Welcome RI MomsPRN Practices

Maternal Psychiatry Resource Network

November 26, 2024 Kickoff Meeting

Lifespan
Physician Group, Inc.
Obstetrics & Gynecology
Delivering health with care®

VICTA

Tri-County
Community Action Agency
Helping people. Changing lives.

Care New England
Family Care Center

Agenda

Topic *Presenter*	Timing
Welcome and Introductions *Jim Beasley, MPA, RIDOH Program Manager*	5 minutes
Practice Report Outs *VICTA* *Tri-County* *Lifespan OB/GYN* *Family Care Center*	30 minutes
New Funding Opportunity Discussion *Jim Beasley, MPA, RIDOH Program Manager*	20 minutes
Next steps *Susanne Campbell, RN, MS, PCMH CCE, CTC-RI Senior Program Administrator*	5 minutes


VICTA
"Empowering Individualized Recovery"
110 Elmwood Ave Providence RI 02907
401-300-5757

PDSA plans and progress

AIM

- **For perinatal clients at VICTA to have a menu of supports available to them as they navigate pregnancy and parenting. These resources to include community agencies, written materials as well as their own treatment and follow-up plans.**

PLAN

- **Consider staff workflows, staff training, EHR reporting**

DATA

- **Completed staff knowledge survey for baseline measurement**

SUCCESSES

- **Cross-training provided for community providers including WIC, breastfeeding supports; staff visit to WIH neonatal unit for orientation; connected with Doulas**

CHALLENGES

- **Gaps in continuum of care for pregnant persons experiencing withdrawal**

What are you excited about? Share success story

- Dr. Diaz was able to join a meeting where we had a very in-depth multidisciplinary team consult on a pregnant client with extensive history of SUD and DCYF involvement who remains ambivalent about abstinence. Between her feedback and the various 'lenses' of the provider team, multiple potential interventions and strategies were developed to help maintain engagement and encourage any positive change.
- VICTA was asked to present about our SUD services for the WIC nutritionist team meeting and did so on 11/14/24.
- The identified gap in available services for pregnant people experiencing withdrawal presents a systemic opportunity to explore partnerships and expand upon existing expertise to create new projects to target a very underserved population.

Reminder: Do not include any protected health information (PHI)


Tri-County
CommunityAction Agency

TriCounty MomsPRN – 11/26/24 Learning Collaborative Mtg.

PDSA #1 and progress

Aim: By September 1,2024 we will be screening 90% of patients for safety and intimate partner violence

Plan:

- Additional workflow specific for safety and DV screening
- Train EHR documentation
- Data testing
- Gather available resources

Data - 64% perinatal patients screened using PRAPARE tool;

Successes:

- Don't rely on electronic mechanism to fill out screenings, rather have patient fill out assessment in exam room/real time; allows for contacting BH on the spot
- Monthly OB team mtg – discuss screenings, IPV, and now adult immunizations

Challenges

- Behavioral health depart. Changes – limited availability for warm handoffs; true emergencies (acute safety concerns) will be seen
- Loss of BH staff (but one recently returned from medical leave)
- Outpatient BH can schedule patients (ease clinicians time) (prioritize DULCE/MomsPRN program patients)

TriCounty MomsPRN – 11/26/24 Learning Collaborative Mtg.

PDSA #2 and progress

Aim: By January 1,2025 100% of *undocumented patients with positive BH* screens will have a warm hand-off to Behavioral Health and be screened for PTSD

Plan:

- Review current process for referral to counseling and resources
- Increase staff competency/capacity in responding to undocumented patient/family psycho-social stressors

Data: as of 11/5 there have been 0 positive screens for IPV and Safety most likely due to lack of trust, language barrier and limited knowledge of our system of care

Successes:

- We recognized early enough to change our process to the new AIM statement

Challenges:

- We have recognized that screening this population for IPV & Safety will result in false negatives
- Post traumatic stress with patients out of the country/undocumented patients – they hesitate to fill out PRAPARE screening with negative; Hearing in the community an uptick on restraining orders; domestic violence

TriCounty MomsPRN – 11/26/24 Learning Collaborative Mtg.

