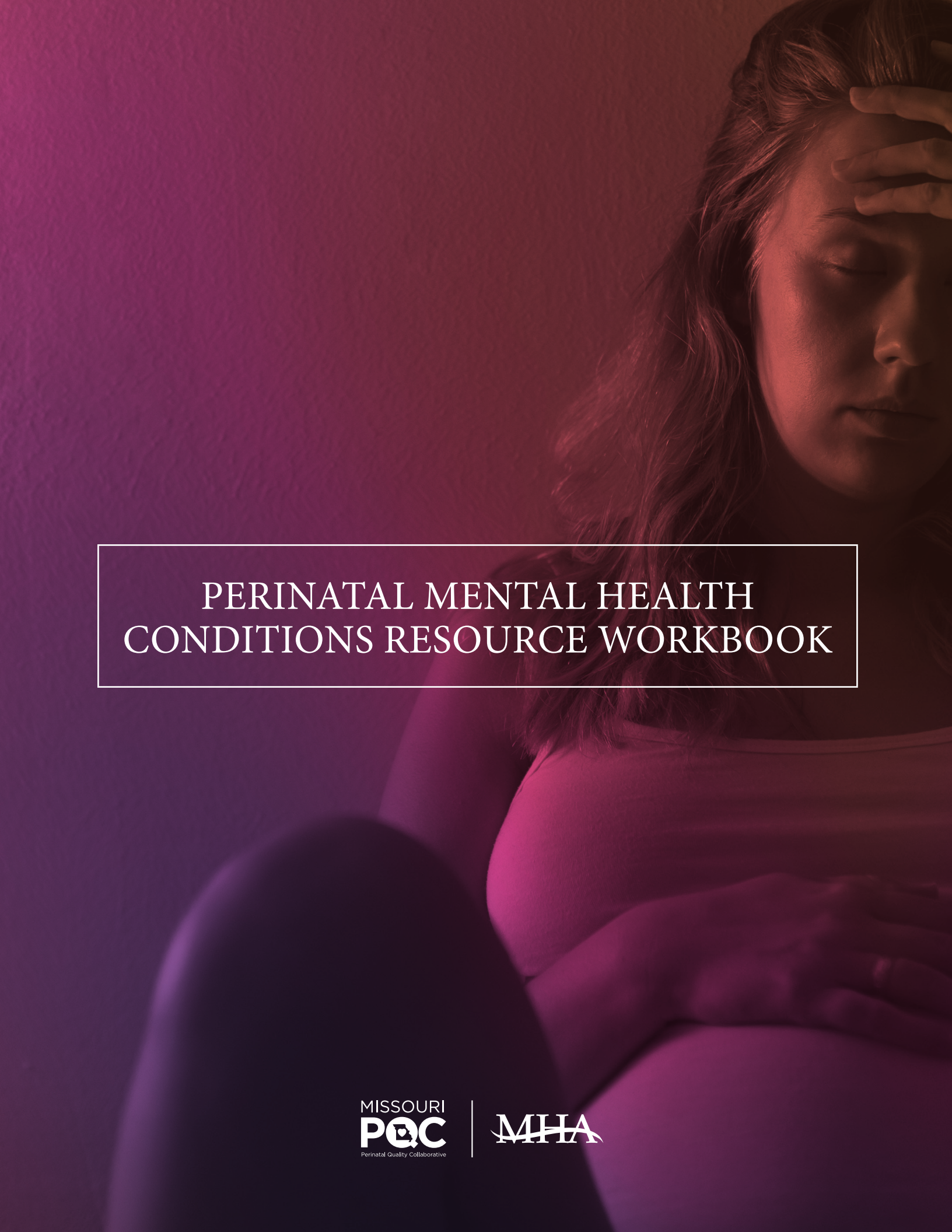

PERINATAL MENTAL HEALTH CONDITIONS RESOURCE WORKBOOK

MISSOURI PQC Perinatal Quality Collaborative | MHA

Acknowledgements

Improving the health outcomes of maternal and infant populations is a critical priority in Missouri. The Missouri Perinatal Quality Collaborative serves as a statewide convener, resource, and change agent to support decreased variations in care and outcomes, support optimized use of evidence-based practice, and support clinical-community integration — all noted gaps in achieving equitable and improved health.

