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ISSUE BRIEF

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TRANSITION OPTIONS, OPPORTUNITIES FOR INTEGRATION, AND FUNDING CONSIDERATIONS FOLLOWING COORDINATED SPECIALTY CARE

KEY FINDINGS

- CSC programs manage transitions differently based on their program length, the nature of step-down processes already in place, and the location of placement following transition.
- Transition services typically have reduced frequency and intensity of services and can be provided by a stand-alone, step-down program or can be incorporated with the CSC programs.
- Approximately three-quarters of clinical staff and administrators interviewed favored either a three-to-five-year CSC program model, or reported that the program length should be tied to client need and not fixed. The concept of longer period of services contrasts with the original concept of CSC as a two-year, time-limited intervention.
- CSC programs that are well integrated into larger systems (e.g. large hospitals or community mental health centers) tend to have greater options to serve their clients following graduation.
- Transition Age Youth (TAY) programs match the developmental stage of most clients in CSCs program and, if available, are preferred option for post-discharge placement.

BACKGROUND

Approximately 100,000 adolescents and young adults experience a first episode psychosis (FEP) each year. Symptoms can include loss of contact with reality, hallucinations, and delusions. Early intervention for psychosis is well-supported by empirical evidence. In the United States, these services are often referred to as Coordinated Specialty Care (CSC). As typically implemented, CSC is a team-based intervention that combines well-established evidence-based treatments, including assertive case management, psychotherapy, supported employment and education (SEE) services, family education and support, and low doses of antipsychotic medications, delivered within a shared decision-making framework (Heinssen, Goldstein & Azrin, 2014). Coordinated Specialty Care (CSC) provides services soon after an individual first experiences symptoms of psychosis, and for a limited amount of time. Based on recommendations from the National Institute of Health, many programs have adopted a two-year framework. Approximately 91% of CSC programs in the United States report that the average time to complete their program is between one and three years (Rosenblatt et al., 2018).

Over the past five years, an increasing number of CSC programs have noted challenges associated with identifying appropriate services for young adults after they "graduate" from the program. Given the highly supportive and specialized nature of CSC (see box above), services available through routine community avenues often fall short of delivering the level and type of care that many clients who have experienced a first episode of psychosis (FEP) require (Jones et al., 2020; Goldman, 2020). To address this gap, some CSC programs have created or link to "step-down" programs, have lengthened their program, or adapted their structure.

Drawing across multiple sources of data, this brief:

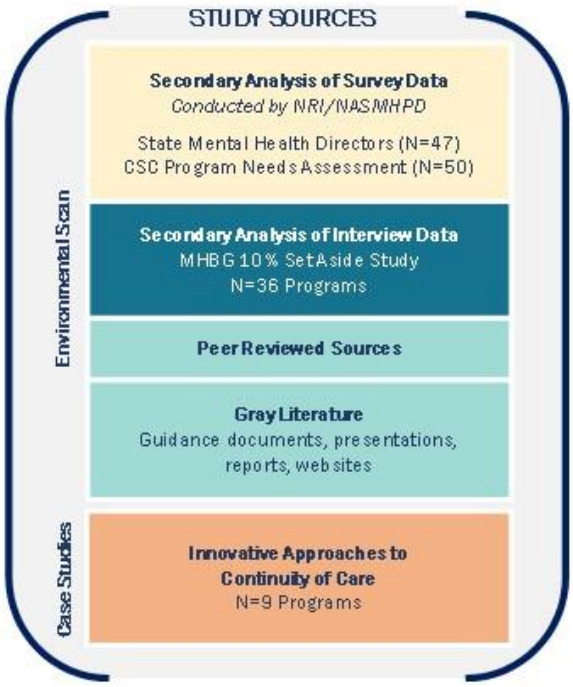
- Provides a framework to describe common ways that CSC programs approach transition processes within the structure of their programs.
- Highlights different approaches currently in use by programs to provide continuity of care for young adults who have attended CSC programs.
- Explores avenues for integration within programs and organizations as a way to support young adults following completion of a CSC program.
- Discusses financing for step-down programs.

