Perinatal Depression and Anxiety: Interdisciplinary Teams Facilitate Integration of Obstetric & Mental Health Care in the U.S.

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Disclosure Statement:
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- Founding Leader, Lead Obstetric Liaison, MCPAP for Moms, MA Department of Mental Health
- Co-Founder, Medical Director, Lifeline4Moms
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- McGraw Hill, Reviewer, Perinatal Depression Case Chapter
Perinatal mental health complications are one of the most common complications of pregnancy.

Perinatal depression affects as many as one in seven women.

http://www.acog.org/Womens-Health/Depression-and-Postpartum-Depression
1 in 5 women around the world will suffer from a maternal mental health complication.

#MaternalMHHMatters
Perinatal mental health disorders negatively effect mom, child & family

- Poor medical care adherence
- Smoking & substance use
- Preeclampsia
- Suicide
- Low birth weight
- Preterm delivery
- Cognitive delays
- Behavioral problems
- Infanticide

Maternal suicide exceeds hemorrhage and hypertensive disorders as a cause of maternal mortality.
Perinatal mental health complications are under-diagnosed and under-treated

There exists patient, provider and practice-level barriers to addressing perinatal mental health care

**Patient**
- **Barrier**: Undetected, Fear/stigma, Limited access
- **Intervention**: Self-management support, Community resources

**Provider**
- **Barrier**: Lack of training, Lack of guidance, Few resources
- **Intervention**: Provider decision support

**Systems**
- **Barrier**: Screening not routine, Isolated providers
- **Intervention**: Clinical Info. systems, Health care organization

**Barriers**
- **Women do not disclose symptoms or seek care**
- **Underutilization of Treatment**
- **Unprepared OB/Gyns with limited resources**

**Intervention**
- **Informed, Activated Women**
- **Treatment Engagement**
- **Prepared, Activated OB/Gyns and staff**

**Poor outcomes**

**Improved outcomes**

www.chroniccare.org
The perinatal period is ideal for the detection, assessment and treatment of perinatal depression and anxiety

Regular opportunities to screen and engage women in treatment

Ob/Gyn providers have a pivotal role
- Patient acceptability
- Decrease stigma
- 80 OBG:20 Psych
Many obstetric providers are inadequately prepared and resourced (and motivated) to address perinatal mental health.

Not part of professional identity.
- Lack of training
- Lack of guidance

Few resources.

Challenges with reimbursement.

Lack of Processes.
Screening for Depression During and After Pregnancy

**ABSTRACT:** Depression is very common during pregnancy and the postpartum period. At this time, there is insufficient evidence to support a firm recommendation for universal antepartum or postpartum screening. There are also insufficient data to recommend how often screening should be done. There are multiple depression screening tools available for use.

Clinical depression is common in reproductive-aged women (1). A recent retrospective cohort analysis in a large U.S. managed care organization found that one in seven women was treated for depression between the year prior to pregnancy and the year after pregnancy (2). According to the World Health Organization, depression is the leading cause of disability in women, which accounts for $30 billion to $50 billion in lost productivity and direct medical costs in the United States each year (3).

Screening for, diagnosing, and treating depression have the potential to benefit a woman and her family. Infants of depressed mothers display delayed psychologic, cognitive, neurologic, and motor development (3). Furthermore, children's mental and behavioral disorders improve when maternal depression is in remission (4). Women with recurrent depression should be screened at every prenatal visit. Women with current depression or a history of major depression warrant particularly close monitoring and evaluation.

**Conclusion**

Depression is very common during pregnancy and the postpartum period. At this time there is insufficient evidence to support a firm recommendation for universal antepartum or postpartum screening. There are also insufficient data to recommend how often screening should be done. However, screening for depression has the potential to benefit a woman and her family and should be strongly considered. Women with a positive assessment require follow-up evaluation and treatment if indicated. Medical practices should have a referral process for identified cases. Women with current depression or a history of major depression warrant particularly close monitoring and evaluation.
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**Conclusion**
Depression is very common during pregnancy and the postpartum period. At this time, there is insufficient evidence to support a firm recommendation for universal antepartum or postpartum screening. There are also insufficient data to recommend how often screening should be done. However, screening for depression has the potential to benefit a woman and her family and should be strongly considered. Women with a positive assessment require follow-up evaluation and treatment if indicated. Medical practices should have a referral process for identified cases. Women with current depression or a history of major depression warrant particularly close monitoring and evaluation.
SCREENING FOR PERNITAL DEPRESSION

