Bree Collaborative Meeting

November 15th, 2023 1-3PM

DR. ROBERT BREE COLLABORATIVE

Welcome

From Unsplash by Johannes Plenio

Agenda

- **Welcome and Introductions** (10 minutes)
  - COVID-19 Update
  - Welcome New Chair Dr. Emily Transue
  - Adopt September Minutes
  - Review Report Process
- **Bree 2023 Reports**
  - Complex Discharge (25 minutes)
  - Diabetes (25 minutes)
  - Perinatal Behavioral Health (25 minutes)
- **Bree 2024 Topics Highlights** (5 minutes)
- **Implementation Highlights** (10 minutes)
- **Evaluation Highlights** (10 minutes)
- **Thank You Hugh and Close** (10 minutes)

Welcome the new Chair of the Bree Collaborative: Dr. Emily Transue!

Minutes

Dr. Robert Bree Collaborative Meeting Minutes
September 27th, 2023 | 1:00-3:00
Held Hybrid

Members Present

Hugh Straley, MD, Bree Collaborative (Chair)
Susie Dade, MS, Patient Representative
June Alteras MN, RN, MultiCare
Sharon Eloranta, MD, Washington Health Alliance
Gary Franklin, MD, Washington State Department of Labor and Industries
Colin Fields, MD, Kaiser Permanente
Darcy Jaffe, MN, ARNP, FACHE, Washington State Hospital Association
Norifumi Kamo, MD, MPP, Virginia Mason Franciscan Medical Center
Kimberly Moore, MD, Franciscan Health System
Mary Kay O'Neill, MD, MBA, Mercer
Susane Quistgaard, MD Premera Blue Cross
Angie Sparks, MD, UnitedHealthcare
Nicole Saint Claire, MD, Regence BlueShield
Judy Zerzan-Thule, MD, MPH, Washington State Health Care Authority

Members Absent

Colleen Daly, PhD, Microsoft
Patricia Egwuatu, DO
Mark Haugen, MD, Walla Walla Clinic
Greg Marchand, The Boeing Company
Carl Olden, MD, Pacific Crest Family Medicine
Kevin Pieper, MD, MHA, Kadlec Regional Medical

Staff, Members of the Public

Beth Bojkov, MPH, RN
Karie Nicholas, MA, GC, FHCQ
Emily Nudelman, DNP, RN, FHCQ
Ginny Weir, MPH, FHCQ
Amanda Blake
Chris Chen, MD, HCA
Kathy Davis, MultiCare
Billie Dickinson, WSMA
Summer Duman, Regence
Amy Dura
Amy Florence
Jason Fodeman
Charissa Fotinos
Lucinda Grande
Audrey J
Carissa Kemp, ADA
Ji Young Nam, L&I
Hillary Norris, WSMA
K Pestsas, UHC E&I
Rodica Pop
Jep Shepard
Jamie Teuteberg, HCA
Emily Transue
Shelby Wiedmann
Sarah Walker, UW CoLab
Morgan Young, L&I

Report Review Process

- Chair Presentation of Content (15 minutes)
- Q&A and Public Comment (8 minutes)
- Voting (2 minutes)
  - Bree members in person: say Aye or Nay out loud
  - Bree members online please type Aye or Nay in the chat *(Bree staff will monitor chat and report number of Ayes and Nays)*
  - Bree staff will announce if passed or not before moving to next topic

Bree 2023 Report Review

1:10 – 2:25PM

Complex Patient Discharge

Presented by Chair Darcy Jaffe, MN, ARNP, FACHE

1:10-1:25

Members

Name	Organization
Darcy Jaffe (chair)	Washington State Hospital Association
Shelley Bogart	DSHS-DDA
Gloria Brigham, EdD, MN, RN	Washington State Nursing Association
Amy Cole, MBA	MultiCare
Jay Cook, MD, MBA	Providence
Billie Dickinson	Washington State Medical Association
Kelli Emans	DSHS
Jeff Foti, MD	Seattle Children's
Jas Grewal	Washington State Health Care Authority
Karla Hall, RN	PeaceHealth
Kathleen Heim, MSN, RN	PeaceHealth
Carol Hiner, MSN	Kaiser Permanente
Linda Keenan, PhD, MPA, BSN, RN-BC	UnitedHealthcare
Jen Koon, MD	Premera Blue Cross
Danica Koos, MPH	Community Health Plan of Washington
Cathy MacEnraw, MSW	Providence
Elena Madrid, RN	Washington Health Care Association (WHCA)

