Attachment A: **TEMPLATE FOR TRANSFORMATION PROJECT SUGGESTIONS**

For projects to be considered for inclusion in the Medicaid Transformation Project List, please provide the information requested in the template. We are looking for summarized information – **2-3 pages maximum per project**.
Please email completed templates by **January 15, 2016,** to MedicaidTransformation@hca.wa.gov with the subject **Medicaid Waiver Project**. Thank you for your interest and support.

Contact Information	*Haley Lowe, Division of Behavioral Health and Recovery* *Which organizations were involved in developing this project suggestion?* **Washington Council for Behavioral Health**
Project Title	*Early Psychosis Initiative (EPI)*

Rationale for the Project

- ***Problem statement – why this project is needed.***

Approximately 3 out of every 100 people worldwide will experience a psychotic episode at some stage during their lifetime; psychotic disorders are among the most burdensome and costly illnesses worldwide. These disorders affect people of all races, cultures, religions, and socioeconomic classes. Usually a first episode of psychosis occurs in adolescence or early adulthood. As with most disease processes, treatment is most effective and benign in the earliest stages of illness. In the United States, however, numerous studies have documented unacceptable durations of untreated psychosis, averaging 18 months between the onset of psychosis and the initiation of treatment.

Washington continues to be a leader in healthcare reform, and there is strong interest in innovation and upstream interventions. Yet, state mental health policy and financing remains focused on late-stage interventions and management of high-risk, high-cost populations with virtually no investment in mental health prevention and early intervention. Further, there is little knowledge or understanding within health and behavioral health systems or among health policy makers that there are now evidence-based interventions that can interrupt or prevent onset of full-blown psychosis and a lifelong trajectory of chronic disability.

In 2014, Congress appropriated additional funds to SAMHSA which then directed states to use a 5% set-aside from their Mental Health Block Grant (MHBG) to serve transition age youth (ages 15-25) experiencing a first episode of psychosis. DBHR embraced this opportunity and launched the Get Help Early: Washington's Early Psychosis Initiative. For youth who are Medicaid enrollees, flexibility in benefit design could significantly advance the impact of this initiative on both health outcomes and cost by providing earlier access to evidence-based interventions.

- ***Supporting research (evidence-based and promising practices) for the value of the proposed project.***[i]

Psychotic illnesses usually develop gradually over months or years. The longer the psychosis is untreated, the greater the risk other serious problems will occur such as declining performance at school or work, social isolation, depression, self-harm or suicide, hospitalization, drug or alcohol abuse, or aggressive behavior. Delays in treatment are associated with a slower and less complete recovery. Disparities in life expectancy for people with mental illness are well-documented. A November 2015 study indicates that people with schizophrenia are losing 28.5 years of life.[1]

Accordingly, the EPI project detailed in this proposal aims to facilitate earlier identification and treatment of psychotic disorders by increasing community awareness through education and by implementing early intervention services for individuals experiencing first episode psychosis, which include evidence-based treatment (recovery-oriented psychotherapy, family psychoeducation and support, pharmacotherapy and primary care coordination, supported employment and education services, and case management) that are key components of the

Coordinated Specialty Care model (CSC) highlighted in *Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care* (Heinssen RK, Goldstein AB, Azrin ST, http://www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh-white-paper- csc-for-fep_147096.pdf, 2014).

- ***Relationship to federal objectives for Medicaid[ii] with particular attention to how this project benefits Medicaid beneficiaries.***

A statewide Early Psychosis Initiative (EPI) would improve health outcomes for Medicaid and low-income populations by providing earlier, targeted treatment to persons experiencing a first episode of psychosis. By investing in early intervention, the state can reduce costs through fewer psychiatric hospitalizations and reduced use of ER and crisis services. This project would also increase the efficiency and quality of care for Medicaid and other low-income populations by transforming service delivery: early intervention services can help people living with schizophrenia avoid a lifetime of disability. In addition, the knowledge gained through expansion of this initiative could be extended to the commercial market, promoting readier access to appropriate treatment for this enrollee population and reducing the historic pattern of cost-shifting to the public sector (largely Medicaid).

