Bringing Integrated Care into the Perinatal Setting

Joan Kenerson King RN, MSN
joank@thenationalcouncil.org

- Sir Isaac Newton
1643-1727

Fearless Parent

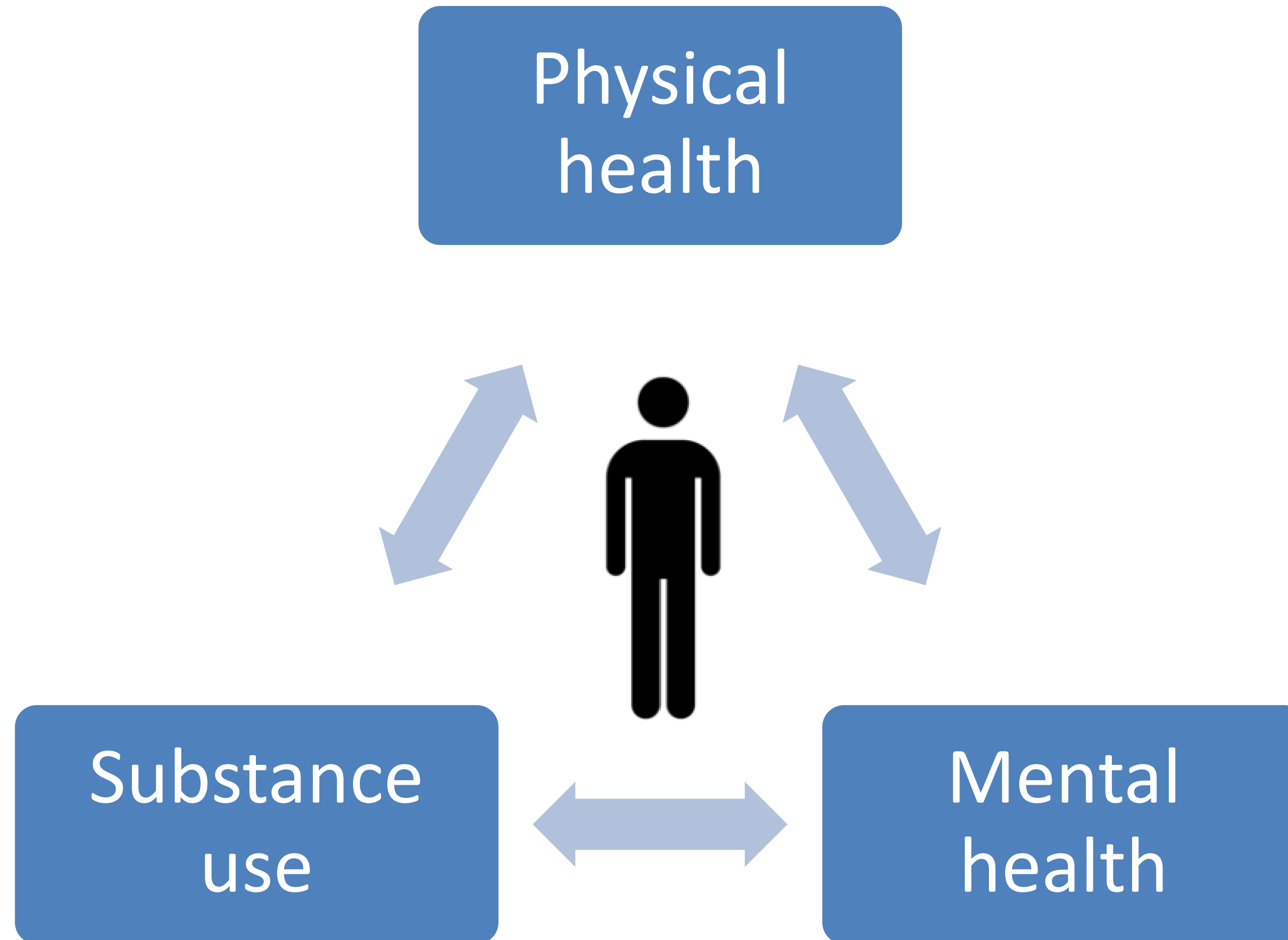
What have we learned?

Incredibly simple….

Infinitely complex.

Why is that?

