

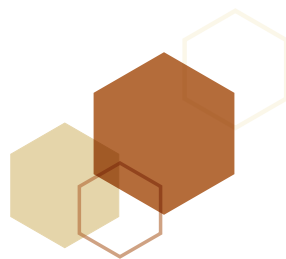


POLICY BRIEF

Coordinated Specialty Care— First Episode Psychosis Programs: Why specialty early intervention programs are a smart investment

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The implementation of the Patient Protection and Affordable Care Act (ACA) requires coverage of mental health services at parity with general health services with an emphasis on early intervention, and the provision of collaborative, and coordinated care.

Healthcare delivery systems will need to consider approaches to address serious mental illness (SMI) *early* before symptoms become complex, disability occurs, and long term costs of SMI escalate. This brief, made possible through support of the Substance Abuse and Mental Health Services Administration (SAMHSA), discusses the business case for payers to use a specialized early intervention treatment program which has demonstrated positive results (e.g., improving symptoms, functioning and quality of life) in persons experiencing initial symptoms of SMI; specifically their first episode of psychosis.

Employers and health plans responsible for meeting the behavioral health needs of adolescent and young adult beneficiaries might select prescription opioid misuse, suicide prevention and integrating medical and behavioral healthcare as essential. First episode psychosis (FEP) is likely not rated as a target area to address. But, if the small numbers of adolescents and young adults who are first experiencing psychotic symptoms are overlooked, they are likely to experience poor long term outcomes and will be very costly to treat. Given the age at which people develop psychotic disorders (and ACA coverage mandates), commercial insurance plans are more likely to have beneficiaries with FEP than would have occurred pre-ACA. If these young people are not identified early and engaged in specialty early intervention treatment soon after their psychotic symptoms



appear, they are more likely to have a long term course of illness with frequent psychiatric hospitalizations and may need to rely on disability programs. Most will stay on their parents' health insurance plan for years, even a decade or more before they reach age 26 and go off their parents' insurance. These young people experiencing initial symptoms of psychosis have not yet developed disability and are less likely to be enrolled in Medicaid than other persons with longer term SMI. With early intervention, they may not become disabled. Fortunately, given the low incidence of FEP and the reasonable cost of providing specialty early intervention program services to these individuals on a per member per month (PMPM) basis, these programs are affordable in the short term and will surely save societal costs in the long-term.

The purpose of this policy brief is two-fold:

1. Describe what coordinated specialty care—first episode psychosis (CSC-FEP) treatment programs are and why these programs are greatly needed in today's healthcare delivery systems, and
2. Make the business case for payers to consider CSC-FEP programs.

Current Efforts to Address Serious Mental Illness (SMI) Are Costly and often Ineffective

SMI affects individuals of all socioeconomic backgrounds, races and ethnicities. In the U.S., nearly one adult in 25 has schizophrenia, schizoaffective disorder, bipolar disorder or another SMI.¹ SMI has the potential to greatly derail a person's life—such as disrupting a person's work life, their educational goals, and even worse it is associated with premature death. These illnesses can exact a painful toll on individuals and families (see *Maggie's Story* and *Maggie's Mother's Story*). Persons living with SMI often require non-medical supports such as housing and income support, and some face complex problems such as homelessness or criminal justice system involvement. One-quarter of homeless adults have a SMI, and a similar proportion of adults in prison have a SMI.² People with mental illnesses are 4.5 times more likely to be arrested than their peers.³ Ninety percent of people who die by suicide had an underlying mental illness.⁴

Following the deinstitutionalization of the state hospitals in the 1960's and 70's, states were pressed to preferentially serve individuals with severe and disabling illnesses. Ultimately, in most states, adults are not eligible for state funded services until they meet criteria for SMI. To meet SMI criteria, individuals typically must have a significant duration of illness and have disability associated with their mental illness. Traditional public mental health systems, therefore, have not been effective in identifying individuals early and providing services to stem the course of illness and disability resulting in many of the problems noted earlier.