Project Description

Which Medicaid Transformation Goals[iii] are supported by this project/intervention? Check box(es)

X Reduce avoidable use of intensive services
X Improve population health, focused on prevention
☐ Accelerate transition to value-based payment
☐ Ensure Medicaid per-capita growth is below national trends

Which Transformation Project Domain(s) are involved? Check box(es)

X Health Systems Capacity Building
X Care Delivery Redesign
X Population Health Improvement – prevention activities

- ***Region(s) and sub-population(s) impacted by the project. Include a description of the target population (e.g., persons discharged from local jail facilities with serious mental illness and or substance use disorders).***

A statewide Early Psychosis Initiative (EPI) would serve both Medicaid and non-Medicaid Transition Age Youth (TAY) from 15 to 25 who have experienced symptoms lasting no longer than twelve months and who are not already receiving treatment for psychosis. The project would include a Request for Proposal process to add two additional pilot sites as we move toward statewide implementation.

- ***Relationship to Washington's Medicaid Transformation goals.***

In addition to achieving the *Triple Aim* pursuit of better health, better care, and lower costs, the EPI project addresses two Medicaid Transformation Goals (reduce avoidable use of intensive services; and improve population health, focused on prevention) through the following objectives:

  - Improve the long-term trajectory of schizophrenia and reduce its disability over the lifetime by providing rapid, comprehensive, effective treatment at the first episode of psychosis (FEP);
  - Develop and evaluate an intervention for FEP that can be delivered in a wide range of clinical settings;
  - Build and sustain a system that provides appropriate levels of evidence-based service delivery to stabilize and support individuals with FEP, and conduct community education and outreach to increase the number of pre-psychosis or early FEP individuals receiving services; and
  - Increase awareness and reduce the stigma associated with schizophrenia and psychosis.

- ***Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities.***

The primary purpose of the EPI project is to ensure that the service elements required in an evidence-based early intervention model are fully covered by both Medicaid and commercial insurance plans.

Goal #1: Design and Fully Fund a Benefit Package

In October 2015, CMS, NIMH, and SAMHSA released the Joint Informational Bulletin: *Coverage of Early Intervention Services for First Episode Psychosis*. The bulletin was developed to assist states in designing a benefit package to guide early treatment intervention options that will meet the needs of youth and young adults experiencing first episode psychosis (FEP). Washington's Coordinated Specialty Care (CSC) model is aligned with the benefit design outlined in the bulletin. This project will identify which program components are already covered within the state plan structure and where flexibility in benefit design is needed to amplify effectiveness and cost-savings.

Goal #2: Secure Flexible Funds to Supplement Practice Transformation Efforts

Existing Medicaid state plan benefits, commercial insurance benefits, and the MHBG 5% set-aside funds form the basis for financing the Early Psychosis Initiative (EPI). Waiver funds will supplement these resources to accelerate implementation by supporting staff training, public and gatekeeper outreach and education activities, and any service delivery components that fall outside traditional benefit structures. Most mental health clinicians have not been trained in the latest research and evidence-based interventions related to early intervention for psychosis; likewise, program models are not designed to meet these best practices. The EPI transformation project will allow our state to implement early intervention services and train mental health clinicians to deliver the CSC model to individuals experiencing first episode psychosis.

Intervention: Coordinated Specialty Care Model

Coordinated Specialty Care (CSC) is a team-based, multi-element approach to treating first episode psychosis that has been broadly implemented in Australia, the United Kingdom, Scandinavia, and Canada. Component interventions include: assertive case management, individual or group psychotherapy, supported employment and education services, family education and support, and low doses of select antipsychotic agents.

In clinical trials, CSC has been restricted to persons with non-organic, non-affective psychotic disorders who have been ill for five years or less; empirical evidence regarding the effectiveness of CSC is greatest for persons who meet these criteria. Early intervention programs are designed to bridge existing services for these groups and eliminate gaps between child, adolescent, and adult mental health programs. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. CSC services are also highly coordinated with primary medical care, with a focus on optimizing a client's overall mental and physical health.

Outcomes

Research shows that early intervention programs result in a number of improved outcomes for persons experiencing a first episode of psychosis, including reduced secondary problems and work/school disruption; retention of social skills and support; decreased need for hospitalization; more rapid recovery and better prognosis; reduced family disruption and distress; and less treatment resistance and lower risk of relapse. For example, in 2008, the National Institute of Mental Health (NIMH) launched the Recovery After an Initial Schizophrenic Episode (RAISE) project. The study showed that participants in the RAISE CSC research project: experienced significantly greater improvement in quality of life; were more likely to be working or going to school; showed a significantly greater degree of improvement on overall symptoms, including depression; and showed the greatest improvement when treatment was offered within the first 18 months of illness.

