Working together to improve health care quality, outcomes, and affordability in Washington State.

First Episode Psychosis
2025

Contents

Glossary

- **Coordinated Specialty Care (CSC):** A multicomponent, evidence-based, early intervention services for individuals experiencing a first episode of psychosis (FEP) that can improve their quality of life and social and clinical outcomes.[i]
- **Duration of Untreated Psychosis (DUP):** time elapsing between onset of psychosis and initiation of appropriate treatment (e.g., CSC)[ii]
- **Fee-for-Service:** separate payment to healthcare providers for each medical service rendered to a patient. Often applied to traditional Medicaid, to distinguish it from Medicare managed-care plans and alternative payment models (APMs)[iii]
- **First Episode Psychosis (FEP):** an initial "episode" of psychosis, with critical opportunity for early intervention
- **Long-acting injectables (LAIs):** medications administered via injection providing coverage for a period ranging from weeks-months. LAIs may support consistency with medication and lower risk of adverse outcomes for patients with a first episode of psychosis[iv]
- **Psychosis**: a collection of symptoms that affect the mind, where there has been some loss of contact with reality. During an episode of psychosis, a person's thoughts and perceptions are disrupted and they may have difficulty recognizing what is real and what is not.[v]
- **Psychotic Disorder**: any number of severe mental health disorders, characterized by specific symptoms such as delusions, hallucinations, markedly disorganized speech ,thought or behavior. Examples include schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder, brief psychotic disorder, and psychotic disorders due to substance (substance-induced psychotic disorder); NOTE: this report acknowledges that folks experiencing substance-induced psychotic disorders should generally receive treatment for their underlying substance use as cause of psychotic symptoms.
- **Warm Handoff:** transfer of care between two members of the health care team, where the handoff occurs in front of the patient and family. Transparent handoff of care allows for patients and families to hear what is said and engages patients and families in communication, giving them the opportunity to clarify or correct information or to ask questions about their care.[vi]

Executive Summary

Growing evidence suggests that the people living with any of a complex spectrum of psychotic disorders benefit from early detection and early intervention. There is a critical window in which timely care can improve outcomes and quality of life and may even prevent transition to a first episode of psychosis (FEP). Early intervention is important to reduce the duration of untreated psychosis, which the World Health Organizations recommends should be less than 90 days from symptom onset.

Coordinated Specialty Care (CSC) is the gold standard of early intervention care for psychosis. Recommended by the American Psychiatric Association (APA), CSC is a recovery-oriented, multidisciplinary team-based approach to treating first episode psychosis. The CSC model is collaborative, uses shared decision-making to support treatment and recovery goals, and tailors treatment to the unique needs and preferences of participants and their support system to optimize behavioral and physical health. CSC is the most effective intervention for adolescents and younger adults experiencing a first episode psychosis, and is associated with improved quality of life, improved clinical outcomes, and economic benefits to both the family system and the health care system. Recovery is possible!

The first episode psychosis workgroup of the BREE Collaborative has elected to prioritize the following foci for the report and guidelines:

1. Strategies for early detection identification and streamlined referral to specialty behavioral healthcare for FEP, and transition out of intensive early intervention to lower level of care
2. Promoting spread of evidence-based program CSC, and alternative best options for systems unable to implement or provide CSC
3. Coding and reimbursement structure to support the broader implementation of coordinated specialty care
4. Financial and educational capacity building to support the broader implementation of CSC

Focus Area	**Components**
Rapid Detection & Early Access	• Screening, identification, and rapid referral • Community engagement & education • Rapid assessment and access to Coordinated Specialty Care (CSC)
Improvements in Treatment	• Reimbursement parity • Evidence-based components of coordinated specialty care • Special considerations (e.g., concurrent substance use disorders) • Medication considerations
Transitions of Care	• Coordinated transitions • Step-down services

Stakeholder Specific Guidelines

Primary Care Settings

Rapid Detection & Early Access

- Know the signs and symptoms of psychosis. See Allied Professionals Toolkit here.
    - Physical symptoms: insomnia/hypersomnia, poor food intake, complaints without clear physical etiology, bizarre behavior with no clear purpose, inappropriate affect, catatonia, neurological abnormalities
    - Psychological symptoms: hallucinations, delusions (including paranoia), disorganized thoughts/speech/behavior
- Educate providers on coordinated specialty care and appropriate referral (Get Early Psychosis Care | Washington State Center of Excellence in Early Psychosis)
- Build rapport and trust with patients and their support system. See this toolkit and other resources for further details.
    - Understand patient's definition of their concerns and use their terms in conversation
    - Encourage support system, community health workers, and other relevant individuals (e.g., school professionals) to participate in planning and goal setting conversations with consent
    - Use trauma-informed, nonjudgmental and non-stigmatizing language. See Words Matter in our report.
    - Prioritize patient-identified treatment goals
    - Include a trained interpreter as part of the care team when appropriate.
- **Screen using validated tool (e.g., PCCL, PQ-B, Bipolar Spectrum Diagnostic Scale, Depression Anxiety Stress Scale-21)** if there are concerns of potential psychosis.
- For anyone with a positive screen, recommend further assessment by a qualified mental health professional (e.g., refer to a CSC program, such as New Journeys)
- Always assess risk for suicide, violence and ability to care for self adequately. In the case of elevated risk, refer to Bree Collaborative's Suicide Care Guidelines and other evidence-based guidelines for further guidance.
    - If safety is a concern, engage in safety planning and involve natural supports, as much as possible. Consider hospitalization if risk is elevated.
    - Consider calling mobile crisis unit to respond on site, to provide early intervention from a mental health professional. If no team is available, consider recommending a visit to a psychiatric emergency department.
- Seek psychiatric consultation (e.g., UW Psychiatric Consult Line) as needed (support with diagnosis, medication management, etc.)
- Refer to behavioral health organizations with first episode psychosis service

- Maintain a regularly updated directory of CSC programs in your area. Make it easily accessible to clinicians.
- Refer through warm handoffs whenever possible. Encourage in-person or joint meetings with intake staff at coordinated specialty care.

Treatment

- Concurrently with referral to CSC, rule out other causes of suspected psychosis,[vii] such as medical (neurological, endocrine, metabolic) or substance related (intoxication, withdrawal, medication side effects).
- For patients experiencing active psychosis, do not delay use of antipsychotic medication.
  - To select an appropriate medication, solicit patient input, review past records and history of side effects, and consider sustainability of medication
  - Initiate on lowest possible dose, considering individual characteristics
  - Recommend long-acting injectable (LAI) antipsychotic medication
  - Communicate that treatment with medications may take weeks to months to see full benefits
  - Troubleshoot common barriers to medication adherence (e.g., medication schedule, schedule recurring appointments)
  - Monitor symptoms through early and frequent assessment (e.g., within first 2 weeks of starting new medication, monthly until stabilization)
- Monitor for side effects of antipsychotic medications
  - When starting new medication or adjusting dose, follow up within 1 week for acute side effects (e.g., extrapyramidal symptoms, sedation, etc.)
  - Take baseline measurements and continue monitoring:
    - Weight & BMI at every visit for 6 months, at least quarterly thereafter
    - Hemoglobin A1c, fasting blood glucose (FBG) and lipid panel 4 months after initiating treatment, annually thereafter
    - Pregnancy testing for people of childbearing potential
    - Electrocardiogram (EKG) before treatment and with dose changes for appropriate medications.
  - Offer monitoring through telehealth/virtual contact if unable to meet in person
  - Teach patient's support system how to monitor for side effects, and instructions for how to support seeking help as needed.
- Provide physical activity and nutrition counseling to maintain metabolic health
- Ensure LAIs are on formulary and incorporated into treatment workflows as an available option

