

Maternal Health Awareness Day Event

Maternal Mental Health During the Pandemic

*Innovations to Address the Rising Needs of
Pennsylvania's Birthing People & Their Care Teams*

Tuesday, Jan 26 7:15-9:00 AM

facebook.com/WHAMglobal



ACCREDITATION for Physicians:



This activity has been planned & implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint providership of the Pennsylvania Medical Society and the Pennsylvania Section of The American College of Obstetricians and Gynecologists, (ACOG.) The Pennsylvania Medical Society is accredited by the ACCME to provide continuing medical education for physicians.



The Pennsylvania Medical Society designates this live activity for a maximum of 1.75 AMA PRA Category Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

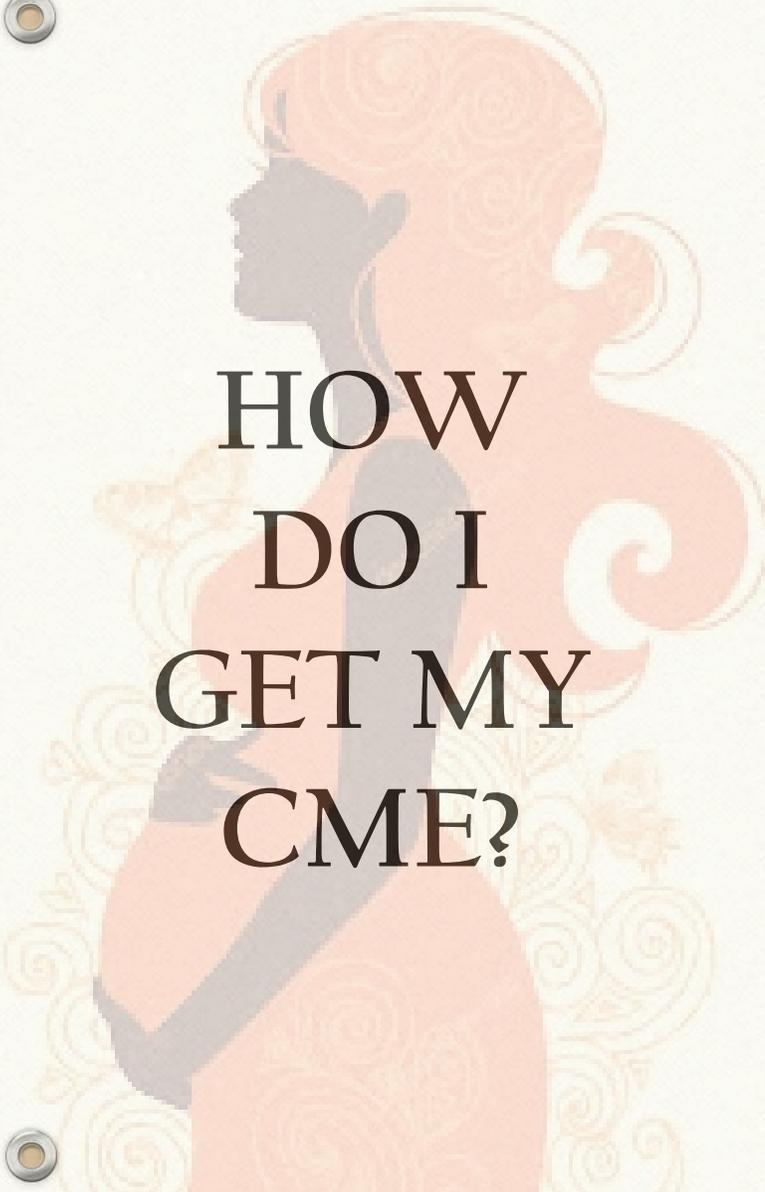


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HOW
DO I
GET MY
CME?

Meeting registrants look for an email with a link to an online evaluation and attestation form on Wednesday.

The form will be open from:

January 26 April 30, 2021

You must complete and submit the online evaluation and electronic attestation form by April 30th to receive CME credits.

If you have participated via Facebook Live or as part of a large group, please follow the link below to claim your credits.

<https://form.jotform.com/210248083151143>

Where to get help:

- **National Domestic Violence Hotline**

<http://www.thehotline.org/>

1-800-799-7233 (SAFE)

1-800-787-3224 (TTY for the Deaf)

- **Pennsylvania Coalition Against Domestic Violence**

<http://www.pcadv.org/>

<https://www.pcadv.org/find-help/find-your-local-domestic-violence-program/>

Among the services provided to domestic violence victims are: Crisis intervention; counseling; accompaniment to police, medical, and court facilities; and temporary emergency shelter for victims and their dependent children. Prevention and educational programs are provided to lessen the risk of domestic violence in the community at large.

1-800-932-4632 (in Pennsylvania)

1-800-537-2238 (National)





UPMC | WESTERN
BEHAVIORAL HEALTH

UPMC | MAGEE-WOMENS
HOSPITAL

**Maternal Mental Health During the Pandemic:
Innovations to Address the Rising Needs of
Pennsylvania's Mothers and Their Care Teams**

Priya Gopalan, MD

*Services for Women's
Behavioral Health*

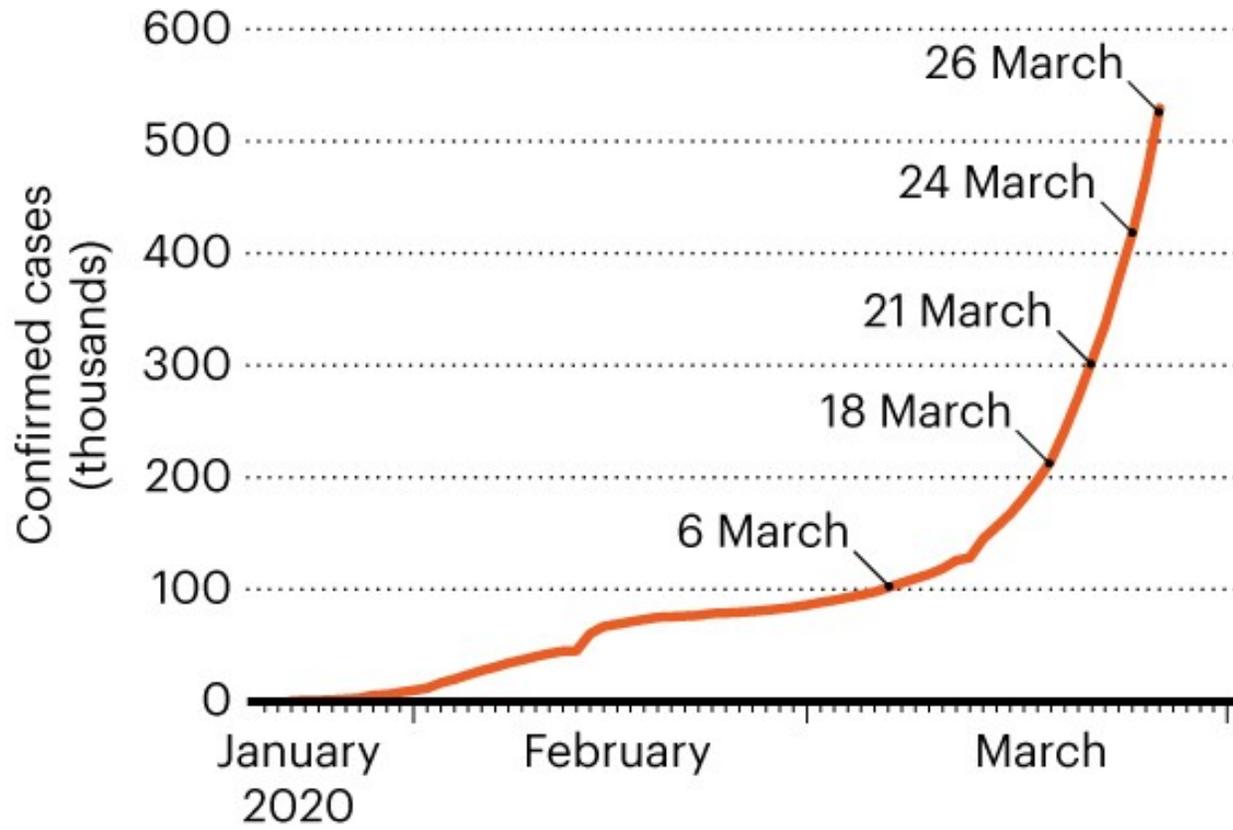


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HOSPITAL**

HALF A MILLION INFECTIONS

There have been more than 500,000 confirmed cases of coronavirus worldwide. It took 67 days for the 100,000 cases to be reported, but just 3 days to go from 400,000 to 500,000 cases.



Data correct as of 27 March 2020

©nature

Provisional Death Counts for Coronavirus Disease 2019 (COVID-19) By Week of Death

Select Sex

All Sex

Select Measure

COVID-19 Deaths

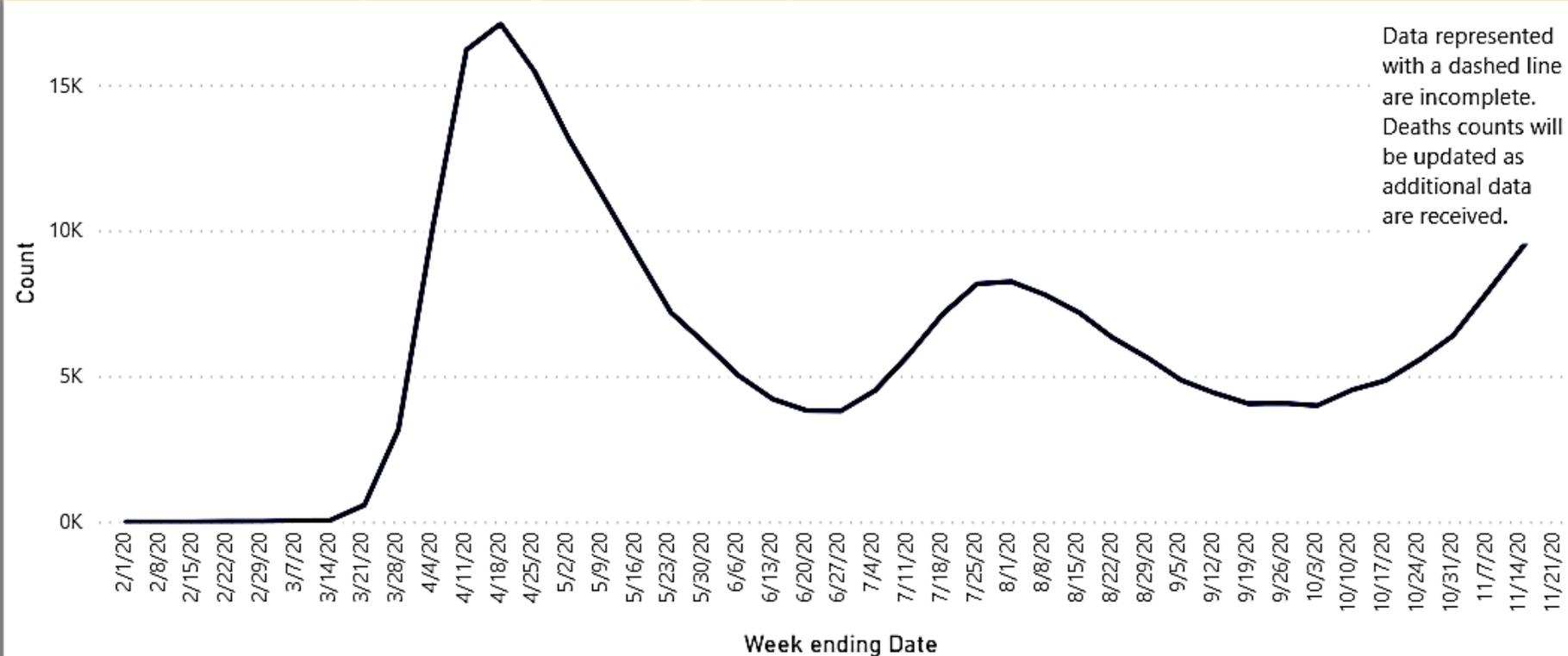
Select Age Group

All ages

Reporting Period

Week ending 2/1/2020 through 12/12/2020

Provisional Death Counts, by Week Ending Date and Age Group



NOTE: Provisional death counts are based on death certificate data received and coded by NCHS as of the date of analysis and do not represent all deaths that occurred in that period. Data for the most recent 5 weeks (shown with dashed line) are typically less than 90% complete, with lower levels of completeness in more recent weeks. Death counts are updated as additional deaths are received and coded.

SOURCE: NCHS, National Vital Statistics System. Estimates are based on provisional data.

TOTAL CASES

25,018,520

+142,259 New Cases

AVERAGE DAILY CASES PER

100K IN LAST 7 DAYS

50.7

TOTAL DEATHS

417,936

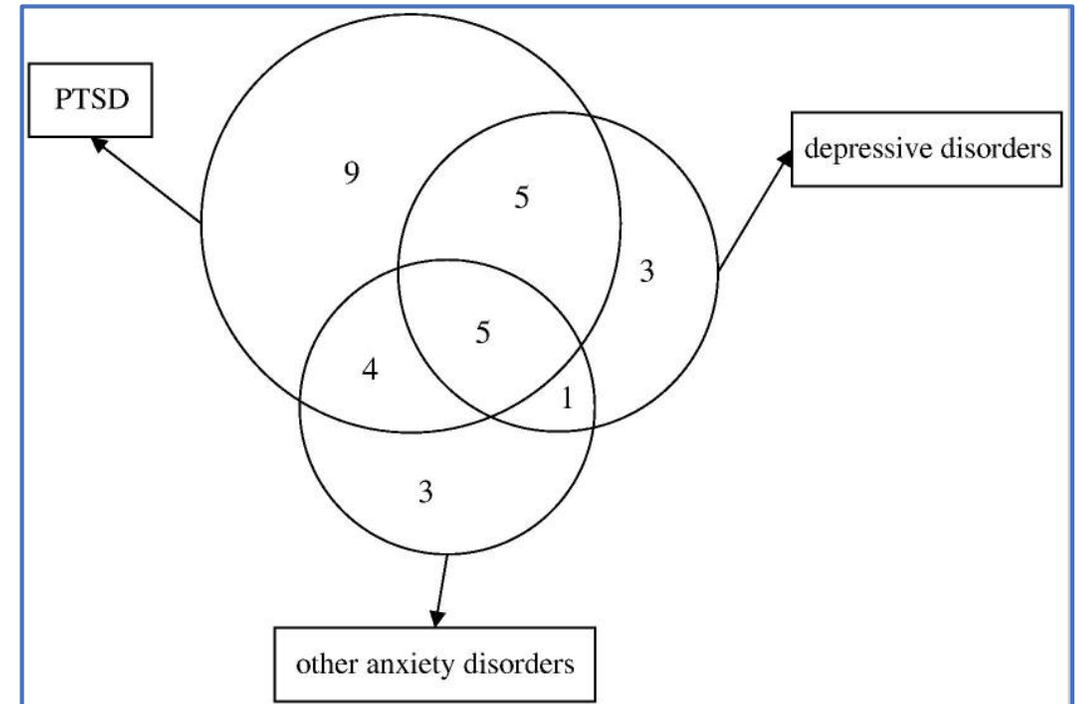
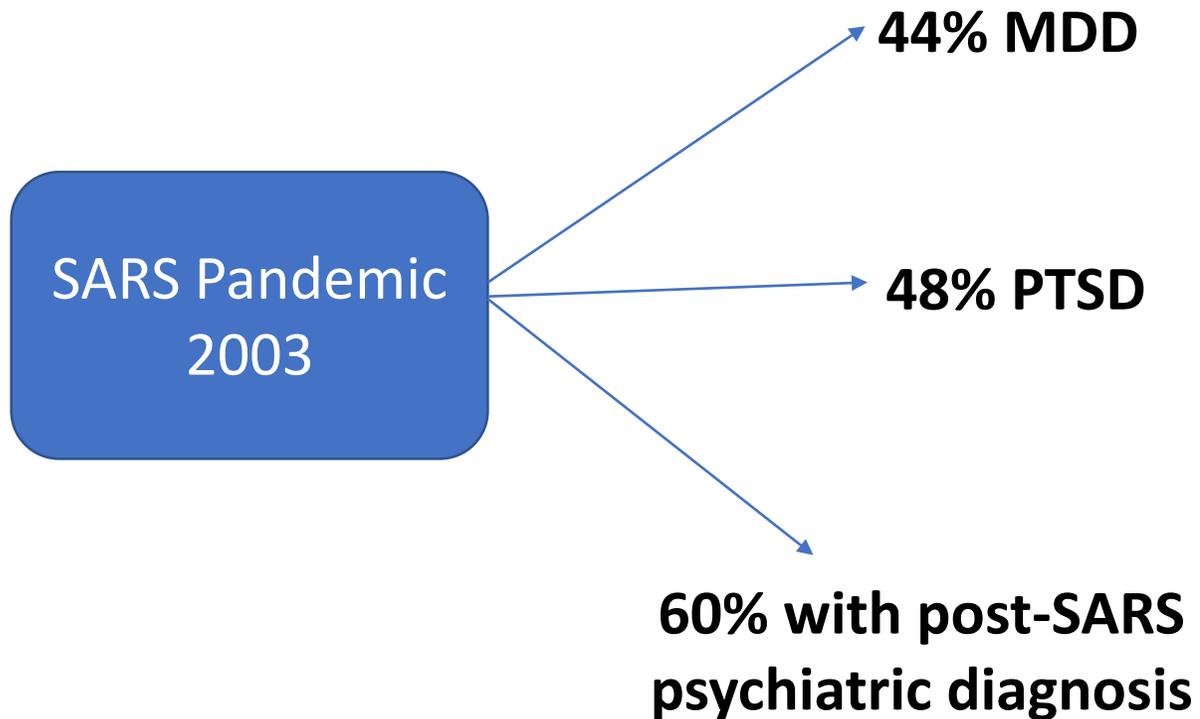
+1,926 New Deaths

CDC | Updated: Jan 25 2021 5:16PM

What do you think are the mental health effects of a pandemic?