METHODS

This brief integrates data from an environmental scan and nine case studies. The Environmental Scan drew from two surveys conducted by NRI/NASMHPD, interviews collected as part of the MHBG Ten Percent Set Aside Study (Rosenblatt et al., 2018), and peer and gray literature focused on transitions and related topics. The nine case studies included interviews conducted primarily with CSC team members, representatives from organizations housing the CSC programs, and individuals from state mental health agencies. We conducted remote interviews with a total of 88 respondents as part of the case studies. The findings in this report focus primarily on nine programs that were selected on the basis of their innovative approaches to the development of a step-down program, implementation of an extended length model of CSC (more than three years), or another approach to continuity of care. The nine sites appear below:

- EPICENTER (Columbus, OH)
- EPIC-NOLA (New Orleans, LA)
- PEACE (Philadelphia, PA)
- ETCH (East Lansing, MI)
- Felton (re)MIND® (San Mateo, CA)
- Deschutes EASA (Bend, OR)
- OnTrackTN First Episode Psychosis Initiative (Nashville, TN)
- HOPE (Minneapolis, MN)
- OnTrackNY & Early Treatment Program (Glen Oaks, NY)

CSC Transitions Study Sources



National Association for State Mental Health Program Directors (NASMHPD) Research Institute (NRI).

FINDINGS

A Transition Framework

Based on a review of survey data from 50 CSC programs, there are three main factors that shape how a program manages transitions and which contribute to decisions about continuity of care. First, programs vary in their **program length** and whether program length is flexible or not. A second factor that shapes transition-related trajectories is whether the program has **any type of step-down process** and the nature of that process. Some sites have created step-down services that are separate from their CSC program, whereas others have an internal mechanism to decrease the intensity and frequency of services. Some programs have both, and some have neither. Lastly, programs vary in the **location of placement following transition** and whether clients can be accommodated

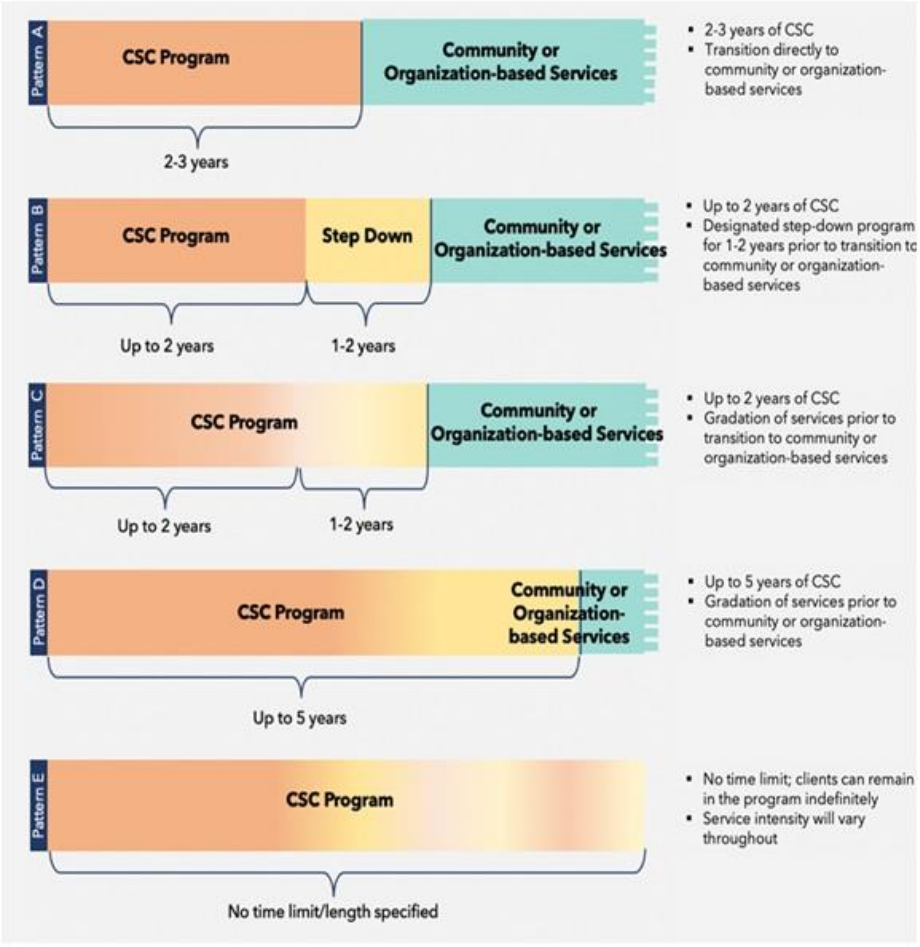
46% of programs do not have step-down services in place.

within the same organization, or need to be referred to services in the broader community. Putting these together, we saw five general patterns, which appear in Exhibit 1.