Transitions of Care

- Continue to co-manage medical side effects of antipsychotic medication as needed once engaged in coordinated specialty care

- Communicate with coordinated specialty care teams to provide increased support patients transitioning out of the program
- If transitioning to receiving BH care within primary care, review guidelines below for BHP
    - If changing antipsychotic medication yourself – consult with psychiatry (e.g., consult line)
- Do not unnecessarily discontinue antipsychotic medications

Behavioral Health Agencies

Early Identification & Rapid Access

- Train all behavioral health providers on signs and symptoms of psychosis, benefits of early intervention, differential diagnosis, initial management steps and referral process to coordinated specialty care
- Build rapport and trust with your patient and their support system
    - Understand the patient's definition of their concerns and use their terms in conversation
    - Encourage support system, community health workers, and other relevant individuals (e.g., school professionals) to participate in planning and goal setting conversations with consent
    - Use trauma-informed, nonjudgmental and non-stigmatizing language
    - Prioritize patient-identified treatment goals
    - Include a trained interpreter as part of care team when appropriate.
- For people with suspected psychosis, screen with validated short screening tools (e.g., PQ-B, SIPS)
- Discuss treatment options, prioritizing patient preferences and considering barriers to treatment (e.g., transportation, cost, etc.). Provide psychoeducation about benefits of early intervention (better outcomes and long-term functioning).
- Develop referral capacity and workflow to coordinated specialty care teams.
    - Refer through warm handoffs when not eligible for CSC whenever possible

Treatment

- Incorporate increased multidisciplinary service provision (e.g., psychiatric prescriber, therapist trained in cognitive behavioral therapy for psychosis (CBTp), supported employment & education, peer and family support, etc.)
- If unable to access coordinated specialty care, deliver and/or refer out for core elements with available staff and resources. CSC services offer the gold-standard of care, but components offered individually can still positively impact quality of life, symptoms and functioning. Components include the following:
    - Psychiatric care and medication management
    - Physical activity, nutrition and sleep
    - Individual and/or group therapy
    - Family/support system education
    - Education and employment support
    - Case management
    - Peer support services
- Provide integrated care for people experiencing psychosis and substance use disorders.

    - At a minimum, provide dedicated care coordination between coordinated specialty care teams and other involved physical and behavioral health team professionals.
- Medication management considerations
    - Initiate on lowest effective dose
    - Titrate slowly over days to minimize side effects, and continuously monitor for side effects
    - Discuss with the patient whether a long-acting injectable (LAI) medication might be appropriate or preferred
        - Ensure LAIs are on formulary and incorporated into treatment workflows as an available option
        - Train prescribers and care teams on LAI administration, shared decision-making and side effect monitoring
- For patients with co-occurring substance use disorders
    - Offer evidence-based treatments for both conditions concurrently within CSC teams ideally.
    - Consider severity and type of substance use when prescribing medication for psychosis. Substances, especially alcohol, may alter metabolism, decrease effectiveness or increase risk for side effects of prescribed medication. **However, substance-induced psychosis should be treated with substance use disorder services. Engage psychiatric consultation for any concern identifying underlying cause of psychosis.**
    - Discuss risks and potential interactions between substances and prescribed medication when appropriate
    - If substance use services are not available within agency/teams, coordinate care between substance use professionals and other members of the behavioral healthcare team,
- For patients with co-occurring autism spectrum disorder and psychosis
    - Uncover whether symptoms are related to a primary psychotic condition or related to individual autism spectrum disorder
    - For individuals with co-occurring autism, ensure cognitive functioning will allow for engagement in CSC components and needs are not better met by DDA
    - When DDA is involved, strong coordination with DDA and MH services is recommended

Behavioral Health Agencies: Coordinated Specialty Care Teams

Early Detection & Rapid Access

- Engage organizations in the community such as schools, community-based organizations, universities/colleges, primary care offices, correctional facilities, crisis care providers and other behavioral health providers in the region about the importance of early intervention and in

community education on basic signs and symptoms of prodromal and acute psychosis, and that recovery is possible

Treatment

- Ensure meeting the core functions of coordinated specialty care, including:
    - Access to clinical providers with specialized training in first episode psychosis.
    - Maintain a "no wrong door," policy for referrals
    - Easy entrance to the first episode psychosis program through active outreach and engagement
    - Provision of services in home, community and clinic settings as needed
    - Acute care during or following a psychiatric crisis
    - Transition to step-down services with the coordinated specialty care team or discharge to regular care as appropriate, depending on patient's level of symptomatic and functional recovery
    - Integrated measurement-based care and other data-driven practices to monitor symptoms and inform treatment planning
- Integrate and co-locate care for common co-occurring conditions, such as substance use.
- Incorporate culturally adapted practices as able. See resources for cultural adaptation (e.g., Delivering Culturally Competent FEP). Incorporate, as appropriate, principles of the Cultural Formulation Interview or other cultural adaptations of tools into assessments.
- Do not exclude patients with co-occurring substance use and a primary psychotic disorder from age-appropriate behavioral healthcare for psychosis because of their substance use, and vice versa.
- Ensure fidelity to coordinated specialty care program. Consider receiving training through the Washington-based Center of Excellence in Early Psychosis or other recognized centers of excellence or training centers.

Transitions of Care:

- Transition criteria:
    - Significant improvement from baseline appointment as indicated by overall wellbeing and measurement-informed care with standardized tools (CAPE-P15)
    - Has met some of their identified recovery goals
    - Engaged in meaningful activities (e.g., school, employment)
    - Increased socialization
- Develop a clear collaborative transition plan that promotes self-efficacy in managing health and social goals
- Begin discussing transitions early (at entry) and communicate clearly about treatment timeline
- Use standardized tools to evaluate symptoms severity, readiness and patient/family voice

- Identify and mitigate non-medical barriers (e.g., transportation to appointments, insurance coverage)
- Reconcile medications prior to transition
- Co-create relapse prevention plan, including early warning signs, specific action steps and relevant contacts. Coordinate with primary care and services to address health-related social needs.
    - Facilitate direct introductions to receiving providers
    - Arrange for as needed consultation post-transition
- Continue to provide necessary services (e.g., psychotherapy) as able
- Allow flexibility to increase intensity after transition as needed
- Establish standard follow up protocol (e.g., once per week) for initial post-graduation period
- For individuals with persistent symptoms of multiple complex needs, coordinate direct handoff to assertive community treatment, intensive case management and/or residential programs

Hospital Systems

Early Identification & Rapid Access

- Know the signs and symptoms of psychosis
    - Physical symptoms: insomnia/hypersomnia, poor food intake, complaints without clear physical etiology, bizarre behavior with no clear purpose, inappropriate affect, catatonia, neurological abnormalities
    - Psychological symptoms: hallucinations, delusions (including paranoia), disorganized thoughts/speech/behavior
- Build rapport and trust with patients and their support system
    - Understand patient's definition of their concerns and use their terms
    - Prioritize patient-identified concerns and goals
- Follow evidence-informed guidelines for patients experiencing acute psychosis, including systematically assessing safety and urgency of symptoms, using least restrictive means of care, and consulting psychiatry to support determining underlying cause of psychosis related symptoms. See Contemporary Practices for Medical Evaluation of Psychiatric Patients in Emergency Department.

