Notes

# Children and Youth Behavioral Health Work Group – Prenatal through Five Relational Health (P5RH) Subgroup

*August 21, 2024*

## Glossary of Terms

AIHC: American Indian Health Commission
DCYF: Department of Children, Youth and Families
DOH: Washington State Department of Health
ECEAP: Early Childhood Education and Assistance Program
HCA: Health Care Authority
IECMH: Infant and Early Childhood Mental Health
IECMH-C: Infant and Early Childhood Mental Health Consultation
MMRP: Maternal Mortality Review Panel
NICU: Neonative Intensive Care Unit
WSPC: Washington State Perinatal Collaborative

## Meeting Topics

Presentation: Maternal Mortality Review recommendations, Deborah Gardner (DOH)
Collaborative Discussion of P5RHS Priorities

## Discussion Summary

### Maternal Mortality Review Recommendations

1. The presentation on the Maternal Mortality Review Panel (MMRP) Recommendations included the following (see slides for details):
    a. MMRP Overview and Background, including:
        i. The MMRP was established by the Washington State Legislature in 2016 and made permanent with an amendment in 2019.
            1. The MMRP is housed at the DOH, with over 80 members on the panel covering a breadth of expertise and backgrounds.
            2. The MMRP provides a report to the legislature every three years.
        ii. MMRP cases are reviewed using an anonymized, de-identified case narrative summary, covering:
            1. Was the death pregnancy-related?
            2. Was the death preventable?
            3. Did racism, discrimination, and bias play a role?
            4. What factors contributed?
            5. What were the oppportunities for intervention?

iii. The Maternal Mortality Review Process, which includes 4 levels of review, from identitification of pregnancy-associated deaths to systems-level recommendation development.
    1. This culminates in a report covering systems-level recommendations to prevent maternal mortality.

b. Key Messages, Data, and Findings from the Report, including:
    i. The 2023 report came out in February, and covers over 100 recommendations.
        1. The scope includes cumulative data from 2014-2020 deaths, while the recommendations focus on 2017-2020 deaths that were pregnancy-related and preventable.
        2. The report has an addendum from the American Indian Health Commission (AIHC) with recommendations from tribal and urban Indian health leaders and communities based on listening sessions.
    ii. Data considerations, including that maternal mortality is a rare event and observations from maternal mortalities in Washington state are not generalizable outside of the state.
    iii. Data from the 2023 report, including:
        1. Overall pregnancy-associated mortality in Washington state has remained relatively stable in recent years.
            a. Washington's maternal mortality rate is lower than the national average.
        2. For 2014-2020, the panel found that:
            a. 97% of the pregnancy associated deaths were pregnancy-related.
            b. Of those 97%, 80% of those deaths were preventable.
                i. This number likely reflects the fact that the panel understands preventability better than they used to.
        3. Discrimination, bias, interpersonal racism, or structural racism was present in nearly half of preventable pregnancy-related deaths from 2017-2020.
    iv. Data graphs for all maternal deaths and pregnancy-related death, broken down by age, race/ethnicity, insurance, and residence type (see slides).
    v. Key Messages include Racism, Discrimination, and Bias.
        1. Communities most burdened by perinatal health inequities have the expertise and cultural knowledge to lead solutions to reduce maternal mortality.
            a. Folks in these communities must be centered as leaders for the successful implementation of many of the recommendations in the report.
    vi. Common questions surrounding the leading causes of death, the impact of COVID-19, and why the report includes through one-year postpartum.
    vii. The timing of pregnancy-related, preventable death – which shows that the timing is distributed relative to how long the timeframes are (pregnancy, same day as delivery, pregnant within 2-42 days of death, and pregnanct withing 43 days-1 year of death).
    viii. Behavioral Health Considerations, including the following:

1. Pregnancy-associated deaths from unintentional substance overdose.
2. Pregnancy-associated deaths from suicide.

ix. The majority of the contributing factors to death were at the system and provider levels.

c. Recommendations from the Report, including:
   i. The panel's recommendations (pages 51-75 of the report) fall under 6 broad priority recommendations, each with detailed recommended actions for four key audiences:
      1. Policy and Budget actions (legislature)
      2. Perinatal systems of care (providers and facilities)
      3. Governmnetal, academic, community and professional agencies and organizations
      4. The DOH.
   ii. The recommendations (see slides for more details about each recommendation):
      1. Address racism, discrimination, bias, and stigma in perinatal care.
      2. Increase access to mental health and substance use disorder prevention, screening, and treatment for pregnant and parenting people.
      3. Expand equitable and high-quality health care by improving care integration, expanding telehealth services, and increasing reimbursement.
      4. Strengthen the quality and availability of perinatal clinical and emergency care that is comprehensive, coordinated, culturally appropriate, and adequately staffed.
      5. Meet basic needs of pregnant and parenting people by prioritizing access to housing, nutrition, income, transportation, child care, care navigation, and culturally relevant support services.
      6. Prevent violence in the perinatal period through survivor-centered and culturally appropriate coordinated services.
   iii. The American Indian Health Commission addendum has seven recommendations as well, regarding the following topics:
      1. The top priority is to reduce native maternal mortality until the disparity is eliminated.
      2. Culturally appropriate engagement and trust building.
      3. Tribal-led data needs assessment, planning, administration and analysis.
      4. Addressing historical inequities and building trust in health transformation systems change.
      5. Improving and expanding access for culturally relevant services and resources.
      6. Building and supporting Tribal-led workforce planning and development to successfully recruit and train an American Indian/Alaska Native workforce.
      7. Supporting and funding Tribal-led nutrition and plan and planning project development initiatives.
d. Implementing Recommendations: One Year In, including:

i. There are people all over the state implementing recommendations from the report.
ii. Washington State Perinatal Collaborative (WSPC) has started a monthly newsletter, and are working to end preventable morbidity, mortality, and disparities in pregnancy, postpartum and infant care through quality improvement initiatives and fostering a network of statewide perinatal leaders.
iii. Some of the other projects that have arisen from the recommendations include:
    1. The Center of Excellence for Perinatal Substance Use
    2. Birth Doula Certification
    3. Blue Band initiative for patients at risk of pre eclampsia
    4. Birth Equity Project, funded via DOH, to reduce racism.
    5. The Smooth Transitions Project
    6. TeamBirth
    7. Rural Care Access work.

e. Applying recommendations to the subgroup's work, including thinking about key questions related to the most relevant recommendations to your region, field, or community, which recommendations best match your priorities and current needs, who you'd like to collaborate with, and other efforts in existance.

2. Discussion following the presentation included the following:
    a. This subgroup took the recommendation from the 2017 report about postpartum Medicaid coverage to help get that passed in 2021.
    b. Oregon has nurse home visiting for new parents – things like this are very important.
    c. It is challenging to for individual counties to get data if there are targeted recommendations specific to geography, due to small numbers and strict confidentiality rules.
    d. Agencies were directed to submit decision packages that are maintaining, not expanding or creating new things, as much as possible, given the current legislative climate – this applies to items related to these recommendations as well.

## Collaborative Discussion of P5RHS Priorities

1. The discussion of priorities covered the following topics:
    a. Prioritization survey results – the top items, in order, and corresponding discussion:
        i. Sustaining an increasing investment in Infant and Early Childhood Mental Health Consultation (IECMH-C).
            1. There was a substantial funding increase for this last year – which is allowing the programs to grow from 15-25 consultants across the state.
                a. The team decided to equitably distribute the mental health consultants in the regions based on the number of childcare providers in the region.
                b. This is a limited service – the team was able to serve about 2% of providers at any given point in time, and with this increase the program will be at about 3.5%.

i. The long term strategic goal is to get to the point where the team can serve approximately 10% of the providers at any given time.

c. Incremental growth of the program allows them to reach more providers and provide higher level group based consultation services to providers who are currently on the waitlist for the onsite service delivery model.

d. The program collects data on the number of programs served, hours of service, number of children impacted, and the overall license capacity of the programs impacted, as well as tracking providers and children/families who are referred for external services and supports.

i. They regularly send out feedback surveys as well.

ii. Expanding perinatal supports per the maternal mortality review recommendations.

1. There is a lack of staffing and resources at DOH to do patient interviews and dive into severe maternal morbidity.
    a. States that have done family interviews have generally hired as additional social worker for this – and it takes about a year to get this process and staffing in place.
2. Separately, there are recommendations from MMRP about the impact of staffing shortages among providers on perinatal health.
3. Services for families with children in the Neonative Intensive Care Unit (NICU) and staffing shortages in coordinatiors and providers – this may be an oppportunity for coordination across issues.
4. Department of Children, Youth and Families (DCYF) has an ask related to Tribal-led programs – implementing a program called Positive Indian Parenting.
    a. DCYF also has an ask to sustain the expansion of the home visiting program.
5. There are a lot of recommendations in the behavioral health section of the MMRP report regarding education and training of the workforce, though there isn't one specifically focusing on diversifying the perinatal behavioral health workforce.
    a. People don't necessarily need to use the exact language from the report, but can cite information across different recommendations from the report to support or make a case for something legislatively.

iii. Alternative payment model for Infant and Early Childhood Mental Health (IECMH).

iv. Enhancing family therapy provider reimbursement rates.

v. Enhancing coordination between providers and community based navigators and coordinators and their connection to Early Early Childhood Education and Assistance Program (ECEAP) and IECMHC services and family supports.

vi. Expanding early ECEAP slots.

vii. Sustaining an increasing investment in ECEAP and childcare complex needs funds.
viii. Sustaining and expanding community based whole family supports as part of the Washington plan of safe care.

