Collaborative Care: The Integration of Perinatal Mental Health into Medical Settings

BACKGROUND

Perinatal depression and anxiety are the leading complications of pregnancy and childbirth. According to the most recent Los Angeles Mother & Baby (LAMB) Survey, administered by the Los Angeles County Department of Public Health, 29.7% of new mothers in Los Angeles County self-report some form of depression during pregnancy, and an astounding 47.3% (representing more than 60,000 women) self-report depression during the postpartum period. Rates of self-reported depression during pregnancy are significantly higher among ethnic minority and low-income women. And, although the rates of any self-reported postpartum depression are fairly consistent across the county, the rates of severe symptoms are much higher among our most vulnerable populations. But many women do not seek treatment due to various barriers, including stigma, lack of informed providers, financial and insurance limitations, transportation issues, lack of childcare, and other concerns.

Perinatal, or maternal, depression encompasses a range of mood and anxiety disorders that can affect a woman during pregnancy, around the time of birth, and throughout her infant’s first year of life. If left untreated, these disorders, commonly called perinatal mood or anxiety disorders (PMADs), can lead to chronic mental illness in the mother, lack of emotional availability for the baby, and detrimental outcomes in the development of the fetus, newborn, and child. In fact, perinatal depression is the number one complication of pregnancy. Approximately one million women in the United States struggle with PMADs. These conditions cause toxic stress in the developing child and are therefore considered an adverse childhood experience.

The good news is that these conditions are highly treatable and often avoidable. By establishing systems of care, we intend for these women and their families to achieve emotional health.

SIGNS AND SYMPTOMS OF PERINATAL MOOD AND ANXIETY DISORDERS

Most women may not experience all symptoms, but may notice some of these:

- Feelings of sadness
- Mood swings, highs and lows, feeling overwhelmed
- Lack of interest in activities they used to enjoy
- Nervousness, anxiety and panic attacks
- Thoughts of harming themselves or their babies
- Fear they cannot take care of their babies
- Excessive worry about their babies
- Difficulty concentrating
- Changes in sleep and eating habits
- Feelings of guilt and inadequacy
- Difficulty accepting motherhood
- Irrational thinking; seeing or hearing things that are not there
This paper reflects on the experiences of the Los Angeles County Perinatal Mental Health Task Force with integrating perinatal mental health into medical settings in Los Angeles in order to make recommendations for those wishing to achieve some level of integration in their own varied medical practices. This includes pediatric, obstetrics/gynecology, primary care and hospital settings. Our purpose in integrating a team of experts both in medical and perinatal mental health is to improve the care of new mothers, their offspring and entire families. The recommendations derive from three years of experience with our demonstration project, The New Family Care Team, at USC-Eisner Family Medical Center, in which we provided training and expert technical assistance in order to facilitate integration. We have also provided these services across Los Angeles County in varied settings, including UCLA-Westwood, Harbor Community Clinic, and Harbor-UCLA, which have all contributed toward the recommendations and observations reported in this paper as well. These recommendations are not meant to be prescriptive, but rather to provide useful strategies for those medical or mental health settings wishing to provide more integrated care to their patients.

In this paper, we discuss the successes of The New Family Care Team, as well as lessons learned, and highlight other demonstration projects, so that others can replicate these models and improve care for perinatal women and their families.

### EFFECTS OF UNTREATED PMADS

#### ON MOTHER
- Increased risk of substance abuse
- Increased risk of smoking
- Decreased likelihood of attending prenatal visits
- Chronic depression and/or anxiety
- Increased complications of pregnancy

#### ON PARENTING
- Increase in child abuse and neglect
- Less likely to play, talk, read with infant
- Less likely to follow routines and safety practices
- Decreased duration of breastfeeding
- Less likely to follow up on pediatric recommendations

#### ON FETUS AND INFANT
- Increased likelihood of low birth weight and pre-term birth
- Poor attachment to mother or primary caregiver
- Increased dysregulation, irritability, crying, hypervigilance, low activity or tone
- Increased level of stress hormones, including cortisol

