Collaborative Care in Perinatal Settings

May 9, 2024

MC3 zero TO THRIVE PRISM

Learning objective

- Describe the Collaborative Care Model and its use with perinatal patients.

About the presenters

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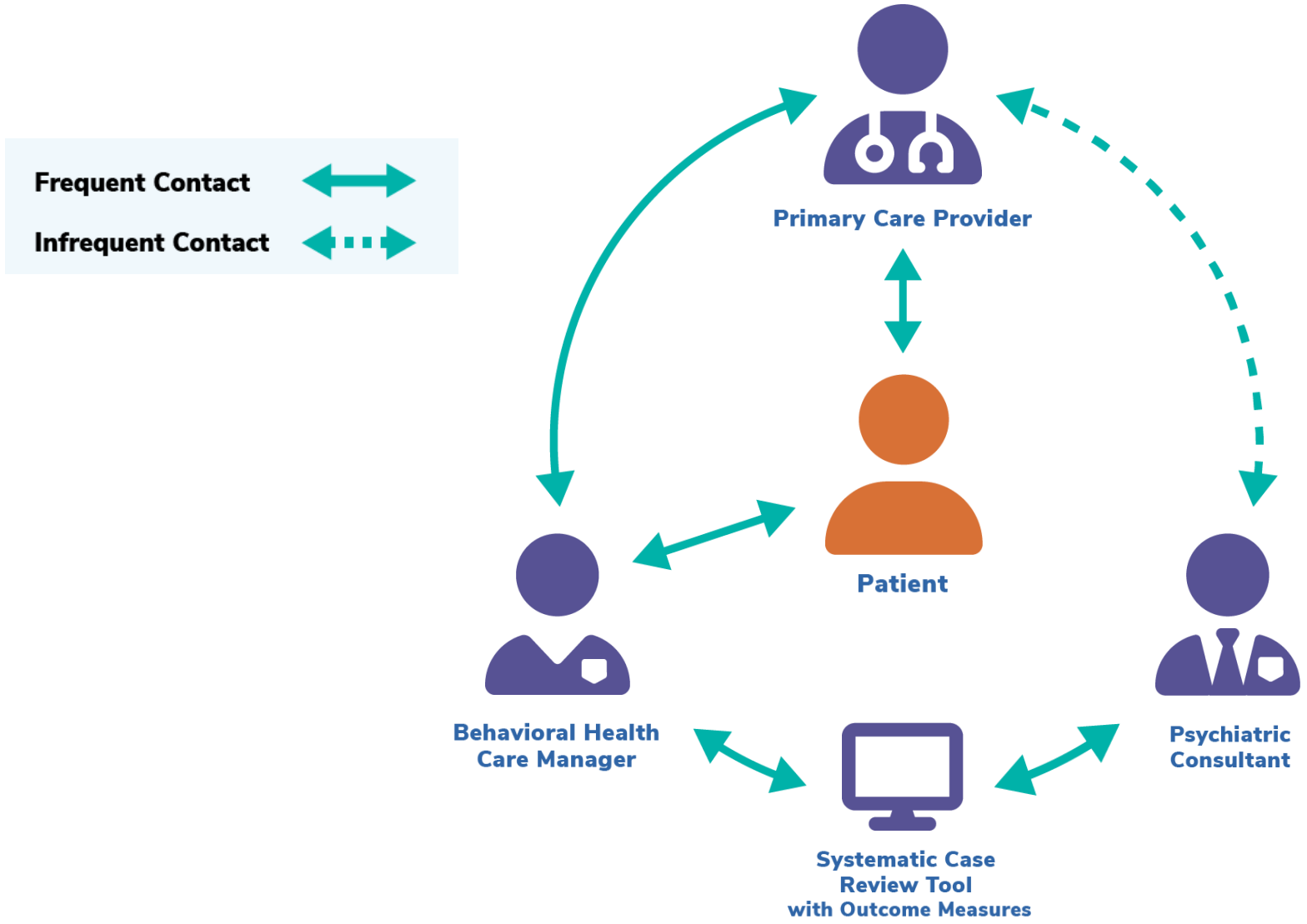
Collaborative Care treatment team



