RI MomsPRN
Maternal Psychiatry Resource Network

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE

BROWN Department of Family Medicine

# MomsPRN

## Session Topic: Behavioral Health Screening conversations and referral to treatment (including cultural considerations)

Facilitator: Mary Beth Sutter, MD

Faculty Presenter(s): Wilmaris Soto-Ramos, MSW, LICSW

Case Presenter(s): Wilmaris Soto-Ramos, MSW, LICSW

Date & Time: November 19th, 2024, 12PM-1PM

*PLEASE NOTE: Project ECHO case consultations do not create or otherwise establish a provider-patient relationship between any clinician and any patient whose case is being presented in a project ECHO setting*

*Care Transformation Collaborative of RI*

# Agenda

| Time | Topic | Presenter/Facilitator |
|---|---|---|
| 12:00 – 12:05 PM | Welcome & Faculty Introduction | Mary Beth Sutter, MD |
| 12:05 – 12:25PM | Didactic: | Wilmaris Soto-Ramos, MSW, LICSW |
| 12:25 – 12:40PM | Case Presentation | Wilmaris Soto-Ramos, MSW, LICSW |
| 12:40 – 12:55PM | Q&A and Discussion | Mary Beth Sutter, MD |
| 12:55 –1:00PM | Wrap up; Evaluation; Announcements | Susanne Campbell, CTC-RI |

# Welcome

Please note that the didactic portion of an ECHO session will be recorded for educational and quality improvement. The case presentation portion of an ECHO session will never be recorded.

Remember to never disclose protected health information (PHI), verbally or in writing, to preserve patient confidentiality.

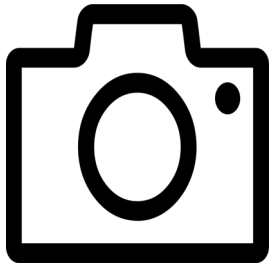
We are participating in an open and welcoming learning environment. Thank you for generously sharing your knowledge and experience so that all can benefit from it!

# Video Meeting Etiquette

Mute your microphone when not talking.

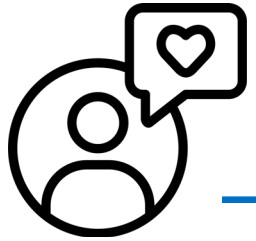
Limit distractions as best as possible.

Use reactions & the raise hand feature.



Engage and turn your camera on if you are able.

Use the chat to ask introduce yourself, ask questions and share resources.



Engage - ask questions, offer feedback, provide support.

# Faculty Introduction:

*Wilmaris is a Licensed Independent Clinical Social Worker (LICSW) with a strong focus on Perinatal Mental Health. She currently works as a Clinical Therapist at the Women and Infants Day Hospital Partial Program, where she provides essential support to pregnant and postpartum mothers dealing with Perinatal Mood and Anxiety Disorders (PMADs). In addition to her full-time role, Wilmaris runs a private practice dedicated to assisting individuals and couples who have endured pregnancy loss. Her expertise extends to offering support to those affected by PMADs. Wilmaris employs evidence-based treatment modalities such as Cognitive Behavioral Therapy, Mindfulness, and Cognitive Processing Therapy, among others. She's not only a dedicated mental health professional but also a survivor of pregnancy loss and PMADs, making her passionately committed to the well-being of Black Maternal Mental Health. Her mission is to continue helping mothers and their families on their journey to healing.*

# Disclosures

Session presenters have no financial relationships with a commercial entity producing healthcare-related products used on or by patients.

If CME credits are offered, all relevant financial relationships of those on the session planning committee have been disclosed and, if necessary, mitigated.

# Why this topic Matters:

- 1 in 5 Mother's are impacted by PMADS
- Suicide and overdose are the **leading cause** of death for women in the first year following pregnancy
- 1 in 10 fathers experience postpartum depression
- Women of color are **3-5x** more likely to experience complications during pregnancy and childbirth and die from these complications than white woman
- 75% of individuals impacted by Maternal Mental Health Conditions remain untreated, increasing risk of negative impacts on mother, babies and families
- 60% of Pregnancy-related deaths are **preventable**
- Now, more than ever, our mother's need us to listen, to see them, validate them and support them while creating a safe space for them

***Let's take a moment of silence to honor all of the women who have lost their lives due to pregnancy related complications***

*Maternal Mental Health Leadership Alliance. (n.d.). Fact sheets. Retrieved November 7, 2024, from https://www.mmhla.org/fact-sheets/*

# Learning Objectives:

- **Understand the Importance of Early Behavioral Health Screening in primary care and other settings:**
  Providers and other participants will learn the significance of timely behavioral health screenings, focusing on identifying mental health disorders early, and the impact these screenings have on improving patient outcomes.