Transitions in Care

- Maintain directory of coordinated specialty care programs in WA state by social work/case management staff. See here for current New Journey's programs.
- Allow coordinated specialty care team members to visit potential referred patients while still in hospital
- Develop a clear discharge plan with patients and their relevant support systems.
- Review and reconcile medications with the patient and support system before discharge
- Create a relapse prevention plan with patients and their support system, including when and who to contact for help after discharge. Coordinate with established outpatient mental health clinicians after admission to inform about previous responses to treatment and other relevant information for relapse prevention
- Send aftercare summaries to outpatient care providers within 3 days of discharge

Health Plans

Early Detection & Rapid Access

- Create an internal system to flag members that receive a new diagnosis of schizophrenia spectrum disorder or psychotic disorders. Route to case management team for outreach and connection to coordinated specialty care (CSC) resources
- Contact member within 1 week after discharge for first hospitalization or emergency room visit with psychiatric concern to offer support in connecting to care. Encourage follow up appointments to be made before discharge.
- Maintain and publish a list of CSC providers within network easily accessible to members within time and distance standards
- In contracting with teams providing CSC, incorporate reimbursement for full scope of services, including dedicated time for education and outreach in the community
- Train member-facing staff in therapeutic communication approaches (e.g., trauma-informed care, motivational interviewing) and non-stigmatizing, person-first language
- As able, move towards alternative payment model structure that links meaningful clinical measures (e.g., psychiatric hospitalizations, psychiatric emergency room visits) to coverage arrangements of CSC programs

Treatment

- Cover core CSC services through a model that allows for and supports integrated team-based care based on team makeup. (e.g., PMPM + encounter team-based rate, episode of care model tied to quality metrics, etc.)
    - Core components include diagnosis and evaluation of medical and behavioral health conditions, medication management, individual and group psychotherapy, family psychoeducation, supported employment and education, peer support services, case management and outreach
    - **Incorporate team-based case rate and per encounter rate for CSC (e.g., HCPCS billing codes H2040:** Coordinated specialty care, team-based, for first episode psychosis, per month, **and H2041:** Coordinated specialty care, team-based, for first episode psychosis, per encounter**. See Towards Statewide Coverage for more details**
    - Consider partnering with Washington Center of Excellence for Early Psychosis or other center of excellence body in reviewing and identifying teams meeting fidelity to the standard of care for CSC
    - As able in contracting, incorporate in case rate reimbursement to support components of CSC model that are not directly billable services but support fidelity to the model (e.g., overheard costs, administrative costs
- Provide coverage for evidence-based treatments for patients that experience psychotic symptoms but do not qualify for CSC, including but not limited to psychological interventions,

such as cognitive behavioral therapy and pharmacological interventions, for co-occurring concerns (e.g., antidepressants, mood stabilizers, etc.)

- Minimize prior authorization and cost-sharing for second-generation antipsychotics, including long-acting injectable medications, as a first line therapy for FEP.
- Once enrolled in CSC, minimize prior authorization for continuous access to program until meeting criteria for transition.
- Move towards offering incentives for reducing adverse outcomes (e.g., psychiatric hospitalizations, psychiatric emergency room visits) as part of alternative payment arrangements for CSC providers

Transitions of Care

- Provide increased case management services to patients with identified psychosis Support scheduling follow up appointments with providers
- Support patients and family in identifying and scheduling with a primary care provider before and during transition to less intensive care
- Support access to specialty consultations as needed after transition

Employers

- Promote workplace accommodations that are easily accessible (e.g., flexible work arrangements, working from home/telecommuting, flexible break schedule, private/quiet space for rest, reduced distractions or noise in work area, etc.)
- Provide access to employee resources groups/support groups either internally or through partnership with community-based organizations
- Provide leave policies covering time off to attend to behavioral health concerns of dependents

Early Detection & Rapid Access

- Ensure employee assistance program (EAP) benefit vendors have training in signs and symptoms of psychosis and a referral pathway to specialty behavioral health services (ideally coordinated specialty care programs)
- Provide navigation support through case management to connect families and/or patients to coordinated specialty care (CSC) programs
- Develop/adapt protocols for responding to mental health crises in the workplace that draft from evidence-based practices.

Treatment

- Promote benefit vendor to cover CSC for people with first episode psychosis through team-based rates that cover the cost of service delivery and overhead.
- Ensure coverage supports the CSC program to fidelity through a multidisciplinary team trained in CSC

Transitions of Care

- Partner with supported employment and education (SEE) services and other vocational support services to offer employment opportunities as able

Washington Health Care Authority

Early Detection & Rapid Access

- Invest in/partner with other state agencies to promote early psychosis awareness campaign with goal of increasing public and health provider awareness of first episode psychosis signs and symptoms and importance of early intervention
- Consider investing in/training centralized referral network for all people experiencing first episode of psychosis to support early detection and referral to assessment by a qualified mental health professional.
- Consider partnering with OSPI to develop standardized education and recommended pathway for school nurses and counselors to refer students to coordinated specialty care
- Consider development of continuing education-accredited courses for mental health professionals and primary care professionals on recognizing signs and symptoms of psychosis, appropriate diagnostic assessment and referral to specialty behavioral health care.
- Consider convening a subject matter expert workgroup to identify evidence-based practices for clinical high risk for psychosis

Improvements in Treatment

- Develop curricula and other resources to support CSC teams in integrating care for people with co-occurring first episode psychosis and intellectual disability (IDD) and/or autism spectrum disorder.
- Consider investments to develop a learning health system structure for New Journeys teams to utilize collected data to drive system-wide improvement in measurement. This includes a shared data system for all New Journeys teams with localized dashboards to track outcomes and provide feedback to individual teams, and workforce training in utilizing available data to drive continuous quality improvement.

Transitions of Care

- Advocate for further development of services to provide full continuum of care for people with intensive behavioral health needs. (e.g., partial hospitalization programs, residential treatment programs, etc.)
- Encourage culturally specific and trauma-informed behavioral health services through inclusion of language in grants/contracts
- Disseminate directory of coordinated specialty care programs to medical providers in regions where service is available
- Advocate for funding for a workgroup specifically on developing standards for transitions of care after CSC programs

Schools

Early Detection & Rapid Access

- Educate teachers, counselors, school nurses and other relevant staff on early signs of psychosis relevant to school context, including:
    - Withdrawal, changes in academic performance, and unusual experiences
    - Overt symptoms include hearing things that aren't there, delusional or confused thinking, appearing distracted by internal stimuli, and sudden changes in behavior
- Develop pathway for referral to coordinated specialty care programs for students with concern for potential psychosis.
- Consider requiring continuing education related to psychosis for school nurses and licensed mental health staff.
- Consider including a broad mental health in-service for high school teachers that includes information about psychosis

Academic Institutions

- Implement measures to support students who experience a first episode of psychosis while in college with academic and administrative accommodations, addressing on-campus stigma against mental health concerns, and preparing campus counseling and healthcare staff to identify and engage students with early psychosis. See here.

Towards Statewide Coverage

The workgroup endorses a bundled payment model from public and private insurance that covers cost of program operation and service delivery. Reimbursement models should shift focus from productivity (fee-for-service model) to meeting the needs of each patient and their support system, improving engagement, outcomes and experience.

Many components of the CSC model are not covered through traditional fee-for-service reimbursement methodologies (e.g., peer support, supported education and employment, education and outreach), further described below in **Table 1** from the Meadows Mental Health Policy Institute.

