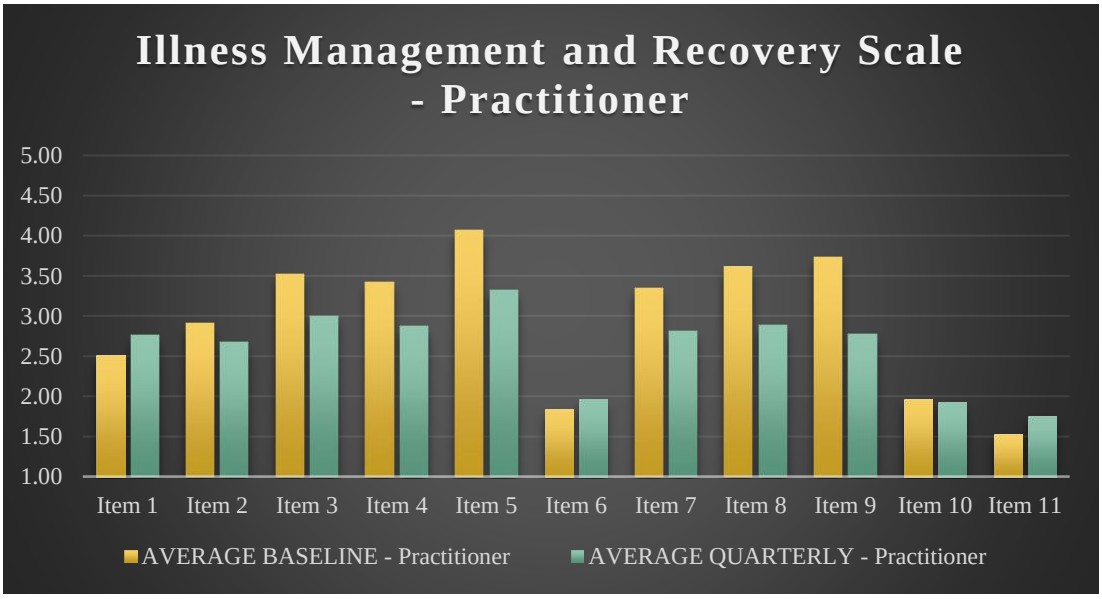

Figure 6

Some of the survey items showing the greatest improvement from baseline to quarterly assessments include Item 5 – Involvement with Self-Help Activities,[1] Item 8 – Knowledge,[2] and

[1] Item 5 – Involvement with Self-Help Activities asks: "How involved are you in consumer run services, peer support groups, Alcoholics Anonymous, drop-in centers, (WRAP) Wellness Recovery Action Plan), or other similar self-help programs?"

[2] Item 8 – Knowledge asks: "How much do you feel like you know about symptoms, treatment, coping strategies (coping methods), and medication?"

Item 9 – Relapse Prevention Planning.[3] The average response for Item 5 – Involvement with Self-Help Activities improved 0.4 points from 3.7 to 3.3 in consumer reports and 0.7 points from 4.1 to 3.3 in practitioner reports. This represents an average change from "I know about some self-help activities, but I'm not interested," to "I'm interested in self-help activities, but have not participated in the last year." There was also a clear improvement in clients' knowledge of symptoms, treatment, coping strategies, and medication. Consumers indicated an average improvement from 2.9 to 2.2, which is roughly an average shift from a response of "alright" to "well." Similarly, practitioners reported an average shift from 3.6 to 2.9, which translates to nearly an average response change of "not very well" to "alright." Furthermore, practitioners reported the greatest change in average response from baseline to quarterly assessment for relapse prevention planning. Data indicated an improvement of an entire 1.0 point from "know a little, but haven't made a relapse prevention plan" to "know one or two things to do, but don't have a written plan."

The results for Items 6, 10, 11 can be deceiving because there is little to no improvement; however, clients on average, were already performing extremely well on these three indicators, leaving very little room for positive change. These indicators measure using prescribed medication effectively and drug and alcohol use. However, these three items contained a substantial number of missing values and represented 50 percent of all missing responses across the 11 items (See Figure 7, below). This is likely due to consumers feeling uncomfortable responding and/or believing that it does not apply to them, and practitioners believing it is unnecessary to report in some instances. Communicating with the CSBs is advisable to understand why these three items are skipped more frequently and to work together to ensure more complete report submissions.