- **Develop Effective Communication Strategies for Screening and Referrals:**
  Providers and other participants will explore techniques to conduct culturally sensitive behavioral health screening conversations and how to refer patients in primary care and other settings to the appropriate level of care

- **Enhance Referral Pathways to Treatment for Diverse Populations:**
  Providers and other participants will gain insights into ensuring that diverse cultural values, beliefs, and practices are respected when referring patients to appropriate treatment services.

# Historical Mistrust in Medical Settings:

- Due to a history of exploitation and unethical medical practices, many communities of color harbor mistrust toward medical institutions.
  - Ex. Tuskegee Syphilis Study and the sterilization of Puerto Rican women.

- **Impact:** This mistrust leads to decreased willingness to seek care, lower adherence to treatment, and sometimes avoidance of healthcare settings altogether for the BIPOC community
  - Local example: **PBS: The Risk of Giving Birth, Rhode Island**

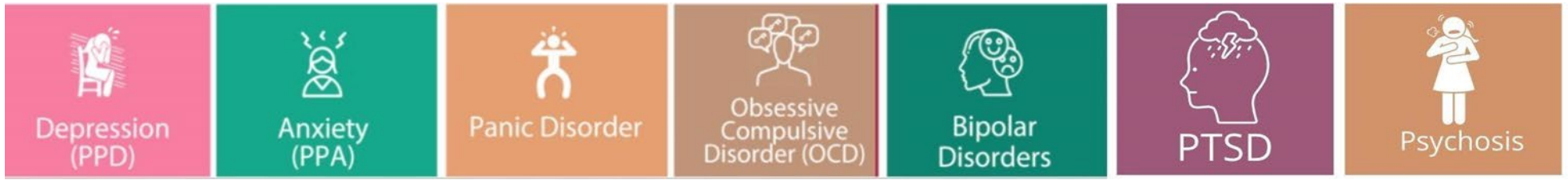
- Implicit Bias and Stereotyping:
  - Studies show that healthcare providers often hold unconscious biases, perceiving patients of color as being more likely to misuse pain medications, exaggerate symptoms, or be less compliant.

- **Impact:** These biases can lead to inadequate pain management, delays in diagnosis, and less effective treatment, which significantly harms health outcomes.
  - the effects on pregnant and birthing BIPOC women
  - fear of DCF involvement so symptoms are minimized leading to not having appropriate and timely care

# Understand the Importance of Early Behavioral Health Screening:

***Postpartum depression is the most under-diagnosed obstetric complication in the U.S. (Earls, 2010)***

- **Why do we screen?**
  - Screening saves lives
  - Screening patients often and consistently can lead to early identification of symptoms and needs for the patient i.e SDOH needs that may be impacting pts mood
  - Screening can be used to provide psychoeducation to the patient and their family
  - Screening is the "responsible, ethical and empathetic requirement"
  - For women who've experienced perinatal or infant loss, their chances of experiencing PMADs are twice as high
- **What are the recommendations for screening pregnant/postpartum patients?**
  - Universal screening
  - During an intake, second and third trimester
  - Two weeks postpartum and six weeks postpartum
  - During pediatric check-ups at 2, 4, 6, 9 and 12 months postpartum (ACOG, PSI)
- **Which evidence-based assessments are often used?**
  - **Edinburgh Perinatal Depression Scale (EPDS) → *Most effective for BIPOC Birthing Parents (Dr. Marissa Long, Seleni Institute)***
  - **Patient Health Questionnaire (PHQ-9)**
  - **General Anxiety Disorder (GAD-7)**
  - **The Beck Depression Inventory-2 (BDI-2) → *Most effective for BIPOC Birthing Parents (Dr. Marissa Long, Seleni Institute)***
- **What are we assessing for?**
  - PMADS and other needs




*https://training.seleni.org/p/black-perinatal-mental-health-training*

## Understand the Importance of Early Behavioral Health Screening Cont'd:

Screening is not meant:

- to call DCF on parents unless there is imminent risk ( *A situation where abuse has not yet occurred but is "ready to take place"*) to the child
- to make a parent feel bad about what they are going through
- ignore a patient's symptoms or cries for help/support