Table 1. Meadows Mental Health Policy Institute – Fee For Service Models [viii]

Practitioner	Service	Fee-for-service Bill Code & Description
Team leader	• Team leader • Indirect costs of supervision of and coordinating multi-disciplinary team • Team staffing, including unlicensed practitioners • Extraordinary training, supervision, and certification costs • Non-billable face-to-face professional services, including collateral contacts, travel associated with community-based services, daily team meetings, outreach, telephone calls, screening before intake, and extraordinary documentation related to certification	• H0023 – engagement and outreach, **non-billable**
Psychiatrist/ Prescriber	• Pharmacotherapy • Primary care coordination	• 99214 – Level 4 established office visit
Licensed Certified Social Worker (LCSW)/ Certified Drug and Alcohol Counselor	• Individual and group psychotherapy	• 90837 – Psychotherapy, per 60 minutes • 90853 – Group therapy, per session • 90846 – Family therapy, per 60 minutes
Master's / Bachelor's Level Professional / Nurse / Peer	• Psychoeducation and support • Case management	• H0036 – Community psychiatric supportive treatment, face-to-face, per 15 minutes • T1016 – Case management, per 15 minutes • H0038 – Self-help/peer services, per 15 minutes
Educational or Vocational Specialist	• Individualized assessments, training, and supports integrated with treatment to achieve or maintain educational or vocational success	• N/A – Typically not reimbursed by commercial plans, although existing national codes such as H2024 – Supported Employment per diem, and H2023 –Supported Employment per 15 minutes, can be utilized. Medicaid and Vocational Rehabilitation have paid for these services in particular situations.

Coordinated specialty care when delivered to fidelity has been shown to reduce overall healthcare costs by preventing hospitalizations, improving functional outcomes and promoting recovery, even with heterogenous service delivery models.[ix] In the foundational Recovery After an Initial Schizophrenic Episode (RAISE) study, those enrolled in CSC had significantly lower inpatient service utilization and more engagement in school or work, translating into direct and indirect cost savings.[x] An economic analysis of the New York statewide CSC program estimated that every dollar invested saved $1.40 in reduced hospitalization and improved productivity over time.[xi] Another economic evaluation of a Connecticut-based CSC program found reduced cost at 6 months and 12 months after enrollment from reduced hospitalizations and crisis service utilization, although findings were not statistically significant.[xii]

The New Journeys teams in Washington reimbursed through Washington Medicaid To provide more comprehensive coverage than strict fee-for-service methodologies, the Coordinated Specialty Program through Washington State Medicaid (New Journey's) is currently reimbursed through the team-based rate that is calculated based on the utilization of services and cost of the team. Teams are paid for based on a tiered rate, with a higher tier 1 reimbursement rate for the first 6 months of service provision and a lower tier 2 reimbursement rate for the next 7-24 months. Many teams still use grant funding to fill gaps in covering the cost of providing care.

Another example that has seen success in commercial insurance plans is a per member per month case rate combined with an encounter rate for patients with 5 or fewer encounters for the initial months. Then the team transitions to just the encounter case rate after that, shown below. To ensure fidelity to the model, teams receive training and fidelity monitoring from a center of excellence in early psychosis.

CSC should be covered through a reimbursement method that encompasses the services, staff and overhead, and for a minimum of two years. While initial studies showed that CSC was effective at a time period of 2 years, there is some evidence to support that outcomes improve when CSC is provided for longer periods of time (e.g., 3-45 years) – transition out of CSC should depend on the individual and their family's readiness for graduation from the program and transition to lower level of service acuity, instead of a predetermined length of time.

Initial Treatment	Maintenance
PMPM Monthly Case Rate Procedure Code H2040 Coordinated specialty care team-based for first episode psychosis, per month Minimum of 6 encounters or more per month	**Encounter Case Rate** Proposed procedure code: H2041, Coordinated specialty care, team-based, for first episode psychosis, per encounter Minimum programmatic requirement for submitting an encounter defined in the manual
Encounter Case Rate Proposed procedure code: H2041, Coordinated specialty care, team-based, for first episode psychosis, per encounter Minimum programmatic requirement for submitting an encounter defined in the manual	

Background

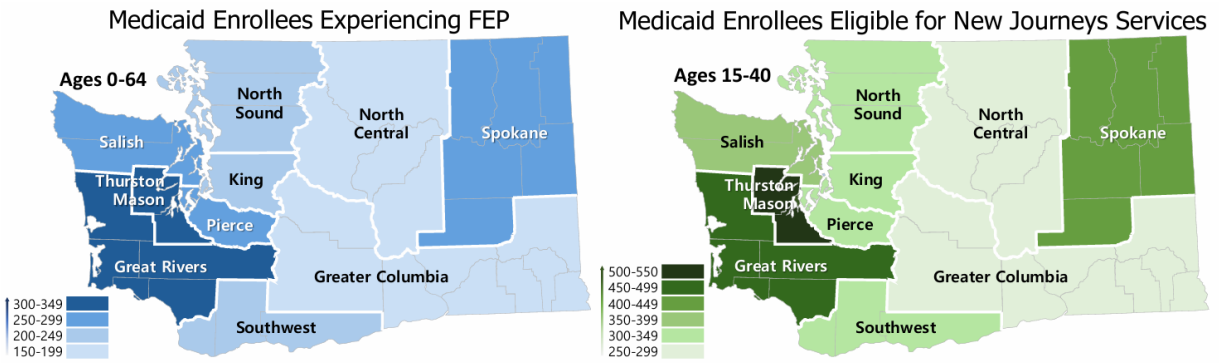
In Washington in 2023 alone, over 4,000 Medicaid enrollees experienced their first episode of psychosis.[xiii] Based on Medicaid claims data from Washington state, some Washington communities experience a higher burden of psychosis, including those with intellectual disabilities or autism spectrum disorders and those dually enrolled in Medicare and Medicaid coverage. These differences may reflect a combination of social, health system and individual factors that influence risk and detection. Estimated annual incidence for Medicaid enrollees based on SFY2023 is depicted in the diagram below

Primary Psychiatric causes of psychosis	Other disorders where symptoms of psychosis can occur (secondary psychosis)
• Schizophrenia • Schizoaffective disorder • Schizophreniform disorder • Brief psychotic disorder • Delusional disorder	• Posttraumatic stress disorder • Dissociative identity disorder • Personality disorders: paranoid, schizotypal, schizoid, borderline personality disorder • Eating disorders: anorexia nervosa • Delirium/altered mental status • Mood disorder: bipolar disorder or • major depressive disorder with psychotic symptoms

In Washington in 2023 alone, over 4,000 Medicaid enrollees experienced their first episode of psychosis.[xiv] Based on Medicaid claims data from Washington state, some Washington communities experience a higher burden of psychosis, including those with intellectual disabilities or autism spectrum disorders and those dually enrolled in Medicare and Medicaid coverage. These differences may reflect a combination of social, health system and individual factors that influence risk and detection. Estimated annual incidence for Medicaid enrollees based on SFY2023 is depicted in the diagram below:

Estimated Annual Incidence Rates among the Medicaid Population

SFY 2023, by Apple Health managed care region per 100,000 eligible Medicaid enrollees



[xv]

Psychosis symptoms and conditions are experienced on a spectrum, and do not present in the same ways from individual to individual. Most individuals who experience early warning signs or have sub-threshold symptoms do not progress to experience full psychosis – only approximately 15% of those with clinical high-risk for psychosis transition to experiencing psychosis within 1 year, and up to 30% in 4 years.[xvi] Those with attenuated positive symptoms (e.g., sub-threshold hallucinatory experiences) may not progress to experiencing full psychosis, but meet criteria for other behavioral health concerns (e.g., anxiety, mood disorder, personality disorders, trauma-related conditions).