- ***Links to complementary transformation initiatives - those funded through other local, state or federal authorities (such as the health home program and Early Adopter/Behavioral Health Organization regional purchasing) and/or Medicaid Transformation initiatives # 2 and 3.***

The Early Psychosis Initiative (EPI) transformation project directly complements transformation initiatives funded through federal authorities, including the SAMHSA MHBG 5% set-aside funding discussed in the first section of this proposal (i.e., Rationale for Project). The 5% Set-Aside (approximately $521,000 in FFY 2015 and $528,000 in FFY 2016) has provided the opportunity for DBHR to launch New Journeys, a pilot site in Yakima, specifically designed to meet the needs of transition age youth experiencing a first episode of psychosis. The 5% Set-Aside has allowed Washington State to begin this important work, and the EPI transformation project will allow our state to accelerate the implementation and dissemination of this life-changing intervention.

This project also complements Medicaid Transformation Initiative #3 (i.e., provision of targeted foundational community supports). As discussed throughout this proposal, supported employment and education services are an integral part of the Coordinated Specialty Care model that would be implemented through this project.

- ***Potential partners, systems, and organizations (e.g., health and social service providers, ACH participants) needed to be engaged to achieve the results of the proposed project.***

DBHR is partnering with the Washington Council for Behavioral Health, along with representatives from Washington State's Department of Health and Health Care Authority, the Early Assessment and Support Alliance (Oregon's leading Early Psychosis Program), NAVIGATE Consultants (the CSC program developed from the RAISE Study), Central Washington Comprehensive Mental Health (Washington's first Early Psychosis Program Pilot Site), and the University of Washington School of Medicine.

These strong partnerships, along with plans to engage additional partners (e.g., Washington State's Children's Administration, Office of Superintendent of Public Instruction, Juvenile Justice and Rehabilitation Administration, and Department of Vocational Rehabilitation), will ensure we are able to achieve results by engaging ACH participants, health and social service providers, and most importantly, the youth and families that will benefit from the vital services and resources offered through the Early Psychosis Initiative (EPI). The collaborative structure of the EPI will support the ongoing implementation and dissemination of critical early psychosis resources and information.

Core Investment Components

- ***Proposed activities and cost estimates ("order of magnitude") for the project.***

The plan for Year One is to create a First Episode Psychosis (FEP) Learning Collaborative led by Dr. Maria Monroe-DeVita with UW School of Medicine, Department of Psychiatry and Behavioral Sciences. The Collaborative will consist of the current FEP CSC Team at New Journeys pilot site in Yakima as well as two additional pilot sites that will be established through a Request for Proposal process. We estimate that the three pilots will serve 95 individuals collectively, and while we do not have an exact amount, we estimate the cost of the three pilots at $800,000 annually, including all training, supervision, and consultation associated with service delivery.

Additionally, DBHR is contracting with Washington State University to conduct a formal evaluation of the New Journeys pilot. Because this is the first program of its kind, we are especially interested in the outcomes of this evaluation which will focus on documenting the following: (1) community outreach activities; (2) engagement and retention of youth and families in the New Journeys program; (3) clinical outcomes of New Journeys participants, including program cost-savings; and (4) the experience of youth, families, providers, and administrators participating in this project.

- ***Best estimate (or ballpark if unknown) for:***
  - ***How many people you expect to serve, on a monthly or annual basis, when fully implemented.***

- ***How much you expect the program to cost per person served, on a monthly or annual basis.***

Using the "Flexible Tool to Estimate Number of Teams Needed for People with First Episode Psychosis (FEP) and Associated Costs" developed by Center for Practice Innovations at the New York State Psychiatric Institute, the following estimates were based on Washington's population of 7,061,400, with an incident rate of 16.7:

- Incidence of non-affective psychoses (ICD 10 codes F20-F29 including schizophrenia, schizotypal disorder, delusional disorders, brief psychotic disorder, shared psychotic disorder, schizoaffective disorders, other psychotic disorder not due to a substance or known physiological condition, and unspecified psychosis not due to a substance or known physiological condition) are estimated at 16.7/100,000 (Kirkbride).
- Affective psychoses are estimated at 6.8/100,000 (Kirkbride) and 11.6/100,000 (Baldwin)
- Incidence of schizophrenia alone is estimated at 8.9/100,000 (Kirkbride) and 7.0/100,000 (Baldwin)

Based on these estimates, the EPI project will require 11.22 Coordinated Specialty Care teams, with each team serving 35 individuals per year (392.7 statewide when all teams are fully operational and at capacity).

