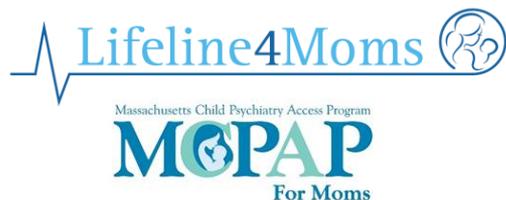




Perinatal Depression and Anxiety: Interdisciplinary Teams Facilitate Integration of Obstetric & Mental Health Care in the U.S.



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Founding Leader, Engagement Director, MCPAP for Moms

Disclosure Statement:

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- Founding Leader, Lead Obstetric Liaison, MCPAP for Moms, MA Department of Mental Health



- Co-Founder, Medical Director, Lifeline4Moms



- Participant Ad Hoc Advisory Boards, Research Consultant and Speaker Honoraria, Sage Therapeutics



- Consultant, Ovia Health



- Author, Perinatal Depression Chapter, Scientific American Ob/Gyn, Decker Intellectual Properties



- 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.**

1 in 5

women around the world will suffer from a
maternal mental health complication



#MaternalMHMatters

Perinatal mental health disorders negatively effect mom, child & family

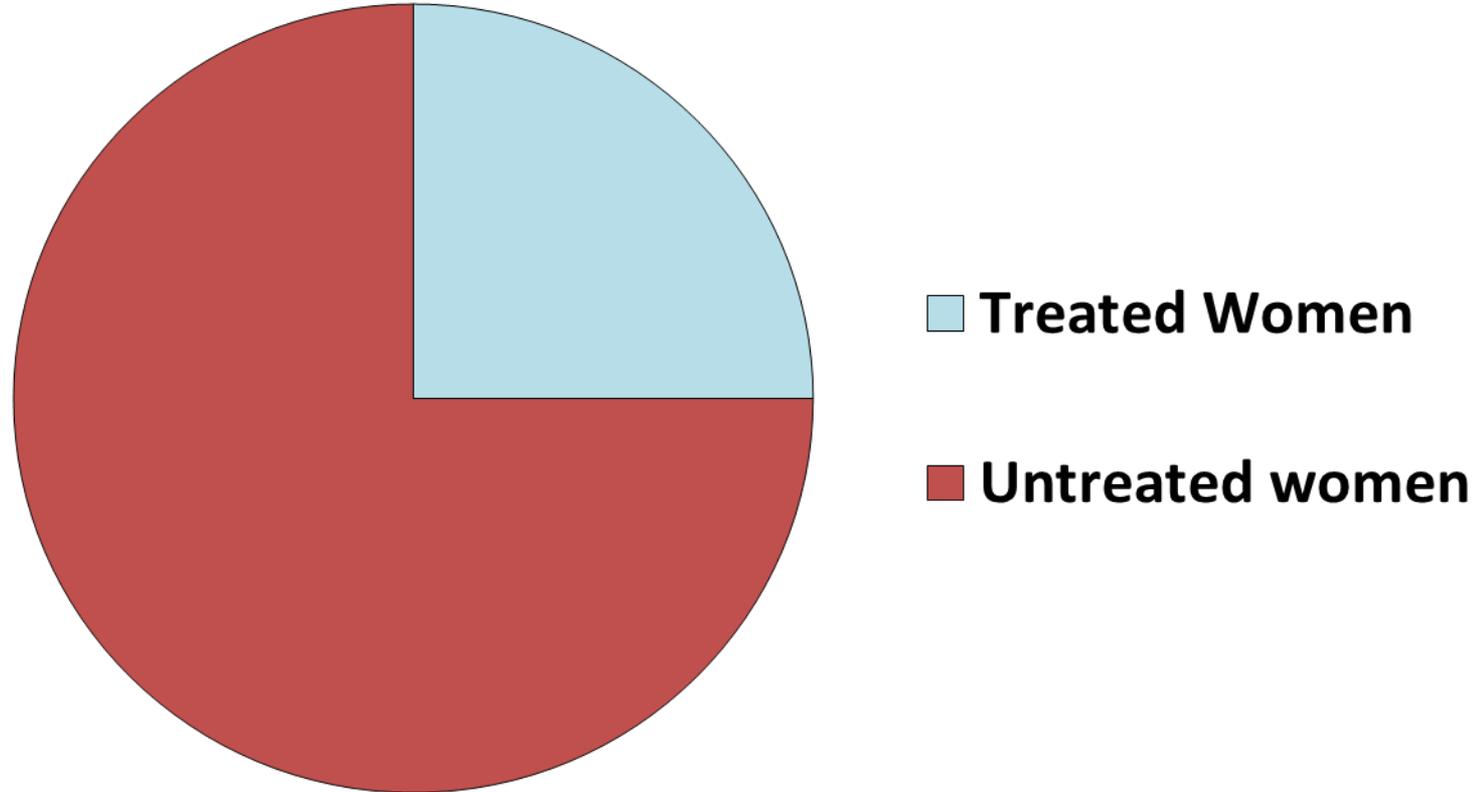
Poor medical care adherence
Smoking & substance use
Preeclampsia
Suicide