What are you excited about? Share success story

- Some patients have had experience with DCYF, TriCounty connection / support of handling this challenge
- One patient with 2nd child, DCYF involvement (first child also involved); FS and provider offering support
- Coordination with case worker; attend team mtg with patient; advocating through this experience
- Highlighting patient strengths – follow up with resources and DCYF mandated appointments
- Patient resiliency; hand holding
- Patient also has history of domestic violence; not always realized by the patient (re: unhealthy relationship/ unsafe for family)
- Successful, comprehensive team to help support these patients
- Many prenatal patients of Tri-County come back to the health center with their newborn

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PDSA #1: Improve staff/provider comfort in behavioral health screening

- **Aim:** Increase staff/provider competency and comfort in working with patients with behavioral health concerns.
- **Plan:** Targeted education/training for each staffing group (MD/DO/CNM, RN, MA) based on expressed needs of the group. Change will be measured with pre/post testing of comfort and confidence ratings.
- **Data:**
  - Providers = 7, RN = 7, MA = 8
  - Scale 0 – not at all, 1 – slightly, 2 – neither/nor, 3 – moderately, 4 – very
  - $\leq$2 – area of immediate need, $\geq$3 – strength

Responding to a patient crying in office/on the phone
Providing depression/anxiety screening measures
Interpreting behavioral health screening results
Discussing behavioral health treatment options
Assessing safety for patient expressing SI/HI
Recognizing signs/symptoms perinatal depression
Recognizing signs/symptoms perinatal anxiety

Responding to patient crying in the office

Providing dep/anx screenings.

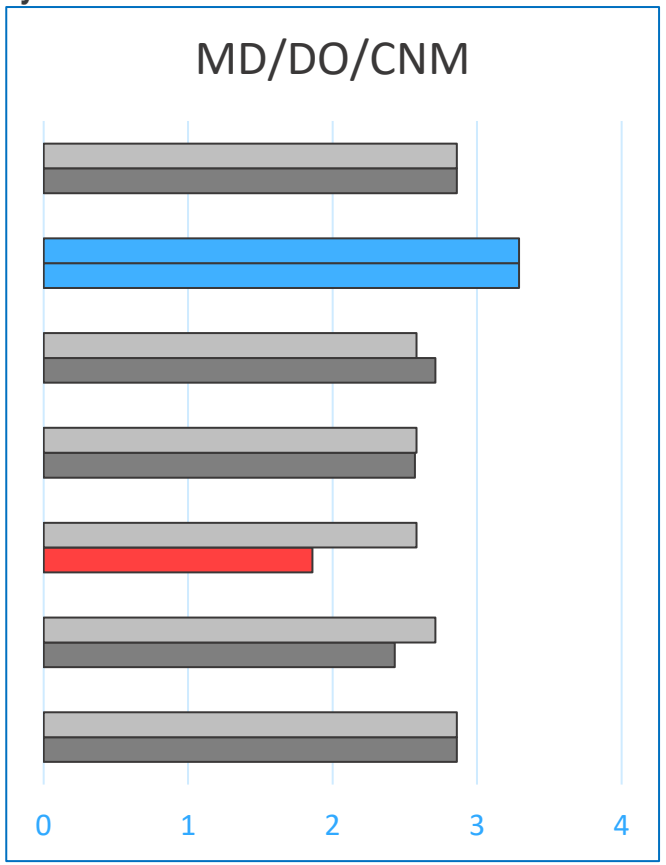
Interpreting screenings.

Discussing BH treatment options.