#### ON DEVELOPING CHILD
- Cognitive, emotional and developmental delays:
  - Learning difficulties
  - Later walking, talking and other developmental milestones
  - Increased risk for developing anxiety or depression at young age
  - Increased aggression
  - Difficulty making and keeping friends

#### ON PARTNER AND FAMILY
- Increased eelings of helplessness and depression in partners
- Older children impacted
- Grief and feelings of loss and confusion in family
- Divorce, marital conflict

#### ON INTERGENERATIONAL TRANSMISSION
- Trauma of having a mother with untreated perinatal depression is often passed down from one generation to the next

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### A Collaborative/Integrated Care Model For Maternal Depression

#### MEDICAL HOME

The medical home of a family practice can be a trusted community support for families in distress due to maternal mental health disorders. It is often within the context of physical medical care that mental health symptoms may be normalized and supported in a safe environment that does not suffer the same stigma as a mental health clinic. This is especially true in the perinatal period when the barriers to mental health care and stigma surrounding mental health disorders are exceedingly high. It is important to note as well that patients report feeling more satisfied with their experience of care and are more likely to say connected to a medical home when emotional, social and behavioral aspects of their lives are recognized. This in turn increases the consistency and quality of their medical care experience.

Therefore, the goals of perinatal integration are to help enhance medical homes where pregnant and postpartum women and their families can have their behavioral health needs met in the same place, by the same providers, and at the same time as their more “physical” health needs. This integration will improve care and outcomes overall, at less cost to the patient, clinic, and health care system at large.

Recent health policy, as reflected by the Affordable Care Act, recognizes the value of medical home models in treating physical and mental health together, which vastly improve overall health compared to our current fragmented health systems. Integrated care moves beyond these current systems, or even the idea of co-located services, and instead embraces true partnership between biomedical and behavioral care provision. The collaborative care model includes a set of specific elements with the goals of providing higher-quality care, improving patient satisfaction, and reducing costs. Elements of collaborative care include standardized depression and anxiety screening tools; a thorough medical and psychosocial assessment and diagnosis for any positive screens; stratification of patients into risk categories; evidence-based, “stepped” care that is linked to levels of risk; case management; patient and family education and activation; clinical and staff training; psychiatric and other expert consultation; ongoing tracking of outcomes using screening tool scores; and continuous quality improvement.

When it comes to behavioral and medical health, indeed there are different levels of integration. It is not a one size fits all problem or solution. Rather, different factors such as the setting, population served, institutional will, presence of a champion, and available resources, all inform the level of integration that is desirable or even possible at a given point in time for a particular agency, clinic, or even sector as a whole. There is a continuum of integrating behavioral and physical health. Having this knowledge can help an agency focus on its near and long term goals for integration and evaluate what is desirable and what is doable. The first step is understanding where an agency or clinic lies on the continuum.
<table>
<thead>
<tr>
<th>Levels of Behavioral and Mental Health Integration</th>
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<tbody>
<tr>
<td><strong>Level 1</strong> Minimal Collaboration: Healthcare and mental health providers work in separate facilities and rarely communicate about individual cases.</td>
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<tr>
<td><strong>Level 2</strong> Basic Collaboration: Separate sites, some communication via telephone about shared patients, use each other as resources.</td>
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<tr>
<td><strong>Level 3</strong> Onsite First Level of Collaboration: Share facility but different systems; some face to face meetings communication more regular.</td>
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<tr>
<td><strong>Level 4</strong> Close Collaboration: Partially integrated system - same site, some sharing of systems, regular face to face interactions, some coordinated treatment plans for complex patients, basic understanding of each others roles and responsibilities.</td>
</tr>
<tr>
<td><strong>Level 5</strong> Close Collaboration: Fully integrated system, physical/behavioral health share systems, on same team, share same site, share overall vision, in depth understanding of each others roles and responsibilities.</td>
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**Why Integrated Care Is Important in Recognizing and Responding to Perinatal Mental Health**