Integrated Care = Whole Person Care



Integration: why

- Access: there will never be enough specialty providers/specialty care needs to be for people who need it
- Referrals by and large don’t work—at least the “cold” ones
- Decrease patient burden, catches people where they are?
- Improved outcomes
- Restores the mind/body connection
- Decreases discrimination (stigma)

Perinatal Depression and Anxiety

- Postpartum depression is the most common complication following childbirth, affecting one in every seven women.[1,2]
- Prevalence estimates of prenatal anxiety range from 13-21% of all new mothers, with postpartum prevalence estimated between 11-17%. [3]
- Women are more likely to develop depression and anxiety during the first year after childbirth than at any other time in their life.[4]
- It's estimated that 10% of fathers experience depression and anxiety during the perinatal period; the most significant risk factor for depression in fathers, both prenatally and in the postpartum period, is maternal depression[5,6]

- Only 40% - 50% of mothers with perinatal mood and anxiety disorders seek treatment.[7,8]

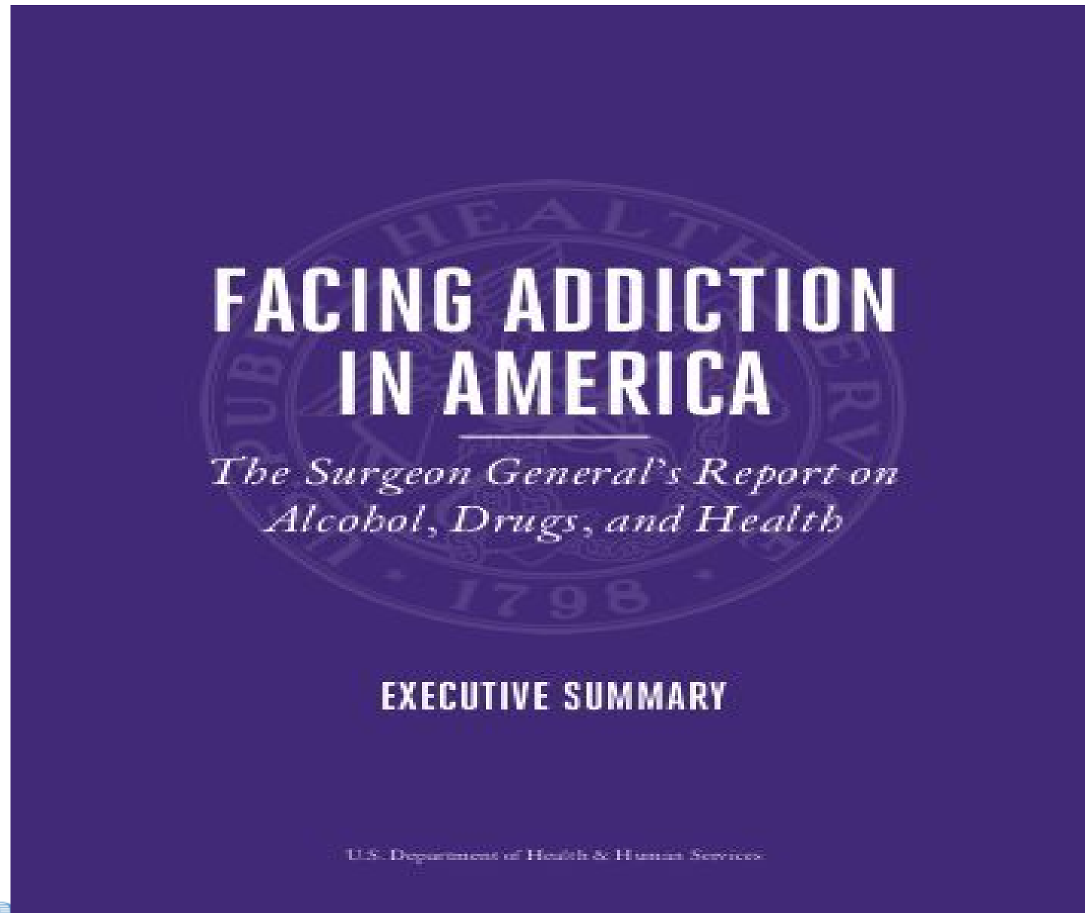
Perinatal Substance Use

- Pregnant people use illicit substances at half the rate of their non-pregnant peers - and use less during their third trimester – however more than 400,000 infants are exposed to alcohol or illicit drugs in utero each year.[9]
- Estimates suggest that about 5 percent of pregnant women use one or more addictive substances.[10]
- Some factors that correlate with perinatal substance use disorder include depression, intimate partner violence, sexual abuse, and childhood trauma.[11]
  - Because people who use substances are often criminalized and marginalized, substance use and illicit substance use can carry additional risks unrelated to their pharmacological effects, such as an increase risk of structural violence, imbalance of power in intimate relationships, and involvement with the criminal justice system, all of which can contribute to new experiences of trauma.[9,11]

