NH AIM/ERASE Monthly Webinar
April 13, 2023

WELCOME!

• We will begin shortly
• Please type your name and email into the chat box for attendance
• Reminder, we will be recording this session
• Please mute your line upon entering and chat in your comments or questions
• Vicki Flanagan will monitor the chat box and call on you to unmute yourself
• If you have trouble connecting, please email Victoria.A.Flanagan@Hitchcock.org

Please Note: New CME/CNE Process!

To Receive CME/CNE Credit for Today’s Session
Text: 833-884-3375 – NEW PHONE #
Enter Activity Code: 134394
Need help? clpd.support@hitchcock.org
The impact of perinatal mental health conditions on the health and wellbeing of birthing people in NH

NH AIM/ERASE Monthly Webinar
April 13, 2023
Daisy Goodman, DNP, MPH, CNM
Maggie Coleman, MPH
Alison Palmer, APRN, WHNP-BC, PMHNP-BC

Agenda
1. NH AIM updates
2. AIM CPPPSUD bundle
3. AIM PMHC bundle

Learning Objectives
1. Discuss current data on the prevalence of and factors associated with perinatal depression in NH
2. Describe elements in the AIM Patient Safety Bundle on Perinatal Mental Health Conditions
3. Recognize potential barriers and facilitators to implementing the Perinatal Mental Health bundle

Todays speakers have no conflicts of interest to disclose
A quality improvement initiative to support best practices that make birth safer, improve maternal health outcomes and save lives.

CDC works with MMRCs to improve review processes that inform recommendations for preventing future deaths.


Critical Collaborations: NNEPQIN, ERASE and AIM
SUD Safety Bundle: Currently...

- Patient-level REDCap project is up and running for most facilities
  - Support available for onboarding, data entry questions, surveillance reports
  - Challenges: process design, bandwidth, identifying eligible patients

Source: all de-identified eligible patients from 01/01/23 – 02/28/23

SUD Safety Bundle: What’s next?

- Scheduling quarterly check-ins
  - 30 min call, aiming for end of April/early May
- Facility-level structure measures
- Uploading to AIM portal
  - comparison across all (blinded) hospital reports
Looking Ahead....
Coming Soon!
Perinatal Mental Health Care Practice Self-Assessment

• Baseline assessment of practice patterns around perinatal mental health
  • Screening
  • Interventions
  • Patient education
  • Culturally and linguistically appropriate services
  • Billing and coding practices
• Intended for ambulatory maternity care providers

Please share with you colleagues, patients and communities!

➢ New project exploring mental health needs for New Hampshire Birthing People

OBJECTIVES

01 Discuss current data on the prevalence of and factors associated with perinatal depression in New Hampshire

02 Describe elements in the AIM Patient Safety Bundle on Perinatal Mental Health Conditions

03 Explain potential barriers and facilitators to implementing the Perinatal Mental Health bundle.
"Every pregnancy and birth creates two windows of opportunity to improve outcomes: one for the mom and one for the child. Unlike with many other issues, interventions that improve maternal mental health outcomes pay dividends across two or more generations."

— The Perigee Fund

CDC data: 2018 - 2021

Maternal Mortality Rates Are Climbing

2018 | 2019 | 2020 | 2021
---|---|---|---
Total | 17.4 | 20.1 | 23.8 | 32.6
Non-Hispanic Black | 17.4 | 20.1 | 23.8 | 32.6
Non-Hispanic White | 17.4 | 20.1 | 23.8 | 32.6
Hispanic | 17.4 | 20.1 | 23.8 | 32.6

Statistically significant increase from previous year (p < 0.05)

NOTE: Race groups are single-race


In 2021 the maternal mortality rate for non-Hispanic Black women was SIGNIFICANTLY higher than rates for White and Hispanic women.
700 women die each year in the United States as a result of pregnancy or delivery complications.

