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"Mountain Climber" Award Application Form 2025

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.

Nomination pathways:

For questions P1 and P2, please indicate which nomination pathway has nominated you for this award and answer the question appropriate for that pathway:

P1) The Bree Collaborative topic: **Perinatal Behavioral Health**

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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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

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.

P2) The Washington Patient Safety Coalition (project):

Perinatal Behavioral Health

Equity award application form:

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?
   a. We capture several metrics for HEDIS related to Perinatal Behavioral Health including rates of prenatal depression screening, prenatal depression follow-up, postpartum depression screening, and postpartum depression follow-up. These screenings can be broken down by clinical location, age, race, ethnicity, language, sexual orientation, gender identity, hearing loss, speech loss, vision loss.

Note: See screenshots of this data on the next pages along with breakdown by racial/ethnic groups.

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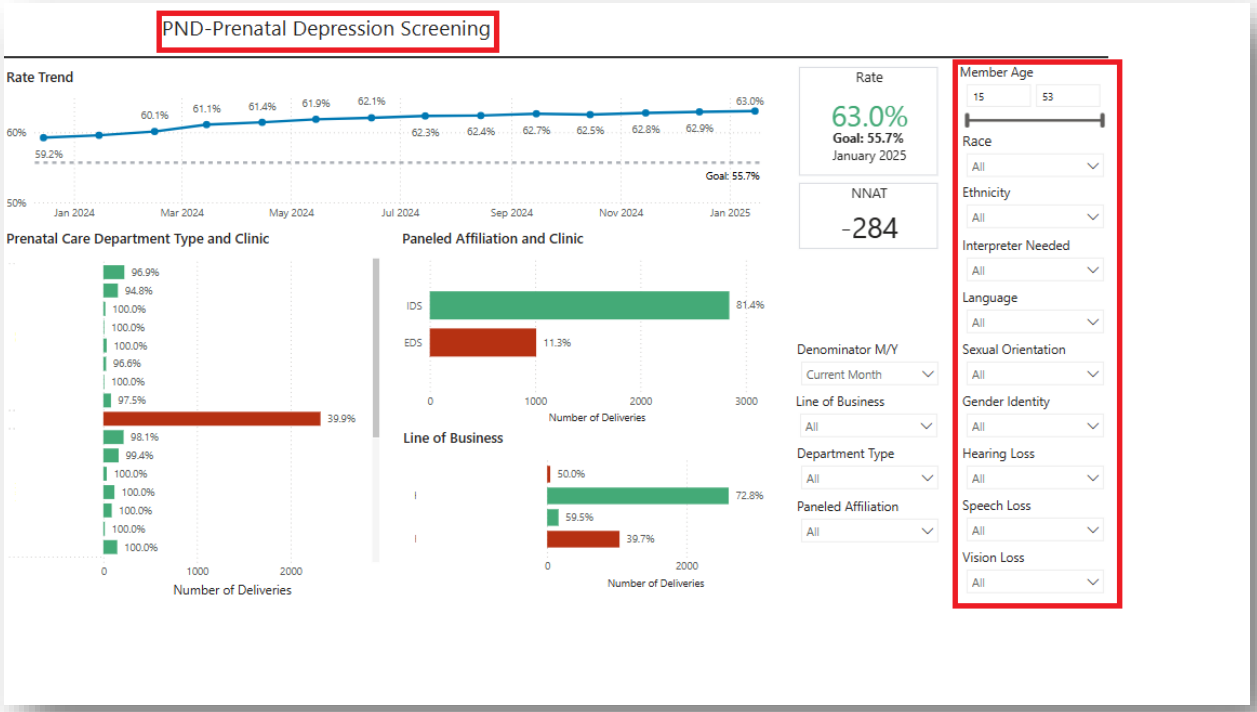

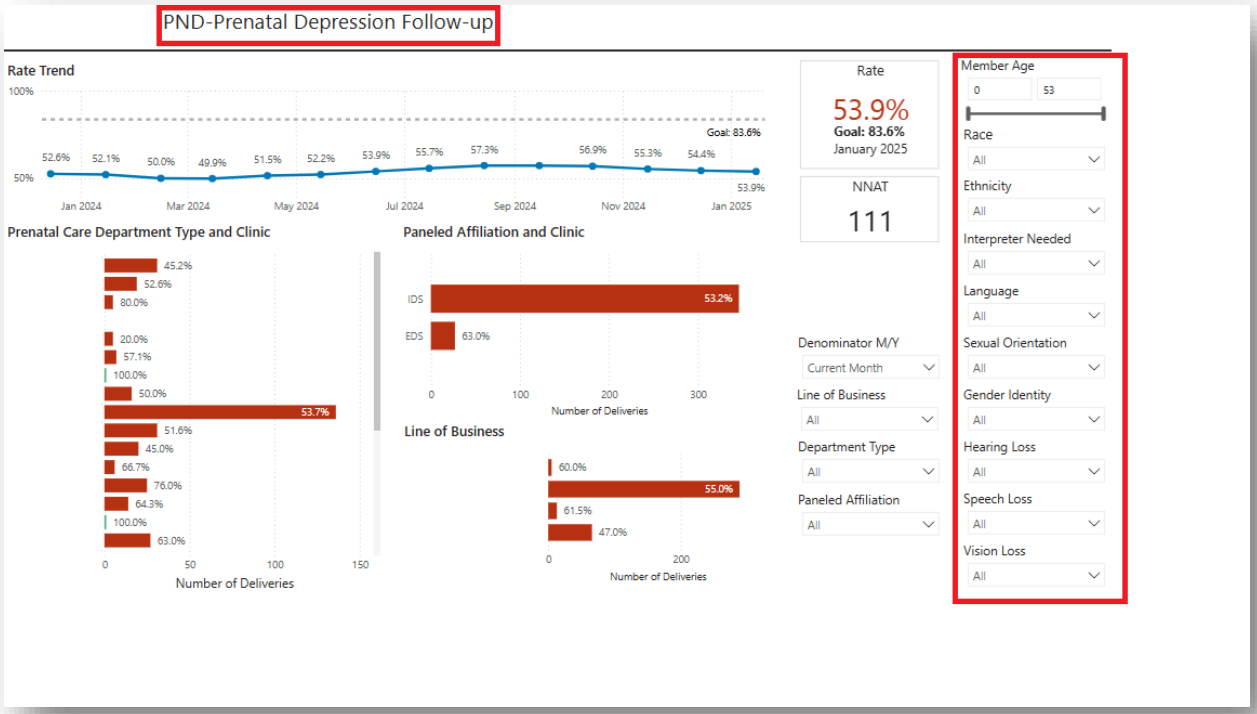

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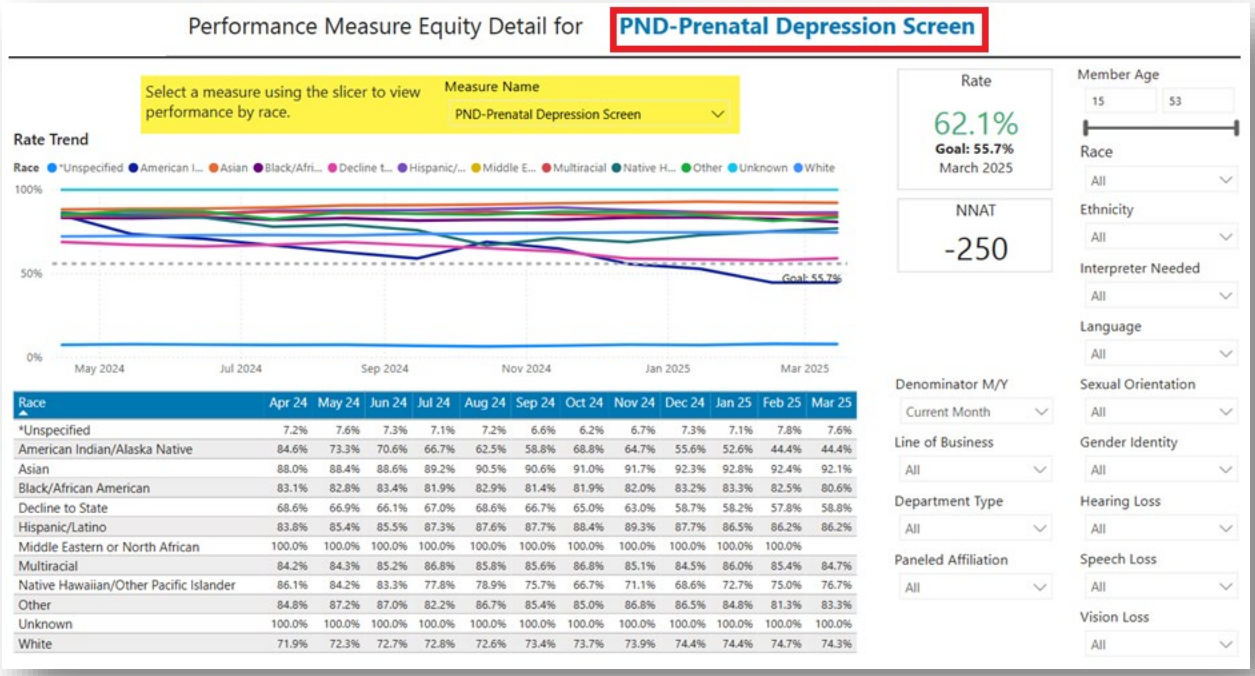
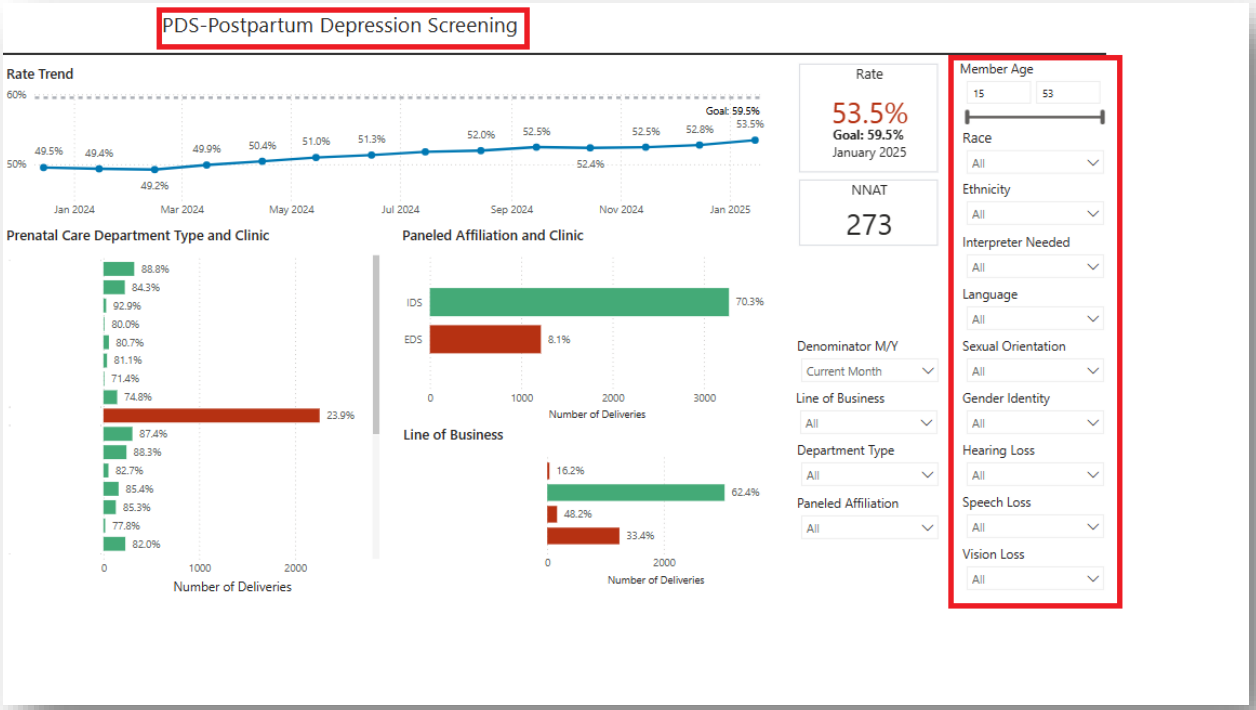


Race	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
*Unspecified	7.2%	7.6%	7.3%	7.1%	7.2%	6.6%	6.2%	6.7%	7.3%	7.1%	7.8%	7.6%
American Indian/Alaska Native	84.6%	73.3%	70.6%	66.7%	62.5%	58.8%	68.8%	64.7%	55.6%	52.6%	44.4%	44.4%
Asian	88.0%	88.4%	88.6%	89.2%	90.5%	90.6%	91.0%	91.7%	92.3%	92.8%	92.4%	92.1%
Black/African American	83.1%	82.8%	83.4%	81.9%	82.9%	81.4%	81.9%	82.0%	83.2%	83.3%	82.5%	80.6%
Decline to State	68.6%	66.9%	66.1%	67.0%	68.6%	66.7%	65.0%	63.0%	58.7%	58.2%	57.8%	58.8%
Hispanic/Latino	83.8%	85.4%	85.5%	87.3%	87.6%	87.7%	88.4%	89.3%	87.7%	86.5%	86.2%	86.2%
Middle Eastern or North African	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Multiracial	84.2%	84.3%	85.2%	86.8%	85.8%	85.6%	86.8%	85.1%	84.5%	86.0%	85.4%	84.7%
Native Hawaiian/Other Pacific Islander	86.1%	84.2%	83.3%	77.8%	78.9%	75.7%	66.7%	71.1%	68.6%	72.7%	75.0%	76.7%
Other	84.8%	87.2%	87.0%	82.2%	86.7%	85.4%	85.0%	86.8%	86.5%	84.8%	81.3%	83.3%
Unknown	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
White	71.9%	72.3%	72.7%	72.8%	72.6%	73.4%	73.7%	73.9%	74.4%	74.4%	74.7%	74.3%



