NH AIM/ERASE Monthly Webinar
May 9, 2024

WELCOME!

- We will begin shortly
- Reminder, we will be recording this session
- Your line will be muted upon entering. Please enter comments or questions in the chat
- Julie Bosak & Stephanie Langlois will monitor the chat box and call on you to unmute yourself
- If you have trouble connecting, please email **Stephanie.E.Langlois@hitchcock.org**

To Receive CME/CNE Credit for Today's Session
Text: 833-884-3375
Enter Activity Code: 143621

Need help? **clpd.support@hitchcock.org**

CE is ONLY available for live attendance.

NH AIM/ERASE Monthly Webinar
May 9, 2024

REMINDERS:

- Please feel free to share the recording with colleagues and those you feel would benefit if they are unable to attend @ **www.NNEPQIN.org:** Educational Offerings | NNEPQIN
- We HIGHLY value your input. Please be sure to **complete the evaluation** that Stephanie Langlois will send to you immediately following the webinar. It takes less than 5 minutes to complete.

How To Provide Appropriate Mental Health Treatment In Your Community To Meet Your Patients' Needs.

NH AIM/ERASE Monthly Webinar
May 9, 2024

Today's Agenda

NH Perinatal Services Data and Bundle details
Julie Bosak, DrPH, CNM

Providing appropriate care in the community setting
Rebecca Casey, MSN, APRN

Creating a Patient Centered Response
Brittini Cusson, LCSW

AIM Perinatal Mental Health Condition Bundle next steps

NOTE: Todays speakers have nothing to disclose

AIM ALLIANCE FOR INNOVATION ON MATERNAL HEALTH
NHPQC New Hampshire Perinatal Quality Collaborative
NH DIVISION OF Public Health Services Improving health, preventing disease, reducing costs for all
NNEPQIN NORTHERN NEW ENGLAND PERINATAL QUALITY IMPROVEMENT NETWORK

Gender Statement

We recognize that pregnant people have a variety of gender identities. There may be gendered language in this presentation, especially when citing other sources but the content of this presentation is applicable to all pregnant people.

AIM ALLIANCE FOR INNOVATION ON MATERNAL HEALTH
NHPQC New Hampshire Perinatal Quality Collaborative
NH DIVISION OF Public Health Services Improving health, preventing disease, reducing costs for all
NNEPQIN NORTHERN NEW ENGLAND PERINATAL QUALITY IMPROVEMENT NETWORK

A quality improvement initiative to support best practices that make birth safer, improve maternal health outcomes and save lives.

AIM

ERASE MM
Enhancing Reviews and Surveillance to Eliminate Maternal Mortality

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

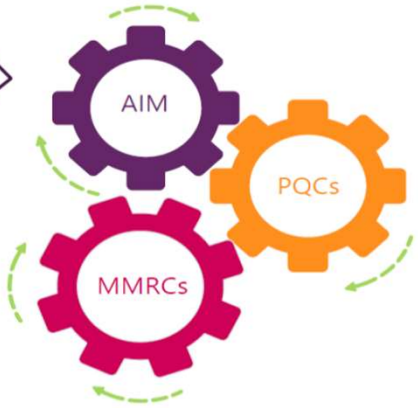
https://saferbirth.org/

https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/index.html

Critical Collaborations: NNEPQIN, ERASE and AIM

Alliance for Innovation on Maternal Health moves established guidelines into practice with a standard approach to improve safety in care

Maternal Mortality Review Committees conduct detailed reviews for complete and comprehensive data on maternal deaths to prioritize statewide prevention efforts



Perinatal Quality Collaboratives mobilize state or multi-state networks to implement clinical quality improvement efforts and improve care for mothers and babies

Created from a Centers for Disease Control, Division of Reproductive Health source

AIM
ALLIANCE FOR INNOVATION ON MATERIAL HEALTH

NHPQC
New Hampshire Perinatal Quality Collaborative

NNEPQIN
NORTHERN NEW ENGLAND PERINATAL QUALITY IMPROVEMENT NETWORK

NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs for all

PERINATAL MENTAL HEALTH CONDITIONS

For the purposes of this bundle, perinatal mental health conditions refer to mood, anxiety, and anxiety-related disorders that occur during pregnancy or within one year of delivery and are inclusive of mental health conditions with onset that predates pregnancy. These conditions include and are not limited to depression, anxiety and anxiety-related disorders like posttraumatic stress disorder and obsessive-compulsive disorder, bipolar disorder, and postpartum psychosis.

READINESS

Develop Workflows
- **Identify tools**
- **Response Protocol**
- **Education on Optimal Care**

RECOGNITION & PREVENTION ⊕

RESPONSE ⊕

REPORTING & SYSTEMS LEARNING ⊕

RESPECTFUL, EQUITABLE & SUPPORTIVE CARE ⊕

QUICK LINKS

- Patient Safety Bundle (PDF)
- Element Implementation Details (PDF)
- Implementation Resources (PDF)
- Data Collection Plan (PDF)
- Change Package (PDF)
- Implementation Webinar (Video)
- National Maternal Health Hotline
- Bundle Element Context and Reference List (xlsx)

Perinatal Mental Health Conditions (PMHC) Safety Bundle QA project

- **GOAL:** improved accuracy of PMHC birth certificate data for outcome measure
  - **3/1-3/14**: each site actively tracked every delivery on the unit for PMHCs
  - **Currently:** each site comparing self-surveillance with birth certificate facility worksheet data