Name	Organization
Colin Maloney, MPH	WA DOH
Amber May, MD	Kaiser Permanente
Liz McCully, MSW	Swedish
Jason McGill, JD	WA HCA
Kellie Meserve, MN, RN	Virginia Mason Franciscan Health
Tracey Mullian, MSW	Swedish
Kim Petram, BSN	Valley Medical Center
Lou Reyes	Swedish
Sheridan Rieger, MD	Concerto Health
Odilliah Sangali	WA DOH
Zosia Stanely, JD, MHA	Washington State Hospital Association
Cyndi Stilson, RN, BSN	Community Health Plan of Washington
Ric Troyer, MD	Iora Health
Janice Tufte	PICORI West Ambassador/Hassanah Consulting

Goals

Adoption of a common definition for patients in an acute care bed without an acute care need. Lack of a common definition has led to differences in calculating avoidable days, length of stay, and medical necessity.

Collecting **standard patient characteristic data** during the discharge planning process

Coordination and communication between acute settings, post-acute settings, public agencies, and health plans

Recording all discharge barriers for all patients (delivery sites) or members (health plans)

Definition

Goal: establish a common definition for complex patient discharge across settings

- **Definition**: a patient who is medically ready to be transferred outside of an acute care setting but is unable to do so due to discharge barriers.

Health systems, health plans, and public agencies should collect standard patient characteristic data during the discharge planning process to understand and proactively address

- Action: Created a **Standard Discharge Barrier List**.

Standard Discharge Barrier List Categories

- Medical
- Behavioral
- Social Needs
- Legal
- Payment
- Process
- Post-Acute Placement

Target Audiences

- Hospitals
- Health Plans
- DSHS, HCS, DDA
- Post-Acute Facilities
- AFH & Assisted Living

Asking all to:

- Adopt the common definition
- Use complete and timely two-way communication of patient information (including identified discharge barriers)

Hospitals

- Collect **patient characteristic data and potential discharge barriers** early in admission
- Develop and/or adapt a **complex discharge tool**
- Develop a way to share complex discharge barriers information across teams in the hospital.
- Universally **screen for SDOH** – link to previous reports
- Refer patients to **a complex discharge team or lead** within the hospital, and maintain staffing of team/lead on weekends
- That team or lead has **regular discharge planning meetings**, uses the **adapted complex discharge tool**, follows specific recs for working with **Home and Community Services** and **Developmental Disabilities Administration**, and develops a **patient-centered discharge plan**

Health Plan

- Develop process of receiving **standard discharge barrier information**
- **Identify and track members** that qualify as a complex patient discharge
- Implement **standardized post-acute coverage setting criteria** and **standard medication prior authorization criteria**
- Provide **dedicated team and process** for assisting with discharge planning and disposition when a member is identified as a complex discharge
- **Screen for and track rates of SDOH screening and referral**, stratify by race, ethnicity and language (REaL) data to identify disparities – develop processes to address these disparities.
- Maintain **adequate network of post-acute providers**
- Participate in creating **secondary discharge plans** when applicable

Department of Social and Health Services (DSHS)

- Develop process of receiving **standard discharge barrier information.**
- Continue to **identify and communicate barriers in organizational processes** that delay discharge
- Establish and maintain an **online directory** with list of Washington state post-acute facility capabilities publicly available and reliable contact information available to verify information before patient transfers.
- Streamline assessment processes by making **DSHS staff contact** easily accessible, establishing EHR **data sharing agreements**, and establishing **clear assessment expectations**

DSHS: HCS

- Home and Community Services
  - **Flag and prioritize** clients that are experiencing complex discharge
  - Communicate when **cases transfer to different staff** to hospital discharge team. Minimize delays due to case transfers.
  - **Collaborate on care planning**
  - **Keep involved agencies up to date** on assessments, rates and ETR reviews

DSHS: DDA

- Developmental Disabilities Administration
  - **Flag and prioritize clients** that are experiencing complex discharge
  - Communicate **case transfers to different staff** to hospital discharge team. Minimize delays due to case transfers
  - **Collaborate on care planning**

Post-Acute Facilities (e.g., SNF, Acute Rehab)