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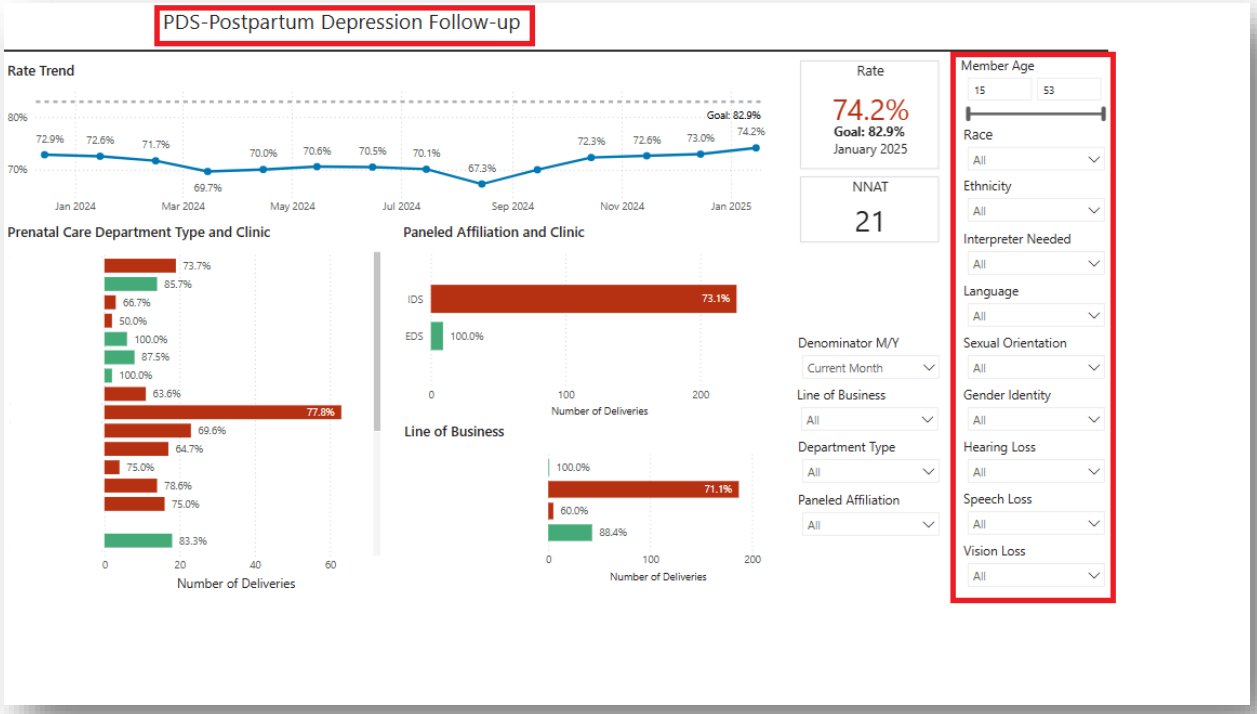

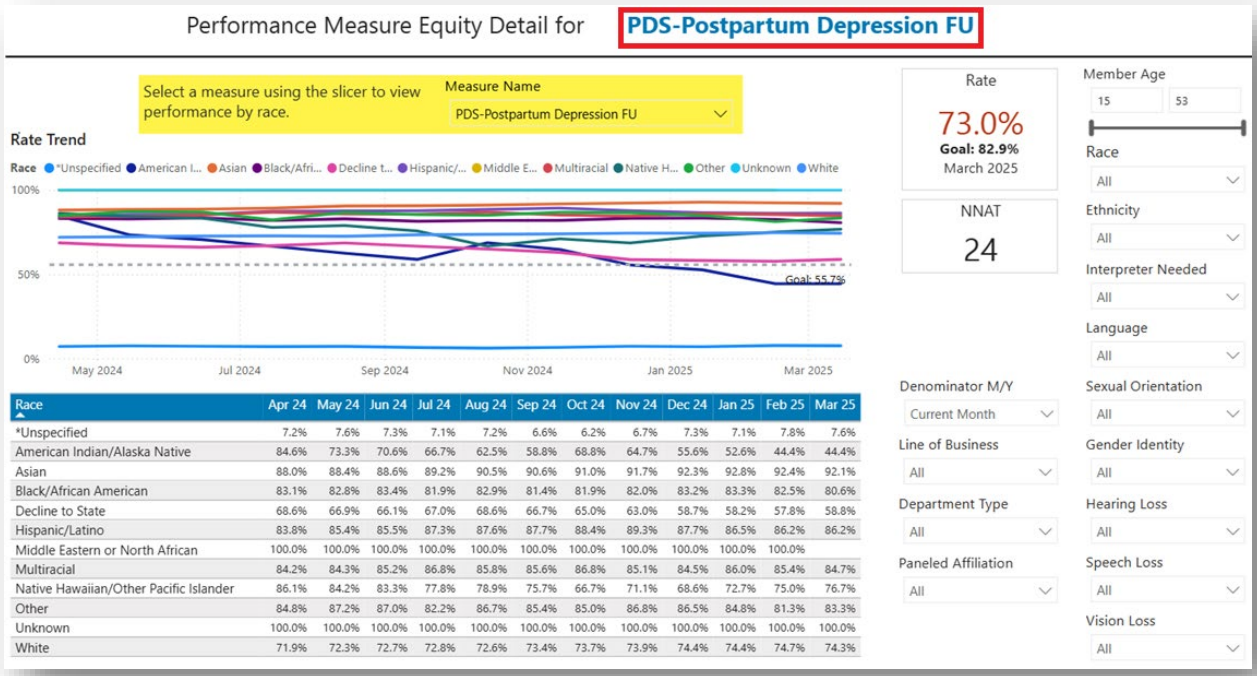

Race	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
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American Indian/Alaska Native	84.6%	73.3%	70.6%	66.7%	62.5%	58.8%	68.8%	64.7%	55.6%	52.6%	44.4%	44.4%
Asian	88.0%	88.4%	88.6%	89.2%	90.5%	90.6%	91.0%	91.7%	92.3%	92.8%	92.4%	92.1%
Black/African American	83.1%	82.8%	83.4%	81.9%	82.9%	81.4%	81.9%	82.0%	83.2%	83.3%	82.5%	80.6%
Decline to State	68.6%	66.9%	66.1%	67.0%	68.6%	66.7%	65.0%	63.0%	58.7%	58.2%	57.8%	58.8%
Hispanic/Latino	83.8%	85.4%	85.5%	87.3%	87.6%	87.7%	88.4%	89.3%	87.7%	86.5%	86.2%	86.2%
Middle Eastern or North African	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Multiracial	84.2%	84.3%	85.2%	86.8%	85.8%	85.6%	86.8%	85.1%	84.5%	86.0%	85.4%	84.7%
Native Hawaiian/Other Pacific Islander	86.1%	84.2%	83.3%	77.8%	78.9%	75.7%	66.7%	71.1%	68.6%	72.7%	75.0%	76.7%
Other	84.8%	87.2%	87.0%	82.2%	86.7%	85.4%	85.0%	86.8%	86.5%	84.8%	81.3%	83.3%
Unknown	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
White	71.9%	72.3%	72.7%	72.8%	72.6%	73.4%	73.7%	73.9%	74.4%	74.4%	74.7%	74.3%

b) How did you revise or stratify these metrics to provide a better view of equity?
    a. As noted above, this data can be further stratified into clinical location, age, race, ethnicity, language, sexual orientation, gender identity, hearing loss, speech loss, vision loss. The "Equity Detail" view was added to provide a single view of the trend over time by racial category.
c) How did you determine appropriate benchmarks?
    a. Our benchmarks represent the HEDIS 90th percentile for performance across National HMO plans for performance in 2023.

Q2) How did your organization measure patient satisfaction?

a) What metrics did you use?
    a. We collect data on patient satisfaction through 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. The data from Press Ganey can be further aggregated into different demographic groups.
    b. Additionally, we use Real-Time Feedback Surveys, which are a mobile-based member and patient feedback tool deployed in all locations we serve to collect patient experience data (both qualitative and quantitative) following a 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.
b) What survey methods did you use?
    a. Refer to above.

Note: See screenshots of the experience ratings for Midwifery/OB/Gyn and Real-Time Feedback Surveys on next pages.

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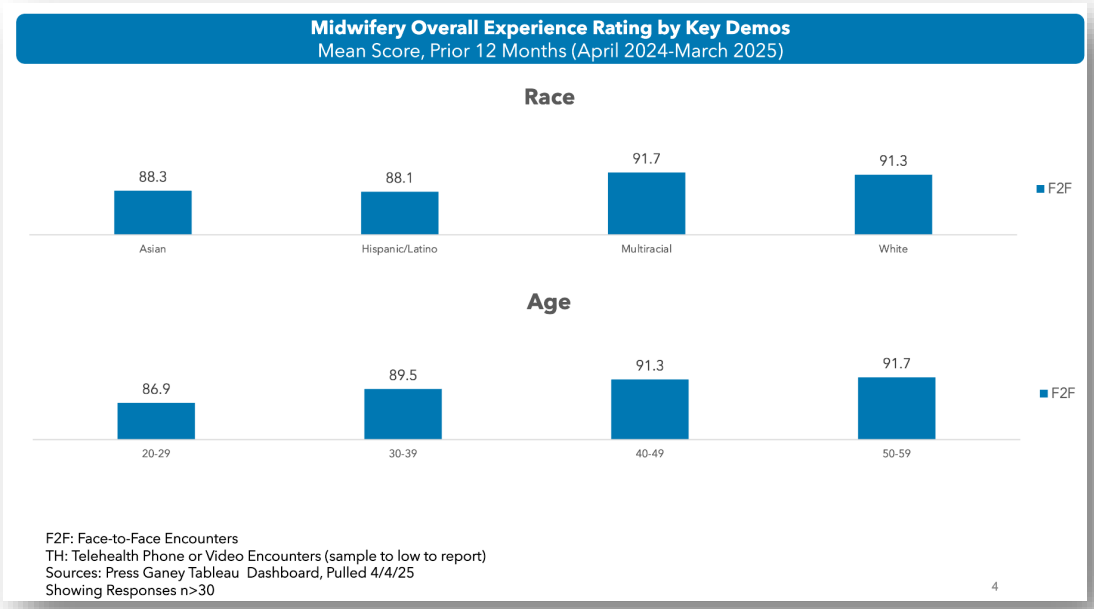
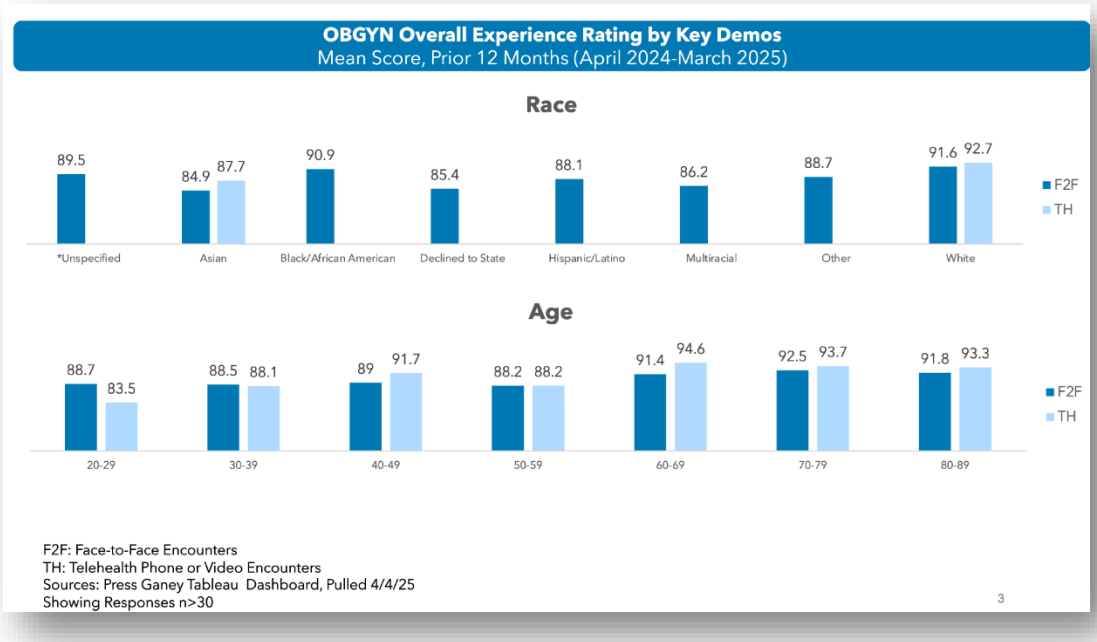
Press Ganey Surveys





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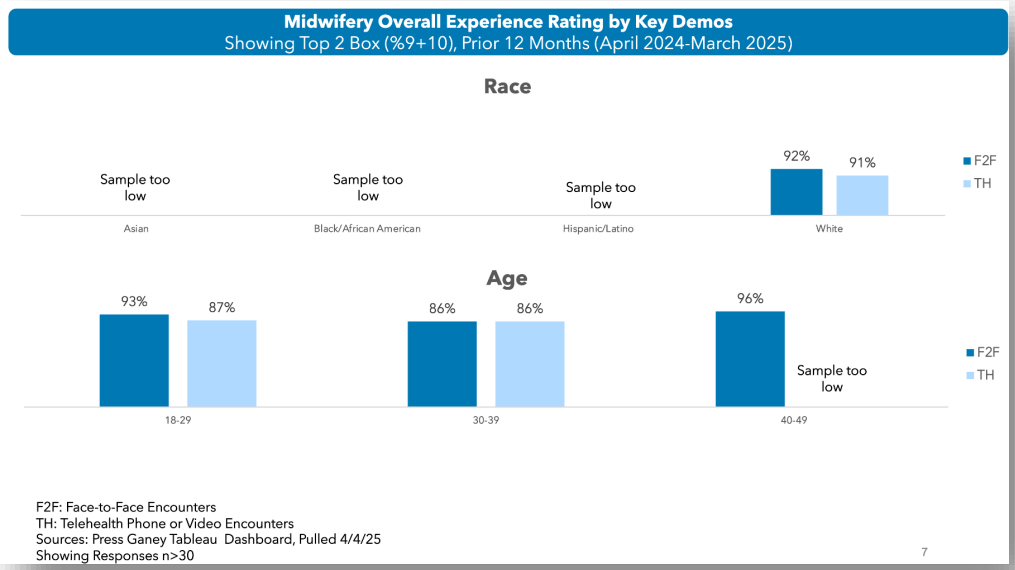
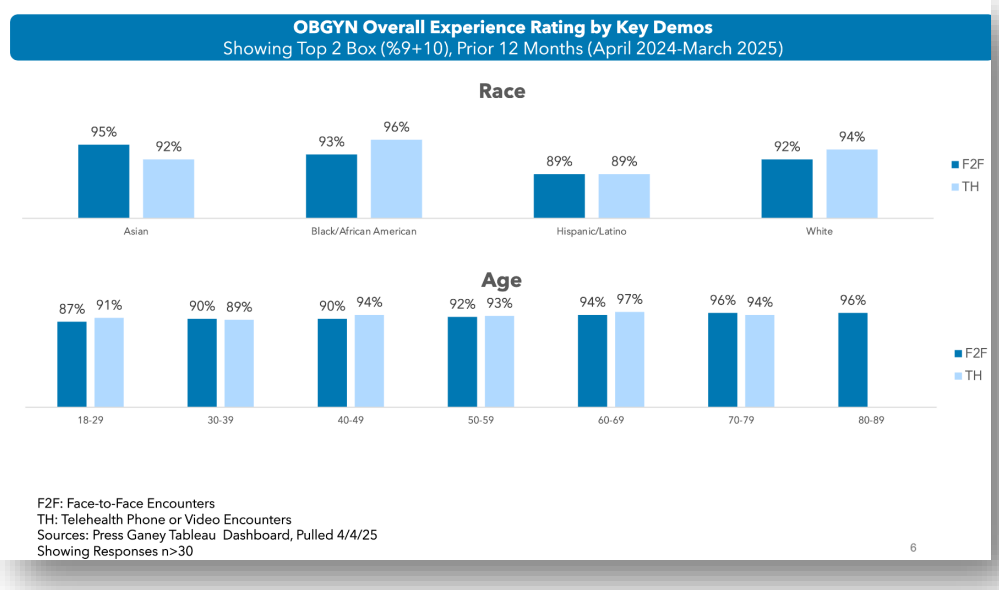
Real-Time Feedback Surveys: % of patients who indicated 9 or 10 out of 10 for question #1 of the survey.





