



Session # 67

Integrated Behavioral Health in a Women's Care Clinic: Practical Applications Regarding Implementation and Case Discussions Demonstrating the Efficacy of the IBH Model During Pregnancy and Postpartum.

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Faculty Disclosure

The presenters of this session currently have or have had the following relevant financial relationships (in any amount) during the past 12 months:



Dr Jennifer Hyer is a medical advisor for SAGE Therapeutics.



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Conference Resources

Slides and handouts shared by our conference presenters are available on the CFHA website at https://www.cfha.net/page/Resources_2019 and on the conference mobile app.





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Learning Objectives

At the conclusion of this session, the participant will be able to:

- Understand the importance of the use of an integrated care model in specialty care populations
- Be able to articulate the barriers to care that pregnant and postpartum women face in accessing adequate mental health support
- Gain an increased understanding of the complex psychiatric needs of pregnant and postpartum women



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Learning Assessment

- A learning assessment is required for CE credit.
- A question and answer period will be conducted at the end of this presentation.



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Why do we do this work?

"Mental illnesses contribute substantially to the global burden of disability, particularly for women." - National Institute on Mental Health

"Gender is a critical determinant of health, including mental health...gender is important in defining susceptibility and exposure to a number of mental health risks." - World Health Organization

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CASE: AW

- 24 y/o G2P1 with a history of "postpartum psychosis" per her report
- Presented for OB care at 13 weeks, screened positive on the Edinburgh Postnatal Depression Scale (EPDS), referred to Behavioral Health
- Initially presented with anxiety in pregnancy related to past postpartum symptoms
- Declined therapy initially, interested in medication consultation



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Why Screen for PMAD's

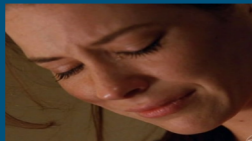
- Depression is the most common complication of pregnancy
- Prevalence rates range from 7-19%.
- Research shows in populations with complex social and psychological concerns, the rates are nearly double.
- Maternal mental health complications impact:
 - Mother's quality of life
 - Transitions to parenthood
 - Fetal development



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The PMAD Numbers:

- 80% of women have "normal baby blues."
- 1 in 7 women will experience PMAD.
- 1-2 in 1000 get PP psychosis
- 1 in 10 fathers experience PPD
- Depression in pregnancy is also associated with: poor prenatal care, poor nutrition, substance misuse, self-harm, and possible preterm birth and low birth weight



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The PMAD Numbers: Severe mental illness

- Risk factors: numerous and variable
- 70% of women with a history or true bipolar disorder, who go off their meds will have a relapse of symptoms in the perinatal or postpartum period
- Women with bipolar mood disorder are 7x more likely to be hospitalized with a first time mood episode postpartum
- 60% of bipolar women initially present as depressed postpartum
- 1-2% will get PP Psychosis. Good clinical screening is important







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Case: AW

- Intrusive thoughts 1 year after the birth of her first baby. Thoughts about driving into the river with baby in the car. No intent or action. Patient sought care at the time, she felt very concerned about these thoughts. Diagnosed with major depressive disorder with psychotic features. Started on citalopram 5 mg. More anxious symptoms began, propranolol added. Eventually aripiprazole 2.5 mg was also added. She was not planning on pregnancy at the time, had Nexplanon for birth control.
- Remained on medication for about 1 year. Felt well, stable. Discontinued medication in anticipation of another pregnancy. Nexplanon removed.
- We started seeing her in her 2nd trimester of her 2nd pregnancy. She noted some "obsessive" behaviors while on Abilify previously - extreme couponing, increasing purchasing, increased alcohol use to once a week