ABSTRACT: Perinatal depression, which includes major and minor depressive episodes that occur during pregnancy or in the first 12 months after delivery, is one of the most common medical complications during pregnancy and the postpartum period, affecting one in seven women. It is important to identify pregnant and postpartum women with depression because untreated perinatal depression and other mood disorders can have devastating effects on women, infants, and families. Several screening instruments have been validated for use during pregnancy and the postpartum period. Although definitive evidence of benefit is limited, the American College of Obstetricians and Gynecologists recommends that clinicians screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool. Although screening is important for detecting perinatal depression, screening by itself is insufficient to improve clinical outcomes and must be coupled with appropriate follow-up and treatment when indicated; clinical staff in obstetrics and gynecology practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources when indicated, or both.
Women need to be screened for Perinatal Depression and Anxiety Disorders

- At least once during the perinatal period
- At least once during pregnancy and again postpartum

Screening needs to be coupled with adequate systems to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
MISSION
Continually improve patient safety in women’s health care through multidisciplinary collaboration that drives culture change

VISION
Safe health care for every woman

PURPOSE
The Council on Patient Safety in Women’s Health Care’s purpose is to reduce harm to patients by fostering:

- Investigation to better understand the causation of harm
- Programs and tools to implement patient safety initiatives
- Education to promote patient safety
- Dissemination of patient safety information
- A health care culture of respect, transparency, and accountability
COUNCIL ON PATIENT SAFETY IN WOMEN’S HEALTH CARE

safe health care for every woman

2015 – Interdisciplinary work group convened
2016 – Patient safety bundle & resource listing available
2017 – Consensus statement published
PATIENT SAFETY BUNDLE

Maternal Mental Health

Every Clinical Care Setting

Every Woman

Every Case

Every Clinical Care Setting
Every Clinical Care Setting

- Identify mental health screening tools to be made available in every clinical setting (outpatient OB clinics and inpatient facilities).
- Establish a response protocol and identify screening tools for use based on local resources.
- Educate clinicians and office staff on use of the identified screening tools and response protocol.
- Identify an individual who is responsible for driving adoption of the identified screening tools and response protocol.
RECOGNITION & PREVENTION

Every Woman

- Obtain individual and family mental health history (including past and current medications) at intake, with review and update as needed.
- Conduct validated mental health screening during appropriately timed patient encounters, to include both during pregnancy and in the postpartum period.
- Provide appropriately timed perinatal depression and anxiety awareness education to women and family members or other support persons.

COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE

safe health care for every woman
RESPONSE

Every Case

- Initiate a stage-based response protocol for a positive mental health screen.
- Activate an emergency referral protocol for women with suicidal/homicidal ideation or psychosis.
- Provide appropriate and timely support for women, as well as family members and staff, as needed.
- Obtain follow-up from mental health providers on women referred for treatment. This should include the necessary release of information forms.
REPORTING/SYSTEMS LEARNING

Every Clinical Care Setting

- Establish a non-judgmental culture of safety through multidisciplinary mental health rounds.
- Perform a multidisciplinary review of adverse mental health outcomes.
- Establish local standards for recognition and response in order to measure compliance, understand individual performance, and track outcomes.
Consensus Statement

Consensus Bundle on Maternal Mental Health

Perinatal Depression and Anxiety

Susan Kendig, JD, MSN, John P. Keats, MD, CPE, M. Camille Hoffman, MD, MSCS, Lisa B. Kay, MSW, MBA, Emily S. Miller, MD, MPH, Tiffany A. Moore Simas, MD, MPH, Ariela Frieder, MD, Barbara Hackley, PhD, CNM, pec Indman, EdD, MFT, Christena Raines, MSN, RN, Kisha Semenuk, MSN, RN, Katherine L. Wisner, MD, MS, and Lauren A. Lemieux, BS


Maternal Mental Health: Perinatal Depression and Anxiety Complete Resource Listing
Empowering Patients, Improving Outcomes: Maternal Mental Health

December 14, 2015

Presenters: Lisa Kay, MSW, Lynne McIntyre, MSW and Katherine Stone

Presentation of Maternal Mental Health Patient Safety Bundle: Perinatal Depression and Anxiety
February 23, 2016