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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
        i. 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.
        ii. Leaders are required to participate in equity-related programming and are encouraged to consider equity in communication with team members.
        iii. Leadership encourages employees to raise concerns around equity, as well as to practice patience and compassion when receiving feedback.
        iv. Our organization holds a monthly "Equity Matters CME series" open to all clinicians and staff. 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.

Note: See screenshots of some of the presentation slides below.

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Equity Matters CME – April 18, 2025
12:15-12:45 pm
Black Maternal Health

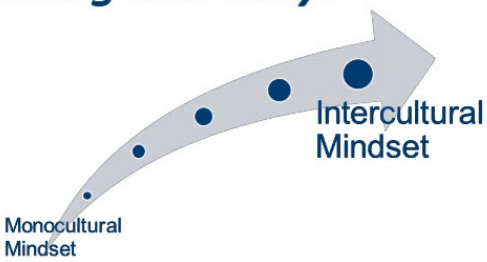
Presenters -
[redacted] DNP, CNM, ARNP
[redacted] EID Consultant

Equity Matters

Culturally Responsive Care Seminars for Staff and Clinicians
Third Fridays in 2025, 12:15-12:45 pm

Build awareness of equitable care goals, showcase effective practices, build cultural humility and equip the people of with skills and tools to deliver equitable care.

Activating Our Why!



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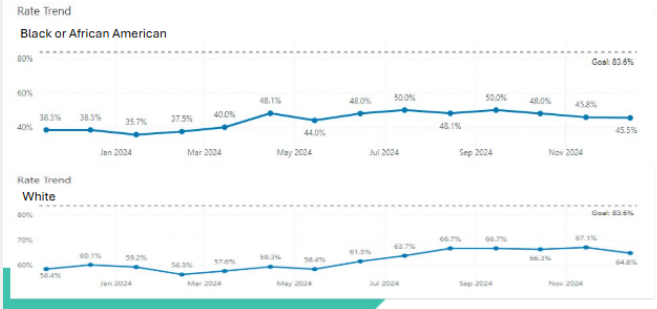
The Data

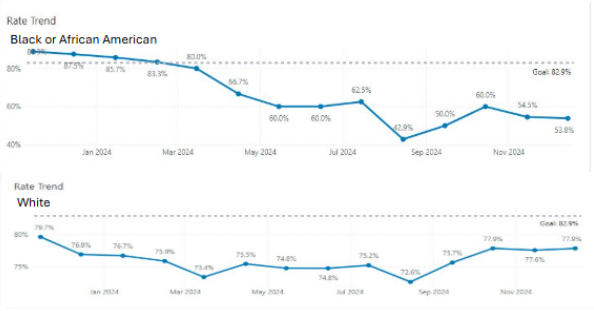
(12/2024)	Prenatal Depression Screen	Prenatal Depression Follow-up	Postnatal Depression Screen	Postnatal Depression Follow-up
Total respondents	62.9%	54.4%	52.8%	73.0%
"White"	74.4%	64.8%	62.1%	77.9%
"Black or African American"	83.8%	45.5%	63.6%	53.8%
(GOAL)	55.7%	83.6%	59.5%	82.9%

- In 2023, the maternal mortality rate for non-Hispanic Black people was 50.3 deaths per 100,000 live births, **nearly 3.5 times** the rate for non-Hispanic White women (CDC, 2025).
- Black gestational parents are **two-times more likely** to express suicidal ideation compared to their white counterparts (Tabb et al., 2020)
- **29-44%** of Black postpartum parents experience postpartum depression symptoms (NIH, 2023)

Prenatal Depression Follow-up



Postnatal Depression Follow-up



The How: Current Projects

Clinical safety

- Preconception
  - Medication safety + mental health
- Pregnancy
  - Telemedicine abortion program
  - Re-vamp OB intake process
  - Prenatal vaccines – eStar and "Celebrating our Communities" focus
  - Remote monitoring BP program?
- Postpartum
  - Update mental health job aid to ensure appropriate follow-up
  - Develop clinical pearl on partner mental health

General

- Critically evaluating how we screen for PPD (EPDS versus PHQ-9)
- Evaluate scheduling system + explore Epic-based scheduling reminders to increase perinatal care attendance, particularly in the postpartum period (01/2025 = 85.3% PP attendance)
- Update site with provider/patient-facing resources
  - Culturally specific information (e.g. personal care products)
  - Community-based organizations

b. In communication about the program with patients and families
    i. Leadership has ordered lanyards / badge reels / t-shirts / label pins celebrating black maternal health for frontline clinicians to be able to visibly express their support and increase BIPOC patients' psychological safety.
    ii. During Black Maternal Health Week (April 11-17) clinics had patient-facing materials visible in waiting areas to recognize this topic.
    iii. We have patient-facing materials for pregnancy that include information about equity and mental health. The equity statement reads:

> "[…] is committed to providing the best outcomes for all expecting parents and their families. Sadly, hundreds of people in the U.S. die each year from complications during and after pregnancy and childbirth. And Black people are 3 times more likely to die from pregnancy-related causes than white people.
>
> We're actively working to identify and address the causes of injury and death related to pregnancy, particularly for Black parents. Our goal is to be the best and safest place to have a baby. Some of the many steps we're taking include:
>
> - Training our clinicians and staff to recognize and avoid unconscious bias (the social stereotypes people form without being aware of them)
> - Expanding access to remote care, such as at-home blood pressure monitors
> - Using a program to prevent and treat one of the leading causes of pregnancy-related death — bleeding complications
> - Partnering with patients and family members of diverse backgrounds to hear their perspectives on quality and safety initiatives"

Note: See screenshot of patient facing website below.

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iv. Patient-facing material also includes videos about mental health and pregnancy:
    1. Emotions and Changes in Pregnancy
    2. Mental Health for New Parents
    3. Getting the Care You Need
    4. Self-Care for New and Expecting Parents
    5. After Childbirth: Your Fourth Trimester
    6. Coping with Difficult Birth Experiences
v. There is also a section with articles on “Caring for your mental and emotional health” which is divided into Pregnancy, Postpartum, and Relationships sub-sections. Each section has unique articles.
    1. Pregnancy:

a. How to reduce stress during your pregnancy
b. Manage anxiety and keep a positive body image
c. What to know about depression in pregnancy
d. Exercise and healthy weight gain during pregnancy

2. Postpartum
    a. What to know about postpartum depression
    b. Understanding postpartum emotions
    c. If it’s more than the baby blues, seek support
    d. Managing stress with a new baby
3. Relationships
    a. Relationships and emotion health during pregnancy
    b. Intimate partner violence
    c. Adjusting to life with your new baby

Note: See screenshot of patient facing website on next page with pages in English and Spanish.

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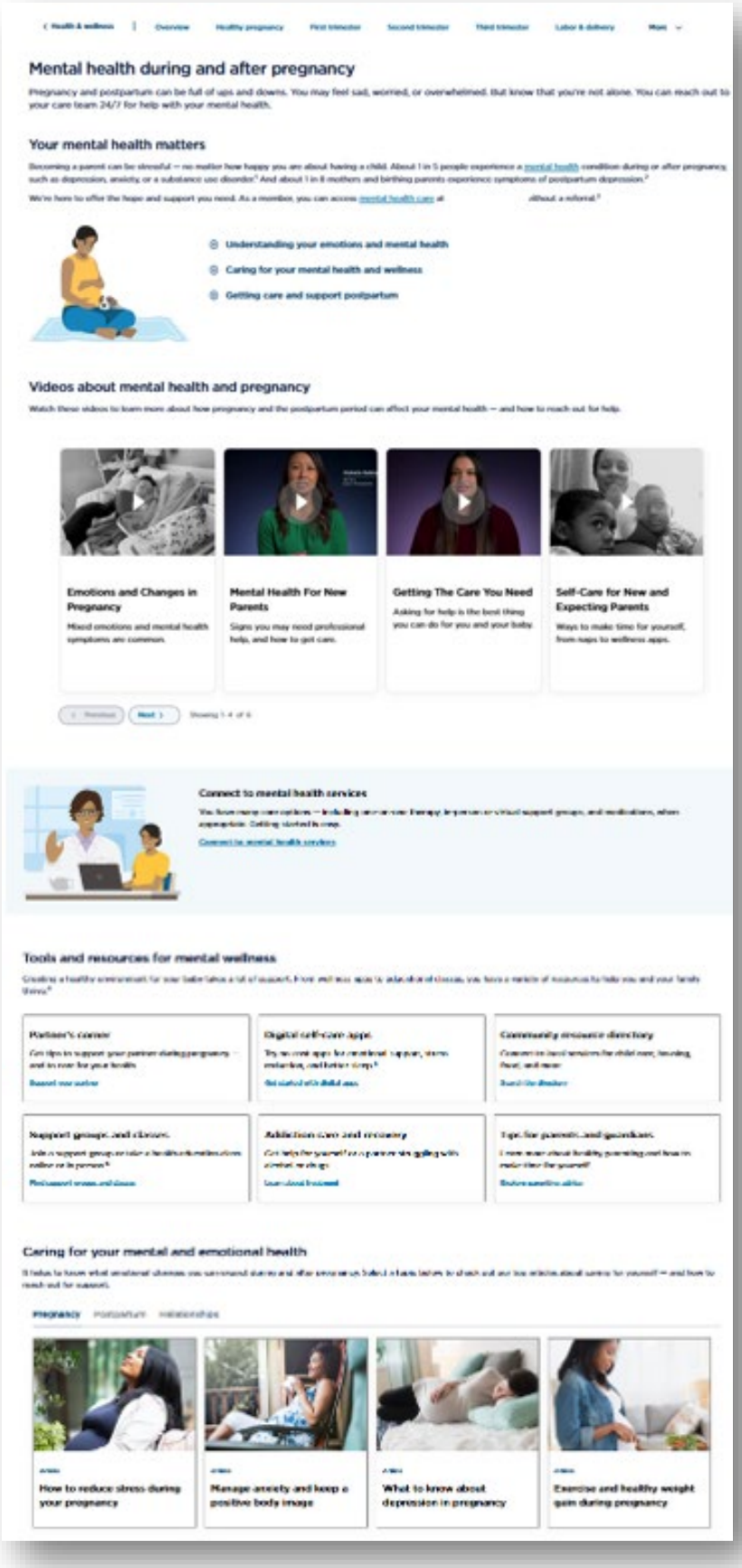

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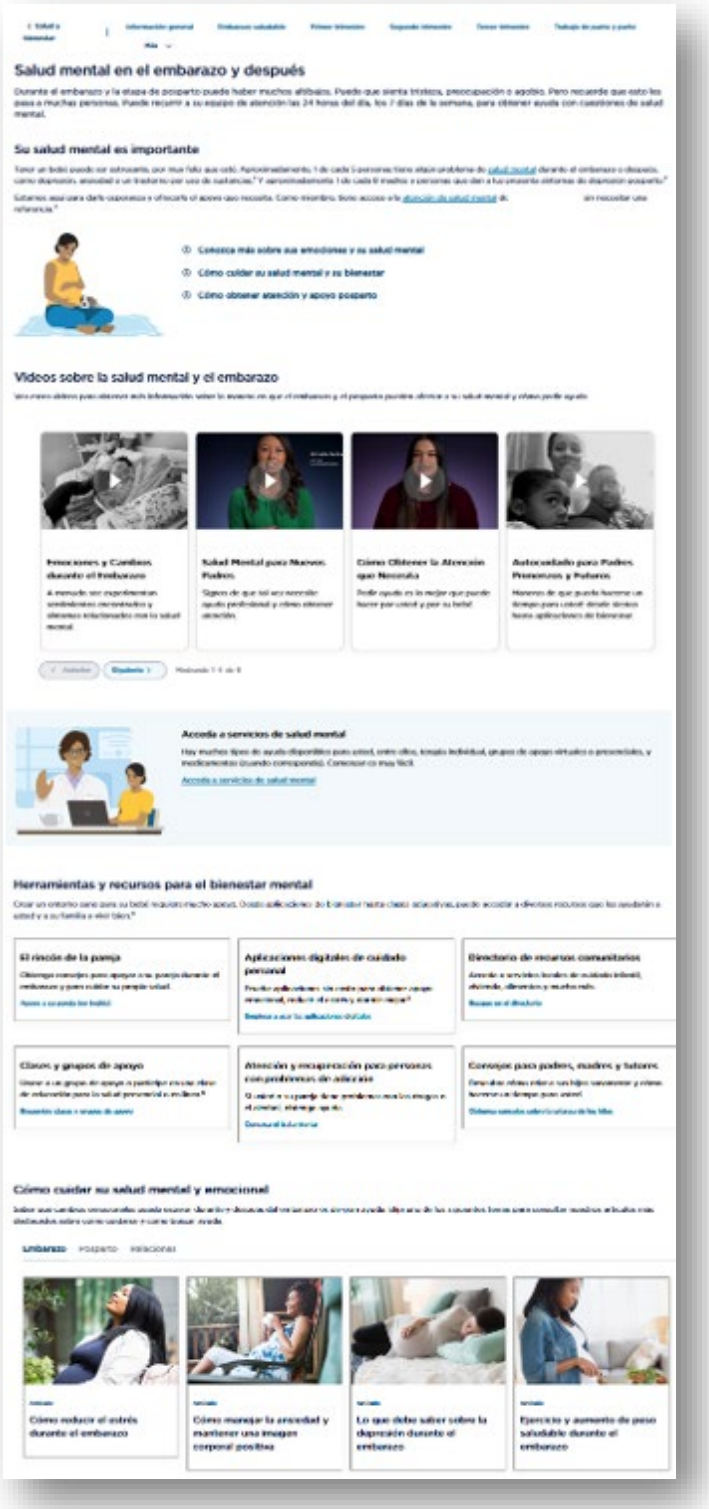
Spanish version:



c. In communication about the program with community
    i. Our organization has incorporated community voices into the medical group's programmatic development across the organization with the Equity Governance Collaborative (EGC). The EGC is a standing board committee which started in 04/2021 in collaboration with our 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 9 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. An achievement of the collaborative includes creation of a governance level dashboard which includes aggregated HEDIS measure broken out by race/ethnicity and employee diversity engagement by race/ethnicity, LGBTQIA and sex.

b) Education and training
    a. We have a seven-page Job Aid on Perinatal Mental Health Screening. This job aid is being updated to remove exclusionary language. This 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. There is priority outreach by our Mental Health & Wellness program for referrals received for pregnant patients.