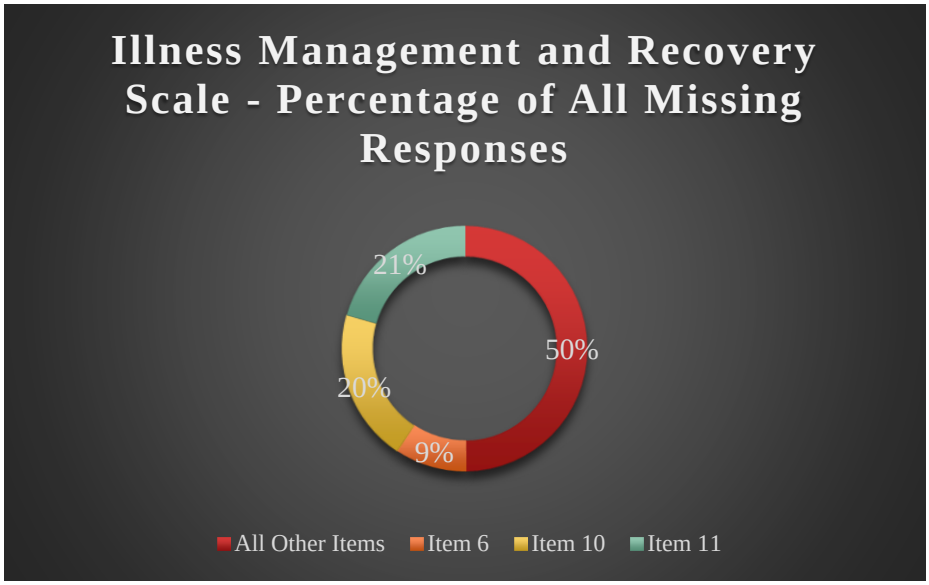

Figure 7

[3] Item 9 – Relapse Prevention Planning asks: "Which of the following would best describe what you know and have done in order to not have a relapse?"

Modified Colorado and Symptom Index

CSBs employed an additional instrument, the Modified Colorado and Symptom Index, to understand clients' improvement with a variety of emotional, behavioral, and social disturbances and how distressful these experiences are to each individual. For example, consumers report how often they feel depressed, paranoid, and lonely, and trouble with processing information. For each question, the client first responds to how frequently an issue impacts them in the past month (on a scale from "not at all" (1) to "at least every day" (5)) then reports on how much that issue bothers or distresses them (also ranging from "not at all" (1) to "at least every day" (5)). Only the consumer completes this survey and fills one out at admission and each subsequent quarter of enrollment in the CSC program.

In summation, Figures 8 and 9 below demonstrate that, on average, consumers' responses to the quarterly surveys trend closer to more favorable responses (closer to 1) than at the time of admission to the CSC program. The chart below displays that the average response across all items drops about a half a point on the 1-5 scale, and that there is less variation from the mean for quarterly averages signifying a greater percentage selecting positive responses.