Hospital blind #	1	2	3	4	5	6	7	8	10	11	12	13	14	15	16
PMHCs (observed on unit)	**39**	**No data***	**25**	**10**	**13**	**14**	**9**	**1**	**0**	**7**	**3**	**7**	**1**	**2**	**4**
Tx/referral (observed on unit)	36		25	5	8	4	5	1	0	3	2	4	0	1	2
No tx/referral (observed on unit)	3		0	5	5	10	4	0	0	4	1	3	1	1	2
PMHCs (reported via facility worksheet)	**12**		**20**	**18**	**1**	**17**	**0**	**1**	**0**	**0**	**2**	**0**	**1**	**0**	**2**
Tx/referral (reported via facility worksheet)	8		19	7	1	6	0	0	0	0	1	0	0	0	1
No tx/referral (reported via facility worksheet)	4		1	11	0	11	0	1	0	0	1	0	1	0	1

*site did not participate in QA; providers fill out birth certificate facility worksheet

NEXT STEPS

- **ONGOING:** meetings with sites to compare site surveillance with facility worksheet data
  - Talking through each site's process for recording facility worksheet data, identifying opportunities to improve accuracy (e.g. staff education, provider participation, adjusting existing admission interview workflow)
- **END OF JUNE:** QA-specific Webinars to share learnings as a state
  - **6/26 (Weds) at noon**
  - **6/27 (Thurs) at 3pm**
  - **Maggie to share meeting link via email**

Dartmouth Health

Psychiatry
DARTMOUTH HITCHCOCK MEDICAL CENTER

Providing appropriate perinatal mental health treatment for mild/moderate anxiety/depression in our communities

May 9, 2024

Becca Casey, MSN, PMHNP-BC

Dartmouth Health

Goals of Today

- Why we need Midwives & OB-Gyn like you caring for the mental health of birthing people.
- Brief review of screening for depression/anxiety
- Review of evidenced based treatments for **mild/moderate** depression/anxiety
- Common side effects with antidepressant treatment and strategies to mitigate
- Share resources
- Putting it all together: Case Study

Dartmouth Health

You have been recruited!

"Major depression affects women twice as often as it does men over the course of a lifetime, with the highest rate occurring during reproductive and menopausal transition years. Many women seek care during these peak years of depression incidence in obstetrics and gynecology (OB-GYN) settings for birth control, pregnancy, and gynecological problems. In fact, *one-third of visits for women aged 18 to 45* and the majority of non-illness-related visits for women younger than age 65 are to OB-GYN physicians."

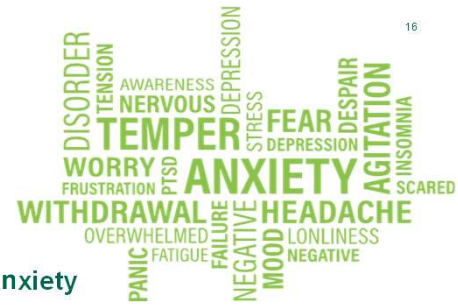
(Katon, 2014)

Dartmouth Health

16

Screening: PHQ-9 (Depression) GAD-7 (Anxiety)

- **PHQ-9**
  - **10-14 mild depression**
  - **15-19 moderate depression**
- **GAD-7**
  - **5-9 mild anxiety**
  - **10-14 moderate anxiety**



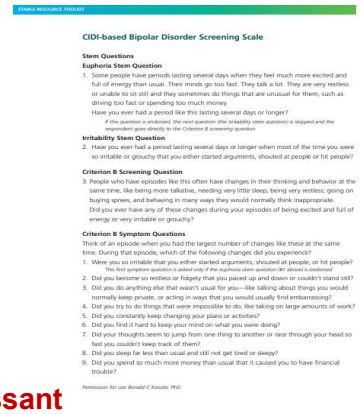
Don't forget your clinical interview!

- Symptom frequency/duration and impact on functioning
- Current and prior treatment (medications and therapy)
- Family history
- Previous psychiatric admissions
- Previous suicide attempts
- Current thoughts of self harm (must be evaluated further)

Dartmouth Health

Screen for Bipolar Disorder

- Bipolar disorder is a rare disorder but is frequently missed
  - "The aggregate lifetime prevalence of BD-I was 0.6%, BD-II 0.4%" (Jain et al, 2023)
  - The CIDI scale is more specific then mood disorder questionnaire
- **If positive screen/interview do not prescribe an antidepressant**
  - This can increase risk of hypomania/mania and mood cycling
- Recommend referral to psychiatric consultant or call perinatal consult line for support



STANLEY RESOURCE TOOLKIT

CIDI-based Bipolar Disorder Screening Scale

Stem Questions

Euphoria Stem Question

1. Some people have periods lasting several days when they feel much more excited and full of energy than usual. Their minds go too fast. They talk a lot. They are very restless or unable to sit still and they sometimes do things that are unusual for them, such as driving too fast or spending too much money.
   Have you ever had a period like this lasting several days or longer?
   If this question is endorsed, the next question (the irritability stem question) is skipped and the respondent goes directly to the Criterion B screening question

Irritability Stem Question

2. Have you ever had a period lasting several days or longer when most of the time you were so irritable or grouchy that you either started arguments, shouted at people or hit people?

Criterion B Screening Question

3. People who have episodes like this often have changes in their thinking and behavior at the same time, like being more talkative, needing very little sleep, being very restless, going on buying sprees, and behaving in many ways they would normally think inappropriate.
   Did you ever have any of these changes during your episodes of being excited and full of energy or very irritable or grouchy?