Previous Pandemics and Mental Health

90 patients who had confirmed SARS followed at 30 months



Factors Leading to Poor Mental Health During Pandemics

Social isolation

Increased IPV

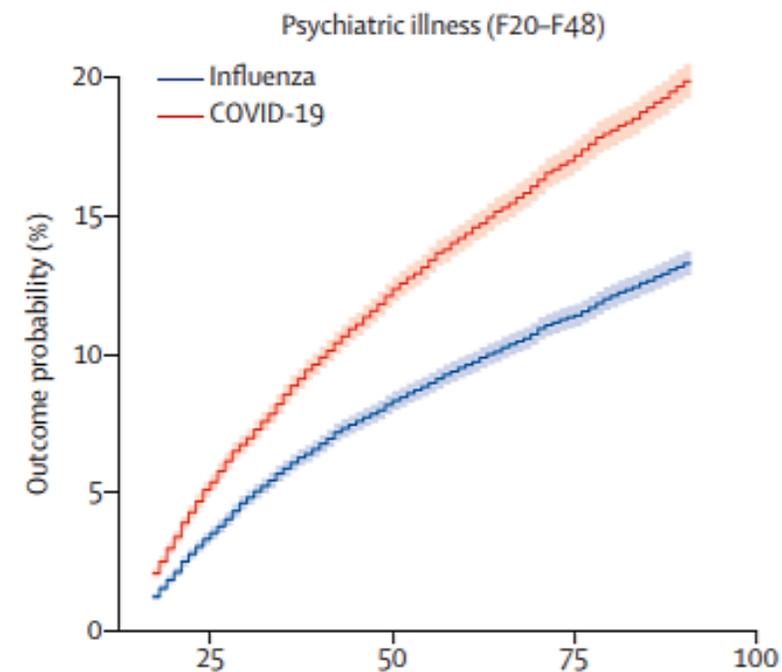
Increased SUDs

Increased stress

Increased depression/suicide

Caregiver burden

Figure 2: Kaplan-Meier curves for any (first or recurrent) psychiatric diagnoses after COVID-19 compared with influenza



Number at risk	30 days	45 days	60 days	75 days	90 days
COVID-19 group	19851	15786	12396	9362	6649
control group	23215	21359	19851	18439	16936

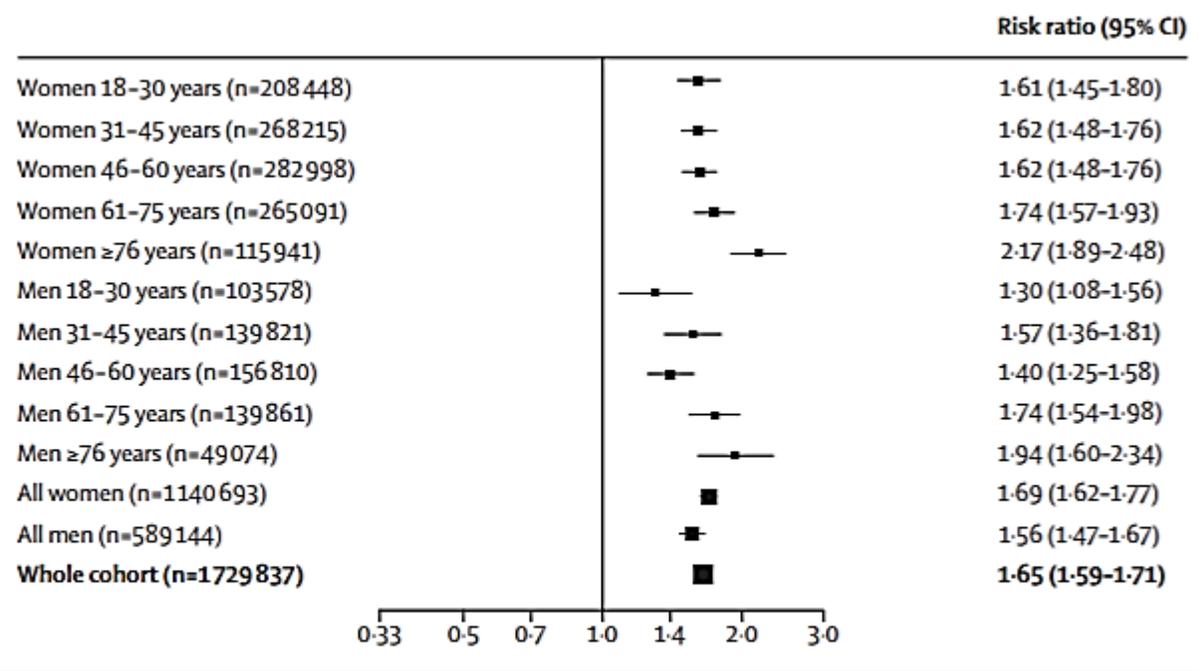


Figure 3: Relative risks of COVID-19 among patients with a psychiatric illness recorded in the past year compared with a matched cohort of patients with no history of psychiatric illness
RR=risk ratio.

Use

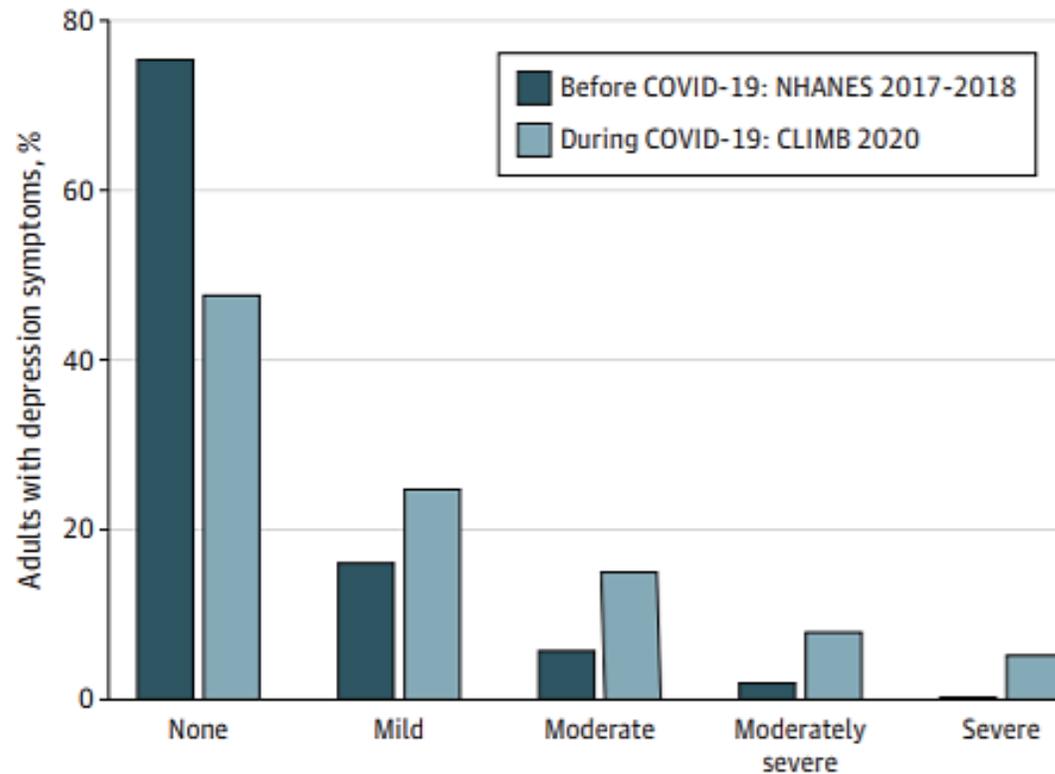


Original Investigation | Public Health

Prevalence of Depression Symptoms in US Adults Before and During the COVID-19 Pandemic

Catherine K. Ettman, BA; Salma M. Abdalla, MD, MPH; Gregory H. Cohen, MPhil, MSW, PhD; Laura Sampson, PhD; Patrick M. Vivier, MD, PhD; Sandro Galea, MD, DrPH

Figure. Depression Symptoms in US Adults Before and During the Coronavirus Disease 2019 (COVID-19) Pandemic



Before COVID-19 estimates from the National Health and Nutrition Examination Survey (NHANES) from 2017-2018. During COVID-19 estimates from the COVID-19 and Life Stressors Impact on Mental Health and Well-being (CLIMB) study collected from March 31 to April 13, 2020. Depression symptoms categories calculated using the Patient Health Questionnaire-9: none (0-4), mild (5-9), moderate (10-14), moderately severe (15-19), and severe (≥ 20). Percentages weighted to the population of noninstitutionalized US adults aged 18 years or older.

- Prevalence of depression symptoms in the US increased more than 3x during the COVID-19 pandemic
 - 8.5% before COVID-19 to 27.8% during COVID-19
- Women were more likely to have depression symptoms than men
 - Pre-pandemic: 277 women [10.1%] vs 181 men [6.9%]
 - Pandemic: 233 women [33.3%] vs 149 men [21.9%]

Ms. A is a 28 year old female G2P1 who presents to your office to establish care after a positive pregnancy test. She presents to you at approximately 10 weeks gestation. She reports to you that this was an unplanned, wanted pregnancy and that she has limited supports.



Ms. A notes that she is very concerned about having a baby during the COVID-19 pandemic. She is working full-time while trying to home-school her child, and feels guilt that she is not doing either effectively. She also voices concerns about her partner's "short fuse" and his increased alcohol use.

How would you approach Ms. A?





ELSEVIER

Contents lists available at [ScienceDirect](#)

Social Science & Medicine

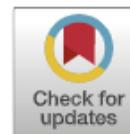
journal homepage: <http://www.elsevier.com/locate/socscimed>



Review article

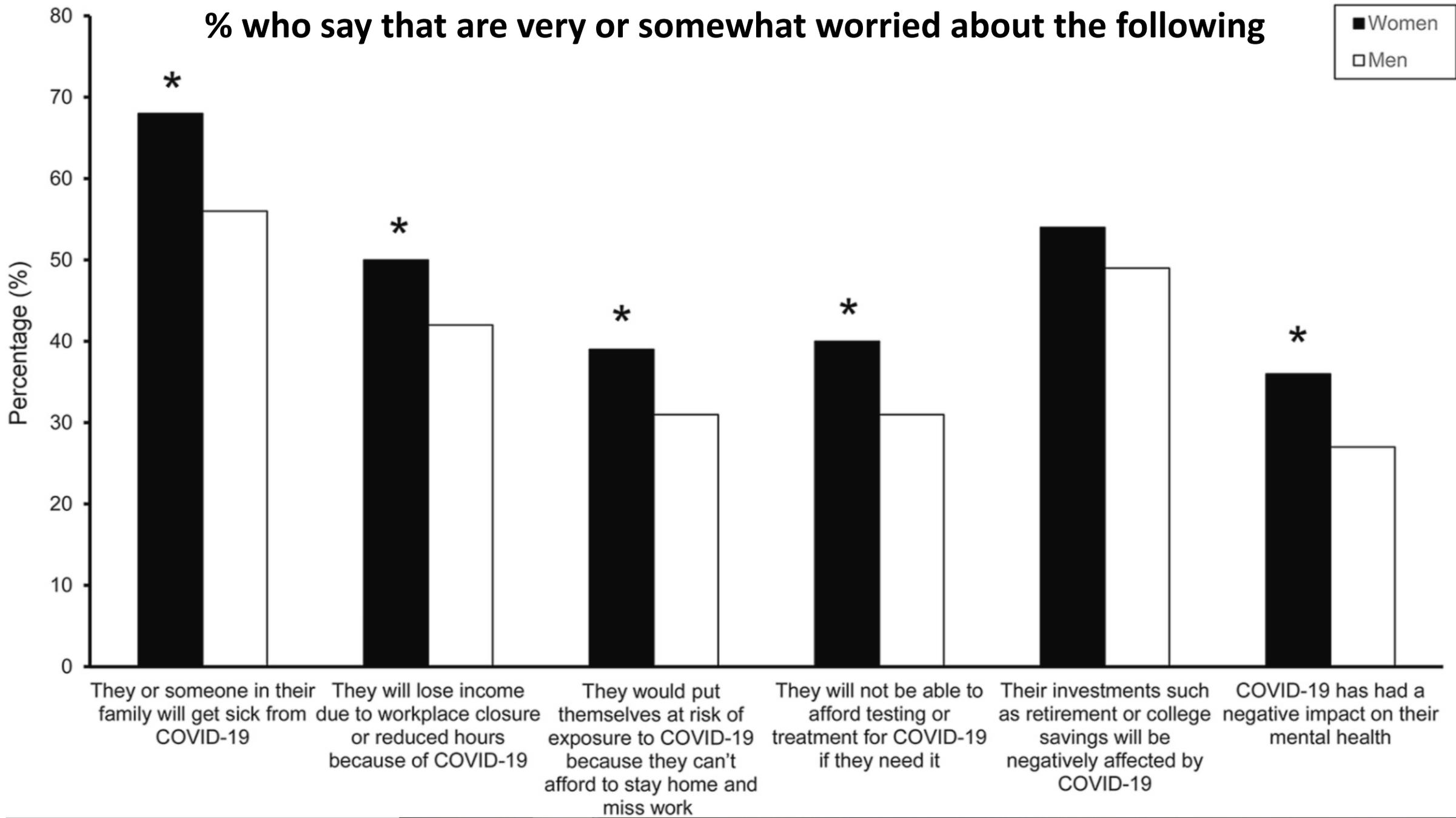
Health risks and outcomes that disproportionately affect women during the Covid-19 pandemic: A review

Jade Connor^{a,*}, Sarina Madhavan^a, Mugdha Mokashi^a, Hanna Amanuel^a,
Natasha R. Johnson^{a,b}, Lydia E. Pace^{a,c,d}, Deborah Bartz^{a,b,d}



% who say that are very or somewhat worried about the following

■ Women
□ Men



COVID-19 and Trauma

[Am J Emerg Med](#). 2020 Dec; 38(12): 2753–2755.

PMCID: PMC7195322

Published online 2020 Apr 28. doi: [10.1016/j.ajem.2020.04.077](https://doi.org/10.1016/j.ajem.2020.04.077)

PMID: [32402499](https://pubmed.ncbi.nlm.nih.gov/32402499/)

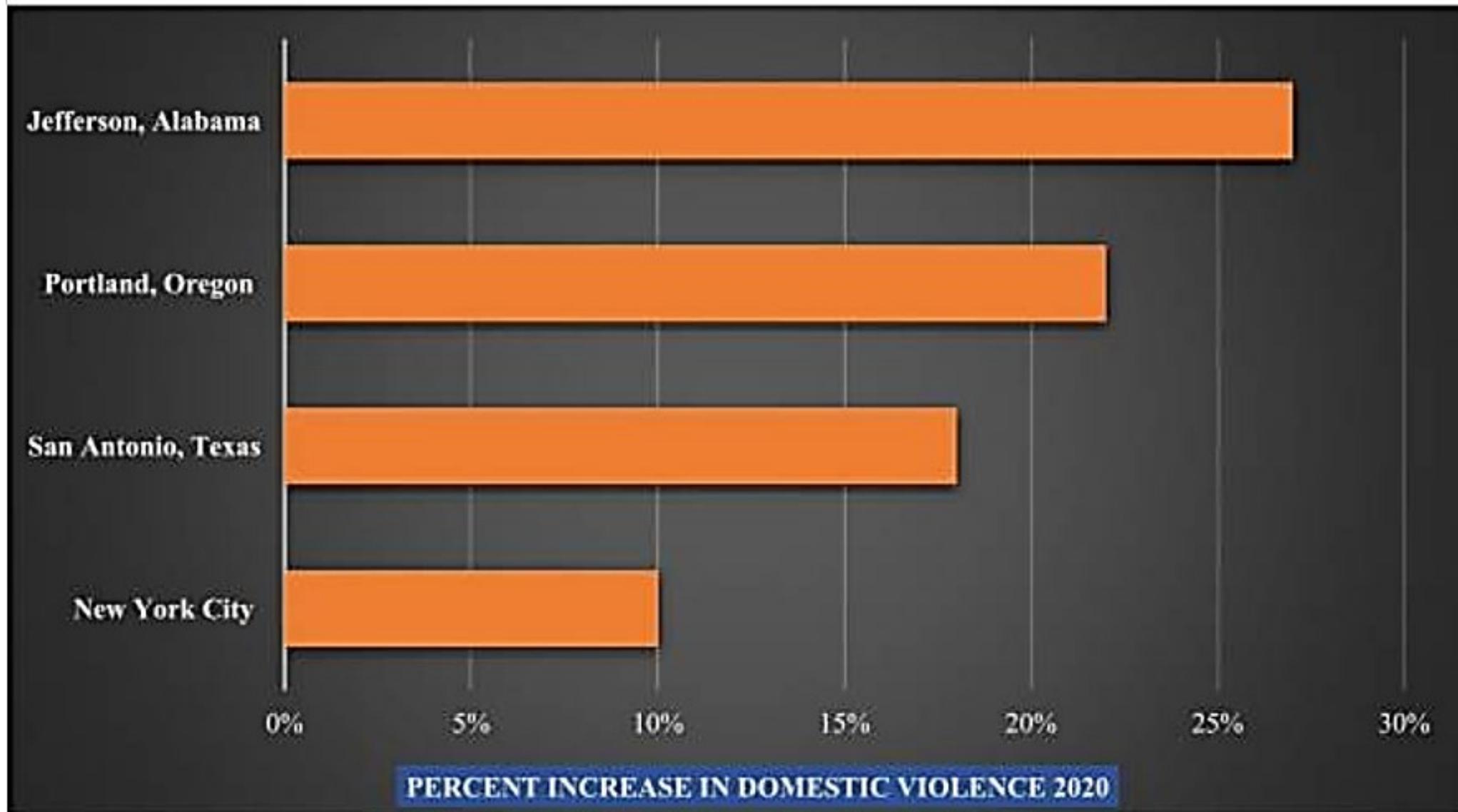
Alarming trends in US domestic violence during the COVID-19 pandemic

[Brad Boserup](#),^a [Mark McKenney](#), MD, MBA,^{a,b} and [Adel Elkbuli](#), MD, MPH^{a,*}

▶ [Author information](#) ▶ [Article notes](#) ▶ [Copyright and License information](#) [Disclaimer](#)

- Review of police data from stay-at-home orders
- Jefferson, AL; Portland, OR; San Antonio, TX; NYC, NY

COVID-19 and Trauma



Tom Farrell, Shuja Reagu, Suruchi Mohan*, Riham Elmidany, Feras Qaddoura, Ebtehag Elfadil Ahmed, Gillian Corbett, Stephen Lindow, Salwa Mohammed Abuyaqoub and Majid Ali Alabdulla

The impact of the COVID-19 pandemic on the perinatal mental health of women

- Patient Health Questionnaire Anxiety-Depression Scale (PHQ-ADS)
- 288 completed
- 34.4% anxiety and 39.2% depression symptomatology
- Rates much higher than pre-pandemic (3.1% reported pre-pandemic mental health concerns)



Mental Health of Pregnant and Postpartum Women During the Coronavirus Disease 2019 Pandemic: A Systematic Review and Meta-Analysis

Haohao Yan, Yudan Ding and Wenbin Guo*

37% anxiety

31%
depression

70%
psychological
distress

49% insomnia

22% PPD

- Review of 23 studies
- 20,569 participants
- Prevalence rates of anxiety, depression, psychological distress, and insomnia

Ms. A tells you that she has never experienced postpartum depression before, but is concerned because her sister had a severe episode of this with her pregnancy. She wonders about how common these conditions are.