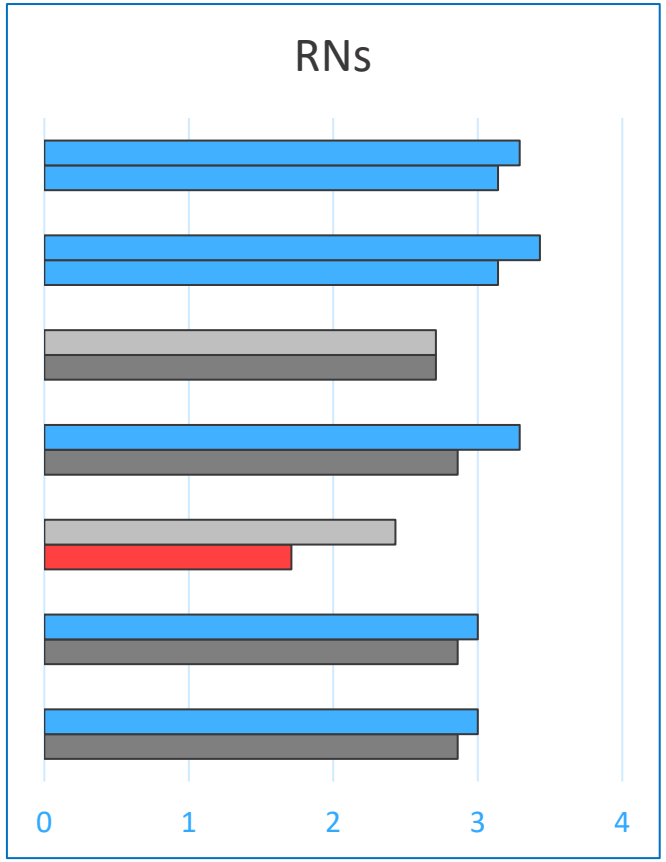
Assessing SI/HI safety.

Recognizing s/s perinatal depression.

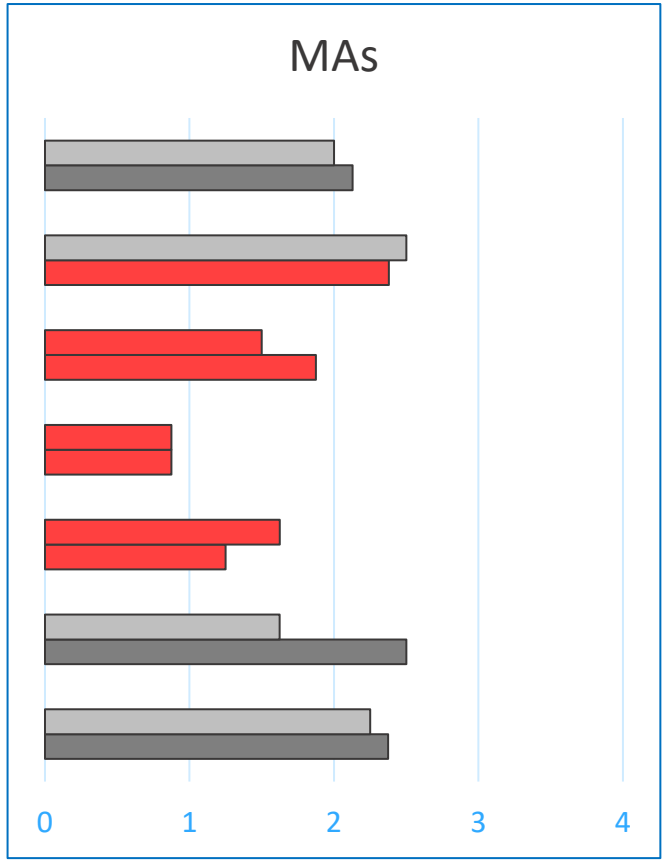
Recognizing s/s perinatal anxiety.