Pattern A is one in which a client receives focused CSC services for approximately two years (though sometimes longer), followed by a referral for services either within the same organization or outside the organization. Clients receive assistance in making a transition, such as through a warm handoff where the clinician might accompany the client to a session or otherwise help establish a new connection; a discussion of relapse prevention; and other preparatory strategies. Among the 50 CSC programs reviewed, 46% followed Pattern A.

Pattern B reflects CSC programs that have developed step-down services that are separate from their usual CSC programming. The services received in the step-down program can be either a reduction in frequency or intensity, or they can also be a different set of services, and often last between one and two years, although can be longer. After participating in the step-down program, clients are discharged and receive services either in the same organization or within the community. Among the 50 CSC programs reviewed, 15% followed Pattern B.

EXHIBIT 1. Patterns of CSC Program Length, Step-Down Processes, and Location of Placement



Pattern C contrasts with B in that step-down services are incorporated into the CSC program. These programs tend to be two to three years in length, and include both CSC services and post-CSC transitional care. Clients may receive services less frequently or may receive fewer services overall, for example, shifting from therapy, medication management, supported employment, and case management to just medication management and

case management. After a transitional period, clients are formally discharged from the CSC program and receive services either in the same organization or at some other location in the community. Among the 50 CSC programs reviewed, 17% followed Pattern C.

Pattern D describes programs in which participation in the CSC program is up to five years. Since services spread out over a longer time, there are periods where clients may have limited contact with the program and may come back if needed within that window. There may be a natural decrease of intensity or frequency of services with an eventual transition out of the program to care either at the same organization or in the community. Approximately 13% of programs follow Pattern D.

Pattern E reflects programs in which clients can remain indefinitely. The intensity of services within the CSC program will vary according to the clients' needs, but there is no stated maximum time that a client can be enrolled. Approximately 9% of programs follow Pattern D.

Approaches to Continuity of Care

The approaches taken by programs discussed on the previous pages provide a general framework; in practice, programs vary in many different ways. The case studies illustrate this variability. For example, one of the case study sites, Zucker Hillside, has two different step-down options and both are more than two years in length. An example of Pattern C is HOPE. They identify clients as falling into either the engagement, active treatment, or transition phase. A client in the transition phase can move back into active treatment if needed, and ramp back up their services. EPICENTER and EPIC-NOLA, which reflect Patterns D and E, also vary the intensity of their services throughout while working with an individual.

There is no single model of step-down services. CSC programs choose a set of dimensions that fits their context.

Step-Down Programs. Five of the case study sites have explicit step-down options, with a set of services that are designated for individuals who have graduated from the CSC program that is distinct from a "core" CSC program. A notable aspect of these five step-down programs is the variation in implementation across different dimensions, highlighted in Exhibit 2. Much of the variability around these dimensions is a result of structural and fiscal constraints. For example, age restrictions for step-down services in the Deschutes Early Assessment and Support Alliance (EASA) program are due to age limitations in the step-down transition age youth (TAY) program; the time limit in the Felton re(MIND)® program is due to stipulations from their funding source. The shift in focus for step-down services following PEACE and ETCH, towards functional skills (in PEACE) and values and goals (in ETCH) are, however, purposeful choices by the program leadership to provide a different type of experience for clients.

EXHIBIT 2. Variation in Implementation of Step-Down Programs					
Characteristics of Step-Down Program	**PEACE**	**EASA Deschutes**	**Felton (re)MIND®**	**ETCH**	**ETP**
	Step Up	**TAY**	**Alumni**	**NAV2GO**	**BOOST**
Serves clients in the same location	Same	Same	Same	Same	Same
Major shift in focus during step-down vs. extension of CSC	Shift in focus	Extension	Extension[c]	Shift in focus	Extension
Client eligibility	Selective	All (within age range)	Selective	Selective	All (within age range)
Intensity of step-down services	Lower only	Same level if needed	Same level if needed	Same level if needed	Lower only
Step-down serves CSC population only	Only CSC	Others also	Others also	Only CSC	Others also
Age of served population	All ages	Up to age 25	All ages	All ages	Age 18+
Duration of step-down services	Limit (time-based, 2 years)[a]	Limit (age-based)	Limit (time-based, 2 years)[d]	No limit currently defined[e]	No limit currently defined
Staff members are same or different					
Prescriber/Licensed Medical Provider	Same	Different	Same	Same	Different
Therapist	Different	Same[b]	Same	Different	Likely different
Case Manager	Same	Different	Not a position	Not a position	Not a position
SEE Specialist	Same	Different	Same	Different	Not a position
Peer Support Specialist	Same	Same	Same	Same	Not a position

NOTES:
a. Some flexibility in length of step-down.
b. Could be same or different, depending on needs of the client.
c. Shift from primarily psychotherapy/medication management to primarily SEE and peer/family support, but the program will feel like an extension of services for existing clients.
d. The total amount of time in CSC plus the alumni program cannot be greater than 4 years, so the length in 1 could be longer than 2 years and less than 2 years in the other.
e. Typically around 18 months.