What do you tell her?





1 IN 7       

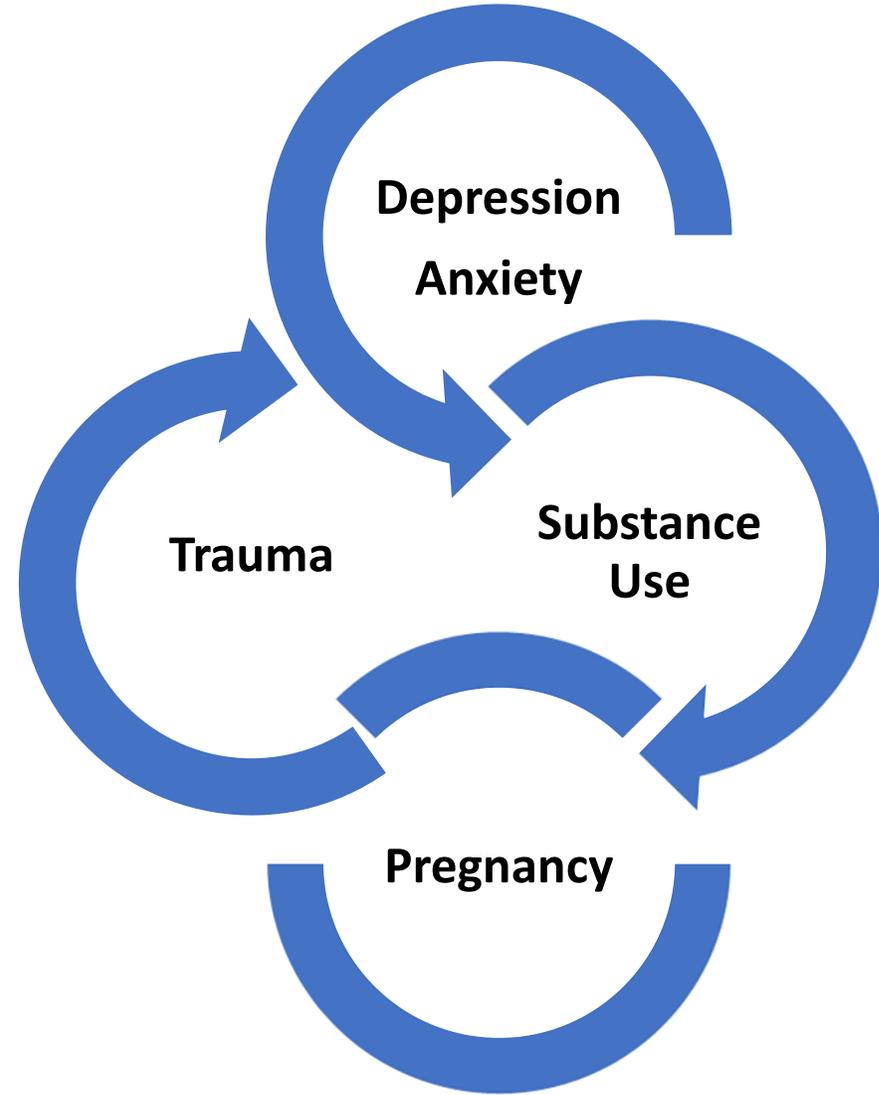
**WOMEN THAT GIVE BIRTH EXPERIENCE
POSTPARTUM DEPRESSION**

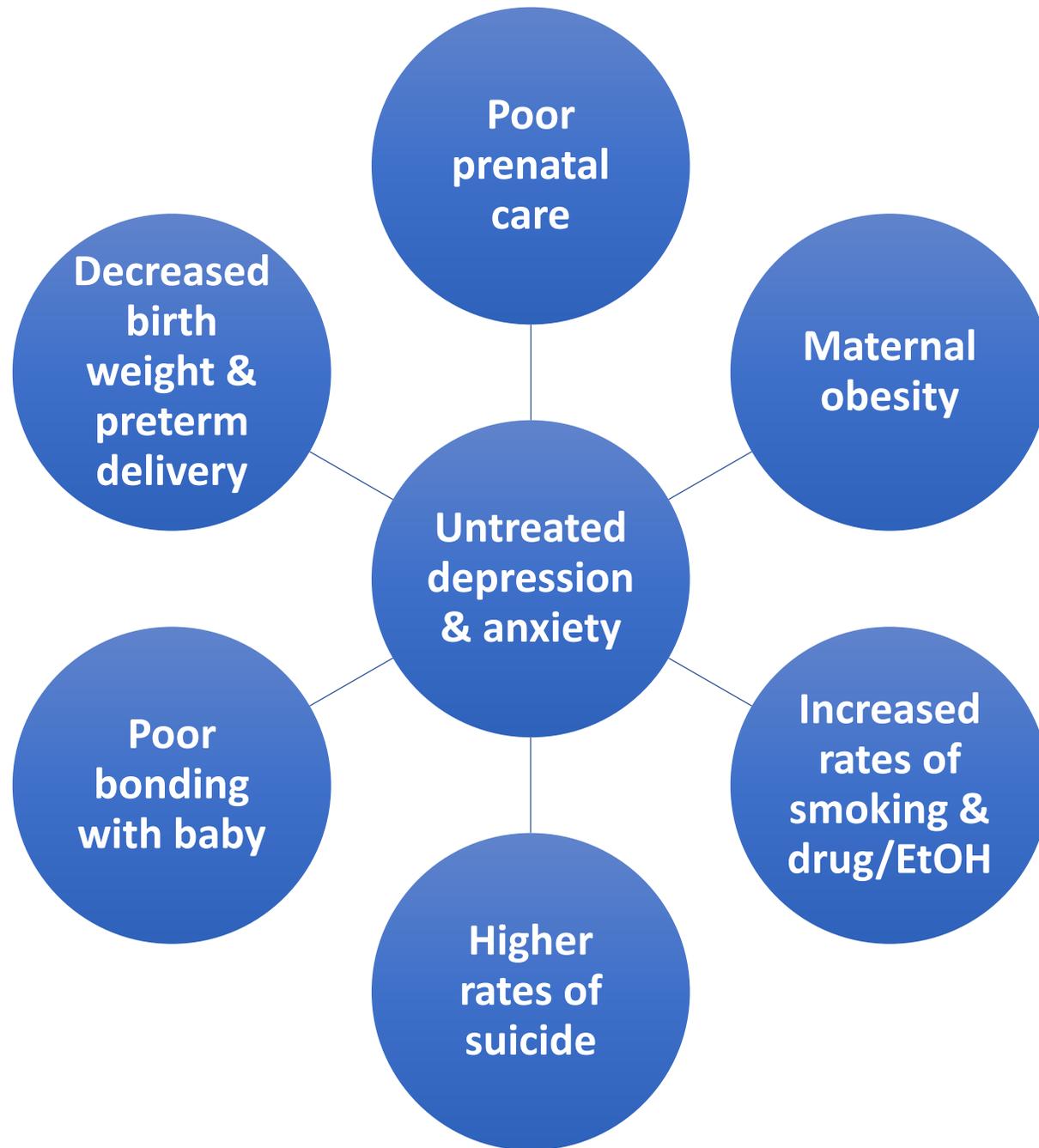


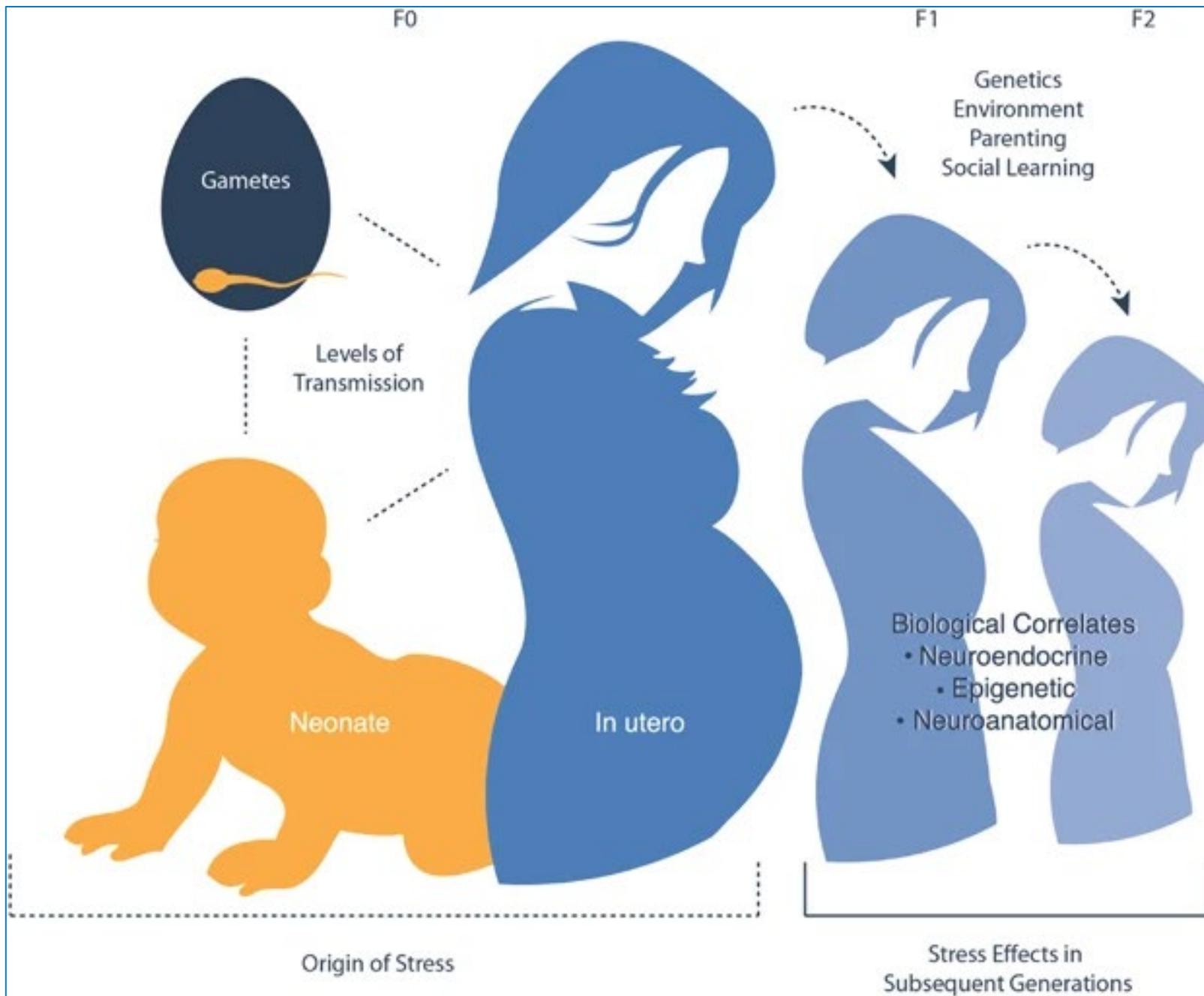
1 IN 5



**ANY PERINATAL MENTAL
HEALTH CONDITION**



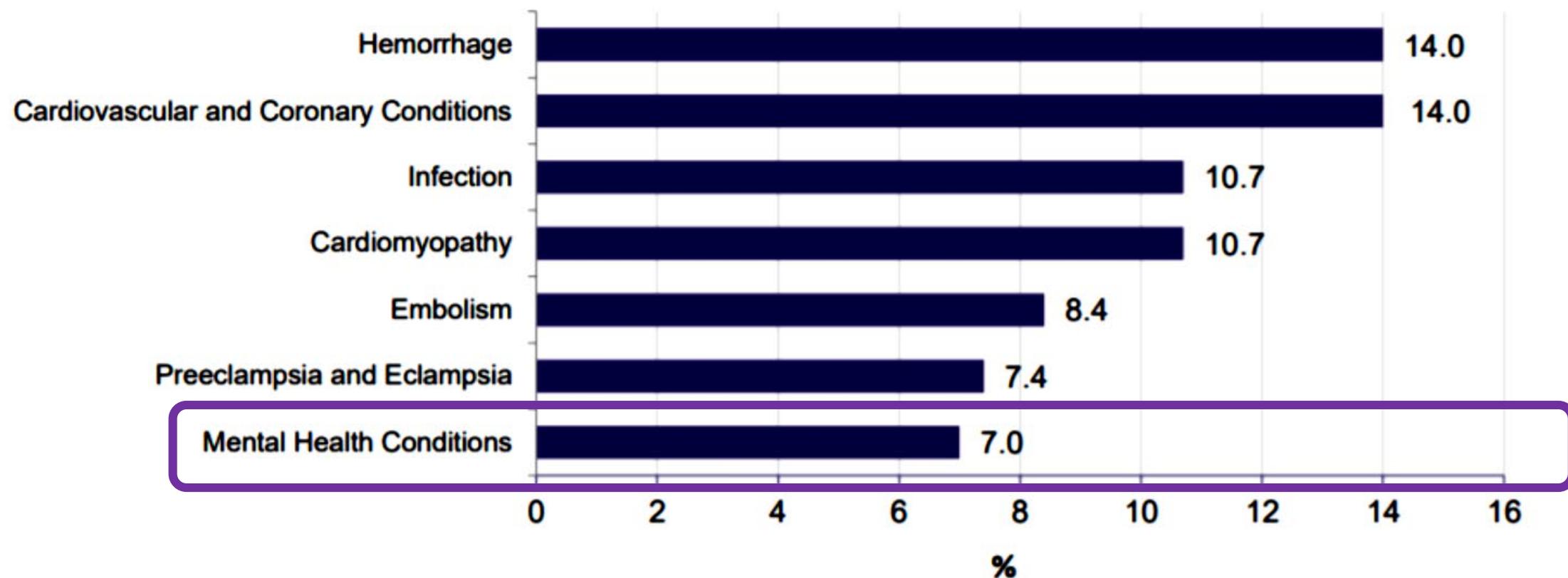




- Bowers and Yehuda, Nature 2015; <https://www.nature.com/articles/npp2015247>

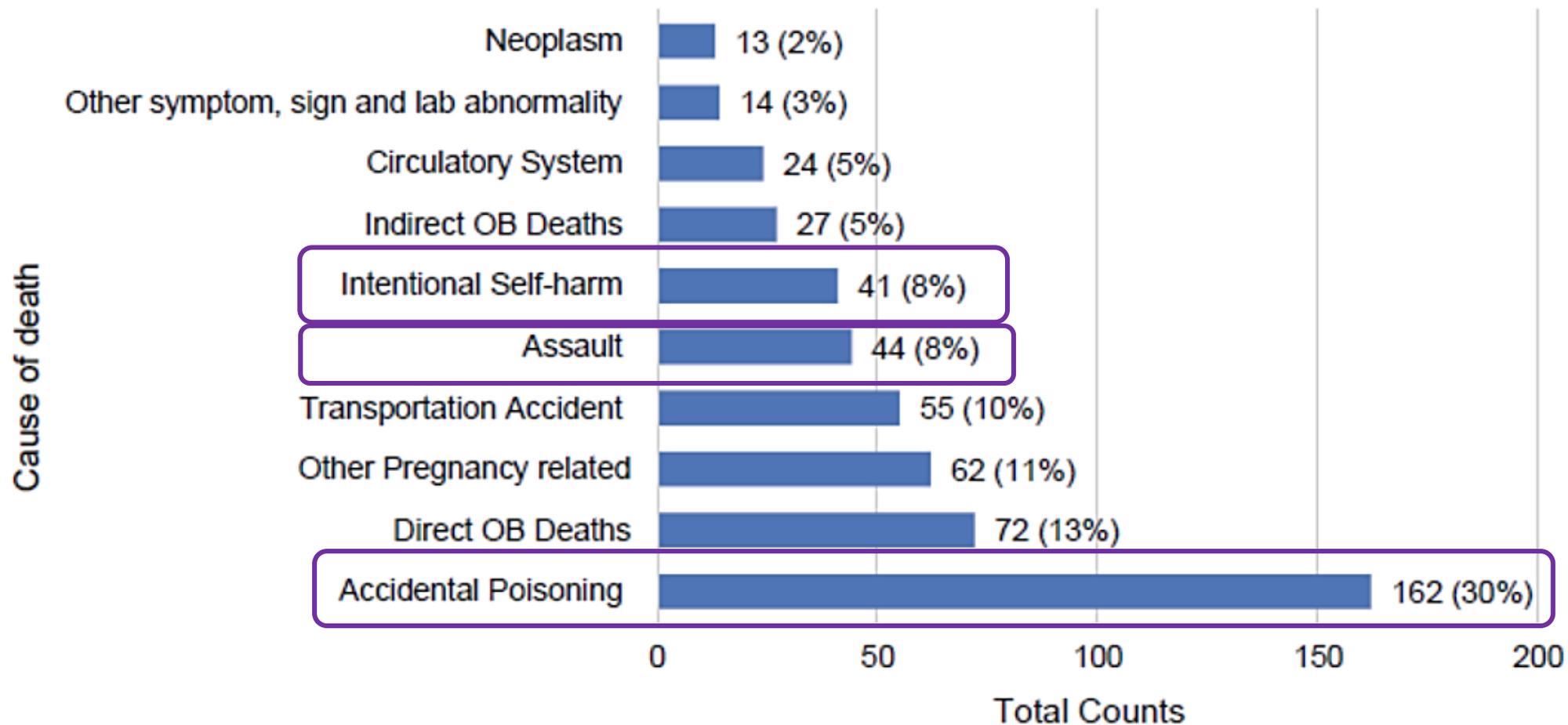
Maternal Mortality/Morbidity

Figure 4. Leading Underlying Causes of Pregnancy-Related Deaths*



- 1) Pregnancy-related death:** CDC defines pregnancy-related death as “the death of a woman while pregnant or within one year of the end of a pregnancy – regardless of the outcome, duration, or site of the pregnancy – from any cause related to or aggravated by the pregnancy or its management.” An example of pregnancy-related death would be a maternal death from a complication of eclampsia.²
- 2) Pregnancy-associated but not related death:** CDC defines pregnancy-associated but not related death as “the death of a woman while pregnant or within one year of termination of pregnancy from any cause, which is not a cause of pregnancy or illness exacerbated by pregnancy.”² An example of pregnancy-associated but not related death is maternal death from a motor vehicle accident.

Figure 11. Leading Causes of Pregnancy-Associated Deaths in Pennsylvania, 2013 – 2018 (N=547)



Note: Numbers rounded to the nearest whole.
Data Source: DOH Bureau of Health Statistics & Registries

Health Care Disparities



Ms. A is admitted to the hospital for induction of labor and states that she has been doing a lot of reading and is concerned as a Black women about delivery risks and COVID-19 risks. She is concerned about dying and tearfully tells you that she needs to be there for her children.

What do you tell her?