The collaborative or integrated care model is particularly suited for a perinatal population. The risks associated with the fragmented care that result in receiving conflicting treatment in multiple medical sites are well-known. Due to the stigma associated with maternal depression in particular, financial limitations, transportation struggles, childcare issues, and other concerns, compliance with stand-alone mental health treatment is often poor. Community-based mental health resources are limited, particularly for the specialized care needed for the treatment of perinatal mental health disorders. This is especially evident in lower income, higher risk communities. Other health and environmental/psychosocial concerns, such as intimate partner violence and substance abuse, are often comorbid with depression. Identification of these issues can be very challenging, and they are difficult to address once revealed.

These barriers to care in the current system can impede recovery, and may even put patients at risk for falling through the cracks and not receiving adequate treatment or medication interventions. This leaves not only a mother exposed to the consequences of depression or anxiety but her children and extended family as well. In addition, a perinatal mood disorder during pregnancy can itself be a barrier to a woman entering and/or continuing prenatal care with her physician. These issues make the perinatal period an ideal one for instituting a true integrated care model that treats both the medical and mental health needs of a woman and her family under one roof.

**CASE IN POINT:**

**THE PERINATAL MENTAL HEALTH INTEGRATION DEMONSTRATION PILOT AT USC-EISNER**

The New Family Care Team began in 2011 and was born out of the relationship formed between the USC-Eisner Family Medicine Center and the Los Angeles County Perinatal Mental Health Task Force. The New Family Care Team’s purpose is to address maternal depression clinically, while creating a model of integrated care that can be spread throughout Los Angeles and beyond. At its inception, USC-Eisner, a Federally Qualified Health Clinic, family practice clinic, and medical training site, serving 36,000 patients per year, identified that many of its patients presented at the clinic with complex mental health symptoms. This was especially evident during pregnancy and postpartum, and impacted the clinic’s ability to care for the medical needs of these families. Both agencies, partners in the Magnolia Place Community Initiative, identified the shared benefits of joining their efforts to increase healthy birth outcomes and decrease maternal depressive symptoms in the communities served by USC-Eisner Family Medicine.

The New Family Care Team model integrates behavioral health care into routine prenatal, postpartum, and well-baby visits. Prenatal care visits are often a woman’s first entry into the health care system, as she is guaranteed health care coverage during pregnancy. Because of this access, plus the routine nature of prenatal care, these visits present a unique opportunity to capture women who may be experiencing a perinatal mood or anxiety disorder. By embedding mental health screening and care into her medical home, we are able to provide competent, cost-effective, integrated care and at the same time, reduce the many obstacles that may prevent women from getting the help they need. For example, while there may be a great deal of stigma associated with going to a mental health center, medical care for pregnancy is not only socially acceptable, it is, in fact, positively reinforced in the community. In addition, by receiving care in one medical home, transportation is only needed to one location and accessing different insurance systems is no longer necessary.
The team is then able to follow the woman and her family through delivery, into the postpartum, and through the early months and years of her child’s life. By monitoring a mother at her baby’s well-child visits, we can also identify how a baby’s development may be impacting or reflecting her mother’s mental health. The opportunities for continuity of care are present throughout the entire project (prenatal through the first two years of baby’s life). Also, by tracking care, we can help mother with inter-conception care, identification of healthy lifestyle choices, and community resources for herself and baby as she concludes her time with The New Family Care Team.

KEY ELEMENTS OF INTEGRATED PERINTAL MENTAL HEALTH

Our demonstration project is a collaborative care model for perinatal mood and anxiety disorders. The following steps outline our model in detail, as well as discuss lessons learned and recommendations for replication and/or adaptation of the model.

