FOUNDATION FOR
Health Care Quality

Mountain Climber Award Winners 2025
Project Summaries

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Award Background

In 2022, the Foundation for Health Care Quality (FHCQ) and the Bree Collaborative developed an awards program to recognize organizations that have high fidelity with Bree guidelines and that have worked to embed equity into their best practices.

Award Submissions

Organizations that have previously won a Trailblazer Award for fidelity with Bree Guidelines are eligible to submit details on how they have embedded equity into the topic.

Submission and judging processes

On presentation of the Trailblazer award, organizations are sent an email inviting them to provide further information on the equity aspects of the topic. (See Appendix A)

Between February and June, a panel of judges representing different health care ecosystem stakeholders and decision makers is convened. In 2025, these judges represented quality improvement specialists, payors, patient safety advocates, and patient advocacy groups. Submissions are de-identified for review, and judges use a standardized judging form to score projects on impact, patient satisfaction, comprehensive strategies, adequate accountability processes, addressing social drivers of health, and adaptability of the program.

Award Summaries

The organizations that have received these awards represent different actors in the health care system. Community Health Plan of Washington (CHPW) is a non-profit health plan created by

federally qualified health centers. CHPW has been striving to embed equity into their Diabetes Care programs with focuses on community input and provider partnerships.

Kaiser Permanente Washington (KP Washington) is a large, integrated health system that has won this award for their work in Perinatal Behavioral Health. KP Washington's focus is on improving systemwide measurement, processes, and developing additional resources for patients.

Virginia Mason Franciscan Health St. Francis hospital (VMFH St. Francis) is a small hospital which is part of a larger health system, and this award was given for the work done in their Family Birth Center. The focus of their work is on improving equity within their best practice bundle for perinatal mood and anxiety disorders.

For Bree guidelines to be successful, many organizations need to have fidelity with them across all levels of the health care system. Similarly, for patients to experience an equitable health care system, equity needs to be embedded into best practices at all levels of the health care system.

These organizations represent the spirit of the Bree Collaborative and the Foundation for Health Care Quality as they strive to implement and improve practices that create good health for all the patients they serve.

Community Health Plan of Washington – Diabetes Care

Programs and strategies

Community Health Plan of Washington (CHPW) has put forth several programs and initiatives to address health quality priorities, including special resources, attention, and efforts to address Diabetes Care through the Diabetes HbA1c Control measure. This work has been done in specific programs to address disparities based on geographical location, race/ethnicity, spoken languages, Community Health Centers (CHCs), etc. The activities to implement their Diabetes work were assessed for alignment with Bree Collaborative recommendations and include:

- A dedicated team of Certified Diabetes Care and Education Specialists (CDCES) Registered Dietitians (RDN) and a Case Manager Registered Nurse (RN) working collaboratively to provide a robust, evidence-based foundation for diabetes management.
- A Health Coaches and Diabetes Educators team that have partnered with the Equity & Quality Performance team to deliver at-home A1c tests paired with health coaching to provide education and support on diabetes management.
- Implementation of the Community Health Network of Washington Community Transformation Incentive program, which provides funding and technical support to our CHC partners to create innovative, equitable interventions and programs to address healthcare inequities.

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- Regional Care Teams (RCTs), which leverage their regional knowledge and relationships to address specific diabetes-related disparities in their regions.
- CHPW Health Coaches and Diabetes Educators teams which proactively reach out to members with gaps in A1c to offer health coaching and share educational materials.

CHPW uses two methods for identifying disparities. First, they use their statewide organizational average as the benchmark to compare other racial, ethnic, and linguistic groups and look for disparities in care that are greater than 5%. Second, they look at the highest performing demographic group within the measure as the benchmark and compare other groups to that benchmark.

CHPW has a team dedicated to addressing SDOH and is focusing on recruiting and hiring more diverse staff, particularly those who are bilingual and who have experience with the challenges of not having access to all health-promoting social drivers of health (SDOH).