Bars above 0 suggest that a given race/ethnicity group is experiencing a **disproportionately high** percent of COVID-19 deaths relative to their percent of the population. The higher the bar, the larger the disparity.



Bars near 0 indicate that there is little or no disparity for a given race/ethnicity group. The percent of COVID-19 deaths experienced by that group is similar to their percent of the population.



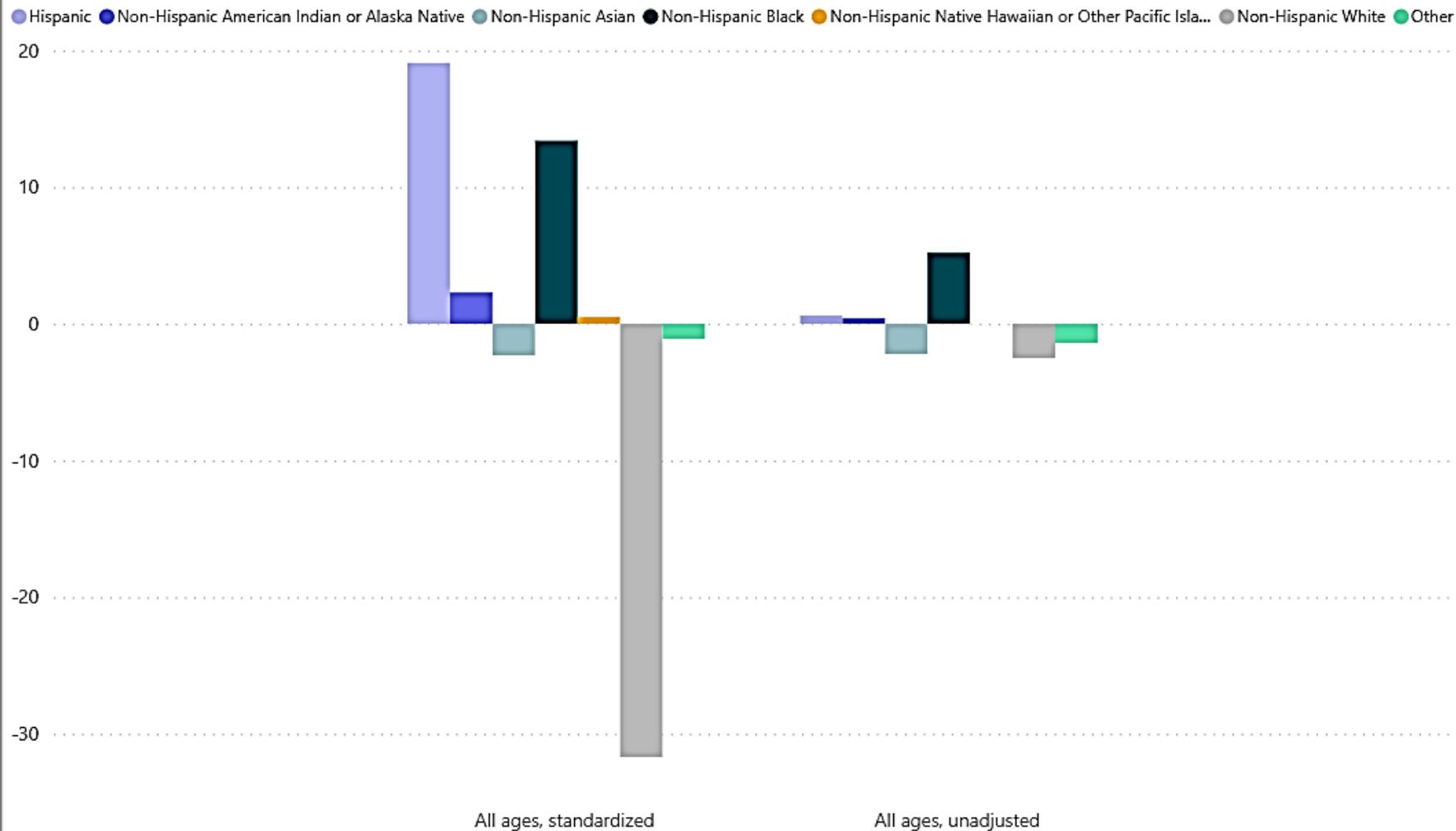
Bars below 0 indicate that the percent of COVID-19 deaths experienced by a specific race/ethnicity group is **smaller** than their percent of the population.



Figure 2. Difference between the percent of COVID-19 deaths and the population distributions by race and Hispanic origin: the impact of adjusting for age

Select a jurisdiction:

United States



COVID and Health Care

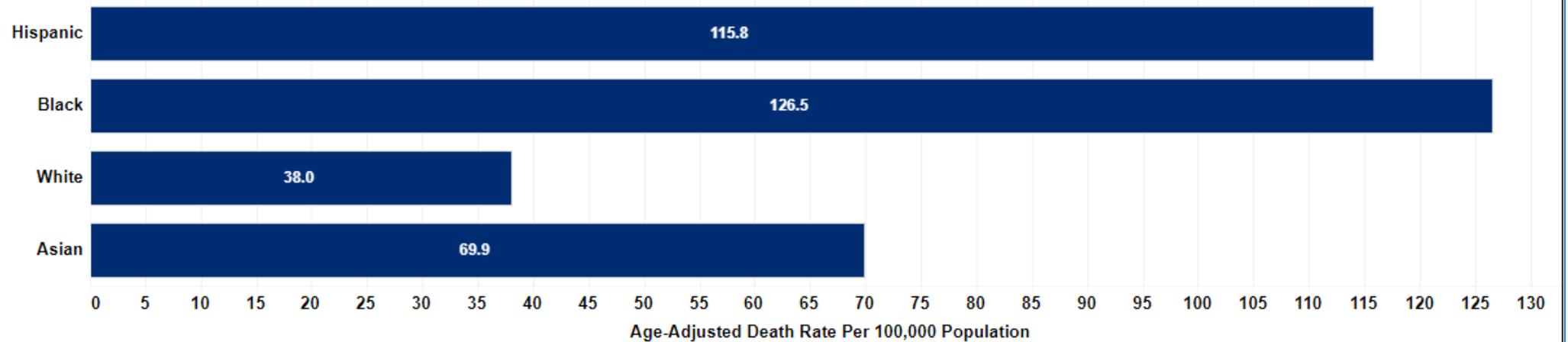
Age Adjusted Rate of Fatality COVID-19 Cases per 100,000 by Race/Ethnicity Group



Data is preliminary. With 99% reporting, below is the breakdown for NYS Excl. NYC.

For a complete explanation of age-adjusted rates, click here: <https://www.health.ny.gov/statistics/cancer/registry/age.htm>

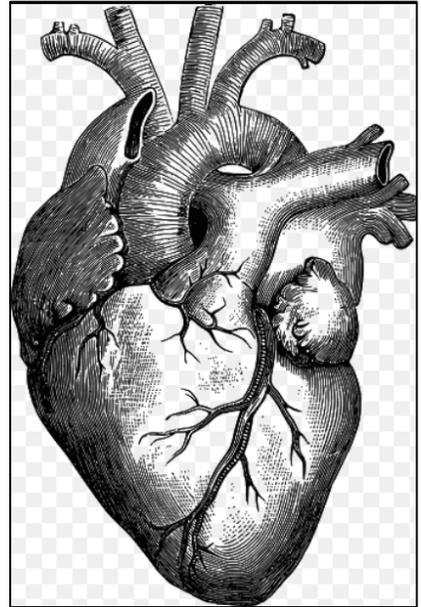
New York State Excluding NYC



Compared to White women, a Black woman is

12x more likely to die from pregnancy- and childbirth-related causes

69% more likely to die from CAD



352% more likely to die from HTN





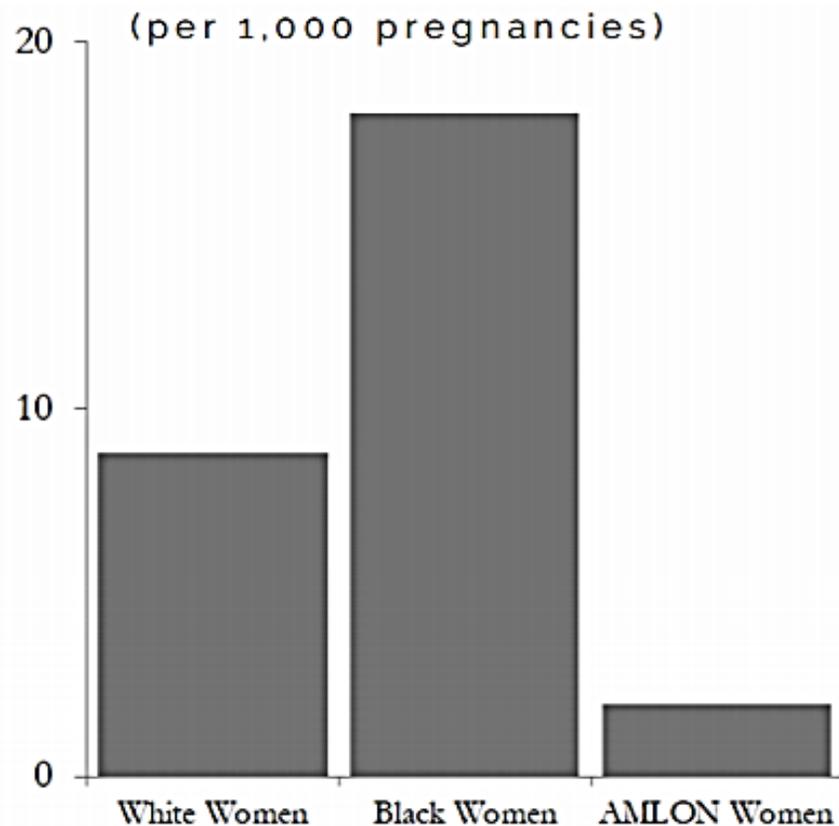
**PITTSBURGH'S
INEQUALITY ACROSS
GENDER AND RACE**

2019

CITY OF PITTSBURGH'S
GENDER EQUITY COMMISSION

HEALTH

Fetal Mortality Rate

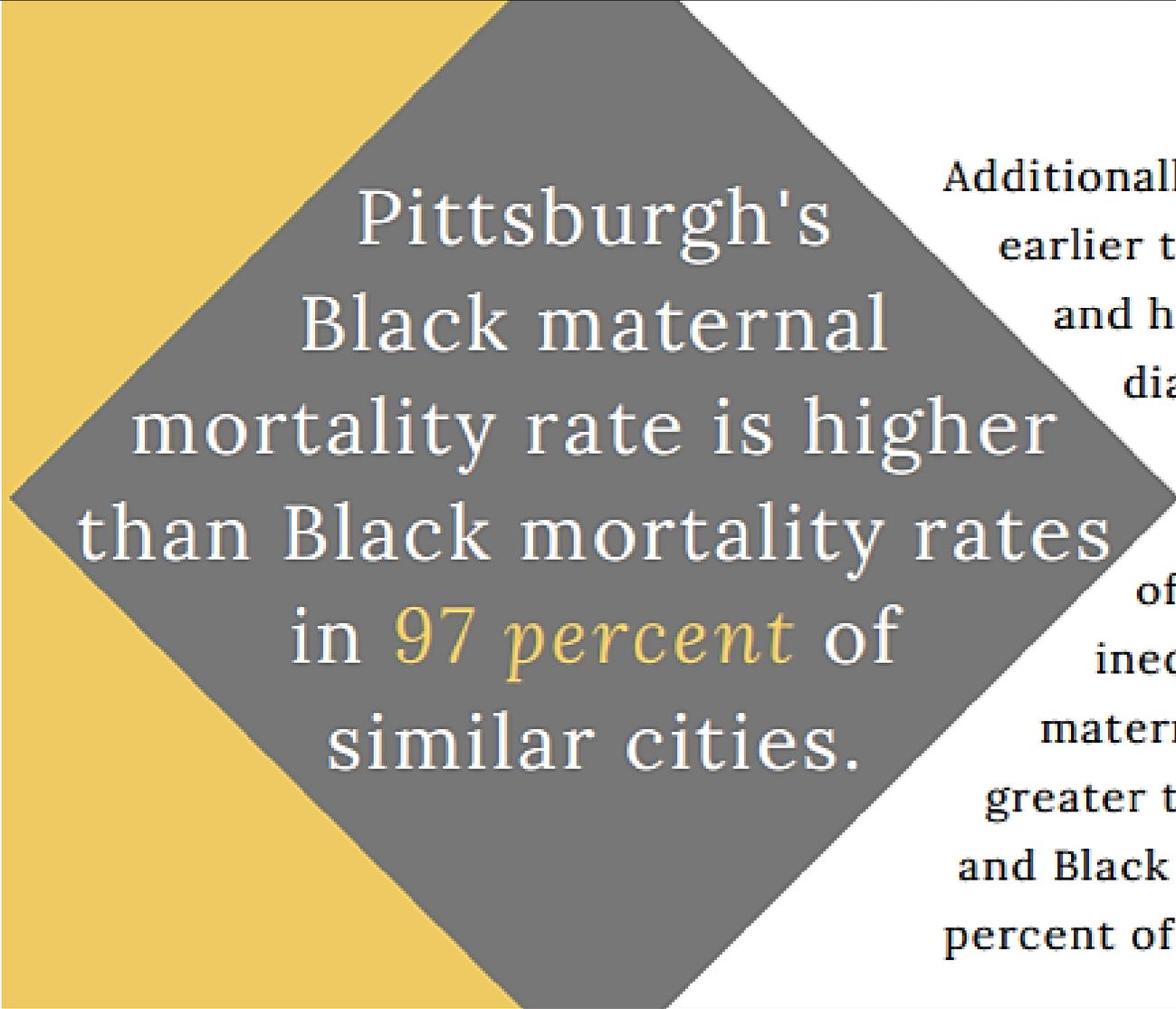


Fetal deaths are relatively common in Pittsburgh. Pennsylvania counts fetal deaths as all pregnancies, at least 16 weeks gestation, where the fetus shows no signs of life once born. Fetal deaths are influenced by the quality of maternal health. Thus, high fetal deaths serve as an indicator of women's overall health.

For Pittsburgh's Black women, 18 out of every 1,000 pregnancies end in a fetal death. This is compared to only 9 out of every 1,000 White pregnancies and 2 out of every AMLON pregnancies.

◆ Fetal deaths are **2 times** more likely
◆ among Pittsburgh's Black women
◆ compared to White women.





Pittsburgh's
Black maternal
mortality rate is higher
than Black mortality rates
in *97 percent* of
similar cities.

Additionally, despite starting prenatal care earlier than Black women in similar cities and having lower rates of gestational diabetes, hypertension and infection, Black women's maternal mortality is higher in Pittsburgh than 97 percent of similar cities. Moreover, the inequality between White and Black maternal mortality rates in Pittsburgh is greater than the inequality between White and Black maternal mortality rates in 84 percent of similar cities.



Black mothers are **much more likely** than White mothers to suffer from PMADs like postpartum depression.

Risk factors include:

- Lack of access to high-quality medical care
- Higher risk of pregnancy and childbirth complications
- Lack of social support
- Gaps in medical insurance
- Financial barriers, including lack of PTO
- Unsafe neighborhoods
- Increased stress
- Exposure to trauma

US Black/Latina women
↑ prevalence PPD
35-67% compared to 10-15%

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Risk factors include:

- Lack of access to high-quality medical care
- Higher risk of pregnancy and childbirth complications
- Lack of social support
- Gaps in medical insurance
- Financial barriers, including lack of PTO
- Unsafe neighborhoods
- Increased stress
- Exposure to trauma



Health Care Disparities

- BIPOC identified at ↓ rates for perinatal mood and anxiety disorders
- Screening tools designed for white women
- Fear of repercussions
 - CYF disproportionately removes black children from homes (https://www.childwelfare.gov/pubpdfs/racial_disproportionality.pdf)

Table 2

Outcomes for low-income white, black, and Latina women who initiated treatment for postpartum depression within six months of delivery^a

Outcome	Whites (N=13,001)		Blacks (N=13,416)		AOR	95% CI	p	Latinas (N=3,184)		AOR	95% CI	p
	N	%	N	%				N	%			
Initiated care for postpartum depression	1,120	9	568	4	.43	.39–.48	<.001	162	5	.59	.49–.69	<.001
Type of care initiated ^b												
Any antidepressant	1,069	95	546	96	1.34	.79–2.26		159	98	2.62	.80–8.59	
Any mental health outpatient visit	1,056	94	553	97	2.19	1.23–3.92	<.01	157	97	1.81	.71–4.60	
Follow-up ^c	730	65	316	56	.66	.53–.81	<.001	89	55	.67	.48–.94	<.05
Medication refill	471	44	124	23	.37	.29–.47	<.001	43	27	.43	.29–.63	<.001
Second mental health outpatient visit	395	37	236	43	1.20	.96–1.50		59	38	1.10	.77–1.57	
Continued care ^d	386	35	179	32	.81	.65–1.02	<.10	42	26	.67	.46–.99	<.05

^a Odds ratios and 95% confidence intervals are from logistic regression models, all of which included an intercept term and controlled for age at delivery, drug dependency, high-risk pregnancy, cesarean delivery, preterm delivery, and diabetes. All outcomes were evaluated within an acute treatment phase of 120 days after initiation.