I. IDENTIFICATION

Standardized Depression Screening Tool

Screening for perinatal mood and anxiety disorders must be consistently provided to all perinatal women at the medical clinic. This ensures reduced feelings of shame associated with being “identified,” and protects women from provider bias or accidental oversight. Repeated screening through a designated time frame in the pregnancy and postpartum also allows for the recognition of women who may develop depression later in pregnancy, or in the first year of her child’s life, as well as to track the progress of those who are receiving ongoing care.

We chose the Patient Health Questionnaire-9 for depression screening. This 10-item, self-report screen, available in both English and Spanish, was originally developed for a primary care population, and has since been validated for perinatal women. The PHQ9 was also chosen because it can be used to track a woman’s response to treatment over time, which is essential in a model built on monitoring outcomes. Increasingly, many medical practices are becoming familiar with the PHQ9, as they are using it in other patient populations (such as the elderly and any other patients who are at risk for depression). This makes it easier to incorporate into an existing clinic protocol.

In addition, we recommend the Edinburgh Postnatal Depression Scale-3 (EPDS3), a 3-item subscale of the longer 10-item depression screen. This subscale has specificity and sensitivity for anxiety symptoms. This addition is important because of the prevalence of anxiety disorders in pregnant and postpartum women; in fact, some studies show rates of anxiety disorders to be higher than depression. Used in combination with the PHQ9, it gives a clearer picture of a woman’s symptoms.

Elements of Successful Identification

The screening workflow itself consists of the following:

1. Medical assistant staff members prepare The New Family Care Team intake packets and place them on color-coded clipboards, which inform the staff that this individual is a perinatal patient. These packets include the following documents:
   - Speak Up When You’re Down brochures: educational brochures, available in seven languages, that explain symptoms of perinatal mood and anxiety disorders
   - Explanation of The New Family Care Team, with Informed Consent Disclosure
   - PHQ9
   - EPDS3

2. Medical assistant staff members verbally introduce project and paperwork in examination room when woman enters, using a script developed to ensure sensitivity and privacy. Clinical staff is trained only to discuss the screening tools and The New Family Care Team with the patient in examination room to protect privacy. They assess for literacy and language preference, and administer screens verbally if necessary. The medical assistants also ask the patient’s partner to step out for screens, as many of the women face challenges of intimate partner violence and may need privacy to answer screens honestly.

3. After the patient has completed the PHQ9 and EPDS3, the medical assistant takes the screens and places them at the front of the chart for medical resident to score prior to entering examination room.

4. The medical resident uses screening scores to address concerns with patient, consults with faculty, and informs the case manager of any positive screens.

5. The screening sheets are downloaded into the electronic medical record (EMR), and women entering the care of The New Family Care Team have their scores entered into a separate tracking system in i2i (please see section on “Tracking Systems.”)

THE CASE OF MS. T - IDENTIFICATION

Ms. T is a 27-year-old old single woman who came to the USC-Eisner Family Practice Clinic when she found out she was pregnant with her second child. She had previously been diagnosed with Bipolar Disorder and had been stable on her medications for years. She had successfully parented her first child, held a job, and developed a relationship with a new partner. However, when she found out she was pregnant, her psychiatrist told her to stop taking all of her medications. She did, and she quickly relapsed. During her first visit to USC-Eisner, at 8 weeks pregnant, she scored a 9/9 on her anxiety screen, demonstrating extreme anxiety, and an 11/27 on her depression screen, indicating moderate depression. The medical provider scoring the screening tests introduced her right away to the case manager. The case manager was able to assess Ms. T’s immediate needs, and she also scheduled a convenient time for Ms. T to meet with the pilot’s social worker for a full intake assessment.
II. MEDICAL ASSESSMENT AND DIAGNOSIS

After the screening is completed, the medical resident informs the case manager of any patients with a positive score. The case manager meets with the patient at that moment, in a “warm hand-off.” This allows the case manager to assess the patient’s immediate needs. If there are any symptoms requiring urgent treatment, medical staff is notified. Otherwise, the case manager provides resources and contact information, and if available, introduces the patient to the social worker. Ideally, an appointment for a full intake assessment by the social worker is set for a convenient time during the following week.