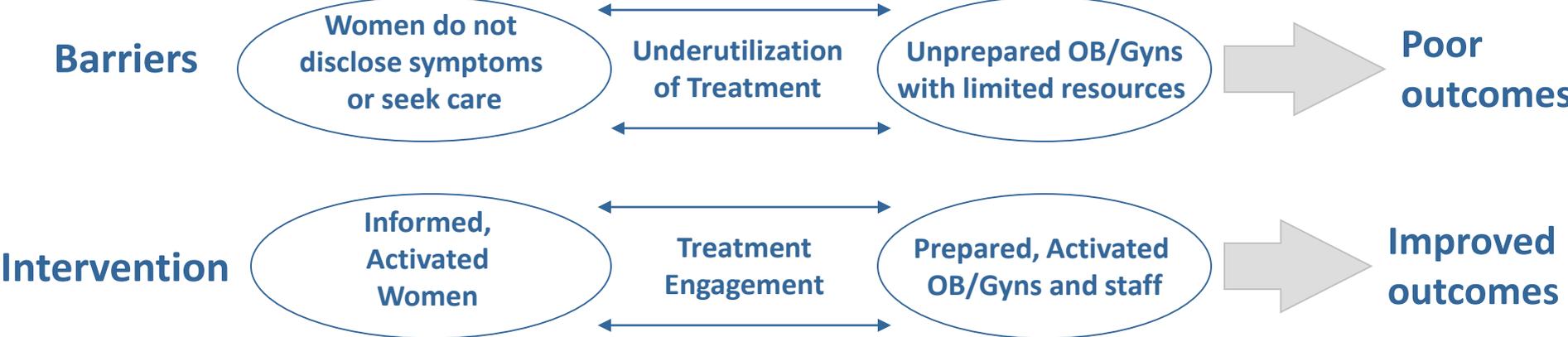
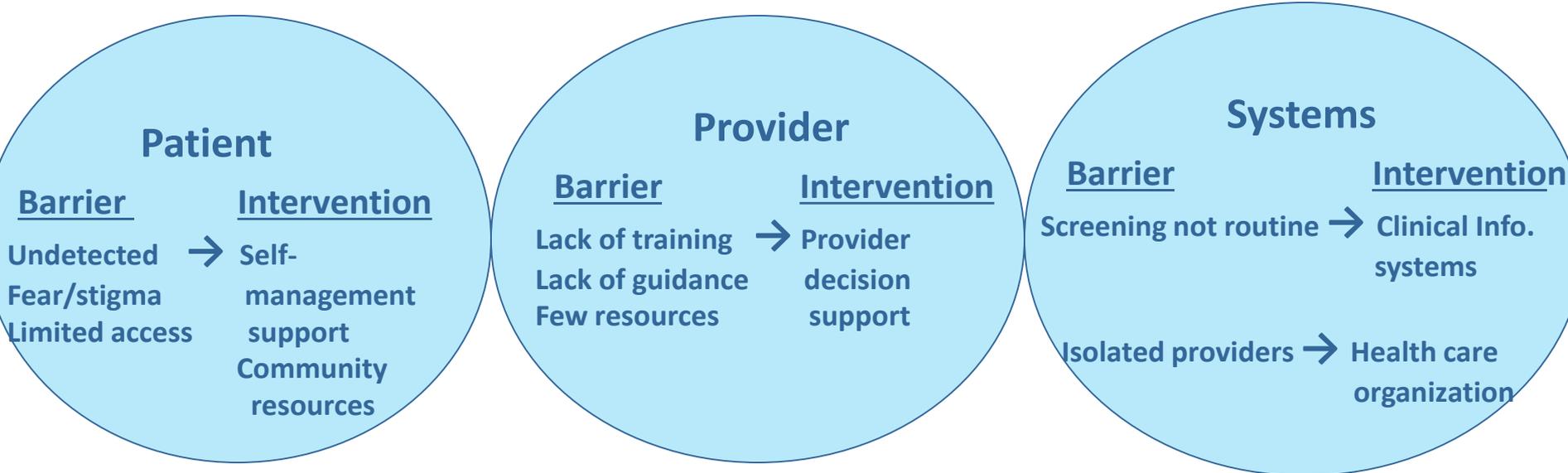
Low birth weight
Preterm delivery
Cognitive delays
Behavioral problems
Infanticide

