Bree Collaborative | Perinatal/Maternal Mental Health
June 12th, 2023| 8:00 – 9:30 a.m.
Virtual

MEMBERS PRESENT

Colleen Daly, PhD, Microsoft (chair)
Cheryl Altice, MPH, HRSA
Trish Anderson, MBA, BSN, WSHA
Billie Dickinson, WSMA
Andrea Estes, MBA, HCA
Cindy Gamble, MPH, AIHC
Mandy Herreid, MN, United Healthcare
Ellen Kauffman, MD
Gina Legaz, MPH, WA Department of Health
Jenn Linstad, MSM, LM, CPM, Center for Birth
MaryEllen Maccio, MD, Valley Medical Center
Brianne Probasco, WACHC
Sheryl Pickering, DOH, WIC
Lewissa Swanson, MPA, HRSA
Beth Tinker, PhD, MPH, MN, RN, HCA
Brittany Weiner, WSHA
Josephine Young, MD, MBA, Premera

STAFF AND MEMBERS OF THE PUBLIC

Nick Locke, MPH, Bree Collaborative
Ginny Weir, MPH, Bree Collaborative
Emily Robson, RN, DNP, Bree Collaborative

WELCOME

Nick Locke, Bree Collaborative, welcomed everyone to the Bree Perinatal/Maternal Mental Health workgroup and thanked members for moving the meeting up a week to accommodate the Juneteenth holiday. Members introduced themselves via chat. Mr. Locke also shared two new updates of interest: The American College of Obstetricians and Gynecologists have released updated guidance on screening and treatment for perinatal mental health conditions, and the UW is starting an ECHO project of monthly case conferences on maternal substance use and mental health, starting in October 2023.

Action: Adopt May Minutes.

DISCUSSION: EVIDENCE REVIEW UPDATE

Mr. Locke began the meeting by sharing updates to the evidence review draft. Mr. Locke walked through new material for Screening, Patient-Provider Interactions, and Clinical Structure, and introduced new evidence on Access.

Screening:

- New evidence on screening highlighted maternal mental health screening in pediatric practice, as well as implementation concerns for screening and intervention workflows.
- Members discussed the communication and coordination required to follow-up in pediatric practices. We may need to address the barriers of communication.
    - The Washington Chapter of the AAP has recently looked into this area.
- Having some sort of referral pathway to follow-up on identified social need is absolutely necessary, with information about potential resources an initial step.
- Up to date resources are difficult. We should look into existing resources for up-to-date resource lists
- Coverage may be a part of access to screening and interventions.

Patient-Provider Interactions:

- New evidence from qualitative studies, especially with women of color, demonstrate the importance of relationship building. Other case studies highlight the use of implicit bias training.
- Members discussed additional comments about long-term solutions to culturally-appropriate care, such as workforce development and diversity.

Clinical Structure:

- New evidence looked at outcomes for group prenatal care and the community midwife model.
- Members discussed the overlap between group prenatal care (which has stronger evidence for medically underserved pregnant people) and inequities in care.
    - The Prenatal to 3 program in Spokane has more information about outcomes for group prenatal care.

Access:

- New evidence on access to perinatal/prenatal care was presented. Most evidence is focused on access to routine perinatal care, not specifically mental health access.
- Members discussed the many ways access could be expanded to include other big priorities for maternal mental health.
    - Impact of mental health access prior to pregnancy (is there a protective effect)
    - Preventative access – awareness, ease of access to behavioral health for reproductive age people.
    - Association between depression and post-partum depression
    - The relationship between access and education to pregnant people about perinatal mood disorders.
    - Education services should be given to pregnant people who don't screen positive as well to increase awareness and reduce stigma.
    - Any education campaign must understand the gendered associations around mental health concerns and "hysteria."
    - Access might include behavioral health programs and state health insurance. Medicaid (prior to pregnancy) does not include many behavioral health benefits, and many private behavioral health providers do not offer Medicaid benefits.

DISCUSSION: DRAFT RECOMMENDATIONS

Mr. Locke transitioned the workgroup to discuss draft recommendations based on the evidence. Initial recommendations focused on evidence reviewed in May.

- Clinical Screening/Referrals:
    - Members discussed how to expand recommendations about treatment and follow-up once a pregnant person screens positive for perinatal mood disorders. This could be as simple as an SBIRT model and motivational interviewing.
    - Members also discussed expansive options for treatment – offering all pregnant people a mental health consultation. This recommendation may belong later in the document.
- Patient-Provider Interactions:
    - Members approved of the recommendations, but requested greater clarity on the difference between clinicians (OBGYNs, midwives, nurse practitioners) and other community service supports (such as doulas).
- Clinical Structure:

- Initial recommendations will focus on the opportunity for integrated behavioral health, collaborative care, group prenatal care, home visits, and more.
- Members added telehealth options, the community midwife model of care, and community health workers for mental health.

PUBLIC COMMENT AND GOOD OF THE ORDER

Mr. Locke invited final comments or public comments, then thanked all for attending. Between meetings, Bree staff will continue the evidence process and update draft recommendations for increasing access. The workgroup's next meeting will be on **Monday, July 17th from 8:00 – 9:30 AM**.