The full intake assessment was developed by the Los Angeles County Perinatal Mental Health Task Force, and it covers both psychosocial issues and psychiatric symptoms. The psychosocial issues include demographic information, information about the current pregnancy, reproductive history, health of existing children, social support, available resources, substance use, intimate partner abuse, trauma history, (including the ACE* Adverse Childhood Experience Questionnaire) and current level of stress. Many of the psychosocial questions are drawn from the Comprehensive Perinatal Services Program (CPSP), a statewide program for pregnant women receiving Medi-Cal that has shown improvement in birth outcomes for low-income and at-risk women.

The psychiatric assessment covers both current and past symptoms. Special areas of focus include past reproductive psychiatric history, including any symptoms during previous pregnancies or postpartum periods, before a woman’s menstrual cycle, or while on hormonal contraception. Several evidence-based screens look at current symptoms as well, including the PHQ9, EPDS3, Mood Disorders Questionnaire (MDQ) for bipolar disorder, a Post Traumatic Stress Disorder Scale, and several questions regarding panic disorder, obsessive compulsive disorder, and psychosis. The goal is to create as complete a picture of the woman’s psychological health and history as possible, so that accurate recommendations can be made by the interdisciplinary care providers and consultants.

THE CASE OF MS. T - ASSESSMENT

Once Ms. T was referred to The New Family Care Team, she had a thorough intake assessment completed by the social worker. The social worker brought her information to the next Team Meeting, and each discipline made recommendations for Ms. T’s care. The case manager agreed to help her explore options for housing, as she was concerned about the sustainability of continuing to live with her own mother. The social worker agreed to provide therapy sessions focusing on Ms. T’s relationship with the father of the baby and her own transition to motherhood for the second time. Due to the complex nature of Ms. T’s ongoing medication needs, the reproductive psychiatrist facilitated a transfer of psychiatric care to a university-based specialty clinic, and she opened lines of communication between the psychiatrist there and Ms. T’s primary care doctor at Eisner. When Ms. T was rescreened eight weeks later, her anxiety screen had dropped to 7, and her depression screen to 9 (which indicates minimal-to-mild depression).

III. AN INTER-DISCIPLINARY APPROACH

To ensure the most integrated care, it is essential that all medical office staff share equal understanding and responsibility for screening and treatment of perinatal mental health. The team is made up of both administrative, front and back office staff, medical staff, mental health staff, and consulting experts. Engaging this team begins with administrative leaders understanding the importance of mental health in a medical home environment and setting the expectations, guidelines, protocol, and time for all other staff to implement screening and treatment. Training includes educating all staff on the prevalence and consequences of perinatal mood and anxiety disorders; informing all members of the goals and purpose of the project; and clarifying team members’ roles in preparing, screening, and following through with patients. In addition, training includes helping all members of the team cultivate empathetic responding to patients. This is a key component of building trust, which is fundamental to a productive therapeutic experience.

Team Members Include:

- Medical Director
- Physicians and Residents
- Medical Assistants
- Case Managers
- Nurse Managers
- Social Workers
- Social Work Interns
- Occupational Therapist/Residents
- Clinic Mental Health Clinicians (Psychologist, LMFT, LPCC, LCSW)
- Consulting Perinatal/Reproductive Psychiatrist
- Consulting Psychotherapist/Expertise in Perinatal Mental Health

Role Of The Medical Clinic

Commitment from Clinic Director, Medical Director, Case Manager, Medical Assistants, Nurse Manager, Medical Residents, Social Worker and other clinical and administrative staff to:

- Adopt collaborative medical/mental health care.
- Participate in initial and on-going training.
- Assign and follow through with screening, scoring, and implementing care.
- Participate in interdisciplinary weekly meetings.
- Share data collected to validate work and adopt necessary changes.
- Develop extensive case management resources.
IV. PERINATAL MENTAL HEALTH TRAINING

Training on the prevalence, signs, symptoms, screening, and interventions of PMADs is an essential component of an integrated care project. Not only should training be provided to all clinical staff, but training is necessary for all office staff in order to clarify the benefits of engaging in this pilot and to provide every opportunity for patients’ concerns to reach the Interdisciplinary Care Team. While a patient may be intimidated by a physician, she may feel more comfortable opening up to a medical assistant, who may feel more like a peer. Providing differential training to all levels of team participation is the best way to share this information.