These illnesses that have become severe and disabling are expensive to treat and become even more expensive through a person's lifetime. In 2002, SMI cost the U.S. at least \$193 billion annually in lost earnings.⁵ Only Walmart had revenues that exceeded this lost productivity in 2002 meaning that SMIs cause the loss in productivity associated with the revenues of one of the largest U.S. companies. For a person living with a SMI, the average lost wages are a little over \$16K a year.⁶ The average monthly expenditure for beneficiaries with schizophrenia in employment-based health plans is more than four times the average cost of demographically matched beneficiaries (\$1,806 versus \$419).⁷ Medicaid is the single largest payer in the U.S. for mental health services. For example, in 2011, the total cost of delivering care to the Medicaid population with behavioral health diagnoses (20 percent of Medicaid recipients) was \$131 billion; which was almost half of all Medicaid expenditures that year.^{8,9} Current approaches for treating SMI only after it becomes severe, is not serving these individuals, their families or their communities well and is very expensive. Exploration of other treatment modalities that lead to better outcomes is essential.

During my initial onset (of psychosis) I was so scared to share the details of what I was going through with anyone because I did not want to scare anyone or make them feel scared of me.

– An FEP Program Client





MAGGIE'S STORY: A young woman's journey to get better after experiencing her first episode of psychosis

Maggie is a 20 year old nursing student who works part-time and lives with schizophrenia. She was 15 ½ years old when she experienced her first episode of psychosis. She remembered the details of what happened—she was at a friend's house for a sleepover and was confused and frightened by the voices in her head telling her to do unimaginable things. She was hopeful the voices she was hearing would stop but they did not.

– They (the voices) were saying mean things about me like—you're worthless, you're not going to amount to anything, cut your fingers, this person is out for you—you need to watch out. I was so scared—scared to share what I was going through with anyone else because I did not want to scare them or make them feel scared of me.

Maggie's older sister picked her up from her friend's house after the sleepover and took Maggie to her job which was to handle food prep. Within two hours of working, Maggie broke down and could not work anymore and went home. The voices were just too much for her to bear while working in the kitchen—the voices kept telling her to cut herself. Later she told her boss she could not work at the kitchen anymore because of her symptoms. The next day Maggie went to school and was not feeling well and was in crisis. Her mom picked her up from school. Before this incident occurred, her mom scheduled an appointment with a therapist to talk through stress she was experiencing, though the appointment was two weeks away. Maggie's mom tried to get Maggie an appointment to see a therapist but no one was available; therapists recommended taking Maggie to the hospital right away. Maggie and her mom waited several hours in the ER waiting to get care—finally at 3am a psychiatric hospital bed was available at another county, over 100 miles away. After a long drive Maggie got to a psychiatric hospital. Maggie spoke about the treatment she received at the hospital.

– Therapy sessions were focused on talking about my life and not helping me deal with the voices, it was frustrating. I finally told my mother I want out. In order to get out I had to agree to go to 2 hour sessions of group therapy 5 times a week. I went to the group therapy sessions and it was challenging to keep up with school and attend therapy and it was just not helpful at all, I was frustrated. They wanted me to draw pictures and I just wanted help with managing the voices—they would not stop.

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Psychotic Disorders and First Episode Psychosis (FEP)

Approximately 100,000 adolescents and young adults in the U.S. will experience a first episode of psychosis each year.¹⁰ The peak onset of first episode psychosis (FEP) typically occurs between 15 to 25 years of age.¹¹ Symptoms of psychosis that emerge in the teens and early twenties include false beliefs (delusions) and hallucinations (seeing or hearing things that others do not see or hear). Psychotic symptoms may appear with mental health conditions such as bipolar disorder and depression. However psychosis is a definitive symptom of schizophrenia, and this policy brief highlights an effective approach to providing early treatment to persons experiencing a first episode of non-affective psychosis associated with illnesses such as schizophrenia, schizoaffective disorder, and schizophreniform disorder.



Youth with schizophrenia experiencing their initial symptoms of psychosis often do not know what is happening, why they are experiencing these symptoms and are terrified of sharing what they are going through to get help (see *Maggie's Story*). The nature of symptoms may discourage a young person from seeking help which presents challenges for family members and clinicians. If young people decide to get help—the journey of getting treatment for early psychosis is often complex, frustrating and may be demoralizing. Many end up in the emergency room or encounter law enforcement. If they get into conventional clinical treatment, the services may not meet their needs and they may drop out only to need crisis and continuing mental healthcare in the future.