- **Maintain list of referring acute facilities** and notify when unable to accept weekend admissions
- **Develop and maintain staffing capacity and competencies** to accept patients who have listed discharge barriers
- **Identify and work to develop solutions to barriers to admissions** to assist in the ability to accept an admission
- Receive **electronic documented discharge information**, communicate if incomplete or unable to access.
- Provide necessary information to DSHS for **online directory**.
- When applicable, collaborate on developing **secondary discharge plans**

Adult Family Home & Assisted Living Facilities (who can accept complex patients)

- **Understand** the specific requirements and recommendations for post-discharge care. Communicate with acute facility as soon as possible to address potential delays in discharge.
- When applicable, collaborate to develop a **secondary discharge plan**.
- Request a care plan that can be **replicated in this setting**.
- **If denying admission**, note what supports would be necessary for consideration of acceptance for admission.
- **Communicate** with resident's PCP and behavioral health providers; **assist in identifying** a PCP when needed.

Q&A Time

Voting Period

Diabetes

Presented by Chair Norris Kamo, MD

1:35-1:50

Workgroup Members

Name	Title	Organization
Norris Kamo, MPP (chair)	Section Head, Adult Primary Care	Virginia Mason Medical Center
Susan Buell	Health and Wellness Director	YMCA of Tacoma and Pierce County
LuAnn Chen, MD, MHA	Medical Director	Community Health Plan of Washington
Sharon Eloranta, MD	Medical Director, Performance Measurement and Practice	
Rick Hourigan, MD	Market Medical Executive	Cigna
Carissa Kemp, MPP	State Government Affairs and Advocacy Director	American Diabetes Association
Vickie Kolios, MSHSA, CPHQ	Program Director, Surgical and Spine COAP	Foundation for Health Care Quality
Robert Mecklenberg, MD	Medical Director (retired)	Virginia Mason Medical Center
Mamatha Palanati, MD	Family Medicine	Kaiser Permanente
Khimberly Schoenacker, RND, CSP, CD	CYSHCN Program	WA Department of Health
Cynthia Stilson, RN, BSN, CMM	Care Management Manager	Community Health Plan of Washington
Sally Sundar	Program Executive, Health Integration and Transformation	The Y of Greater Seattle
Nicole Treanor, MS, RD, CD, CDCES	Diabetes Care and Education Specialist	Virginia Mason Franciscan Health
Leah Wainman		WA Department of Health

Goal

- **Aim**: Improve health care quality, outcomes, affordability, equity, and workforce sustainability related to diabetes care in Washington state.

Key Priorities

- Increase performance on NCQA measures for people who have been diagnosed with diabetes.
- Identify individuals with prediabetes or diabetes who are unaware and engage them in treatment.
- Uniformly use team-based care to support individuals with diabetes or at risk for diabetes.
- Promote connection to community resources, address social needs, access to prevention and health promotion activities.
- Support patients' medication and supplies use by removing payment barriers.

Focus Areas

Focus Areas	Evidence Review Topics
Team-Based Care & Empanelment	- Effectiveness of team-based care for diabetes, especially in rural or medically underserved communities - Professional roles to be included in the care team - Comprehensive, whole-person care
Population Health	- Prevention of diabetes through identification and early intervention - Strategies to reach medically underserved populations. - Connection to community - Identifying and addressing food insecurity - School based care, Dental care, and Eye care
Financial	- Removing or minimizing payment barriers to evidence-based services, medications, and devices for patients - Standardizing coverage of diabetes prevention and care services

Audiences

- Clinicians and Health Professionals
- Ambulatory Care Setting
- Inpatient Care Setting
- Health Plans and Dental Plans
- Eye Care Professionals and Clinics
- Employer Purchasers
- Washington State Legislature
- Schools
- Dentists and Dental Clinics

Clinicians and Health Professionals

All patients	• Person-centered communication • Screen according risk factors/clinical guidance • Psychosocial and SDOH screening/assessment
At risk for diabetes/with prediabetes	• Create a person-centered management plan and goals • Refer to preventative services (e.g., NDPP, intensive behavioral therapy, CHWs)
Patients with diabetes	• Use health system registry to track care gaps • Educate patients and use patient education strategies • Refer to services and specialists, communicate management plan to external team members