Mental health conditions: 25%
Hemorrhage: 15%
Infection: 10%
Cardiac and coronary conditions: 10%
Thrombotic embolism: 5%
Cardiomyopathy: 5%
Hypertensive disorders of pregnancy: 5%

Causes of Pregnancy-Associated Deaths in NH 2017 - 2021

- **Overdose (drug abuse: fentanyl, cocaine, etc.)** (19) - 59%
- **Cardiovascular and/or cardiomyopathy** (4) - 12.5%
- **Suicide (hanging/neck wounds)** (2) - 6.3%
- **Amniotic fluid embolism** (2) - 6.3%
- **Hemorrhage** (2) - 6.3%
- **Cancer** (2) - 6.3%
- **Blunt head injury (MVA)** (1) - 3.1%

Frequency of selected committee determinations on circumstances surrounding death for reviewed cases:

<table>
<thead>
<tr>
<th>Committee determinations</th>
<th>Yes</th>
<th>No</th>
<th>Probably</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did obesity contribute to the death?</td>
<td>2</td>
<td>23</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Did discrimination contribute to the death?</td>
<td>0</td>
<td>13</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Did mental health conditions contribute to the death?</td>
<td>13</td>
<td>7</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Did substance use disorder contribute to the death?</td>
<td>15</td>
<td>7</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Was this death a suicide?</td>
<td>2</td>
<td>19</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Was this death a homicide?</td>
<td>0</td>
<td>28</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Data Source: MMRIA
Postpartum Depression is the most common complication of childbirth

75% of women w/symptoms go UNDETECTED


NH PRAMS DATA BRIEF: MATERNAL DEPRESSION 2016-2020

### Frequency of Maternal Depression in NH (2016-2020)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>5-year average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before pregnancy</td>
<td>16 – 23%</td>
<td>18%</td>
</tr>
<tr>
<td>During pregnancy</td>
<td>14 – 19%</td>
<td>16%</td>
</tr>
<tr>
<td>After pregnancy</td>
<td>11 – 16%</td>
<td>13%</td>
</tr>
<tr>
<td>After pregnancy</td>
<td>13 – 15%</td>
<td>13%</td>
</tr>
</tbody>
</table>

**SOURCE:** NH PRAMS Data Brief 2016-2020.

### What Are The Costs and Consequences of Untreated Perinatal Mental Health Conditions?

**CONSEQUENCES OF UNTREATED PMH DISORDERS**

<table>
<thead>
<tr>
<th>PARENT</th>
<th>BABY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents with untreated PMH disorders are more likely to:</td>
<td></td>
</tr>
<tr>
<td>Mismange their own health</td>
<td>Low birth weight or small head size</td>
</tr>
<tr>
<td>Have poor nutrition</td>
<td>Preterm birth</td>
</tr>
<tr>
<td>Use substances such as alcohol, tobacco, or drugs</td>
<td>Longer stay in the NICU</td>
</tr>
<tr>
<td>Experience physical, emotional, or sexual abuse</td>
<td>Excessive crying</td>
</tr>
<tr>
<td>Be less responsive to baby’s cues</td>
<td>Impaired parent-child interactions</td>
</tr>
<tr>
<td>Have fewer positive interactions with baby</td>
<td>Behavioral, cognitive, or emotional delays</td>
</tr>
<tr>
<td>Experience breastfeeding challenges</td>
<td>Untreated mental health issues in the home may result in an Adverse Childhood Experience, which can impact the long-term health of the child.</td>
</tr>
</tbody>
</table>

**SOURCE:** Maternal Mental Health Leadership Alliance New Hampshire Fact Sheet.

MATERNAL DEPRESSION and HEALTH BEHAVIORS

PERINATAL MENTAL HEALTH CONDITIONS

BEFORE PREGNANCY

27% enter pregnancy with anxiety or depression

DURING PREGNANCY

33% develop symptoms during pregnancy

POSTPARTUM

40% develop symptoms after birth

3 – 6 MONTHS

Peak onset of postpartum depression

6 – 12 MONTHS

Increased incidence of suicide

Sources:
CDC, 2020; Davis, 2019; NIMH 2012, MMHLA 2023
Who says we should screen?

Screening should be implemented with ADEQUATE SYSTEMS IN PLACE to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

ACOG recommends screening patients:
- at least once during the perinatal period for depression and anxiety.
- if screening in pregnancy, it should be done again postpartum.