Extended Length Models. Two of the case study sites, EPICENTER and EPIC-NOLA, are structured to provide services for more than three years. EPICENTER, which is an example of Pattern D, is a five-year program. During those five years, clients can access as many or few services as they wish, and can also discontinue services and return within the five year window. EPIC-NOLA, an example of Pattern E, does not have a stated time limit.

> *"Recovery is a journey and I think it's pretty challenging to say this journey is only going to be 2 years. This approach gives people more opportunities for growth and also it gives us this opportunity to really trace people's changes over time.*
> *-EPICENTER team member*

Clients can receive services until the team, client, and family decide that services through EPIC-NOLA are no longer appropriate. The longer period of services provided by these two programs contrasts with the original concept of CSC as a time-limited intervention. A longer program length, however, is consistent with the perspective of many staff who work with individuals with first-episode psychosis. Among those interviewed through the case study sites, **approximately three-**

quarters of clinical staff and administrators favored either a 3-5 year model, or reported that the program length should be tied to client need and not fixed.

Integration with Organizations and Programs

Most CSC programs are located either within a community mental health center (CMHC), a hospital, or a university setting. As originally conceptualized, CSC programs have a set discharge date. Additional services in the community or within the larger organization can be accessed after discharge. A transfer within an organization, even if with different providers, will allow a client a familiar environment and the possibility for communication between CSC providers and new clinicians. Below, we describe how CSC programs have maximized continuity of care for clients through integration with organizations and programs.

Integration within Organizations. Among the case study sites, EPICENTER, based within the Ohio State Wexner Medical Center, is an example of integration of a CSC program within a larger organization that provides clients many post-discharge options. The medical campus has an 84-bed adult psychiatric hospital on site in addition to partial hospitalization and intensive outpatient programs. This allows EPICENTER to leverage a continuum of care both ways; patients can move from the acute settings into EPICENTER and if needed, can also move from EPICENTER to a more intensive setting. The Wexner Medical Center has specialty clinics, medication management within outpatient services (including a long-acting injectable clinic), group and individual psychotherapy, and clients can access primary care internally. EPICENTER also has ties to the university outside the medical center, through a relationship with university counseling services and the training clinic that serves the doctoral program in clinical psychology. This facilitates post-discharge services for clients who are also students at the Ohio State University.

HOPE is also located in a hospital setting, and it offers inpatient and outpatient psychiatry; a partial hospitalization program with multiple tracks; a dialectical behavioral therapy group; a child and adolescent clinic; and primary care. HOPE team members coordinate with these programs, and this array of services has allowed approximately two-thirds of HOPE clients to receive post-discharge services through Hennepin Healthcare.

OnTrackTN in Nashville, located in a CMHC called Mental Health Cooperative, is a third example of CSC program integration within an organization. Over the past four years, OnTrackTN has placed approximately 60% of graduates into one of seven different in-house programs. Most of these provide a lower level of services; all are available at the same location as the CSC program, which allows a sense of familiarity even though the client sees new providers in the new programs.

Integration with Programs. Across the case study sites, several CSC programs have connections with specific programs that can enhance care for individuals following a transition.

60% of CCBHCs provide first-episode services.
-2019 Report to Congress

Certified Community Behavioral Health Clinics (CCBHCs) are state-certified clinics that directly provide or contract to provide nine different services, such as 24/7/365 mobile crisis team, substance use, care coordination, integration with schools, and/or integration with physical health care. Deschutes EASA is based in a county organization that is also a CCBHC. As a result, the team has had a primary care provider attend weekly meetings for the CSC team and the step-down program, and the team collects data on all EASA clients using the core CCBHC metrics. At least one CSC program, OnTrackNY BestSelf in Buffalo, has used CCBHC funds specifically to support a step-down program.

One of the challenges for youth completing an early intervention program is that programs geared toward adults may feel like a mismatch, especially if youth are mixed with older adults who have more chronic schizophrenia.