Ambulatory Care Setting

- Align with Bree Collaborative Primary Care Guidelines
- Follow tenets of the **Chronic Care Model** in organizational policies: using a registry, using an EHR with structured data fields, using clinical decision support tools, proactive outreach to encourage annual visits
- Provide a **multidisciplinary coordinated care team**
- Align **clinic workflows** with most recent clinical guidelines (e.g., ADA) and use consider using recognition programs like AHA's Target: Type 2 Diabetes to assist in alignment
- Develop protocols for **social needs screening and referral to external services and specialists**
- Develop capabilities to track and report a set of **diabetes-related performance measures** (including but not limited to NCQA measures)
- If possible, **host health fairs** and/or **community-based screenings** and utilize tactics to reach

Hospital Setting

- ADA **Hospital Care Delivery Standards** or more updated clinical guidance
- Utilize **discharge planning toolkits** such as AHRQs RED Toolkit – coordinate care transitions with PCP
- Meet the Key Indicators for Recognition under Leapfrog's **Recognized Leader in Care for People with Diabetes Program**
- Develop capabilities to track and report **diabetes-related performance measures** as determined by payor contracts and/or reporting requirements.

Health Plans

- Minimize **barriers to prior authorization** by ensuring members who meet inclusion criteria for on label prescribing for medication, supplies, and equipment designated as recommended by the most current version of American Diabetes Association (ADA) Standards of Care (using grade A evidence)
- **Minimize cost sharing** to members for on label prescribing of medications with grade A evidence per most recent clinical guidance.
- Cover **prediabetes and diabetes** services along the spectrum of fee-for-service (FFS) to alternative payment models with risk-adjusted, person-level payments (e.g., PMPM)
- **Assign PCP** to each member at enrollment
- **Communicate** coverage to members, and **target outreach** to members with gaps in care
- **Partner** with community-based orgs to address food insecurity
- Require collection of standardized **diabetes performance measures** in contracts, including NCQA

Employer Purchasers/Dental Plans

Employer Purchaser

- The WA HCA Health Technology Clinical Committee (HTCC) should consider re-reviewing the coverage of Continuous Glucose Monitoring devices.
- Review benefits to ensure adequate behavioral health coverage.
- Ensure contracted health plans follow health plan guidance above; if self-funded, review the health plan guidance above, where appropriate.
- Ensure health plans provide coverage for remote patient monitoring codes

Dental Plan

- If a member is at risk for, or has Periodontal Disease, cover for full-mouth subgingival instrumentation and four supportive (periodontal) maintenance visits annually (similar to Apple Health).
- Fully cover dental exams for members with diabetes at least every 6 months.

Department of Health & Public Health Agencies

- Develop a **patient facing diabetes resource platform** (Examples: Utah, Montana).
- Develop and support tactics and outreach systems (e.g., mobile vans) to **engage with communities with known disparities**
- Develop interventions to support individuals in **addressing social needs** (fruit and veggie prescription programs)
- Train all **CHW**s on diabetes prevention and care, encourage clinicians to meet with CHWs, support CHW programs, and support integration of CHW into delivery systems,
- Consider testing **Prediabetes Measures for Medicaid beneficiaries** in concert with AMA's work to have quality measures vetted through Medicare Mock Measures for NDPP.

Washington State Legislature / Schools

Washington State Legislature

- Support Health Care Authority budget asks that align with whole-person health (e.g., primary care payment reform)
- Washington state HCA should consider supporting a State Plan Amendment for coverage of the National Diabetes Prevention Program

Schools

- Follow American Diabetes's Association' Guide for School Personnel
- Educate nurses and staff on diabetes, diabetes management and insulin administration.
- Engage with children, adolescents, parents, and school staff to support the development of educational lifestyle health programs
- Provide healthy food options

Dentists and Dental Clinics

- Follow **American Dental Association's** recommendations on providing dental care to patients with diabetes.
- Follow International Consensus Report guidelines for management of **periodontal disease** among patients with diabetes.
- Inform patients with diabetes that they are at increased risk for oral complications and serious systemic complications
- **Consult** with the patient's PCP **prior to oral interventions and/or surgery**
- Ensure the **Electronic Dental Record** is current with lab values and medications.
- **Screen patients** to determine if they have been evaluated by a PCP within the past 6 months. If not, encourage the patient to schedule an appointment or refer them to establish care with a PCP
- Screen patients for tobacco use. Provide tobacco cessation support to patients who use tobacco or refer to a PCP.
- Offer dental rehabilitation to restore adequate mastication for proper nutrition.