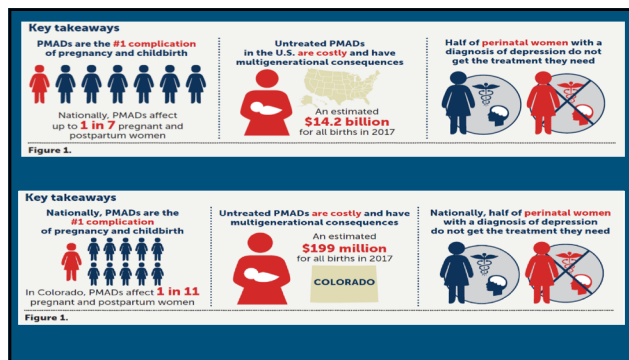
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Estimates of societal costs of PMADs and Impacts for births in 2017			
Highest maternal and child costs	Outcome	Among 2017 births, untreated PMADs could lead to...	Cost estimate (in million \$)
 \$4.7 billion in productivity losses	Maternal		
	Productivity losses	An additional 5,054 unemployed women, and an increase in absenteeism and presenteeism	\$4,652
	Health expenditures*	Insurer-paid expenditures that are \$1,376 higher per mother (individual out-of-pocket expenditures that are \$271 higher)	\$2,932
	Cesarean delivery	An additional 34,168 cesarean deliveries	\$408
 \$2.9 billion in maternal health expenditures	Peripartum stay	An additional 115,280 days spent in the hospital	\$271
	Suicide	An additional 1,049 suicides	\$204
	Benefit receipt	An additional 1,651 women enrolled in Medicaid, 1,570 in SNAP, 1,359 in TANF, and 1,196 in WIC	\$168
	Preeclampsia	An additional 15,615 cases	\$20
 \$3.3 billion in preterm births	Child		
	Preterm birth	An additional 61,098 preterm births	\$3,306
	Child behavioral and developmental disorders	An additional 24,297 children with behavioral and developmental disorders	\$1,551
	Child injury	An additional 15,513 injuries per year	\$306
 \$1.6 billion in child behavioral and developmental disorder costs	ED visits	An additional 85,760 ED visits per year	\$202
	Asthma	An additional 15,615 children developing asthma	\$123
	Breastfeeding	An additional 22,072 mothers per year not breastfeeding	\$74
	Childhood obesity	An additional 22,473 children developing obesity	\$31
	SIDS	An additional 516 SIDS cases	\$11
	Well-child care visits	71,914 fewer well-child visits per year ²⁰	-\$101

*Maternal health expenditures consist of all health care costs (including mental health), but do not include obstetric costs (reported separately).

Figure 4.

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National Recommendations:

- The **USPSTF** recommends: Screening for depression in all adults including pregnant and postpartum women
- **ACOG** recommendations were revised in Oct. 2018 to state that all OB's should be screening women in pregnancy and providing more comprehensive postpartum screening/care
- **AAP** recommends further screening of mothers and caregivers throughout the first year of an infant's life.

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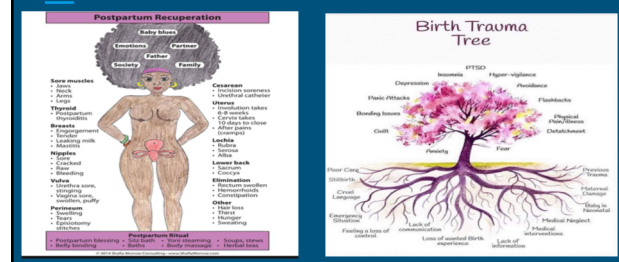
Setting women up for failure

Bombarded with unrealistic expectations: by others, in the news, and in the media:



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The complexity of the Postpartum Period:



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Gender specific factors:

- **Physical**
Genetic Predisposition
Sensitivity to hormonal change
Previous diagnoses
- **Psychosocial Factors**
Inadequate support
Perfectionism, Superwoman
- **Concurrent Stressors**
Sleep disruption
Poor nutrition
Health challenges for mom or baby
Cultural stress and barriers/Interpersonal stress



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Gender specific factors:

Gender based violence and trauma

- Rates of rape or attempted rape are as high as 18% in women, 3% in men
- Women are 5 times more likely than men to report childhood sexual trauma

Disproportionate socioeconomic standing

- Lower ranking jobs, more insecure housing
- Lower income or lower income equality