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MAGGIE'S STORY—While attending therapy Maggie met a psychiatrist who connected her with a NIMH/NIH research study focused on a CSC-FEP model program (called NAVIGATE). Within the first session of this treatment intervention Maggie immediately felt a difference in the type of care she was receiving.

– *When I first arrived to the program they explained that I had schizophrenia. This was the first time I was ever given this diagnosis; it was scary to hear that word “schizophrenia” because of what you hear about in the media but in a way it was a relief to finally know what I was dealing with. I immediately met with a team of four people—a psychiatrist, a general team leader therapist, a social skills therapist, a school and work therapist. I was able to bring my mom. I always had the choice to have a family member there with me for sessions. I chose to have my mom there to give me the support I needed. When I first met the team we all just sat around the table and talked. The team explained my illness to me in a way that made me feel like I could manage this illness and get my life back on track. For the first time I did not feel like a patient or that I was in therapy. I felt like our sessions were discussions and not one way conversations with the therapist asking all the questions. At first, sessions were twice a week and then once a week; I met with my team as frequently as I needed—it was all based on my needs, what worked for me.*

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Maggie ended up sticking with the CSC- FEP program receiving treatment for almost 2.5 years. While at the program she tried at least 30 medications to determine the best dose and type of psychotropic medications for her with the least amount of side effects.

– *If I experienced side effects my psychiatrist would always ask my opinion. At first when she asked my opinion—I asked her, “well aren’t you supposed to tell me what to take?” and she said “no, you can choose, tell me how you feel, what you think is best.” Having a doctor that asked me how I felt about my treatment made me feel like I could trust the people caring for me; I never felt like I could trust mental health professionals.*

Maggie is 20 years old today and attending nursing school and has not been to a hospital for psychiatric emergency care since. She reflected on the care she received through the CSC-FEP program.

– *I never felt like I was just another patient; I felt like my team always saw me as a real person that wanted to get her life back together. They always supported me in school, helped me find a job. The school and work therapist drove me around for close to 3 hours to help me get to job interviews, they coached me on my job interviews, helped me complete job applications. This sort of help is not common—they helped me get my life back! The social skills therapist helped me feel comfortable in social situations—we did role play on various uncomfortable scenarios that could happen in my personal life—that helped me a lot. They taught me how to tune out the voices in my head so that I could function. I did not think these types of services existed!*



I don’t know how much these types of programs (cost)—though this program helped me stay out of the hospital, get a job, get on with my life—and that is priceless, you can’t put a price tag on this type of treatment! I saw a psychiatrist who told me that I should quit nursing school because of my diagnosis. If I did not have access to the program (CSC-FEP program) I would have listened to that doctor and quit nursing school and lived off of my parents probably for the rest of my life. I give all the credit to the CSC-FEP program that I am in school today, that I have a job, and that I know I am going to do something with my life. I will have a career and live on my own. I would not have this confidence to achieve my life goals without this program. This program helped bring me out of my symptoms to function in reality. It took me 3 years to go from completely defeated by this illness to feeling almost on top of the world—that I can accomplish anything. Other people that I met along the way in my journey in getting better that had my diagnosis were older, in and out of hospitals, and that is just so upsetting to me. If they had the chance I had, they probably would not have as many issues as they do with their illness. Everybody needs a chance to get better as fast and as early as possible.

Specialty Early Intervention Programs: Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)

A substantial amount of data has accumulated over the past two decades demonstrating that timing is critical when it comes to addressing early symptoms of SMI; specifically psychosis. Compelling evidence suggests that a shorter duration of untreated psychosis (DUP) is associated with improved outcomes for persons with SMI—such as remission of

psychotic symptoms, improved quality of life and social functioning.¹² Implementation of specialty early intervention programs such as coordinated specialty care for first episode psychosis (CSC-FEP) programs have demonstrated improvement in patient functional and clinical outcomes. CSC-FEP programs have been shown to:

- Improve quality of life
- Reduce psychopathology
- Improve involvement in school and work
- Reduce use of hospital services

The sooner young people exhibiting psychotic symptoms get access to CSC-FEP programs, the greater the likelihood that these services can be effective.^{13, 14, 15, 16}

The CSC-FEP program model is a team-based approach for youth or young adults experiencing symptoms of psychosis associated with disorders such as schizophrenia. Table 1 lists common core components of CSC-FEP programs.¹⁷ This model program promotes the youth/young adult, their family, psychiatrist and recovery specialists to work together to support the youth/young adult's recovery. These programs emphasize shared decision making to address the youth/young adult's unique needs and recovery goals. Most CSC-FEP programs aim to provide low-dose, evidence-based pharmacotherapy that strives to minimize side effects and nonadherence to medication.