Note: See screenshot of the first page of this screening tool on next page.

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Job Aid – Perinatal Mental Health Screening

Contents

Overview

Pregnant and postpartum patients are at higher risk for depression, anxiety, and domestic violence during pregnancy and for the first year of their baby's life. Therefore, routine screening using the Maternal Behavioral Health Screening (MBHS) questionnaire is recommended at the following routine visits:

Pregnancy Care (Midwifery, Obstetrics, or Family Medicine)	**Pediatric Care (Pediatrics or Family Medicine)**
• First prenatal visit • 16 week visit • 32 week visit • Postpartum (6wks post delivery)	• 7-14 day well baby visit • 4 month well baby visit • 6 month well baby visit • 12 month well baby visit

Mental Health Screening during Pregnancy Care

Flow Staff Rooming

If the patient did not fill out the questionnaire prior to their visit – **Provide the paper MBHS screen** at first face-to-face prenatal, 14-18 week, 32 week, and postpartum visits. Presenting the explanation side first will help the patient understand rationale for serial screening. Note: Asking the patient to read this statement eliminates the need for Release of information (ROI). Scripting: "We are screening all pregnant patients 3 times during pregnancy and at the post-partum visit. Could you please fill this out for me? "	**Why we do this Health Screening** Your well-being is very important to the health of your baby and family. During pregnancy and the first year of the baby's life, we ask all women about depression, anxiety, and safety issues. Being a new parent can be exciting, but also sometimes difficult both physically and emotionally. Asking these questions helps us know how you're doing and can help us connect you to care if needed. Please fill out the back of this form and let us know if you have any questions or concerns. We will enter this information in your medical record if you are a o your doctor knows how you're doing with the new baby. We're here to make sure you are both healthy and safe.
Provide additional questionnaires to assess higher risk responses as needed. These include the Substance Use Checklist and Alcohol Use Checklist. The provider will	"Following up Behavioral Health Screens" guides care for high-risk responses.

b. Once job aids and protocols/guidelines are finalized, these will be shared widely with all relevant clinicians and saved in appropriate clinical libraries.
c. We have standards in perinatal and postpartum SmartSets to include screenings on Mental Health. There are 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.

Note: See screenshot of screening tool, post-partum SmartSet, and clinical note on next pages.

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Name _____

Consumer Number _____

Date of Birth _____

Maternal Behavioral Health Screening

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watch television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
10. Feeling nervous, anxious or on edge	0	1	2	3
11. Not being able to stop or control worrying	0	1	2	3
12. Have your problems interfered with your work, family, or social activities?	0	1	2	3

Please answer these questions about your drinking and substance use in the last 3 months.

13. How often did you have a drink containing alcohol?	**Never** 0	**Monthly or less** 1	**2 to 4 times a month** 2	**2 to 3 times a week** 3	**4 or more times a week** 4
14. How many drinks containing alcohol did you have on a typical day when you were drinking?	**None** 0	**1 or 2 drinks** 0	**3 or 4 drinks** 1	**5 or 6 drinks** 2	**7 or 9 drinks** 3	**10 or more drinks** 4
15. How often did you have 4 or more drinks on one occasion?	**Never** 0	**Less than monthly** 1	**Monthly** 2	**Weekly** 3	**Daily or almost daily** 4
16. How often have you used marijuana?	**Never** 0	**Less than monthly** 1	**Monthly** 2	**Weekly** 3	**Daily or almost daily** 4
17. How often have you used an illegal drug or used a prescription medication for non-medical reasons?	**Never** 0	**Less than monthly** 1	**Monthly** 2	**Weekly** 3	**Daily or almost daily** 4
18. Do you have access to guns?	No	Yes			

Many health problems can be affected by stress in our relationships.
Making the connection can help you take steps toward better health.

19. Are you currently in a relationship where your partner hits, slaps, kicks, or hurts you?	No	Yes	Prefer not to answer
20. Does your partner control where you go or make you feel afraid?	No	Yes	Prefer not to answer
21. Have you ever had a partner who physically hurt or threatened you?	No	Yes	Prefer not to answer

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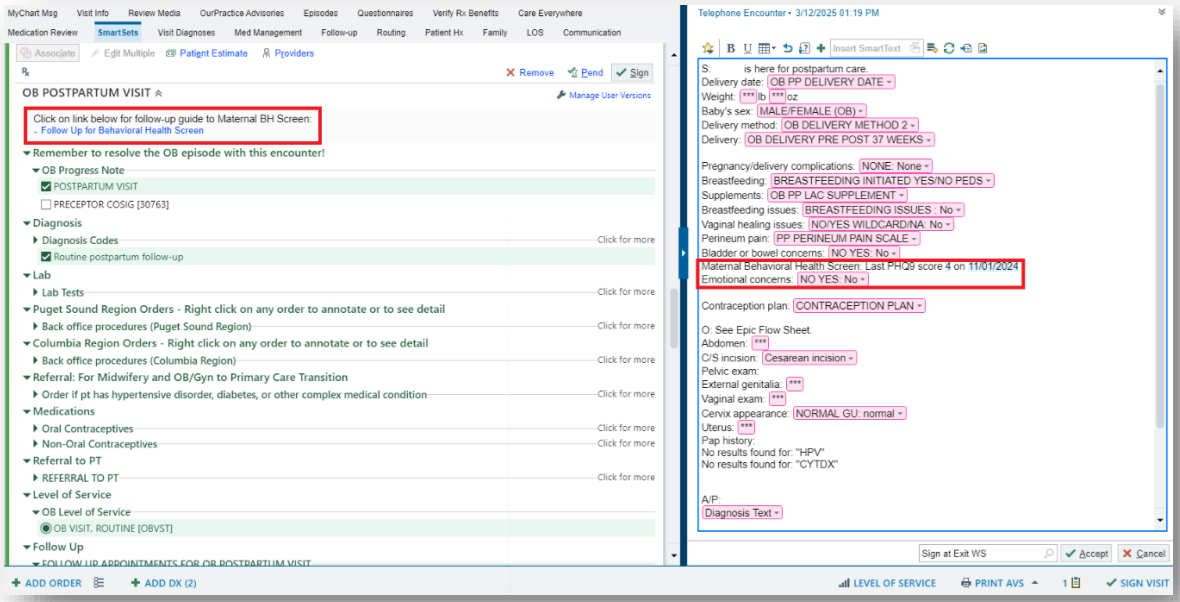
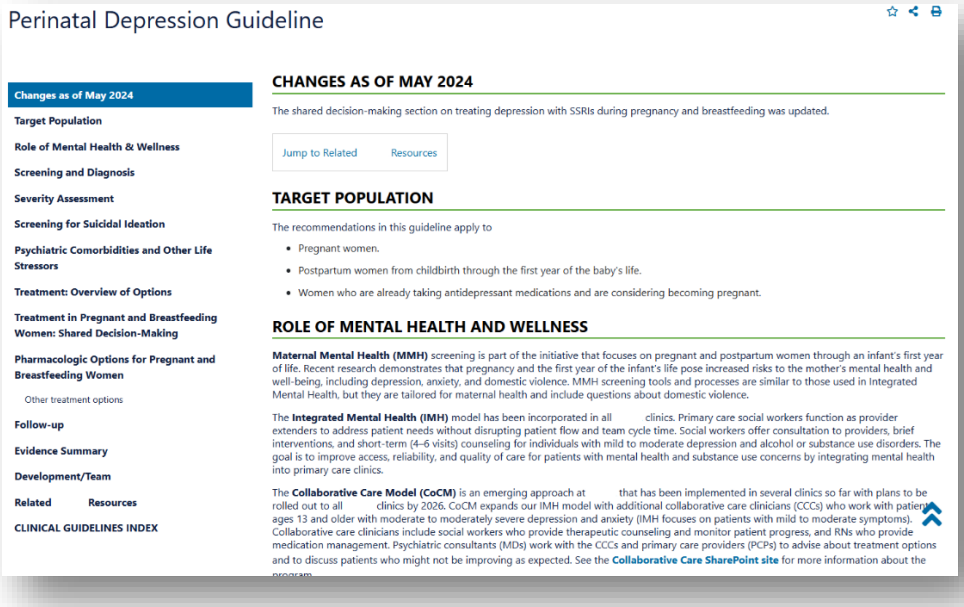


d. Additionally, we have a “Perinatal Depression Guideline” which is an evidence-based guideline available for all clinicians within the organization. This guideline was updated in 2024. We also have an “Opioid Use Disorder Diagnosis and Treatment Guideline” which includes a section around opioid use disorder during pregnancy.

Note: See screenshots of the guidelines and Clinical Update sent to clinicians below.



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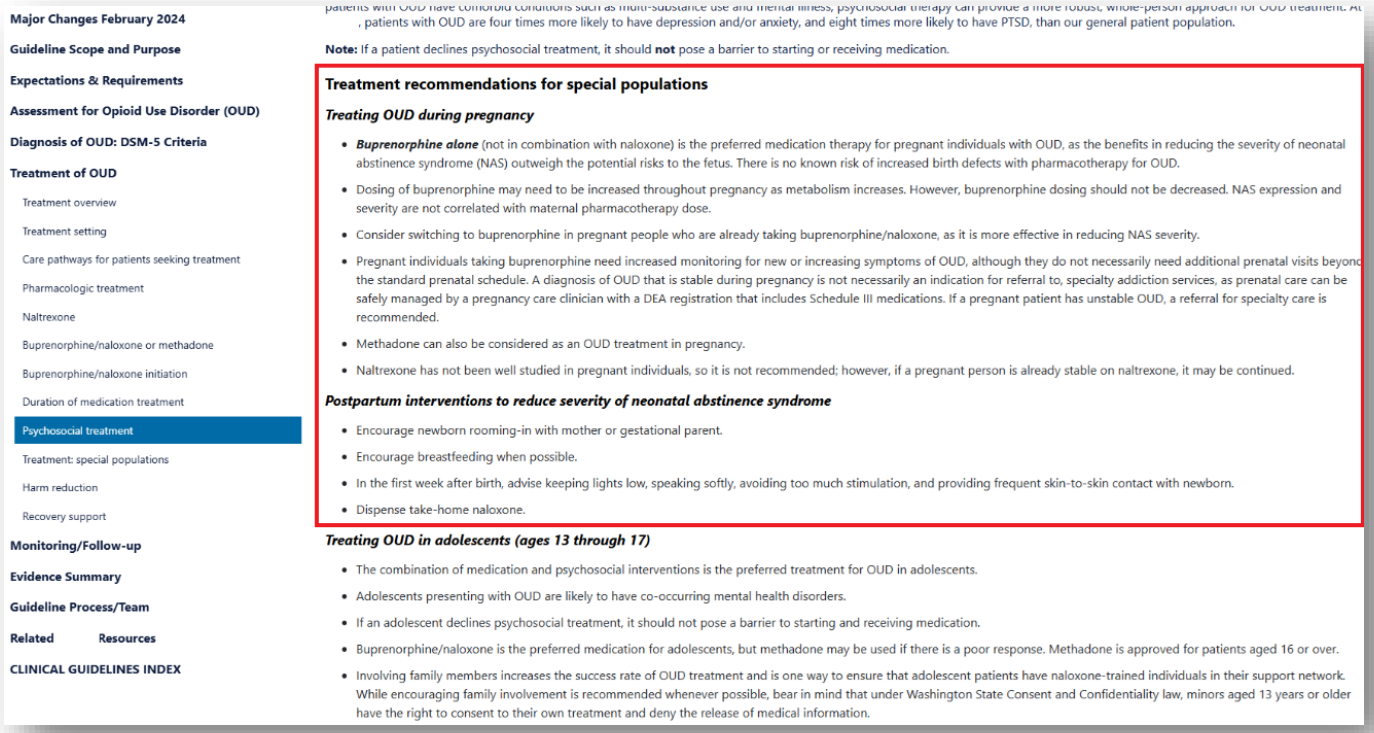
Opioid Use Disorder (OUD) Diagnosis and Treatment with subsections on "Treating OUD during pregnancy" and "Postpartum interventions to reduce severity of neonatal abstinence syndrome":



Major Changes February 2024
Guideline Scope and Purpose
Expectations & Requirements
Assessment for Opioid Use Disorder (OUD)
Diagnosis of OUD: DSM-5 Criteria
Treatment of OUD
- Treatment overview
- Treatment setting
- Care pathways for patients seeking treatment
- Pharmacologic treatment
- Naltrexone
- Buprenorphine/naloxone or methadone
- Buprenorphine/naloxone initiation
- Duration of medication treatment
- Psychosocial treatment
- Treatment: special populations
- Harm reduction
- Recovery support

Monitoring/Follow-up
Evidence Summary
Guideline Process/Team
Related Resources
CLINICAL GUIDELINES INDEX

, patients with OUD are four times more likely to have depression and/or anxiety, and eight times more likely to have PTSD, than our general patient population.

Note: If a patient declines psychosocial treatment, it should **not** pose a barrier to starting or receiving medication.

Treatment recommendations for special populations

Treating OUD during pregnancy

- ***Buprenorphine alone*** (not in combination with naloxone) is the preferred medication therapy for pregnant individuals with OUD, as the benefits in reducing the severity of neonatal abstinence syndrome (NAS) outweigh the potential risks to the fetus. There is no known risk of increased birth defects with pharmacotherapy for OUD.
- Dosing of buprenorphine may need to be increased throughout pregnancy as metabolism increases. However, buprenorphine dosing should not be decreased. NAS expression and severity are not correlated with maternal pharmacotherapy dose.
- Consider switching to buprenorphine in pregnant people who are already taking buprenorphine/naloxone, as it is more effective in reducing NAS severity.
- Pregnant individuals taking buprenorphine need increased monitoring for new or increasing symptoms of OUD, although they do not necessarily need additional prenatal visits beyond the standard prenatal schedule. A diagnosis of OUD that is stable during pregnancy is not necessarily an indication for referral to, specialty addiction services, as prenatal care can be safely managed by a pregnancy care clinician with a DEA registration that includes Schedule III medications. If a pregnant patient has unstable OUD, a referral for specialty care is recommended.
- Methadone can also be considered as an OUD treatment in pregnancy.
- Naltrexone has not been well studied in pregnant individuals, so it is not recommended; however, if a pregnant person is already stable on naltrexone, it may be continued.

