Bree Collaborative | First Episode Psychosis
April 2nd, 2025| 3-4:30PM
Hybrid

MEMBERS PRESENT VIRTUALLY

Darcy Jaffe, ARNP (chair) WSHA
Brian Allender, MD, KC-BHRD
Maria Monroe-Davita, PhD, UW
Carolyn Brenner, MD, Harborview Medical Center
Becky Daughtry, LICSW, CMHS, Washington HCA
Tobias Dang, MD, KP
Christina Warner, MD, Seattle Children's
Kim Moore, MD, VM Franciscan Health
Ryan Robertson, CHPQ, WSHA
Stephanie Giannandrea, MD, Confluence
Tawnya Christiansen, MD, CHPW
Sarah Kopelovich, PhD, UW
Oladunni Oluwoye, PhD, WS
Cammie Peretta, MSW, LICSW, UW
Greg Jones, DNP PMHNP-BC, CPC, Lucid Living
Chivonne Mraz, LCSW, Regence
Anne Marie Patterson, ARNP
Rebekah Woods, LMFT, CMHS, KC-BHRD
Deepa Yerram, MD, MHA, FAAFP, United Healthcare
Matt Goldman, MD, Crisis System Medical Director KCBHRD

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN, Bree Collaborative
Emily Nudelman, DNP, RN, Bree Collaborative
Karie Nicholas, MA, GDip, Bree Collaborative
Cora Espina, ARNP, Foundation for Health Care Quality (Intern)
Megan Frye, PhD, EdM, Seattle Childrens/UW SMART Center

WELCOME

Beth Bojkov, Bree Collaborative, welcomed everyone to the April Bree First Episode Psychosis Workgroup. Beth invited the guests to introduce themselves.

PRESENT & DISCUSS: FEP in Schools

Beth invited Dr. Megan Frye from UW SMART Center/Seattle Children's to share a bit more about school settings and mental health

- School-based mental health services are crucial for accessing children where they are, increasing the likelihood of completing evidence-based treatments and addressing chronic absenteeism
- The gold standard right now is the multi-tiered systems of support framework, which deivides students' needs into three tiers: universal positive behavior supports, targeted support for at-risk students and intensive interventions for a few students.
- School-based health centers provide coordinated and integrated care, including primary, behavioral and sometimes dental health, in school buildings
- There's limited awareness of early detection and connection with services, and variability in training and experience among school nurses and psychologists

Questions

- Do school nurses get any extra training to identify signs and symptoms of psychosis?
    - There's nothing consistent or predictable about it
- What about school psychologists?

    - There's a difference between licensed and credentialed – licensed psychologists have to have doctoral level training, including comprehensive diagnosis using DSM. Masters level clinicians do not require that, they are not trained in differential diagnosis.
- What would be the best way to partner with a school professional, practical tips like time of year?
    - Teaming up with organizations like OSPI at the state level would be good, pushing out basic psychoeducation about things that we've seen be successful, keeping education very basic
- What is the process if a school nurse identifies someone with something concerning, do they have someone to ask?
    - There's a lot of local control – it doesn't look the same across all settings. There's typically a group of people in charge of students for which there are concerns and they get referred to them
- Do NJ programs already communicate with schools?
    - Many NJ teams already do, to create some awareness of themselves as a resource
    - Big gap in our teams being able to get face time with anyone in school districts
    - Idea of prodromal psychosis doesn't get a lot of face time at the OSPI/state level
- What about universities/colleges?
    - College counseling centers typically employ more clinical folks that have more training and background in detection of psychosis, more prevalent in their population given the age
    - https://www.nri-inc.org/media/1552/nri_back_to_school_toolkit_staff_administrator.pdf
- Benefit of working with OSPI is that they have the whole state in mind, thinking about outreach especially among rural communities

PRESENT & DISCUSS: Causes of Psychosis

Beth then invited Dr. Brenner to share a bit about different causes of psychosis and the appropriate treatments for those underlying causes.