2. Subgroup members who have expressed interest in working together should collaborate to draft recommendations.
3. The refined recommendations should be submitted by the August 28th.
4. Health Care Authority (HCA) cannot draft recommendations, but can provide feedback and technical assistance.
5. The group has the month between August 28th and October 1st to refine recommendations to a final version for voting.

## Look Ahead: 24/25 Schedule

Next meetings

1. 8/28/2024 10-11:00AM

# WASHINGTON STATE MATERNAL MORTALITY REVIEW PANEL

## MMRP ACROSS WA: 2023 Report Highlights and 2024 Updates

Deborah Gardner, MPH, MFA, Washington State Department of Health

# Presentation Agenda

- MMRP Overview and Background
- Key Messages, Data, and Findings from the Report
- Recommendations from the Report
- Implementing Recommendations: One Year In
- Applying Recommendations to Your Work

# OVERVIEW AND BACKGROUND: Washington State's MMRP

At least **60,000** people each year in the United States experience severe complications related to pregnancy and childbirth.

# WA's Legislative Mandate for Maternal Mortality Review

- The Washington State Legislature established the **Maternal Mortality Review Panel in 2016**, following enactment of Senate Bill 6534.
  - State maternal mortality review law: **RCW 70.54.450**.
  - **In 2019, the law was amended to permanently establish the Panel** and the maternal mortality review process.
  - Directs the MMRP to conduct comprehensive reviews of deaths of Washington state residents during pregnancy or up to one year after the end of pregnancy.

# Maternal Mortality Review Panel (MMRP)

- At **Washington State Department of Health (DOH)**
- **80+ members** currently
- About **30–45** members **per meeting**
- **Breadth** of expertise and backgrounds
- Prioritize growing expertise from **American Indian / Alaska Native** communities
- **Report** to the legislature **every three years**

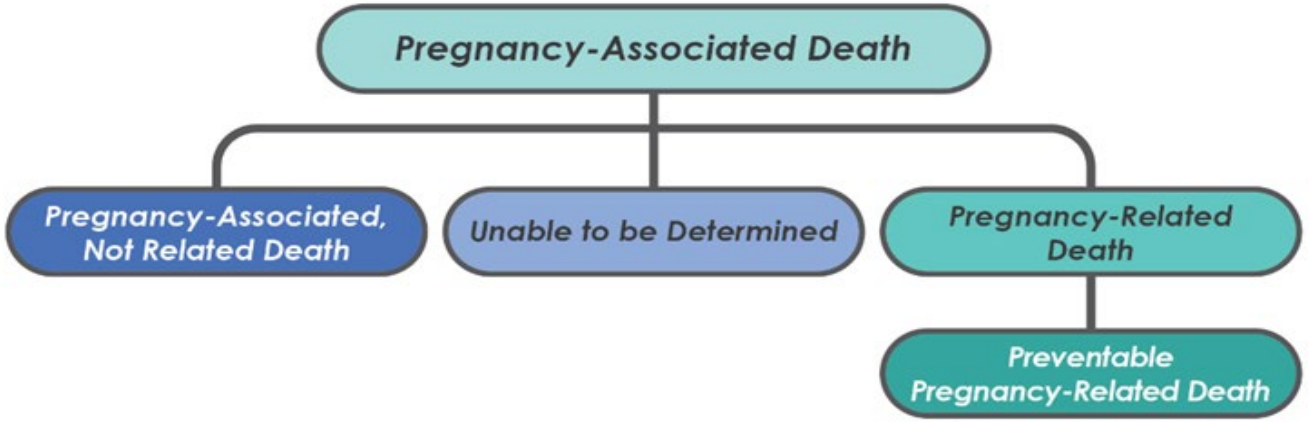
# Washington's MMRP: A Wealth of Expertise

# How MMRP Cases are Reviewed

- A respectful review of each potentially pregnancy related death, using an anonymized, de-identified case narrative summary**:**
  - Was the death **pregnancy-related**?
  - If it was pregnancy-related, was it **preventable**?
    - From a **clinical** perspective?
    - From an **equity and social determinants of health** perspective?
  - Did **racism, discrimination, and bias play a role**?
  - What **factors contributed** to pregnancy-related, preventable deaths?
  - **Making recommendations**: What were the opportunities for intervention?

    These are the basis for our legislative report every three years.

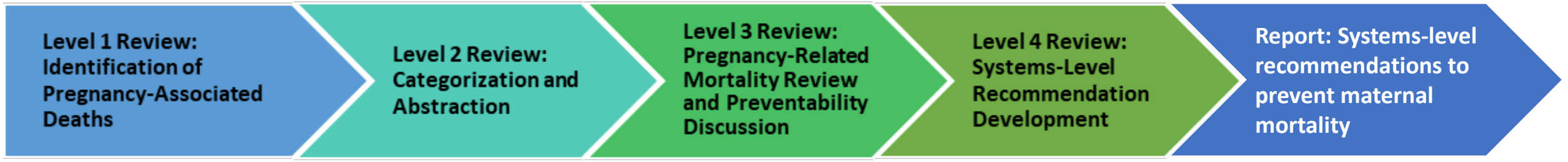
# Key Definitions




**Pregnancy-ASSOCIATED deaths:** Deaths *from any cause* during pregnancy or within one year of the end of pregnancy. This includes:

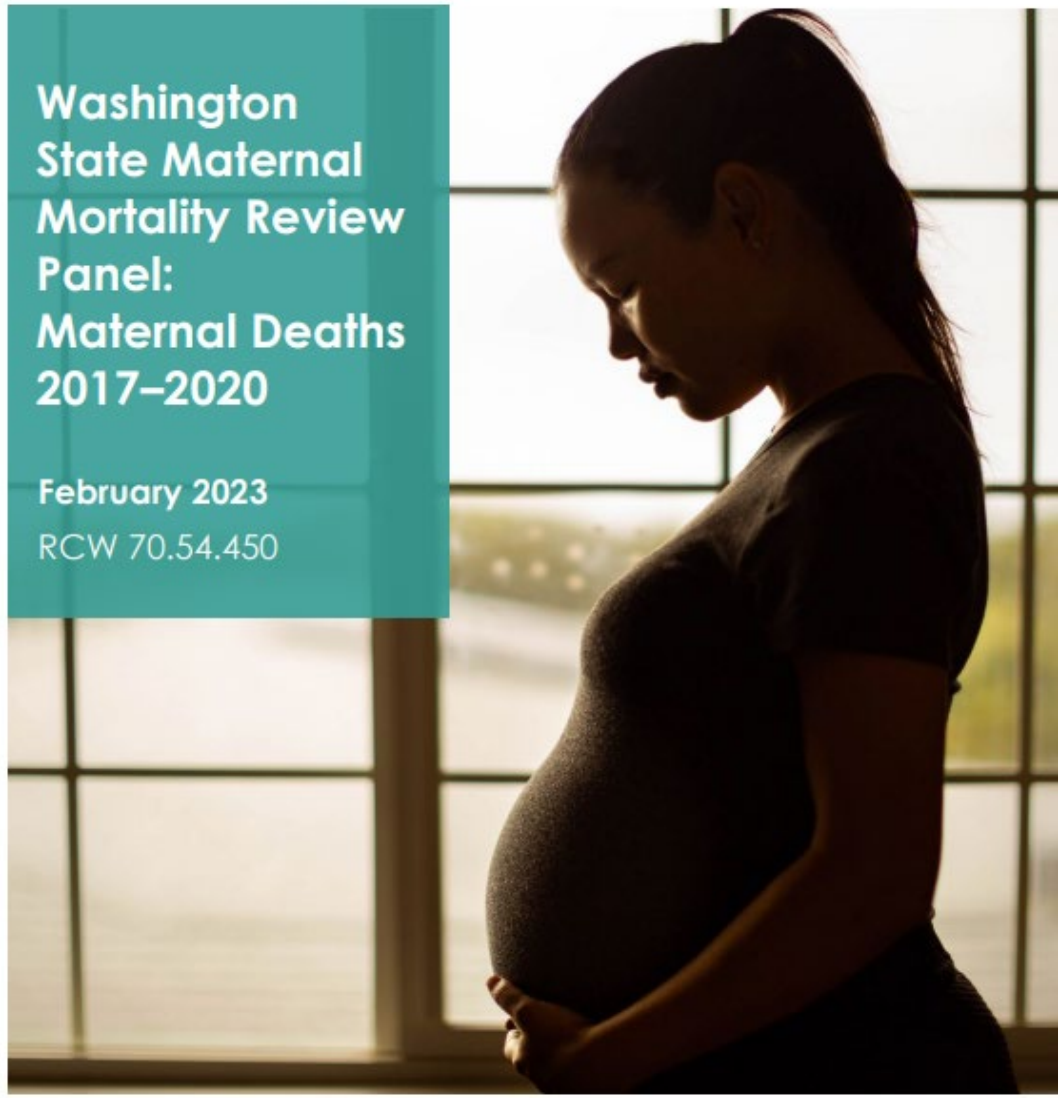
- **Pregnancy-RELATED deaths:** Deaths due to a pregnancy complication, a chain of events initiated by pregnancy, or aggravation of unrelated condition(s) by the effects of pregnancy.
  - ***Preventable pregnancy-related deaths:*** *at least some chance of being averted by one or more reasonable changes to patient, family, provider, facility, system, or community factors.*
- **Pregnancy-Associated-but-NOT-RELATED deaths:** Deaths not due to, related to, or aggravated by pregnancy.
- **UNABLE-to-be-determined deaths:** Deaths for which the MMRP does have enough information to be able to determine whether it was pregnancy-related.