Postpartum interventions to reduce severity of neonatal abstinence syndrome

- Encourage newborn rooming-in with mother or gestational parent.
- Encourage breastfeeding when possible.
- In the first week after birth, advise keeping lights low, speaking softly, avoiding too much stimulation, and providing frequent skin-to-skin contact with newborn.
- Dispense take-home naloxone.

Treating OUD in adolescents (ages 13 through 17)

- The combination of medication and psychosocial interventions is the preferred treatment for OUD in adolescents.
- Adolescents presenting with OUD are likely to have co-occurring mental health disorders.
- If an adolescent declines psychosocial treatment, it should not pose a barrier to starting and receiving medication.
- Buprenorphine/naloxone is the preferred medication for adolescents, but methadone may be used if there is a poor response. Methadone is approved for patients aged 16 or over.
- Involving family members increases the success rate of OUD treatment and is one way to ensure that adolescent patients have naloxone-trained individuals in their support network. While encouraging family involvement is recommended whenever possible, bear in mind that under Washington State Consent and Confidentiality law, minors aged 13 years or older have the right to consent to their own treatment and deny the release of medical information.

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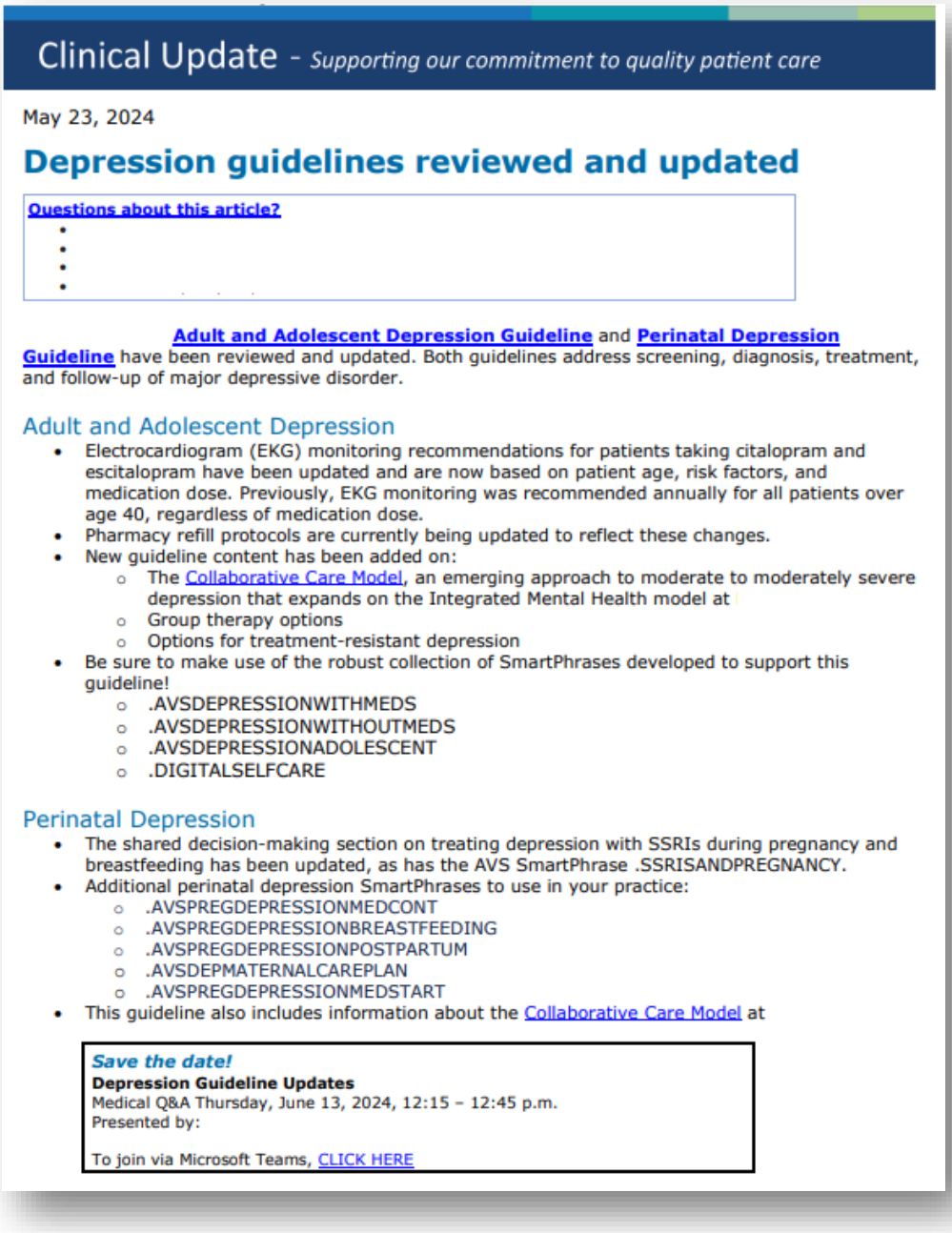


Clinical Update - *Supporting our commitment to quality patient care*

May 23, 2024

Depression guidelines reviewed and updated

Questions about this article?

-
-
-
-

Adult and Adolescent Depression Guideline and **Perinatal Depression Guideline** have been reviewed and updated. Both guidelines address screening, diagnosis, treatment, and follow-up of major depressive disorder.

Adult and Adolescent Depression

- Electrocardiogram (EKG) monitoring recommendations for patients taking citalopram and escitalopram have been updated and are now based on patient age, risk factors, and medication dose. Previously, EKG monitoring was recommended annually for all patients over age 40, regardless of medication dose.
- Pharmacy refill protocols are currently being updated to reflect these changes.
- New guideline content has been added on:
  - The Collaborative Care Model, an emerging approach to moderate to moderately severe depression that expands on the Integrated Mental Health model at
  - Group therapy options
  - Options for treatment-resistant depression
- Be sure to make use of the robust collection of SmartPhrases developed to support this guideline!
  - .AVSDEPRESSIONWITHMEDS
  - .AVSDEPRESSIONWITHOUTMEDS
  - .AVSDEPRESSIONADOLESCENT
  - .DIGITALSELFCARE

Perinatal Depression

- The shared decision-making section on treating depression with SSRIs during pregnancy and breastfeeding has been updated, as has the AVS SmartPhrase .SSRISANDPREGNANCY.
- Additional perinatal depression SmartPhrases to use in your practice:
  - .AVSPREGDEPRESSIONMEDCONT
  - .AVSPREGDEPRESSIONBREASTFEEDING
  - .AVSPREGDEPRESSIONPOSTPARTUM
  - .AVSDEPMATERNALCAREPLAN
  - .AVSPREGDEPRESSIONMEDSTART
- This guideline also includes information about the Collaborative Care Model at

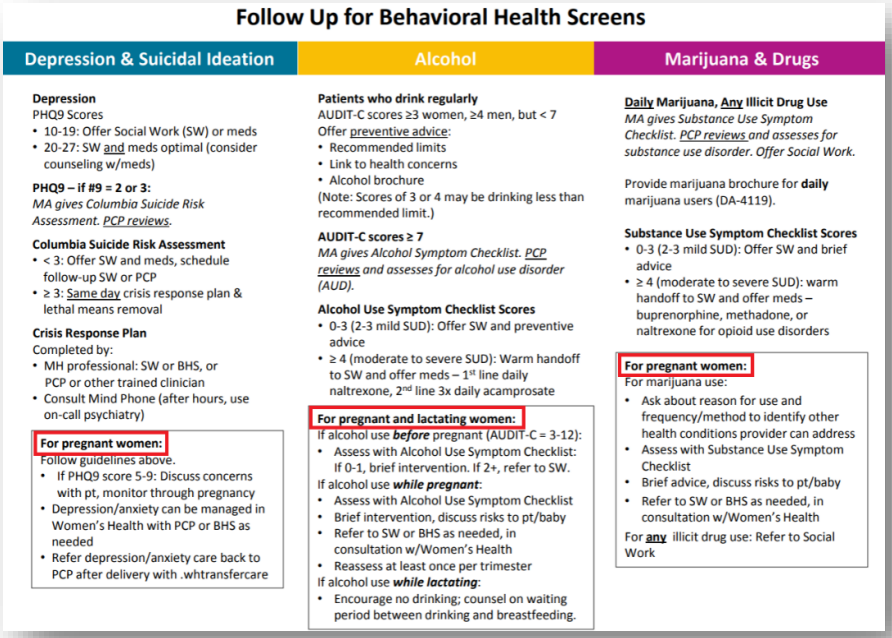
Save the date!
Depression Guideline Updates
Medical Q&A Thursday, June 13, 2024, 12:15 – 12:45 p.m.
Presented by:

To join via Microsoft Teams, CLICK HERE

i. Please note that there are system-wide phrases that are specific to perinatal behavioral health including:
   1. .AVSPREGDEPRESSIONMEDCONT
   2. .AVSPREGDEPRESSIONBREASTFEEDING
   3. .AVSPREGDEPRESSIONPOSTPARTUM
   4. .AVSPREGDEPRESSIONMEDSTART
   5. .AVSDEPMATERNALCAREPLAN

e. We have created job aides to help at point-of-care with interpretation of screening tools and coding/documentation:

Note: See screenshots of job aides below.



Follow Up for Behavioral Health Screens

Depression & Suicidal Ideation

Depression
PHQ9 Scores
- 10-19: Offer Social Work (SW) or meds
- 20-27: SW and meds optimal (consider counseling w/meds)

PHQ9 – if #9 = 2 or 3:
MA gives Columbia Suicide Risk Assessment. PCP reviews.

Columbia Suicide Risk Assessment
- < 3: Offer SW and meds, schedule follow-up SW or PCP
- ≥ 3: Same day crisis response plan & lethal means removal

Crisis Response Plan
Completed by:
- MH professional: SW or BHS, or PCP or other trained clinician
- Consult Mind Phone (after hours, use on-call psychiatry)

For pregnant women:
Follow guidelines above.
- If PHQ9 score 5-9: Discuss concerns with pt, monitor through pregnancy
- Depression/anxiety can be managed in Women's Health with PCP or BHS as needed
- Refer depression/anxiety care back to PCP after delivery with .whtransfercare

Alcohol

Patients who drink regularly
AUDIT-C scores ≥3 women, ≥4 men, but < 7
Offer preventive advice:
- Recommended limits
- Link to health concerns
- Alcohol brochure

(Note: Scores of 3 or 4 may be drinking less than recommended limit.)

AUDIT-C scores ≥ 7
MA gives Alcohol Symptom Checklist. PCP reviews and assesses for alcohol use disorder (AUD).

Alcohol Use Symptom Checklist Scores
- 0-3 (2-3 mild SUD): Offer SW and preventive advice
- ≥ 4 (moderate to severe SUD): Warm handoff to SW and offer meds – 1st line daily naltrexone, 2nd line 3x daily acamprosate

For pregnant and lactating women:
If alcohol use ***before*** pregnant (AUDIT-C = 3-12):
- Assess with Alcohol Use Symptom Checklist: If 0-1, brief intervention. If 2+, refer to SW.

If alcohol use ***while pregnant***:
- Assess with Alcohol Use Symptom Checklist
- Brief intervention, discuss risks to pt/baby
- Refer to SW or BHS as needed, in consultation w/Women's Health
- Reassess at least once per trimester

If alcohol use ***while lactating***:
- Encourage no drinking; counsel on waiting period between drinking and breastfeeding.

Marijuana & Drugs

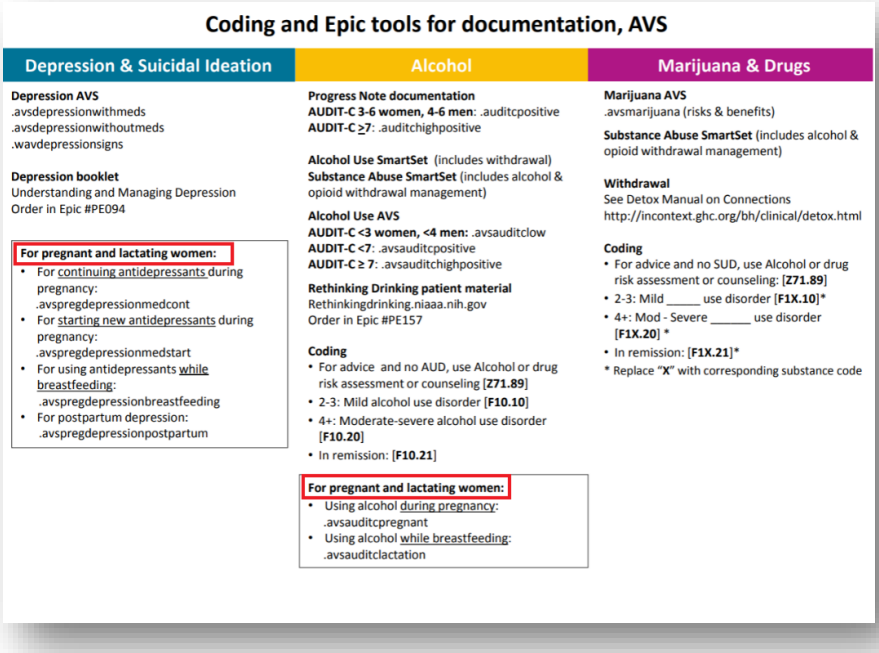
Daily Marijuana, Any Illicit Drug Use
MA gives Substance Use Symptom Checklist. PCP reviews and assesses for substance use disorder. Offer Social Work.

Provide marijuana brochure for **daily** marijuana users (DA-4119).