While CSC is the gold standard of care for people with FEP due to a primary diagnosis of a psychotic condition, many people experience psychosis not caused by or related to a psychotic condition. Consider below alternate treatment considerations for those with psychosis not caused by a primary psychotic concern or with psychosis-like symptoms without experiencing an episode of psychosis:

Population Impacted	Evidence-based Treatment Recommendation
Age 15-40 Primary diagnosis of a psychotic disorder (including depression or bipolar with psychotic features) IQ>70 Not induced by substance use or medical cause	Coordinated Specialty Care (*e.g., New Journeys in Washington*)

Late Onset Psychosis (40+) and Very-Late Onset Psychosis (45+)[xvii]	First step is elimination of possible causes of secondary psychotic symptoms • Medications • Neurological disorders • Delirium • Substance intoxication/withdrawals contributing to/exacerbating psychosis If psychotic symptoms are due to primary psychotic disorder, combination pharmacotherapy and psychosocial modalities are recommended. Caution in prescribing antipsychotics in elderly is advised.
Substance-induced psychosis	Treat underlying substance use, often also with psychiatry but CSC is not established to serve those with psychosis secondary to substance use
Psychosis due to a medical condition	Treat underlying medical condition**s** (e.g., delirium)
Postpartum psychosis	Refer to Obstetrician (and psychiatrist as needed) Postpartum psychosis has a separate etiology, recommended care model, and evidence-based treatments
Psychosis-like symptoms caused by intellectual disability (IDD) or autism spectrum disorder (ASD)	Evidence-based therapy specific to needs of patient**s** with IDD or ASD, including therapies such as applied behavioral analysis (ABA). Patients with a primary psychotic condition and co-occurring ASD should still receive CSC as they are able to engage with it.
Psychosis-like symptoms caused by post-traumatic stress disorder (PTSD) or obsessive-compulsive disorder (OCD)	Evidence-based therapy specific to needs of patient with PTSD or OCD. Those experiencing psychosis should receive acute treatment for symptoms and then transition to treatment for underlying PTSD or OCD
Chronic psychosis	Transition to a chronic specialty behavioral healthcare (PACT/ACT team)
Clinical High Risk for Psychosis[xviii]	Those at risk for psychosis, including those experiencing initial symptoms without meeting the threshold for psychosis, may benefit from similar components such as cognitive behavioral therapy (CBT), and treatment for co-occurring concerns (e.g., depression, anxiety) If best plan of treatment unclear, consult a psychiatric provider.

Early Identification and Treatment

Once an individual is experiencing psychosis, it is critical to reduce the duration of untreated psychosis (DUP) as much as possible. **The earlier a person accesses treatment, the better their outcomes.** Individuals with psychosis are often first identified in settings outside the medical system. Family and friends are often the first to notice early warning signs and symptoms of people with psychosis. Settings like schools, youth programs, pediatricians/primary care providers, inpatient facilities, emergency rooms, crisis services and jail systems are areas where individuals might first interact before accessing treatment. To support decreasing the duration of untreated psychosis, individuals working in these systems should understand the emerging signs and symptoms of psychosis and have the knowledge of where to refer individuals to seek care.

The next step once someone has been identified is to connect them with a provider that can meet their needs. For those with primary psychosis, coordinated specialty care (CSC) is the recommended, evidence-based recovery oriented team approach to treating early psychosis, promoting easy access

to care and shared decision-making among specialists, the person experiencing psychosis and family members.[xix] Compared to usual care, CSC is more effective at reducing symptoms, improving quality of life, and increasing involvement in work or school.

Tenets of Coordinated Specialty Care Model

- **Individual and/or group psychotherapy:** evidence-based cognitive or behavioral therapy to reduce symptoms and improve functioning
- **Family education and support**: outreach and education to help families support members with FEP. Families are involved regardless of client age with consent of client.
- **Case management**: coordination with other medical and behavioral health services to support access to needed medical, educational, social and other services
- **Medication management**: prescribing and monitoring medications to help manage symptoms and improve functioning
- **Supported employment and education services**: skill-building and support to achieve and maintain educational and vocational functioning which may include services such as educational coaching, tutoring, and/or developing accommodations (504 plan, IEP) with schools

The Washington State specific program (**New Journeys**) also includes peer support services and a registered nurse care manager as core services. Read more about New Journey's team roles and responsibilities here.

Streamlining Early Detection and Centralizing Assessment

Given the critical nature of reducing duration of untreated psychosis, early detection and referral to appropriate treatment for each person living with psychosis is critical. Fragmented systems of care lead to multiple referrals, delays in recognition and assessment, and therefore longer duration of untreated psychosis.[xx] Those who experience psychosis or psychosis-like symptoms may also seek help at a wide variety of locations, including school, primary care, at home with family or in other community settings. Therefore, providers and professionals that work with adolescents and young adults should be familiar with the signs and symptoms of psychosis and know where to refer and why it is critical to refer individuals and/or families exhibiting concerns to CSC programs. Widespread awareness and shared responsibility is imperative to identify people experiencing a true first episode of psychosis – the National Health Service establishes a benchmark that at least 50% of those experiencing symptoms of a first episode of psychosis start treatment with an early intervention team within the first 2 weeks.[xxi] This encourages general practitioners to establish a no-wrong-door approach and engages them in their responsibility to provide care and adequate referral to specialized services for folks experiencing psychosis.

In Washington, the Center for Excellence in Psychosis has developed a program for centralized assessment and referral for people experiencing psychosis. This model creates a centralized site where folks who are potentially eligible for CSC can be assessed, and either directed to a CSC program or other appropriate behavioral health care. These services can be accessed from anywhere in the state through telehealth, increasing reach across Washington. The data collected through assessments can be utilized to inform further development of CSC programs, better identify and monitor the population of folks with clinical high risk for psychosis in Washington state, reduce administrative burden for current New Journeys CSC teams, and serve as a source for continuous quality improvement in reducing duration of untreated psychosis.[xxii]

The state should prioritize streamlined assessment by a qualified behavioral health professional and referral for all those with symptoms that could be due to a first episode of psychosis, and other strategies that will reduce the duration of untreated psychosis. **A centralized program is one way suggested by the workgroup to reduce duration of untreated psychosis at a system level**, leveraging telehealth and data collection technologies to reach individuals across the state with gold-standard assessment practices and collect high quality data to inform improvements in systems of care for people with psychosis.

Cost Effectiveness

Schizophrenia accounts for 3rd most years lived with disability (YLD) among mental health and substance use disorders in the United States.[xxiii] People who experience schizophrenia-spectrum disorders experience shortened life expectancy,[xxiv] an increased risk of comorbid substance use, homelessness, and incarceration all of which may impact increases risk of mortality.[xxv] Use of second-generation anti-psychotic medications and lower hospitalization rates are associated with lower mortality. The estimated economic burden to the United States in 2019 from schizophrenia was $343.2 billion, including $62.3 billion in direct health care costs and $35 billion in indirect health care costs.[xxvi]

A systematic literature review by the Substance Abuse and Mental Health Services Administration (SAMHSA) found that 14 out of 15 studies concluded that early psychosis intervention services, including CSC, are cost-effective.[xxvii] The primary sources of cost savings were reduced inpatient hospitalizations, emergency room visits, and other healthcare costs. For instance, individuals receiving early intervention services had lower hospital admission rates and shorter hospital stays compared to those receiving standard care. These findings underscore the economic benefits of CSC programs in reducing high-cost adverse outcomes.