Transition Age Youth (TAY) services are a way that CSC programs can address this concern and provide continuity of care. TAY services focus on issues of particular relevance to young adults such as education and employment, life skill development, and relationships, and have an explicitly youth-friendly approach. Two case study sites, Deschutes EASA and OnTrackTN, both have close ties to TAY programs. In Deschutes, CSC team leadership helped design the TAY program specifically to offer services to EASA graduates, although the program serves other youth as well.

Financing Considerations for Continuity of Care

The case study sites in this study generally used the same mixture of sources to fund their step-down services as they do their regular CSC program, namely, Medicaid, private insurance, Mental Health Block Grant (MHBG) set-aside funds, state general funds, and county funds. The key challenges for funding step-down programs are largely the same as those for funding CSC services, which have been highlighted in detail elsewhere (e.g., Shern, 2020; Shern et al., 2017; Jackson et al., 2019; see box).

One issue specific to continuity of care is that funding and program length are inextricably linked. With an increase in program length, program size is likely to increase, since the turnover of clients is neither rapid nor predictable. Increased program size requires additional resources for staffing in order to provide the same level of care. Without additional funding, program managers may be unable to extend the length of time a client can spend in the program. As an example of a state response to this challenge, Oregon is considering legislation to lengthen FEP programs from two to three years across the 26 EASA sites in the state, and the state will increase funding accordingly if passed.

In all nine case study sites, Medicaid is used as a payment source for the CSC program and in most, also for the step-down services or extended care. These sites do not have widespread use of Medicaid waivers to support post-transition services. New York, Ohio and Louisiana, however, all allow the use of Community Psychiatric Support and Treatment codes to bill for contact between therapists and clients that take place in community locations. EPIC-NOLA specifically highlighted the benefit of these codes to allow therapists to meet clients in homes, schools and other community locations.

Key Funding Challenges

- *Medicaid covers only about 50% of costs to run CSC programs and may not cover services such as SEE and family therapy.*
- *Key aspects of CSC that do not involve face-to-face contact, such as care coordination, may not be reimbursed by either Medicaid or private insurance.*
- *Insurance may not cover administration of long-acting injectables and assertive community treatment services in some states.*
- *Private insurance copays can be prohibitive.*
- *CSC programs often serve uninsured clients but community-based post-transition options are extremely limited for those without insurance.*

SUMMARY

CSC programs tend to follow consistent patterns with respect to transition processes. Across a scan of 50 CSC programs, the most common pattern was for programs to work with a client for approximately two years, followed by a referral for services either within the same agency or the community, without explicit step-down

services. A small number of programs have begun developing step-down programs, and some do so as an internal process. A small number of CSC programs lengthen the program beyond three years and allow the intensity of service use to fluctuate within that period.

Step-down approaches differ across multiple dimensions and are often responsive to local contextual factors. Variability across step-down models includes whether the services are a continuation or reflect a shift in focus, whether the step-down can accommodate all CSC clients and at the same level as the full model or not, and the population served, among others. These decisions are shaped by fiscal and programmatic constraints, as well as influenced by the perceived needs of clients in each community. There is no clear pattern to the configuration of these components.

Opportunities for integration of CSC graduates into programs and organizations where CSC services can improve continuity of care. CSC programs located in hospitals and large CMHCs generally have expanded options for CSC graduates, with clients able to transition into medication management clinics and access to other services. TAY programs hold particular appeal because services match the developmental stage of most clients in the program. More information is needed about integration with CCBHCs.

To date, most CSC programs fund continuity of care services through a similar mechanism as their full CSC services, and therefore navigate similar constraints. Reimbursement through Medicaid and private insurance, supplemented with state and MHBG funds is common. Certain services--such as SEE, case management and peer support--are often not covered by insurance, yet these are the services that often are most relevant to individuals once they have stabilized and are in a step-down setting.

CONCLUSION

CSC programs that are well integrated into larger systems tend to have greater options to serve their clients following graduation. Strategies that facilitate continuity of care during transitions include co-location of CSC in large hospitals or community mental health centers (CMHCs), or partnerships with TAY programs. Most respondents in this study favored either a CSC program length of three to five years, or allowing length to vary according to each individual clients' needs. As more CSC programs mature to serve ever-growing numbers of clients, the strategies for providing effective continuity of care illustrated in this brief will continue to grow. Continued services research can document the impacts of those approaches to help guide the development of improved service delivery during transitions from CSC programs.

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