In 2012, EASA contracted with Dale Jarvis and Associates (DJA) to conduct a Cost Study. **Table 1** highlights outcomes from the study to provide basic assumptions about cost per person.

Case Rate Payment Ranges: DJA computed monthly Case Rate payment ranges for Levels A (Year One of the program) and B (Year Two) that reflect differences in program design and economic factors. These differences include salaries, benefits, and other costs for a given program. Table 1 lists the ranges for the two case rate levels.

Table 1: Monthly Case Rate Ranges Level A	**Level B**
Low End of the Range	$900	$600
Middle of the Range	$1,050	$700
High End of the Range	$1,200	$800

Key assumptions for the payment ranges include:

- All figures are in FY2012/2013 dollars (July 2012 – June 2013)
- All Level A rates assume a 10:1 Client to Clinician Ratio
- All Level B rates are based on approximately two-thirds of the service intensity of Level A

- ***How long it will take to fully implement the project within a region where you expect it to be phased in.***

Implementation of each Coordinated Specialty Care team takes about two years; statewide roll-out of Early Psychosis Coordinated Specialty Care teams will occur over a four- to six-year period.

- ***The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.***

Schizophrenia affects approximately 1.1% of the population, meaning that in a community of 100,000 about 1,100 people will be living with the disease. Symptoms usually start between ages 16 and 25, and the costs are enormous. The annual excess direct healthcare cost of schizophrenia in the United States is almost $32 billion, amounting to nearly $12,000 per person.[2]

During the year after diagnosis, the healthcare costs for a person with schizophrenia more than double to $20,000, largely due to costly hospitalizations and emergency room use. While costs drop moderately for people with chronic schizophrenia, their care still totals more than $15,000 per year.[3] In Washington State an average psychiatric inpatient admission costs approximately $8,900. Similar programs in other states have consistently reported reduced hospitalizations for participants, providing a relatively early ROI. In addition, a longitudinal study of the Portland Identification and Early Referral (PIER) program showed that combined early identification and treatment can be effective as a public health approach for reducing rates of hospitalized first psychotic episodes by about one-third.

Comment [LHJ(1]:

Data about the long-term savings from EASA and similar programs are still being established, but the potential savings just during the course of the program are significant. A 2007 review found that "early intervention reduces the duration of untreated psychosis, produces better outcomes in terms of symptomatic and functional domains, and is cheaper than standard models of care."[4] As was shown in a different study of patient data, "the advantage of the early intervention model, both in terms of clinical outcomes and treatment costs, is maintained well beyond the period over which the intervention was provided."[5]

Table 2 provides assumptions from the EASA Cost Study and highlights the economic benefit if EASA programs are able to interrupt the trajectory toward a life of serious mental illness, reducing future healthcare expenditures.

	Table 2: Return on Investment (ROI) Assumptions Inputs	**Comments**	
1	Year 1 EASA Cost/Person	$12,600	Mid Range Cost; $1,000 per month
2	Year 2 EASA Cost/Person	$8,400	Mid Range Cost; $650 per month
3	Two Year Cost/Person	$21,000	Row 1 + Row 2
4	Healthcare Costs per person per year, No SMI	$2,681	JEN Associates California Study
5	Healthcare Costs per person per year, SMI, usual care	$14,365	JEN Associates California Study
6	Per Year Difference	$11,684	Row 5 - Row 4

Project Metrics

The state will monitor implementation of transformation projects at regional and statewide levels through process and outcome measures. Each project will require clearly defined outcomes that relate to the goals and specific process steps.

Wherever possible describe:

- *Key process and outcome measures (and specific benchmark performance data if known) against which the performance of the project would be measured. Include priority measures sets described in the Waiver application* http://www.hca.wa.gov/hw/Documents/waiverappl.pdf *pages 46-47*[iv].
- *If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation*?