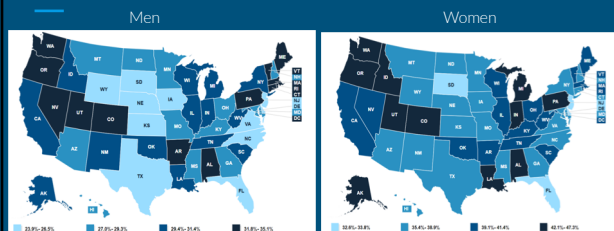
Immense responsibility for the care of others

- Unpaid domestic labor work



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Adults reporting poor mental health status - 2016



Source: Kaiser Family Foundation

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Case: AW

- Began seeing BH/OB team in end of second trimester.
- Initially did not want medications, but wanted a plan to resume meds
 - She wondered whether her prior depressive and anxious episode was related to relationship issues she was having at the time
- Became increasingly anxious and "uncomfortable" throughout later pregnancy.
- At 35 weeks she requested reinitiation of aripiprazole due to anxious symptoms regarding past postpartum symptoms
 - She felt aripiprazole had been the most helpful medication for her
- She delivered at 37 weeks, reported feeling mildly anxious but no other concerns. No changes to medications.

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Influences on accessing care - patients:

Cultural factors - views on mental illness, views on talking about problems outside the family

Family pressures - to seek or not seek treatment

Fears - of revealing too much, of getting in trouble or being in the hospital, losing children or family members

Sign of weakness - "I should be stronger"

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Barriers to accessing care - systemic:

Frequency of appointments - seeing OB every 2-4 weeks, adding more appointments for medically complicated patients

Unable to bring children to appointments

Patients are told to stop their medications when they become pregnant

Lack of mental health care specialists

- 77% of US counties had a severe unmet demand for all mental health professionals
- 96% had some unmet demand



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Considerations to help women:

Provide mental health care in settings women already feel comfortable

Include mental health care as a part of routine care

Identify the strength in seeking care and seeking help, offer support and empathy

- "I have the easy job, you did the hard work of coming here today."
- "I am glad you came in today, I think I can help you feel better."

Making exam rooms or offices family friendly - ex. I have toys, coloring, books in most of my mental health care offices.

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The Denver Health Model:

Appt made at clinic:



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Behavioral Health OB (BHOB) clinic

- One half day a week - 7 open slots between the psychologist and psychiatrist
- 3 slots are linked to an OB midwife visit
- The patient can get their OB care and mental health care on the same day with a team that is able to collaborate face to face in the moment
- Nurse Care Manager to help patients navigate clinic
- Prior referrals from OB/gyn providers and outside clinic referrals
- The psychologist is continuing to take consults from providers in the clinic

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Integrated Care in a Specialty Care Setting

What makes Women's Care unique?

- Variety of providers - MD, NP, residents, midwives
 - Is prescribing antipsychotics outside the scope of OB/gyn care?
- Staff with frequent turnover
 - On my first day, I was told that the psychiatrist did not work there (I was shadowing her that morning) and that I would be with "Carrie" who was the psychiatrist's replacement (I was the replacement)
- Implementing a clinic with limited experience with behavioral health care
 - Some nurses and clerks did not know the difference between a psychiatrist and a psychologist
- Patients often do not have a PCP
 - Who has ownership of the patient?

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What works??

Flexibility

- "If I have 2 chairs and a door, I can see the patient." - I do not have an office, I will see patients anywhere. (conference room, procedure room, during a non-stress test, etc.)

Access

- I sit in provider workrooms for curbside consults
- I have a Vocera on so I can be reached M-F, 8-5
- I take questions over EHR or email
- All the BHC's have my cell and know how to find me

Part of the team - I participate in potlucks, March Madness brackets, signing cards, social events, etc.