Table 1. Coordinated Specialty Care for First Episode Psychosis (CSC-FEP) Treatment Intervention Components

Team Based Care
Case Management
Employment and Education Supports
Psychotherapy
Family Education and Support
Pharmacotherapy and Primary Care Coordination

The Landscape. More than 200 CSC-FEP programs are currently operating across the country, and the number is growing. Few CSC-FEP programs serve more than 35 patients at a time. Most depend on state general funds, Federal block grants and Medicaid, though some are successfully billing commercial insurance for healthcare related services associated with these programs.

Other countries, Australia, the United Kingdom, Scandinavia and Canada, have longer histories of offering CSC-FEP programs.^{18,19,20} Most of the research demonstrating the positive impacts of CSC-FEP programs come from studies in these countries. The Foundation for Excellence in Mental Healthcare and the EASA Center for Excellence publish a [Program Directory of Early Psychosis Intervention Programs](#) and the [International Early Psychosis Association \(IEPA\)](#) website contains information on work that is happening globally on this topic.

A major U.S. study called the Recovery After an Initial Schizophrenia Episode (RAISE), funded by the National Institute for Mental Health (NIMH/NIH) found what studies in other countries have demonstrated:

- Participants who started in a CSC-FEP program within the first year and a half after experiencing symptoms had greater improvement in quality of life and fewer psychotic symptoms than young people receiving usual care.
- Participants were much more likely to be working, going to school, and living successfully without disability.²¹

This type of treatment has the potential to interrupt an illness that can impact generations.

– Consumer/ Researcher (living with Schizophrenia who is the daughter of a mom with Schizophrenia who is severely disabled)

I don't know how much these types of programs (cost)—this program helped me stay out of the hospital, get a job, get on with my life- and that is priceless. You can't put a price tag on this type of treatment! Everybody needs a chance to get better as fast and as early as possible.

– An FEP program client

The RAISE study further demonstrated the cost for CSC-FEP care was slightly more than the costs of usual care during the first two years, but that the programming was cost-effective because it resulted in greater health value than usual care.²² CSC-FEP clients had higher outpatient mental health and antipsychotic medication costs, but overall benefits in quality of life, reduced symptoms and community functioning were worth the additional costs. The modest additional costs of the CSC-FEP program are likely to be recouped multiple times over when considering the societal costs associated with SMI under our current treatment approaches, including potential long term savings to the healthcare system. It is important to note the usual treatment intervention used in the RAISE study was a high quality treatment program using traditional treatment methods.

The three Federal agencies most responsible for the science, services and payment for behavioral health service, the *NIMH*, *SAMHSA* and *the Centers for Medicare and Medicaid Services (CMS)*, endorsed CSC-FEP programs in a [joint announcement](#) (see Resources section) in September 2015:

Targeted treatment in the early stages of illness and integrated medical, psychological, and rehabilitation interventions, are an effective means for treating first episode psychosis. Without such interventions during a first episode, the typical course of psychotic disorder involves multiple episodes of acute mental illness, with accumulating disability between periods of active psychosis and increased long-term healthcare costs—CMS, NIMH/NIH, and SAMHSA.²³

The National Institute for Health and Care Excellence (NICE), the UK's independent body that systematically reviews the scientific evidence on healthcare treatments and recommends cost-effective treatments for the National Health System, declared in 2014:

Early intervention in psychosis services should be accessible to all people with a first episode or first presentation of psychosis. Early intervention in psychosis services should aim to provide a full range of pharmacological, psychological, social, occupational and educational interventions for people with psychosis—NICE.²⁴

The Patient Protection and Affordable Care Act (ACA), paired with the *Mental Health Parity and Addiction Equity Act (MHPAEA)*, make FEP an issue for employers, health plans and Medicaid agencies. ACA permits youth up to age 26 to be covered by parents' health insurance. ACA regulations extended parity requirements of equitable coverage of mental health and physical healthcare for employment based health insurance, fully insured health insurance, small group and individual health insurance, and Medicaid managed care.^{25, 26} About half the states expanded Medicaid, extending coverage to poor and near poor individuals and families. Enrollment through the health insurance exchanges have extended coverage to millions more who previously had no insurance. Thus, adolescents and young adults first experiencing psychotic symptoms are likely to have health insurance coverage which includes mental healthcare.