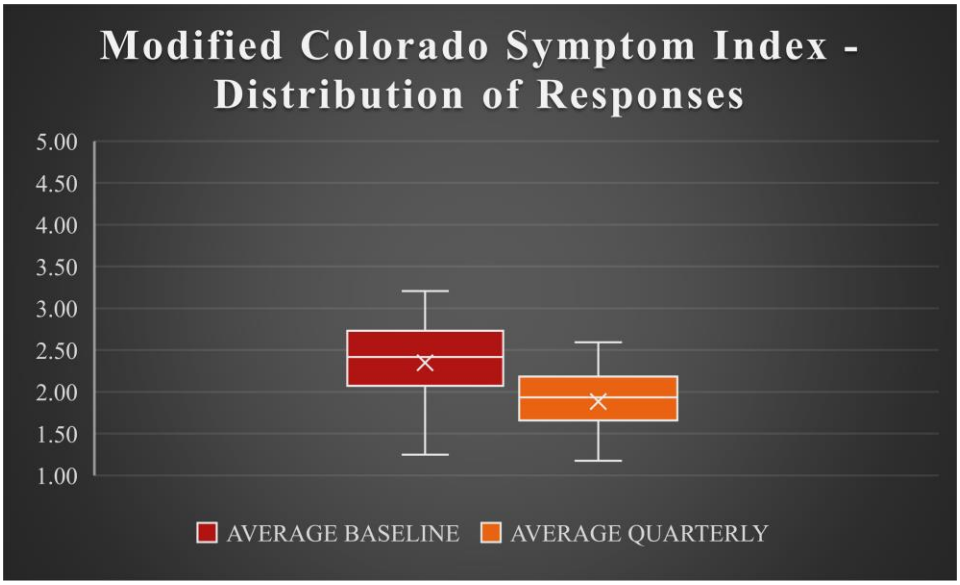

Figure 8

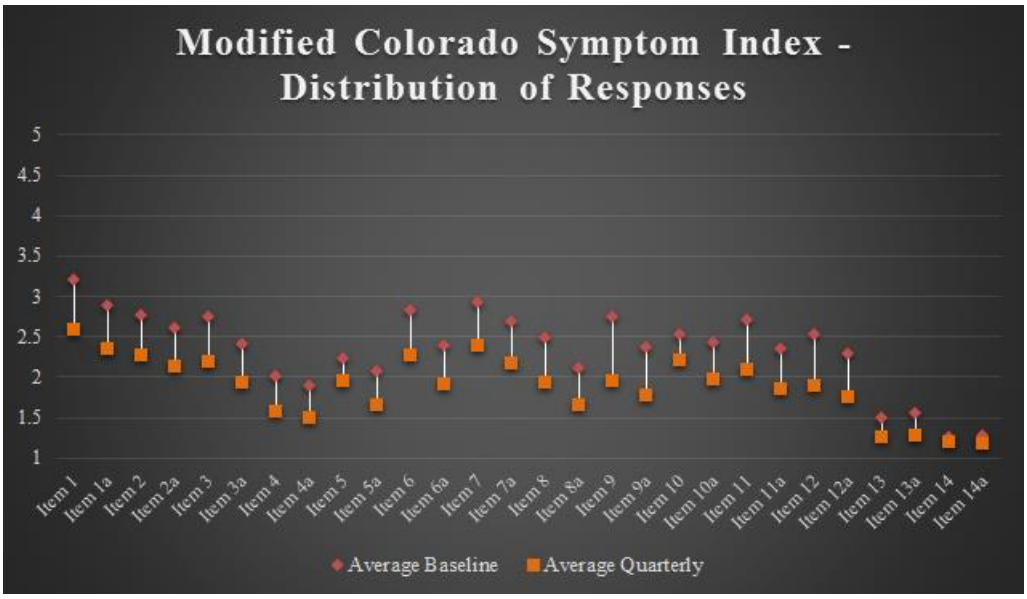

Figure 9

Some of the items with the greatest average change include: Item 9 – In the past month, how often did you feel out of place or like you did not fit in (0.8 points lower on the 1-5 scale); Item 12 – In the past month, how often did you feel suspicious or paranoid (0.7 points lower on the 1-5 scale); and Item 1 – In the past month, how often have you felt nervous, tense, worried, or afraid (0.6 points lower on the 1-5 scale). For example, the average response for Item 9 trended downward (positively) from 2.8, representing a response near "several times during the month" to 2.0, which signifies "once during the month." These trends are a strong indication that the CSC program leads consumers to feel more accepted and comfortable in their surroundings.

Items 13 and 14, thoughts about hurting oneself or others, have minimal changes since the averages were already bordering the lowest possible response: "Not at all" (1).

Modified Mental Health Statistics Improvement Plan (MHSIP) Consumer Survey

The CSBs also administer a final discharge outcomes survey to all CSC clients containing questions from the MHSIP survey. The purpose of this tool is to identify how the program affected clients more generally and to identify areas of the program that may require improvement. All questions have response options of "Strongly Agree" (1) to "Strongly Disagree" (5), with "Strongly Agree" (1) representing the most favorable response.

Overall, consumers indicated that they were pleased with the services received and the program had a positive impact on a range of indicators. Figure 10, below, highlights that out of the responses across all 15 questions on this survey, the vast majority – 78 percent - were especially favorable with responses of "Strongly Agree" (1) or "Agree" (2). Only 8 percent of all responses were designated as negative responses – "disagree" (4) or "Strongly Disagree" (5).