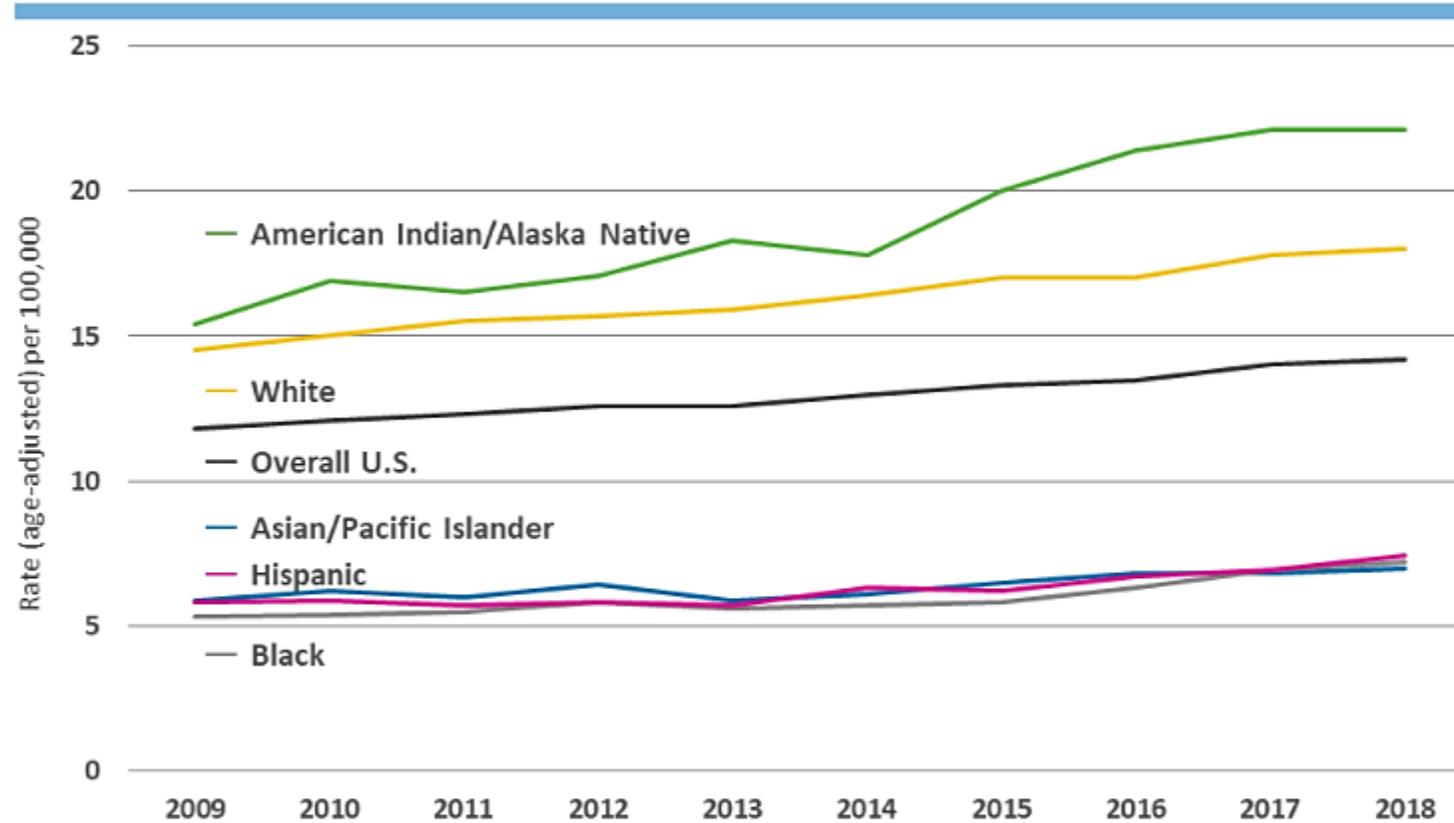
^b Evaluated within an acute treatment phase of 120 outpatient days after initiation, which was indicated by receipt of an antidepressant medication or mental health outpatient visit in the six months after delivery

^c Attained by either a second outpatient visit or a refill of a prescription for antidepressant medication

^d At least three antidepressant prescription refills or three outpatient visits during the acute treatment phase

BIPOC women less likely to initiate postpartum mental health treatment (9% white; 4% Black; 5% Latina; p<0.001)

Rate of Suicide by Race/Ethnicity, United States 2009-2018



www.sprc.org

Source: CDC, 2020

Since 2009, the age-adjusted suicide death rate has increased for all races and ethnicities. For American Indian and Alaska Native populations, the age-adjusted suicide death rate increased from 15.4 per 100,000 in 2009 to 22.1 per 100,000 in 2018.⁴

Crack Babies: The Worst Threat Is Mom Herself

By Douglas J. Besharov

LAST WEEK in this city, Greater Southeast Community Hospital released a 7-week-old baby to her homeless, drug-addicted mother even though the child was at severe risk of pulmonary arrest. The hospital's explanation: "Because [the mother] demanded that the baby be released."

The hospital provided the mother with an apnea monitor to warn her if the baby stopped breathing while asleep, and trained her in CPR. But on the very first night, the mother went out drinking and left the child at a friend's house—without the monitor. Within seven hours, the baby was dead. Like Dooney Waters, the 6-year-old living in his mother's drug den, whose shocking story was reported in *The Washington Post* last week, this child was all but abandoned by the authorities.



Refuting the Claims

Bada et al 2011

- 536g lighter at birth, 2.6 cm shorter, 1.5-cm smaller head circumference
- Gestational age significantly lower by 8.4 days in cocaine-exposed

Buckingham-Howes 2013

- Small differences in behavior, language; effect sizes small
 - questionable clinical importance
- Development influenced by multiple biological and environmental factors (i.e., poverty)



[Home](#) » [American Journal of Public Health \(AJPH\)](#) » **December 2020**

Racial and Ethnic Disparities in Maternal and Infant Outcomes Among Opioid-Exposed Mother-Infant Dyads in Massachusetts (2017–2019)

Mary Peeler MD, MPH, Munish Gupta MD, Patrice Melvin MPH, Allison S. Bryant MD, MPH, Hafsatou Diop MD, MPH, Ronald Iverson MD, MPH, Katherine Callaghan ... (show all authors)

[+] Author affiliations, information, and correspondence details

Accepted: July 20, 2020 Published Online: November 12, 2020

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Accepted: July 20, 2020 Published Online: November 12, 2020

- 1710 deliveries
 - 89.3% (n = 1527) non-Hispanic White
 - 3.3% (n = 57) non-Hispanic Black
 - 7.4% (n = 126) Hispanic

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[+] Author affiliations, information, and correspondence details

Accepted: July 20, 2020 Published Online: November 12, 2020

- Significant differences ($P < .001$) in the use of MOUD during pregnancy by race/ethnicity
 - 88.9% (n = 1357) of non-Hispanic White women receiving any MOUD
 - 75.4% (n = 43) non-Hispanic Black women
 - 77.0% (n = 97) of Hispanic women

Racial and Ethnic Disparities in Maternal and Infant Outcomes Among Opioid-Exposed Mother-Infant Dyads in Massachusetts (2017-2019)

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[+] Author affiliations, information, and correspondence details

Accepted: July 20, 2020 Published Online: November 12, 2020

- Non-Hispanic Black and Hispanic women more likely to receive methadone than buprenorphine ($P < .001$)
- No significant effect of race/ethnicity on infant care characteristics



Training BIPOC HCWs

- Race-concordance improves patients' rating of participatory decision making (felt they were involved more) (Cooper-Patrick et al JAMA; 1999)
- Patients of minority races prefer same-race doctors (Saha et al Health Affairs; 2000)
- Black patients with Black doctors experienced less pain with stimulation (Anderson et al; Pain Medicine; 2020)

Social and Peer Support

- Higher levels of social support had strong protective association against PPD
- Effects of social support did not differ when accounting for race/ethnicity





Window of Opportunity



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

ACOG COMMITTEE OPINION

Number 757

(Replaces Committee Opinion No. 630, May 2015)

Committee on Obstetric Practice

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice.

INTERIM UPDATE: This Committee Opinion is updated as highlighted to reflect a limited, focused change in the language and supporting evidence regarding prevalence, benefits of screening, and screening tools.

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. Several screening instruments have been validated for use during pregnancy and the postpartum period. The American College of Obstetricians and Gynecologists recommends that **obstetrician-gynecologists and other obstetric care providers screen patients at least once during the perinatal period** for depression and anxiety symptoms using a standardized, validated tool. It is recommended that all obstetrician-gynecologists and other obstetric care providers **complete a full assessment of mood and emotional well-being (including screening for postpartum depression and anxiety with a validated instrument) during the comprehensive postpartum visit** for each patient. If a patient is screened for depression and anxiety during pregnancy, additional screening should then occur during the comprehensive postpartum visit. There is evidence that screening alone can have clinical benefits, although initiation of treatment or referral to mental health care providers offers maximum benefit. Therefore, 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.

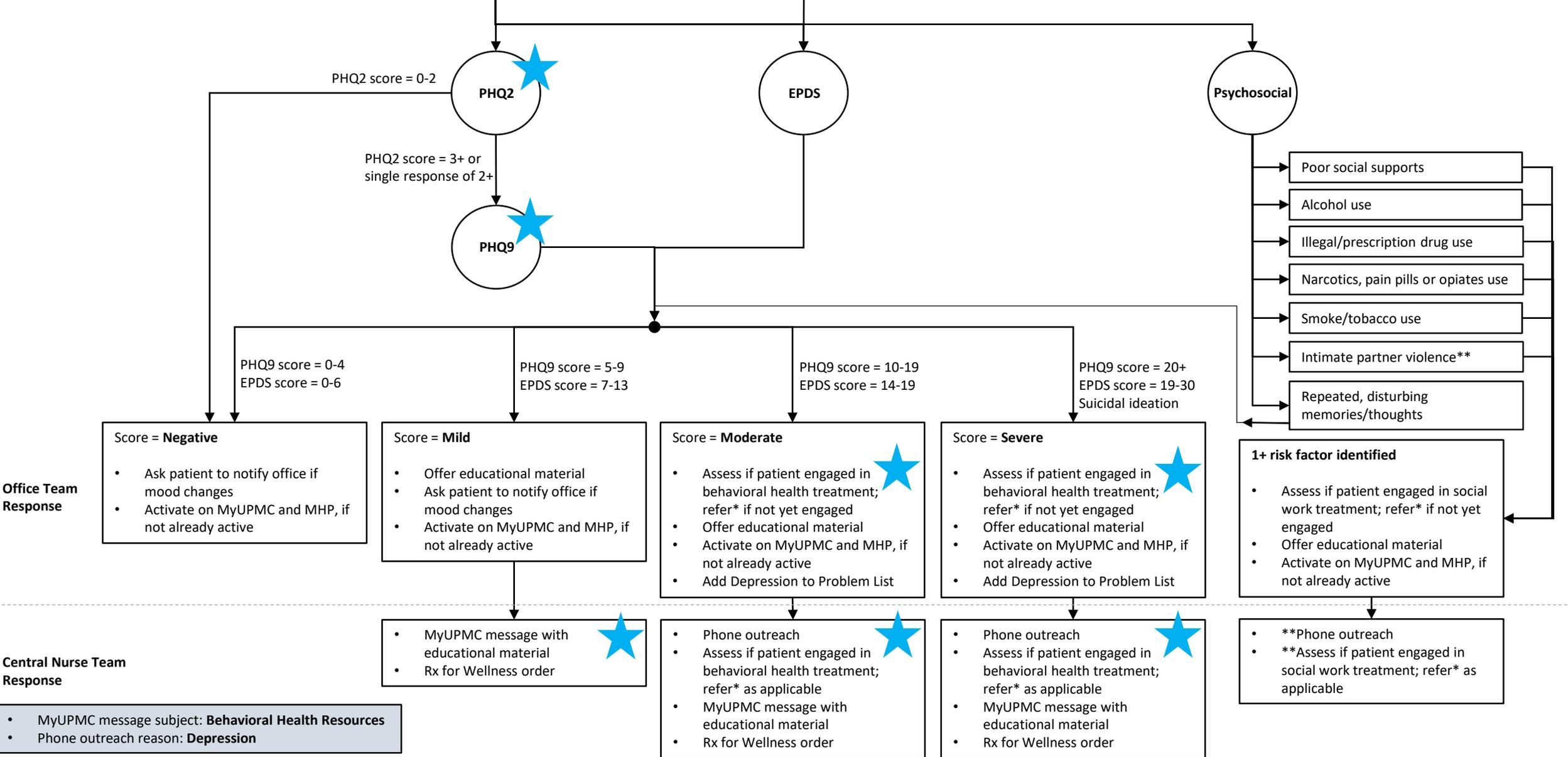
Behavioral Health + Social Work Screening Workflows

UPDATED 12/23/20

*Referral processes on next page

Initial prenatal visit
Distribute at appointment:
PHQ2
Psychosocial risk assessment
Shared via MyHealthyPregnancy:
EPDS

Postpartum visit
Distribute before/at appointment:
EPDS



Score = Negative

- Ask patient to notify office if mood changes
- Activate on MyUPMC and MHP, if not already active

Score = Mild

- Offer educational material
- Ask patient to notify office if mood changes
- Activate on MyUPMC and MHP, if not already active

Score = Moderate

- Assess if patient engaged in behavioral health treatment; refer* if not yet engaged
- Offer educational material
- Activate on MyUPMC and MHP, if not already active
- Add Depression to Problem List

Score = Severe

- Assess if patient engaged in behavioral health treatment; refer* if not yet engaged
- Offer educational material
- Activate on MyUPMC and MHP, if not already active
- Add Depression to Problem List

1+ risk factor identified

- Assess if patient engaged in social work treatment; refer* if not yet engaged
- Offer educational material
- Activate on MyUPMC and MHP, if not already active

• MyUPMC message with educational material

• Rx for Wellness order

• Phone outreach

• Assess if patient engaged in behavioral health treatment; refer* as applicable

• MyUPMC message with educational material

• Rx for Wellness order

• Phone outreach

• Assess if patient engaged in behavioral health treatment; refer* as applicable

• MyUPMC message with educational material

• Rx for Wellness order

• **Phone outreach

• **Assess if patient engaged in social work treatment; refer* as applicable

• MyUPMC message subject: **Behavioral Health Resources**

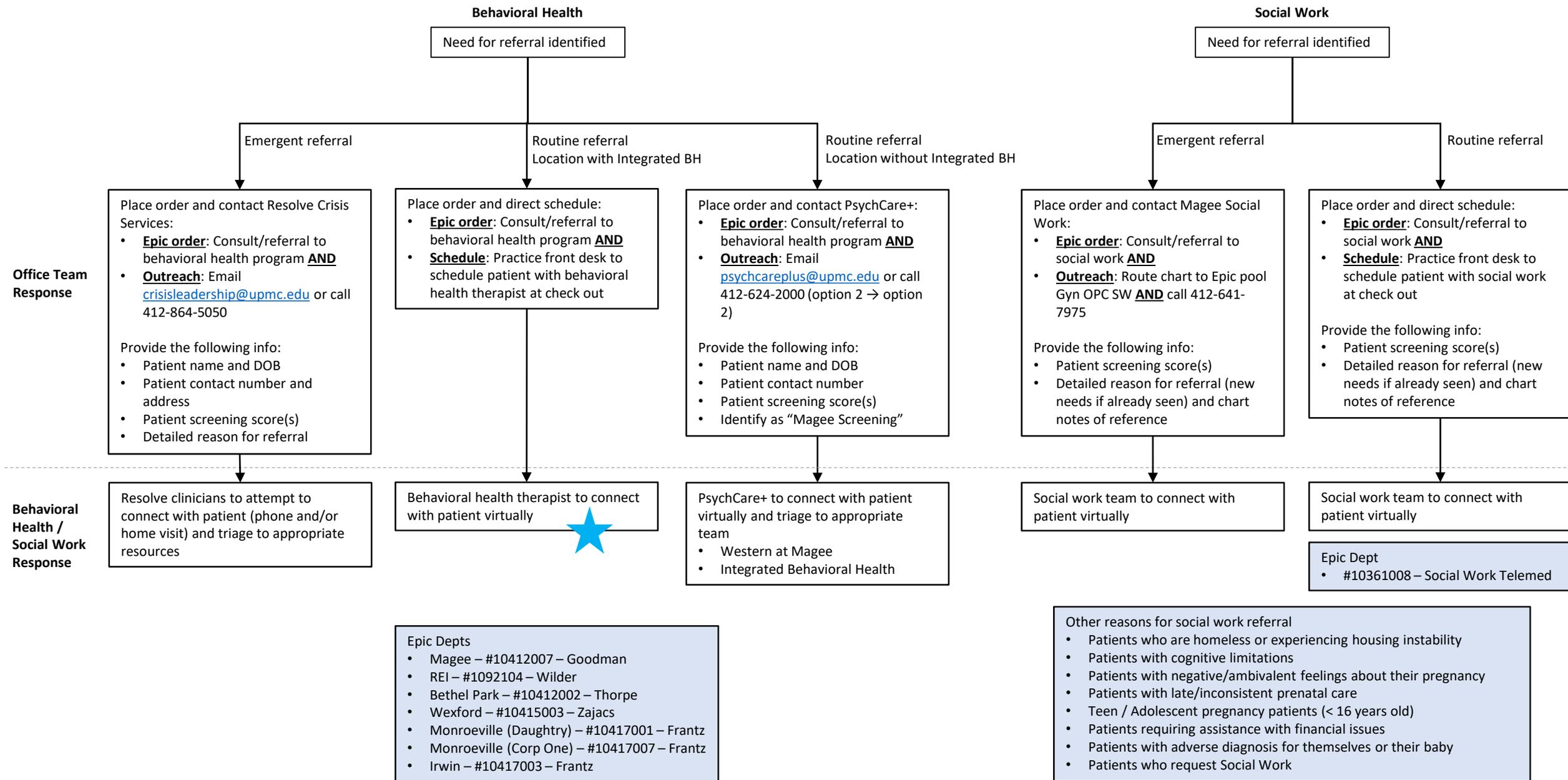
• Phone outreach reason: **Depression**

- Poor social supports
- Alcohol use
- Illegal/prescription drug use
- Narcotics, pain pills or opiates use
- Smoke/tobacco use
- Intimate partner violence**
- Repeated, disturbing memories/thoughts

Behavioral Health + Social Work

Referral Workflows

UPDATED 12/23/20



Action	Volume
PHQ2 Screening	6,366 unique pts
PHQ9 Screening	1,043 unique pts
Referral to Behavioral Health	416 documented orders
Referral to Health Plan maternity team	371 documented referrals
Phone or MyUPMC outreach by Central Monitoring Team	871 documented outreaches
Completed Appt with BH Team Through Algorithm	169 unique pts (but 270 completed integrated BH pts)

What about prevention?

JAMA | US Preventive Services Task Force | RECOMMENDATION STATEMENT

Interventions to Prevent Perinatal Depression

US Preventive Services Task Force Recommendation Statement

US Preventive Services Task Force

IMPORTANCE Perinatal depression, which is the occurrence of a depressive disorder during pregnancy or following childbirth, affects as many as 1 in 7 women and is one of the most common complications of pregnancy and the postpartum period. It is well established that perinatal depression can result in adverse short- and long-term effects on both the woman and child.

OBJECTIVE To issue a new US Preventive Services Task Force (USPSTF) recommendation on interventions to prevent perinatal depression.