These patients don't need help with completing social security applications, they need help with filling out job applications so they can get their lives back on track.

– CSC-FEP Program Director;
Northern Virginia

During 2013, [Healthcare Effectiveness Data and Information Set \(HEDIS\)](#) criteria were added which draws attention to management of SMIs; particularly schizophrenia. Given the expected rise in the number of insured patients with schizophrenia among commercial insurance patient populations, HEDIS measures demonstrate an opportunity to apply new treatment interventions, like CSC-FEP to effectively manage patients with SMI. In particular, the HEDIS criteria includes adherence to antipsychotic medications for patients with schizophrenia. CSC-FEP treatment programs empower patients to manage

their symptoms and identify appropriate treatment through a shared decision making approach. Further, most CSC-FEP programs aim to provide low-dose, evidence-based pharmacotherapy that strives to minimize side effects and nonadherence to medication. The model program also includes a primary care coordination component to ensure physical healthcare needs are addressed.

The Consolidated Appropriations Act of 2014 set aside five percent (\$25 million) of the SAMHSA's Community Mental Health Services Block Grant programs to support early psychosis treatment programs. In 2016, Congress increased the set-aside to ten percent (\$50 million), reflecting strong bi-partisan support for this type of programming. These funds are crucial for getting CSC-FEP programs started.

Cost to Cover CSC-FEP Programs

Relative to other specialty medical services, the costs associated with CSC-FEP programs are modest.^{27,28} The annual cost difference between CSC-FEP and traditional programming is about approximately \$3,674/year; this annual figure includes workforce development training costs.²⁹ The seminal analysis conducted by Rosenheck et al., evaluated CSC-FEP program cost effectiveness over a short period (two years) which did not factor in societal level costs associated with SMI. The analysis determined CSC-FEP programs cost 27 percent more than the comparison intervention; which was a high quality intervention. Despite the short follow up period, significant improvements in quality of life (13 percent) were observed among participants exposed to the CSC-FEP program. The analysis demonstrated that the monetary value of CSC-FEP program benefits such as improved clinical outcomes, functioning and quality of life is worth the additional cost. Furthermore, when comparing CSC-FEP costs with standard treatments delivered for chronic conditions or diseases, the costs associated with CSC-FEP programs are comparable to costs for statins and well below those routinely provided for the treatment of cancer (see Table 2).³⁰

We are not going to have to take care of her for the rest of her life; she is not going to have to go on disability. Offering these programs will help reduce and cut down on the stigma associated with SMI—offering programs like this will offer hope that there is a life of recovery if you have these illnesses.

– Mother of a daughter living with schizophrenia.

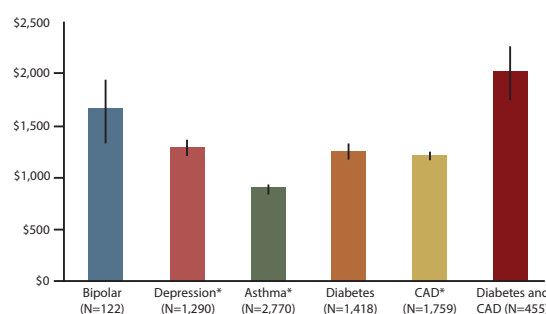
Table 2. CSC-FEP Treatment Intervention Annual Costs compared to Other Chronic Disease Treatment Interventions

CSC- FEP Intervention = \$3,674/year/patient)	
Treatment	Annual Cost
Cancer Chemotherapy Treatment	Avastin: \$100,000/year Herceptin: \$70,000/year
Statins (Walmart)	Lipitor © (1 year supply): \$3,288

In general, the number of young people requiring FEP program services is small. Very few show symptoms before age 12. New cases rise sharply between ages 15-25 before falling sharply.³¹ FEP has a low incidence. For example, the incidence of schizophrenia is approximately 15/100,000 with higher rates among males than females. Provision of counseling, educational, vocational supports, family education and counseling, psychotropic medications, and team based care and coordination costs in the neighborhood of \$1,200 per month. FEP programs typically work intensively with young people and their families for approximately two years and transition patients to providers that can offer further support as necessary. Services generally are most intensive during the first few months and taper off to less intensive.

