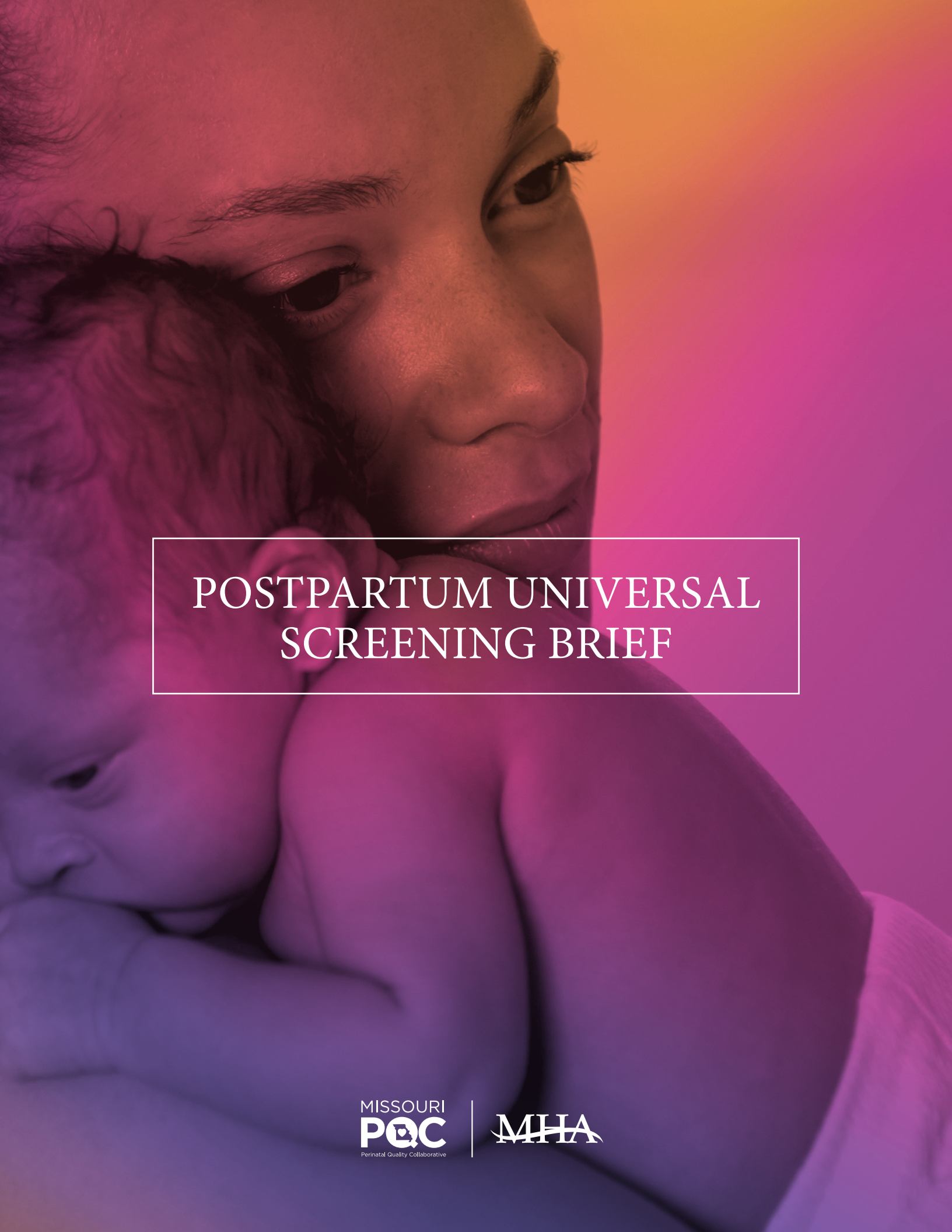

POSTPARTUM UNIVERSAL SCREENING BRIEF

MISSOURI PQC Perinatal Quality Collaborative | MHA

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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.

The Missouri Pregnancy-Associated Mortality Review Board (PAMR) 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.[1] See definitions in Appendix A. The 2023 Missouri PAMR report, reviewing 2018-2020 data, found mental health conditions, including substance use disorders (SUD), to be the leading underlying cause of pregnancy-related deaths.[1] **All of these deaths were determined to be preventable.** This document aims to address these outcomes and provide evidence-based guidance for the first three months after delivery.