The costs associated with providing CSC vary from state to state but are comparable to other chronic disease treatments and well below some other specialty services (e.g., cancer chemotherapy treatment).[xxviii] The Recovery After an Initial Schizophrenia Episode (RAISE) Early Treatment Program (ETP) evaluated the Navigate model of coordinated specialty care. The

incremental cost-effectiveness ratio was $12,081 per standard deviation of improvement on the Quality of Life Scale, with a 94% probability of being cost-effective at a $40,000 per quality-adjusted life year (QALY) threshold.[xxix] Another example showed a reduction in unnecessary hospitalizations and emergency room visits, finding a difference in cost in the 1,000's between participants and non-participants in CSC.[xxx]

These and more studies highlight cost effectiveness of CSC< demonstrating investment in multidisciplinary teams reduce overall healthcare utilization costs and improve quality of life and recovery for those impacted by FEP.

Read more about the benefits to providing CSC here, and here.

Equity in First Episode Psychosis

Addressing health equity is central to improving outcomes for individuals experiencing an FEP. Psychotic disorders disproportionately affect socially and economically marginalized groups, including racial and ethnic minorities, immigrants, and people with low socioeconomic status,[xxxi] who often face barriers to timely access and engagement in care.[xxxii] These disparities contribute to delays in treatment initiation (DUP) which is strongly linked to poorer clinical and functional outcomes.[xxxiii] CSC programs are designed to provide whole-person care for those with FEP, but often do not adequately meet the needs of all communities they are serving. For example, black individuals are diagnosed with schizophrenia-spectrum disorders at higher rates than other groups likely due to bias in diagnosis and environmental stressors.[ix] Culture also influences the perspective and interpretation of experience with illness and symptoms, and where and who to seek help from; the culture of the clinicians providing treatment also influences treatment for people from different communities.

Health equity in FEP care also involves addressing structural and systemic barriers. For example, people from historically underserved racial and ethnic groups are more likely to engage in treatment through coercive pathways such as hospitalization or law enforcement contact rather than voluntary outpatient services.[xxxiv] These inequities reinforce cycles of stigma, mistrust, and disengagement from care. Programs that incorporate community outreach, culturally adapted psychoeducation, and family support have been shown to improve engagement and reduce disparities in access.[xxxv] Equity-centered strategies not only enhance patient-centered care but also strengthen trust between mental health systems and their community. Addressing equity through early, comprehensive care reduces the likelihood of hospitalization, incarceration, and unemployment.[xxxvi] Embedding health equity into CSC models ensures that the benefits of early intervention are not solely found among those with more access to resources.

To center equity in the delivery of care for FEP, delivery systems and Washington state agencies should address inequities across the spectrum of care through targeted, tailored outreach, policies promoting parity in mental health care and financial coverage, integrating culturally affirming and competent care practices that support all individuals and families, translating materials to make them culturally and linguistically appropriate, providing easy and integrated access to translation services, and partnering with communities and advocates to redesign care delivery to better meet the needs of people and families impacted.

Measurement

Outcomes measurement should span clinical indicators, functional recovery and engagement with care, as well as process metrics. Coordinated specialty care programs require intensive fidelity monitoring to ensure adherence to program component and delivery aspects. This fidelity monitoring is often conducted by highly trained researchers through rigorous data collection, site visits and other activities. Plans and employers can rely on this fidelity monitoring to be sure their members and/or employees are receiving the highest quality of care.

The workgroup has identified several priorities in measurement that are further defined in the evaluation framework:

- Decreasing average time between age at first contact with mental health system and age at intake; decrease variation between age at first contact with mental health system and age at intake.
- Decrease duration of untreated psychosis (DUP)
- Measures of patient experience for people with first episode of psychosis
- Increase number of referrals to a concordant program (CSC) made and received
- Increase the number of access points for CSC across the state
- Improvement in the Follow up after hospitalization for a mental illness (FUH)
- Increase in commercial coverage of CSC program

Please review the evaluation framework for further details on evaluating impact of implementing these guidelines and for monitoring quality of care

Words Matter: Language Considerations for People Experiencing Psychosis

Using non stigmatizing language is essential when supporting individuals experiencing a first episode of psychosis (FEP). Words matter deeply; respectful, person-centered communication not only reduces shame and isolation but also fosters trust and willingness to engage in care. By describing symptoms and experiences without labels or judgment, clinicians and caregivers acknowledge the individual as more than a diagnosis, emphasizing strengths, potential for recovery, and the uniqueness of each individuals journey. This approach creates a safe environment where open dialogue and collaboration can thrive, laying the foundation for effective shared decision-making and holistic support.

Consider the below language when working with patients experiencing psychosis:

Stigmatizing Language (Avoid)	Non-stigmatizing Language (Use)
Schizophrenic	Person experiencing psychosis/individual living with schizophrenia
Crazy / insane	Having unusual experiences/experiencing distressing symptoms
Patient is noncompliant	Has concerns about treatment / prefers another approach
Mentally ill person	Person with a mental health concern
Delusional / hallucinating	Describing perceptions that differ from others/experiencing altered perceptions
Refuses treatment	Is considering options/is not ready for treatment at this time
Chronic psychotic	Living with ongoing symptoms/experiencing long-term distress

Reference guidelines for language considerations when working with people experiencing psychosis and other behavioral health concerns:

- National Alliance on Mental Illness (NAMI) Language Matters: Shaping Mental Health Discussions with NAMI's Schizophrenia and Psychosis Lexicon Guide: This guide shares accepted terms, terms that may be acceptable and terminology to avoid. It is geared towards clinicians as well as the public to create a broader understanding and consensus on language considerations for people experiencing schizophrenia and psychosis.
- SAMHSA Stigma and Language: The Power of Perceptions and Understanding | SAMHSA

Other Resources

Caregiver/Family Support

988: free hotline that connects to a trained crisis counselor via phone, text or online chat. Available 24/7 to support those thinking about suicide, concerned about substance use, worried about loved ones or in need of emotional support.

Click HERE to reach 988. Reach 988 through an online chat HERE.

NAMI: National Alliance on Mental Illness – largest grassroots mental health organization, provides support, services and advocacy for families of and people living with mental illness in the US. NAMI provides **support groups, educational information**, a **free help-line** for those experiencing mental illness, **resource directories**, and many other services.

New Journeys: New Journeys is the Washington-based Medicaid-funded coordinated specialty care program. They have several resources to support families of and people experiencing first episode of psychosis, including local crisis lines, educational material and an online initial assessment for folks who may be experiencing symptoms. Visit their website here.

Hearing Voices Network: national charity organizing peer-run organizations and support groups that provide community for those who hear voices, see visions or have other unusual sensory experiences. They offer several groups for people no matter where they live, including for students, parent peer support groups, women-focused groups, and others.

King County Crisis Care Centers: Crisis care centers are walk-in, 24/7 urgent care centers for a wide range of mental health or substance use challenges, regardless of insurance status. The first center, Connections Kirkland, is open as of this reports publication, and the centers are meant to be somewhere safe to go in the event someone is experiencing a behavioral health crisis. See more here.

Coordinated Specialty Care Program Examples

New Journeys (WA Based)

- Find policy, program and procedure manual here

NAVIGATE

- Find the program information and manual here

OnTrackNY

- Find program information here
- Find peer specialist manual here
- Find manual on delivering culturally competent care here

EASA: Early Assessment and Support Alliance (Oregon)

- Training, tools and resources can be found here
- Specific trainings for providers on working with patients with intellectual disabilities (IDD) can be found here.

