Promoting Maternal Mental Health During and After Pregnancy: MCPAP for Moms

Nancy Byatt, DO, MS, MBA, FAPM
Medical Director, MCPAP for Moms
Associate Professor of Psychiatry and Ob/Gyn
UMass Memorial Medical Center/UMass Medical School

Tiffany A. Moore Simas, MD, MPH, MEd, FACOG
Lead Obstetric Liaison, MCPAP for Moms
Associate Professor of Ob/Gyn, Pediatrics & Psychiatry
UMass Memorial Medical Center/UMass Medical School

John H. Straus, MD
Founding Director, MCPAP for Moms
The health care system needs to change to support mothers
Perinatal depression is one of the most common complications of pregnancy

http://www.acog.org/Womens-Health/Depression-and-Postpartum-Depression
Two-thirds of perinatal depression begins before birth

- Pregnancy: 33%
- Before pregnancy: 27%
- Postpartum: 40%

Wisner et al. JAMA Psychiatry 2013
Perinatal depression effects mom, child & family

- Poor health care
- Substance abuse
- Preeclampsia
- Maternal suicide

- Low birth weight
- Preterm delivery
- Cognitive delays
- Behavioral problems

Screening is encouraged to increase detection and diagnosis
Perinatal depression is under-diagnosed and under-treated.
The perinatal period is ideal for the detection and treatment of depression

Regular opportunities to screen and engage women in treatment

Ob/Gyn providers have a pivotal role

80% of depression is treated by primary care providers
Including depression as part of obstetric care can increase access to care
In 2010, Massachusetts passed a Postpartum Depression Act
Massachusetts legislators and stakeholders advocated for MCPAP for Moms funding

2010
MA passes PPD Act, forms PPD Commission

July 2013
MCPAP for Moms funded

July 2014
MCPAP for Moms launch

July 2015
Insurance companies pay surcharge for MCPAP for Moms
Massachusetts passed legislation to fund MCPAP for Moms statewide
MCPAP for Moms was developed using research and feedback from end-users.
The goal of MCPAP for Moms is to increase the capacity of frontline providers to address perinatal depression.
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**Telephone Consultation**

[Image of telephone]

- Obstetric providers/Midwives
- Family Medicine
- Psychiatric providers
- Primary care providers
- Pediatric providers
Care coordination is based on acuity, severity and need

Resources to Provider

Care coordinator will identify 2-3 targeted resources to deliver via phone or email

Does not involve speaking with mom

Outreach to Patient

Care coordinator will contact mom and work with her to schedule appointment

Care coordinator will follow up after 1 month
Practices can call for resources

- OB Case Worker
- OB Nursing Staff
- OB Social Worker
- OB Care Provider

Care Coordination
Administer Edinburgh Postnatal Depression Scale
Antidepressant Treatment Algorithm
(use in conjunction with Depression Screening Algorithm for Obstetric Providers)

Is patient currently taking an antidepressant?

Yes

If medication has helped and patient is on a low dose: increase dose of current medication (see table below)

If patient is on therapeutic dose for 4-8 weeks that has not helped: consider changing medication. If questions contact MCPAP for Moms for consultation

No

Does patient have a history of taking an antidepressant that has helped?

Yes

Prescribe antidepressant that helped patient in the past (see table below)

No

Use sertraline, fluoxetine or citalopram (see table below)

To minimize side effects, half of the recommended dose is used initially for 2 days, then increase in small increments as tolerated.

First line treatment (SSRIs)

*sertraline (Zoloft) 50-200 mg increase in 50 mg increments

*fluoxetine (Prozac) 20-60 mg increase in 10 mg increments

*citalopram (Celexa) 20-40 mg increase in 10 mg increments

*citalopram (Lexapro) 10-20mg increase in 10 mg increments

Second line treatment

SSRIs

*paroxetine (Paxil) 20-60mg increase in 10 mg increments

*venlafaxine (Effexor) 75-300mg increase in 75 mg increments

*fluoxetine (Prozac) 20-60 mg increase in 20 mg increments

SNRIS

*SSRIs (Remeron) 15-45mg increase in 15 mg increments

*venlafaxine (Cymbalta) 60-120mg increase in 15 mg increments

*trazodone (Desyrel) 50-150 mg increase in 50 mg increments

*Other

*If a first or second line medicine is currently helping, continue it strongly consider using first or second line medicine with some success in management

If no/minimal clinical improvements after 4-8 weeks

1. If patient has no or minimal side effects, increase dose.
2. If patient has side effects, switch to a different med.

If you have any questions or need consultation, contact MCPAP for Moms at 855-Mom-MCPAP (855-666-6272)

Reevaluate every week and at postpartum visit. Refer back to patient's provider and/or clinical support staff for psychiatric care once OB care is complete. Contact MCPAP for Moms if it is difficult to coordinate ongoing psychiatric care. Continue to engage woman in psychotherapy, support groups and other non-medication treatments.