These efforts would not be possible without the collective vision and collaboration of the Missouri Department of Health and Senior Services, Missouri Hospital Association, and members of the Missouri Maternal-Child Learning and Action Network. MC LAN members represent a diverse group of stakeholders from clinical backgrounds, professional associations, government agencies, community-based organizations and community representatives who have committed support to reducing maternal morbidity and mortality in Missouri, including the March of Dimes, Missouri Section of the American College of Obstetricians and Gynecologists, Missouri Chapter of the American Academy of Pediatrics, Missouri Primary Care Association, Missouri DHSS, Missouri Department of Social Services MO HealthNet Division, Missouri Foundation for Health, Missouri Chapter of the Association of Women's Health, Obstetric and Neonatal Nurses, Nurse Practitioners in Women's Health Association, Missouri Chapter of the Amniotic Fluid Embolism Foundation, Generate Health, St. Louis Integrated Health Network, Bootheel Perinatal Network, Healthy Blue MO, Home State Health, United Healthcare, Nurture KC, Promise 1000, M-Brace Birthing, SafiMoms365, the Doula Foundation and Simply Strategy. These partners successfully aligned efforts to bring Alliance for Innovation on Maternal Health initiatives to Missouri in 2019 and connect directly to the Missouri Pregnancy-Associated Mortality Review Board, which identifies leading causes of morbidity and mortality.

The MO PQC also acknowledges the contributions of AIM, the national, cross-sector commitment designed to lead in developing and implementing patient safety bundles to promote safe care for every U.S. birth. Founded in 2014 through a cooperative agreement funded by the Health Services Resources Administration, and executed by ACOG, the AIM program provides expert technical support and capacity building to multidisciplinary state-based teams, most often perinatal quality collaboratives, leading targeted rapid-cycle quality improvement via implementation of patient safety bundles. An AIM patient safety bundle is a structured way of improving the process of care and patient outcomes: a small, straightforward set of evidence-based practices that, when performed collectively and reliably, have been proven to improve patient outcomes. Patient safety bundles are developed by expert multidisciplinary working groups, supported by the AIM staff at ACOG. Working groups include representatives appointed by professional member organizations, known experts and researchers specializing in the clinical topic, and patients with lived experience. The bundle development process includes design of measure and metrics for implementation and multiple levels of review from engaged stakeholders.[1,2]

The MO PQC leverages AIM patient safety bundles as one option to support implementation of evidence-based practice and care delivery redesign for birthing units, providers and communities throughout the state.

This publication was produced with grant funding provided by the Missouri Department of Health and Senior Services and the Perinatal Quality Collaborative under contract number CS230931001.

The Evidence

This section contains information on key recommendations and evidence-based guidance for integrating mental health care into obstetric settings to improve outcomes for pregnant and postpartum people.

Perinatal mental health conditions affect one in five pregnant and postpartum people and is the most common pregnancy and postpartum complication in the United States.[3,4,5,6] Furthermore, PMHCs are underdiagnosed and often untreated or undertreated. The AIM PMHC patient safety bundle is a dynamic guide for integrating mental health care into an obstetric setting. The work of the bundle involves creating foundational processes and pathways to identify, intervene, refer and treat PMHCs.[3] Key recommended resources are included in the Resources section of this document.

ACOG recommends universal screening for perinatal depression and anxiety at the initial prenatal visit, later in pregnancy and at postpartum visits. The Lifeline for Moms Perinatal Mental Health Toolkit integrated current research and professional societies' recommendations to develop guidance for screening. The toolkit advocates screening for depression, bipolar disorder, anxiety and post-traumatic stress disorder at the initial prenatal visit and screening for depression, anxiety and PTSD in the second half of pregnancy and during postpartum visits. Assessment of suicide risk is essential for any response other than "*never*" on the self-harm question. The toolkit provides algorithms and directions on incorporating mental health care into a team's process.[7] Validated screening tool options are included in the Resources section of this document.

Screening all pregnant and postpartum people for bipolar disorder prior to initiating an antidepressant is essential because one in five birthing people who screen positive for depression may have bipolar disorder. Treating bipolar disorder with an antidepressant medication alone increases the risk of mania, psychosis and suicide. Furthermore, bipolar disorder is associated with an increased risk of postpartum psychosis, which is further associated with suicide and infanticide.[8]

A PMHC can be categorized as mild, moderate or severe based upon screening endorsement scoring. For mild to moderate illness, the advised priority treatment is behavioral health therapy. The Lifeline for Moms Toolkit contains algorithms to assist obstetric providers in referring birthing people to appropriate, prompt treatment; starting medication when appropriate; and connecting those individuals to additional services and supports as needed.[8] The toolkit is included in the Resources section of this document.