Eye Care Professionals and Clinics

- Follow the **American Optometry Association's** most recent guidelines on eye care for patients with diabetes, or more up to date clinical guidance
- Develop a system to **identify patients with diabetes**.
- Provide **early detection and timely treatment** of diabetes-related eye diseases such as diabetic retinopathy, glaucoma, and cataracts.
- **Educate** patients with diabetes on the effectiveness of lifestyle change in delaying the onset or preventing type 2 diabetes and diabetes related eye complications
- **Collaborate** with other members of the healthcare team to ensure comprehensive diabetes care
- **Screen** patients for tobacco use. Provide tobacco cessation support to patients who use tobacco or refer to a Primary Care Provider (PCP).

Q&A Time

Voting Period

Perinatal Behavioral Health

Presented by Chair Colleen Daly, PhD

2:00-2:15

Workgroup members

Name	Organization
Colleen Daly, PhD (chair)	Microsoft
Trish Anderson, MBA, BSN	Washington State Hospital Association
Aphrodyi Antoine, MPH, MBA	Health Related Services Administration
Christine Cole, LCSW	WA Health Care Authority
Melissa Covarrubias	Community Health Plan of Washington
Billie Dickinson	Washington State Medical Association
Andrea Estes, MBA	WA Health Care Authority
Cindy Gamble, MPH	American Indian Health Commission
Kristin Hayes, MSW	Evergreen Health
Libby Hein, LHMC	Children's Home Society of Washington
Mandy Herreid, MN	United Healthcare
Kay Jackson, CNM, ARNP	Off the Grid Midwifery and Health
Ellen Kauffman, MD, FACOG	
Jillian King, DNPc	University of Washington
Gina Legaz, MPH	March of Dimes
Jennifer Linstad, CNM	Center for Birth

Name	Organization
MaryEllen Maccio, MD	Valley Medical Center
Patricia Morgan, ARNP	Evergreen Health
Sheryl Pickering	WA Department of Health, WIC
Ashley Pina	WA Health Care Authority
Sarah Pine	WA Health Care Authority
Katie Price, LICSW	Katie Price Therapy
Brianne Probasco	WA Association of Community Health
Monica Salgaonkar, MHA	Washington State Medical Association
Nicole Saint Clair, MD	Regence
Caroline Sedano, MPH	WA Department of Health
Lewissa Swanson, MPH	Health Related Services Administration
Beth Tinker, PhD, MPH, MN, RN	WA Health Care Authority
JanMarie Ward, MPA	American Indian Health Commission
Josephine Young, MD, MPH, MBA	Premera

Background

Defines the perinatal period as **pregnancy through 1 year after birth**

Aim: To improve the behavioral health care continuum in Washington State along the reproductive or family building journey including the perinatal and postpartum period

To adequately meet patient needs and population health goals, behavioral healthcare should be **integrated into all settings** where perinatal people interact with the healthcare system and providers. At a minimum**, protocols for SBIRT** should be embedded into perinatal care and pediatric care settings.

Report builds on: Bree Behavioral Health Integration Guidelines, AHRQ Topic Brief on Pregnant and Postpartum Behavioral Health Integration, ACOG, AAP and USPSTF guidelines, available evidence and expert opinion.

Focus Areas

Focus Area	Action Steps
Patient education and provider communication	• Communication between patient and provider • Patient education • Public health education
Integrated behavioral health	• Universal Screening, Brief Intervention, and Referral to Treatment protocols. • Integration of behavioral health (e.g., collaborative care), co-located care, referral systems and/or community linkages to higher levels of behavioral health care • Coordinated Treatment for pregnant and postpartum individuals experiencing substance use disorders.
Care coordination	• Operational systems for quick coordination and triage. • Care coordinators'/peer navigators' role and integration
Community linkages to social programs	• Referral pathways to community-based resources and organizations • Partnerships with community.
Expanded team roles	• Roles of community-based/additional perinatal providers in supporting perinatal behavioral health. • Expanded reimbursement

*Builds upon the Behavioral Health Integration report and Perinatal Bundle Report

Audience Sections

- Perinatal Care Providers
- Pediatric Providers and Clinics
- Ambulatory Care
- Birthing Hospitals
- Health Plans
- Purchasers
- Department of Health, Public Health Agencies and Urban Indian Health Organizations
- Washington State Legislature

Perinatal Providers

- Provide care that is **trauma-informed, patient-centered, culturally humble** and in alignment with **harm reduction** principles.
- **Screen** every pregnant person and/or review for prior diagnoses of behavioral health conditions **at intake, at least every trimester and at routine postpartum visits** using validated instruments. Screen at **intake, later in pregnancy and at postpartum visit** for IPV and SDOH. Consider screening for ACEs.
- **Do not unnecessarily stop treatment** when an individual becomes pregnant.
- If screened positive, **tailor brief intervention and treatment to screening results**; warm handoffs to specialty behavioral health if warranted.
- **Educate** patients on signs and symptoms of mental health concerns and provide educational and community resources.
- Inquire about **doula involvement**, **family and community support, and postpartum healthcare** and **connect to resources** if wanted. Facilitate inclusion in care team.