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



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.





Reaffirmed 2012

The American College of Obstetricians and Gynecologists
Women's Health Care Physicians

COMMITTEE OPINION

Number 453 • February 2010

Committee on Obstetric Practice

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

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).

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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The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 630 • May 2015

(Replaces Committee Opinion Number 453, February 2010)

Reaffirmed 2016

Committee on Obstetric Practice

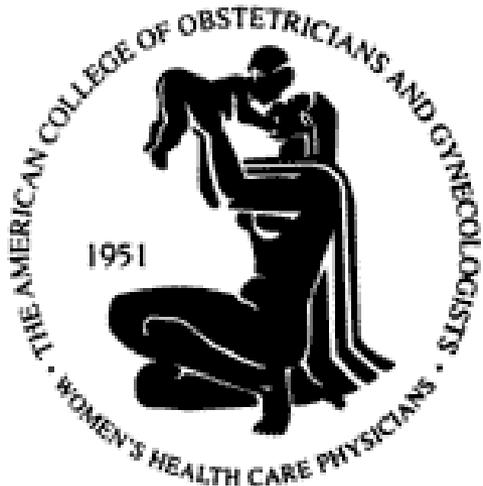
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Screening for Perinatal Depression

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

2015



Depression & Anxiety

At least once during the perinatal period

2016



Depression

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.





**COUNCIL ON PATIENT SAFETY
IN WOMEN'S HEALTH CARE**

safe health care for every woman



American Association of Nurse Anesthetists



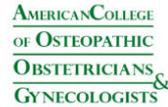
American Board of Obstetrics and Gynecology



American College of Nurse-Midwives



American Academy of Family Physicians



American College of Obstetricians and Gynecologists



American College of Obstetricians and Gynecologists



American Society of Anesthesiologists



American Society for Reproductive Medicine



American Urogynecologic Society



Association of Women's Health Obstetric and Neonatal Nurses



National Association of Nurse Practitioners in Women's Health



Patient Advocate



Patient Advocate

Miranda Klassen



Preeclampsia Foundation



Society for Academic Specialists in General Obstetrics and Gynecology



Society of Gynecologic Oncology



Society of Gynecologic Surgeons



Society for Maternal Fetal Medicine



Society for Obstetric Anesthesia and Perinatology



Society of OB/GYN Hospitalists



Society for Reproductive Endocrinology and Fertility

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



- 2015 – Interdisciplinary work group convened**
- 2016 – Patient safety bundle & resource listing available**
- 2017 – Consensus statement published**

PATIENT
SAFETY
BUNDLE

Maternal Mental Health



READINESS

Every Clinical Care Setting



RECOGNITION & PREVENTION

Every Woman



RESPONSE

Every Case



REPORTING/SYSTEMS LEARNING

Every Clinical Care Setting

READINESS

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.