Fostering a warm and accepting atmosphere, providing anti-racism and stigma/bias staff education and training, and utilizing a trauma-informed approach are some ways of ensuring pregnant and postpartum people feel safe to share their experiences and confident they will receive evidence-based, equitable care and treatment. Screening for social drivers of health will help identify needs and connect individuals to services and supports so they can continue to access care and participate in recommended treatment. Finally, including the birthing person and their identified support person(s) as part of the care team creates trust, aligns goals, and establishes understanding of conditions and treatment recommendations.[9] These approaches create a path for proper identification, treatment, symptom remission, and positive maternal and infant outcomes.

Missouri's Call to Action

The Missouri PAMR Board reviews all deaths of birthing people while pregnant or within one year of the end of the pregnancy. Pregnancy-associated death is the overarching term used when referring to maternal deaths. Within this broad categorization are more specific terms to describe the cause of death, including pregnancy-related death; pregnancy-associated, but not related (PANR) death; and pregnancy-associated, but unable to determine relatedness.[10] See definitions below.

Pregnancy-related death: Death occurring during or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiological effects of pregnancy[10]

PANR: Death during or within one year of pregnancy from a cause that is not related to pregnancy[10] (e.g., pregnant person who dies in a natural disaster)

Pregnancy-associated, but unable to determine relatedness: Cases when the board was unable to determine if a death was pregnancy-related or PANR[10]

Maternal morbidity: Unexpected negative outcomes of childbirth resulting in short- or long-term health impacts[10]

Maternal mortality: The World Health Organization defines a maternal death as "a death while pregnant or within 42 days of the end of the pregnancy from any cause related to or aggravated by pregnancy or its management, but not from accidental or incidental causes."[11] In Missouri, the term maternal mortality is used to describe deaths that occur during pregnancy, at delivery and up to one year after the end of a pregnancy.[10]

The 2023 Missouri PAMR report, reviewing maternal deaths from 2018 to 2020, found **mental health conditions to be the leading underlying cause of pregnancy-related deaths**. Suicide deaths doubled from the 2022 report. Significant disparities persist for Black women and those who have Medicaid insurance coverage. Every death due to mental health conditions was found

SUICIDE DEATHS DOUBLED FROM THE 2022 REPORT

to be preventable, and the majority occurred between 43 to 365 days postpartum.[10] These data demonstrate the need for bolstered support during the postpartum period.

A significant barrier to positive outcomes is the lack of mental health providers in Missouri. The Policy Center for Maternal Mental Health's 2023 U.S. Maternal Mental Health State Report Cards gave Missouri a D minus. One key finding was an inadequate perinatal mental health provider-to-patient ratio.[12] An emerging resource to help support the provision of quality mental health services to perinatal patients across the state is the Missouri Maternal Health Access Project. As of April 1, 2024, Missouri perinatal care providers can enroll in the Missouri MHAP. MHAP is a statewide perinatal psychiatry access program developed to offer health care providers the tools and support to recognize and effectively treat perinatal mental and behavioral health conditions, including substance use disorder. More information is available by contacting MHAP; providers can enroll in the program online.[13]

A key strategy outlined in the patient safety bundle involves incorporating maternal mental health screening during pediatric visits.[9] This cross-specialty collaboration is one essential theme of the bundle and strategy to improve care outcomes, although pediatric offices need to ensure they have identified efficient referral pathways. Though there are many hurdles, the PMHC bundle provides a thoughtful approach and a myriad of resources to create the needed system changes. The work will require education, culture shifts and creative innovation to address and provide quality mental health care to pregnant and postpartum people.

The AIM PMHC patient safety bundle aims to improve care delivery across care settings for pregnant and postpartum people experiencing mental health conditions. Bundle components are included below and resources for key process implementation are included in the Resources section of this document.

Birthing organizations interested in implementing the AIM PMHC Patient Safety Bundle may register with the MO PQC.