Substance Use Symptom Checklist Scores
- 0-3 (2-3 mild SUD): Offer SW and brief advice
- ≥ 4 (moderate to severe SUD): warm handoff to SW and offer meds – buprenorphine, methadone, or naltrexone for opioid use disorders

For pregnant women:
For marijuana use:
- Ask about reason for use and frequency/method to identify other health conditions provider can address
- Assess with Substance Use Symptom Checklist
- Brief advice, discuss risks to pt/baby
- Refer to SW or BHS as needed, in consultation w/Women's Health

For **any** illicit drug use: Refer to Social Work



Coding and Epic tools for documentation, AVS

Depression & Suicidal Ideation

Depression AVS
.avsdepressionwithmeds
.avsdepressionwithoutmeds
.wavdepressionsigns

Depression booklet
Understanding and Managing Depression
Order in Epic #PE094

For pregnant and lactating women:
- For continuing antidepressants during pregnancy: .avspregdepressionmedcont
- For starting new antidepressants during pregnancy: .avspregdepressionmedstart
- For using antidepressants while breastfeeding: .avspregdepressionbreastfeeding
- For postpartum depression: .avspregdepressionpostpartum

Alcohol

Progress Note documentation
AUDIT-C 3-6 women, 4-6 men: .auditcpositive
AUDIT-C ≥7: .auditchighpositive

Alcohol Use SmartSet (includes withdrawal)
Substance Abuse SmartSet (includes alcohol & opioid withdrawal management)

Alcohol Use AVS
AUDIT-C <3 women, <4 men: .avsauditclow
AUDIT-C <7: .avsauditcpositive
AUDIT-C ≥ 7: .avsauditchighpositive

Rethinking Drinking patient material
Rethinkingdrinking.niaaa.nih.gov
Order in Epic #PE157

Coding
- For advice and no AUD, use Alcohol or drug risk assessment or counseling [**Z71.89**]
- 2-3: Mild alcohol use disorder [**F10.10**]
- 4+: Moderate-severe alcohol use disorder [**F10.20**]
- In remission: [**F10.21**]

For pregnant and lactating women:
- Using alcohol during pregnancy: .avsauditcpregnant
- Using alcohol while breastfeeding: .avsauditclactation

Marijuana & Drugs

Marijuana AVS
.avsmarijuana (risks & benefits)

Substance Abuse SmartSet (includes alcohol & opioid withdrawal management)

Withdrawal
See Detox Manual on Connections
http://incontext.ghc.org/bh/clinical/detox.html

Coding
- For advice and no SUD, use Alcohol or drug risk assessment or counseling: [**Z71.89**]
- 2-3: Mild _____ use disorder [**F1X.10**]*
- 4+: Mod - Severe _____ use disorder [**F1X.20**] *
- In remission: [**F1X.21**]*

* Replace "**X**" with corresponding substance code

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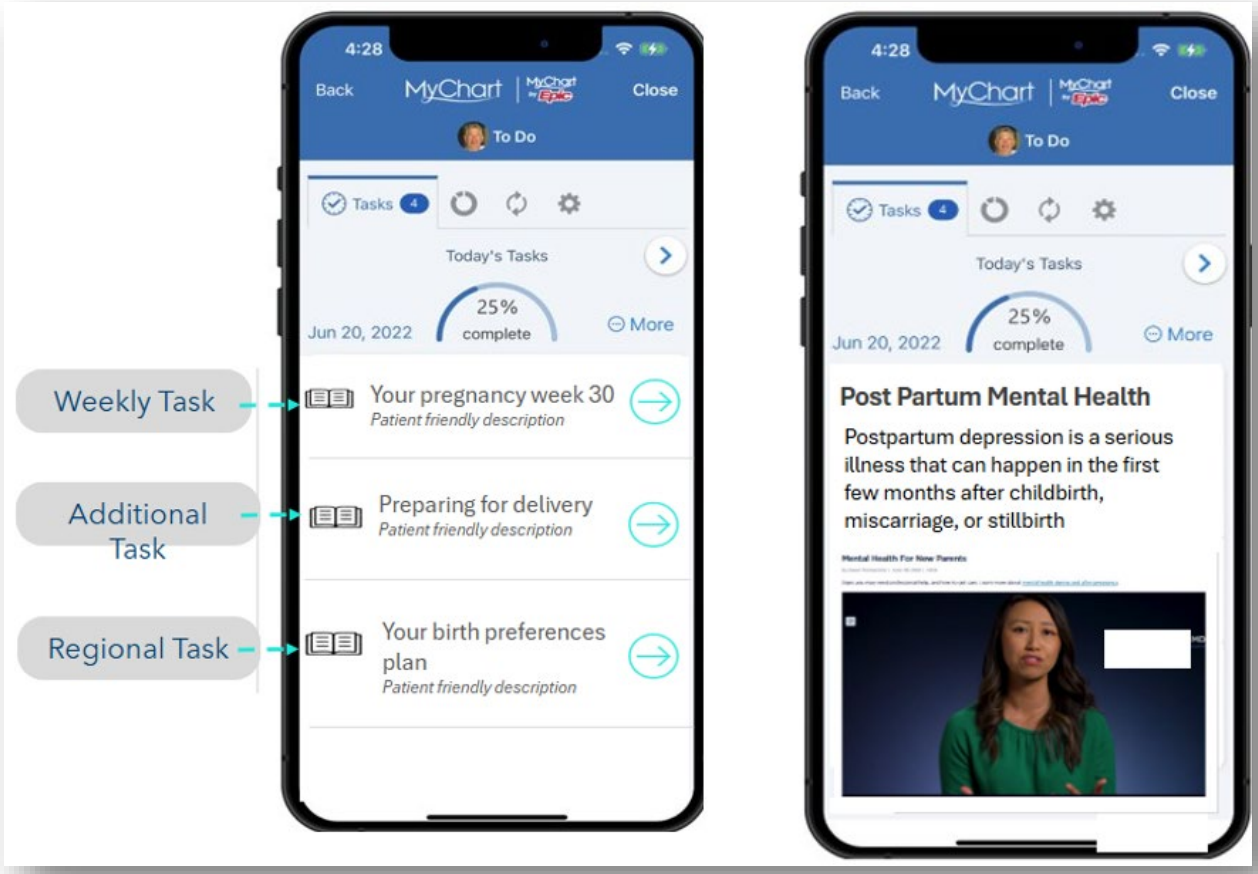
c) Through policies, procedures, or activities
    a. Documents noted above including:
        i. Perinatal Depression Guideline
            1. Updating 'job aid' – clinical flow aspect of this document - to ensure acute post-partum mental health concerns found in newborn visits be routed back to OB provider and not PCP (noted above).
        ii. Opioid Use Disorder Diagnosis and Treatment
            1. Includes the section on Opioid Use Disorder in Pregnancy (noted above).
    b. Revamping our 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). Additionally, we have an Equity Guardians program with small groups taking on projects to improve our system. In 2025, one of these subgroups will be working on "Maternal Health Equity Group." Part of this project will be looking directly at mental health and continuing to address disparities in prenatal and postpartum depression health screenings and follow-up.
    c. We are in the process of addressing "partner mental health" in the peripartum space. We have determined not to have clinicians from our organization actively screen partners in the postpartum or pregnancy visits (some partners do not have the same insurance and there is not enough evidence for this in the literature to prompt this level of change to clinician ask). However, we are 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. Additionally, we are developing a "Clinical Update" to share information on the importance of partner perinatal mental health and resources.
    d. Increasing safety relative to prescription of "Category X" and select "Category D" medications for non-pregnant patients who have the capacity to become pregnant. These are medications which are either contraindicated during pregnancy or high risk of fetal harm during pregnancy. There are some psychoactive medications that fall into Category X or Category D. We are in the process of adding best practice alerts (BPAs) in EPIC to prompt discussion of need for pregnancy prevention when prescribing these drugs and to consider alternative options if conception is planned. As we see higher rates of medical conditions like hypertension in black patients, these patients are at increased risk of being prescribed a teratogenic drug. The goal is to find substitutes for these medications in people who may become pregnant before the pregnancy occurs.
    e. In 2025, we will be 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. Patients will have educational resources regarding their

pregnancy and will be able to do corresponding activities based on the pregnancy trimester and the number of weeks gestation. This will include tasks around:

i. Emotional changes and wellness tips
ii. Pregnancy and Mental Health during weeks 10, 18, 26, and 34
iii. Hormone changes and emotional ups and downs
iv. Coping with difficult birth experiences
v. Recognizing and managing baby blues/post partum mental health

Note: See screenshots of this app and corresponding educational topics below



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Summary of 1st Trimester Education Topics

AT – Additional Task
RT – Regional Task
RT* - Regional Roving Task

Trimester 1

Weeks 1-4
- Early pregnancy symptoms.
- RT: Enrollment
- AT: Safe medications

Week 5
- Importance of nutrition and hydration.
- AT: Miscarriage and complications
- AT: Foods to avoid

Week 6
- Common early pregnancy symptoms and management.
- AT: Staying healthy throughout pregnancy

Week 7
- Hormonal changes; what to avoid (alcohol, etc.) during pregnancy.
- AT: Nausea and vomiting
- RT*: Preparing for your first prenatal visit
- RT*: Genetic screening

Week 8
- Fatigue and morning sickness management.
- AT: Safe medications

Week 9
- Symptom management (i.e., heartburn, hemorrhoids); vaginal discharge.
- AT: Headaches and pregnancy
- AT: Intimacy and pregnancy
- RT*: Prenatal classes

Week 10
- Emotional changes and wellness tips
- RT: Pregnancy and mental health

Week 11
- Increased energy and appetite.

Week 12
- Importance of dental care.
- RT: Dental care while pregnant

Week 13
- Morning sickness subsides.
- RT: Work and leave

Education by week may change – review in progress

Summary of 2nd Trimester Education Topics

AT – Additional Task
RT – Regional Task
RT* - Regional Roving Task

Trimester 2

Weeks 14
- Managing round ligament pain. Good rest and exercise.

Week 15
- Immunizations to stay well.
- AT: Staying healthy: Vaccinations during pregnancy
- AT: Safe medications
- RT: Managing cold, flu and Covid (regional resources)

Week 16
- Managing stress; what to expect in anatomy scan.
- AT: Travelling while pregnant

Week 17
- Common skin conditions, breast changes. New baby and siblings.
- AT: Benefits of breastfeeding

Week 18
- Leg cramps and varicose veins; gestational diabetes.
- AT: Pregnancy and mental health

Week 19
- Fetal movement; self-care; intimacy while pregnant.
- RT*: Prenatal Classes

Week 20
- Staying hydrated; emptying bladder; contractions and pre-term labor education.

Week 21
- Iron rich foods; tips for a restful sleep.

Week 22
- Foot swelling; social support; body positivity. Tips for unsolicited advice.
- RT*: Third trimester labs.

Week 23
- Preeclampsia awareness and risk education.

Education by week may change – review in progress

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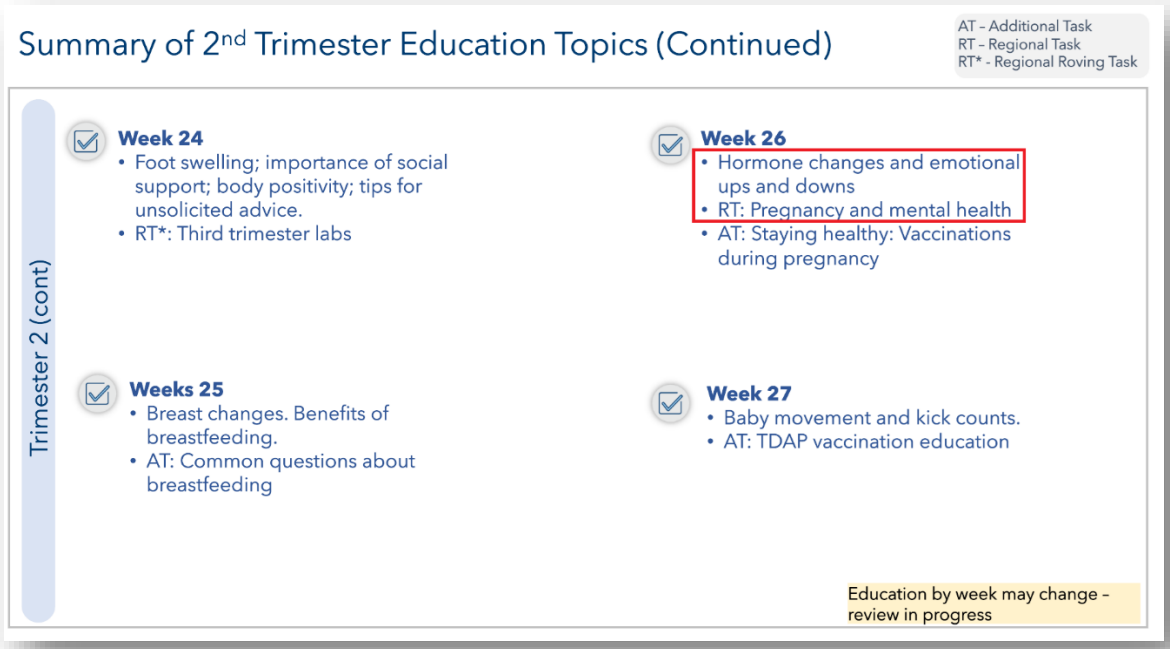