# Maternal Mortality Review Process



# 2023 MMRP Report

- **February 2023**
- **Washington residents** who died during pregnancy or up to one year after pregnancy
- **Findings and data** from 2014–2020 deaths (cumulative)
- **Recommendations** from 2017–2020 deaths that were **pregnancy-related** and **preventable**
  - **Over 100** recommendations
  - Organized in **6 priority recommendation categories**



# 2023 MMRP Report: American Indian Health Commission Addendum

- **Addendum** from the American Indian Health Commission (AIHC) with recommendations from **tribal** and **urban Indian health leaders** and **communities.**

- In response to **deep disparities** in the **2019 report,** which were reflected **again in 2023.**

- Discusses report **data** and makes **recommendations** that reflect **inequities, social determinants of health, and strengths** in American Indian / Alaska Native communities.

AMERICAN INDIAN HEALTH COMMISSION
ADDENDUM TO THE WASHINGTON STATE
DEPARTMENT OF HEALTH'S
MATERNAL MORTALITY REVIEW PANEL
REPORT TO THE LEGISLATURE

Tribal and Urban Indian Leadership Recommendations September 2022

PULLING TOGETHER FOR WELLNESS

# Addendum from the American Indian Health Commission

"It is essential to American Indian / Alaska Native healing to rely on **Tribally developed and implemented solutions**. What the Tribes and Urban Indian Health Organizations need is partnership with the state in funding and collaboration. It has been 500+ years of trauma and discrimination; it will take time to heal."

# MESSAGES, DATA, and FINDINGS

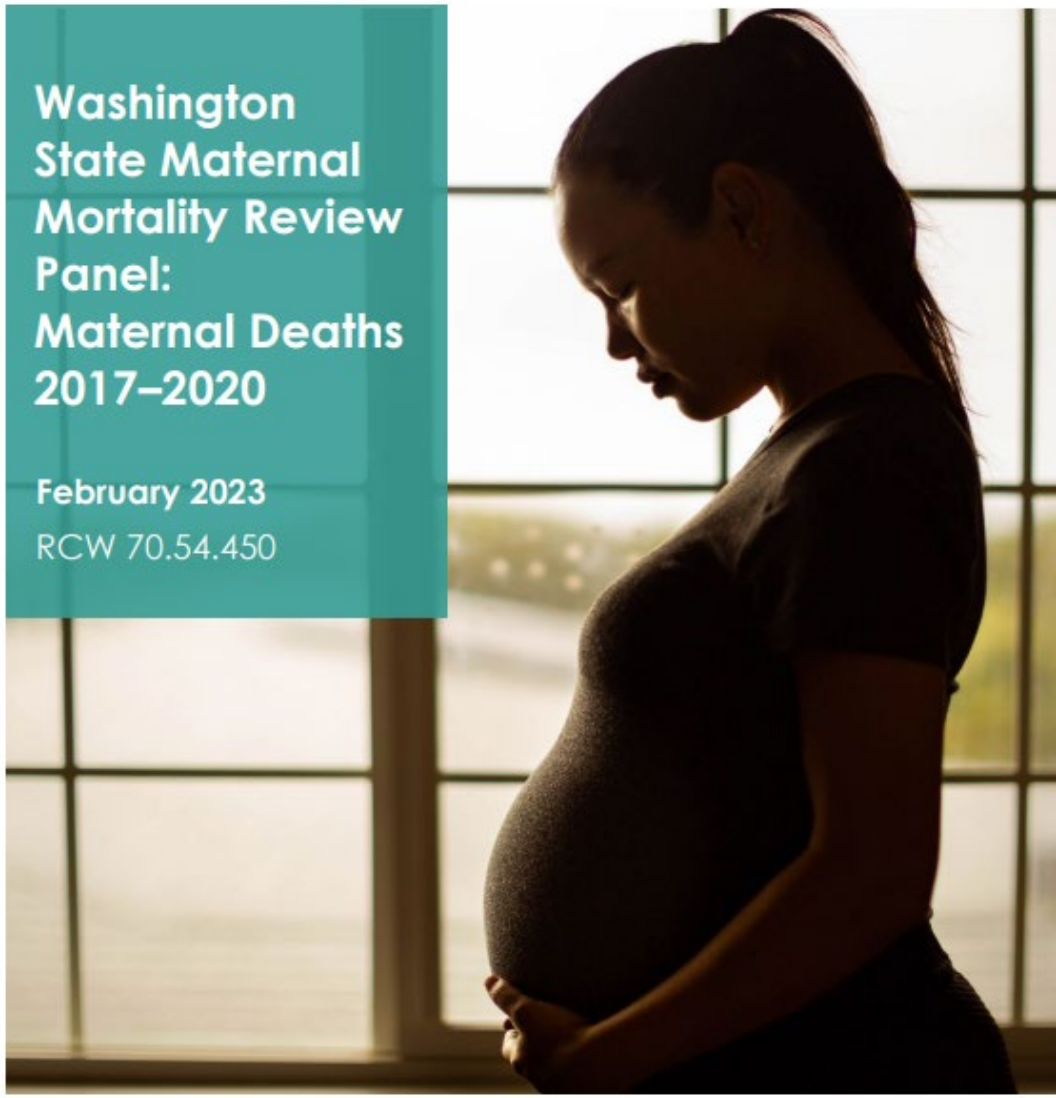
# Data Considerations

- **Maternal mortality is a rare event.**
- Observations from maternal mortalities in Washington state are **not generalizable outside of the state of Washington.**
- Small numbers often make rates unstable, making it difficult to discern true change on a year-to-year basis.
- We can still make meaningful recommendations, observations, and interventions.