Criterion B Symptom Questions

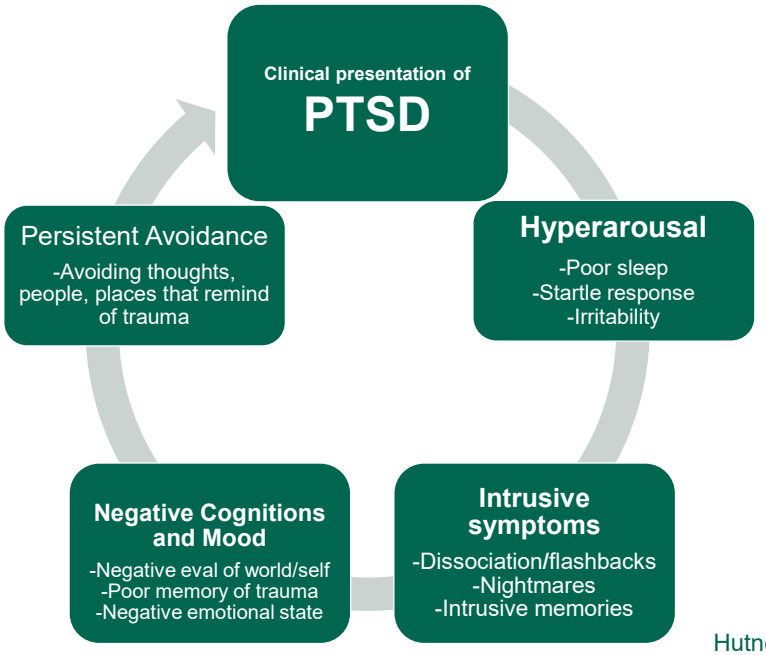
Think of an episode when you had the largest number of changes like these at the same time. During that episode, which of the following changes did you experience?

1. Were you so irritable that you either started arguments, shouted at people, or hit people?
   This first symptom question is asked only if the euphoria stem question (#1 above) is endorsed
2. Did you become so restless or fidgety that you paced up and down or couldn't stand still?
3. Did you do anything else that wasn't usual for you—like talking about things you would normally keep private, or acting in ways that you would usually find embarrassing?
4. Did you try to do things that were impossible to do, like taking on large amounts of work?
5. Did you constantly keep changing your plans or activities?
6. Did you find it hard to keep your mind on what you were doing?
7. Did your thoughts seem to jump from one thing to another or race through your head so fast you couldn't keep track of them?
8. Did you sleep far less than usual and still not get tired or sleepy?
9. Did you spend so much more money than usual that it caused you to have financial trouble?

Permission for use Ronald C Kessler, PhD

Dartmouth Health

18



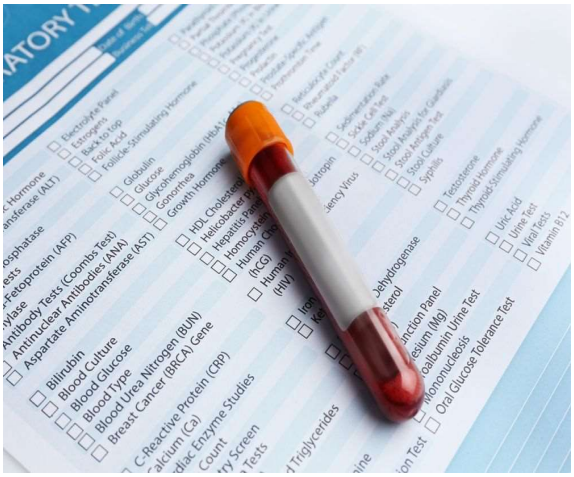
Hutner et al., 2022

Dartmouth Health

Lab tests to help rule out non-psychiatric causes of symptoms

- Complete blood count for anemia
  - Low iron can present as anxiety and restless legs in pregnancy
- TSH for thyroid disease
  - hypo vs. hyper thyroid can present as depression/anxiety
- Vitamin D and B12
  - Linked to depression when deficient

(Hutner, et al.)



Dartmouth Health

Complementary Treatments

- Yoga
- Exercise
- Acupuncture
- Bright light therapy (seasonal depression)

(Reza et al, 2018)

Meditation

- Mindful birthing trainings showed reduction in fear of childbirth/stress (Francisca et al, 2023)

*Consider financial cost and potential barriers

Dartmouth Health

21

Psychotherapy: what works in the perinatal population?

Interpersonal Psychotherapy

- Focus is on improving interpersonal relationships during big life transition (e.g., pregnancy). Evidence shows can improve mood/reduce anxiety (Sokol, 2018)

Cognitive Behavioral psychotherapy

- Challenging negative thoughts which can influence emotions and behavior

Check out: PSI directory and PsychologyToday for local providers

Dartmouth Health

22

Prescribe Sleep

- One of the most important questions I ask is about the *quality and quantity* of sleep during pregnancy and post partum
- 4 hours of interrupted sleep can make a big difference on mood/anxiety in the post partum period
  - Work with partners to support birthing person to protect sleep
  - Breastfeeding is important but sleep should be prioritized if woman is struggling with symptoms of PMADs
- Cognitive behavioral therapy for insomnia is gold standard

Dartmouth Health

The Risk-Risk Analysis (untreated illness)

- **Risks of psychiatric illness in pregnancy have long been underestimated:**
  - "Depression during pregnancy has been associated with pre-term delivery, low birth weight, higher rates of preeclampsia, gestational diabetes, decreased infant motor tone and activity, higher infant cortisol levels, poor reflexes, and overall worse infant health status" (Hutner et al., 2022)
  - Post partum depression impacts infants and children development including lowered IQ, slower language development, higher rates of behavioral problems, increased rates of ADHD, depression & anxiety
  - Anxiety during pregnancy is an independent risk factor for postpartum depression
  - Most importantly; there is increased suffering for mothers and families collectively

(ncrptraining.org)

Dartmouth Health

The Risk-Risk Analysis (antidepressant use in pregnancy)

- Associated with small increased risk of pre-term labor
  - Depression itself carries this risk (Hutner at al., 2022)
- Associated with small increased risk of pulmonary hypertension in a newborn
  - Absolute risk is small and conflicting studies (Huybrechts et al., 2016)
- Risk of poor neonatal adaption syndrome
  - Self limited & mild
  - Usually lasting 24-48 hours
  - Symptoms include: irritability, jitteriness, tremor, harder to soothe, increased muscle tone, rapid breathing

Dartmouth Health

The Risk-Risk Analysis

Important to communicate to patients:

Psychiatric Medication = Exposure

Psychiatric illness = Exposure

Goal: Mitigate risk of both!