Leveraging national accreditation is a primary equity strategy for CHPQ. Current they are planning for the National Committee of Quality Assurance (NCQA)'s Health Equity Accreditation Plus (HEA+) which focuses on the collection, storage, and use of SDOH data, requires enhanced community-based partnerships and contracting, stakeholder engagement and meaningful evaluation efforts, and further stratification and evaluation for demographic factors (race, ethnicity, language, sexual orientation, gender identity, etc.).

Strategies for developing partnerships include Regional Care Teams (RCTs), strong ties with Community Health Centers (CHCs), and reliance on teams across the organization whose roles and responsibilities are to strengthen our partnerships with the community.

CHPW supports its providers by giving several of the CHCs in our network $50,000 annual funding for a Community Transformation Initiative to create equity programs to improve diabetes care in their communities and ensure that community members, leaders, and organizations are involved in designing programs.

Accountability and training

CHPW's Health Disparities Reduction work, and specifically their diabetes measures, are directly tied to their annual strategic plan goals, which help hold staff and leadership accountable for their work to reduce disparities. To keep staff updated on the progress, they provide monthly updates, hold in-service meetings, utilize member-facing teams to gain insight into the usefulness of their interventions, identify gaps in care, and continue to develop or improve resources for patients.

Diabetes educator teams at CHPW work with patients and families to provide comprehensive diabetes education sessions covering essential topics such as nutrition, medication management, physical activity, food resources, referrals to community health workers and case management, and coping strategies. Their North Central and Greater Columbia regional care teams have worked with members from the communities experiencing diabetes-related

disparities, including patients and families in decision-making and program development that provides additional accountability for the team members.

To ensure that staff are accountable and have the education, training and knowledge to advance equity, CHPW has required annual, new hire, and optional training and educational opportunities, including:

- Foundational Equity/Culturally and Linguistically Appropriate Services (CLAS)
- all translation and interpretation services
- training on understanding and serving tribal communities
- training on providing care for sexual and gender minorities
- requiring CEU courses on diabetes management and/or relevant medical nutrition therapy topics through online webinars, in-person conferences, or other teleconference options
- Offering monthly townhall series on a variety of equity topics
- CHPW is currently developing a “Social Drivers of Health” (SDOH) training to go live in 2025

Buy-in and overcoming barriers

CHPW sought buy-in from leadership to make equity a key component of their diabetes work. Tools that they have used to elicit buy-in include community advisory councils, member advisory councils, and other committees, town halls and focus groups.

To ensure patient satisfaction CHPW collects qualitative feedback for their diabetes programming and measure patient satisfaction through a member satisfaction survey that is distributed to any members who have engaged with diabetes education or care management. (Appendix B)

Finding culturally and linguistically responsive diabetes resources that are relevant to our communities and being able to validate them, training staff on them, was a primary barrier that CHPW had to overcome. When trying to partner with CHCs they heard feedback that even if they have the resources, the time and capacity to train staff on them or find and fund bilingual staff was a real barrier. To address this barrier CHPW is working to develop, translate, and validate tools homegrown tools which includes creating a pilot diabetes education (in English and Spanish) intervention paired with access to diabetes management tools (Continuous Glucose Monitors (CGMS) and at-home A1c tests) as well as increasing the number of bilingual staff.

Another barrier to imbedding equity into best practices is the complexity of providing self-management tools (CGMs), including cost, workflows, reimbursement, requirements for eligibility, staffing capacity, training, and patient comfort. To address this CHPW is bringing together multidisciplinary teams including providers, CHCs, researchers at UW, their diabetes

educator team, and their finance/reimbursement team to design a comprehensive plan to provide CGMs to patients in the most effective way possible.

Policies and procedures

Health Equity Program Description and Evaluation documents are one example of some of the polices that CHPW employs which hold the organization accountable to CLAS standards and are used to monitor and oversee our overarching Health Disparities Reduction work. Culturally and Linguistically Appropriate Services (CLAS) are reviewed and updated annually.

One example of a successful process that CHPW uses is to have diabetes educators call and speak with their members with diabetes to understand their needs and how they can best support them. This process helps to provide individualized, whole-person care, setting tailored goals to support effective diabetes self-management.