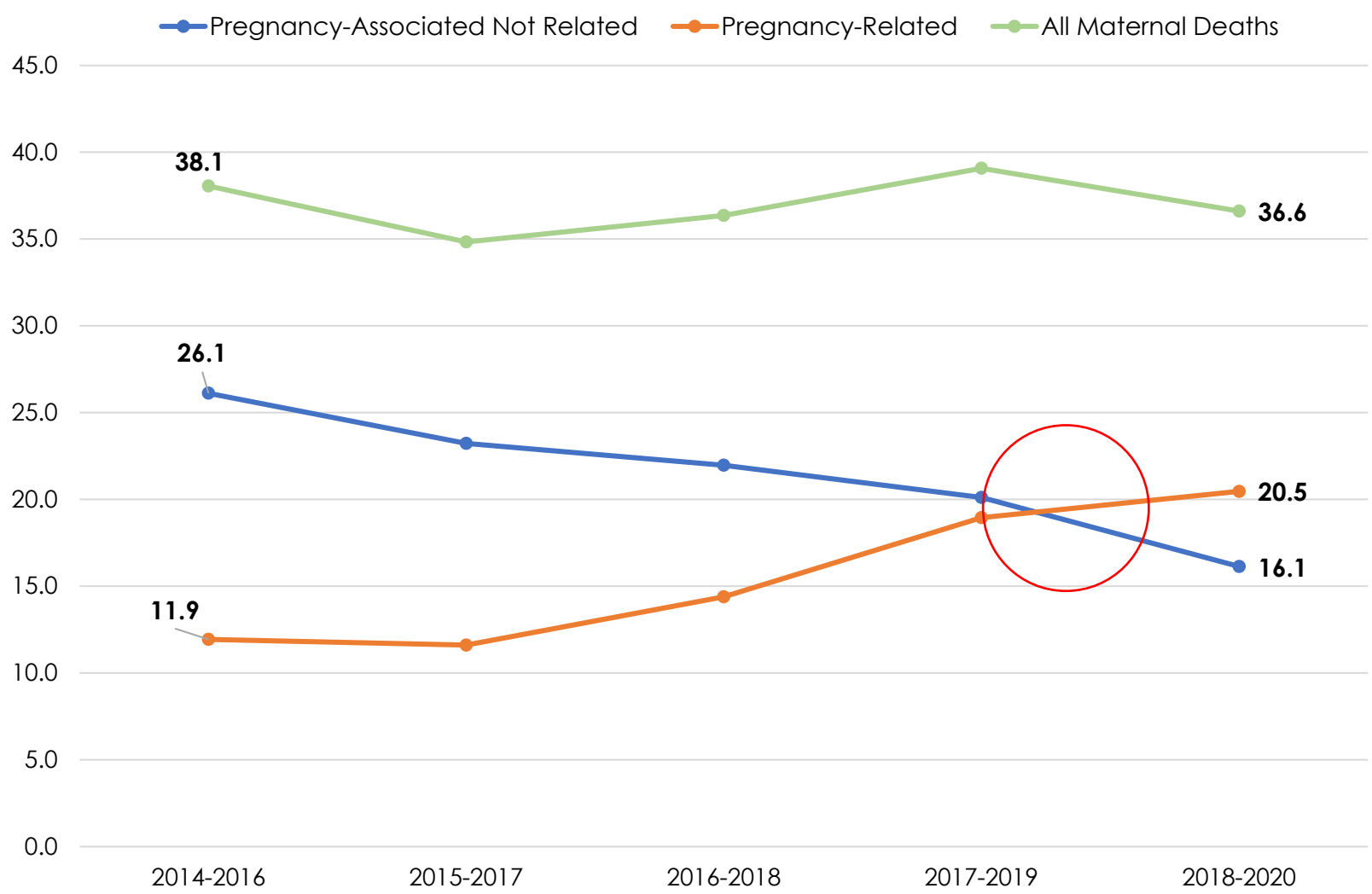
# Maternal Mortality Rate

*Have rates in Washington increased?*

- **Overall** pregnancy-associated mortality in Washington state has remained **relatively stable in recent years** and did not increase in the period 2014–2020
- However, **disparities persist**
- Washington's maternal mortality rate is **lower than the national average**



# Rolling 3-year Maternal Mortality Rate Trends per 100,000 Live Births, WA, 2014–2020



# Maternal Mortality
# WA and US 2014–2020

## Washington

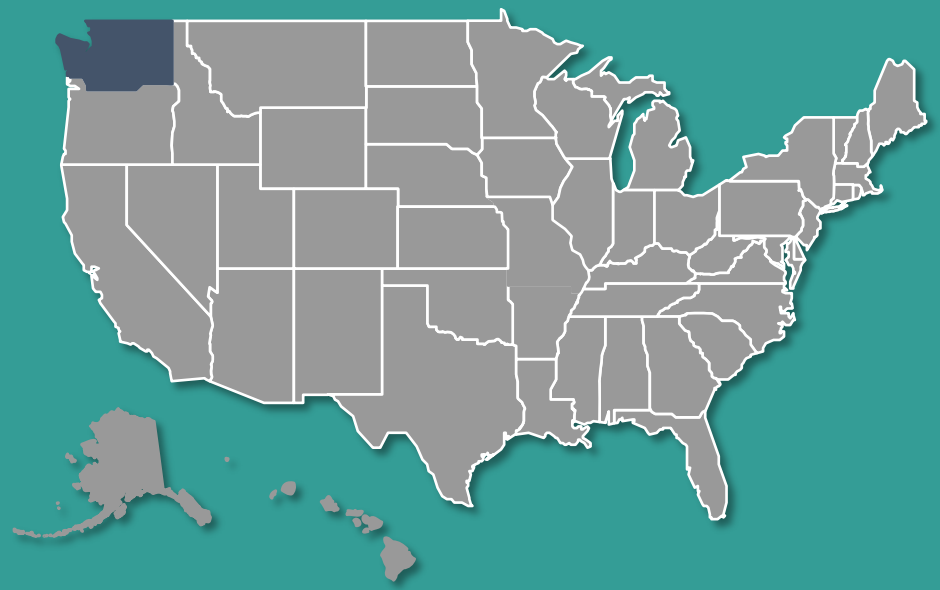
- 15.9 pregnancy-related deaths/100,000 live births.*

## United States

- 18.6 pregnancy-related deaths/100,000 live births.**
- 861 pregnancy-related deaths per year (PMSS – CDC 2020).
- Rates increasing since 1980s.
- Higher than rates in Canada, countries in Europe, and other wealthy nations.

*This rate (WA) includes deaths from substance use overdose and suicide.

**This rate (US) does NOT include deaths from accidental or incidental causes.



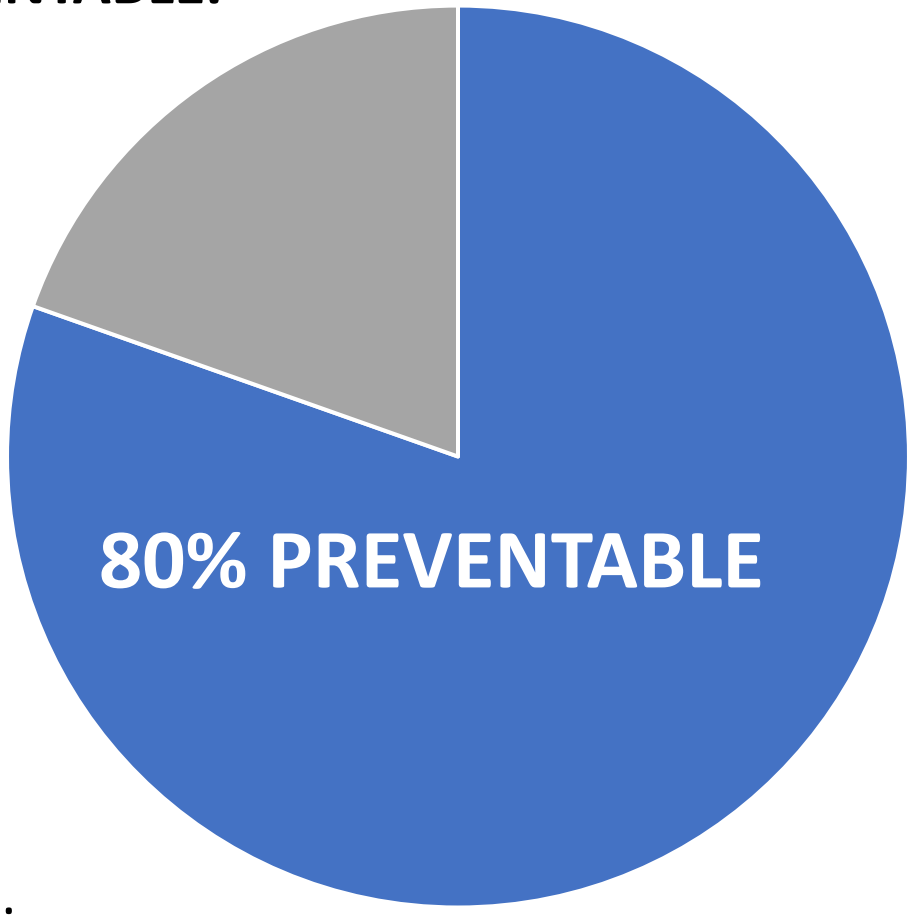
# Counts of Maternal Deaths and Pregnancy-Relatedness, WA, 2014-2020

| **Total Pregnancy-Associated Deaths** | **224** |
|---|---|
| Pregnancy-Associated, Not Related | 106 |
| Pregnancy-Related Deaths | **97** |
| of these, how many preventable | **78** (80% of 97) |
| Pregnancy-Associated but Unable to Determine if Related | 18 |

# Preventability

**80 PERCENT of pregnancy-related deaths were PREVENTABLE.**

- At least some chance of being averted if a factor that contributed to the death had been different.




This high percentage reflects:

- **A broader understanding of preventability:**
  Clinical, equity, and social-determinants-of-health factors.
- **An opportunity to take action:**
  Better understanding of what's behind maternal deaths.