Dartmouth Health

Antidepressant use in perinatal period

- Ask patient if they have had good experience with medications in the past, start with what *has worked*
- Continue medications that are working and taper/discontinue medications that are ineffective
  - Limit fetus exposure to multiple psycho-tropic medications where possible
  - This is ideal to complete *prior to conception*
- In later pregnancy, often need to increase dose of medication to higher then typical maximum dosing (e.g, Sertraline 250mg or Fluoxetine 100mg)
  - Due to increase in blood volume, changes in glomerular filtration rate and liver metabolism. Plasma antidepressant concentrations can drop by 40% to 50%. (Hutner et al., 2022)

Dartmouth Health

First-line Treatment Options for Mild, Moderate, or Severe Depression, Anxiety Disorder, and PTSD

Medication	sertraline* (Zoloft)	fluoxetine (Prozac)	citalopram** (Celexa)	escitalopram** (Lexapro)
Starting dose and timing	25 mg qAM (if sedating, change to qHS)	10 mg qAM	10 mg qAM	5 mg qAM
Initial increase after 4 days	↑ to 50 mg	↑ to 20 mg	↑ to 20 mg	↑ to 10 mg
Second increase after 7 more days	↑ to 100 mg			
Reassess Monthly (increase as needed until symptoms remit)	↑ by 50 mg	↑ by 20 mg	↑ by 10 mg	↑ by 10 mg up to 20 mg
Therapeutic range***	50-200 mg	20-80 mg	20-40 mg	10-20 mg
Individualized approach to titration	Slower titration (e.g., every 10-14-days) is often needed for patients who are antidepressant naïve or with anxiety symptoms			

*Lowest degree of passage into breast milk compared to other first-line antidepressants; **Side effects include QTc prolongation (see below);
***May need higher dose in 3rd trimester and when treating an anxiety disorder
In general, if an antidepressant has helped during pregnancy, it is best to continue it during lactation.
Prescribe a maximum of two (2) antidepressants at the same time.

lifeline-for-moms-toolkit-obstetric-care-clinician-algorithms.pdf (umassmed.edu)

Dartmouth Health

Second-line Treatment Options for Mild, Moderate, or Severe Depression, Anxiety Disorder, and PTSD

Medication	duloxetine (Cymbalta)	venlafaxine (Effexor XR)	fluvoxamine (Luvox)	paroxetine (Paxil)	mirtazapine (Remeron)	bupropion HCL (Wellbutrin XL)
Starting dose and timing	30 mg*** qAM	37.5 mg qAM	25 mg qHS	10 mg*** qAM (if sedating, change to qHS)	7.5 mg qHS	150 mg qAM
Initial increase after 4 days		↑ to 75 mg	↑ to 50 mg	↑ to 20 mg	↑ to 15 mg	
Second increase after 7 more days	↑ to 60 mg		↑ to 100 mg			
Reassess Monthly (increase as needed until symptoms remit)	↑ by 30 mg	↑ by 75 mg	↑ by 50 mg	↑ by 10 mg	↑ by 15 mg	↑ by 150 mg
Therapeutic range ***	30-120 mg	75-300 mg	50-200 mg	20-60 mg	15-45 mg	300-450 mg
Individualized approach to titration	Slower titration (e.g., every 10-14-days) is often needed for patients who are antidepressant naïve or with anxiety symptoms					

***May need higher dose in 3rd trimester and when treating an anxiety disorder

lifeline-for-moms-toolkit-obstetric-care-clinician-algorithms.pdf (umassmed.edu)

Dartmouth Health

29

SSRI/SNRI treatment algorithm

Start → **Monitor** → **Optimize** → **Augment/ Switch**

Start any SSRI/SNRI

PhQ-9 & GAD- 7:
At least 50% reduction in symptoms

Have you maximized dose?

- Bupropion (depression)
- Mirtazapine (sleep, anxiety, depression)
- Buspirone (anxiety, depression)
- SGAs like Aripiprazole/Quetiapine (depression/Anxiety)
- SWITCH? SSRI/SNRI (intolerance no response)

Dartmouth Health

30

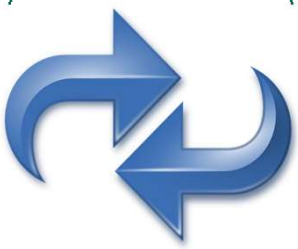
How to switch/taper

- **Direct switch** when similar class of antidepressant (Uptodate has some helpful graphs)

  Fluoxetine (SSRI) → Sertraline (SSRI)

  Switching classes you might need **cross taper**

  SNRI (Duloxetine) → Bupropion



- Antidepressants should be tapered
  - Monitor for relapse of psychiatric illness
  - discontinuation symptoms are common with **paroxetine & venlafaxine**
  - Ideally done over 4-6 weeks

Dartmouth Health

31

Tips during treatment

- Remind patients that it can take 4-6 weeks to see benefit from SSRI/SNRI
- **Benzodiazepines** offer quick relief from anxiety but carry risk of dependence
  - Avoid daily use and use shorter acting like Lorazepam
  - Harmful in PTSD
- Provide space for patients to discuss their ambivalence about treatment
- Support and empower patients particularly *anxious patients*
  - Consider starting very low (e.g., Sertraline 12.5mg)
  - Provide dosing range to increase when they are ready
  - I often tell patients, "the goal is to feel more like yourself"

