Bree Collaborative Meeting

November 15th, 2023 1-3PM
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!
<table>
<thead>
<tr>
<th>Members Present</th>
<th>Members Absent</th>
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<tbody>
<tr>
<td>Hugh Straley, MD, Bree Collaborative (Chair)</td>
<td>Norifumi Kamo, MD, MPP, Virginia Mason</td>
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<tr>
<td>Susie Dade, MS, Patient Representative</td>
<td>Francisca Medical Center</td>
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<td>June Alteras MN, RN, MultiCare</td>
<td>Kimberly Moore, MD, Franciscan Health System</td>
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<td>Sharon Eloranta, MD, Washington Health Alliance</td>
<td>Mary Kay O’Neill, MD, MBA, Mercer</td>
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<td>Gary Franklin, MD, Washington State Department of Labor and Industries</td>
<td>Susane Quistgaard, MD Premera Blue Cross</td>
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<td>Colin Fields, MD, Kaiser Permanente</td>
<td>Angie Sparks, MD, UnitedHealthcare</td>
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<td>Darcy Jaffe, MN, ARNP, FACHE, Washington State Hospital Association</td>
<td>Nicole Saint Claire, MD, Regence BlueShield</td>
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<td>Judy Zerzan-Thule, MD, MPH, Washington State Health Care Authority</td>
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<td>Members Absent</td>
<td>Carl Olden, MD, Pacific Crest Family Medicine</td>
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<td>Colleen Daly, PhD, Microsoft</td>
<td>Kevin Pieper, MD, MHA, Kadlec Regional Medical</td>
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<td>Patricia Egwuatu, DO</td>
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<td>Mark Haugen, MD, Walla Walla Clinic</td>
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<td>Greg Marchand, The Boeing Company</td>
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<td>Staff, Members of the Public</td>
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<td>Beth Bojkov, MPH, RN</td>
<td>Lucinda Grande</td>
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<td>Karie Nicholas, MA, GC, FHCQ</td>
<td>Audrey J</td>
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<td>Emily Nudelman, DNP, RN, FHCQ</td>
<td>Carissa Kemp, ADA</td>
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<td>Ginny Weir, MPH, FHCQ</td>
<td>Ji Young Nam, L&amp;I</td>
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<td>Amanda Blake</td>
<td>Hillary Norris, WSMA</td>
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<td>Chris Chen, MD, HCA</td>
<td>K Pestas, UHC E&amp;I</td>
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<td>Kathy Davis, MultiCare</td>
<td>Roldica Pop</td>
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<td>Billie Dickinson, WSMA</td>
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<td>Summer Duman, Regence</td>
<td>Jamie Teuteberg, HCA</td>
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<td>Amy Dura</td>
<td>Emily Transue</td>
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<td>Amy Florence</td>
<td>Shelby Wiedmann</td>
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<td>Jason Fodeman</td>
<td>Sarah Walker, UW CoLab</td>
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<td>Charissa Fotinos</td>
<td>Morgan Young, L&amp;I</td>
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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
<table>
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<tr>
<td>Darcy Jaffe (chair)</td>
<td>Washington State Hospital Association</td>
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<tr>
<td>Shelley Bogart</td>
<td>DSHS-DDA</td>
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<td>Gloria Brigham, EdD, MN, RN</td>
<td>Washington State Nursing Association</td>
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<td>Amy Cole, MBA</td>
<td>MultiCare</td>
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<td>Jay Cook, MD, MBA</td>
<td>Providence</td>
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<td>Billie Dickinson</td>
<td>Washington State Medical Association</td>
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<td>Kelli Emans</td>
<td>DSHS</td>
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<td>Jeff Foti, MD</td>
<td>Seattle Children's</td>
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<td>Jas Grewal</td>
<td>Washington State Health Care Authority</td>
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<td>Karla Hall, RN</td>
<td>PeaceHealth</td>
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<td>Kathleen Heim, MSN, RN</td>
<td>PeaceHealth</td>
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<tr>
<td>Carol Hiner, MSN</td>
<td>Kaiser Permanente</td>
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<tr>
<td>Linda Keenan, PhD, MPA, BSN, RN-BC</td>
<td>UnitedHealthcare</td>
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<tr>
<td>Jen Koon, MD</td>
<td>Premera Blue Cross</td>
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<td>Danica Koos, MPH</td>
<td>Community Health Plan of Washington</td>
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<td>Cathy MacEnraw, MSW</td>
<td>Providence</td>
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<tr>
<td>Elena Madrid, RN</td>
<td>Washington Health Care Association (WHCA)</td>
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<td>Colin Maloney, MPH</td>
<td>WA DOH</td>
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<td>Amber May, MD</td>
<td>Kaiser Permanente</td>
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<td>Liz McCully, MSW</td>
<td>Swedish</td>
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<td>Jason McGill, JD</td>
<td>WA HCA</td>
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<td>Kellie Meserve, MN, RN</td>
<td>Virginia Mason Franciscan Health</td>
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<td>Tracey Mullian, MSW</td>
<td>Swedish</td>
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<td>Kim Petram, BSN</td>
<td>Valley Medical Center</td>
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<td>Lou Reyes</td>
<td>Swedish</td>
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<td>Sheridan Rieger, MD</td>
<td>Concerto Health</td>
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<td>Odilliah Sangali</td>
<td>WA DOH</td>
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<td>Zosia Stanely, JD, MHA</td>
<td>Washington State Hospital Association</td>
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<td>Cyndi Stilson, RN, BSN</td>
<td>Community Health Plan of Washington</td>
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<td>Ric Troyer, MD</td>
<td>Iora Health</td>
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<tr>
<td>Janice Tufte</td>
<td>PICORI West Ambassador/Hassanah Consulting</td>
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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
• 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**.
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
· 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.
Voting Period
Diabetes