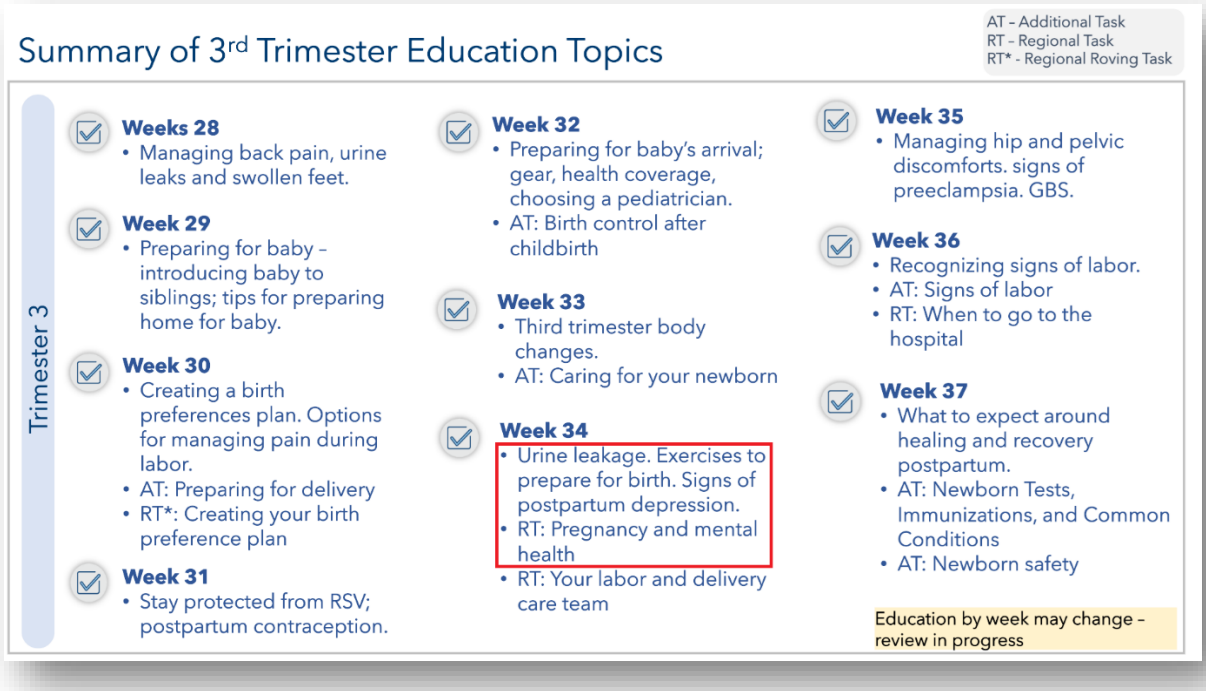

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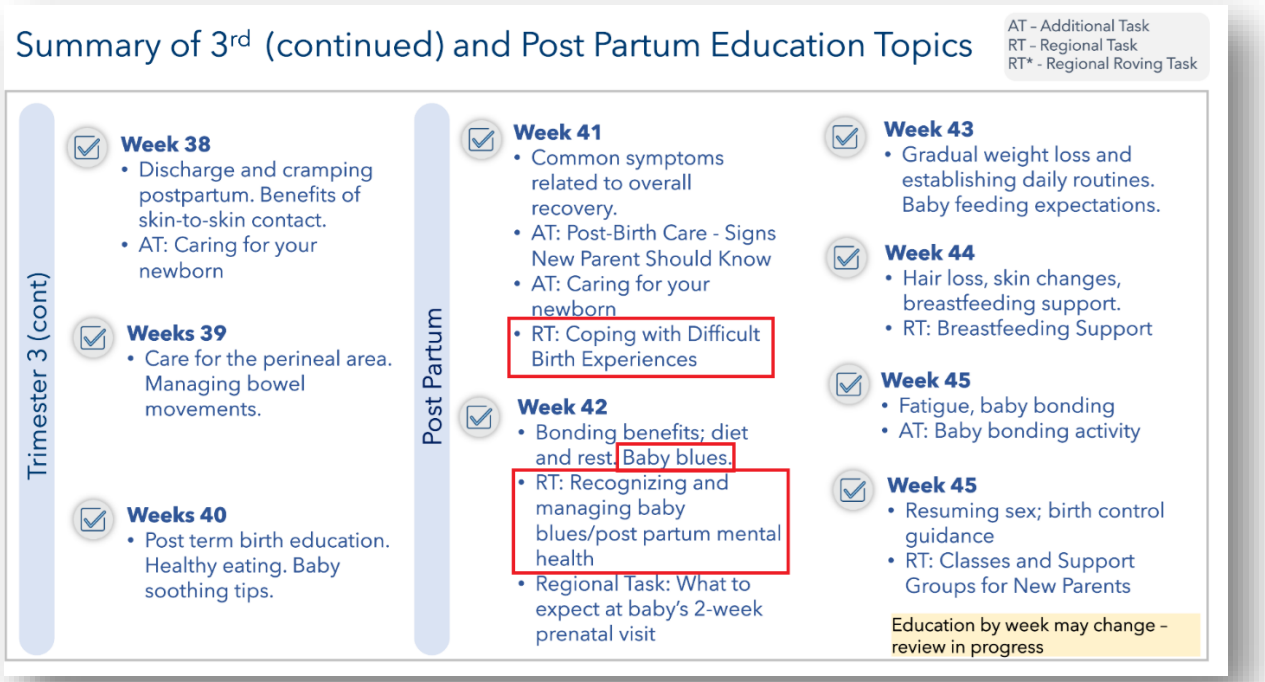

Q4) How did your organization address social drivers of health? (list all that apply)

a) In workforce hiring, training, and development
   a. We have developed guidance on "Promoting Equity, Inclusion, and Diversity (EID) in Recruitment" with tools to provide inclusive, culturally sensitive care and recognizing bias.
   b. Our organization seeks to contribute to both diverse, inclusive work environments and the ability of clinicians to provide respectful and culturally appropriate care by:
      i. Ensuring that all providers receive training and practice in thoughtful and respectful communication with patients and their team members.
      ii. Leaders, through our Leadership Pathway, receive training and skills practice opportunities to lead inclusively and support their whole team including addressing personal biases that might lead to less positive experiences of our work community.
      iii. Making available to leaders and their teams opportunities to assess our ability to address personal and systemic biases through the tools like the Intercultural Development Inventory (IDI).
      iv. Coordinating access to a diverse group of external coaches that can reflect and expand the cultural perspectives of the leaders receiving coaching so that they-- in turn-- can create better environments for all.

b) With programs and/or policies changes
   a. We have worked on the infrastructure for social drivers of health over the last year. 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. The social health screening includes questions on finances, food, transportation, housing, and assistance wanted. If the patient does not have a computer or cell phone, we use an iPad to address these questions at the time of the visit. If the screener is positive for any social needs, this populates a dashboard and goes to a work queue for our community resource specialists to outreach to them. The screener asks if the patient wants us to help. If they do, then it will ask how will be best to outreach to the patient.

b. We are currently working on standardizing the process for screening for intimate partner violence. This is currently being done routinely in obstetrics and midwifery throughout the pregnancy. Refer to the Maternal Behavioral Health Screening above.

Note: See screenshots of Social Health Screener and dashboards on next page.

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Brief Social Health Screener

Having enough food, a place to live, transportation, and ability to take care of your other basic needs is important to your health and well-being. We are here to partner with you and connect you with help if you need it. This information is confidential and will become part of your medical record. It can be updated as your situation changes.

Finances

How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

☐ Not hard at all ☐ Not Very Hard ☐ Somewhat hard ☐ Hard ☐ Very hard ☐ Decline/Patient Refused [1]

Food

Some people have made the following statements about their food situation. Please tell us how often these statements were true for you in the last 12 months.

Within the past 12 months, you worried that your food would run out before you got money to buy more.

☐ Never true ☐ Sometimes true ☐ Often true ☐ Decline/Patient Refused

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

☐ Never true ☐ Sometimes true ☐ Often true ☐ Decline/Patient Refused

Transportation

In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?

☐ Yes ☐ No ☐ Decline/Patient Refused

In the past 12 months, has the lack of transportation kept you from meetings, work, or from getting things needed for daily living?

☐ Yes ☐ No ☐ Decline/Patient Refused

Housing

In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?

☐ Yes ☐ No ☐ Decline/Patient Refused

In the last 12 months, how many places have you lived? ☐ << this is a free text box)

In the last 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (including now)? ☐ Yes ☐ No ☐ Decline/Patient Refused

Think about the place you live. Do you have problems with any of the following?

☐ Pests, such as bugs, ants or mice ☐ Mold ☐ Lead paint or pipes ☐ Lack of heat

☐ Oven or stove not working ☐ Smoke detectors missing or not working ☐ Water leaks ☐ None of the above

☐ Prefer not to answer

Assistance Wanted [This is the Social Needs Question (SNQ)]

Would you like us to assist you in getting help with any of the following? *(Select all that apply)*

☐ Food ☐ Housing ☐ Utilities ☐ Internet access ☐ Finances ☐ Transportation

☐ Loneliness or social isolation ☐ Employment ☐ Child care ☐ Caregiver [2] ☐ Not at this time

If a member selects one or more needs and does not select 'Not at this time' in SNQ, the following assistance options A, A1, B, C and D are available. The markets can choose to configure one of the following assistance options combination – A, B and C OR B and C OR B, C and D

We are here to help. Please select how you prefer to get assistance.

A. I want a member of my care team to call me <<if this is selected, A1 below will display (branching).

A1. Call me at _____ <<member can then add their phone #

B. I will call by phone at (800) to talk with a specialist

C. I will use online at

D. I would like to address my concerns during my visit

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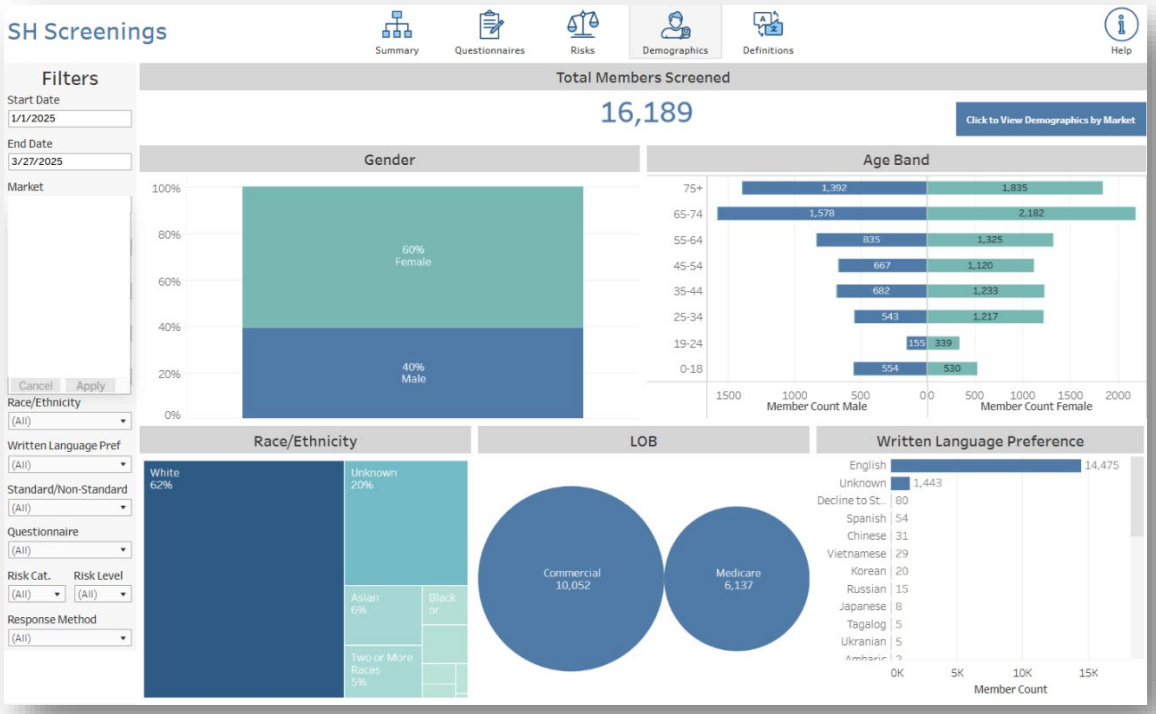

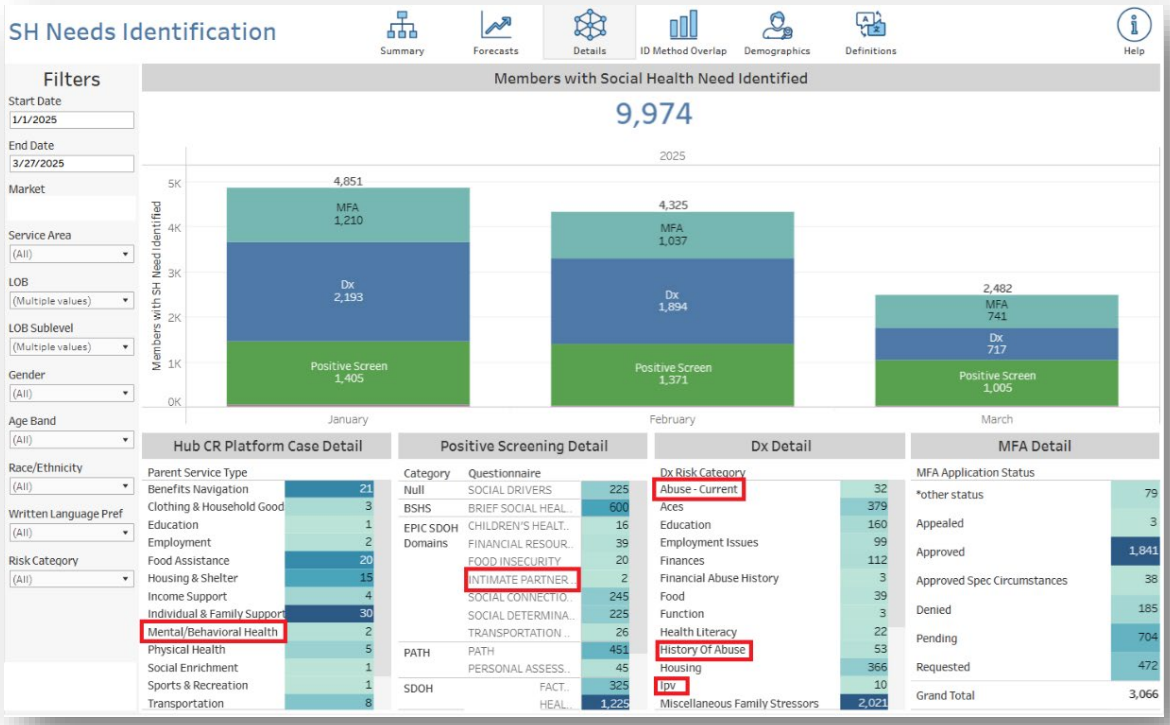

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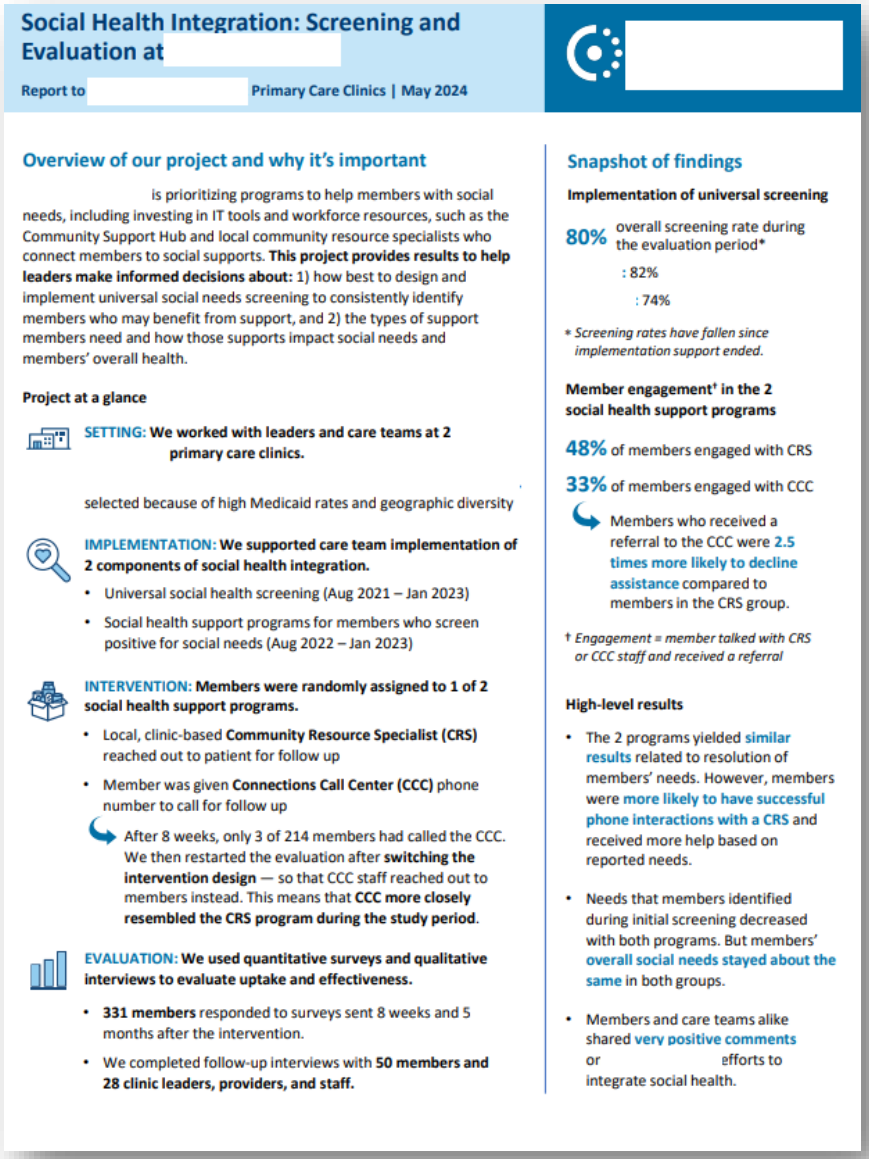
c) What measures did your organization use to evaluate the effectiveness of the efforts to address social needs?

a. The social health integration screening and evaluations program conducted a pilot from 08/2021-01/2023 at two different clinical sites. The program published a report in 05/2024 with the findings and guidance for broader implementation. This program was evaluated through the research institute affiliated with our organization.