Presenters: John Keats, MD, CPE, FACOG and Susan Kendig, JD, WHNP-BC, FAANP

Maternal Mental Health: Enhancing Screening and Better Practices
May 5, 2016

Presenters: Tiffany A. Moore Simas, MD, MPH, MEd, FACOG and Christena Raines, RN, MSN, APRN-BC

Collaborative Care Models for Perinatal Mental Health: A Systems Approach to Best Practices
May 12, 2017 from 12:00 pm - 1:00 pm EDT

Presenters: Nancy Grote, PhD, MSW Principal Investigator, MOMCare Program and Research Associate Professor, University of Washington School of Social Work Emily Miller, MD, MPH Assistant Professor, Obstetrics and Gynecology-Maternal Fetal

Effectively Communicating with Moms About Screening for Perinatal Depression & Anxiety
May 19, 2017 from 1:30 pm - 2:30 pm EDT

Presenters: Lenore Jarvis, MD Emergency Specialist, Children's National Health System Lakshmin, MD Psychiatrist, George Washington University

Access Archived Materials »
Maternal Mental Health Expert Work Group

Mission Statement

ACOG’s MMH EWG is a multidisciplinary collaboration of specialists in women’s health, obstetrics, psychiatry, psychology, nursing, social work, and public health who aim is to promote the integration of maternal mental health into the delivery of perinatal care. Through efforts focused on current clinicians as well as the next generation of providers the MMH EWG will lead provider education and support resource identification, vetting, and development that promotes access to evidence-based treatment and sustainable system change.
Mental Health Journey in an Obstetric Care Setting

Readiness
- Prepare practice
  - Develop procedures
  - Initiate staff preparedness
  - Identify community resources
  - Identify treatment and consultation resources

Recognition + Response
- Take mental health history
- Assess mental health risk
- Educate
- Negative screen
- OB as PCP, or handoff to other provider

Reporting
- Facility/practice/office
- State
- Process measures
- Outcome measures
- Multidisciplinary rounds

Key:
- Care Pathway
- Release Medical Records
- Patient Care
- Readiness
- Recognition
- Reporting

Provider Situation: Today (Pain Points)
- As new recommendations around screening for Maternal Mental Health (MMH) have emerged, obstetricians have begun to consider how to incorporate them
- Budget restraints, staffing, and technology impact the preparation phase to varying degrees across settings
- Staff perceives process and protocols as more work
- Lack of knowledge of how to identify and leverage community-based resources for referrals
- Return on investment (ROI), or uncertainty of ROI, makes administrative and staffing buy-in challenging; practices need the development of a business case, e.g., value-based reimbursement, linking mental health to overall quality cost and satisfaction outcomes
- Critical to success are standardized policies and procedures that practices can implement with a minimal amount of customization

- Staff training on identifying and responding to MMH is lacking
- Ability to integrate procedures into existing workflow is both difficult and not incentivized
- EMR functionality does not universally accommodate mental health screening or communication of screening scores and subsequent treatment

- Often assessment results are not reviewed with patients to validate results
- Coordination of care plan and response pathways are not in place
- Multidisciplinary rounds that would allow for consultation are not always in place or possible
- Evolving models of care for integrated behavioral services present opportunities and challenges which are not consistent across care settings
  - OB care providers lack confidence and knowledge to treat mild or moderate cases without referral
  - Depending on resources, both in staffing and in the community, response and referral, as well as patient education, varies across medical care settings

- For most practices, positive health outcomes of mental health treatment are difficult to demonstrate and measure due to small caseload and limited resources
- There are no consistent state or federal requirements or accrediting standards for reporting MMH - so best practices vary by local setting
- Due to HIPAA constraints as well as staffing constraints, referrals may produce unknown outcomes for patients making data collection of referrals and outcomes difficult
- No way to measure if patient’s experience is the same as provider’s
- Providers may or may not learn best-practices from colleagues and be able to compare their own outcomes
Review Bundle

Acknowledge Implementation Barriers

Identify Existing Resources

Develop Needed Resources

Obtain Feedback from Obstetric Community

Revise

Implement & Evaluate
Severe Mental Illness
Integrating mental health care into obstetric practices can be transformative for the women we serve. Led by professional societies and governmental organizations, expectations of obstetric care providers are changing.
Thank you

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Safety Bundle
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