Measurements

During the development of this work CHPW engaged in conversations with internal staff, national equity leaders, community members, and others to determine the benchmarks are most appropriate to use for their equity work. They use the HEDIS measure HBD: Hemoglobin A1c Control for Patients with Diabetes, HbA1c Poor Control (>9.0%) and then stratified the metric by race, ethnicity, and language to identify inequities within our member population and by various demographic indicators,

To collect data patient satisfaction data CHPW staff went to Fiestas Mexicanas, a community event held during Hispanic Heritage Month, and distributed surveys to solicit patient feedback on their experiences with our diabetes resources, and what additional resources might help them better manage their diabetes. Surveys were offered in English and Spanish.

CHPW has not yet specifically measured the impact of addressing SDOH factors such as food, transportation, education, and cost on the diabetes disparities.

Those who are interested in learning more about CHPW's work can review supplemental information on:

- Diabetes A1c Fishbone Diagram (Root Cause Analysis)
- At Home A1c Workflow
- A1c Pilot Program FAQ
- North Central RCT Diabetes Project Poster *(presented at the Sea Mar Latino Health Forum 2024)*

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Kaiser Permanente of Washington – Perinatal Behavioral Health

Programs and strategies

KP Washington incorporated community voices into the medical group's programmatic development across the organization with the Equity Governance Collaborative (EGC) as part of the strategy for reducing disparities in Perinatal Behavioral Health (PBH). The EGC is a standing board committee which started in April of 2021 in collaboration with their board of directors. It includes representatives from equity leaders across the organization along with designates from four other standing board committees, at large employee members, and currently has nine community members as full voting members. This group is responsible for oversight of the Anti-Racism Strategic Plan which was adopted by the board of directors in December 2020.

KP Washington employs many different strategies to communicate with patients about their equity work. Leadership has ordered lanyards, badge reels, t-shirts, and label pins celebrating black maternal health. The aim is for frontline clinicians to be able to visibly express their support and increase BIPOC patients' psychological safety. During Black Maternal Health Week (April 11-17) clinics had patient-facing materials for pregnancy visible in waiting areas which include information about equity and mental health. KP Washington also leveraged videos including information for pregnant people and new parents on topics such as *Emotions and Changes in Pregnancy, Mental Health for New Parents, Getting the Care You Need, Self-Care for New and Expecting Parents,* and *After Childbirth: Your Fourth Trimester, Coping with Difficult Birth Experiences.*

Accountability and training

KP Washington staff have access to several equity-related programs and training related to learning about equity and interacting/communicating with patients through a lens of equity. Leaders are required to participate in equity-related programming and are encouraged to consider equity in communication with team members. Leadership encourages employees to raise concerns around equity, as well as to practice patience and compassion when receiving feedback. Their organization holds a monthly "Equity Matters CME series" open to all clinicians and staff. For example, the Equity Matters CME held on April 18, 2025, focused on Black Maternal Health. Presenters covered maternal health disparities, Black Maternal Health Week, and culturally responsive care, aiming to raise awareness and provide actionable insights for improving maternal health outcomes.

A seven-page job aid on Perinatal Mental Health Screening provides support and additional training. It includes sections on mental health screening during pregnancy and during well baby visits with sub-sections for postpartum patients who have received care within the organization and those who received care outside of the organization.

Additionally, KP Washington has developed guidance on "Promoting Equity, Inclusion, and Diversity (EID) in Recruitment" with tools to provide inclusive, culturally sensitive care and recognizing bias.

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Standard training practices include:

- All providers receive training and practice in thoughtful and respectful communication with patients and their team members
- Through our Leadership Pathway, leaders receive training and skills practice opportunities to lead inclusively and support their whole team including how to address personal biases
- Access to tools like the Intercultural Development Inventory (IDI)
- Access to a diverse group of external coaches that can reflect and expand the cultural perspectives of the leaders receiving coaching

Buy-in and overcoming barriers

One of KP Washington's primary strategies to address buy-in is leveraging groups of residents and faculty which came together in 2017 to establish RPrIDE (Residents Promoting Inclusion, Diversity, and Equity). RPrIDE engages deeply with the community, creating and leading workshops—from training on microaggressions to broader initiatives presented at CME-accredited conferences.