Note: See screenshots of the report findings below.



Social Health Integration: Screening and Evaluation at

Report to **Primary Care Clinics | May 2024**

Overview of our project and why it's important

is prioritizing programs to help members with social needs, including investing in IT tools and workforce resources, such as the Community Support Hub and local community resource specialists who connect members to social supports. **This project provides results to help leaders make informed decisions about:** 1) how best to design and implement universal social needs screening to consistently identify members who may benefit from support, and 2) the types of support members need and how those supports impact social needs and members' overall health.

Project at a glance

SETTING: We worked with leaders and care teams at 2 primary care clinics.

selected because of high Medicaid rates and geographic diversity

IMPLEMENTATION: We supported care team implementation of 2 components of social health integration.

- Universal social health screening (Aug 2021 – Jan 2023)
- Social health support programs for members who screen positive for social needs (Aug 2022 – Jan 2023)

INTERVENTION: Members were randomly assigned to 1 of 2 social health support programs.

- Local, clinic-based **Community Resource Specialist (CRS)** reached out to patient for follow up
- Member was given **Connections Call Center (CCC)** phone number to call for follow up

After 8 weeks, only 3 of 214 members had called the CCC. We then restarted the evaluation after **switching the intervention design** — so that CCC staff reached out to members instead. This means that **CCC more closely resembled the CRS program during the study period**.

EVALUATION: We used quantitative surveys and qualitative interviews to evaluate uptake and effectiveness.

- **331 members** responded to surveys sent 8 weeks and 5 months after the intervention.
- We completed follow-up interviews with **50 members and 28 clinic leaders, providers, and staff.**

Snapshot of findings

Implementation of universal screening

80% overall screening rate during the evaluation period*

: 82%

: 74%

* *Screening rates have fallen since implementation support ended.*

Member engagement† in the 2 social health support programs

48% of members engaged with CRS

33% of members engaged with CCC

Members who received a referral to the CCC were **2.5 times more likely to decline assistance** compared to members in the CRS group.

† *Engagement = member talked with CRS or CCC staff and received a referral*

High-level results

- The 2 programs yielded **similar results** related to resolution of members' needs. However, members were **more likely to have successful phone interactions with a CRS** and received more help based on reported needs.
- Needs that members identified during initial screening decreased with both programs. But members' **overall social needs stayed about the same** in both groups.
- Members and care teams alike shared **very positive comments** or efforts to integrate social health.

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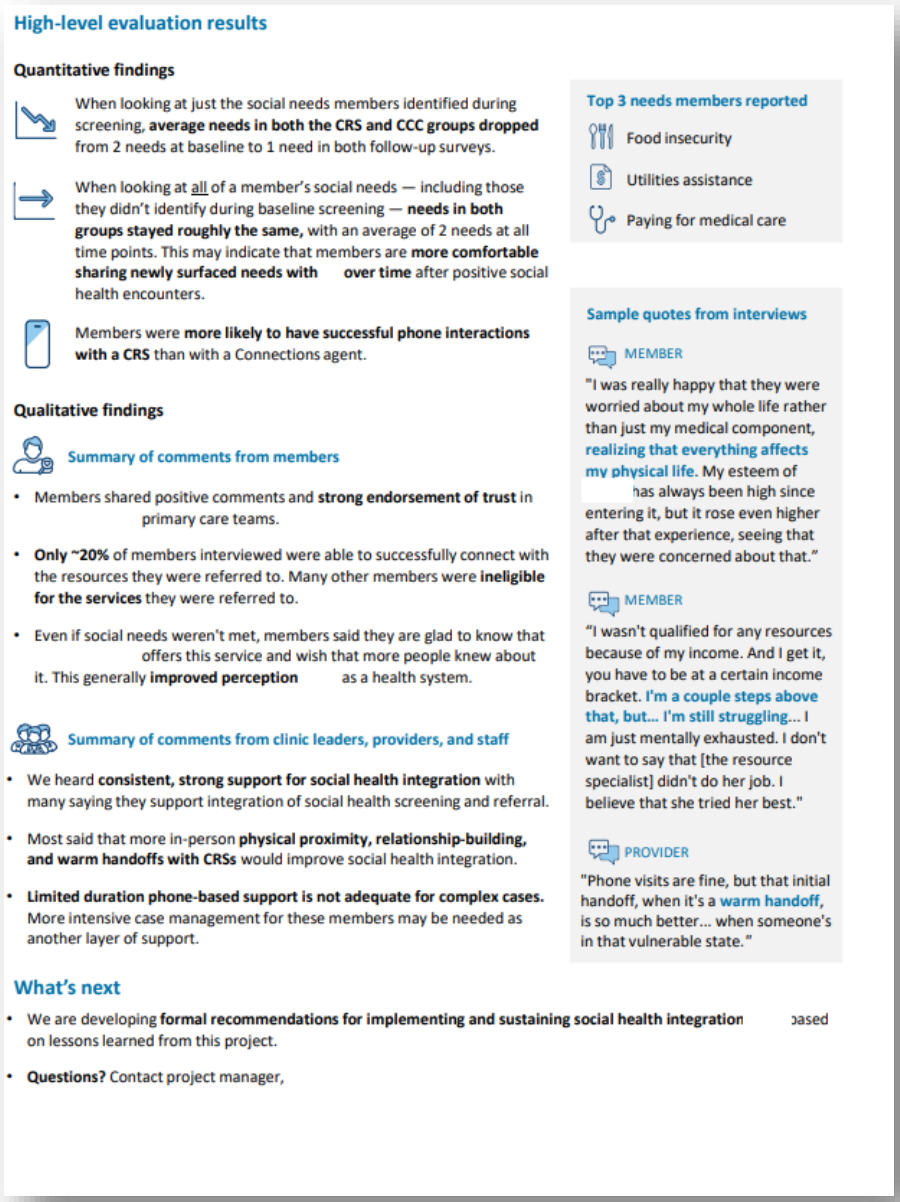

High-level evaluation results

Quantitative findings

When looking at just the social needs members identified during screening, **average needs in both the CRS and CCC groups dropped** from 2 needs at baseline to 1 need in both follow-up surveys.

When looking at all of a member's social needs — including those they didn't identify during baseline screening — **needs in both groups stayed roughly the same,** with an average of 2 needs at all time points. This may indicate that members are **more comfortable sharing newly surfaced needs with over time** after positive social health encounters.

Members were **more likely to have successful phone interactions with a CRS** than with a Connections agent.

Top 3 needs members reported

- Food insecurity
- Utilities assistance
- Paying for medical care

Qualitative findings

Summary of comments from members

- Members shared positive comments and **strong endorsement of trust** in primary care teams.
- **Only ~20%** of members interviewed were able to successfully connect with the resources they were referred to. Many other members were **ineligible for the services** they were referred to.
- Even if social needs weren't met, members said they are glad to know that offers this service and wish that more people knew about it. This generally **improved perception** as a health system.

Sample quotes from interviews

MEMBER

"I was really happy that they were worried about my whole life rather than just my medical component, realizing that everything affects my physical life. My esteem of has always been high since entering it, but it rose even higher after that experience, seeing that they were concerned about that."

MEMBER

"I wasn't qualified for any resources because of my income. And I get it, you have to be at a certain income bracket. I'm a couple steps above that, but... I'm still struggling... I am just mentally exhausted. I don't want to say that [the resource specialist] didn't do her job. I believe that she tried her best."

Summary of comments from clinic leaders, providers, and staff

- We heard **consistent, strong support for social health integration** with many saying they support integration of social health screening and referral.
- Most said that more in-person **physical proximity, relationship-building, and warm handoffs with CRSs** would improve social health integration.
- **Limited duration phone-based support is not adequate for complex cases.** More intensive case management for these members may be needed as another layer of support.

PROVIDER

"Phone visits are fine, but that initial handoff, when it's a warm handoff, is so much better... when someone's in that vulnerable state."

What's next

- We are developing **formal recommendations for implementing and sustaining social health integration** based on lessons learned from this project.
- **Questions?** Contact project manager,

Q5) What strategies did your organization use to:

a) to understand patient needs
   a. We have taken a critical look at our data through equity as well as access lens.
   b. Report on rates of depression screening and broken down by clinic location and can be further stratified by age, race, ethnicity, language, sexual orientation, gender identity, hearing loss, speech loss, vision loss.
   c. We have collected data on initial prenatal depression screening, prenatal depression follow-up, post-partum depression screening, and post-partum depression follow-up.

b) to develop community partnerships
    a. In the Midwifery/OB/GYN department, we have many flyers posted in patient-facing areas advertising community-based events for BIPOC pregnant patients (e.g. OpenArms programming; UW research activities; etc).
    b. In 2017, a group of residents and faculty came together to establish RPrIDE (Residents Promoting Inclusion, Diversity, and Equity). We recognized that racism is a fundamental driver of health inequities and that truly preparing primary care leaders and healers required a strong commitment to antiracism.
    Since then, we have developed a robust curriculum focused on several key areas: fostering internal reflection, exploring the history of racism in medicine, identifying structural inequities in patient care, responding effectively to microaggressions, and critically examining the use of racial categories in clinical practice.
    RPrIDE has also engaged deeply with the community, creating and leading workshops—from training on microaggressions to broader initiatives presented at CME-accredited conferences. Additionally, our lead faculty member teaches a course at the University of Washington School of Medicine titled *African Americans and Health Disparities*, which addresses healthcare inequities and leads critical discussions on strategies to confront and reduce these disparities.

c) to address power imbalances
    a. We developed an institution specific equity training in collaboration with the Groundwater Institute. The first training module was called "Breaking Bias." Breaking Bias was completed by over 90% of employees system-wide at all levels of the organization.
    b. Module 2 was called "Re-examine Racism." In 2023, this module was mandatory for our board of directors and executive leaders. This was an in-person/virtual training facilitated by the Groundwater Institute.
    c. In 2024, we offered continuing medical education credit for people managers to complete the "Re-examine Racism" module. This training was sun-setted in early 2024 as part of a planned vendor contract expiration, so our completion rate was about 40% of people leaders.
    d. In alignment with local and national Equity, Inclusion, and Diversity (EID) efforts, our organization's Mental Health & Wellness anti-racism committee (ARC) hosted a racial trauma training. The goal of this National Institute for the Clinical Application of Behavioral Medical (NICABM)-developed program was "to provide a better understanding of the stressful and traumatic impact that racism can have on clients of color each and every day". This training is part of our onboarding process and is repeated annually.
        i. The first module looked "at how racial stress can lead to trauma, as well as the unique psychological impact that racism can have on clients". Providers were presented with "strategies to help uncover a client's experiences with racism during intake, plus expert interventions that can help clients process their stress and trauma".

ii. The second module had a "focus on how we can help clients of color respond to experiences of racism… [and] … get into the impact of institutional racism". There was exploration of "the trauma that can come from witnessing or hearing about racial violence…[and] specific strategies for working with each of those traumas".
iii. The third module focused "on one type of racial trauma that's so insidious, it often goes undetected by both clients and practitioners". It is "about intergenerational and historical racial trauma; how [providers] can work with this type of trauma; [and] ways of helping clients work through internalized racism".
iv. For the final module, the program will "uncover some of the biases in our psychotherapeutic schools of thought and how that can harm and potentially re-traumatize clients of color. [Providers] heard why there's often a mistrust of mental health services among communities of color; some common mistakes to avoid, where [providers] might go wrong in our diagnoses, and why some of our standard interventions fall short".

e. As noted above, RPrIDE has actively engaged with the community by creating and leading workshops that not only focus on microaggressions but also address broader issues, such as power imbalances in healthcare. These initiatives are presented at CME-accredited conferences to foster awareness and change. Additionally, our lead faculty member teaches a course at the University of Washington School of Medicine titled *African Americans and Health Disparities*. This course explores healthcare inequities, examines the role of power in shaping these disparities, and facilitates critical discussions on how to address and dismantle these power imbalances in healthcare systems.

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?
      i. Not meeting goal on postpartum visit completion.
   b. How did you identify it?
      i. Through the HEDIS data that has been submitted above.
   c. How did you address it?
      i. There is work currently underway 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. They apply this research over an 18-month period.

B) Barrier 2
   a. What was it?

i. Our clinicians have not had clarity about how to manage postpartum mental health concerns, especially outside of OBGYN/Midwifery.

b. How did you identify it?
   i. This was identified by speaking with pediatric and primary care clinicians within our system.

c. How did you address it?
   i. We updated clinical flows to ensure postpartum mental health concerns are looped back to OBGYN/Midwifery/Family Medicine with OB where the concerns can be appropriately managed.
   ii. We have Collaborative Care Model at all primary care sites, which is population based mental health care imbedded within primary care. This program includes MLTs who partner with a psychiatrist for case review. If there is a high score on the Edinburgh Postnatal Depression Scale, this will populate a registry for outreach to the patient.
   iii. There is a mental health crisis team available for all of our clinicians. This team can be accessed for patients in crisis (severe depression, suicidal ideation).

C) Barrier 3

a. What was it?
   i. There is no process in place for partner mental health screenings.

b. How did you identify it?
   i. This is a gap in care that continues to need a solution.

c. How did you address it?
   i. Determined not to include formal screening of partners after in-depth discussion with clinical leaders. We are working 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.

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.*

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