ACOG recommends patients have contact with their OBGYN w/n the first 3 weeks postpartum.

ACOG recommends a full assessment:
- of physical, social, and psychological well-being
- within a comprehensive postpartum visit
- that occurs no later than 12 weeks after birth.
2019 PERINATAL DEPRESSION CLINICAL RISK FACTORS

- Personal or family history of depression
- History of sexual abuse
- Unplanned/unwanted pregnancy
- Current stressful life events (housing move, job change, key change in relationship status, etc.)
- Diabetes or gestational diabetes
- Complications during pregnancy (premature contractions, hyperemesis)
- Low income
- Lack of family/social support
- Teen parent
- Single parent

BARRIERS TO CARE

Public Awareness & Education

- Recognition of symptoms
- Partner/friends tell them emotions are normal, don’t worry
- Stigma
- Parents do not understand risk of untreated mental health condition to baby’s health

Screening & Referral for Care

- OB/Pedi don’t feel qualified to screen for maternal mental health conditions
- Time...time...time
- No financial incentive to screen
- Moral distress r/t lack of resource options

Treatment Availability & Accessibility

National shortage of behavioral health providers
Limited number of reproductive psychiatric specialists
Insurance coverage, cost of care, transportation, language barriers, paid leave, childcare …all the SDoH
PERINATAL MENTAL HEALTH CONDITIONS

HEALTHCARE PROVIDER EDUCATION
- PCP, OB, Pedi
- Family Practice
- L&D, M/B, NICU, Pedi, ER, Psych
- CBE, VNA, home visitors, doulas
- Ambulatory behavioral health
- Mobile Crisis

CLINICAL WORKFLOWS
- Screening tools [including bipolar disorder and suicide risk assessments]
- Response protocols
- Pharmacotherapy guidance
- Treatment options
- Lifeline for Moms Toolkit

PATIENT EDUCATION
- Perinatal mental health psychoeducation for ALL
- Innovative Evidence-Based Prevention Programs
- ROSE (Mothers & Babies)

COMMUNICATION PATHWAYS
- OB Pedi Family Practice Psych

RESOURCES & REFERRALS
- Implement Resource Mapping
- Community based organizations
- State/public health agencies
- Local support groups
- Postpartum Support International

For support, understanding, and resources, call or text 1-833-945-5746

AREAS OF OVERLAP
- Care for Pregnant and Postpartum People with Substance Use Disorder
- Perinatal Mental Health Conditions

PROTOCOLS

DATA COLLECTION

EDUCATION

COORDINATION

Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion
**READINESS**
Develop workflows for integrating mental health into obstetric care
- Tools
  - Response Protocols
  - Training

**Validated screening tools**
- EPDS
- PHQ-9
- MDQ
- PC-PTSD
- C-SRSS
- PSS

**Establish response protocol**
Evidence-based treatment options

**Provider training**
Talking points for clinicians

**Address racism, implicit bias, stigma**

**Multidisciplinary communication + collaboration**
Inclusive, multi-media Patient/Support Person Education

**Develop + maintain set of referral resources**
Trauma informed care

**Crisis Intervention Pathway**

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**Plan the workflow:**
- Process for assessment, electronic documentation, referral, follow up

**WHO:**
- Frontline staff in practice settings
- Information technology specialists

**Trial and evaluate** the new workflow within individual practice settings.

**CHANGING PRACTICE**

**HOW and WHERE** will screening be completed?

**WHO** follows up with patient regarding plan of care?

**WHO** makes a referral to mental health support services and how?

**HOW** are patients linked to available resources?

**WHO** makes an action plan with the patient?

**HOW** and **WHERE** will performance be completed?

**WHO** will perform the screening?

**WHO** will review the results and **WHEN**?

**WHO** follows up with patient regarding plan of care?

**HOW** are results documented in medical record?
Maternal Depression Documentation in Well-Baby Template

ANTICIPATORY GUIDANCE:
(E.P 4 MONTH ANTICIPATORY GUIDANCE:14907)