Providers and Clinics working with Pediatric Patients

- Provide care that is **trauma-informed, patient-centered, culturally humble** and in alignment with **harm reduction** principles
- **Screen** postpartum people for behavioral health concerns according to AAP, USPSTF, and Bright Futures guidelines – extend through 1 year well-child visit. Consider screening for SDOH, IPV, ACEs
- If screenings are positive, **develop a plan on the same day for intervention**
- Consider and develop pathways to **coordinate care with parent's postpartum clinician**
- **Connect the patient and parent with care team members** to support their referral to interventions for the further assessment and treatment of the parent and community support. **Follow up with the parent within two weeks.**
- Track system-level data regarding screening for behavioral health and follow-up; use quality improvement efforts to achieve screening and follow up goals.

Ambulatory

- Provide care that is **trauma-informed, patient-centered, culturally humble** and in alignment with **harm reduction** principles. Staff should understand and receive training on these concepts, plus antiracism, gender inclusivity, behavioral health for perinatal individuals and behavioral health integration
- Offer to connect patients to **racially concordant provider**, educate on role of **doulas** and other **community birth support** and facilitate **inclusion in care team**
- Develop **perinatal patient registry** for pregnant-1 year postpartum; track system level behavioral health screening, intervention and referrals. Consider stratifying by demographics to identify disparities.
- Establish **protocols for screening, intervention and referral** for BH concerns, IPV and SDOH that follow most recent clinical guidance. Create referral systems for specialty BH and SDOH resources
- Develop capabilities to **measure and track** a set of perinatal behavioral health related performance measures
- Change **clinic policy** to address structural barriers: (e.g., **extended clinic hours, child-friendly waiting rooms, virtual care options, translation/interpretation services**)

Birthing Hospitals

- Provide care that is **trauma-informed, patient-centered, culturally humble** and in alignment with **harm reduction** principles. Staff should understand and receive training on these concepts, plus antiracism, gender inclusivity, behavioral health for perinatal individuals and behavioral health integration
- Align with requirements to become a Birthing Center of Excellence from the DOH
  - Requires: screening for behavioral health, a provider onsite for OUD medication initiation/adjustment (if not available have protocol for consult to initiate/adjust medications) allow birth parent and infant in room together
- Consider participating in the Washington Health Care Authority's **Substance Using Pregnant People (SUPP) Program** for individuals who are pregnant, covered through Apple Health and have a substance use history
- Offer an easy-to-access specialty behavioral health referral list for providers to conduct a **warm handoff at discharge.**

Health Plans

- Cover **midwives** as perinatal providers
- **Reimburse** for doula support, virtual care options, warm handoffs and shared referrals
- Consider reimbursing for **diverse models of perinatal care** delivery including integrated care, home visits by nurses, group prenatal care, telehealth, community midwives, community health workers
- Have a system to **track and identify disparities in behavioral health screening and referral rates** of pregnant and postpartum members through 12 months postpartum. Address these disparities.
- Ensure **adequate provider network** including behavioral health professionals with expertise in perinatal behavioral health
- Provide **patient navigation** services and pathways to **address identified social needs**
- **Educate** members on BH signs and symptoms and all options to manage perinatal episode

Purchasers

- HCA should work to **increase access to perinatal integrated behavioral health**
- **Cover behavioral health consultation** as part of perinatal health care and post-delivery in recognition of pregnancy being a significant life event.
- **Cover diverse options (e.g., individual providers, care and delivery settings)** for individuals to receive perinatal care so the member may choose care that best aligns with them and their desired birthing process
- **Educate** members on the options available to them.
- **Expand coverage** for **community-based pregnancy and maternity care** (e.g., midwives, home visits, group visits, community-based doulas)

Department of Health, Public Health Agencies, Urban Indian Health Organizations

- **Increase education** around perinatal behavioral health and existing services. Partner with community organizations and public health agencies. Increase access to these services.
- Create **education campaigns** for the public on signs and symptoms of perinatal behavioral health concerns and where to go to receive care.
- Collaborate across all public health care and social needs agencies (i.e. DSHS, DCYF, HCA, DOH, ESD, Commerce) in **unified educational messaging**
- Develop and support **programs to address and consider individual social needs**, such as transportation to and from clinics, food insecurity and housing instability.
- **Educate doulas and other community birth workers** on perinatal behavioral health signs, symptoms, and resources available to support them.