Being nice - I try to nicely answer phone calls, offer helpful support and encouragement

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Case: AW

- Readmitted 2 days later for postpartum pre-eclampsia
- Feeling more depressed and tearful. OB consulted Psychiatry.
 - Dr. Jindal happened to be on call for Psychiatry - go integrated care!
 - Sertraline added
- She was seen about every 2-4 weeks postpartum by a member of the BHOB team. She typically reported anxiety, some intrusiveness.
- Around 2 months postpartum she presented with rapid speech, overly bright affect, increased spending on unnecessary household items, increased activity like rearranging furniture in the home
 - More concern for mania and bipolar disorder
 - Sertraline stopped, antipsychotic optimized

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How has IBH changed a Specialist's Practice:

- Practice before IBH: don't ask, don't tell
- Screening identifies patients that from the outside look like they are 'fine'
- Movement towards expanded screening allows for OB/Gyn's to know more about their patients and provide trauma informed care.
- Training the next generation of OB/Gyn's

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How To in Specialty Care:

- Get a clinic champion
- Work on system buy-in
- Train the WHOLE team
- Find funding



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Case: NV - Background

- 35 y.o. G4P3 presenting to clinic for prenatal care complicated by GDM at 24w4d after release from jail and subsequent restraining order placed by husband
- Undocumented, uninsured
- History of schizophrenia spectrum disorder, aggressive behaviors, self harm and IP care

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Case: NV Course

- Presenting at 1st visit with psychotic symptoms, poor DM control, and passive HI.
- 2nd visit: active HI, increasing agitation, responding to internal stimuli/PES/Duty to Warn
- History of 8+ hospitalizations.
- Hospitalized 3 times during pregnancy and in year following delivery often with catatonia sx
- Seen in integrated visits with psychology, psychiatry and OB MD due to barriers

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Case: NV - Role of Integrated Care

- Maintain safety of the patient and the public
- Ease of follow up
- Ability to frequently monitor
 - A check in occurred at a lab draw or OB visit
- Case management and care navigation
 - Particularly with access to medications and connections to follow up care
- Advocacy with other services
 - We understand the possibilities but also the limitations of the medical clinic within complex psychiatric care

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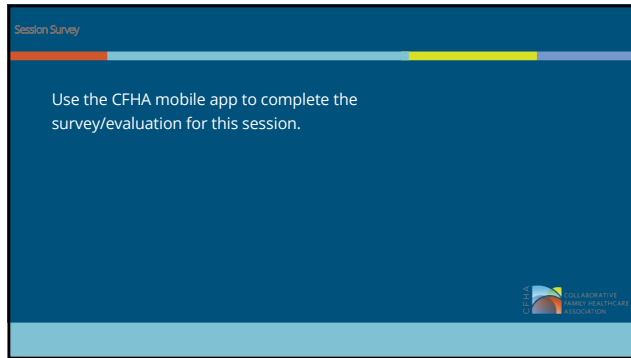
You Can't Tell

When this picture was taken I was suffering from postpartum depression and severe anxiety. You can't tell by looking, but I felt like a horrible mother. I had been suicidal a few months prior. I was having racing & intrusive thoughts, experiencing moments of rage I couldn't explain or understand, constantly sweating from anxiety, having at least one panic attack daily, and found myself stuck in gravity wells of sadness every few days that made just getting out of bed painful and exhausting."

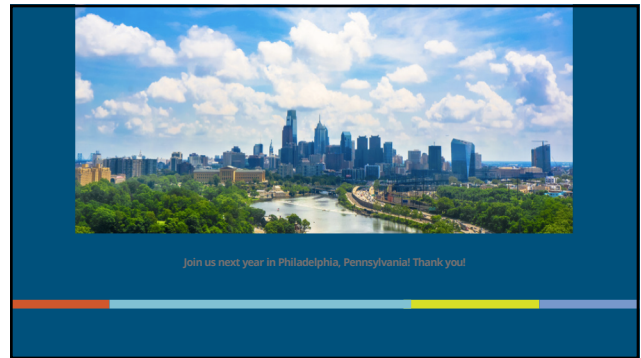
~ A'Driane Nieves



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