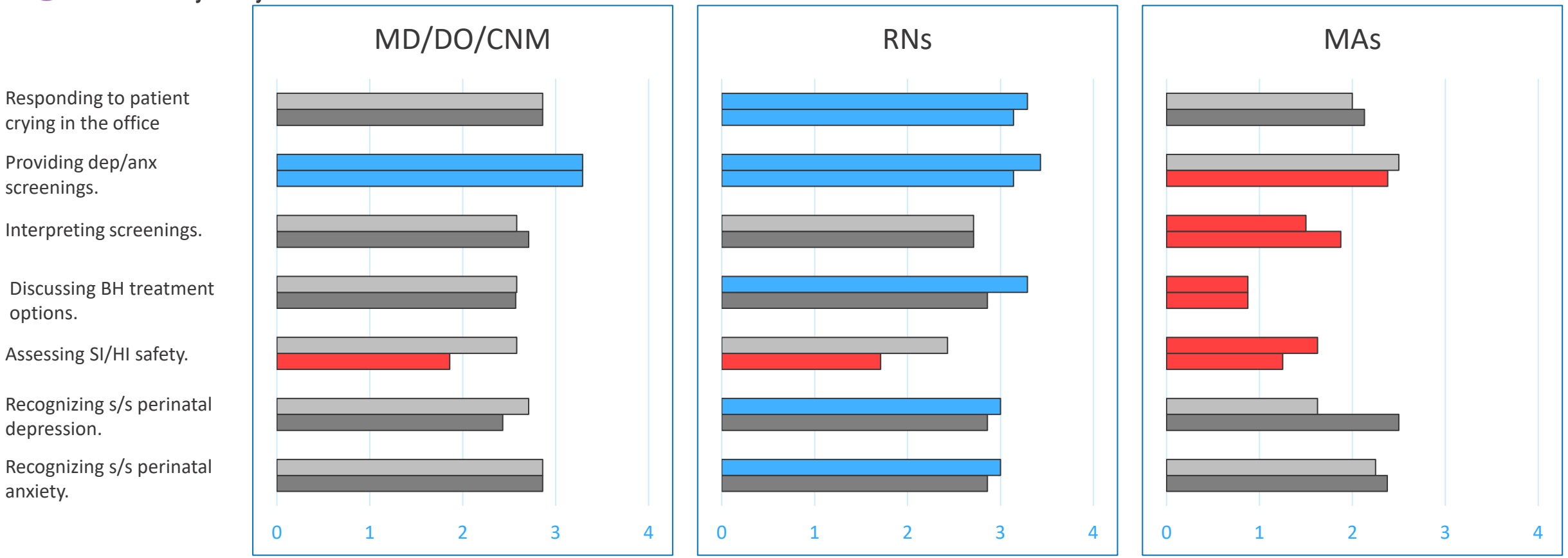
Strengths: Providing screening tools
Area of need: SI/HI assessment



Strengths: Responding to patients crying, providing screening tools, discussing treatment options, recognizing s/s dep/anx
Area of need: SI/HI assessment



Strengths: -
Area of need: providing screening tools, interpreting screening measures, discussing treatment options, SI/HI assessment



Verbal and non-verbal communication, concern of "doing the wrong thing;" psychiatric medications and related response, updates on depression/anxiety and treatments.

Responding to high PHQ/GAD scores on the phone or portal, helping patients prepare for postpartum (normative adjustment, depression, anxiety), behavioral health treatment options, SI/HI/crisis care

SI/crisis, behavioral health treatments, substance use care options, grief/bereavement following perinatal loss

PDSA #1: Improve staff/provider comfort in behavioral health screening

- **Successes:**
  - Identifying a common need – SI/HI, crisis, safety care.
  - Highlighting the need for more robust training and support for MAs.

- **Challenges**
  - Scheduling appropriate training for each staffing group.
  - Creating a culture of knowledge and support.
  - Identifying strategies to improve providers' confidence/comfort in interpreting screening measures, recognizing s/s of anxiety and depression, and discussing treatment options.

PDSA #2: Improve mid-pregnancy behavioral health screening rates

- **Aim:** Improve behavioral health screening in mid-pregnancy.
- **Plan:** Anxiety (GAD-7) and depression (PHQ-9) screening will be added into the clinical workflow in 2nd and 3rd trimesters of pregnancy.
- **Data:**
  - 1st trimester and postpartum depression screening rates are >95%
  - Baseline: 2nd trimester – 16.3%, 3rd trimester – 2.9%
- **Successes:**
  - Successfully shifted from EPDS to PHQ-9 at all measurement points.
  - Introduced a new workflow with MAs using a modified pregnancy checklist in Epic, implemented 10/01/2024.
- **Challenges**
  - Developing a workflow to integrate front desk staff
  - MAs/Providers remembering to provide screeners to patients, tying to GDM screening and TDAP.