EVIDENCE REVIEW The USPSTF reviewed the evidence on the benefits and harms of preventive interventions for perinatal depression in pregnant or postpartum women or their children. The USPSTF reviewed contextual information on the accuracy of tools used to identify women at increased risk of perinatal depression and the most effective timing for preventive interventions. Interventions reviewed included counseling, health system

- ← [Editorial page 550](#)
- + [Author Audio Interview](#)
- ← [Related article page 588 and JAMA Patient Page page 620](#)
- + [CME Quiz at jamanetwork.com/learning and CME Questions page 606](#)
- + [Related articles at jamainternalmedicine.com jamapediatrics.com jamapsychiatry.com](#)

Interventions to Prevent Perinatal Depression

US Preventive Services Task Force

Recommendation Statement

US Preventive Services Task Force

- Reviewed 50 good or fair quality studies
- 20 related to counseling (n = 4107)
- Median 8 weeks; 12 hours of contact time

USPSTF Intervention to Prevent Perinatal Depression

Figure 2. Clinical Summary: Interventions to Prevent Perinatal Depression

Population	Pregnant and postpartum persons	
Recommendation	Provide or refer persons at increased risk of perinatal depression to counseling interventions.	
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate, or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
Risk Assessment	There is no accurate screening tool for identifying who is at risk of perinatal depression and who might benefit from preventive interventions. A pragmatic approach, based on the populations included in the systematic evidence review, would be to provide counseling interventions to women with 1 or more of the following risk factors: a history of depression, current depressive symptoms (that do not reach a diagnostic threshold), certain socioeconomic risk factors such as low income or adolescent or single parenthood, recent intimate partner violence, or mental health-related factors such as elevated anxiety symptoms or a history of significant negative life events.	
Interventions	Studies of counseling interventions to prevent perinatal depression mainly included cognitive behavioral therapy and interpersonal therapy. The USPSTF found limited or mixed evidence that other studied interventions such as physical activity, education, pharmacotherapy, dietary supplements, and health system interventions were effective in preventing perinatal depression.	
Relevant USPSTF Recommendations	The USPSTF recommends screening for depression in adults, including pregnant and postpartum women. The USPSTF also recommends screening for depression in adolescents aged 12 to 18 years and found insufficient evidence to recommend for or against screening in children 11 years or younger.	

For a summary of the evidence systematically reviewed in making this recommendation, the full recommendation statement, and supporting documents, please go to <https://www.uspreventiveservicestaskforce.org>.

Risk Factors in Pregnancy/Postpartum

Perinatal Depression

Maternal anxiety

Life stress

History of depression

Lack of social support

Unintended pregnancy

Medicaid insurance

Domestic violence

Lower income

Lower education

Smoking

Single status

Poor relationship quality

Postpartum Depression

Depression during pregnancy

Anxiety during pregnancy

Experiencing stressful life events during pregnancy or early postpartum period

Traumatic birth experience

Preterm birth/infant admission to neonatal intensive care

Low levels of social support

Previous history of depression

Breastfeeding problems

Slide credit: Dr. Neeta Shenai

- Lancaster CA, Gold KJ, Flynn HA, Yoo H, Marcus SM, Davis MM. Risk factors for depressive symptoms during pregnancy: a systematic review. [Am J Obstet Gynecol 2010;202:5-14](#).
- Robertson E, Grace S, Wallington T, Stewart DE. Antenatal risk factors for postpartum depression: a synthesis of recent literature. [Gen Hosp Psychiatry 2004;26:289-95](#).

USPSTF

- Provide or refer persons at increased risk of perinatal depression to counseling services
- How many have easy access to counseling services?



Barriers to Care/Social Determinants

Childcare

Transportation

**Finances/
Employment**

Housing

Trauma

**Food
Instability**

A blurred photograph of a hospital hallway. In the foreground on the left, a gurney with a blue patient bed is visible. In the background, several medical staff members in teal scrubs are standing near a counter or desk. The hallway has a polished floor that reflects the lights and staff. The overall scene is brightly lit and appears to be a busy medical environment.

Access to Care

Physician Shortage

- 2019 study conducted for the AAMC
- Predicts that US will face a shortage of 46,900 and 121,900 physicians by 2032
- Both primary and specialty care



I'm afraid there aren't any DOCTORS available but we DO have a mangement consultant who is going to give your condition a helpful acronym and set up a policy review committee to consider its treatment...

Medical Schools, Teaching Hospitals



AAMC Members

- [Medical Schools](#)
- [Teaching Hospitals](#)
- [Academic Societies](#)

Member Center

- [AAMC Affinity Groups](#)
- [Data and Analysis](#)
- [Learning Opportunities](#)
- [Service Programs](#)
- [CareerConnect](#)

Medical School Enrollment to Approach 30 Percent Increase by 2019

Washington, D.C., April 30, 2015—U.S. medical schools are on target to reach a nearly 30 percent increase in enrollment by 2019, according to results of the annual [Medical School Enrollment Survey](#) conducted by the AAMC (Association of American Medical Colleges).

“With the United States facing a shortage of up to 90,000 physicians by 2025, we are pleased to see our nation’s medical schools increasing enrollment, both through the expansion of existing medical schools and the establishment of new ones,” said AAMC President and CEO Darrell G. Kirch, MD. “However, without an increase in federally funded residency training positions, all these new medical school graduates may not be able to complete their training and become practicing physicians.”

The results of the survey by the AAMC [Center for Workforce Studies](#) were released during the center’s 11th [Annual Health Workforce Research Conference](#). The report shows that first-year medical school enrollment in 2019–20 will reach 21,304—a 29.2 percent increase over the baseline enrollment level in 2002–03 and only 130 positions shy of the 30 percent target. This puts projections on track to meet enrollment increases that the AAMC called for in 2006 to address a projected physician shortage.

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- **↑ 29.2% over baseline enrollment level in 2002-2003**
- **Target was 30% ↑**
- **What is the issue?**

Why are there so few physicians graduating from residency training?

- A. The American Medical Association lobbies to keep slots limited to keep salaries up
- B. The state medical societies restrict residency slots to keep costs down
- C. There are not enough medical schools in the US
- D. The federal government “caps” the number of residency positions

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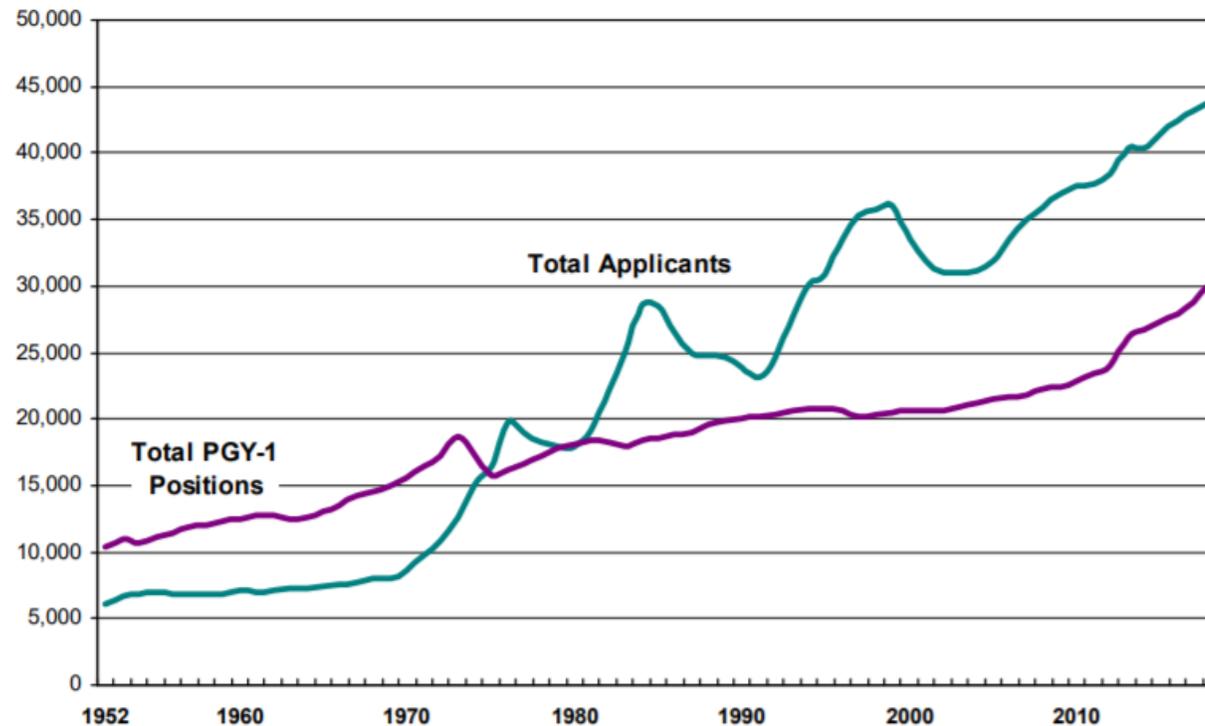
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- **↑ 29.2% over baseline enrollment level in 2002-2003**
- **Target was 30% ↑**
- **What is the issue?**

Physician Shortage (aka Residency Shortage)

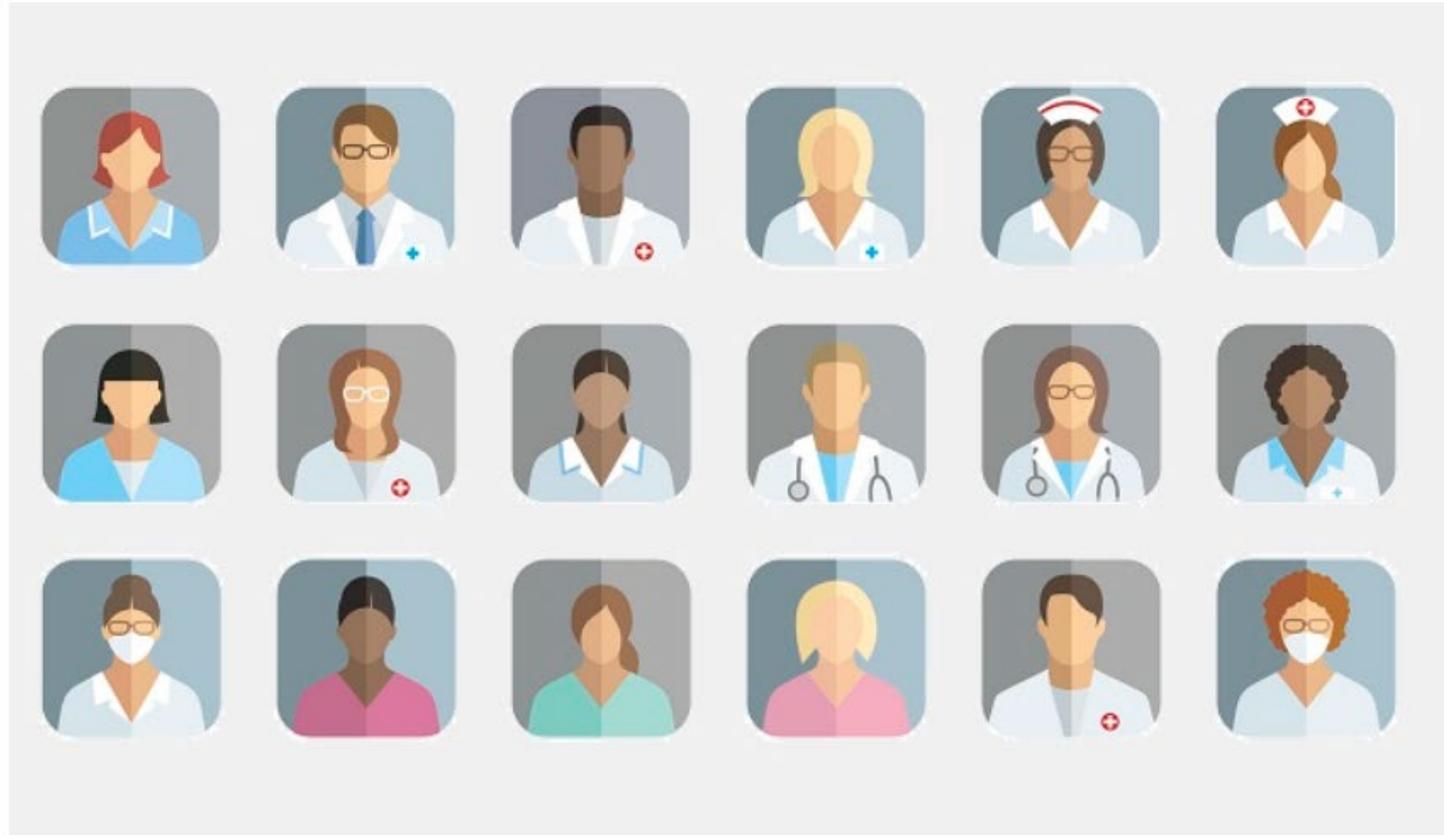
- What has happened to residency positions in this time?

Figure 1 Applicants and 1st Year Positions in the Match, 1952 - 2018



Proposed Bill Targets Medical Resident Program, Physician Shortage

The legislation specifically pertains to Medicare-funded medical resident slots.



Source: Thinkstock



**Association of
American Medical Colleges**

655 K Street, NW, Suite 100, Washington, DC 20001-2399

T 202 828 0400

aamc.org



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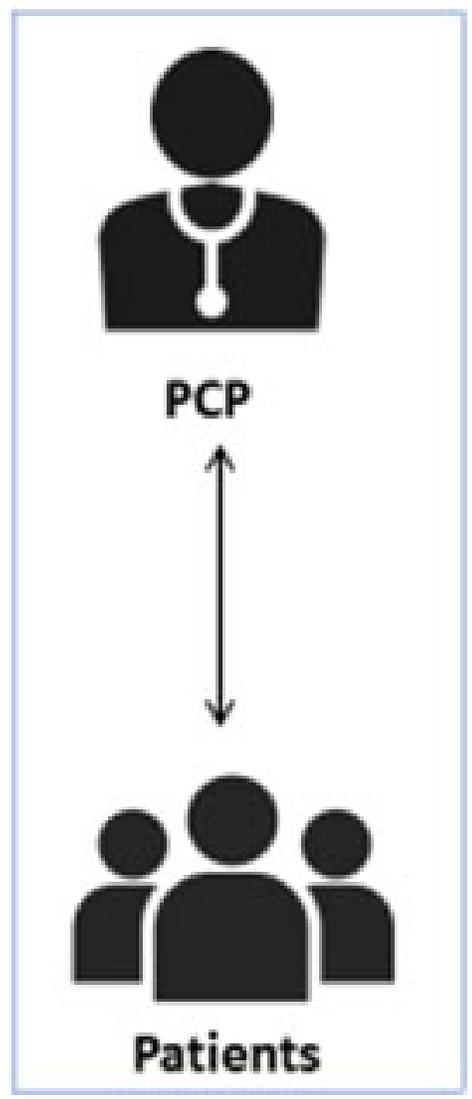
aamc.org

The Resident Physician Shortage Reduction Act of 2019 (H.R. 1763)

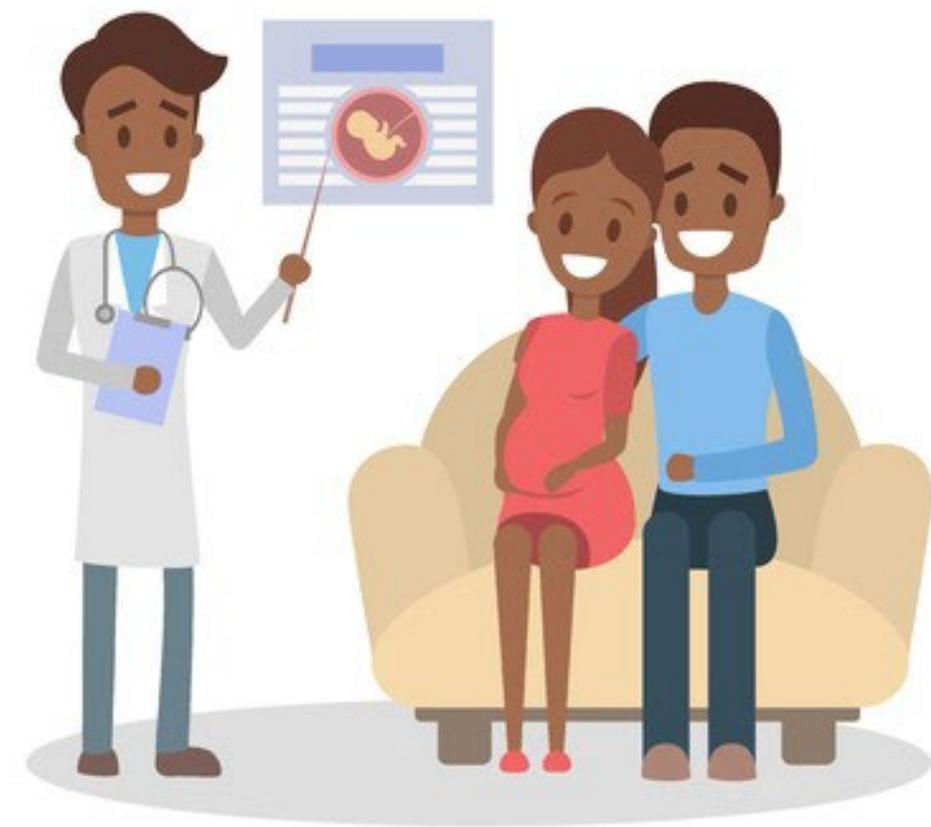
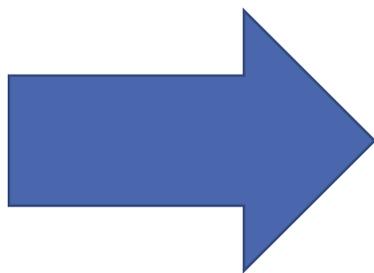
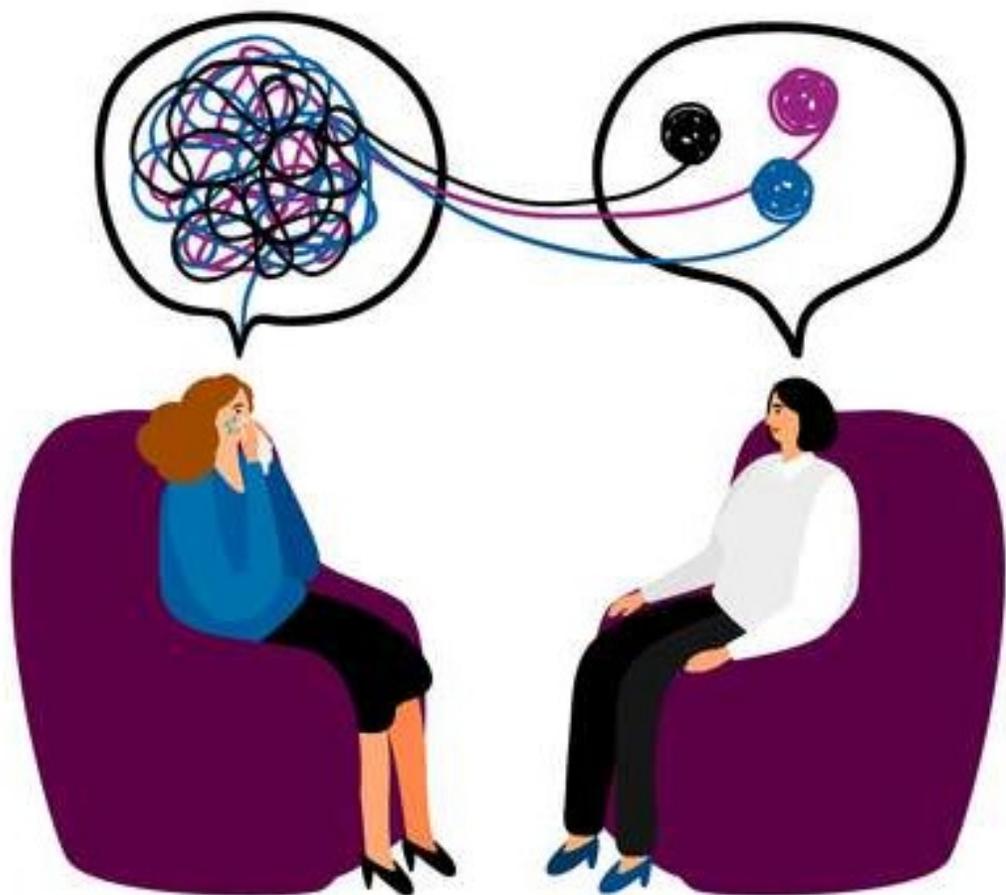
Section-by-Section Summary

On March 14, 2019, Reps. Terri Sewell (D-Ala.) and John Katko (R-N.Y.) introduced the “Resident Physician Shortage Reduction Act of 2019 (H.R. 1763).” This legislation would take critical steps to address the growing physician shortage and strengthen the nation’s health care system.