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 Optimizing Postpartum Care Task Force. Task Force 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.

This universal screening brief would not be possible without the collaborative partnerships, programmatic alignment and passionate engagement from stakeholders throughout Missouri who are firmly committed to moving the health outcomes of mothers and infants from one of the worst in the nation to one of the best. A wide net was cast to contacts across the state in order to form the Task Force, the authors of this brief.

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.

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UNIVERSAL SCREENING AS A BEST PRACTICE

The days, weeks and months following delivery are a critical time of transition for birthing people, bringing many changes and setting the stage for future health. The comprehensive plan of care after birth contains key components, including physical recovery from birth; mood and emotional well-being; education on managing pregnancy-related conditions; future reproductive life planning; bonding with and incorporating the new baby into the family structure; and making plans for long-term medical care. For some, it also may include coping with grief or loss, as well as identifying and managing chronic conditions.[2] This makes the postpartum period a unique time to improve maternal health overall by addressing health concerns and ensuring a successful transition to primary care.

Identifying physical and mental health risk factors earlier, educating patients on signs and symptoms to monitor, and supporting early access to care and intervention during the postpartum period can lead to better health outcomes for birthing individuals and children.[3] Screening for mental health and substance use disorders (SUD) is paramount throughout pregnancy and a critical part of providing quality comprehensive postpartum care.[2] The application of universal, standardized screening and referral to treatment can mitigate the effects of implicit bias and stigma, thereby helping to reduce health-related disparities. Health care team members, community birth workers and community-based organizations that interact with birthing people during the postpartum period are well positioned to screen for risk factors prevalent during this time, including mental health and SUD.

This document primarily discusses universal screening, response and referral as it relates to critical maternal health issues in mental health and SUD in the postpartum period. This information is intended to provide an overview of the need for universal mental health and SUD screening as a vital health indicator, commonly used evidence-based screening tools, and other information that health care team members, community birth workers, and community-based organizations can use when caring for those in the postpartum period, both in clinical and community settings. The Task Force acknowledges that mental health disorders and SUDs do not exist separate from social drivers of health and intimate partner violence, in addition to other key components in the delivery of comprehensive postpartum care.[3] The Task Force is developing a more comprehensive report, which will encompass addressing the holistic health needs during the entire one-year postpartum period. Additionally, the Task Force recognizes that mental health and SUD concerns are not limited to the postpartum period or to the birthing person, and supports broader universal screening efforts as appropriate.

SECTION 1:

Administration, Setting and Timing of Universal Screenings

In the case of maternal mental health and SUD, universal screening involves implementing standardized protocols and systems to screen all who are pregnant or postpartum. Postpartum care touch points may cross a variety of providers, including but not limited to clinicians, community birth workers, community health workers (CHWs), doulas, nurses, nurse practitioners, midwives, social workers, therapists and medical assistants among others, all of whom can perform screenings.

As such, many organizations, including the American College of Obstetricians and Gynecologists, the American College of Nurse-Midwives, the U.S. Preventive Services Task Force, the Women's Preventive Services Initiative, Postpartum Support International, and the American Academy of Pediatrics, have made recommendations on when, where, and who should conduct screening and referral to treatment for mental health and SUD.[4,5,6,7,8,9,10,11] These recommendations, thoroughly reviewed throughout this document, can be found in Appendix C.

The Missouri PQC and the Task Force recommend that, at a minimum, mental health and SUD screening and education occur in accordance with the framework below, adapted from the Perinatal Mental Health Education and Screening Project, which sought to combine screening recommendations from a variety of national medical organizations and governing bodies.[12]