A barrier implementing their equity work, that KP Washington identified through analysis of their HEDIS data, was that they were not meeting goal on postpartum visit completion. They addressed this barrier by utilizing the E-STAR program. E-STAR is a learning system research project. This is a partnership with scholars who are recent PhD graduates applying their research skills to solve health system problems.

The second barrier, which was identified through interviews, was that clinicians have not had clarity about how to manage postpartum mental health concerns, especially outside of OBGYN/Midwifery. This barrier was addressed by 1) updated clinical flows to ensure postpartum mental health concerns are looped back to OBGYN/Midwifery/Family Medicine, 2) implementing a collaborative care model which is population based mental health care embedded within primary care.

Finally, a current barrier to improving equity is that there is no process in place for partner mental health screenings. KP Washington continues to work on ways to increase awareness of postpartum partner mental health, EPIC-based alerts for primary care to be aware of "new parent" status and gathering and disseminating resources on partner mental health.

Policies and procedures

KP Washington leverages many policies and procedures to embed equity into their best practices. Their organization has standardized screenings for mental health at the intake visit, 16-week visit, 32-week visit, and post-partum visit. If there is a history of mental health concerns, screening can be done more regularly. KP Washington has created job aids to help at point-of-care with interpretation of screening tools and coding/documentation.

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An evidence-based "Perinatal Depression Guideline" is available for all clinicians within the organization. This guideline was updated in 2024. In addition, they have an "Opioid Use Disorder Diagnosis and Treatment Guideline" which includes a section around opioid use disorder during pregnancy.

Currently, the organization is revamping their OB/pregnancy intake process to ensure all newly pregnant patients are fully aware of their prenatal care provider options (OB, CNM, FMOB) and move forward with a provider type they feel comfortable with (assuming clinically appropriate). KP Washington is also in the process of launching many new tools and processes to improve Perinatal Behavioral health care, including:

- moving towards adding an alert to the EPIC chart for primary care to note whether a patient is within that first year of parenthood and adding ticklers to SmartSets to remind clinicians to address this aspect of mental health care.
- Launching a new tool called "Pregnancy Care Companion," which will be available on the MyChart app. Initially, this will launch in English and then will be translated to Spanish. It may include other languages based on the vendor's (EPIC) capabilities.

One example of processes to address SDOH is that every patient who is brought in for an OB intake with a registered nurse is sent a social drivers of health screener in advance of their appointment. KP Washington is also working on standardizing the process for screening for intimate partner violence.

Measurements

KP Washington uses four different measures for depression that can be broken down by clinical location, age, race, ethnicity, language, sexual orientation, gender identity, hearing loss, speech loss, vision loss. Their performance benchmarks represent the HEDIS 90th percentile across National HMO plans for performance in 2023.

- prenatal depression screening
- prenatal depression follow-up
- postpartum depression screening
- postpartum depression follow-up

To measure patient satisfaction KP Washington uses Press Ganey surveys which are comprehensive medical practice surveys with questions about access, moving through the medical visit, nursing/medical assistants, care provider, care coordination, personal concerns, and overall assessment. They also used Real-Time Feedback Surveys, which are a mobile-based member and patient feedback tool deployed in all locations served, to collect patient experience data (both qualitative and quantitative) following clinician interaction. All survey results are consolidated into a dynamic dashboard that is visible to leaders and clinic managers allowing staff to adjust for any issues in real time and celebrate successes.

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To measure the effectiveness of their social health integration screening and evaluations program, KP Washington conducted a pilot from August of 2021 to January of 2023 at two different clinical sites which looked at overall screening rates and top member needs.

Those who are interested in learning more about KP Washington's award submission can reach out to the Foundation for Health Care Quality at fhcq@qualityhealth.org or to knicholas@qualityhealth.org .