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

[Obstet Gynecol. 2017 Mar;129\(3\):422-430.](#)



**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

[Access Archived Materials »](#)



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

[Access Archived Materials »](#)



Maternal Mental Health Expert Work Group Mission Statement

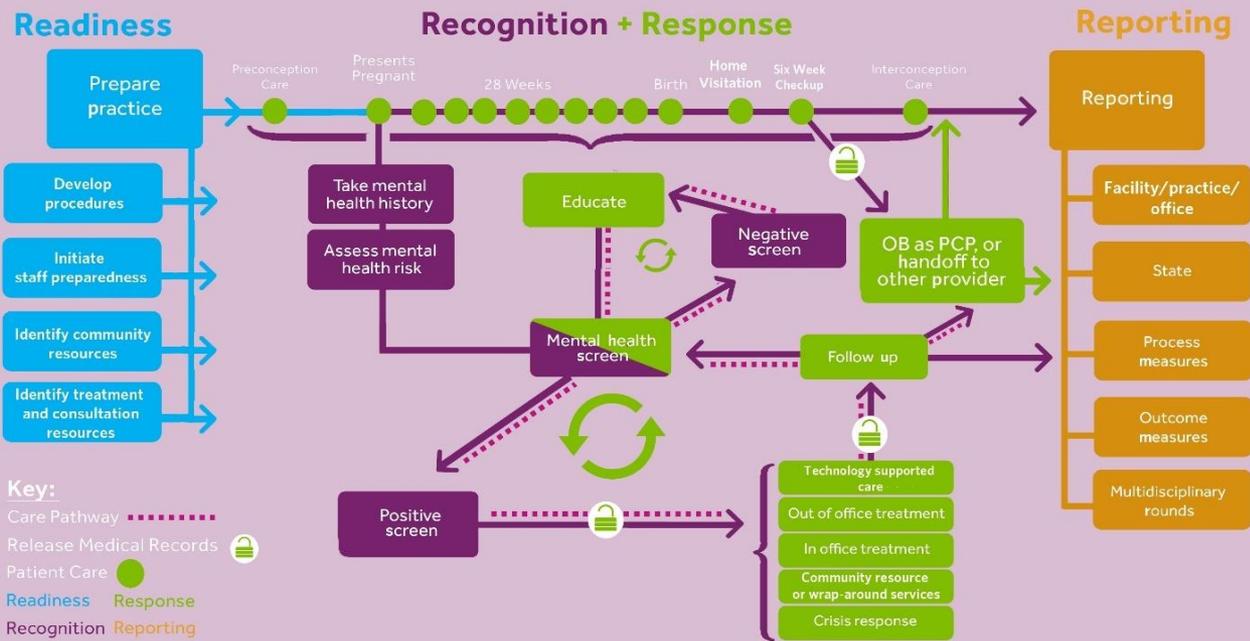
ACOG's MMH EWG is a multidisciplinary collaboration of specialists in women's health, obstetrics, psychiatry, psychology, nursing, social work, and public health who aim to promote the integration of maternal mental health into the delivery of perinatal care. Through efforts focused on current clinicians 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.