CALL MCPAP FOR MOMS WITH CLINICAL QUESTIONS THAT ARISE DURING SCREENING OR TREATMENT AT 855-666-6272

MCPAP for Moms: Promoting maternal mental health during and after pregnancy

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1-855-Mom-MCPAP

Telephone Consultation
Discuss potential management strategies

Recommend a Face to Face Evaluation

Refer to the community
Education about various treatment and support options is imperative.
Care coordination links with support groups and community resources

Support the wellness and mental health of perinatal women
Can refer moms to [www.mcpapformoms.org](http://www.mcpapformoms.org)

Support Groups for Mothers and Expectant Mothers

MCPAP for Moms partners with William James College Interface Referral Service to develop and maintain community-based resources to support mothers and fathers experiencing mental health issues related to the challenges of becoming parents. Interface maintains a comprehensive listing of support groups by geographic area. It is important to call before planning to attend a support group as the dates and times of groups change frequently.
Since our launch in July 2014, MCPAP for Moms has served many providers and parents

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Program costs are low

1.2 FTE Perinatal Psychiatrist

2.3 FTE care coordinators
Untreated depression comes at a high cost

$22,000/yr

$192,400,000/yr
MCPAP for Moms can result in significant savings

$22,000/yr
$11.81/yr
$192,400,000/yr
$0.98/month

$850,000/yr

Jose Y. Diaz and Richard Chase. Wilder Research, 651-280-2700 October 2010
Funding is a line item in the state budget.
50% of cost is recuperated through surcharge to commercial insurers
MCPAP for Moms is spreading and being viewed as a national model
MCPAP for Moms inspired the Bringing Postpartum Depression out of the Shadows Act

Bipartisan bicameral federal legislative bills (HR 3235 and S 2311)
Bringing Postpartum Depression out of the Shadows Act of 2015

20th Century Cures
Bringing PPD out of the Shadows Act was signed into law in December 2016
There is a critical need for MCPAP for Moms to address substance use disorders


The Working Group’s Findings:

1. Individuals in crisis cannot access the right level of treatment at the right time 12
2. Youth drug use and addiction trends must be addressed through prevention education 18
3. Pregnant women and mothers with a substance use disorder need specialized care 21
4. Opioid medications must be safely managed by prescribers, pharmacists, and patients 23
5. The stigma associated with a substance use disorder is a barrier to treatment and recovery 28
6. Lack of transparency and accountability hinder our ability to respond to the opioid crisis 29
7. Courts and Jails should not be the primary mode of accessing long-term treatment 30
8. Recovery resources are insufficient and difficult to access 31
9. Increasing access to Naloxone will save lives 32
10. Insurance barriers prevent individuals from receiving treatment 33
11. The opioid crisis is a national issue that requires both state and federal solutions 34
MCPAP for Moms is broadening its scope to address substance use disorders

Consultation and care coordination for obstetric providers to build their capacity to address substance use disorders

Consultation for MAT providers to build their capacity to address psychiatric comorbidities

Education, training and toolkit
MCPAP for Moms has transformed perinatal mental health care in Massachusetts
Now it is time to bring MCPAP for Moms to the rest of the country
Please contact us
www.mcpapformoms.org

Nancy Byatt, DO, MS, MBA, FAPM
Medical Director
Nancy.Byatt@umassmemorial.org

Tiffany Moore Simas, MD, MPH, MEd, FACOG
Lead Obstetric Liaison
TiffanyA.MooreSimas@umassmemorial.org

John H. Straus, MD, Founding Director
John.Straus@beaconhealthoptions.com

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Thank you!
QUESTIONS?

Nancy.Byatt@umassmemorial.org
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Thank you!