Primary Care Setting Resources

- Psychosisscreening.org: educational resources, workflows, language guides, and more for primary care settings
- New Journey's Presentation for Primary Care Providers
- Center for Excellence in Psychosis Allied Health Professional Guide

Medical Necessity Criteria

Level of Care Utilization System (LOCUS) and Child and Adolescent Level of Care Utilization System (CALOCUS) provide standardized tools to identify appropriate level of service intensity needed for adults as well as children and adolescents and their families. Recently, AACAP and AACP have unified the CALOCUS with the Child and Adolescent Service Intensity Instrument (CASII) into a single instrument (CALOCUS-CASII) to guide ongoing service provision, treatment planning and outcome monitoring in all settings.

To learn more about and access the LOCUS and CALOCUS-CASII, see here and here.

Academic Institutions

Back to School: Toolkits to Support the Full Inclusion of Students with Early Psychosis in Higher Education.: a comprehensive toolkit for academic staff and administrators on integrating and including students with psychosis and other mental health concerns. The toolkit covers recognition of signs of distress and engaging students with early psychosis, accommodations that should be provided at the academic, administrative and campus level, examples of successful implementation, and tools to support increased awareness among students, staff and others.

Appendices

Appendix A. Bree Collaborative Members

Name	Title	Organization
June Altaras, MN, NEA-BC, RN	Executive Vice President, Chief Quality, Safety and Nursing Officer	MultiCare Health System
Colleen Daly, PhD	Director, Global Occupational Health, Safety and Research	Microsoft
Jake Berman, MD MPH	Medical Director for Population Health Integration	UW Medicine and UWM Primary Care and Population Health
Gary Franklin, MD, MPH	Medical Director	Washington State Department of Labor and Industries
Colin Fields, MD, AAHIVS	Medical Director, Government Relations & Public Policy	Kaiser Permanente
Darcy Jaffe, MN, ARNP, NE-BC, FACHE	Senior Vice President, Safety & Quality	Washington State Hospital Association
Norifumi Kamo, MD, MPP	Internal Medicine	Virginia Mason Franciscan Health
Kristina Petsas, MD MBA MLS	Market Chief Medical Officer, Employer & Individual	UnitedHealthcare
Greg Marchand	Director, Benefits & Policy and Strategy	The Boeing Company
Kimberly Moore, MD	Associate Chief Medical Officer	Franciscan Health System
Carl Olden, MD	Family Physician	Pacific Crest Family Medicine, Yakima
Nicole Saint Clair, MD	Executive Medical Director	Regence BlueShield
Mary Kay O'Neill, MD, MBA	Partner	Mercer
Susanne Quistgaard, MD	Medical Director, Provider Strategies	Premera Blue Cross
Emily Transue, MD, MHA (Chair)	Chief Clinical Officer	Comagine Health
Judy Zerzan-Thul, MD, MPH	Chief Medical Officer	Washington State Health Care Authority

Appendix B. First Episode Psychosis Charter & Roster

The Bree Collaborative
Draft First Episode Psychosis Charter and Roster

Problem Statement

Psychosis involves "… some loss of contact with reality… [where] a person's thoughts and perceptions are disrupted...[and they] may have difficulty recognizing [what is] real and [unreal]"[xxxvii] that can be part of a variety of diagnoses including schizophrenia, bipolar disorder, and depression. Psychosis impacts ~3/100 people at some time in their life and 100,000 people over 21 years old annually nationwide.[xxxviii] However, only about 10-15% of people experiencing their first episode of psychosis receive an evidence-based coordinated specialty care model.[xxxix] The best practice is intervention within the first three months of symptom onset that decreases psychosis duration, probability of recurrence, lifetime cost, and improves quality of life. In Washington State, over 4,300 people with Medicaid received their first psychotic disorder diagnosis in 2021, with an estimated incidence of 235/100,000 Medicaid enrollees annually.[xl] Incongruent coverage between public and private payors creates barriers to access for people on private or employer-sponsored plans.

Aim

To improve access to and use of evidence-based coordinated specialty care across Washington State for people experiencing first episode psychosis.

Purpose

To propose evidence-informed guidelines to the full Bree Collaborative on practical methods for improvement of access to coordinated specialty care models, including:

- Barriers and facilitators to spreading/improving coverage (public and private) of existing evidence-based model/practices
- Identifying evidence-based care models and practices for first episode psychosis in Washington state
- Best practices for people transitioning out of the coordinated specialty care model
- Reimbursement models to support early detection and intervention for psychosis
- Standardization of screening and outreach process across a variety of settings for rapid access to coordinated specialty care
- Addressing barriers leading to population-level gaps in care or inequities in outcomes
- Special considerations (concurrent substance use, neurodiverse)
- Where able, improving capacity to provide coordinated specialty care in the state (e.g., expanding New Journey's teams)
- Other areas, as indicated

Out of Scope

- Chronic psychosis, persistent psychotic disorder
- Others as identified by the workgroup

Duties & Functions

The workgroup will:

- Research evidence- and expert-opinion informed guidelines and best practices (emerging and established).
- Consult relevant professional associations and other stakeholder organizations and subject matter experts for feedback, as appropriate.
- Meet for approximately nine months, as needed.
- Provide updates at Bree Collaborative meetings.
- Post draft report(s) on the Bree Collaborative website for public comment prior to sending report to the Bree Collaborative for approval and adoption.
- Present findings and recommendations in a report.
- Recommend data-driven and practical implementation strategies including metrics or a process for measurement. *(can also be included in evaluation framework)*
- Create and oversee subsequent subgroups to help carry out the work, as needed.
- Revise this charter as necessary based on scope of work.

Meetings

The workgroup will hold meetings as necessary. Less than the full workgroup may convene to: gather and discuss information; conduct research; analyze relevant issues and facts; or draft recommendations for the deliberation of the full workgroup. A quorum shall be a simple majority and shall be required to accept and approve recommendations to send to the Bree Collaborative.

Bree Collaborative staff will conduct meetings, arrange for the recording of each meeting, and distribute meeting agendas and other materials prior to each meeting. Additional workgroup members may be added at the discretion of the Bree Collaborative director.

Name	Title	Organization
Darcy Jaffe, ARNP (chair)	Senior Vice President for Safety and Quality	WSHA
Rebecca (Becky) Daughtry, LICSW, CMHS	First Episode Psychosis Program and Policy Manager	HCA
Kim Moore, MD	VP Medical Operations	Virginia Mason Franciscan Health
Anne Marie Patterson, NP	Family Psychiatric Nurse Practitioner	Behavioral Health Resources, Thurston, Mason & Grays Harbor
Rebekah Woods, LMFT CMHS	Children and Youth Crisis Services Program Manager	KC Behavioral Health and Recovery Division
Lauren Farmer	Director of Children, Youth, and Family Services	Behavioral Health Resources - Olympia