Dartmouth Health

Common Side Effects with SSRI/SNRI

- Common to have H/A, GI upset and INCREASED anxiety in early days of treatment
  - generally this passes after 5-7 days but not always

Additional side effects:

Sexual side effects	Weight Gain	QTC prolongation
Drowsiness	Insomnia	Hypotension

Dartmouth Health

33

Drug	Anticholinergic	Drowsiness	Insomnia/ agitation	Orthostatic hypotension	QTc prolongation*	Gastrointestinal toxicity	Weight gain	Sexual dysfunction
Selective serotonin reuptake inhibitors¶								
Citalopram	0	0	1+	1+	2 to 3+Δ	1+¶	1+	3+
Escitalopram	0	0	1+	1+	2+	1+¶	1+	3+
Fluoxetine	0	0	2+	1+	1+	1+¶	0	3+
Fluvoxamine	0	1+	1+	1+	1+	1+¶	1+	3+
Paroxetine	1+	1+	1+	2+	1+	1+¶	2+	4+
Sertraline	0	0	2+	1+	1+	2+¶◇	1+	3+
Atypical agents								
Agomelatine§ (not available in United States)	0	1+	1+	0	0	1+	0	0 to 1+
Bupropion	0	0	2+ (immediate release) 1+ (sustained release)	0	0 to 1+¥	1+	0	0
Mirtazapine	1+	4+	0	0	1+	0	4+	1+
Serotonin-norepinephrine reuptake inhibitors¶‡								
Desvenlafaxine†	0	0	1+	0	0	2+	Unknown	1+
Duloxetine	0	0	1+	0	0	2+¶	0 to 1+	1+
Levomilnacipran†	0**	0	0 to 1+	0 to 1+	0	2+¶	0	1+

https://www.uptodate.com/contents/image?imageKey=PC/62488

Dartmouth Health

34

Do ask about sexual side effects:

Table 1

Meta-analysis of the prevalence of sexual dysfunction in patients taking antidepressants [3].

Antidepressant	Prevalence of Sexual Dysfunction	Main Form of Sexual Dysfunction
Moclobemide	0.22%	Desire (4.11%), orgasm (0.41%), arousal (1.91%)
Agomelatine	0.25%	Desire (1.52%), orgasm (1.31%)
Amineptine	0.46%	Insufficient data
Nefazodone	0.46%	Desire (1.53%), orgasm (0.32%), arousal (0.19%)
Bupropion	0.75%	Desire (1.29%), orgasm (1.26%), arousal (1.83%)
Mirtazapine	2.32%	Desire (6.03%), orgasm (4.4%), arousal (3.92%)
Fluvoxamine	3.27%	Desire (6.31%), orgasm (11.91%), arousal (31.42%)
Escitalopram	3.44%	Desire (1.10%), orgasm (4.23%), arousal (0.68%)
Duloxetine	4.36%	Desire (5.25%), arousal (10.95%)
Phenelzine	6.43%	Desire (5.71%), orgasm (11.85%), arousal (5.76%)
Imipramine	7.24%	Desire (6.33%), orgasm (5.25%), arousal (6.07%)
Fluoxetine	15.59%	Desire (45.59%), orgasm (11.91%), arousal (31.42%)
Paroxetine	16.68%	Desire (46.99%), orgasm (18.45%), arousal (44.44%)
Citalopram	20.27%	Desire (55.30%), orgasm (14.39%), arousal (82.48%)
Venlafaxine	24.82%	Desire (23%), orgasm (15.94%), arousal (54.04%)

Strategies to mitigate:

- Ask about symptoms
- Switch antidepressants
- Drug holiday
- Reduce dose
- Consider adding: bupropion, mirtazapine
- Psychotherapy for couples/sex therapy

Montejo et al, 2019

Dartmouth Health

35

Breastfeeding considerations

- Generally SSRI/SNRIs are in low levels in breastmilk
  - No need to stop antidepressant if mother chooses to breastfeed
  - Infant serum levels less then 10% maternal levels
    - Fluoxetine is exception and in higher levels in breastmilk
  - All can increase prolactin and cause galactorrhea
- Lactmed and Mothertobaby great resources to consult

Dartmouth Health

36

New Drug Treatment: Zuranolone

‹ Previous Next ›

New Oral Drug Zuranolone (Zurzuvae) for Postpartum Depression is Now Available

By MGH Center for Women's Mental Health | December 28th, 2023 | Postpartum Psychiatric Disorders | 0 Comments

We have been talking about zuranolone for a long time, and it is now available. Zuranolone will be marketed under the brand name **ZURZUVAE** by Sage Therapeutics in partnership with Biogen. Zuranolone represents a new option for the treatment of PPD, a rapidly acting oral medication with a good safety profile and a novel mechanism of action.

We received news about a month ago that the full 14-day course of zuranolone treatment would cost about $15,900. At that point it was not clear how insurers would handle access to the new medication. A few weeks into the game, we have a little bit of information to share.

Dartmouth Health

Putting it all together: Case study

- A 32yo woman is expecting her second child at 12 weeks gestation. She has PMH of asthma, MDD & GAD. She comes to her midwife to discuss her options for psychiatric care. Her anxiety/depression have responded partially to Escitalopram 5mg and Buspirone 5mg BID. She stopped medications in her last pregnancy at the recommendations of her PCP. She had preterm labor and delivered at 32 weeks gestation. She describes distressing anxiety during pregnancy. Post partum, she took an extended leave from her work as an elementary school teacher due to significant pp depression. She describes during the post partum period; difficulty caring for her baby, anhedonia, poor sleep, excessive tearfulness & poor appetite. She restarted Escitalopram and Buspirone at 6 months after she stopped breastfeeding so to not expose her baby. She wants to have a different experience this pregnancy. She continues to have only partially treated depression/anxiety on low dose Escitalopram and Buspirone and worries she can't function without them.