Impact of Perinatal Behavioral Health Issues

- Perinatal mood and anxiety disorders are associated with increased risks of maternal and infant mortality and morbidity.[1]
- The impact of parental depression and anxiety, especially the mother, can be quite significant both on the attachment relationship and on the neurodevelopment of the baby. This impact is exacerbated when the parent experiences more clinically significant mental health issues, such as psychosis.[12, 13]
- Regular use of some drugs can cause neonatal abstinence syndrome (NAS)
- The type and severity of an infant's withdrawal symptoms depend on the drug(s) used, how long and how often the birth mother used, how her body breaks the drug down, and whether the infant was born full term or prematurely.[14]
- Parents are rightly and understandably fearful that seeking prenatal care, disclosing substance use, and initiating treatment for a Substance Use Disorder may result in harmful and punitive child welfare involvement.[15]
    - This, unfortunately, increases the risk of obstetrical complications, preterm birth, and delivery of low birth weight infants. It also contributes to higher rates of unmanaged Neonatal Abstinence Syndrome[16]
- Current research and practice has found that when parents partner in their prenatal care with supportive and knowledgeable staff, receive coordinated care to address the negative consequences of their substance use, and are able to room-in with their infant after delivery, the parent-infant bond is preserved and outcomes are better[17, 18]

Changing the Addiction Paradigm



- Moving from addiction as a moral failing to a chronic brain disorder
- Moving from criminal justice approaches to pubic health strategies
- Dropping old, stigmatizing language and developing new terminology
- Developing a science base that informs policy and practice
- Addressing substance use, misuse, and disorders across a full continuum and the lifespan: *prevention, treatment, recovery management*

Substance Use Disorder Treatment Continuum of Care

Enhancing Health

- Promoting optimum physical and mental health and well being through health communications and access to health care services, income and economic security and workplace certainty

Primary Prevention

- Addressing individual and environmental risk factors for substance use through evidence-based programs, policies and strategies

Early Intervention

- Screening and detecting substance use problems at an early stage and providing brief intervention, as needed, and other harm reduction activities

Treatment

- Intervening through medication, counseling and other supportive services to eliminate symptoms and achieve and maintain sobriety, physical, spiritual and mental health and maximum functional ability

Recovery Support

- Removing barriers and providing supports to aid the long-term recovery process. Includes a range of social, educational, legal and other services that facilitate recovery, wellness and improved quality of life

U.S. Department of Health and Human Services (HHS), Office of the Surgeon General. (2016, November). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health.

Integrated Behavioral Health: definition

- “A practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.
- This care may address mental health and substance abuse conditions, health behaviors (incl. their contribution to chronic medical illness), life stressors and crises, stress-related physical symptoms, and in-effective patterns of health care utilization”

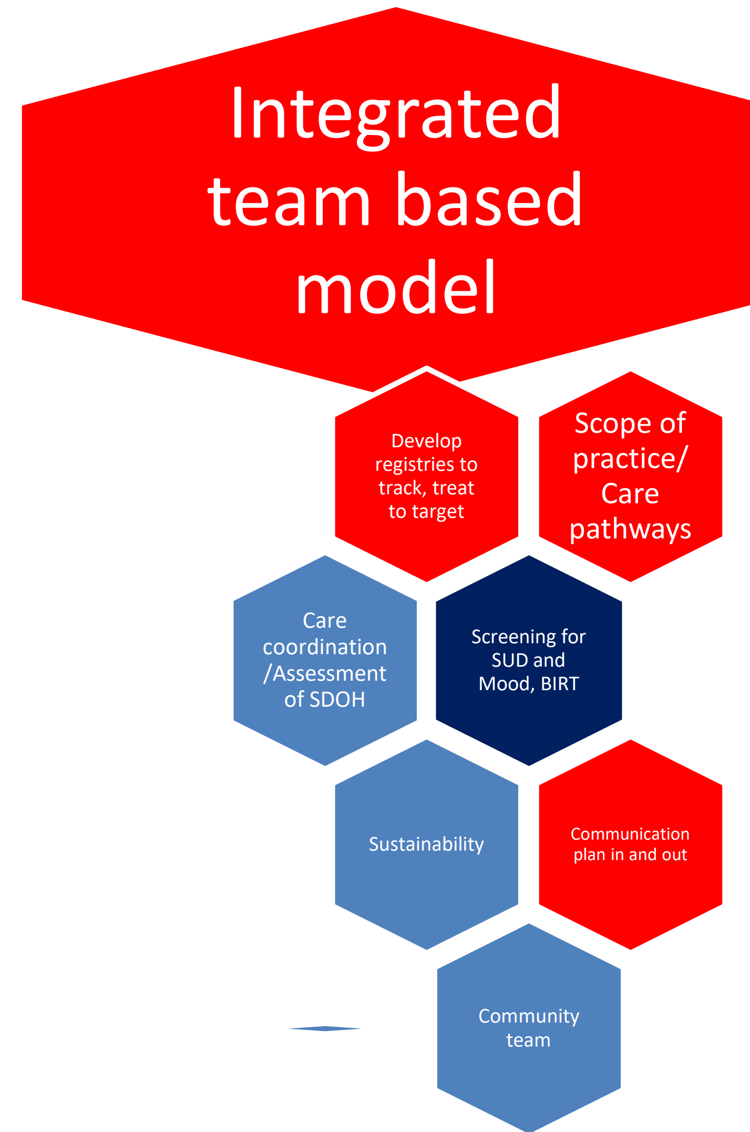
Peek, C.J. (2013). https://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf

Core Elements of Integration

- Intentional choice of level of integration
- Team based care
- Evidence based clinical models
- Clear leadership
- Stepped care
- Defined continuum of care
- Care coordination
- Psychiatric consultation

Core Components

Building on core elements of integration



Core component #1

- Work Plan Item #1: Begin offering an integrated, team-based model of clinical care for pregnant and post-partum women with SUD; service must start within the first six months of the grant.

Clinical Team: why a team

Integration: the what

WHAT IT IS NOT

- Just collocation and consultation
- Shared records but no treatment integration
- Compartmentalization
  - "This part is your job and this part is my job"
- Referral system via computer
- Basic case management
  - "Here is a resource guide"
- Warm handoff for appointment another day
  - "I don't have time for a warm hand off, so just have them schedule an appointment for next week"
- Long-term, 60 min sessions

WHAT IT IS

- True Team-Based Care
  - Team Assessment
  - Shared Care Plans
  - Shared Accountability
  - Real time collaboration w PCP & team members
- Continuum of care with inter-disciplinary team
- Brief consultation and/or Intervention: 30 minute sessions solution and symptoms focused (Treat to Target)
- Data Driven and Evidence Based; Universal screenings (MH SUD Trauma)
- Patient Centered and Patient Directed

Screening

Work Plan Item #2: Implement of SBIRT as a routine part of perinatal care for a majority of patients in the community as well as screening for perinatal and postpartum mood disorders.

Screening:

- Use standardized tools for substance use, mood and SDOH
- Universal
- Opportunity for high engagement
- Consider workflow simplicity and efficiency

Core component: plan for care

- Implement a scope of practice and care pathways that clearly define when to treat, when to consult, and when to refer individuals to higher levels of SUD or mood disorder treatment .

Complete Depression Screening (PHQ9)

Diagnosis of Depression?

No

Yes

Score ≥ 9

Yes

No

Complete Suicide Risk Assessment (CSSR-S)

Review/Update Crisis Intervention Plan

Annual Cycle

Low Risk

No to All

Mild Risk

Yes to #1 &/or #2

Moderate Risk

Yes to #3 no to #4

High Risk

Yes to #4 &/or #5 With Intent

Consult Care Team

Psychiatric Consult

Facilitate Referral If Necessary

Weekly Follow-Up Calls

Routine Appts/Quarterly

Review/Update Crisis Intervention Plan

Follow-Up w/ Client Daily if remain Outpatient

Routine Appts/Monthly

Update Crisis Intervention Plan

Nurse Care Manager

Care Coordinator/Manager

Therapist

Primary Care Consultant

Psychiatric Consultant

Component #3: data driven care

Establish specific treatment targets and manage outcomes using disease registries.

Registries for tracking:

- Are PHQ9/EPDS scores tracking down
- Who are you concerned about when?
- Social determinants (tomorrow)

Sustainability

Complete a sustainability plan for transitioning the program to stable, non-grant funding sources by the conclusion of MHCF funding (must be completed by month 18 of the grant)

- Integrated BH billable
- Care coordination: developing models

Communication

Implementing a communications and outreach plan directed to clinical staff and the community served by the new program.

- Change in approach impacts all internal systems: how do you share the message?
- Change in approach connects to the community: how do you share the message?
- 8 times/8 ways: developmental and on going.