AIM Bundle Components[9]

An AIM patient safety bundle is a structured way of improving the process of care and patient outcomes: a small, straightforward set of evidence-based practices that, when performed collectively and reliably, have been proven to improve patient outcomes.

Readiness — Every Unit/Team

- ☐ Develop workflows for integrating mental health care into preconception and obstetric care before pregnancy through the postpartum period, including provision of pharmacotherapy when indicated.
  - ☐ Identify mental health screening tools to be integrated universally in every clinical setting where patients may present.
  - ☐ Establish a response protocol based on what is feasible for each area of practice and local mental health resources.
  - ☐ Educate clinicians, office staff, patients and patients' designated support networks on optimal care across the preconception and perinatal mental health pathway, including prevention, detection, assessment, treatment, monitoring and follow-up best practices.
- ☐ Provide training and education to address racism, health care team member biases and stigma related to PMHCs, and promote trauma-informed care.
- ☐ Develop and maintain a set of referral resources and communication pathways between obstetric providers, community-based organizations, and state and public health agencies to address patient needs, including social drivers of mental and physical health.

Recognition and Prevention — Every Patient

- ☐ Screen for perinatal mental health conditions consistently throughout the perinatal period, including, but not limited to, the following.
  - ☐ Obtain individual and family mental health history at intake, with review and update as needed.
  - ☐ Screen for depression and anxiety at the initial prenatal visit, later in pregnancy and at postpartum visits, ideally including pediatric well-child visits.
  - ☐ Screen for bipolar disorder before initiating pharmacotherapy for anxiety and depression.
- ☐ Screen for structural and social drivers of health that may impact clinical recommendations or treatment plans and provide linkage to resources.

Response — Every Event

- [ ] Initiate an evidence-based, patient-centered response protocol that is tailored to condition severity, and is strength-based, culturally relevant, and responsive to the patient's values and needs.
    - [ ] Activate an immediate suicide risk assessment and response protocol as indicated for patients with identified suicidal ideation, significant risk of harm to self/others or psychosis.
- [ ] Establish care pathways that facilitate coordination and follow-up among multiple providers throughout the perinatal period for pregnant and postpartum people referred to mental health treatment.

Reporting and Systems Learning — Every Unit

- [ ] Incorporate mental health into multidisciplinary rounding to establish a nonjudgmental culture of safety.
- [ ] Convene inpatient and outpatient providers in an ongoing way to share successful strategies and identify opportunities for prevention and evaluation of undesired outcomes related to perinatal mental health.
- [ ] Identify and monitor data related to perinatal mental health care, with disaggregation by race and ethnicity at a minimum, to evaluate disparities in processes of care.

Respectful, Equitable and Supportive Care — Every Unit/Provider/Team Member

- [ ] Include each pregnant and postpartum person and their identified support network as respected members of and contributors to the multidisciplinary care team.
- [ ] Engage in open, transparent, empathetic, and trauma-informed communication with pregnant and postpartum people and their identified support network to understand diagnoses, options and treatment plans.[9]

Resources Section

Bundle Resources

AIM: Perinatal Mental Health Conditions Patient Safety Bundle

AIM: PMHC Element Implementation Details

AIM: PMHC Implementation Resources

AIM: PMHC Change Package

Screening Tool Resources

Policy Center for Maternal Mental Health: Screening Tools

Wisconsin Department of Public Instruction: Behavioral Health Screening Tools

Provider and Health Care Worker Resources

MHAP: MHAP Provider Registration Form

MHAP: MHAP Consultation Online Request

American Psychiatric Association: Perinatal Mental Health Toolkit

UMass Chan Medical School: Lifeline for Moms Perinatal Mental Health Toolkit

- Examples for Talking With Your Patients About Mental Health, page 7
- Assessing Perinatal Mental Health Algorithm, page 18
- Starting Treatment for Perinatal Mental Health Conditions Algorithm, pages 19-20
- Follow-up Treatment of Perinatal Mental Health Conditions Algorithm, page 21
- Assessing Risk of Suicide, page 22
- Assessing Risk of Harm to Baby, page 23
- Assessment and Management of Bipolar Disorder and Psychosis, page 24

Massachusetts Child Psychiatry Access Program for Moms: Obstetric Provider Toolkit

Postpartum Support International: National Psychiatric Consultation Line: 877-499-4773