What would you do differently this pregnancy?

Dartmouth Health

Perinatal resources

National Maternal Mental Health Hotline — HRSA

Parents: don't struggle alone

The National Maternal Mental Health Hotline provides free, confidential mental health support. Pregnant people, moms, and new parents can call or text any time, every day.

Start a call: 1-833-TLC-MAMA (1-833-852-6262)

Text now: 1-833-TLC-MAMA (1-833-852-6262)

Use TTY: Use your preferred relay service or dial 711, then 1-833-852-6262.

Learn more about the Hotline

Dartmouth Health

39

Helpful perinatal mood and anxiety disorder resources:

- **MGH Reproductive Psychiatry:** https://womensmentalhealth.org/ (MGH Reproductive Psychiatry site with up to date, evidence-based information for patients and providers as well as opportunities to participate in research studies)
- **Postpartum Support International:** https://www.postpartum.net/ (Postpartum Support International--grass roots organization providing information and support for perinatal mood and anxiety disorders, including provider directory and online support groups)
- **Postpartum Support International Support Groups:** https://www.postpartum.net/get-help/psi-online-support-meetings/ (online support groups)
- **UK Teratology Information Service:** https://www.medicinesinpregnancy.org/. (Best Use of Medicines in Pregnancy: UK Teratology Information Service site regarding safety of medications in pregnancy)
- **MotherToBaby:** https://mothertobaby.org/- provides free and uptodate evidence-based information on the benefit or risk of medications and other exposures during pregnancy and while breastfeeding. Great patient handouts

Dartmouth Health

40

Helpful perinatal mood and anxiety disorder resources:

- **Birth Trauma Resource Website**: https://www.birthtraumaassociation.org/ . Support birthing people who identify traumatic birth experiences. Serves to educate health care professions
- **LactMed**: https://www.ncbi.nlm.nih.gov/books/NBK501922/ - “contains information on drugs and other chemicals to which breastfeeding mothers may be exposed. It includes information on the levels of such substances in breast milk and infant blood, and the possible adverse effects in the nursing infant.”
- **Reprotox**: https://reprotox.org/login “contains summaries on the effects of medications, chemicals, biologics, and physical agents on pregnancy, reproduction, lactation, and development.” subscription only access
- **NCRP**: https://ncrptraining.org/ “The mission of the National Curriculum in Reproductive Psychiatry is to advance knowledge about the diagnosis and treatment of psychiatric disorders throughout the reproductive life span. To build a common foundation for education and training in this emerging field, and to inspire lifelong learning about reproductive psychiatry, particularly during pregnancy and the postpartum period.”

Dartmouth Health

Thank you!

Email: Rebecca.A.Casey@hitchcock.org

What does patient-centered mental health care look like: the patient and provider perspective

Brittini Cusson, LCSW

NNEPQIN NORTHERN NEW ENGLAND PERINATAL QUALITY IMPROVEMENT NETWORK

NHPQC

AIM ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

NH DIVISION OF Public Health Services Improving health, preventing disease, reducing costs for all

My personal experience

- Almost avoidance of addressing mental health.
- Seemed like it was a taboo topic.
- Felt like it was avoided versus any type of safety planning.
- Long history of anxiety and depression that was documented in my chart
  - Did they not read my chart?
  - Or they weren't comfortable addressing it?
- I am already scared and nervous about the pregnancy, it isn't helpful to sense a discomfort from the provider
- Already on medication that was from my PCP. I brought up what my plan should be for med management to protect postpartum period
  - I was a very good advocate for myself
- Rushed feeling of all my visits (understand from a provider perspective)

My personal experience

- Positive:
  - The approach during labor helped me with my anxiety.
  - Very patient centered
  - Benefit of a small hospital and personalized care
  - Completely unexpected and rushed labor, but I was completely informed.
  - Kew what was **going in** my body and why
  - What was **going on** my body and why

My professional lens

- If you **have a comfort level** around discussing anxiety and depression
  - Patients pick up on that and share very openly
  - A providers discomfort is pretty obvious and then patient's aren't going to be open and honest
- My experience really **reframed the concept of whole person** care for me
  - Awareness of how interwoven it all is and I think of patients and if they can talk about their mental health freely helps.
  - If their anxiety increased due to medical issues, that impact their blood pressure, then worsens their symptoms
- Recognizing that the patient knows themselves best and being able to understand that it is a give and take between patient and provider
  - **Don't dismiss or diminish their concerns**

How do I ensure I show up in the room and be patient centered

- Know who your patient is when you show up in the room
  - Follow up on their last progress note
  - Read the new referral/ information
  - This shows the patient that their time and their history is important enough to me when I make the time to be prepared
- The other important factor is self-care
  - Music, napping (I have three kids)
  - Monthly massage
  - Know your own warning signs and recognize when I am being triggered by what someone is sharing. Sometimes I know to take 5-10 minutes to regroup.

Challenges

- The EMR documentation is challenging and a barrier
- Volume
  - The expectation for numbers of patients to see on top of all the administration demands

AIM ALLIANCE FOR INNOVATION ON MATERNAL HEALTH
NHPQC
NNEPQIN NORTHERN NEW ENGLAND PERINATAL QUALITY IMPROVEMENT NETWORK
NH DIVISION OF Public Health Services

Questions & Comments?