TABLE 1

MENTAL HEALTH AND SUD SCREENING FRAMEWORK		
CLINICAL CARE PROVIDERS	Pregnancy	At initiation of prenatal care (whenever it occurs) and at least once during each trimester
	Delivery	Prior to discharge from the hospital or birthing center (or prior to release from the care of a home birth professional), with a special emphasis on educating pregnant and postpartum individuals and their support person(s) about warning signs
	Postpartum	Within the first three weeks postpartum and at the comprehensive postpartum visit (no later than 12 weeks after birth)[2]
	Nonobstetric	Throughout the first full year following pregnancy, including annually at preventive care visits[11] and at one-, two-, four- and six-month pediatric visits[10] (Note: Some patients may consider obstetric providers to be their primary care provider.)
COMMUNITY- BASED PROVIDERS	At least once during the care relationship and/or per agency guidelines (this may be a home visitor, doulas, CHWs or other community-based providers)	

Table 1: Adapted from the Maternal Mental Health Leadership Alliance Framework

The transition from specialized maternity care to primary care is an essential part of postpartum care, including the identification and treatment of mental health disorders and SUDs. Establishing a relationship between the birthing person and primary care provider prior to birth discharge is ideal; however, the Task Force acknowledges that there is a dearth of primary care providers (PCPs) and that patients may not attend postpartum visits or become established with a primary care provider for different reasons. Therefore, support for postpartum individuals must come from a variety of mechanisms, such as through telehealth, video visits, group care and community-based organizations. It is imperative that respectful and bidirectional communication exists among all members of the care team, especially between clinical providers and those who may be community-based, such as doulas and CHWs.

Using evidence-based screening tools that are validated for use with the population being screened is a best practice.[13] These tools are generally comprised of a short list of questions at an appropriate reading level that can be answered in a few minutes by the patient. Tools may be validated for patient-administration and/or provider-administration, as well as many being available and validated in other languages. While the specific, validated tool selected may vary across settings, it is critical that the same tool be used per each individual over time, allowing for measurable changes in that individual's score on that particular tool.

Examples of commonly used mental health screening tools validated for use in the postpartum period include the Edinburgh Perinatal/Postnatal Depression Scale (EPDS), the Patient Health Questionnaire (PHQ)-9, and the General Anxiety Disorder (GAD)-7. Substance use screening tools validated for use in the postpartum period include Tobacco, Alcohol, Prescription medication and other Substance use (TAPS); Parents, Partners, Past and Pregnancy (4Ps); and Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT), which is specifically validated for teenagers. The Missouri PQC and the Task Force do not formally recommend a specific screening tool for maternal mental health and SUD screenings at this time, and instead emphasize the importance of universal, consistent administration of a validated, evidence-based screening tool to set the stage for a nonjudgmental, supportive patient-provider conversation. A table of commonly used tools can be found in Appendix C, and details regarding the importance of consistent administration of screening tools is discussed in Sections 2 and 4.

SECTION 2:

Addressing Bias, Building Trust and Educating Patients

Despite the availability of validated screening tools in multiple languages and recommendations for universal screening, research has shown a disparity in screening rates due to factors such as socioeconomic status, preferred language, history of depression, number of prenatal visits, and race/ethnicity.[14] Screening every patient across the care continuum is critical to mitigating systemic bias and ensuring all patients who need and want support receive it, particularly those facing the most inequitable outcomes. Other approaches, such as universal toxicology testing and screening restricted to specific populations or based on arbitrary perceived risk, are not recommended.[2,15]

It is equally important to understand how to conduct screenings, respond to positive screenings and make referrals in a way that supports patient engagement.[13] Mental health, substance use, and related concerns, such as intimate partner violence and barriers to accessing care, can be difficult topics for patients to discuss. Building trust and safety in the screening process that encourages patients to seek support can look like the following.

- acknowledging the prevalence of the disorders you are discussing and letting the patient know that everyone is screened to reduce perceived stigma
- using techniques such as motivational interviewing, active or reflective listening, suicide prevention, and trauma-informed care[13]
- asking if the patient would like you to read the screening aloud to them or if they would like to read it to themselves
- establishing rapport with the patient before screening
- explaining that the screening could bring up a variety of thoughts and emotions, and that you are here to talk more during and after they take the screening
- being well-informed about symptoms, the range of treatment and treatment pathways, and potential confusion/fears
- empowering patients to ask questions and involve people they trust in the discussion like family members, etc.
- being sensitive to cultural differences that may impact responses to screening questions

Even when screening is negative, the screening process provides an opportunity to educate patients regarding warning signs and when to seek help. Regardless of the results of the screening, the process must be standardized and consistent. (See Table 1 for recommended screening cadence.)

