|  |  |
| --- | --- |
| **Name of FEP Program:** |  |
| Parent Agency/Hospital: |  |
| FEP Clinic Site Address: |  |
| Name (Primary Contact): |  |
| Position (Primary Contact): |  |
| Email (Primary Contact): |  |
| Phone (Primary Contact): |  |

## Section 1. Program Overview

#### On what date did your program enroll your first client into your CSC program?

|  |  |  |
| --- | --- | --- |
| Month: |  |  |
| Year: |  |  |

|  |
| --- |
|  |

### How many clients are currently enrolled in your CSC program?

|  |
| --- |
|  |

### What is the maximum client capacity of your CSC program?

1. What are the eligibility criteria for participation in your FEP CSC program? (e.g., age, included and excluded psychiatric diagnoses, duration of psychosis, minimum IQ)

|  |
| --- |
|  |

1. What are the cultural, linguistic and other needs of the communities that you serve?

|  |
| --- |
|  |

### What catchment area does your program serve? (e.g., Suffolk County, DMH Western Massachusetts Area, state of Massachusetts)

|  |
| --- |
|  |

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

Less than a mile

1-10 miles

11-20 miles

21-50 miles

More than 50 miles

1. In the past 3 months, what percentage of visits in your clinic have been conducted via telehealth?

None

Less than half

About half

More than half

All

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

Less than 1 year

12-18 months

19-24 months

25-36 months

37-42 months

43-60 months

More than 5 years

Other (Specify):

#### What is the maximum length of time that clients can receive services within your CSC program? Select one.

Less than 1 year

12-18 months

19-24 months

25-36 months

37-42 months

43-60 months

No set time limit

1. Please describe what ‘space’ is available to the FEP CSC program (e.g. dedicated milieu space, group room, etc.). Have you encountered (or do you anticipate) any difficulties with regard to space constraints for CSC activities?

|  |
| --- |
|  |

### Please list any disability accommodations that are available to clients in this program (e.g., translation for Deaf/Hard of Hearing clients, website accessibility settings)

|  |
| --- |
|  |

## Section 2. Staffing & Services

### Please indicate the total number of staff who are a part of your CSC team:

|  |  |  |  |
| --- | --- | --- | --- |
| **Program Staffing** | # Current CSC staff\* | # To be hired (vacancy) | FTE allocated to role |
| Team Leader |  |  |  |
| Individual Therapist |  |  |  |
| Family Therapist |  |  |  |
| Prescriber |  |  |  |
| Employment & Education Specialist |  |  |  |
| Case Manager/Care Coordinator |  |  |  |
| Additional Roles  Peer Specialist/Family Partner  Nurse  Administrative/Research Assistant  Substance Use Specialist  Other (Specify): |  |  |  |
| **TOTAL** |  |  |  |

*\*Does not include trainees (i.e., interns or other temporary staff)*

14a. Please provide details on how you use other resources (e.g. volunteers, trainees, or other community organizations) to complement services provided by agency staff.

|  |
| --- |
|  |

|  |
| --- |
|  |

### In the past year, how many staff members have left the team?

|  |
| --- |
|  |

### In the past year, how many staff members have joined the team?

1. Do any team members in your CSC program offer services in a language other than English (including American Sign Language)?

|  |
| --- |
|  |

Yes (Specify):

No

1. Apart from bilingual services provided by team members, does your program offer live translation for languages other than English (including American Sign Language)?

|  |
| --- |
|  |

Yes (Specify):

No

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

|  |
| --- |
|  |

Yes (Specify):

No

#### Please indicate which treatment services and supports your CSC program provides, and whether these are offered at the clinic or through partnerships with external providers.