MATERNAL ASSESSMENT:
Edinburgh Postnatal Depression Scale [NUMBERS 1-20 12831]
Thoughts of harming myself (self: 40000010)
Thoughts of hurting by baby (baby: 40000011)
PCP/OB Care Provider
PPD Education and Support provided (YES/NO) [63]

Referrer for further assessment and intervention [YES/NO] [61]
PPD Referral 40000012

RECOGNITION & PREVENTION SCREENING
Obtain individual and family psych hx
SCREEN Depression Anxiety Bipolar disorder at intake and prior to initiating pharmacotherapy
Social drivers of health

Provide psychoeducation:
• destigmatize perinatal mental health conditions
• engage perinatal individuals using strength-based and culturally-responsive approach.

Implement screening for depression and anxiety:
• TWICE during pregnancy (at initiation and at 24-28 weeks gestation)
• at least once in the postpartum period (6 weeks postpartum).

Implement screening for bipolar disorder:
• at initiation of care
• or after a positive depression screen
• particularly prior to initiating pharmacotherapy
When a perinatal mental health screening tool is positive:

• assess the patient and determine treatment approach.

Develop and use a repository of:

• mental health resources
• treatment referral sources
• tailored to the needs of your patient population.

Refer patients who screen positive for:

• psychotherapy
• group therapy
• other treatment and support options.

Start medication treatment when indicated

Lifeline for Moms App – for clinical guidance

Outcome Measures:

• % of Pregnant and Postpartum People with PMHC who RECEIVED or WERE REFFERED to TREATMENT

Process Measures:

• Patient Education
• Provider and Nursing Education
  • OB providers, Nursing L&D and PP – completed education on PMHC within last 2 years, including education on respectful and equitable care

Structure Measures:

• Inpatient-Outpatient Coordination Workgroup
• Resource Mapping / Identification of Community Resources
• Perinatal Mental Health Assessment and Response Protocol
• Patient Education Materials on Urgent Postpartum Warning Signs
• Validated Screening Tools Shared w/Prenatal Care Sites
RESPECTFUL, EQUITABLE, & SUPPORTIVE CARE

Include each pregnant/postpartum person and their identified support networks as respected members of and contributors to the multidisciplinary team.

Open, transparent, empathetic, trauma-informed communication
Understand dx, options, tx plans

www.coloradomaternalmentalhealth.org

The Perinatal Continuum of Care: A Toolkit for Action

- Shared decision-making approach to care
- Follow up and monitor perinatal mental health conditions once treatment is initiated.
- Ensure mental health care is ongoing at least one year postpartum
- Transition to primary care or another provider as needed
FOR PATIENTS AND FAMILIES

PSI Volunteer Warmline:
Resources for pregnancy, postpartum, post-loss support
Support Groups
Call: 1-800-944-4773
Text: “Help” to 800-944-4773 (English)
Text en Español: 971-203-7773

FOR HEALTHCARE PROVIDERS

MGH CENTER for Women’s Mental Health
Reproductive Psychiatry Resource & Information Center

Perinatal Psychiatric Consult Line
• for medical professionals 1-877-499-4773
• no charge / fee

PREScribing RESOURCES FOR HEALTHCARE PROVIDERS

The picture can't be displayed.
When PARENTS are well....
the FAMILY is well

PERINATAL PSYCHIATRY ACCESS PROGRAMS

Provide education, consultation, resources and referrals to increase the capacity of frontline healthcare providers to address perinatal mental health.

MCPAP for MOMS 2014. www.mcpapformoms.org

AIM PERINATAL SAFETY BUNDLE RESOURCES
NNEPQIN.ORG

AIM Perinatal Mental Health Bundle: Click here »
NEEDS ASSESSMENT
Where are we now?
Where do we need to go?

BRIDGING THE GAP ACROSS PRACTICE SETTINGS

Who Are the People in Your Neighborhood?

RESOURCE MAPPING

Inpatient to Ambulatory OB / Pedi / NICU Primary Care

COMMUNICATION TOOLS

QUESTIONS???
LET’S DISCUSS!

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www.palmerperinatal.com
Questions & Comments?

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