Compare the monthly cost of \$1,200 to \$1,400 for CSC- FEP programs with average monthly healthcare costs of beneficiaries in employment-based health insurance who had bipolar disorder, depression, diabetes, or coronary artery disease in Figure 1.³² Clearly, the cost for FEP programs are comparable to services for other psychiatric or general health conditions.

Figure 1. Total Healthcare Utilization Costs per Health Plan Member per Month by Condition (N=7,311)



MPPM costs for a typical insurance program. Based on expected incidence rates for schizophrenia³³ and costs from Virginia CSC-FEP programs, we projected the likely annual number of new cases of schizophrenia as an example, and calculated the per capita annual cost of CSC-FEP treatment if spread across the Virginia population aged 0-64 years old (see Table 3). We further assumed that the average duration of the specialty treatment would be 2 years. This analysis illustrates that the average cost per person of offering these services is about 22 cents per person per month; which further illustrates the modest cost in offering these types of programs.³⁴

Table 3. State Case Example: Estimated Annual Costs to Provide CSC-FEP Treatment Program Services

Virginia (N=8,326,289)	Rate	Total
Incidence rate of schizophrenia for population age 18-64	15.2/100,000	807
75% Presenting for Service		606
Total cost of FEP program	\$1,200/mo. X 24 mo. X 606	\$17,452,800
Cost/year per person in VA age 0-64		\$ 2.70
Cost/month/person in VA		\$ 0.22

Key Considerations

The public healthcare sector is promoting implementation of CSC-FEP programs within public mental healthcare systems (see Case Examples section). Specific guidance was issued by CMS/CMCS, SAMHSA, NIMH/NIH (as referenced earlier) specifying details on how to finance these programs. However, public payer efforts alone and associated public funding will not sufficiently address FEP in the U.S. Commercial payers have an important key role to play in the delivery of CSC-FEP program services. The Federally mandated extension of commercial coverage to adult children until age 26 years has increased the prevalence of patients with SMIs such as schizophrenia among commercially insured populations. Given psychosis can be first exhibited as early as 15 years of age or younger, commercial insurers will need to consider they will serve these individuals for at least 10 years. The cost associated with not *addressing* psychosis (associated with SMI) early is likely greater than early intervention efforts over the long term—especially if considering societal costs.

CSC-FEP treatment programs do not appear to be considered by commercial insurance plans currently. This was a key observation based on a small set of key informant

interviews conducted with commercial insurance plans and community based organizations (implementing CSC-FEP programs). The outreach, engagement, family education and vocational related services that are essential for CSC-FEP programming are typically not reimbursed in commercial insurance programs. Additionally, the fee-for-service payment model that is based on procedures delivered and discretely billed is inadequate for delivery of CSC-FEP services. A few CSC-FEP community-based programs bill private health insurers for ordinary clinical services but this is not adequate for CSC-FEP

programming. The team-based care coordination of FEP services requires bundled or enhanced payment mechanisms similar to those commonly used for Assertive Community Treatment for SMI patients, rehabilitative care for stroke patients, or patient centered medical homes for medically complex patients. Health plans and employers are familiar with enhanced reimbursement rates, bundled/ fixed price rates and capitation for other low frequency, specialty medical services. This can serve as a template for the development of effective reimbursement methods for CSC-FEP programs.

As referenced earlier, there are a little over 100 FEP programs scattered across the country.^{35, 36} The small numbers of young people first experiencing psychotic symptoms who are in any health plan or employer health insurance pool means that one or a few CSC-FEP programs can serve a geographic area. Commercial insurance plans considering offering CSC-FEP program services as part of their essential health benefits (EHBs) will need to consider whether it makes fiscal sense to purchase these services for their beneficiaries from community-based provider organizations already delivering these services or provide these services within their network. Given the low incidence of FEP, it may make more sense to purchase these services from a specialty vendor.