Our general training for Medical Assistants includes technical issues, such as prevalence, impact, and signs and symptoms of PMADs. Critically, it also focuses on empathy-based approaches that teach Medical Assistants how to develop trust and rapport with women during an exceedingly vulnerable time in their lives, which makes screenings both more comfortable and more accurate.

For clinical staff, the training is more intensive, and ensures participants will be able to:

- Describe the prevalence and impact of maternal depression on the mother, infant, family, and her greater community.
- Assess the many risk factors and symptoms of maternal depression.
- List the psychological spectrum of maternal depression and anxiety.
- Differentiate between maternal depression and maternal psychosis.
- Build upon communication skills to talk with women and families about these debilitating mental health illnesses.
- Incorporate the EPDS3 into screening with the PHQ9 to detect maternal depression and anxiety.
- Learn to recognize and respond empathically to women with perinatal mood disorders.
- Communicate and understand maternal depression in a culturally sensitive manner.
- Learn strategies for prevention, referral, and intervention.
- Recognize the importance of collaborative care in the treatment of perinatal mood and anxiety disorders.

Our consulting psychiatrist provides training specifically for medical residents and faculty. These case conference meetings occur 4-5 times annually, allowing residents to inquire about evolving research or standards on medication regimen for psychiatric perinatal care, and remind members of the team about other supports available at the clinic for perinatal women who might be struggling.

V. STEPPED-CARE

After a patient has screened positive for a perinatal mood or anxiety disorder, a case manager meets with the social worker to review the case, and it is brought to the Interdisciplinary Care Team meeting to discuss and determine treatment based on risk. A patient’s level of risk is determined through a combination of her screening scores and other information gathered from the intake assessment.
### RISK ALGORITHM (INTERVENTION/REFERRALS)

**PHQ-9 Score of less than 10 (minimum-to-mild depression):** Prevention measures. Brochure provided, psycho-education, reminder about self-care, on-going monitoring. If patient has been on medication, continue until intake assessment has been performed and medications reviewed with treatment team, consulting psychiatrist, and primary care physician.

**PHQ-9 Score of 10-14 (moderate depression):** The Interdisciplinary Care Team care recommendations. Psycho-education continues to be available to all women. In addition, counseling, case management, referral for outside care and psychiatric medication may be considered as treatment options. On-going monitoring.

**PHQ-9 Score of 15-20 (moderately severe depression):** The Interdisciplinary Care Team care recommendations. Psycho-education continues to be available to all women. In addition, counseling, case management, depression self-care, risk assessment monitoring, referral for outside care, and psychiatric medication may all be considered as treatment options. On-going monitoring.

**PHQ-9 Score of 20+ (severe depression):** The Interdisciplinary Care Team care recommendations. Same as above but closer monitoring, safety plan, inclusion of family members in care. If patients have complicated psychiatric histories or treatment regimens, they may be referred to outside mental health clinics, including the Maternal Wellness Clinic at LAC+USC for additional evaluation and specialized care.

### INTERVENTIONS

**Case Management:** Each patient may receive individualized case management support. Often this may include basic needs, such as housing, nutrition support and referrals (WIC), transportation, and referrals to other outside agencies/programs. Case manager will also go over depression self-care tools. Very often, the case manager’s work with family members may focus on psychoeducation to ensure that others are available to identify symptoms and red flags, and to help patient with treatment compliance.