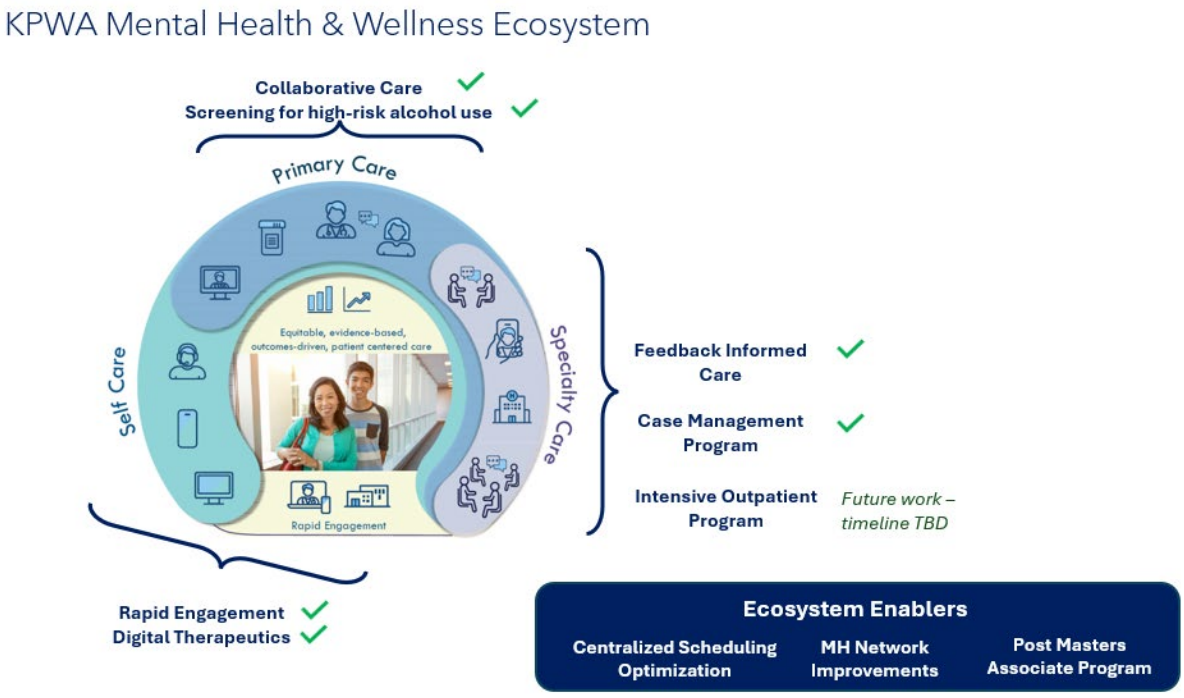
- New Journeys/CSC is not always the appropriate treatment depending on the cause of psychosis
- The evidence for CSC is strongest to provide better treatment outcomes for people with primary psychotic disorders
- Women often have a later onset of psychosis, so the age range was expanded to 40
- It often takes an intake to sort out whether someone is appropriate for NJ
    - First rule out medical causes caused by medication or medical cause from an inpatient consult
    - Postpartum psychosis is a separate concern
    - Substance-induced is very common, and its more indicated to have substance-focused treatment plan
    - If psychosis is secondary to developmental delay or autism spectrum disorder – there's not a great place to send them – general outpatient mental health center but looking for a better fit
    - Personality disorders – exclude in evaluation
    - Psychosis secondary for PTSD/OCD – primary treatment should be for those underlying causes
    - There are also individuals that start using substances that then convert to experiencing schizophrenia
- For people with diagnosed primary psychosis condition, they pretty much always get NJ?