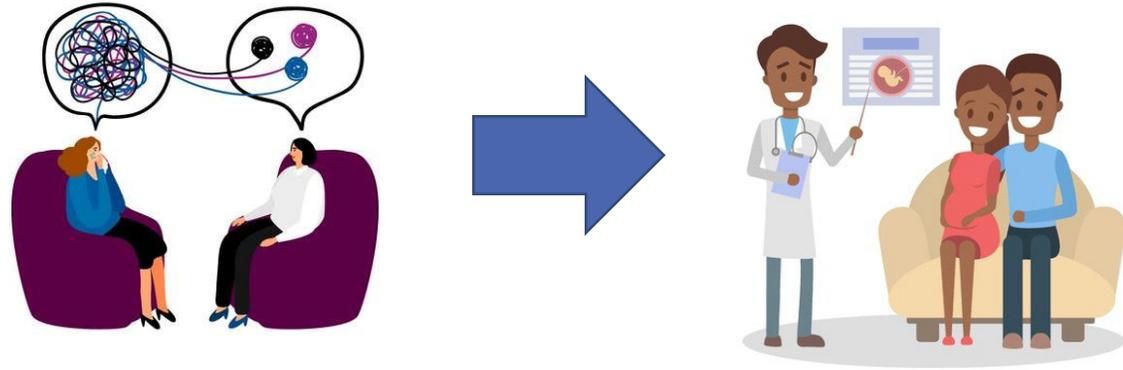
Usual Care/Traditional Model



Integrated Care



Integrated Care



- Roll-out of integrated care to OB practices
- Collaborative care models as a unique model of care
- Medical home; meet people where they are in the community
- 4 therapists in integrated care; complements 2 therapists in the behavioral health clinic at Magee

Telepsychiatry in Peripartum Mothers

- Shore et al – Telepsychiatry in integrated care (med-psych outpatient)
 - 96% treatment engagement
 - Low ED utilization rates and high breastfeeding rates in depressed moms
- Nair et al – Meta-analysis of 8 studies found improved depression scores with outpatient telepsychiatry interventions
- More studies needed



What does our own data tell us?

What did conversion to telepsychiatry during a pandemic do to UPMC's pregnant/postpartum patient no-show rates:

- A. Increased no-show rates
- B. No effect
- C. Decreased no-show rates

What does our own data tell us?

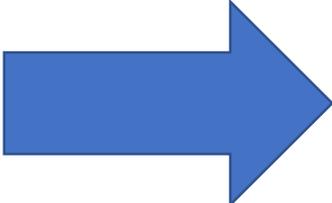
What did conversion to telepsychiatry during a pandemic do to UPMC's pregnant/postpartum patient no-show rates:

- A. Increased no-show rates
- B. No effect
- C. **Decreased no-show rates**

Evaluations and Return Visits Averaged

WBH Magee Behavioral

Pre-Covid show: 61.75%



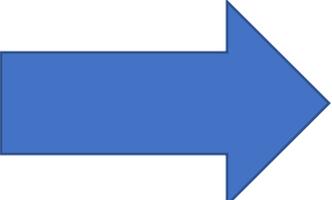
WBH Magee Behavioral

Post-Covid show: 65%

5% decrease in no-show rates

OB Integrated

Pre-Covid show: 59%



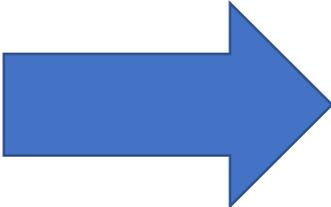
OB Integrated

Post-Covid show: 70%

26% decrease in no-show rates

**Overall OB averaged (Magee
BH + OB integrated):**

Pre-Covid show 60.4% show

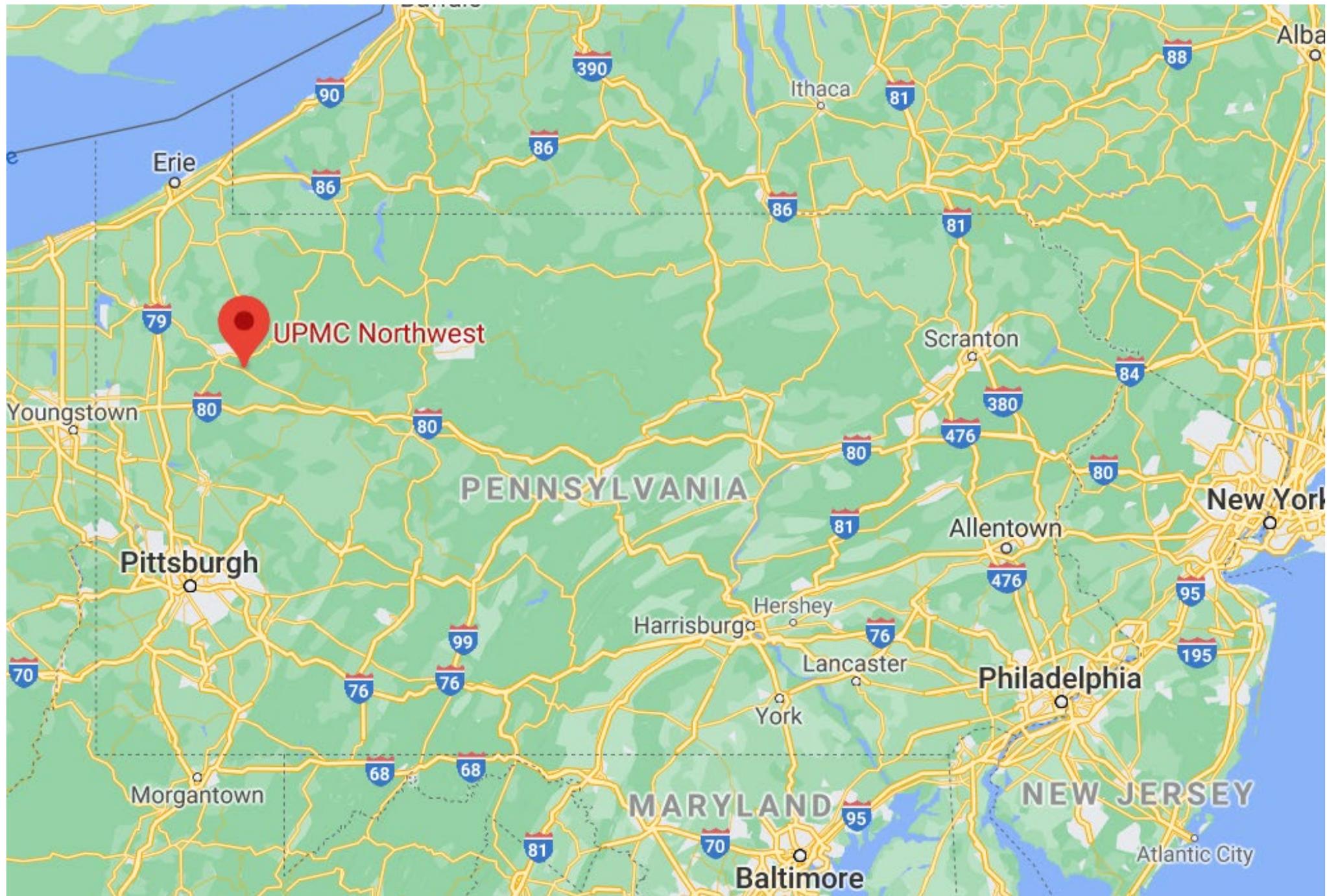


**Overall OB averaged (Magee
BH + OB integrated):**

Post-Covid show 67.5% show

12% decrease in no-show rates





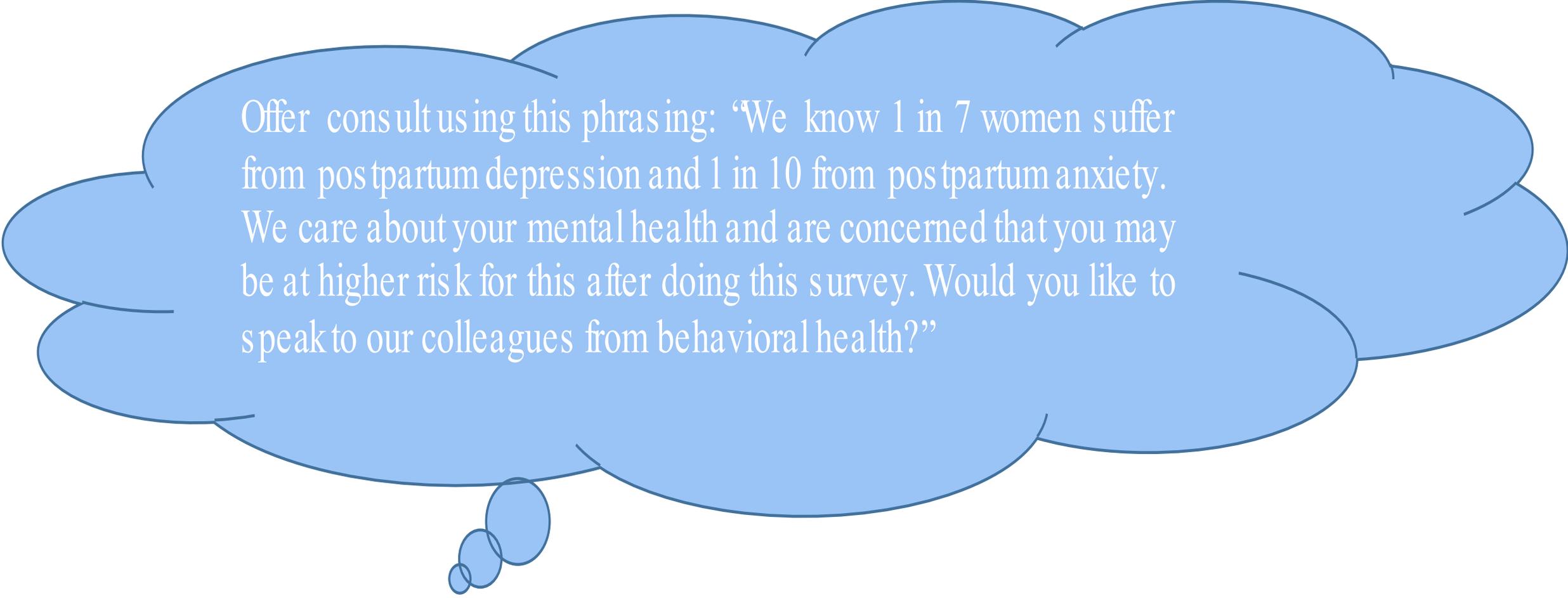
Depression / anxiety during pregnancy *
Prescription of psychiatric meds during / before pregnancy *
Prior history of postpartum depression, anxiety or psychosis *
History of trauma or current intimate partner violence
Substance use / MAT program
Low social support
Complications during delivery / baby transferred / IUFD
PHQ-2 screen ≥ 3

Consult offered if patient answers / chart review is yes ≥ 2 questions

Consult offered automatically if patient answers / chart review is yes to (*) questions

PHQ-2 Questions

Over the last 2 weeks how often have you been bothered by the following problems:	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3



Offer consult using this phrasing: “We know 1 in 7 women suffer from postpartum depression and 1 in 10 from postpartum anxiety. We care about your mental health and are concerned that you may be at higher risk for this after doing this survey. Would you like to speak to our colleagues from behavioral health?”

UPMC Northwest – OB Consults

May-November 2020

Total number of deliveries = 314

Number of screening forms done = 302 (96%)

Number of at-risk patients noted via survey = 170 (56%)

Consults at-risk not offered = 11 (6%)

Consults at-risk declined = 102 (60%)

Consults at-risk accepted = 57 (33%) of high risk

Consults done = 55 of high risk

UPMC Northwest – OB Consults

May-November 2020

17% of the total number of deliveries seen by psychiatry

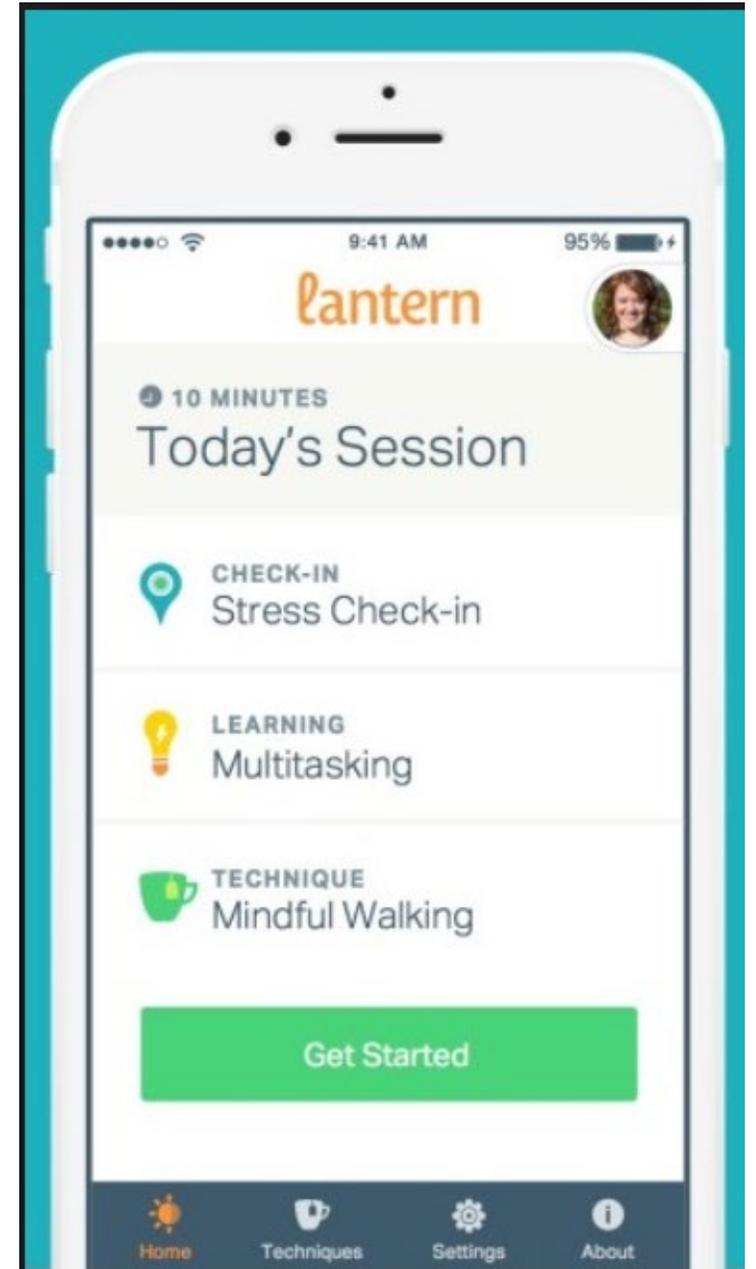
32% of those designated high risk seen

Perinatal psychiatrists did the consult

Compared to 2019?
ZERO WOMEN SEEN

Innovative Models of Care

- Technology-based interventions
- UPMC: RxWell
- Echo model



How many perinatal access lines exist in the United States?