Starting at the beginning….change the future one family at a time

Sources

[1] Gaynes, B., Gavin, N., Metzger-Brody, S., Lohr,K., Swinson, T., Gartlehner, G., et al. Perinatal depression: prevalence, screening accuracy, and screening outcomes. Evidence report/technology assessment no. 119. (Prepared by the RTI-University of North Carolina Evidence-based Practice Center, under contract no. 290-02-0016). AHRQ publication no. 05-E006-2. Rockville, MD: Agency for Healthcare Research and Quality, 2005.

[2] Wisner, K., Sit, D., McShwa, M., Rizzo, D., Zoretich, R., Hughes, C., et al (2013). Onset timing, thoughts of self-harm, and diagnoses in postpartum women with screen-positive depression findings. JAMA Psychiatry, 70:490-8.

[3] Fairbrother, N., Young, A., Antony, M., Tucker, E. (2015). Depression and anxiety during the perinatal period. BMC Psychiatry, 15:206.

[4] Newport, D., Hostetter, A., Arnold, A., Stowe, Z. (2002). The treatment of postpartum depression; minimizing infant exposures. Journal of Clinical Psychiatry, 63 (Suppl 7): 31-44.

[5] Paulson, J.F., Bazmore, S.D. (2010). Prenatal and postpartum depression in fathers and its association with maternal depression. JAMA, 303(19), 1961-1969.

[6] Kim, P., & Swain, J. E. (2007). Sad Dads: Paternal Postpartum Depression. Psychiatry (Edgmont), 4(2), 35–47.

[7] Thio, I., Browne, M. & Coverdale, J., “Postnatal Depressive Symptoms Go Largely Untreated,” Social Psychiatr and Psychiatr Epidem48:814-818 (2006). doi: 10.1007/s00127-006-0095-6.

[8] Centers for Disease Control (CDC). (2008). Prevalence of self-reported postpartum depressive symptoms—17 states, 2004–2005. Morbidity and Mortality Weekly Report, 57(14), 361–366.

[9] Tenore PL. Psychotherapeutic benefits of opioid agonist therapy. Journal of Addictive Diseases. 2008; 27(3), 49-65. doi: http://dx.doi.org/10.1080/10550880802122646.

[10] Wendell AD. Overview and epidemiology of substance abuse in pregnancy. Clin Obstet Gynecol. 2013;56(1):91-96. doi:10.1097/GRF.0b013e31827feeb9

[11] Torchalla I. “Like a lot’s happened with my whole childhood”: Violence, trauma, and addiction in pregnant and postpartum women from Vancouver’s downtown eastside. Harm Reduction Journal. 2015; [12] (1), 1-10. doi: https://doi.org/10.1186/1477-7517-12- 1.

[12] Gelfand, D. M., Teti, D.M. (1990). The effects of maternal depression on children. Clinical Psychologist Review, (10), 329-353.

[13] Hall, S. L., Hynan, M. T., Phillips, R., Lassen, S., Craig, J. W., Goyer, E., Hatfield, R.F., Cohen, H. (2017). The neonatal intensive parenting unit: an introduction. Journal of Perinatology, 1-6.

[14] MedlinePlus, U.S. National Library of Medicine. Neonatal abstinence syndrome: MedlinePlus Medical Encyclopedia. https://medlineplus.gov/ency/article/007313.htm. Published December 21, 2017. Accessed January 12, 2018.

[15] Wexelblatt SL, Ward LP, Torok K, Tisdale E, Meinzen-Derr JK, Greenberg JM. Universal maternal drug testing in a high-prevalence region of prescription opiate abuse. Journal of Pediatrics. 2015; 166(3):582-6. doi: 10.1016/j.jpeds.2014.10.004.

[16] Patrick SW, Schiff DM, Quigley J, Gonzalez PK, Walker LR and Committee on Substance Use and Prevention. Pediatrics. 2017; 139(3): e20164070. doi: 10.1542/peds2016-4070.

[17] Hodgson ZG, Abrahams RR. A rooming-in program to mitigate the need to treat for opiate withdrawal in the newborn. Journal of Obstetrics and Gynaecology Canada. 2012; 34(5), 475-81. doi: 10.1055/s-0035-1566295

[18] Jones HE, Fielder A. Neonatal abstinence syndrome: Historical perspective, current focus, future directions. Preventive Medicin.e 2015; 80, 12-17. doi: 10.1016/j.ypmed.2015.07.017.