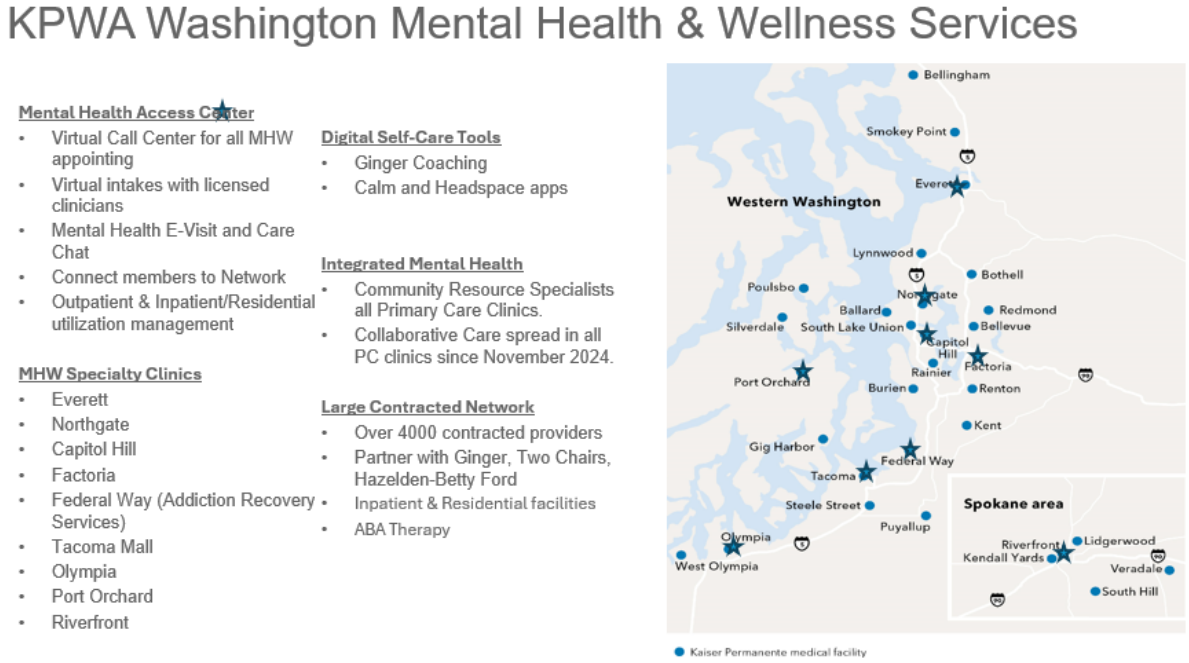
    - Yes, it's starting to get more full – we need more resources ut we would try to get them into King County teams but there is always a wait.
    - All teams get training from the UW Spirit center through the contract with the HCA, to be doing differential diagnosis – folks for which a diagnosis is difficult to determine, they are referred for support with diagnosis
- Treatment is not for everyone, it is intense, and may not be what that person and their family want. CSC is not meant for those with chronic psychosis
- Education needed and recognition of psychosis in primary care especially, but anywhere in our system reckoning with psychosis early and who's appropriate for NJ versus continuing mental health care in primary care clinic or mental health center.

PRESENT & DISCUSS: KAISER PERMANENTE MENTAL HEALTH

Beth invited Dr. Dang to share a bit about Kaiser Permanente's system for mental health care.

- Kaiser has 600,000 members in Washington state – also have about 15,000 Molina Apple Health members.
- There's a separate for profit Medical Group called Washington Permanente Medical Group – alls roviders are part of that group, but exclusively contracted with Kaiser Permanente and then Kaiser has different insurance products (HMO, PPO, Medicare Advantage, Molina)
- 50% of members are cared for by our internal system, 50% are carted for in network of contracted providers in the community
- Kaiser acquired Group Health in 2017
- Nationwide, Kaiser has developed a mental health and wellness ecosystem for all 8 regions:





- 8 specialty clinics in the state delineated by the sates, staffed by a variety of folks. Integrated mental health with collaborative care rolled out to all primary care clinics since November 2024, and also have community resource specialists in primary care.
- Do not currently have a structured program for first episode psychosis, 80-90% of current members identified with psychosis are managed in our specialty care clinics. Do not have a specific pathway.

Questions

- There are different models of CSC, such as without a peer support specialist. Models can differ based on population needs, and provider types. How would you envision a program like this working in your system?
    - Might just be formalizing the pathway and structure for CSC/FEP care, KP already has a number of components such as nurses, case managers, therapists, etc but without a specific focus on this population.
- Would supported education/employment and family therapy/education be difficult to get paid for?
    - Yes, probably.
- Is there a minimum number of people serving that would make this cost efficient?
    - Not necessarily, this is more cost effective than other utilization for this population (e.g., hospitalization, ED visits)
    - With the payment structure ahs looked like so far, caseloads are about max of 30 people. Sustainability of model was figured out by HCA to be between 28-30 people maximum
- Childrens' is beginning their own program, a lot of the work is not compensated currently, one of the hugely limiting aspects to why individual providers cannot provide this treatment

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PUBLIC COMMENT AND GOOD OF THE ORDER

Beth invited final comments or public comments, then thanked all for attending. The workgroup's next meeting will be on Wednesday, May 7th from 3-4:30PM.

Note: Public survey for topic selection for the Bree Collaborative will open in May. Please consider ideas for the Bree Collaborative to address in 2026!