SECTION 3:

Warm Hand-offs and Closed-loop Referrals

Following a positive mental health or SUD screening, providers should engage in a brief intervention to educate, motivate behavior change and connect the patient with additional resources, including referral for further assessment. (See Section 4, Box 2: SBIRT Model or Appendix B for list of interventions.) Ideally, this referral will be done through a warm hand-off (see Box 1), which should include updated information regarding the patient's care, treatment, condition, and any recent or anticipated life changes.[16] When a face-to-face conversation is not possible, a phone call is the preferred alternative.[17]

Box 1

Definitions

A warm hand-off is a transfer of care between two members of the health care team, where the interaction occurs in front of the patient and support person(s). This transparent care transition allows patients and families to hear what is said and engages them in communication, giving the opportunity to clarify or correct information or ask questions about their care.[16]

A closed-loop referral process requires communication between practices, as well as bidirectional data sharing. The practice making the referral provides all data and information necessary for the receiving practice to act and confirms that action is taken. Receiving practices track referrals, obtain data and necessary information, and provide confirmation that action was taken (e.g., successful referral, cancellation).[19]

Establishing seamless transitions and follow-up among maternity care providers, mental health care professionals and primary care providers for care beyond pregnancy and the postpartum period is essential.[18] The use of closed-loop referrals, if possible, helps support successful referrals to clinical and community resources.[19]

SECTION 4:

Implementation

The following section contains recommendations for implementing or strengthening a screening and referral process. Continued monitoring of new and existing processes helps to ensure effectiveness. The Missouri PQC and the Task Force acknowledge that policy, technology and payment barriers exist that may limit implementation. For further discussion on these barriers, please see Section 5.

1. Select a screening tool.

Several evidence-based, validated tools may be used for mental health and/or substance use screening of birthing people. Examples of commonly used evidence-based screening tools can be found in Appendix C. Regardless of which tool is selected, it is critical that the same screening tool be administered to the same patient throughout the continuum of care. This ensures that a benchmark measure is established, and changes to the benchmark can be recognized and treated as necessary.

2. Develop an internal screening and referral process.

Clearly defining who, when and how to screen and using established processes and checklists makes it easier to consistently screen and refer patients to relevant resources. Screening and referral processes can be very simple or highly integrated, depending on the organization, setting and individual inputting screening data into the electronic health record (EHR) system. It also varies based on if paper-based screening tools are utilized once a positive screen has occurred. Sample clinical algorithms outlining responses to positive screens, potential suicide risk and other scenarios can be found in Appendix B. While EHR may be the preferred method to administer screening, paper-based screening tools are simple to implement and more accessible to community organizations and support providers. Paper screening also may help to establish trust and relationships with patients, some of whom may distrust electronic screenings and/or benefit from having a copy of their responses to share with other providers.

Box 2

SBIRT Model

The Screening, Brief Intervention, and Referral to Treatment (SBIRT) model is an evidence-based practice used for the early identification and intervention of health risk behaviors. It has traditionally been used for SUD but can be applied to mental health screenings as well. Clinical and nonclinical practitioners can use the model in a variety of settings to ensure pregnant and postpartum birthing people have access and opportunities to seek support and treatment.

Step 1: Screening

Universally assess patients using a standardized, validated screening tool. Screening can occur in any health care setting. A positive screen does not necessarily indicate the need for treatment, nor should it be used as a diagnostic tool. Screening should not be confused with toxicology testing.

Step 2: Brief intervention

Engage the patient in a short conversation regarding the screening results. Understanding scores and when/how to rescreen is important to include in the conversation. For those who screen patients, it is important to follow positive screens with rescreening to determine improvement or worsening symptoms. If applicable, motivating your patient to change behavior by increasing awareness of the problems associated with the behaviors, such as health, social, financial, legal and relationship consequences, may be one component of the conversation.

Step 3: Referral to resources or treatment

Provide a referral for further assessment, treatment or other support services to patients in need of additional services. The warm hand-off should include up-to-date information regarding the patient's medical care and serve as an interactive discussion between treatment providers.