Zero Suicide: Zero Suicide Toolkit

Maternal Mental Health Leadership Alliance: Fact Sheet Library

Educational Resources

ACOG: Perinatal Mental Health Conditions eModules

MMHLA: Fact Sheet on Trainings in Maternal Mental Health

Additional Resources

Policy Center for Maternal Mental Health: Whole Mom™ Hospital Best Practice Standards

Virginia Commonwealth University: PMH Connect

Resources for Birthing People

HRSA: National Maternal Mental Health Hotline: 1-833-TLC-MAMA (1-833-852-6262)

PSI: PSI HelpLine: 1-800-944-4773

Substance Abuse and Mental Health Services Administration: 988 Suicide and Crisis Lifeline (call or text 988)

PSI: Find a Provider

PSI: Find Local Support

PSI: Online Support Meetings

PSI: Specialized Support Resources

PSI: Chat With an Expert for Moms

PSI: Peer Mentor Program

PSI: Postpartum Planning Webinars

References

[1] Health Resources & Services Administration. (n.d.). Alliance for innovation on maternal health (AIM) capacity. Retrieved November 10, 2023, from https://www.hrsa.gov/grants/find-funding/HRSA-23-066

[2] American College of Obstetricians & Gynecologists. (n.d.). AIM patient safety bundles. Retrieved November 10, 2023, from https://saferbirth.org/patient-safety-bundles/

[3] Moore Simas, T., Bamel, D., & Mather, C. (2023). Perinatal mental health conditions change package. https://saferbirth.org/wp-content/uploads/Perinatal-Mental-Health-Conditions-Change-Package_Final_062023-1.pdf

[4] Masters., G. A., Hugunin, J., Xu, L., Ulbricht, C. M., Moore Simas, T. A., Ko, J. Y., & Byatt, N. (2022). Prevalence of bipolar disorder in perinatal women: A systematic review and meta-analysis. *Journal of Clinical Psychiatry, 83*(5). https://doi.org/10.4088/JCP.21r14045

[5] Fawcett, E. J., Fairbrother, N., Cox, M. L., White, I. R., & Fawcett, J. M. (2019). The prevalence of anxiety disorders during pregnancy and the postpartum period: A multivariate Bayesian meta-analysis. *Journal of Clinical Psychology, 80*(4). https://doi.org/10.4088/JCP.18r12527

[6] Wisner, K. L., Sit, D. K., McShea, M. C., Rizzo, D. M., Zoretich, R. A., Hughes, C. L., Eng, H. F., Luther, J. F., Wisniewski, S. R., Confer, A. L., Moses-Kolko, E. L., Famy, C. S., & Hanusa, B. H. (2013). Onset timing, thoughts of self-harm, and diagnoses in postpartum women with screen-positive depression findings. *JAMA Psychiatry, 70*(5), 490-498. https://doi.org/10.1001/jamapsychiatry.2013.87

[7] ACOG. (2023, May 18). Addressing perinatal mental health conditions in obstetric settings [eModule]. https://www.acog.org/education-and-events/emodules/addressing-perinatal-mental-health-conditions-in-obstetric-settings

[8] Byatt, N., Mittal, L. P., Brenckle, L., Logan, D. G., Masters, G. A., Bergman, A., & Moore Simas, T. A. (2019). Lifeline for moms perinatal mental health toolkit. University of Massachusetts Medical School. http://hdl.handle.net/20.500.14038/44263

[9] ACOG. (2022). Alliance for innovation on maternal health: Perinatal mental health conditions patient safety bundle. https://saferbirth.org/wp-content/uploads/R2_AIM_Bundle_PMHC.pdf

[10] Missouri Department of Health and Senior Services. (2023, July). Missouri Pregnancy Associated Mortality Review 2018-2020 Annual Report. Retrieved from https://health.mo.gov/data/pamr/pdf/2020-annual-report.pdf

[11] Hoyert, D. L. (2023). Maternal mortality rates in the United States, 2021. NCHS Health E-Stats. https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm#ref1

[12] Policy Center for Maternal Mental Health. (2023). 2023 U.S. maternal mental health state report cards. https://state-report-cards.mmhmap.com/

[13] Missouri Department of Social Services. (2024, March). MHAP enrollment flyer – March 2024. https://mydss.mo.gov/media/pdf/mhap-enrollment-flyer-march-2024

MISSOURI PQC Perinatal Quality Collaborative | MHA