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CONFERENCE ABSTRACT

Initial Results of the Design and Implementation of an Integrated Perinatal Mental Health Partnership

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Cara English[1,], Diane Ortega[2], Belinda Hodder [2]

1: Terra's Place, Tempe, Arizona United States
2: Willow Birth Center, Mesa, Arizona, United States

Introduction

Perinatal mood and anxiety disorders (PMADs) are the most common complication of pregnancy and childbearing with an incidence of 20%. In response to an increased rate of PMADs in the state of Arizona and a state-wide mental health service gap for pregnant and postpartum mothers, an integrated midwifery service model was designed to deliver evidence-based behavioral health assessment and treatment for PMADs.
Practice change implemented: This model was implemented in a women's health clinic in the Southwestern United States. Behavioral health concerns among pregnant, postpartum, and primary care women were identified through evidence-based screening tools, including the Edinburgh Postnatal Depression Scale (EPDS), the Mood Disorders Questionnaire (MDQ), and the Adverse Childhood Experiences (ACE). Women who presented with elevated scores or self-reported history of mental health disorders received behavioral health consultation via Warm Handoff and/or follow up behavioral health appointments at the clinic.

Aim

We aimed to reduce the rate of untreated PMADs in our community, increase access to evidence-based behavioral health care for women, and improve access to behavioral health specialty consultations for women's health care providers.

Targeted population and stakeholders

In the first two years of implementation, 1469 women seen in clinic were screened for PMADs by certified nurse midwives. The clinic housed an integrated Doctor of Behavioral Health who was called in for Warm Handoffs and/or scheduled women for follow up visits, and provided treatment for 900 women, their partners, and families. Mothers and families were also linked with community resources, including free therapy and peer groups.

Timeline

The first two years of implementation ran from October 2017 to October 2019.

Highlights

Provider impact was extremely positive; 100% of providers rated the impact of collaborating with BHP as positive; 100% rated additional BH training as helpful; 100% providers reported they utilized consultation with the BHP weekly. Patient impact: 88% reported a greatly improved prenatal/postpartum experience; 60% were unsure or would not have sought BH care if it were not available on site.

Comments on sustainability

This low-cost integration model has accomplished initial aims and has potential to expand impact through implementation in additional clinic and hospital sites.

Comments on transferability

The design and implementation of this model can easily be shared with health systems looking to implement an integrated model of service delivery in women's health and perinatal specialties. The partnership requires limited mental health infrastructure to meet patient and provider needs.

Conclusions

More mental illness was discovered than initially anticipated in this population, and without screening and available treatment, poorer pregnancy, birth, infant, and family health outcomes were likely, based on patient responses indicating they would not have sought help elsewhere or were unsure where else to go for behavioral health care.

Discussions

This model fills a critical service gap and has improved the standard of patient care for women and families through integrated care.

Lessons learned

Embedding a PMHNP or additional training for the staff will increase comfort level with medication management for pregnant and nursing mothers.