3. Collect resources to share with patients.

Being able to direct patients to resources when a screening result is positive is critical to ensure patients feel supported and have a direct path for supporting their needs. It is vital to have a regularly updated repository of resources that is reliable, culturally congruent, and includes local providers and community agencies/organizations that are accessible to those with constraints due to social drivers of health. Within your team, identify who is responsible for maintaining the resource list and making sure it remains current. A list of commonly used resources is available in Appendix B, in addition to those identified in the local community.

4. Provide staff with training.

A vital component of implementing universal mental health and SUD screening is to ensure all staff members who interact with pregnant and postpartum patients are trained on the proper administration of the screening tools, internal processes and the importance of performing universal screening. Staff should be provided with anti-bias, health equity-focused, and trauma-informed care training opportunities to support trusting relationships with patients and reduce health disparities. Standardizing processes can help to eliminate bias and personal judgements. Please see the resources in Appendix B for examples of training programs that are available in Missouri and beyond.

SECTION 5:

Missouri's Call to Action

Missouri's PAMR data clearly demonstrate the need for increased support during the perinatal period around mental health and SUD, inclusive of universal screening, stronger referral networks, and addressing stigma and bias within systems and providers. Perinatal mental health conditions affect one in five pregnant and postpartum people and are the most common pregnancy and postpartum complication in the U.S.[20, 21, 22, 23] Furthermore, perinatal mental health conditions are both underdiagnosed and often untreated or undertreated.[19] SUD is a chronic disease with lasting effects for the birthing person, infant, family and community. Worsening rates of maternal SUD have been perpetuated by the global opioid epidemic, including use of unnecessary prescribing practices for the postpartum population, and are further impacted by the combined effects of adverse traumatic life events and social drivers of health. Significant disparities persist for Black birthing people and those who have Medicaid coverage. Forty-nine percent of pregnancy-related deaths occurred between 43 and 365 days postpartum — calling for interventions across the care continuum.[1] Of critical concern is that all pregnancy-related deaths in Missouri due to mental health conditions, including SUD, were found to be preventable.[1]

Health care team members, community birth workers, and community-based organizations can support early identification of mental health conditions and SUD, educate on signs to monitor for, and support early access to care and intervention through a culturally congruent approach. The Missouri PQC encourages all stakeholders in maternal-infant health to take action to reduce severe maternal morbidity and maternal mortality from mental health conditions and SUD.

While validated screening tools, referral best practices and evidence-based treatments abound, the Task Force recognizes the impact that payment models, health insurance parameters, and both federal and state policy have on the feasibility of accessibility.

Such barriers, which may affect one or more of the steps outlined in this brief, include but are not limited to the following.

- provider awareness and understanding of variations in covered services across insurance plans/types
- provider (obstetric, primary and specialty care) understanding of reimbursement processes during the first year postpartum
- birthing individuals' understanding of postpartum extension of Medicaid benefits in order to receive access to medical, mental health and SUD services throughout the first year postpartum
- low reimbursement rates for mental health care, from either commercial or Medicaid insurance, prohibiting mental health providers from accepting insurance
- difficult and lengthy processes for providers to obtain insurance-required prior authorizations
- inconsistent practices around and understanding of Children's Division "hot-lining" or reporting of positive substance use screens
- coordination of care challenges between providers due to insurance provider networks
- coordination of care challenges between provider types, especially those who conduct screenings in nonobstetric settings such as pediatrics, and getting the information back to those who care for the birthing person
- coordination of care challenges between community-based organizations due to inconsistent access to or application of closed-loop referral systems
- variation in EHR systems that limit provider-to-provider communication

The Task Force is committed to including the input of both state agency experts and managed care experts as they consider navigating these challenges in the process of developing a postpartum 12-month plan of care recommendations document.