# Develop Effective Communication Strategies for Screening and Referral:

- Cultural competence vs cultural humility
  - *Cultural competence:* assumes that the provider is the "expert" on all cultures, assumes that all cultures can be understood through facts, presumes a universal and objective set of best practices
  - *Cultural humility:* The client is the "expert" on their culture and experiences, provider acknowledges that it is impossible to be thoroughly knowledgeable on a culture other than one's own
  - Allows for a subjective set of practices and efforts (*Seleni Institute*)

- **Building rapport with your patients is important!**
  - Go over the screening with patient before they leave
    - If scores are high, make referral suggestions if they are not currently working with a therapist
      - A therapist, The Day Hospital Program at W&I, Online Support Groups through PSI
  - Thorough responses to questions/concerns presented by patient/family
  - Provide options to consider rather than specific advice/direction
    - i.e. have you considered a doula? Would you like more information on their services?
  - Ask for feedback:
    - "How does this plan sound to you? How do you feel about this?"
  - **Treat your patient as a family member; they are in a very vulnerable time in their lives!**

# Develop Effective Communication Strategies for Screening and Referral:

| INTERPRETING THE GAD-7 | | |
|---|---|---|
| SCORE | RISK LEVEL | INTERVENTION |
| 0-4 | No to Low Risk | None |
| 5-9 | Mild | Provide general feedback, repeat GAD-7 at follow-up, consider adjusting treatment plan if not improving in last 4 weeks. |
| 10-14 | Moderate | Further evaluation recommended; For active treatment plans consider adjustment; For text therapy clients, monitor for synchronous therapy. |
| 15+ | Severe | Adjust treatment plan; focused assessment of safety plan and pharmacotherapy evaluation/re-evaluation; If emergent need then consider referral to higher level of care; Client is not a good candidate for text therapy/asynchronous. |

| INTERPRETING THE PHQ-9 | | |
|---|---|---|
| SCORE | DEPRESSION SEVERITY | PROPOSED TREATMENT ACTIONS |
| 0-4 | None | None |
| 5-9 | Mild | Watchful waiting; Repeat PHQ-9 at follow-up |
| 10-14 | Moderate | Treatment plan; Consider counseling and/or therapy |
| 15-19 | Moderately Severe | Active treatment with medication and/or therapy |
| 20-27 | Severe | Medication treatment and if member shows severe impairment and poor response to therapy, refer to mental health specialist or psychotherapy and/or collaborative management |

Sample script for providers when discussing symptoms/treatment options

*Daybreak Health. (n.d.). Understanding clinical metrics and how we use them at Daybreak. Retrieved November 7, 2024, from https://www.daybreakhealth.com/resources/understanding-clinical-metrics-and-how-we-use-them-at-daybreak*

# Develop Effective Communication Strategies for Screening and Referral Cont'd:

| EPDS Score | Action |
|---|---|
| Less than 8 | Continue support [a] |
| 9-11 | Support, re-screen in 2 to 4 weeks. Consider referral to Primary Care Provider (PCP) [a] |
| 12-13 | Monitor, support and offer education. Refer to PCP [a] |
| ≥14 | Diagnostic assessment and treatment by PCP and/or specialist [a] |
| A positive response (1,2,3) to Question 10 regarding suicidal ideation | Requires immediate action with a full risk assessment (plan – means, method, timeframe; prior history of suicide attempts, resources in terms of social supports or other protective factors). If the woman/person reports having a concrete and immediate plan for suicide, consider assessing them in the Emergency Room. Otherwise, arrange referral for mental health support, provide information about crisis phone lines, and develop a safety plan with the woman/person and their care team [a,b,c] |

## Beck Depression Scale Score Interpretation

| Total Score | Levels of Depression |
|---|---|
| 1-10 | these ups and downs are considered normal |
| 11-16 | Mild mood disturbance |
| 17-20 | Borderline clinical depression |
| 21-30 | Moderate depression |
| 31-40 | severe depression |
| Over 40 | Extreme depression |

*Perinatal Services BC. (n.d.). Clinical guidance. Retrieved November 7, 2024, from https://www.psbchealthhub.ca/clinical-guidance/796*

# Enhance Referral Pathways to Treatment for Diverse Populations:

- If traditional therapy is not something your patient has ever engaged with, ask them if they are a part of other support systems like:
  - A church community
  - A moms group (online or in person)
- Consult with colleagues on other referrals that they may be aware of
- Utilize the MomsPRN line for additional consultation on complex cases
- Schedule patient to come back sooner for a follow-up appointment if behavioral concerns are present
- Involve family in patient care if patient gives permission and if there are other concerns
- Continue to assess patient at each visit to ensure they are feeling supported and seen
- Maternal Mental Health Local and Online Resources