Care New England
Family Care Center

PDSA plans and progress #1- Screening

- Aim- Increase screening rates for PHQ-9, GAD-7, and NIDA in the first and third trimesters, and postpartum
- Plan
  - Assign prenatal MA
  - Include screenings in routine for rooming patients
  - Develop Epic report to track outcomes
- Data- Baseline 0 screens prenatally, had consistent Edinburgh only postpartum
- Successes
  - Able to identify and assign role for prenatal MA
  - Behavioral health packets included with rooming routine, shared at team meeting
- Challenges
  - Epic report still in process
  - Ongoing training with MA's and residents

PDSA plans and progress #2 Postpartum support

- Aim- Increase support for postpartum parents in the community to combat isolation
- Plan
  - Needs assessment for community groups
  - Work with Children's Friend to identify a curriculum and space for holding groups
- Data
  - Baseline survey indicated need/ desire for group
- Successes
  - Partnership established with CF for group facilitation
  - Identified Strong Roots curriculum
- Challenges
  - Need to iron out details for group logistics
  - Need to recruit members for group

What are you excited about? Share success story (if applicable)

Enthusiasm for perinatal mental health support in our clinic, building energy and momentum for screenings and perinatal health care among staff and residents.

Excited for future groups with Children's Friend

Reminder: Do not include any protected health information (PHI)

New Funding Opportunity Discussion

Here's what we heard from past RI MomsPRN programs

What clinical or operational topics should be covered with the next practice cohort to ensure success?
MULTIPLE - Education about MOMS PRN and what services are available.
MULTIPLE - Substance use disorder management, referral with specific topics on cannabis use (now that it is legal in RI, best ways to approach this, reporting etc.) and alcohol use in pregnancy.
MULTIPLE – bipolar disorder/PTSD/trauma informed care topics
MULTIPLE - More on motivational interviewing!
Drug dependency, depression, anxiety, etc.
Increased support for substance abuse screening and treatment since there are 2 delays
Improving referral workflows and tracking referrals, increased interval data analysis to show process improvements rather than only summary data.
psychiatric drugs used in pregnant women
Access to therapy services
More info on non-medical alternatives to depression anxiety and substance use
Expanding access for telemed, especially for postpartum/medically underserved
Updates on the Epic build for Social Work and community-based referrals.
accessibility
DCYF involvement noted above
best clinical practice techniques, evidence based treatments
I think we should walk through a referral process from beginning to end, and what happens on the other end of the line
medications review, how to coordinate btwn the many resources in the state
In house substance abuse support
where to refer patients in community
continued ed about psych meds and esp the new meds
domestic violence, stimulant use, h/o eating disorders
Billing

RI MomsPRN
Maternal Psychiatry Resource Network

ADVANCING INTEGRATED HEALTHCARE

ECHO Focus: Evidence based trauma informed, culturally and linguistically appropriate professional education on maternal behavioral health screening, brief intervention treatment, referral to care, follow up support and linkages to community resources.

Dates	Topics	Speakers	Case Presenters
Sept 17	Understanding the needs of birth people with substance use disorder	Margo Katz	Katie Gonzalez
Oct 15	Trauma informed care (including cultural considerations and implicit bias)	Carrie Griffin, MD	Bringing own case
Nov 19	Behavioral Health Screening conversations and referral to treatment (including cultural considerations)	Wilmaris Sotoramos LICSW	Bringing own case
Dec 17	**Perinatal Anxiety and Obsessive-Compulsive Disorder (OCD)**	**Zobeida Diaz, MD, MS**	**Person with Lived Experience**
Jan 21, 2025	Cannabis- what's the evidence and having the conversation	Mara Coyle, MD	Bringing own case
Feb 18, 2025	Engaging with Doulas-Empowering birthing people	Quatia Osorio, BS-HSM, BSBA, SPM	Nicole Siegert (BVCHC)
Mar 18, 2025	DCYF	Ashley Deckert, MSW, MA, Director & Stevens Robillard	Suzanne Lowe (Tri-County)
Apr 15, 2025	Using Interpreter Services	Libertad Flores, MD	Meghan Sharp (Lifespan OBGYN)

Suggestions for future topics from ECHO Session Evaluations

SEPT ECHO

- Childhood ACEs
- Can we deep dive into stressors, stress and coping?
- I would like to see a wide span location wise of resources i.e. newport area
- homeless pregnant women and mothers and their children homeless
- Detox and treatment options for women who are pregnant.