Presented by Chair Norris Kamo, MD

1:35-1:50
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<th>Name</th>
<th>Title</th>
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<tbody>
<tr>
<td>Norris Kamo, MPP (chair)</td>
<td>Section Head, Adult Primary Care</td>
<td>Virginia Mason Medical Center</td>
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<tr>
<td>Susan Buell</td>
<td>Health and Wellness Director</td>
<td>YMCA of Tacoma and Pierce County</td>
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<tr>
<td>LuAnn Chen, MD, MHA</td>
<td>Medical Director</td>
<td>Community Health Plan of Washington</td>
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<td>Sharon Eloranta, MD</td>
<td>Medical Director, Performance Measurement and Practice</td>
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<tr>
<td>Rick Hourigan, MD</td>
<td>Market Medical Executive</td>
<td>Cigna</td>
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<td>Carissa Kemp, MPP</td>
<td>State Government Affairs and Advocacy Director</td>
<td>American Diabetes Association</td>
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<tr>
<td>Vickie Kolios, MSHSA, CPHQ</td>
<td>Program Director, Surgical and Spine COAP</td>
<td>Foundation for Health Care Quality</td>
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<tr>
<td>Robert Mecklenberg, MD</td>
<td>Medical Director (retired)</td>
<td>Virginia Mason Medical Center</td>
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<td>Mamatha Palanati, MD</td>
<td>Family Medicine</td>
<td>Kaiser Permanente</td>
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<td>Khimberly Schoenacker, RND, CSP, CD</td>
<td>CYSHCN Program</td>
<td>WA Department of Health</td>
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<td>Cynthia Stilson, RN, BSN, CMM</td>
<td>Care Management Manager</td>
<td>Community Health Plan of Washington</td>
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<tr>
<td>Sally Sundar</td>
<td>Program Executive, Health Integration and Transformation</td>
<td>The Y of Greater Seattle</td>
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<tr>
<td>Nicole Treanor, MS, RD, CD, CDCES</td>
<td>Diabetes Care and Education Specialist</td>
<td>Virginia Mason Franciscan Health</td>
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<td>Leah Wainman</td>
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<td>WA Department of Health</td>
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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

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>Evidence Review Topics</th>
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| **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**

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<th>Employer Purchaser</th>
<th>Dental Plan</th>
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<tr>
<td>• The WA HCA Health Technology Clinical Committee (HTCC) should consider re-reviewing the coverage of Continuous Glucose Monitoring devices.</td>
<td>• 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).</td>
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<td>• Review benefits to ensure adequate behavioral health coverage.</td>
<td>• Fully cover dental exams for members with diabetes at least every 6 months.</td>
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<td>• Ensure contracted health plans follow health plan guidance above; if self-funded, review the health plan guidance above, where appropriate.</td>
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<td>• Ensure health plans provide coverage for remote patient monitoring codes</td>
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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 **CHWs** 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

• 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
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<td>Trish Anderson, MBA, BSN</td>
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<td>Aphrodyi Antoine, MPH, MBA</td>
<td>Health Related Services Administration</td>
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<td>Kristin Hayes, MSW</td>
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<td>Libby Hein, LHMC</td>
<td>Children's Home Society of Washington</td>
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<td>Mandy Herreid, MN</td>
<td>United Healthcare</td>
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<tr>
<td>Kay Jackson, CNM, ARNP</td>
<td>Off the Grid Midwifery and Health</td>
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<td>Ellen Kauffman, MD, FACOG</td>
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<td>Jillian King, DNPC</td>
<td>University of Washington</td>
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<td>Gina Legaz, MPH</td>
<td>March of Dimes</td>
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<td>Jennifer Linstad, CNM</td>
<td>Center for Birth</td>
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<td>MaryEllen Maccio, MD</td>
<td>Valley Medical Center</td>
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<td>Patricia Morgan, ARNP</td>
<td>Evergreen Health</td>
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<td>Sheryl Pickering</td>
<td>WA Department of Health, WIC</td>
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<td>Ashley Pina</td>
<td>WA Health Care Authority</td>
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<td>Sarah Pine</td>
<td>WA Health Care Authority</td>
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<td>Katie Price, LICSW</td>
<td>Katie Price Therapy</td>
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<td>Brianne Probasco</td>
<td>WA Association of Community Health</td>
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<td>Monica Salgaonkar, MHA</td>
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<td>Beth Tinker, PhD, MPH, MN, RN</td>
<td>WA Health Care Authority</td>
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<td>JanMarie Ward, MPA</td>
<td>American Indian Health Commission</td>
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<td>Josephine Young, MD, MPH, MBA</td>
<td>Premera</td>
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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

<table>
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<tr>
<th>Focus Area</th>
<th>Action Steps</th>
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| 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)
• **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.
• **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
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

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