VMFH St. Francis Hospital – Perinatal Behavioral Health

Programs and Strategies

VMFH St. Francis has implemented a best practice bundle for all inpatients surrounding assessment of and care for patients experiencing perinatal mood and anxiety disorders that includes 3 elements:

1. Every patient is assessed with the Edinburg Postnatal Depression Screening tool within 12 hours of discharge
2. There is a clear process for patients with scores of 10 or above or answer "Yes" to question 10
3. There is a goal that all patients receive education about perinatal mood and anxiety disorder prior to discharge

Accountability and Training

VMFH St. Francis requires ongoing training for use of the Edinburg Postnatal Depression Screening tool and PMAD education are provided to staff monthly, along with transparency around compliance rates and goals.

The organization continues to train on addressing SDOH. This is done through the Pathways (online) education modules, which are assigned to all staff about perinatal mental health and social drivers of health. They also conduct system wide town halls held via webinar for all staff and EMR education provided in person, via email, via tipsheets, and in staff meetings.

Buy-in and overcoming barriers

Staff buy in was one barrier that VMFH St. Francis encountered when they were implementing this project. It was identified through town halls, in person rounding, staff meetings and ultimately addressed by providing just-in-time teaching, reviewing evidence that supports this practice, and discussing in meetings the impact this has on patients.

Social work resource availability was another important barrier which was recognized when they experienced delays in social work consultations and documentation that were not entered in real time. VMFH St. Francis addressed this by collaborating with social work department to create plan for how to mobilize resources available, and prioritize patients being seen before discharge.

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Documentation, in general, was also a barrier for this project since there were multiple places to document care and missing documentation. VMFH St. Francis addressed this through staff education in meetings, tipsheets placed on unit and emailed to staff, discussion during safety huddles, closing the loop for any fallout cases via both one-on-one discussion and emails.

Policies and procedures

A primary supporting policy for embedding equity was that the screening tools and education provided to patients are made available in 30+ languages, and it is required that when discussing/providing education. The staff use an interpreter for any patient that is not English speaking when:

- In communication about the program with patients and families
- In communication about the program with community

Their general policy supporting this project is titled “Perinatal Mood Anxiety Disorder and Suicide Risk Screening in the Family Birth Center” (see links below). It outlines how to screen, what actions to take based on the result, and what education is required for every patient.

Measurement

Compliance for the best practice bundle is measured as all bundle elements being completed prior to discharge. VMFH St. Francis is working to stratify this data across race and ethnicity and primary language spoken with an ultimate goal of a 90% compliance average over 12 months overall, as well as in each race/ethnicity category.

To measure patient satisfaction VMFH St. Francis is using HCAPs surveys post discharge.

To evaluate the effectiveness of their SDOH interventions, VMFH St. Francis utilizes data pulled from the EMR in real time as well as retrospective data and chart review done for all fallout cases in which they did not meet the standards of assessment, treatment, and providing support prior to discharge.

Those who are interested in learning more about VMFH St. Francis work can review supplemental information on:

- Suicide Safety Plan Template
- EPIC Maternal Mental Health Tip Sheet
- Perinatal Mood and Anxiety Patient Education
- Perinatal Mood and Anxiety Disorder Policy
- PMADs EPDS algorithm

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Appendix A – 2025 Mountain Climber Award Submission Form

Organization name:

Organization type:

Organization department or site (if applicable):

Submitter name:

Submitter email address:

Submitter title or position:

Submitter phone number:

Description of awards process:

We will convene a panel of judges from a diverse group of organizations that represent patients or other health care users and Bree stakeholders to review the awards submissions.

The panel members are blinded to the identity of the organizations and score each on both qualitative and quantitative criteria. Quantitative criteria include self-report score cards. Qualitative criteria include the questions on this form (below) and review of supporting documentation. Judges will be asked to rate your work on impact, patient satisfaction, comprehensiveness of strategies, adequacy of accountability processes, effectiveness of addressing Social Drivers of Health, and adaptability (to other organizations or programs).