OCT ECHO

- This session should include a part two to dive deeper into the effects (toll) of working with traumatized clients/patients on our working professionals.
- Inclusive of transgender community - community
- I really would like to learn more about post partum depression and how your brain reacts and why it happens and how to manage it and understand psychosis state of post partum as well.
- Dive deeper on treating substance use disorder in pregnancy

New Funding Opportunity Discussion

We want to hear from you…

Rhode Island MomsPRN Milestone Document

Deliverable	Due Dates	Notes
10-month Practice Team Expectations – June 2024 to March 2025		
Utilize the RI Moms PRN provider teleconsultation line as needed- (401) 430-2800 (Mon-Fri 8 am–4 pm) Quality improvement team **meets monthly with practice facilitator** with additions of WIH/RIDOH staff (as needed)	On-going Practice Team Responsibilities	RI MomsPRN WIH Website
Quality Improvement (QI) team to attend Orientation meeting	June 11, 2024 Noon – 1:00PM	Meeting is recommended for Practice Lead and Provider Champion
PDSA #1: Submit baseline performance and area of focus using the Plan-Do- Study-Act approach that will optimize clinical workflow on topics such as: improving maternal behavioral health screenings, brief intervention, treatment, referral to care, follow up support and linkages to community resources.	August 5, 2024	Submit baseline Plan-Do-Study-Act (PDSA) to: RIDOH@ctc-ri.org Practices that elect to focus on improving screening results are eligible for $1500 supplemental payment.
PDSA #2 (for practices that selected supplemental funding to improve screenings): submit a 2nd PDSA outlining measures to be improved, plan and baseline data (including definition of inclusion/exclusions).	August 5, 2024	Baseline data should consist of numerator of patients screened looking 12 months back (July 1, 2023 – June 30, 2024 / total number of perinatal patients. Compass+ practice should use their measurement specification.
Attend as a full or flexible participant 6-month ECHO Learning Sessions	September 17, 2024 October 15, 2024 November 19, 2024 December 17, 2024 January 21, 2025 February 18, 2025 Noon – 1:00PM	As full participant, attendance is required at 4 out of 6 sessions plus a case presentation for $250 stipend.

Rhode Island MomsPRN Milestone Document (continued)

Deliverable	Due Dates	Notes
10-month Practice Team Expectations – June 2024 to March 2025		
Submit mid-point performance PDSA updates.	November 5, 2024	Submit mid-point PDSA to: RIDOH@ctc-ri.org Data: (July 1 – September 30th)
Quality Improvement (QI) team to attend mid-point meeting and report out on PDSA results: Data Key learnings (successes/challenges)	November 26, 2024 Noon – 1:00PM	Provider Champion and QI team lead is required.
Submit final PDSA results with key learnings and patient story.	**February 25, 2025**	**Submit final PDSA and PPT to: RIDOH@ctc-ri.org** **Data: (October 1 – January 31st)**
Quality Improvement (QI) team to attend Final meeting and report out on PDSA results: **Final PDSA Results** **Screening Results for those practices that chose the supplemental payment option.** **Key learnings (successes/challenges)** **Patient story**	**March 11, 2025** **Noon – 1:00PM**	**Provider Champion and QI team lead is required.**