As described in the previous section (i.e., Core Investment Components), DBHR is contracting with WSU to conduct a formal evaluation of the New Journeys Coordinated Specialty Care Pilot Program, which is a key component of the Early Psychosis Initiative (EPI). The pilot site is currently collecting data related to client demographics to develop benchmark data specific to the EPI project proposal. We will also collect information about the duration of untreated psychosis and the number of previous psychiatric hospitalizations. In addition to providing a cost analysis, the final evaluation outcome report from WSU will provide DBHR with quantitative measures and outcomes.

Finally, in alignment with the Medicaid transformation goal of achieving the Triple Aim, the pilot site's current EPI evaluation measures specific to Participant Functioning will assess the number of times each participant has (1) been hospitalized for psychiatric reasons, (2) been hospitalized for non-psychiatric reasons, (3) used the emergency room for psychiatric reasons, (4) used the emergency room for non-psychiatric reasons, (5) used crisis services, (6) worked for income, (7) attended school or other educational activities, (8) volunteered, and (9) attended social events outside of those offered by New Journeys.

[i] The Washington State Institute for Public Policy, http://www.wsipp.gov, has identified "evidence-based" policies that can lead to better outcomes; Behavioral health research reports developed by the Research and Data Administration are available at: https://www.dshs.wa.gov/bhsia/division-behavioral-health-and-recovery/decision-support-and-evaluation

[ii] Medicaid objectives as stated in GAO report 15-239, April 2015, http://www.gao.gov/products/GAO-15-239:

- Increase and strengthen coverage of low income individuals.
- Increase access to, stabilize, and strengthen provider networks available to serve Medicaid and low-income populations.

- Improve health outcomes for Medicaid and low-income populations.
- Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.
- Criteria established for specific demonstrations described through an informational bulletin or State Medicaid Director's Letter – available at: http://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html.

[iii] Transformation goals as stated in Washington's Medicaid Transformation waiver, http://www.hca.wa.gov/hw/Documents/waiverappl.pdf:

- Reduce avoidable use of intensive services and settings such as acute care hospitals, nursing facilities, psychiatric hospitals, traditional LTSS and jails.
- Improve population health, with a focus on prevention and management of diabetes, cardiovascular disease, pediatric obesity, smoking, mental illness, substance use disorders and oral health; that is coordinated and whole-person centered.
- Accelerate the transition to value-based payment, while ensuring that access to specialty and community services outside the Indian Health system are maintained for Washington's tribal members.
- Ensure that Medicaid per-capita cost growth is two percentage points below national trends.

[iv] This includes the statewide common measure set for tracking health care quality and cost across multi-payer public and private health delivery systems: http://www.hca.wa.gov/hw/Documents/pmcc_final_core_measure_set_approved_121714.pdf and the subset of 2016 Medicaid contract common performance metrics. It also includes priority measures for critical behavioral health and community support services recommended by the 5732/1519 Steering Committee and reported to the Legislature in "*Service Coordination Organizations – Accountability Measures Implementation Status*", (page 36) at: http://www.hca.wa.gov/documents_legislative/ServiceCoordinationOrgAccountability.pdf.

1 Mark Olfson, MD, MPH1; Tobias Gerhard, PhD2,3; Cecilia Huang, PhD2; Stephen Crystal, PhD2; T. Scott Stroup, MD, MPH1, Premature Mortality Among Adults With Schizophrenia in the United States. JAMA Psychiatry. December 2015
2 The economic burden of schizophrenia in the United States in 2002. Wu EQ, Birnbaum HG, Shi L, Ball DE, Kessler RC, Moulis M, Aggarwal J. J Clin Psychiatry. 2005 Sep;66(9):1122-9. NOTE that the cost in the article has been adjusted to 2011 dollars.
3 Burden of schizophrenia in recently diagnosed patients: healthcare utilisation and cost perspective. Nicholl D, Akhras KS, Diels J, Schadrack J. Curr Med Res Opin. 2010 Apr;26(4):943-55.
4 Effectiveness of early intervention in psychosis. Killackey E, Yung AR. Curr Opin Psychiatry. 2007 Mar;20(2):121-5. Review.
5 Is early intervention in psychosis cost-effective over the long term? Mihalopoulos C, Harris M, Henry L, Harrigan S, McGorry P. Schizophrenia Bull. 2009 Sep; 35(5):909-18. Epub 2009 Jun 9. Erratum in: Schizophrenia Bull. 2011 May; 37(3):651.