Libby Hein, LMHC	Director of Behavioral Health	Molina
Brian Allender, MD	Chief Medical Officer	King County Behavioral Health and Recovery Division
Tobias Dang, MD	Medical Director, Mental Health and Wellness, Psychiatrist	Kaiser Permanente
Ryan Robertson, CHPQ	Director, Clinical Excellence	WSHA
Stephanie Giannandrea, MD	Psychiatrist	Confluence
Mary Ameh, ARNP Syed Hashmi, MD	Psychiatric Nurse Practitioner Internal Medicine, Psychiatry	Kadlec Regional Medical Center
Dixie Weber, MSN	Public Health Consultant	Department of Health
Caroline Brenner, MD Corey Thies, MS, LMHC, SUDP	Outpatient Behavioral Health Medical Director, Psychiatrist First Episode Psychosis Manager	Harborview Medical Center
Deepa Yerram, MD, MHA, FAAFP	Chief Medical Officer, Community & State Plan of Washington	UnitedHealthcare
Christina Warner, MD	Attending Psychiatrist | Psychiatry and Behavioral Medicine	Seattle Children's Hospital
Tawnya Christiansen, MD	Behavioral Health Medical Director	Community Health Plan of Washington
Maria Monroe-Davita, PhD	Director | Associate Professor	Washington State Center of Excellence in Early Psychosis | University of Washington School of Medicine
Cammie Perretta, MSW, LICSW Sarah Kopelovich, PhD	New Journey's Program Director Trainer Assistant Professor	UW School of Medicine
Delika Steele	Health Policy Analyst	Washington Office of the Insurance Commissioner
Dana Dean Deoring, ARNP	Senior Clinical & Educational Consultant	Dean Deoring & Associates
Chris DeCou, PhD	Director of Global Behavioral Health	Amazon
Chivonne Mraz, LCSW	Manager of Behavioral Health	Regence Blue Shield
Lucinda Sanchez, LICSW	New Journeys Program Manager	Comprehensive Healthcare

Appendix C. Guideline Literature Review

Source	Guidelines
AHRQ	N/A
Cochrane Collection	Cognitive behavioral therapy added to standard care for first episode and recent-onset psychosis (2024) Specialised early intervention teams for recent-onset psychosis (2020) Specialised early intervention teams (extended time) for recent-onset psychosis (2020) Interventions for prodromal stage of psychosis (2019) Pharmacological treatment for psychotic depression (2021)
Specialty Society Guidelines (via Guideline Clearing House)	American Psychiatric Association: Practice Guideline for the Treatment of Patients with Schizophrenia (2020) Department of Veteran Affairs and Department of Defense: Clinical Practice Guidelines for Management of First Episode Psychosis and Schizophrenia (2023) National Institute for Health and Care Excellence (UK): Psychosis and schizophrenia in children and young people: recognition and management (2016) National Institute for Health and Care Excellence (UK): Psychosis and schizophrenia in adults: prevention and management (2020) National Institute for Health and Care Excellence (UK): Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings (2020)
Health Technology Assessment Program	N/A
Center for Disease Control	N/A
Institute for Clinical and Economic Review	Schizophrenia: An assessment of xanomeline tartrate/trospium chloride (KarXT) (2024)
BMJ Clinical Evidence Systematic Overview	Managing the acute psychotic episode (2007)
Veterans Administration Evidence-based Synthesis Program	Interventions to Improve Pharmacological Adherence Among Adults with Psychotic Spectrum Disorders, Bipolar Disorder and Posttraumatic Stress Disorder (2015)

Appendix D. Considerations for Differential Diagnosis of First Episode of Psychosis

When a person presents for as assessment and is not experiencing overt symptoms of psychosis, it can be challenging to perform a differential diagnosis. A person may experience symptoms that could be attributed to any number of conditions. Common conditions that cause similar symptoms include autism spectrum disorder, obsessive-compulsive disorder and post-traumatic stress disorder. Some practical considerations to distinguish between conditions is provided below:

Autism Spectrum Disorder

Typically, symptoms of ASD appear much earlier in childhood compared to early adulthood for psychosis. Specific speech patterns (tangential, stereotyped or speech restricted to topics of interest) are more characteristic of ASD than psychosis, and people with ASD typically do not experience overt hallucinations or delusions. However, clear distinction between the two is still not always present with rigorous assessment, and a transdiagnostic approach to providing services may be most appropriate.

Obsessive-Compulsive Disorder

Symptoms of OCD and psychosis can overlap – obsessions and compulsions may present similar to delusional beliefs and avoidance behaviors. However, the content of the belief could potentially help in distinguishing between OCD and psychosis, (e.g., contamination versus persecution or grandiosity), intrusiveness and the ability of a person to retain their understanding of the belief's excessive nature can be a clue. Also, ritualistic and repetitive behaviors may indicate OCD compared to psychosis. OCD and psychosis can also be co-morbid so clinicians should consider that possibility in diagnosis and treatment recommendations.

Post-traumatic Stress Disorder

PTSD is a condition characterized by an extended period of symptoms (at least one month of mood alteration, avoidance, etc.) after experiencing a traumatic event. Many people with psychosis have a history of trauma (up to 73%). Many symptoms may overlap or coincide, but some distinguishing features may be present. Symptoms that are specific to the traumatic event may be more related to PTSD, such as hypervigilance or content of hallucinations. Timing of symptom onset or exacerbation may indicate its relation to either PTSD or psychosis as well – symptoms occurring after an event may be more indicative of PTSD than those that were not particularly linked temporally.

Assessment tools are available for clinicians to identify psychosis risk syndromes, first episode psychosis and psychotic-spectrum disorders. The table below was adapted from a review of diagnostic processes for psychosis.

Assessment Type	Instrument	Abbreviation	Description

Psychosis-risk and first-episode psychosis diagnosis	Structured Interview for Psychosis- risk Syndromes	SIPS	Trained rater-administered semi-structured interviews to assess psychosis-risk symptoms and syndromes and first-episode psychosis
	Comprehensive Assessment of At-Risk Mental States	CAARMS	
	Positive Symptoms and Diagnostic Criteria for the CAARMS Harmonized with the SIPS	PSYCHS	
Basic symptom assessment	Bonn Scale for the Assessment of Basic Symptoms	BSABS	Trained rater-administered semi-structured interviews to assess "basic symptoms" which can be associated with psychosis risk, active psychosis, and residual states of psychosis
	Schizophrenia Proneness Instrument	SPI	
Psychotic-spectrum assessment	Structured Clinical Interview for DSM-5 Disorders	SCID-5	Trained rater-administered semi-structured interviews to assess diagnostic criteria for psychotic and other psychiatric disorders in adults (SCID-5; SADS) and youth (K-SADS)
	Schedule for Affective Disorders and Schizophrenia	SADS	
	Kiddle Schedule for Affective Disorders and Schizophrenia for School-aged Children	K-SADS	
Psychosis-risk	Prodromal Questionnaire-Brief Version	PQ-B	Example self-report screening questionnaires for psychosis risk (among others)
	PRIME Screen-Revised	PS-R	
	Youth Psychosis At-Risk Questionnaire	YPARQ	
	The Early Psychosis Screener	EPS-26	

While the lengthy, clinical assessments (SIPS, SCID-5) are the gold standard to identify individuals at risk for or experiencing psychosis, there are several barriers to using them in daily clinical practice. They require extensive training to perform, and time to complete. Employing indicated screening in outpatient primary care or behavioral health contexts using shorter, less complex tools can provide

some initial guidance to indicate need for further assessment while directing patients to the most appropriate care. This needs to be accompanied with the understanding that these scales may not be able to differentiate between those at risk for psychosis and those experiencing overt psychotic symptoms, and many are not currently cross-culturally validated.

Table B. Diagnostic Assessment for First Episode Psychosis[xli]

Domain	Components
Physical Exam	detailed neurologic exam and a complete mental status exam, with the following areas of focus: mood and affect, thought process and content (including an evaluation of delusions, abnormal perceptions, suicidal and homicidal ideation, and insight), and a cognitive exam.
Medical History	review of head injury, seizures, cerebrovascular disease, sexually transmitted infections, and new or worsening headaches. Collateral history from relatives is recommended.
Laboratory/Imaging	CBC CMP Thyroid function tests Urine toxicology Parathyroid hormone, Ca Vit B12 Folate Niacin Based on clinical suspicion, testing for HIV infection and hepatitis C, as well as brain neuroimaging (e.g., CT or MRI), should be considered as part of the initial work-up.

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