To Receive CME/CNE Credit for Today's Session

Text: 833-884-3375

Enter Activity Code: 143621

Need help? **clpd.support@hitchcock.org**

AIM ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

NHPQC New Hampshire Perinatal Quality Collaborative

NNEPQIN NORTHERN NEW ENGLAND PERINATAL QUALITY IMPROVEMENT NETWORK

NH DIVISION OF Public Health Services Improving health, preventing disease, reducing costs for all

NEXT MONTH

NH AIM/ERASE Monthly Webinar

June 13, 2024

How To Find The Right Consult When You Have A Client That Needs A Higher Level Of Care

Julie Frew, MD, Vice Chair of Education, Department of Psychiatry DH Health

Kassie Eafrati, MA, Chief of Operations Mental Health, Northern Human Services

AIM ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

NHPQC New Hampshire Perinatal Quality Collaborative

NNEPQIN NORTHERN NEW ENGLAND PERINATAL QUALITY IMPROVEMENT NETWORK

NH DIVISION OF Public Health Services Improving health, preventing disease, reducing costs for all

NNEPQIN
NORTHERN NEW ENGLAND PERINATAL QUALITY IMPROVEMENT NETWORK
A Dartmouth-Hitchcock Program

2024 NNEPQIN Spring Conference

Thursday, June 6, 2024


Photo by Joel Holland on Unsplash

Live Stream from Lebanon, NH

JUNE 6, 2024
FULLY VIRTUAL – REGISTRATION OPENING SOON!!

TOPICS:

- **Trauma Informed Care for Perinatal Mental Health and Substance Use Disorders**
- **Addressing Obesity Bias in Healthcare**
- **"Wholistic" Multidisciplinary Approaches to**
- **Supporting Socially or Medically Complex**
- **Neonatal Patients and Their Families**
- **Supporting the Partner and Family Following a Traumatic Birth Experience**
- **Second Victims: Peer to Peer Support for Health Care Providers after Adverse Events**

SAVE THE DATE!
JUNE 3, 2024
NH BREASTFEEDING TASK FORCE'S ANNUAL PROFESSIONAL CONFERENCE!
Mill Falls at Church Landing on Lake Winnipesaukee!

New Research to Support Modern Families: Clinical Recommendations for Mastitis, HIV and Promoting Attachment Parenting

Registration via Eventbrite forthcoming!

Dartmouth Health

54

References

- Anxiety-in-Pregnancy-the-Postpartum. (n.d.). Parlab.med.ubc.ca. Retrieved April 22, 2024, from https://parlab.med.ubc.ca/infographic-on-anxiety-in-pregnancy-the-postpartum/anxiety-in-pregnancy-the-postpartum/
- Breslau N. Epidemiologic studies of trauma, posttraumatic stress disorder, and other psychiatric disorders. Can J Psychiatry. 2002 Dec;47(10):923-9. doi: 10.1177/070674370204701003. PMID: 125531
- Breslau N. Epidemiologic studies of trauma, posttraumatic stress disorder, and other psychiatric disorders. Can J Psychiatry. 2002 Dec;47(10):923-9. doi: 10.1177/070674370204701003. PMID: 125531
- CIDI-based Screening Scale for Bipolar Spectrum Disorders - Overview. (n.d.). https://www.ohsu.edu/sites/default/files/2021-10/%28CIDI%29%20Screening%20Scale%20for%20Bipolar%20Spectrum%20Disorders.pdf
- Cipriani, A., Furukawa, T. A., Salanti, G., Chaimani, A., Atkinson, L. Z., Ogawa, Y., Leucht, S., Ruhe, H. G., Turner, E. H., Higgins, J. P. T., Egger, M., Takeshima, N., Hayasaka, Y., Imai, H., Shinohara, K., Tajika, A., Ioannidis, J. P. A., & Geddes, J. R. (2018). Comparative efficacy and acceptability of 21 antidepressant drugs for the acute treatment of adults with major depressive disorder: a systematic review and network meta-analysis. The Lancet, 391(10128), 1357–1366. https://doi.org/10.1016/s0140-6736(17)32802-7
- Contributor, S., & Nagle-Yang. (n.d.). SSRIs and Pregnancy Risk-Risk Conversation Trainee Guide. Retrieved April 28, 2024, from https://ncrptraining.org/wp-content/uploads/2019/10/Depression_Risk-Risk_Classroom_Trainee-Guide_Final_V1.pdf

- Francisca, Veringa-Skiba, I. K., Sauer, A., Esther, & Bögels, S. M. (2023). Cost-Effectiveness of the Mindfulness-Based Childbirth and Parenting Program for Pregnant Women With Fear of Childbirth. Journal of Obstetric, Gynecologic & Neonatal Nursing. https://doi.org/10.1016/j.jogn.2023.10.004
- Frew, J. (2024, April 18). Management of Anxiety and Depression in the OB/Gyn Clinic Setting [Power point Management of Anxiety and Depression in the OB/Gyn Clinic Setting].
- Frew, J., Thorsness, K., Hutner, L., & Saadatmand, J. (n.d.). Perinatal Anxiety Disorders Self-Study Contributors Updated in 2022 by. Retrieved April 28, 2024, from https://ncrptraining.org/wp-content/uploads/2022/03/Perinatal-Anxiety_Self-Study_v2.pdf
- Generalized Anxiety Disorder 7-item (GAD-7) scale. (n.d.). https://www.dartmouth-hitchcock.org/sites/default/files/2021-02/gad-7-anxiety-scale.pdf
- Genovez M, Vanderkruik R, Lemon E, Dimidjian S. Psychotherapeutic Treatments for Depression During Pregnancy. Clin Obstet Gynecol. 2018 Sep;61(3):562-572. doi: 10.1097/GRF.0000000000000388. PMID: 29965823
- Goldfinger, C., Green, S. M., Furtado, M., & McCabe, R. E. (2019). Characterizing the nature of worry in a sample of perinatal women with generalized anxiety disorder. Clinical Psychology & Psychotherapy, 27(2). https://doi.org/10.1002/cpp.2413