Appendix A: Definitions

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[1]

PANR: Death during or within one year of pregnancy from a cause that is not related to pregnancy[1] (e.g., pregnant person who dies in a natural disaster)

Pregnancy-associated, but unable to determine relatedness: Cases when the PAMR board was unable to determine if a death was pregnancy-related or PANR[1]

Maternal morbidity: Unexpected negative outcomes of childbirth resulting in short- or long-term health impacts[1]

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."[24] 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 the pregnancy.[1]

Appendix B: Resources

General

Alliance for Innovation on Maternal Health Community Care Initiative: Community Care for Postpartum Safety and Wellness Bundle
AIM: Perinatal Mental Health Conditions Patient Safety Bundle
AIM: Care for Pregnant and Postpartum People With Substance Use Disorder Patient Safety Bundle
ACOG: Perinatal Mental Health Toolkit
Massachusetts Child Psychiatry Access Program for Moms: Obstetric Provider Mental Health During and After Pregnancy Toolkit

Algorithms and Examples

MCPAP for Moms: Key Clinical Considerations When Assessing the Mental Health of Pregnant and Postpartum Women
MCPAP for Moms: Screening and Brief Intervention for Substance Use in Pregnancy
MCPAP for Moms: Depression Screening Algorithm for Obstetric Providers
MCPAP for Moms: Bipolar Disorder Screen
Missouri Hospital Association: Moving Beyond the S of "SBIRT" — Part 1 and Moving Beyond the S of "SBIRT" — Part 2
Florida Perinatal Quality Collaborative: SBIRT Example Video
Kansas Maternal and Child Health: Additional Example Videos

Telehealth and Mental Health Resources

MHAP: Missouri Maternal Health Access Project
Health Resources and Services Administration: National Maternal Mental Health Hotline
Federal Communications Commission: 988 Suicide and Crisis Lifeline
Postpartum Support International: HelpLine

Education

Health Care Professional-facing Materials

Centers for Disease Control and Prevention: "Hear Her" Campaign
Reproductive Health National Training Center: Urgent Postpartum Warning Signs

Patient-facing Materials

CDC: "Hear Her" Campaign (also available in various languages)
AIM: Urgent Maternal Warning Signs
ACOG: Pregnancy Status Signs in English and Spanish

Respectful, Equitable and Supportive Care

Maternal Mental Health Leadership Alliance: Black Maternal Mental Health
ACOG: Communication Strategies for Patient Handoffs
Agency for Healthcare Research and Quality: Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families
March of Dimes: Beyond Labels: Do Your Part to Reduce Stigma
ACOG: Respectful Care eModules
CMS: Providing Language Services to Diverse Populations: Lessons from the Field
Rural Health Information Hub: Enhancing Services for Deaf, Hard of Hearing, and Deafblind Patients in Rural America

Trauma-informed Care

SAMHSA: Concept of Trauma and Guidance for a Trauma-Informed Approach
Trauma-Informed Care Implementation Resource Center: Resource Repository
AIM: Patient Support After a Severe Event: The Importance of Providing Trauma-Informed Care

Appendix C: Screening Tools

Topic	Tool	Description	Resources
Depression	EPDS (Edinburgh)	10-item depression screener for the pregnancy and the postpartum period (contains anxiety-related questions)	English EPDS Spanish EPDS Using the EPDS Translated Into Other Languages
Depression	PHQ-9/ PHQ-2	9-item (short version: 2-item) adult depression screener	PHQ-9
Bipolar	MDQ	15-question bipolar disorder screener	MDQ
Anxiety	GAD-7/ GAD-3	7-item (short version: 3-item) general anxiety screener	GAD-7
Substance Use	TAPS	4-item screener for tobacco use, alcohol use, prescription medication misuse, and illicit substance use in the past year and brief assessment	TAPS
Substance Use	4Ps Plus	4-item screener for drug, alcohol, and tobacco use among birthing persons and people of childbearing age. The 4Ps Plus© includes additional questions about depression and domestic violence	4Ps Plus©
Substance Use	5Ps	5-item screener for tobacco, alcohol, and drug use, as well as domestic violence among birthing persons and people of reproductive age	5Ps
Substance Use	CRAFFT	9-item screening tool that identifies alcohol, drug use, and substance-related driving risk among adolescents and young adults	CRAFFT
Substance Use	*NIDA Quick Screen*	*Screening tools that detect alcohol, tobacco and drug use; tools can be used sequentially based on the individual's substance involvement score*	*(discontinued in favor of TAPS)*

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