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# Moms PRN ECHO®
# Case Presentation

Presenter(s): Wilmaris Soto-Ramos, MSW, LICSW

Date: November 19th, 2024

Contact Info: wilmarissramos@gmail.com

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***Stop Recording***

# Basic Patient Information

Do Not Include PHI

| | |
|---|---|
| **Age** | 23 y.o |
| **Gender Identity** | Female |
| **Pregnancy/postpartum history** | G2P2, 2 y.o, 8 week old, experienced PPD with first born and now experiencing postpartum anxiety and attachment issues with newborn |
| **Who does the patient live with/family constellation?** | Patient lives with husband, mother, younger brothers |
| **Insurance type (Commercial, Medicaid, Uninsured, Other)** | United Health, Medicaid |

# Reasons for Selecting this Case

Do Not Include PHI

| | |
|---|---|
| | |
| **Presenting problem** | Patient had been experiencing vomiting, nausea, chest pain and low appetite around three weeks postpartum. She presented to the ED several times thinking she was getting very ill, labs were run but ED providers told her she is ok and they could not find anything wrong. The third time she showed up, they recognized her and psych was called, she was further assessed and was dx with postpartum anxiety. She was directly admitted to DHP after her third ED visit with the above complaints. |
| **What questions do you have for the group?** | What could the ED department have done differently on patient's first visit? (*keeping in mind language barrier and recently postpartum*)<br>What services could have been offered?<br>What other interventions could have been suggested at time of ED visit?<br>Would her care have looked differently if she was non-hispanic Spanish-speaking? If so, how? |

# Relevant Background

Do Not Include PHI

| | |
|---|---|
| | |
| **Relevant medications** | Past medications tried: Lexapro and currently on Hydroxyzine, PRN as she does not want to depend on medication and is afraid of long-term effects |
| **Relevant lab results** | |
| **Relevant BH hx Screening results** | Recent screenings: GAD-7, 12, PHQ-9: 18, Edinburgh, 11, no to question 10 |
| **Relevant SDOH Screening results** | Unemployed, receiving WIC, SNAP, living with a lot of people in the home currently |
| **Other team members involved (OB/PCP/Neonatal/behavioral health /doula/family visitor/lactation consultant** | Offered doula services but turned service down as her mom is helpful, OB, Day Hospital Program |
| **Any previous interventions** | Was in therapy for about a year after she experienced a depressive episode a couple of years ago. Found it helpful and felt better after a year of therapy |

# Relevant Social History

Do Not Include PHI

| | |
|---|---|
| **Family history?** | No significant history of mental health in her family |
| **Race/Ethnicity/Language/culture?** | Guatemalan, Spanish-speaking |
| **Relevant work/school history?** | Currently not working and has not been for some time |

# Patient /Family Successes and Strengths?

Do Not Include PHI

## Patient/family Success/Strengths

- Patient is an advocate for herself
- Treatment compliant
- Has family support from mother and FOB
- Honest about her symptoms and what she's experiencing
- Feeling better since coming to DHP

## What matters to patient/family

- Patient wants to continue bonding with her daughter while working on her mental health
- Patient and her family want her to feel better and encourage her to seek the care she needs

# Questions? And Contact information

Thank you!

wilmarissramos@gmail.com

beginagainri@gmail.com

https://www.beginagainri.com/

# Evaluation & CME

- Please provide us your feedback!
- Evaluation/Credit Request Form : https://www.surveymonkey.com/r/MomsPRNECHOeval
- Anyone requesting CME credits or SW CEU credits, or a certificate of participation must fill out the evaluation.
- All participants that signed up to be “full” participants, must complete the evaluation to be counted for attendance.
- Certificates will be emailed ~30 days from today’s ECHO® session.

*Application for CME credit has been filed with the American Academy of Family Physicians. Determination of credit is pending.*

*Application for SW CEU credit has been filed with the NASW RI Chapter. Determination of credit is pending.*

# Announcements & Reminders

| | |
|---|---|
| **Recording, Presentation & Evaluation link** | Will be emailed today |
| **Certificates of Participation:** | October CME Certs will go out this week<br>November CME Certs will go out next month |
| **Next Session Date:** | December 17, 2024, noon-1PM |
| **Topic:** | Perinatal Anxiety and Obsessive-Compulsive Disorder (OCD) |
| **Presenter:** | Zobeida Diaz, MD, MS |


THANK YOU!