# Demographics and Disparities

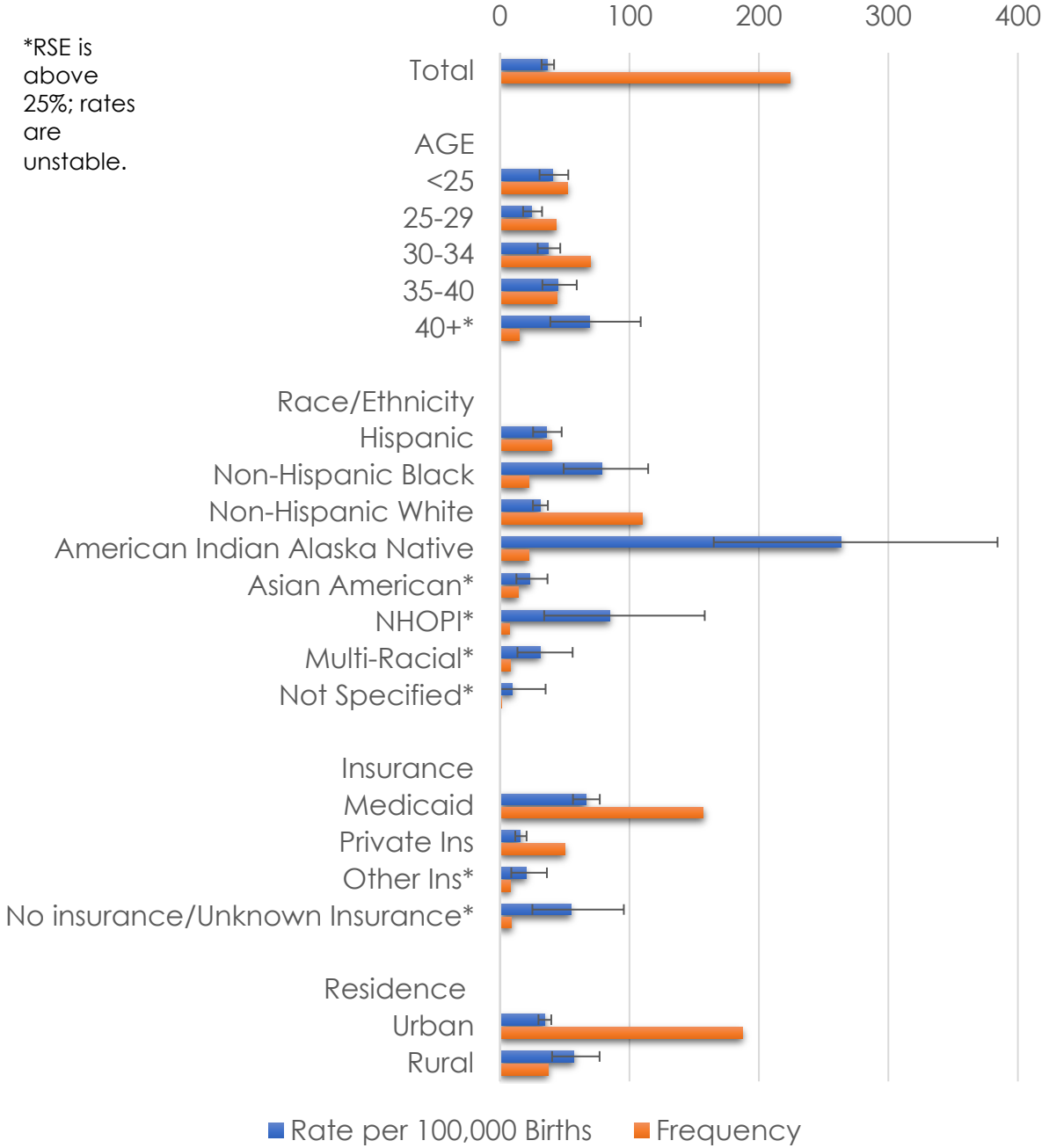
- **Striking disparities experienced**
  - American Indian / Alaska Native
  - Native Hawaiian / Other Pacific Islander
  - Non-Hispanic Black
  - Medicaid coverage
  - Rural areas

- Discrimination, bias, interpersonal racism, or structural racism in **nearly half** of preventable pregnancy-related deaths from 2017–2020.

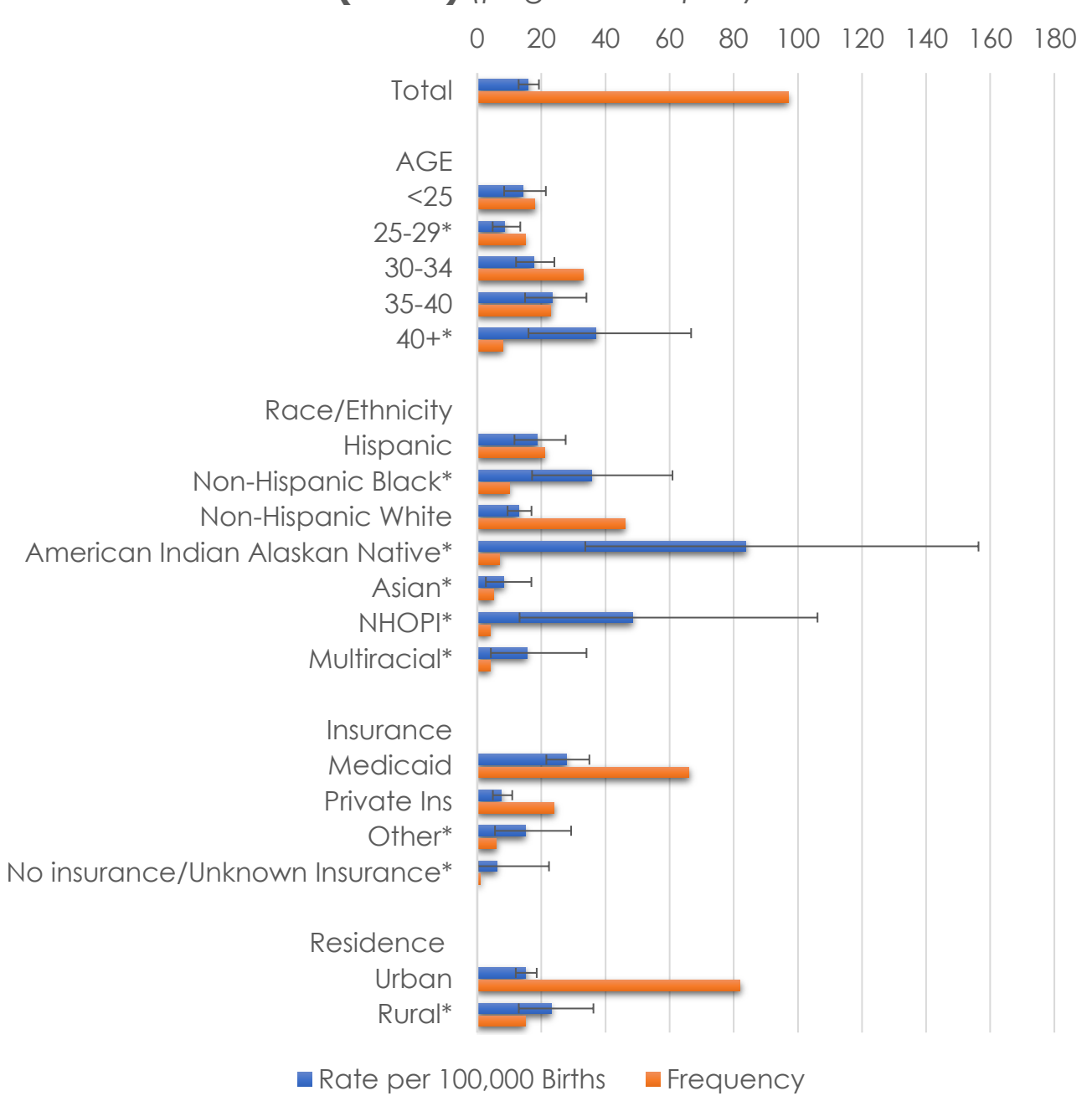
# All Maternal Deaths, 2014–2020 (n=224)

*(page 26 in report)*

*RSE is above 25%; rates are unstable.




# Pregnancy-Related Deaths, 2014–2020 (n=97) *(page 31 in report)*



# Key Messages: Racism, Discrimination, and Bias

We understand this better due to changes in how the Panel reviews cases and how we review data on communities with smaller population numbers.

Communities most burdened by perinatal health inequities have the **expertise** and **cultural knowledge** to **lead solutions** to **reduce maternal mortality**.

Black, Indigenous, and communities of people of color must be **centered as leaders** for the successful implementation of many of the recommendations in this report.