- A. 2**
- B. 5**
- C. 7**
- D. 14**

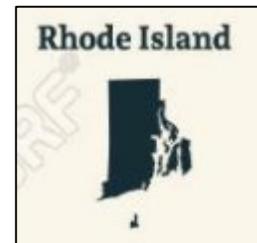
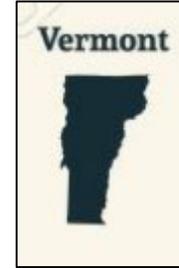


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Perinatal Access Lines





General Hospital Psychiatry

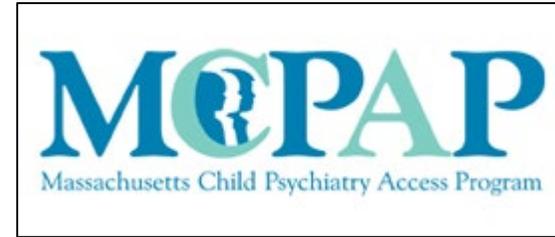
Volume 40, May–June 2016, Pages 12–17



Improving perinatal depression care: the Massachusetts Child Psychiatry Access Project for Moms

Nancy Byatt DO, MS, MBA ^a  , Kathleen Biebel PhD ^a, Tiffany A. Moore Simas MD, MPH, MEd ^a,
Barry Sarvet MD ^b, Marcy Ravech MSW ^c, Jeroan Allison MD, MS ^a, John Straus MD ^c

MCPAP for Moms

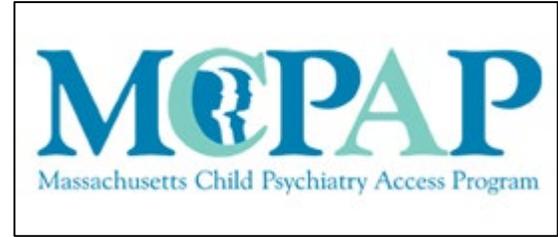


1 full-time perinatal psychiatrist (5 individuals)

2.3 FTE of resource and referral specialists

- (1) trainings and toolkits on depression screening, assessment and treatment
- (2) telephonic access to perinatal psychiatric consultation for providers serving pregnant and postpartum women
- (3) care coordination to link women with individual psychotherapy and support groups

MCPAP for Moms



- 18 months → MCPAP for Moms enrolled 87 Ob/Gyn practices
- Conducted 100 trainings and served 1123 women
- Telephone consults: 64% with obstetric providers/midwives
- 16% with psychiatrists
- **Cost = \$8.38 per perinatal woman per year (\$0.70 per month) or \$600,000 for 71,618 deliveries annually in Massachusetts**

Periscope Project



Contents lists available at [ScienceDirect](#)

General Hospital Psychiatry

journal homepage: www.elsevier.com/locate/genhospsych

Feasibility of model adaptations and implementation of a perinatal psychiatric teleconsultation program

Christina L. Wichman^{a,*}, Audrey Laszewski^a, Jennifer J. Doering^b, Shelby Borchardt^a

^a *Medical College of Wisconsin, Department of Psychiatry and Behavioral Medicine, 8701 W Watertown Plank Road, Milwaukee, WI 53226, United States of America*

^b *University of Wisconsin-Milwaukee, College of Nursing, 1921 E Hartford Ave, Milwaukee, WI 53211, United States of America*

0.5 full-time equivalent (FTE) perinatal psychiatrist

0.8 FTE triage coordinator

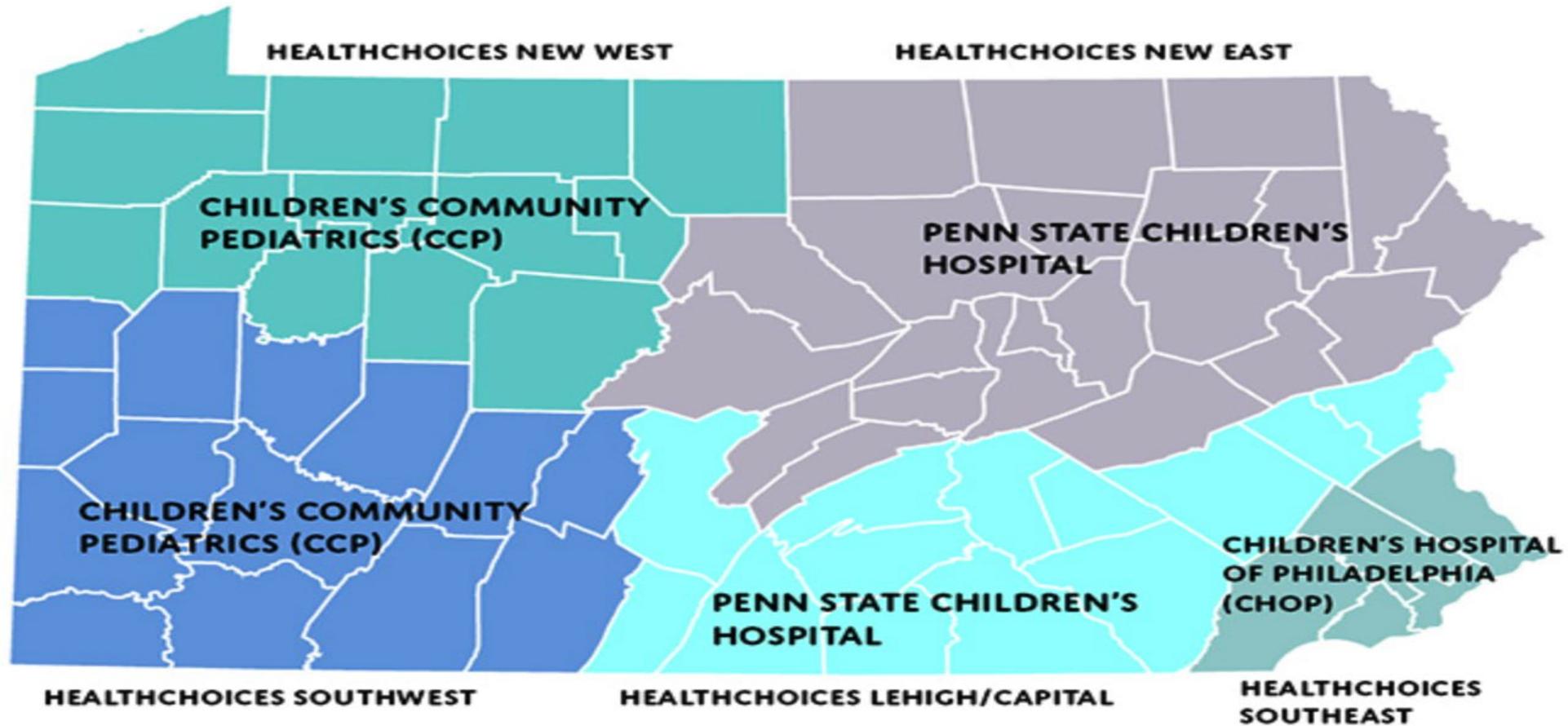
0.7 FTE program administration

Periscope Project



- 485 enrolled; 268 unique providers accessed services
- 594 encounters with 85% of encounters resulting in a teleconsultation
- Mean call-back time from psychiatrist = 6.8 min
- > ½ of utilizing providers practiced in obstetrical settings
- 23% practiced in mental health settings
- **\$7.88 per birth per pregnant/postpartum woman per year based on 66,593 births per year in Wisconsin (start-up; \$5.60 for ongoing)**

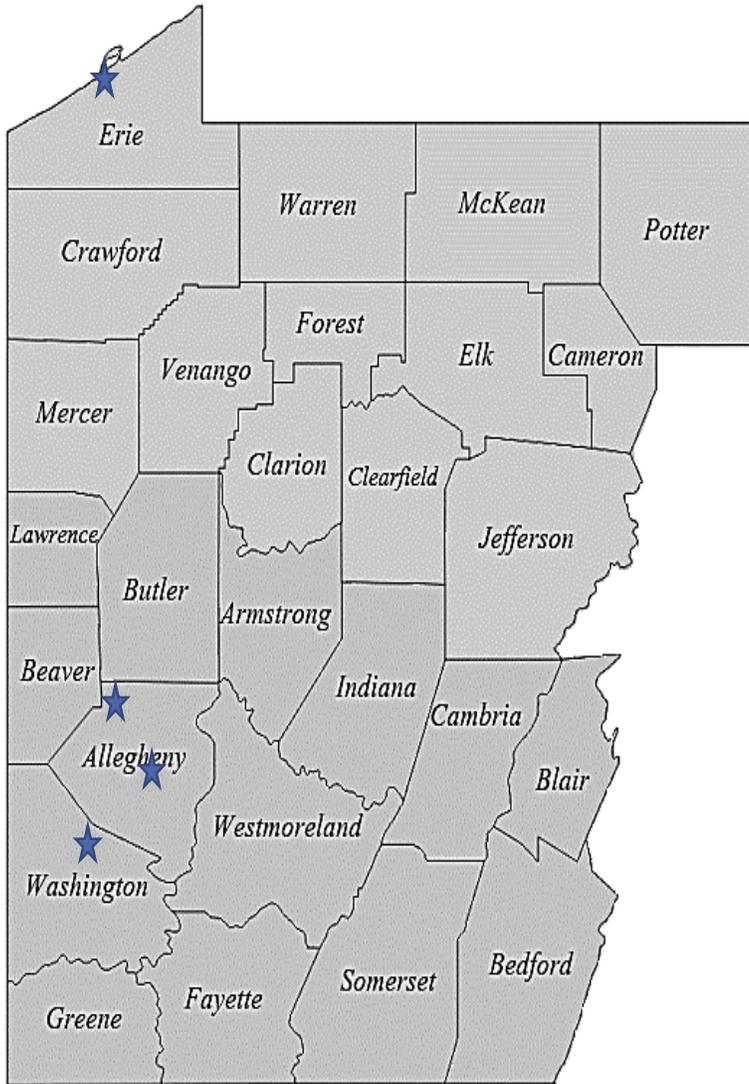
Regional TiPS teams



CHILDREN'S COMMUNITY PEDIATRICS (CCP)
844-972-8477

PENN STATE CHILDREN'S HOSPITAL
800-233-4082
"PRESS 4"

CHILDREN'S HOSPITAL OF PHILADELPHIA (CHOP)
267-426-1776



- Children's TiPS serves 27 counties in Western PA
- Face to face evaluations are available in Wexford, Pittsburgh, Erie, Bridgeville
- Telepsychiatry is also available in the Erie location

PCC has a question about psychotropic medication
or a behavioral health concern

PCC obtains verbal consent & has patient information available



Call: 1-844-WPA-TIPS(1-844-972-8477)

Talk to TiPS team member, who will gather basic information and initiate a return
call from a TiPS child psychiatrist (within 30 minutes or at a time specified by PCP)



PCC and TiPS child psychiatrist consult via phone

TiPS care coordinator provides resources to PCC or family
Evaluation at a hub with TiPS licensed therapist or child psychiatrist, if needed

Three Paths of TiPS Care Coordination

1. Resources to PCP

2. Resources to Family and Follow-Up

3. Schedule TiPS Evaluation, Resources to Family, and Follow-Up

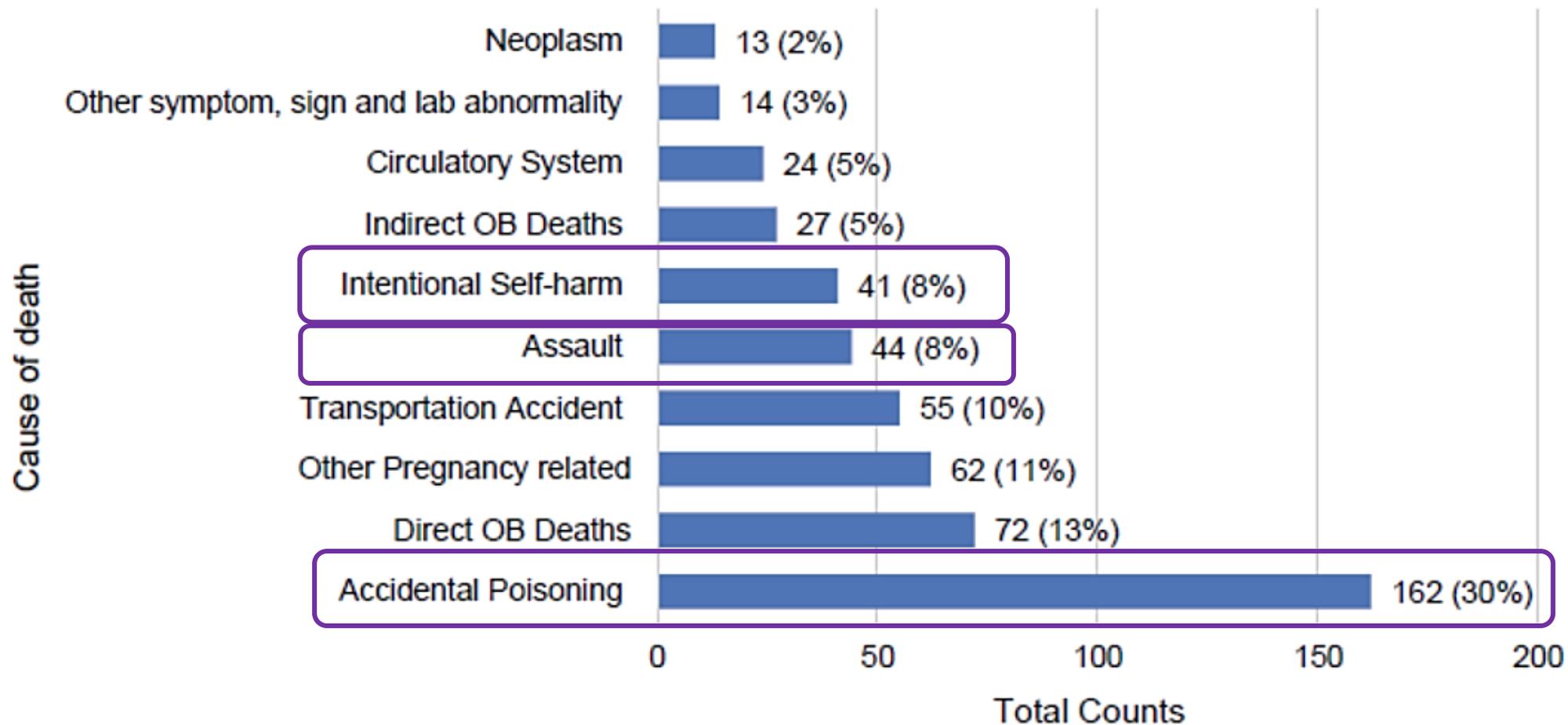
TiPS – One Year Data

- In the academic year ending June 2020
 - 1,391 questions telephonically
 - Direct consultation & bridge treatment for 388 distinct patients; 609 encounters
 - Over 200 providers in Western PA attended TiPS training in person
 - 100s of providers have attended regional webinars

Perinatal Access Lines



Figure 11. Leading Causes of Pregnancy-Associated Deaths in Pennsylvania, 2013 – 2018 (N=547)

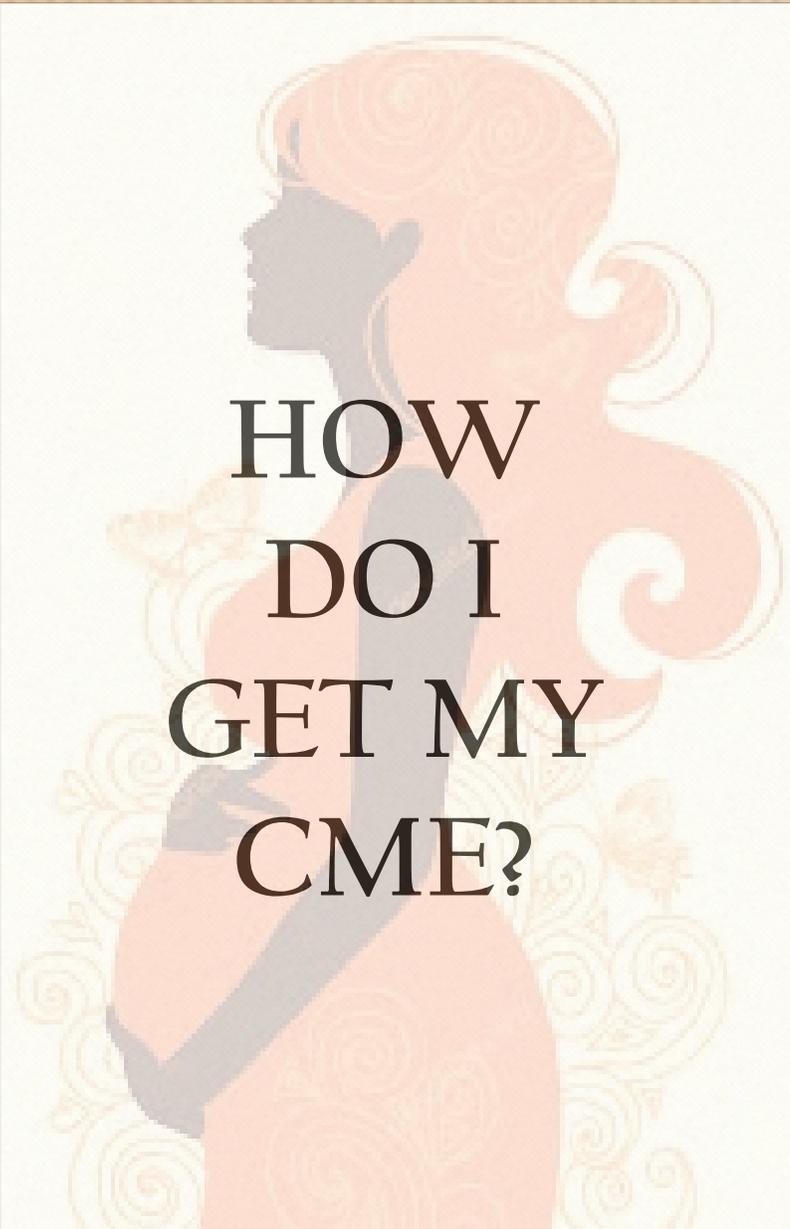


Note: Numbers rounded to the nearest whole.
Data Source: DOH Bureau of Health Statistics & Registries



Questions?

**Dr. Priya Gopalan: gopalanpr@upmc.edu
703-862-6945**



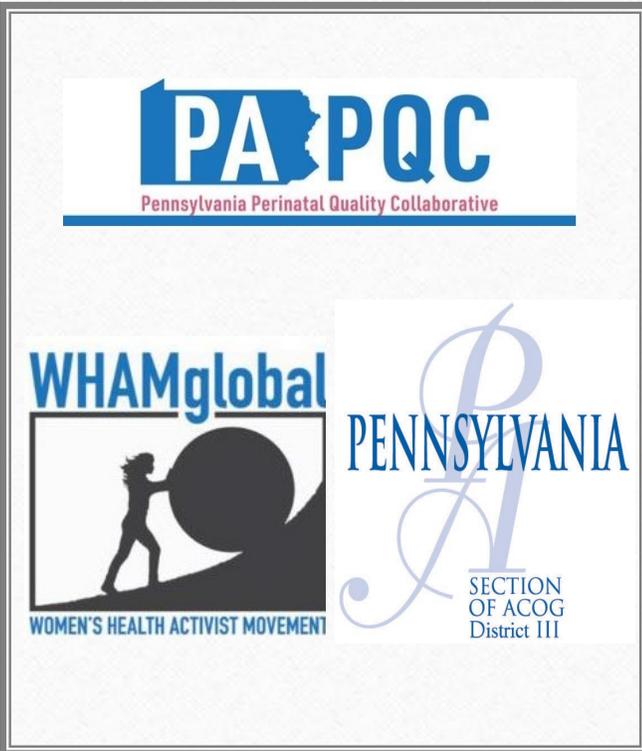
HOW
DO I
GET MY
CME?

Registered attendees, look for an email with a link to an online evaluation and attestation form on Wednesday.

The form will be open from: January 27th - April 30, 2021.
You must complete and submit the online evaluation and electronic attestation form by April 30th to receive CME credits.

If you have participated via Facebook Live or in a large group setting, please follow the link below to claim credits.
<https://form.jotform.com/210248083151143>

*Thank you for
joining us!*



HOW TO CLAIM CME:

- Registered attendees look for an email with a link to an online evaluation and attestation form on Wednesday.
 - The form will be open from:
January 27 – April 30, 2021

You must complete and submit the online evaluation and attestation by Friday, April 30, 2021.

- If you have participated via Facebook Live or in a large group setting, please follow the link below to claim credits.

<https://form.jotform.com/210248083151143>

Where to get help:

- **National Domestic Violence Hotline**

<http://www.thehotline.org/>

1-800-799-7233 (SAFE)

1-800-787-3224 (TTY for the Deaf)

- **Pennsylvania Coalition Against Domestic Violence**

<http://www.pcadv.org/>

<https://www.pcadv.org/find-help/find-your-local-domestic-violence-program/>

1-800-932-4632 (in Pennsylvania)

1-800-537-2238 (National)