| **Treatment Services & Supports**  *\*\* = Core CSC services* *\* = Core CSC procedures* | Fully available through your program | Partially available through your program | Provided via telehealth | Provided via collaborations with other community providers | Not provided for at least 7 of the past 12 months |
| --- | --- | --- | --- | --- | --- |
| \*\* Case management/Care coordination |  |  |  |  |  |
| \*\* Family education or support |  |  |  |  |  |
| \*\* Individual psychotherapy |  |  |  |  |  |
| \*\* Pharmacotherapy |  |  |  |  |  |
| \*\* Supported education & employment services |  |  |  |  |  |
| \* Assessment (Cognitive) |  |  |  |  |  |
| \* Assessment (Functioning) |  |  |  |  |  |
| \* Assessment (Psychosocial) |  |  |  |  |  |
| \* Community outreach |  |  |  |  |  |
| \* Crisis intervention services |  |  |  |  |  |
| \* Primary care coordination |  |  |  |  |  |
| \* Psychoeducation |  |  |  |  |  |
| Individual Resiliency Training |  |  |  |  |  |
| Individual Placement & Support |  |  |  |  |  |
| Multi-family group therapy |  |  |  |  |  |
| Acceptance & Commitment Therapy |  |  |  |  |  |
| Cognitive-Behavioral Therapy for Psychosis (Individual) |  |  |  |  |  |
| Cognitive remediation/CET |  |  |  |  |  |
| Dialectical Behavior Therapy |  |  |  |  |  |
| Family peer support services |  |  |  |  |  |
| Group psychotherapy |  |  |  |  |  |
| Health and wellness services |  |  |  |  |  |
| Housing support and services |  |  |  |  |  |
| Motivational Interviewing |  |  |  |  |  |
| Occupational therapy |  |  |  |  |  |
| Peer support services |  |  |  |  |  |
| Recreational groups |  |  |  |  |  |
| Smoking cessation services |  |  |  |  |  |
| Substance use services, including co-occurring substance use services |  |  |  |  |  |
| Weight loss support/services |  |  |  |  |  |
| Other (Specify below) |  |  |  |  | - |

19a. For “Other” services, those you are able to partially offer through your FEP program, and those provided via collaborations with external providers, please provide details of what you are able to provide and how you deliver these services.

|  |
| --- |
|  |

19b. Please describe any plans that you have to enhance your ability to deliver these services through partnerships, contracts, or other funding sources.

|  |
| --- |
|  |

## Section 3. Procedures & Goals

1. Please indicate the frequency of the following meetings at your CSC program:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | More than 1/week | Weekly | Every other week | Monthly | Other schedule | No regular schedule | No meetings |
| Multi-disciplinary team meetings to review cases |  |  |  |  |  |  |  |
| Regular supervision of individual team members re: FEP work |  |  |  |  |  |  |  |

21a. Specify if “Other schedule”:

|  |
| --- |
|  |

#### Please select all referral sources for your CSC program:

Psychiatric inpatient facilities

Outpatient mental health clinics within the agency

Outpatient mental health clinics outside the agency

Emergency departments

Private practice psychiatrists, counselors, therapists

Primary care practitioners

Courts/correctional facilities

Colleges, high schools, or other educational institutions

Consumer, professional, or family organizations (e.g., NAMI, Mental Health America)

Self-referral

Family referral

State agencies (e.g., MRC, DMH, DTA)

Other (Specify):

1. Where and what community-based education and recruitment activities do you offer (e.g. PCP practices, college health centers, high schools, etc.)?

|  |
| --- |
|  |

1. Do you currently collect patient-level data via the MAPNET assessment battery at intake, 6 month intervals following intake, and discharge?

Yes  No

25a. (If “No”) Describe how you currently evaluate the effectiveness of your program. List all assessment measures you utilize and how often they are administered (e.g. at admission, every 6 months, annually, at discharge).

|  |
| --- |
|  |

25b. *(If “Yes”)* What percentage of patients have completed a baseline and 6-month assessment, respectively?What are the main reasons for non-completion?

|  |
| --- |
|  |

1. Describe how you currently obtain and incorporate feedback from young adults and their families.

|  |
| --- |
|  |

1. Please select all settings clients are referred to following completion of your CSC program.

General outpatient services within the same agency (must include more than just

medication management)

Medication management within the same agency

Assertive Community Treatment (ACT) or similar program for individuals requiring

a higher level of support

Transition Aged Youth (TAY) or similar program for young adults

Step-down program that is separate from CSC

Services provided in the broader community (e.g., community-based psychiatrist,

general practitioner, or other community mental health services, etc.)

No treatment following CSC

Unknown

Other (Specify):

1. Summarize the strengths and needs of your program.

|  |
| --- |
|  |

1. Describe your program’s development goals and plan for the next 2 years.

|  |
| --- |
|  |