**Counseling:** MSW student intern, MSW staff or LCSW will meet individually, in mother/infant dyads, or with family in counseling sessions. These sessions usually meet one time per week at the clinic, but home visits may also be indicated. Models for clinic care are based in Solution Focused Therapy, which we adapted with therapeutic exercises specifically for perinatal women and are targeted at increasing strengths, identifying coping skills, building awareness of symptoms and implementing self-care. The intervention is also trauma informed and includes elements of CBT and dyadic coaching. As treatment may be short term, this model is helpful in providing resources and worksheets, to which the patient can refer after treatment.

**Referrals:** When in-house resources are not available or optimal, referrals are given to trusted resources in the community. These include psychiatric care, parenting education, vocational resources, mental health counseling (when the host institution’s, in this case USC-Eisner, resources are not the best option), or specialized medical care. Patients are assisted with appointment scheduling, transportation concerns, and financial questions, in order to facilitate the success of these referrals. Follow up with patients after referrals are made is essential in assuring compliance and the efficacy of the referral made.

### VI. SYSTEMS OF COMMUNICATION

With the complexities of collaborative care, communication systems must be in place. These communications must meet HIPAA laws, as well as be available to all team members. The Electronic Medical Records have enabled practitioners to share information in vivo; however, challenges such as input of screening scores require that each team member understand the role they play in embedded care. It is also necessary to ensure that there is continuity in the EMR between prenatal, postpartum, and well-child systems. Therefore, development of a clearly explained system of communication is necessary to ensure that all patients are screened, reviewed in The Interdisciplinary Care Team meetings, and provided with adequate treatment and/or referrals.

**Interdisciplinary Team Meetings**

Team meetings should occur weekly in a secure setting. Cases are presented and reviewed by each member of the team and recommendations are made incorporating all aspects of healthcare (medical concerns, social concerns, psychosocial needs, mental health). These recommendations are then entered into the Electronic Medical Record so that all providers interacting with a patient may review and carry them out, as appropriate.

**Tracking Systems (I2I)**

A registry for tracking patients, interventions, and screening scores across time is a vital component of collaborative care. Without such a registry, patients easily “fall through the cracks,” as regular screenings are missed and interventions are not monitored. The creation and maintenance of a registry can be a real challenge in the medical home. Issues to be addressed include HIPAA compliance, which staff member is responsible for data entry, and creating a “forecasting” system that reminds staff when each screening test is due next. For The New Family Care Team, plans for a registry were well underway when funding was rescinded for this aspect of the project. As a result, we used I2I for tracking and data collection.

### SUMMARY OF DEMONSTRATION PROJECT

Approximately 150 pregnant women were seen at the USC-Eisner clinic and given the screening tools. For these women, a total of 209 anxiety screens were performed at the 1st, 2nd, and 3rd trimester visits and at least one postpartum well-child visit. Similarly, a total of 183 depression screens were completed. Approximately 45 women yearly were able to receive consistent care, with 25-28 receiving ongoing psychotherapeutic intervention, sometimes including home visitation by a mental health professional, and medication management, and the majority of the rest were referred out either to higher risk psychiatry clinics or provided with intensive case management. Approximately 50% were unable to follow up with appointments due to the range of barriers that we have identified. Throughout the pilot, PDSAs, (Plan Do, Study, Act) were undertaken to understand glitches in the case pathways and how to correct for those. Consequently screening, treatment and referral rates improved over time.

THE CASE OF MS. T - CONCLUSION

Ms. T continued to have therapy, medication management, and case management through The New Family Care Team at Eisner. Her screening scores continued to reflect her progress. The anxiety score dropped from 7 to 6 in the third trimester; while this is still above 4, and therefore considered positive, Ms. T’s anxiety felt much more manageable than when she was at the initial score of 9. Her depression scores remained stable in the minimal to mild range at 9. Once her baby was delivered, The New Family Care Team continued to check in with Ms. T at her infant’s Well Child Visits.
SPREADING THE MODEL IN LOS ANGELES AND BEYOND

Adaptation of the integrated care model differs at each type of medical setting and at every site. Staff capabilities, training, access to care, and funding sources influence the tailored approaches we have brought to each of our partners. Below is a list of additional models of integrated care that the Los Angeles County Perinatal Mental Health Task Force has been working to develop:

Harbor-UCLA Pediatric Group: Attending physicians and case managers have received specialized training, regularly screen parents of pediatric patients for mental health disorders, and refer women to case managers who provide patients with self-care recommendations and referrals to informed care when needed.