**DISPARITIES PERSIST**

# Causes and Impacts

*Leading Causes?*

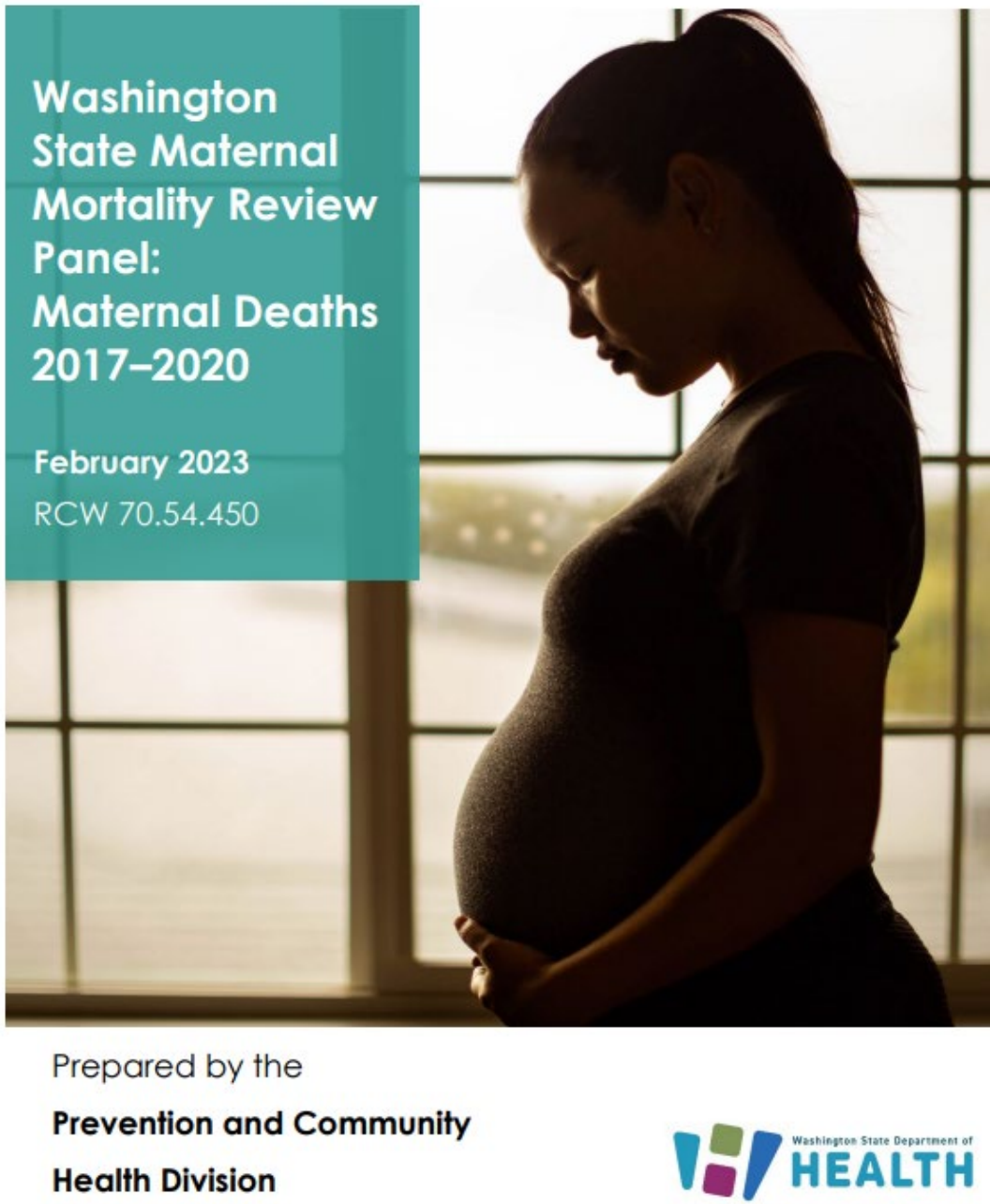
- **Behavioral health** conditions (predominantly by suicide or overdose), **hemorrhage**, **infection**.

*Impact of COVID-19?*

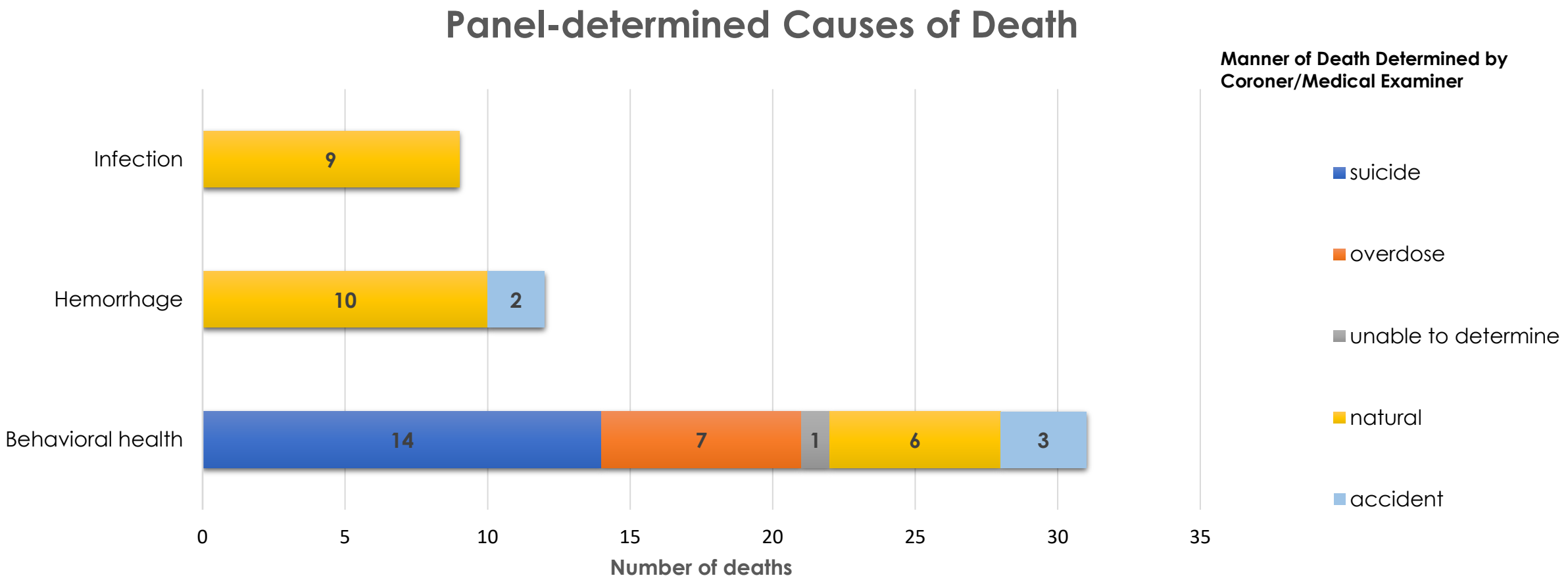
- N**ot able** to draw conclusions
- However, saw **impacts of the pandemic era**

*Why through one year postpartum?*

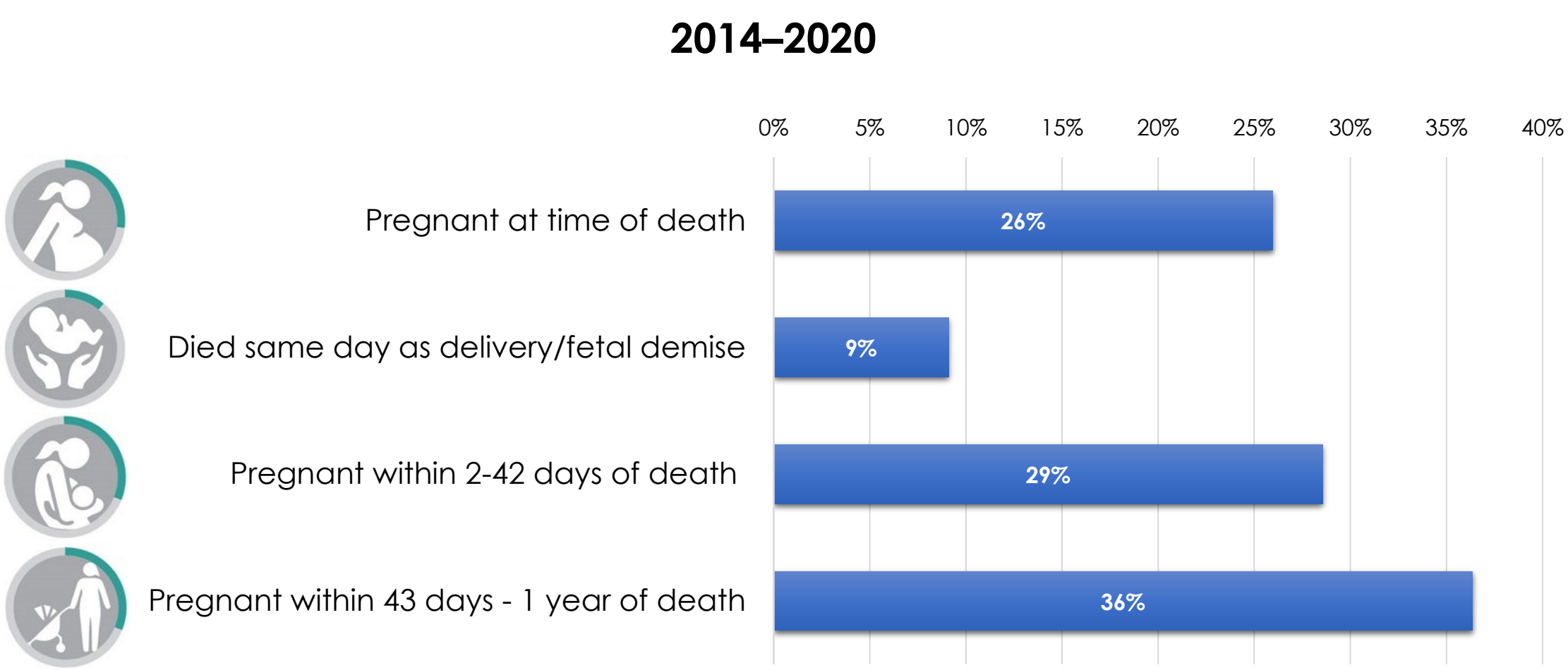
- Many deaths, particularly with behavioral health conditions, **in later postpartum**.