PATIENT SAFETY BUNDLE

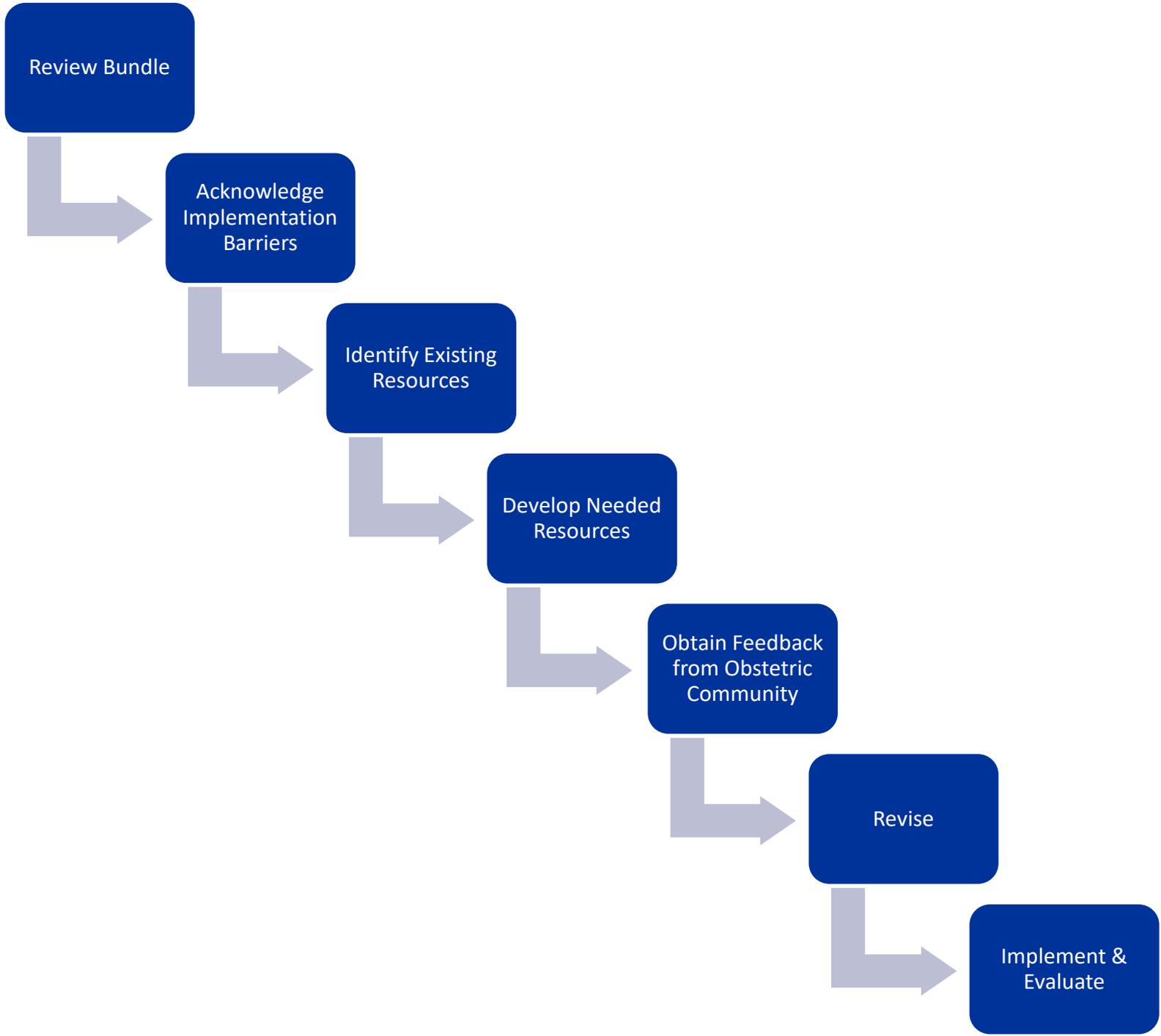
Maternal Mental Health

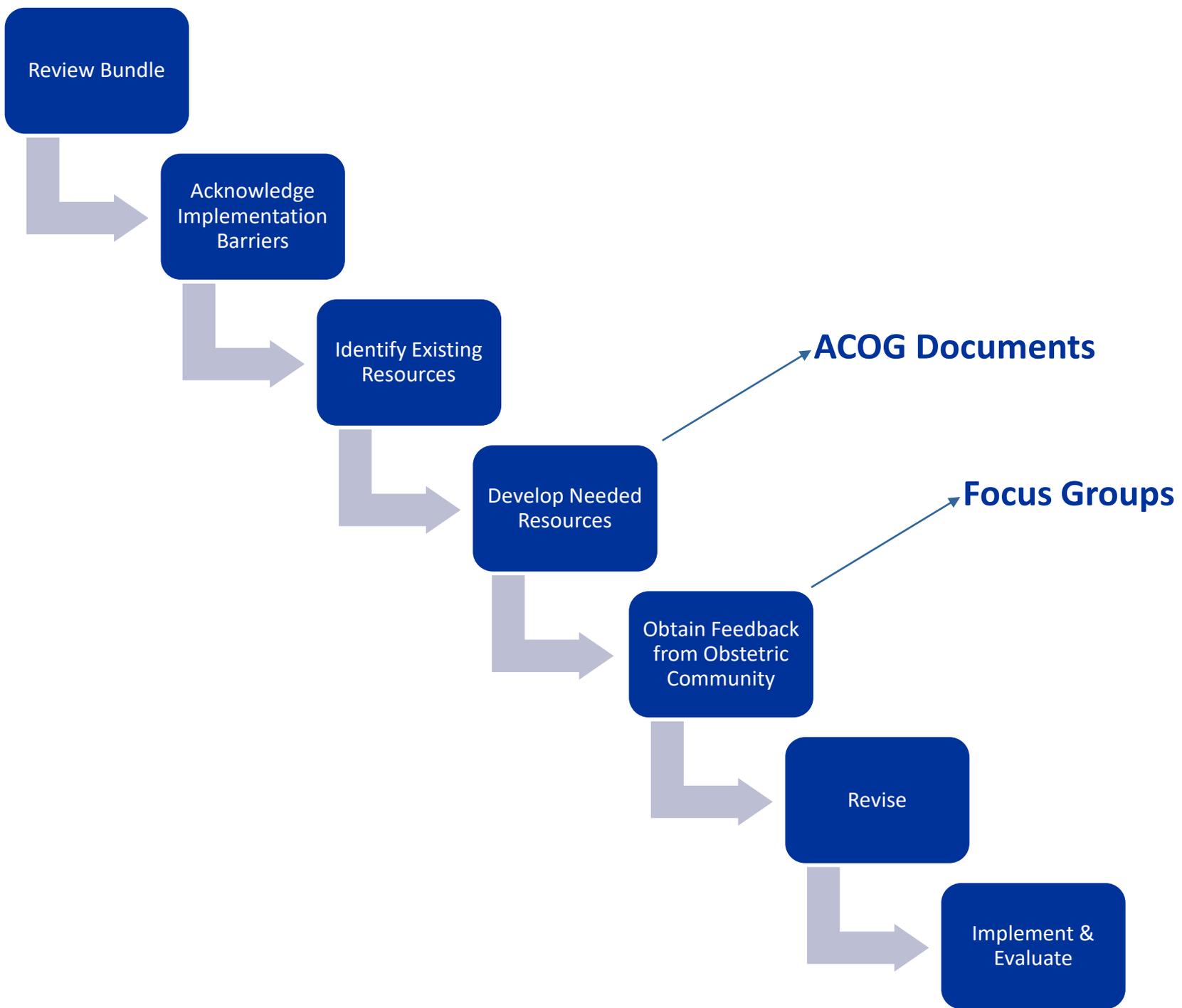
Mental Health Journey in an Obstetric Care Setting



Provider Situation Today (Pain Points)

- As new recommendations around screening for Maternal Mental Health (MMH) have emerged, offices 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 staff 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 outcome data







ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS



CENTERS FOR DISEASE™
CONTROL AND PREVENTION



CDC Foundation
Together our impact is greater



**WORKING TOGETHER TO PREVENT
MATERNAL MORTALITY**



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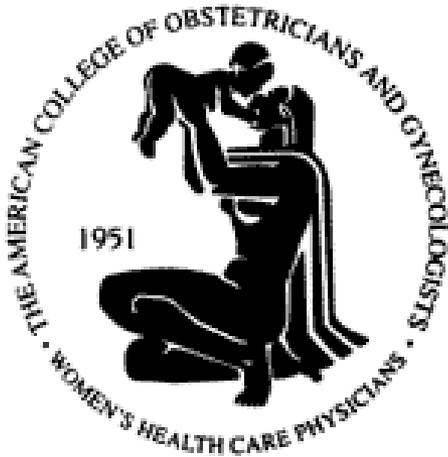


CDC Foundation

Together our impact is greater



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

Tiffany A. Moore Simas, MD, MPH, MEd, FACOG

Co-Chair, ACOG Maternal Mental Health Expert Work Group
Member, Council on Pt Safety in Women's Health, MMH
Safety Bundle

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Quantitative Health Sciences

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