- Grace SL, Evindar A, Stewart DE. The effect of postpartum depression on child cognitive development and behavior: a review and critical analysis of the literature. Arch Womens Ment Health. 2003 Nov;6(4):263-74. doi: 10.1007/s00737-003-0024-6. PMID: 14628179
- Health, M. C. for W. M. (2023, December 28). *New Oral Drug Zuranolone (Zurzuvae) for Postpartum Depression is Now Available - MGH Center for Women's Mental Health*. https://womensmentalhealth.org/posts/new-oral-postpartum-drug-zuranolone-available/
- Hutner, L. A., Catapano, L. A., Nagle-Yang, S. M., Williams, K. E., Osborne, L. M., & American Psychiatric Association Publishing (2022). Textbook of women's reproductive mental health. American Psychiatric Association Publishing.
- Huybrechts KF, Bateman BT, Palmsten K, Desai RJ, Patorno E, Gopalakrishnan C, Levin R, Mogun H, Hernandez-Diaz S. Antidepressant use late in pregnancy and risk of persistent pulmonary hypertension of the newborn. JAMA. 2015 Jun 2;313(21):2142-51. doi: 10.1001/jama.2015.5605. PMID: 26034955; PMCID: PMC4761452
- Jain, A., & Mitra, P. (2023). Bipolar Disorder. PubMed; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK558998/
- Katon, W., & Reed, S. (2014). Improving Depression Care in OB-GYN Settings. Psychiatric News, 49(15), 1–1. https://doi.org/10.1176/appi.pn.2014.8a15

Dartmouth Health

57

- Leistikow, N., Baller, E. B., Bradshaw, P. J., Riddle, J. N., Ross, D. A., & Osborne, L. M. (2022). Prescribing Sleep: An Overlooked Treatment for Postpartum Depression. Biological Psychiatry. https://doi.org/10.1016/j.biopsych.2022.03.006
- Mazzoni S, Brewer S, Durfee J, Pyrzanowski J, Barnard J, Dempsey AF, O'Leary ST. Patient Perspectives of Obstetrician-Gynecologists as Primary Care Providers. J Reprod Med. 2017 Jan-Feb;62(1-2):3-8. PMID: 29999273
- Montejo AL, Prieto N, de Alarcón R, Casado-Espada N, de la Iglesia J, Montejo L. Management Strategies for Antidepressant-Related Sexual Dysfunction: A Clinical Approach. J Clin Med. 2019 Oct 7;8(10):1640. doi: 10.3390/jcm8101640. PMID: 31591339; PMCID: PMC6832699
- Montejo AL, Prieto N, de Alarcón R, Casado-Espada N, de la Iglesia J, Montejo L. Management Strategies for Antidepressant-Related Sexual Dysfunction: A Clinical Approach. J Clin Med. 2019 Oct 7;8(10):1640. doi: 10.3390/jcm8101640. PMID: 31591339; PMCID: PMC6832699
- Pan, WL., Chang, CW., Chen, SM. et al. Assessing the effectiveness of mindfulness-based programs on mental health during pregnancy and early motherhood - a randomized control trial. BMC Pregnancy Childbirth 19, 346 (2019). https://doi.org/10.1186/s12884-019-2503-4
- Pearlstein T. Perinatal depression: treatment options and dilemmas. J Psychiatry Neurosci. 2008 Jul;33(4):302-18. PMID: 18592032; PMCID: PMC2440793

Dartmouth Health

58

- Pfizer (1999). The Patient Health Questionnaire (PHQ-9) -overview. https://coepes.nih.gov/sites/default/files/2020-12/PHQ-9%20depression%20scale.pdf
- Primary Care PTSD Screen for DSM-5 (PC-PTSD-5) - PTSD: National Center for PTSD. (2014). Va.gov. https://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp
- Primary Care PTSD Screen for DSM-5 (PC-PTSD-5) (n.d.) https://www.ptsd.va.gov/professional/assessment/documents/pc-ptsd5-screen.pdf
- Psychiatric Medications: Perinatal and Lactation Considerations Approaching Risk/Risk Discussions around Lithium and Anticonvulsants, SGAs, and Benzos. (n.d.). Retrieved May 5, 2024, from https://ncrptraining.org/wp-content/uploads/2019/12/Risk-Risk_Medications-in-Pregnancy-Self-Study_Trainee.pdf
- Reza N, Deligiannidis KM, Eustis EH, Battle CL. Complementary Health Practices for Treating Perinatal Depression. Obstet Gynecol Clin North Am. 2018 Sep;45(3):441-454. doi: 10.1016/j.ogc.2018.04.002. PMID: 30092920.
- Simas, M. (n.d.). Retrieved April 18, 2024, from https://www.umassmed.edu/globalassets/lifeline4moms/implementation-guide/lifeline-for-moms-toolkit-obstetric-care-clinician-algorithms.pdf

Dartmouth Health

- Sockol, L. E. (2018). A systematic review and meta-analysis of interpersonal psychotherapy for perinatal women. Journal of Affective Disorders, 232, 316–328. https://doi.org/10.1016/j.jad.2018.01.018
- UpToDate. (n.d.) https://www.uptodate.com/contents/switching-antidepressant-medications-in-adults#H4
- Whitton A, Warner R, Appleby L. The pathway to care in post-natal depression: women's attitudes to post-natal depression and its treatment. Br J Gen Pract. 1996 Jul;46(408):427-8. PMID: 8776916; PMCID: PMC1239697.
- Zimmermann M, Julce C, Sarkar P, McNicholas E, Xu L, Carr C, Boudreaux ED, Lemon SC, Byatt N. Can psychological interventions prevent or reduce risk for perinatal anxiety disorders? A systematic review and meta-analysis. Gen Hosp Psychiatry. 2023 Sep-Oct;84:203-214. doi: 10.1016/j.genhosppsych.2023.08.005. Epub 2023 Aug 16. PMID: 37619299; PMCID: PMC10569160.