UCLA Westwood Pediatric Group: Attending physicians, residents, and social work staff have received training on maternal mental health and use of the Edinburgh Postnatal Depression Scale. Data collected will be helpful in identifying physician compliance and patient outcomes.

Los Angeles County + University of Southern California (LAC+USC) Family Wellness Clinic: This novel clinic, scheduled to begin in July 2015, will integrate maternal mental health care, pediatric well-child care, and mother-infant attachment interventions in one comprehensive clinic. The Task Force will provide needed training on attachment interventions, as well as ongoing consultation and technical support.

In addition to the abovementioned groups/clinics, two excellent non-LACPMHTF models include:

The Perinatal Mental Health Integration Program at Montefiore Medical Center, University Hospital for Albert Einstein College of Medicine, Bronx, New York

Integrating Perinatal Mental Health - Departments of Obstetrics/Gynecology, Psychiatry, and Psychiatry and Behavioral Sciences, Harborview Medical Center and University of Washington, Medical Center, Seattle, WA

LESSONS LEARNED FROM THE DEMONSTRATION PROJECT

1. Buy-in from clinic leadership, administrators, and staff is essential. Without this basic support and investment, integrated care projects will not have the “drive” to launch and succeed. Physicians must also recognize the importance of perinatal mental health and be willing to incorporate its care and treatment into their daily practices – from residents to attending physicians.

2. Training all levels of staff is of utmost importance. The physician is often the “last stop” for the patient in the clinic. Encounters with front desk staff, medical assistants, and nurses comprise the bulk of the patient’s visit, and these encounters often make or break the patient’s clinical experience. It is vital that the patient receive a consistent message about the importance of perinatal mental health from all staff, and training is necessary to ensure this. Training must occur regularly to initiate new staff and providers, as well as to refresh, update, and answer concerns for ongoing staff members and providers.

3. A project coordinator is needed to ensure that all details of the project – from making sure that enough screening tests are copied and available to monitoring resident scoring of screens – are carried out consistently. We did not have this position available at Eisner, and patients often “fell through the cracks” as a result.

4. The acknowledgment that it takes time to build integrated care into the culture of any clinic is important. Patience and a willingness to consistently evaluate and try new approaches needs to be an acknowledged element of program development.

5. Even with integrated care, not all logistical and practical barriers will be met. Counseling sometimes must be delivered through home visits and occasional phone sessions. In addition, some women will opt out, be challenging to follow up with, disappear – and protocol must be developed to manage this.

6. Specialized consultation is important because of the unique needs of this population, and having access to a reproductive psychiatrist or specialized psychiatric clinic for referral for patient care allows even the most ill women to receive care.

7. A registry system to track patients’ scores, interventions used, and the outcomes over time must be developed and available. Elements of this system must be HIPAA compliant. It must also be available to all team members with a clear delineation of roles, such as designating staff responsible for entering data. The registry must also have a “forecasting function,” with pre-determined reminders of screening protocols and time frame.

8. Funding for screening and case management should be explored to ensure program continuity and practitioner compliance with screening and treatment. While grant support was helpful in launching the program, most funders want to know – and appropriately so – about the long-term self-sustainability of any integrated care program.

CONCLUSION

As The New Family Care Team demonstrated, an integrated care model in a medical practice can successfully identify and treat women struggling with perinatal depression and anxiety, and do so in a way that eliminates barriers to treatment and reduces stigma. Furthermore, the perinatal mental health demonstration projects spreading up throughout Los Angeles and beyond show that this model is possible in every medical setting that serves women and their families during the perinatal period.
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ADDITIONAL REFERENCES

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