Next Steps

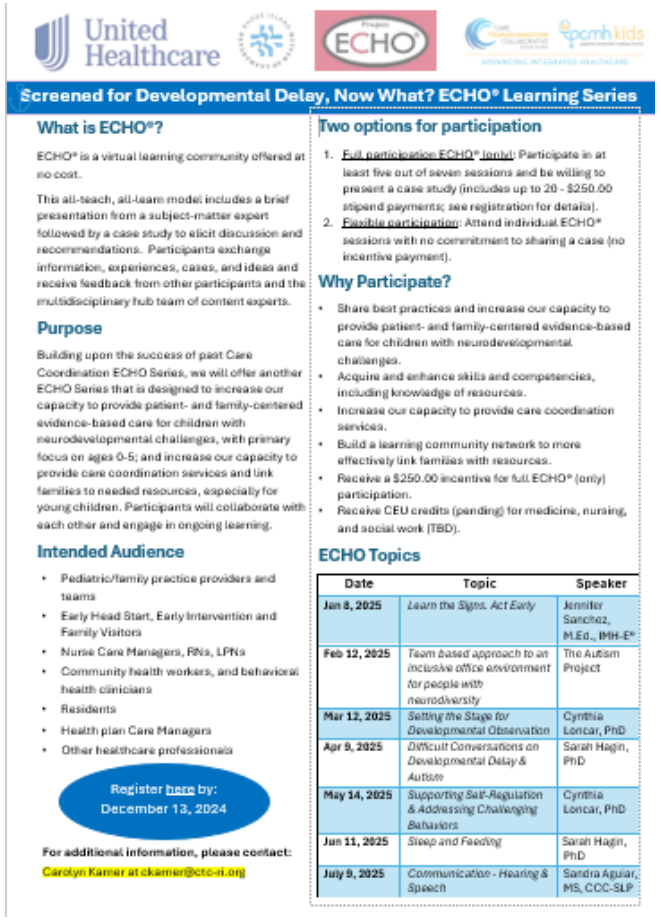
- Final PDSAs due: February 25, 2025

- Next Meetings:

  ECHO Learning Session: Tuesday, December 17, 2024, noon - 1:00PM
  Perinatal Anxiety and Obsessive-Compulsive Disorder (OCD) by Zobeida Diaz, MD, MS

  Final Learning Collaborative Meeting: March 11, 2025, noon – 1:00PM

Screened for Developmental Delay, Now What? ECHO® Series



United Healthcare | Project ECHO

Screened for Developmental Delay, Now What? ECHO® Learning Series

What is ECHO®?

ECHO® is a virtual learning community offered at no cost.

This all-teach, all-learn model includes a brief presentation from a subject-matter expert followed by a case study to elicit discussion and recommendations. Participants exchange information, experiences, cases, and ideas and receive feedback from other participants and the multidisciplinary hub team of content experts.

Purpose

Building upon the success of past Care Coordination ECHO Series, we will offer another ECHO Series that is designed to increase our capacity to provide patient- and family-centered evidence-based care for children with neurodevelopmental challenges, with primary focus on ages 0-5; and increase our capacity to provide care coordination services and link families to needed resources, especially for young children. Participants will collaborate with each other and engage in ongoing learning.

Intended Audience

- Pediatric/family practice providers and teams
- Early Head Start, Early Intervention and Family Visitors
- Nurse Care Managers, RNs, LPNs
- Community health workers, and behavioral health clinicians
- Residents
- Health plan Care Managers
- Other healthcare professionals

Register here by: December 13, 2024

For additional information, please contact:
Carolyn Kanner at ckanner@cte-ri.org

Two options for participation

1. Full participation ECHO® (only): Participate in at least five out of seven sessions and be willing to present a case study (includes up to 20 - $250.00 stipend payments; see registration for details).
2. Flexible participation: Attend individual ECHO® sessions with no commitment to sharing a case (no incentive payment).

Why Participate?

- Share best practices and increase our capacity to provide patient- and family-centered evidence-based care for children with neurodevelopmental challenges.
- Acquire and enhance skills and competencies, including knowledge of resources.
- Increase our capacity to provide care coordination services.
- Build a learning community network to more effectively link families with resources.
- Receive a $250.00 incentive for full ECHO® (only) participation.
- Receive CEU credits (pending) for medicine, nursing, and social work (TBD).

ECHO Topics

Date	Topic	Speaker
Jan 8, 2025	*Learn the Signs. Act Early*	Jennifer Sanchez, M.Ed., IMH-E®
Feb 12, 2025	*Team based approach to an inclusive office environment for people with neurodiversity*	The Autism Project
Mar 12, 2025	*Setting the Stage for Developmental Observation*	Cynthia Loncar, PhD
Apr 9, 2025	*Difficult Conversations on Developmental Delay & Autism*	Sarah Hagin, PhD
May 14, 2025	*Supporting Self-Regulation & Addressing Challenging Behaviors*	Cynthia Loncar, PhD
Jun 11, 2025	*Sleep and Feeding*	Sarah Hagin, PhD
July 9, 2025	*Communication - Hearing & Speech*	Sandra Aguiar, MS, CCC-SLP

Registration link:

https://www.surveymonkey.com/r/DD-NowWhat-ECHOReg


thank you
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格雷西
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