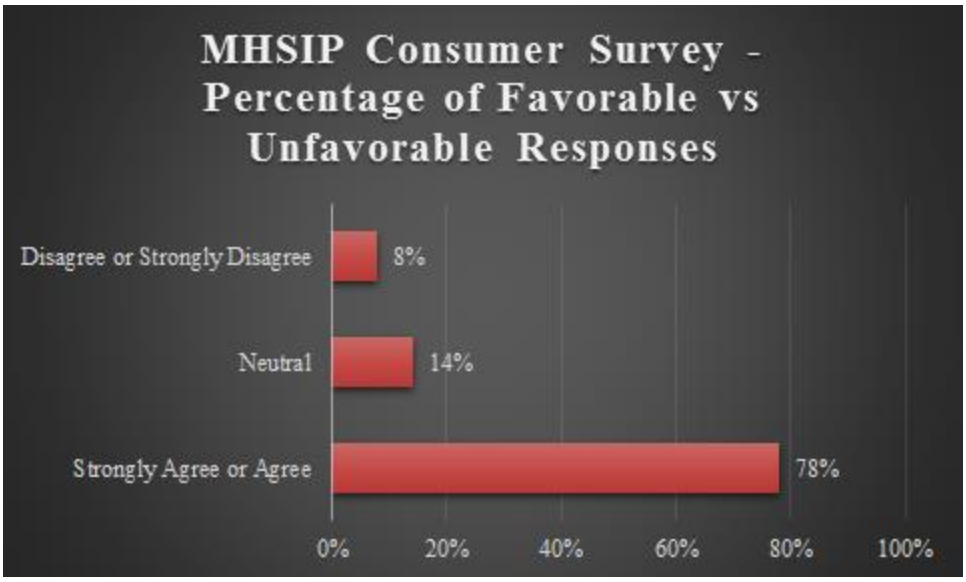

Figure 10

Figure 11, below shows that the questions that address the value of the program, Items 1 – 3, scored the lowest (best) and all had an average around 1.5, which is in between "Strongly Agree" and "Agree." Figure 11 also shows items 4-15 address how the CSC program had a direct result on improving individuals' conditions, such as being in better control, relationship with family, and ability to do meaningful things. All, except Item 9, averaged at or near 2.0, "Agree." The only item to veer away from the 2.0 "Agree" average was Item 9 – I do better in school and/or work" with an average of 2.7, representing an average near "Neutral."

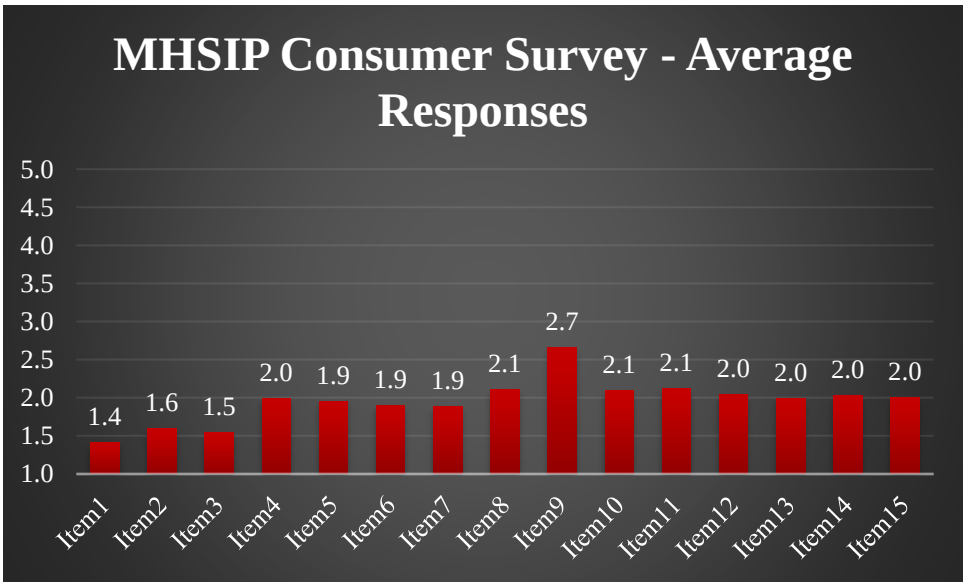

Figure 11

Recommendations to Address Data Limitations

Reviewing the CSC data revealed a few improvements that can be made to ensure the data collected is more complete and reliable:

1. **Ensure answer choices effectively respond to the question posed**
    - Currently, CSBs submit data in unrestricted Excel spreadsheets that allow users to fill cells however they like. Sometimes, users type in responses that are not consistent with the instructions, and we are left to interpret how a response matches the proper response options. This, of course, can produce unreliable and inaccurate assessments. An easy solution is to utilize the "data validation" tool in Excel to ensure that only the proper response options are used.

2. **Create a reporting field for denoting which iteration of the quarterly survey is being reported.**
    - The data does not allow us to disaggregate the quarterly surveys, and we only see if a client or practitioner is submitting data for a baseline or quarterly assessment. Including a field to identify which quarterly survey (the first, second, third, etc.) would enable us to track progress from time of admission to discharge, rather than just comparing baseline responses to *all* quarterly responses lumped together.

3. **Reduce missing values (skipped questions).**
    - Some questions in the different survey tools have more missing values than others. We recommend working with the CSBs to understand why some questions are skipped more frequently and make adjustments as necessary.

Conclusion

The findings from the assessment of the first three years of data strongly suggest that the CSC program is improving the lives of the clients admitted to the program. The data illustrates that clients are making positive movement on cognitive and behavioral skills, social connectedness, access to a variety of supports, and knowledge about coping mechanisms. CSBs are maintaining a substantial caseload of clients enrolled in the CSC program and many are being discharged within the first year. The data also provides insight into where efforts can be focused to continue improving the program, such as lowering the average time between FEP and CSC admission and addressing the components of the program that did not demonstrate as significant improvement across the different survey tools. The project team plans to report on the CSC program more regularly and to begin including an additional assessment of functional outcomes, such as improvements in education/employment, decreased use of crisis services/hospitalizations, and housing stability, in future reports.