FHCQ will post deadlines and award focus area timelines for each awards period on the FHCQ website and provide deadline information to nominees.

Definition of implementation:

Implementation means use of a guideline in part or full during clinical practice, health care contracting, policy making, educational programs, or other health care related activities; and/or use of guidelines to fulfill elements of an initiative, regulation, or requirements.

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Please indicate the health care service for which Bree Collaborative has developed guidelines to be considered. This work should exemplify efforts in creating EQUITY within a single service line, program, or policy. Please make sure that all of your answers are de-identified. We will use the information at the top to link your information to your organization once

List of Bree reports-

Obstetrics Care, Cardiology: Appropriateness of Percutaneous Coronary Interventions, Spine/Low Back Pain, Addiction and Dependence Treatment, End-of-Life Care, Potentially Avoidable Hospital Readmissions, Oncology Care: Early Treatment, Prostate Cancer Screening, Coronary Artery Bypass Graft Surgical Warranty, Behavioral Health Integration, Opioid Use Disorder Treatment, Pediatric Psychotropic Use, Warranty for Bariatric Surgery, Alzheimer's Disease and Other Dementias, Hysterectomy, Dental Opioid Prescribing, Total Knee and Total Hip Replacement bundle, Collaborative Care for Chronic Pain, LGBTQ Health Care, Suicide Care, Lumbar Fusion Bundle and Warranty, Opioid Prescribing: Long-Term Opioid Therapy, Post Operative Opioid Prescribing, Palliative Care, Risk of Violence towards others, Shared Decision Making, Colorectal Cancer Screening, Oncology Care Inpatient Services, Primary Care, Sexual and Reproductive Health, Cervical Cancer Screening, Telehealth, Perinatal Bundled Payment Model, Opioid Prescribing in Older Adults, Outpatient Infection Control, Hepatitis C, Pediatric Asthma, Perinatal Behavioral Health, Complex Discharge, Diabetes Care

Overall description of project:

Q1) How did your organization measure change in ***equity for the health outcomes*** *for* the topic the organization sought to address?

a) What metrics did you use?
b) How did you revise or stratify these metrics to provide a better view of equity?
c) How did you determine appropriate benchmarks?

Q2) How did your organization measure patient satisfaction?

a) What metrics did you use?

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b) What survey methods did you use?

Q3) How does your organization maintain accountability for equity within the program for the following areas:

a) Communication
    a. In communication about the program with staff and leadership
    b. In communication about the program with patients and families
    c. In communication about the program with community
b) Education and training
c) Through policies, procedures, or activities

Q4) How did your organization address social drivers of health? (list all that apply)

a) In workforce hiring, training, and development
b) With programs and/or policies changes
c) What measures did your organization use to evaluate the effectiveness of the efforts to address social needs?

Q5) What strategies did your organization use to:

a) To understand patient needs
b) To develop community partnerships
c) To address power imbalances

Q6) Describe the ease of implementation in embedding equity into this program. What helped facilitate an equitable approach to the development or improvement of this program? (e.g. staffing diversity, leadership buy-in, community feedback, regulatory changes, funding changes, etc.)

What were some of the main barriers to success in your setting?

A) Barrier 1 –
    a. What was it?
    b. How did you identify it?
    c. How did you address it?
B) Barrier 2 –
    a. What was it?
    b. How did you identify it?
    c. How did you address it?
C) Barrier 3 –
    a. What was it?

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b. How did you identify it?
c. How did you address it?

Q7) Please include other information that you believe made this project successful in terms of equity. You may want to consider such aspects as types of staff education, changes in workflows, use of data, culture change work, details on payment or contracting solutions, collaborations, etc.

Examples: It is helpful to attach any examples of documents relevant to your project such as screen shots, workflow map, policy language, contract language, process prompts, posters, communication language, etc.) These can be attached in the email or attached through the submission portal. In previous years, successful applicants have attached charts and graphs, screen shots, sample documents as examples. *Please make sure that your examples are de-identified.*