# Manner of Death and Three Leading Causes of Pregnancy-Related Deaths, WA, 2014–2020 (n=97)



# Timing of Pregnancy-Related, Preventable Deaths



# Deep Dive: Behavioral Health

# Demographics: **Pregnancy-Associated Deaths** from **Unintentional Substance Overdose**(n=23), 2014-2020

Primarily occurred to:

- 30 years old and younger
- Non-Hispanic white
- Insured through Medicaid
- Urban areas

- American Indian/Alaska Native communities made up a disproportionate number of these deaths

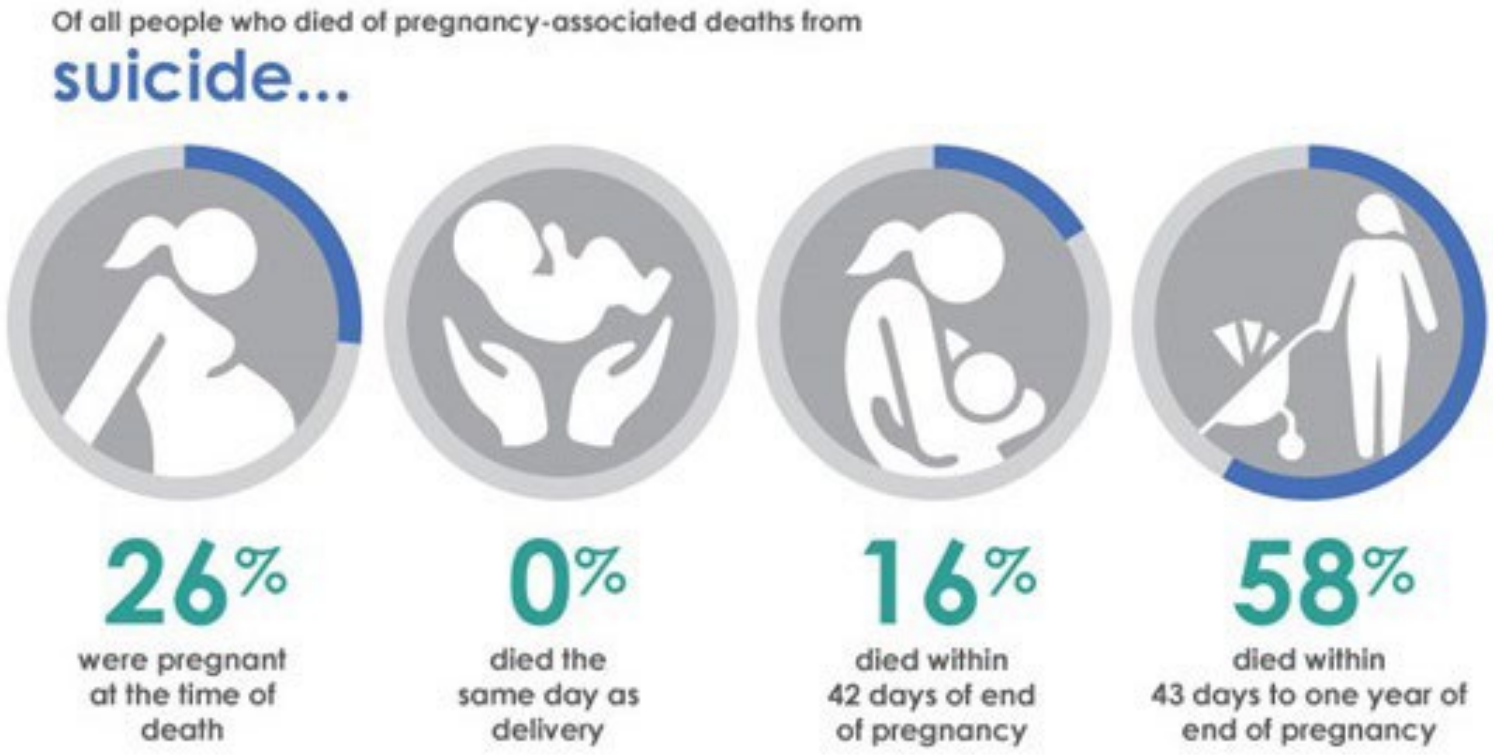
# Timing from Pregnancy to Death from **Unintentional Substance Overdose** (n=22) (pregnancy-associated), 2014–2020

# Demographics: **Pregnancy-Associated Deaths** from **Suicide** (n=19), 2014–2020

Primarily occurred to:

- 30 years old and older
- Living mainly in urban areas
- Insured through Medicaid
- Intentional substance overdose, hanging, firearm discharge

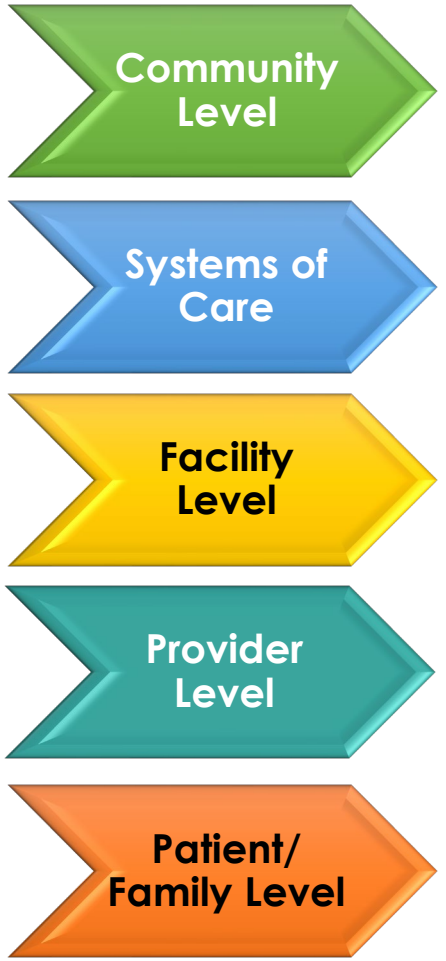
# Time from Pregnancy to Death for Deaths Due to **Suicide** (n=19) (pregnancy-associated, 2014–2020



# RECOMMENDATIONS

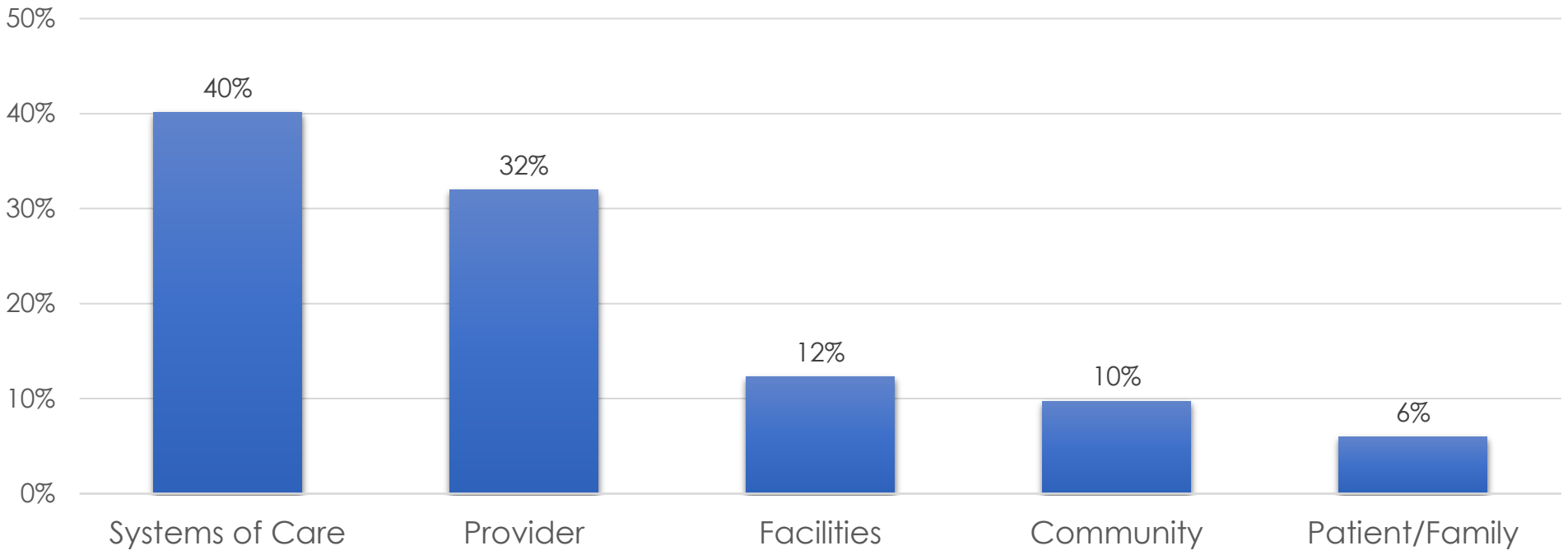
# Contributing Factors to Death

**Event**(s) or **issue**(s) identified by the Panel during the review of each death that **if changed or averted**, may have **prevented the death** from occurring.