Washington State Legislature

- **Fund the initial prenatal visit separately**, including requiring behavioral health screening, SDOH screening and clinician face-to-face time in the initial obstetrical visit.

Q&A Time

Voting Period

Thank you to our Chairs and Workgroup Members

Bree 2024 Topics Update

2024 Workgroup Preparation

CHAIRS

- Heat-related illness – Chair: Dr. Chris Chen (HCA)
- Treatment for OUD – Chair: Dr. Charissa Fotinos (HCA)
- Behavioral Health: Early Intervention for Youth – Chair: still searching…

NEXT STEPS

- Recruiting members
- Begin workgroups in January
- Narrowing Report Scopes

Bree Evaluation Update

Karie Nicholas MA, GC

Bree Implementation Update

Emily Nudelman, DNP, RN

Implementation Update

- Checklists
- Health Equity Action Collaborative
- Spotlight Webinars & Presentations
- Looking into opportunities for 2023 reports
- Bree implementation identity
- Sustainability of implementation work

Public Comment

Please raise hand to be called on to provide comment.

Please state Name, Title and Organization.

Closing

Good of the Order

Hot Topic: Weight Health and GLP1 Medications Event

You are invited to a Bree Collaborative-sponsored Hot Topics session to discuss weight health and GLP1 medications on **December 5 1:00-3:00pm**. This will be a structured hybrid discussion at our FHCQ offices in downtown Seattle, 705 Second Ave Suite 710, Seattle, WA and over Zoom. This will be an opportunity to highlight best practices and barriers to population health but will not result in clinical guidelines.

email bree@qualityhealth.org for more information

Thank you, Hugh!

Next Steps

- **Next meeting Wednesday, January 24th 1-3 PM PT HYBRID**
- Tentative Agenda
  - Finalize Bree Reports 2023
  - Potentially adopt 2024 Workgroup Charters
  - Updates on Implementation & Evaluation

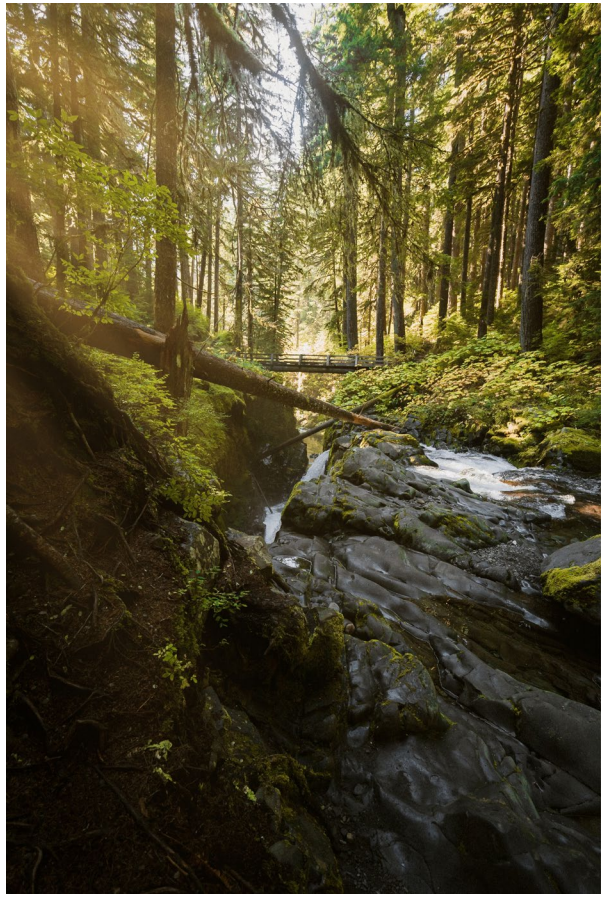

Photo by Karsten Winegeart on Unsplash