I got kicked out of my doctoral program because I was essentially struggling to find help. I was profoundly demoralized and in a very dark place when this all happened. There is no way I would have believed I could go back to school if it had not been for my CSC-FEP clinical team.

– Ph.D., Director of Research and Evaluation (Felton Institute), who lives with schizophrenia.

MAGGIE'S MOTHER'S STORY: A mother's journey to get care for her daughter

Maggie's mom reflected on the care she received from her CSC-FEP program.

– The CSC-FEP program changed Maggie's life and our family's lives. I am not sure my daughter would still be alive today if it weren't for the CSC-FEP program services she received; she definitely would not be where she is today. I feel like a mother whose child had cancer and the cancer went away after treatment. That is the kind of gratitude I have towards the doctors and the CSC-FEP program that helped my daughter. They gave me my child back- they saved her, they really saved her.

Prior to the CSC-FEP program I was terrified, I felt like I was like walking through a mine field, I never knew day-to-day what was going to happen with Maggie. I was scared to death. She was constantly struggling with the voices. My life just went on hold. The CSC-FEP program provided the critical support we needed. The program offered a 24 hour line for us to contact during late or early morning hours if we ever had a crisis or if she was experiencing med side effects. We could talk to the doctor at any moment in time—this type of support was invaluable. The CSC-FEP program has reduced Maggie's hospitalizations because it has provided Maggie with the tools she needs to manage her symptoms. The CSC-FEP program ensured we (Maggie and I) were full partners on Maggie's treatment team...

My husband and I have talked about this many times—if we had to pay for two years of CSC-FEP services out of pocket it would have been less expensive compared to standard treatment. We are not going to have to take care of her for the rest of her life; she is not going to have to go on disability. Offering these programs will help reduce and cut down on the stigma associated with serious mental illness—offering programs like this will offer hope that there is a life of recovery if you have this illness. My daughter is not schizophrenic she is a person that lives with schizophrenia.

Case Examples

Practice Guidelines. CSC-FEP program accreditation standards from NCQA, Joint Commission or CARF do not yet exist. However certain States (e.g., Oregon) have defined the key components of these programs to support quality implementation among

provider organizations. Oregon has used their established [guidelines](#) to support CSC-FEP program model implementation in 27 of a total of 36 counties in the State. Oregon is one the few States with a long history of implementing CSC-FEP programs; the State has been working on implementation since the late 1990's. Implementation of CSC-FEP program implementation has yielded positive



results in the local communities in the State such as reduced psychiatric hospitalizations, improvement in rates of employment and school enrollment. All organizations implementing Oregon's CSC-FEP model program, which is referred to as the *Early Assessment and Support Alliance (EASA)* program are encouraged to go through [regular audits for fidelity](#) to their CSC-FEP program.

Contracting Language. New York State has developed contract language for use with managed care firms to facilitate access to New York's CSC-FEP program, referred to as OnTrackNY. In the [Request For Qualifications \(RFQ\)](#) to which behavioral health managed care firms responded, New York specified requirements to support implementation of their CSC-FEP program, including that health plans be able to identify individuals with FEP and preferentially refer them to services meeting the state's requirements for CSC-FEP services. The New York State Office of Mental Health (OMH) also issued a guidance [memo](#) to assist managed care plans in meeting the requirements for serving persons with FEP, including noting that all OnTrackNY teams met OMH's requirements for serving people with FEP. OMH also developed performance expectations and associated [fidelity criteria](#) that they use to measure the performance of their OnTrackNY team. In addition, OMH collaborated with researchers to create a flexible modeling [tool](#) to estimate the number of specialized treatment teams and associated staffing costs that would be needed to serve given geographic areas in the state. Dr. Tom Smith, Medical Director of the Division of Managed Care within New York State's Office of Mental Health believes investment in implementation of CSC-FEP programs is a smart investment—"The cost is not overly expensive when you consider the low prevalence of the targeted condition. We anticipate that the early intervention services will have relatively modest costs that will more than pay for themselves in the future by limiting disease chronicity and disability while maximizing recovery for people with FEP."