# Contributing Factors to Preventable Pregnancy-Related Deaths

Distribution of **contributing factors** by systems level for preventable pregnancy-related deaths **since last report**



# Recommendations: Key Audiences

The Panel's recommendations **(pages 51–75)** fall under **6 broad priority recommendations**, each with detailed **recommended actions** for **FOUR KEY AUDIENCES:**

1. Policy and Budget Actions (**Legislature**)
2. Perinatal Systems of Care (**Providers and Facilities**)
3. Governmental, Academic, Community and Professional **Agencies** and **Organizations**
4. The **Department of Health**

# 1. Address racism, discrimination, bias, and stigma in perinatal care.

- Expand and diversify the perinatal workforce to **reflect cultures and languages of communities,** including funding training, education pathways, scholarships, grants, low-interest loans, and reimbursement for training. (1.1)

- Prioritize access to perinatal care in **communities experiencing inequities and disparities**. (1.2)

- **Fund community-driven initiatives** that address structural racism, social drivers of health, and promising solutions to reduce inequities. (1.3)

# 2. Increase access to mental health and substance use disorder prevention, screening, and treatment for pregnant and parenting people.

- Policymakers should **enhance reimbursement for mental health and substance use disorder screening**, including: (2.1)
  - Additional depression screenings throughout 1 year postpartum.
  - Routine screening for alcohol and other drugs in pregnancy, postpartum.
  - Parent/caregiver depression screening during well child visits.

- Increase the number of **residential treatment facilities** that **allow parents and children to enter treatment together**. (2.2)
  - Increase funding for higher reimbursement rates for facilities that allow parents to bring their children (at least one facility per county).
  - Provide capital funding for building costs.
  - Expand definitions for who qualifies for the program.
  - Increase access to legal aid supports (Medical Legal Partnership Model).

# 3. Expand equitable and high-quality health care by improving care integration, expanding telehealth services, and increasing reimbursement.

- Increase **funding for out-of-hospital birthing care**, such as midwifery. Fund start-up costs for birthing centers in rural areas or areas that serve populations with disproportionate perinatal outcomes. (3.3)

- **Expand home visiting services** for pregnant and postpartum families across Washington. (3.1)
  - At least one visit from a licensed provider to assess all birth parents and newborns within 2–3 days.
  - Fund culturally relevant programs that offer home visiting.
  - Fund long-term home visiting and case management.
  - Support expansion of MSS and Infant Case Management.
  - Explore options to expand Medicaid reimbursement.

# 4. Strengthen the quality and availability of perinatal clinical and emergency care that is comprehensive, coordinated, culturally appropriate, and adequately staffed.

- Increase and diversify the perinatal health workforce to **address staffing shortages, meet increased demands on the health care system, and improve care quality**. Prioritize diversity of physicians, obstetricians, midwives, nurses, doulas, community health workers. (4.5)

- Support **funding** for state agencies and providers to **implement perinatal quality improvement initiatives**, including activities, programs, and organizations. (4.2)

# 5. Meet basic needs of pregnant and parenting people by prioritizing access to housing, nutrition, income, transportation, child care, care navigation, and culturally relevant support services.

- Increase access for pregnant and postpartum people to **safe, affordable, and stable housing**. (5.1)
  - Expand supportive housing programs with links to health care services.

- Increase funding for **education, employment, child care, transportation**, and other services. (5.2)

- **Streamline processes** so that **pregnant and parenting people can easily access social programs** that support health care, housing, transportation, child care, nutrition, employment, and education. (5.3)

# 6. Prevent violence in the perinatal period through survivor-centered and culturally appropriate coordinated services.

- **Fund safe housing for pregnant and postpartum people**, including shelter and housing specifically for people **experiencing intimate partner violence**. Ensure housing **comes with wraparound services** to help with finances, immigration, advocacy, legal services, substance use, **child care**, and other needs. (6.4)
  - Fund Department of Commerce to **expand low-income housing and fund "housing first" programs** focused on survivors of IPV.

# Addendum from the American Indian Health Commission

## Seven Recommendations

1. **The number one priority is to reduce Native Maternal Mortality until the disparity is eliminated.**
2. **Culturally appropriate engagement** and **building trust** at the **community level** is critical to understanding root causes of Native Maternal Mortality and essential to finding appropriate solutions and strategies.
3. **Tribal-led data needs assessments, planning, administration,** and **analysis**, including Tribal PRAMS, to address root causes of AI/AN maternal morbidity and mortality, substance misuse, and harm reduction strategies.

# Addendum from the American Indian Health Commission

4. Address **historical inequities** and **create trust** in **health transformation system change** through policy, inclusion, and allocation of funds to create and assure culturally relevant services.

5. Improved and expanded **access for culturally relevant services and resources**, utilizing Seven Generations Principles, throughout the continuum of pregnancy, birth and postpartum for both parents.

6. Funding, focus and prioritization to support **Tribal-led workforce planning and development** to successfully recruit, train and hire an **AI/AN workforce** to support the needs of Native pregnant, birthing, and postpartum women and people.

7. Support and fund **Tribal-led nutrition planning and project development initiatives**, such as **Food Sovereignty** and **First Foods** (breastfeeding) work.

# IMPLEMENTATION AND NEXT STEPS: One year since the report

# Washington State Perinatal Collaborative (WSPC)

## Mission

**End** preventable **morbidity, mortality**, and **disparitie**s in pregnancy, postpartum, and infant care through **quality improvement initiatives** and fostering **a network of statewide perinatal leaders**.

## Vision

Washington state is a **safe** and **equitable** place to experience pregnancy, give birth, and parent.

## Values

- Equity
- Open Membership
- Quality
- Transparency & Accountability
- Collaboration

WSPC WASHINGTON STATE Perinatal Collaborative

# MMRP RECOMMENDATIONS

# Center of Excellence for Perinatal Substance Use

- Based on 2019 MMR report recommendation
- Hospital certification program to improve the care for birthing people and infants impacted by substance use
- Hospital must meet eight criteria to become certified

# Birth Doula Certification

- Starting October 1, 2023, a birth doula may voluntarily apply for certification from the Department of Health
- All fees are waived until July 1, 2025
- HCA actively working to establish a doula benefit for Apple Health clients

# Blue Bands

- Patients at risk of developing preeclampsia wear a blue wrist band
- Wear band during pregnancy and after delivery
- The blue band alerts health care providers about a patient's risk for preeclampsia


# Birth Equity Project

- Strategic investments in community-based birth worker organizations
- Reduce racism faced by birth workers and families
- Current grantees
  - Ayan Maternity Health Care Support
  - BLKBRY
  - Nisqually Tribal Health and Wellness Center
  - Shades of Motherhood
  - Spokane Tribal Network

# Smooth Transitions

- Enhance the safety of transferring patients from home or birth center to a hospital
- Brings together midwives, hospitals providers, and EMS personnel to build a collaborative model of care
- Collect and analyze transfer outcomes data

# TeamBirth

- Framework for shared-decision making and amplifying the birthing person's voice
- Shared planning boards (white board) and huddles
- Over three years, all WA hospitals will participate in one of four cohorts

# Rural Care Access

- Convening workgroups
  - Rural OB providers
  - Cross-organization collaborative
- Building a Maternal Health Taskforce prioritizing rural health and four other areas
- Data mapping and analysis focused on rural care access

# Connecting Recommendations to Your Priorities

- What recommendations are **most relevant** in your region, field, or community?
- Is your group **working on implementing or supporting** one or more of these recommendations? Or hoping to start soon?
    - Which best match your **priorities** and **current needs you're aware of**?
    - **With whom** do you hope to **collaborate**?
- Are there other efforts you are aware of?
- How can the report's findings and recommendations **support your work and priorities**?

# Questions?

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