It is the right thing to do, if we don't do something people will continue to die 25 years earlier and a family is going to be bereft or someone will be incarcerated or on the streets homeless. Ethically and economically it just makes sense. We're talking addressing a low incidence issue—it is not that expensive to implement when you consider the societal costs of SMI.

—Youth Adult Services Coordinator
(Oregon State Mental Health Authority)
discussing the value of CSC-FEP programs



Summary

CSC-FEP programs show great potential to positively impact the life trajectory of persons with psychotic disorders like schizophrenia to live a life in recovery versus living a life on disability. CSC-FEP treatment programs are in alignment with population—based, early intervention, patient centered approaches to care which the ACA promotes. Emerging evidence suggests early treatment of psychotic disorders through application of CSC–FEP treatment is associated with positive clinical, functional, and quality of life outcomes. These findings are even more apparent among individuals who receive CSC-FEP care soon after experiencing initial symptoms of psychosis. The relative cost in delivering CSC-FEP care is no different than the cost of delivering treatments for physical chronic diseases. When factoring the impact of these programs in reducing long term societal costs associated with SMI, the likely return on investment (ROI) associated with these programs is even more robust. There are financing mechanisms in place to support implementation of CSC-FEP programs within the public healthcare sector. Commercial payers have an important role to play in assuring that evidence based CSC-FEP program services are available to their young adult beneficiaries. The Federally mandated extension of commercial coverage to serve adult children until age 26 has increased the prevalence of patients with SMIs among commercially insured populations. HEDIS measures focused on SMI help present quality standards for some services provided by CSC-FEP programs.



Resources

Coordinated Specialty Care First Episode Psychosis Programs:

- Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care: [http://www.nasmhpd.org/sites/default/files/Summary%20of%20Evidence-BasedTreatment%20Components%20for%20FEP_14APR_2014_Final\(4\).pdf](http://www.nasmhpd.org/sites/default/files/Summary%20of%20Evidence-BasedTreatment%20Components%20for%20FEP_14APR_2014_Final(4).pdf)
- An Inventory & Environmental Scan of Evidence-Based Practices for Treating Persons in Early Stages of Serious Mental Disorders: [http://www.nasmhpd.org/sites/default/files/Environmental%20Scan%20%202.10.2015_1\(5\).pdf](http://www.nasmhpd.org/sites/default/files/Environmental%20Scan%20%202.10.2015_1(5).pdf)

Centers for Medicare & Medicaid Services (CMS):

- Center for Medicaid and CHIP Services CMCS, SAMHSA, NIMH/NIH Joint Guidance on Coverage of Early Intervention Services for First Episode Psychosis <https://www.medicare.gov/federal-policy-guidance/downloads/cib-10-16-2015.pdf>

New York (OnTrackNY):

- An Interactive Tool to Estimate Costs and Resources for a First-Episode Psychosis Initiative <http://www.nasmhpd.org/content/practical-approaches-measuring-fidelity-coordinated-specialty-care-first-episode-psychosis>
- New York Request for Qualification for Adult Behavioral Health Benefit Administration https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/plan_process/docs/2015-7-3_nys_adult_behavior_hlth_ros.pdf
- Memorandum to Managed Care Plans on CSC-FEP <https://www.omh.ny.gov/omhweb/bho/docs/first-episode-psychosis.pdf>
- CSC-FEP Fidelity Tools: <http://www.nasmhpd.org/content/practical-approaches-measuring-fidelity-coordinated-specialty-care-first-episode-psychosis>

Oregon (Early Assessment and Support Alliance)

- Practice Guidelines EASA: <https://services.oregon.gov/oha/amh/ReportingReqs/Practice%20guidelines%20for%20Oregon%20EASA.pdf>
- CSC-FEP Model Program (EASA) Information: <https://www.oregon.gov/oha/amh/Pages/easa.aspx>
- EASA Implementation Tools: <http://www.easacommunity.org/resources-for-professionals.html>

NIH/NIMH Recovery After an Initial Schizophrenia Episode (RAISE) Initiative Resources:

- <http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml>
- <https://raiseetp.org/>

- <http://schizophreniabulletin.oxfordjournals.org/content/early/2016/01/19/schbul.sbv224.abstract>
- <http://www.nasmhpd.org/content/team-based-treatment-first-episode-psychosis-cost-effective-implications-policy-and-practice>

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Endnotes

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