Role of the treating or specialty care provider in CoCM

- **Oversees all aspects of a patient's care**
- Screens for common mental health issues
- Introduces collaborative care and refers patients to the program
- Receives recommendations from the psychiatric consultant and determines whether to accept them
- **Prescribes medications as needed**

Role of the behavioral health care manager (BHCM) in CoCM

- **Manages caseload** of enrolled Patient using the systematic case review tool
- Provides **brief behavioral interventions** and supports medication management
- Tracks treatment response and side effects using **standardized scales**
- Supports patient through **self-management planning**, safety planning and relapse prevention planning
- Participates in **weekly caseload consultation** with the psychiatric consultant

Role of the Psychiatric Consultant (PC) in CoCM

- Participates in **weekly caseload consultation** with the behavioral health care manager
- **Recommends treatment** adjustments, including medications and other interventions
- Educates the rest of the team on psychopharmacology
- **Does not see patient directly**
- **Does not prescribe medications**

Role of the patient in CoCM

- Consents to enrolling in collaborative care
- Reports **symptoms and side effects**
- Learns about the nature of their mental health condition
- Determines which types of **treatments to accept**
- Creates self-management and relapse prevention plans with the behavioral health care manager

Identifying patients for CoCM

Persons who are cared for **during perinatal period**:

- Pregnancy
- Postpartum (up to 1 year after childbirth)
- Experienced reproductive loss (up to 1 year post loss)

And have mild to moderate **co-occurring mental health needs**:

- Diagnosis of depression and/or anxiety (often historical per chart)
- Current PHQ-9 and/or GAD-7 of score of approximately 10+
- There is some flexibility in which patients can be managed by this model

Boundaries are blurry at times

- Hormonal changes may reactivate symptoms or make presentations more complex
- Mild symptoms may not meet criteria for MDD or GAD
  - Grief and loss, adjustment difficulties, mild depression and/or anxiety
  - Use clinical judgment – mild cases may benefit from CoCM and prevent worsening
- Moderate symptoms also may fall into different diagnosis categories
  - Bipolar II disorder, PTSD, personality disorders
- Consider OB/GYN practice workflow when identifying patients
  - Explore following patients at frequent intervals for longer
  - Explore coordinating CoCM services if plan is to discharge patient back to their treating provider

Special considerations for treating perinatal patients (1 of 2)

- Flexibility needed—may continue working with a patient who has suffered a loss then becomes pregnant again, etc.

- High prevalence of trauma among women
  - Past (developmental, relational), new (related to current perinatal episode) or ongoing (experiencing intimate partner violence)
  - Perinatal period may “re-activate” previous trauma
  - Previous trauma may make women more susceptible to new trauma in the perinatal period

- Racial differences in the perinatal experience
  - Discrepancy in mortality rates
  - Systemic racism

Special considerations for treating perinatal patients (2 of 2)

- Patients and providers may have strong feelings about medications
- Identity changes
  - Unique experiences of what it is to be pregnant, what it is to be a parent, etc.
- Body and life changes
  - Work, partner relationship, etc.
- Cultural differences
  - Variety of cultural practices and attitudes towards pregnancy and postpartum

Severe patients need a higher level of care

- PHQ or GAD **scores greater than 19**
- Patients **not showing improvement** despite careful monitoring and treatment adjustments
- Patients who are **struggling to function** and can't care for self or children
- Patients with **safety risks or concerns**
  - Active safety concerns including active suicidal ideation
  - Severe substance use disorders
  - Active psychosis-like delusions or mania
  - Significant developmental disabilities
  - Personality disorders requiring long-term specialty care
- Patients with **complex diagnoses and unstable symptomology**
  - PTSD/personality disorder, bipolar I – mania in past, schizophrenia, schizoaffective disorder

Perinatal depression

Major depressive disorder (DSM V):

- Five or more symptoms during the same 2-week period and at least one of the symptoms should be either:
  1. depressed mood or
  2. loss of interest or pleasure.

- Must cause marked distress or dysfunction

S: sleep-too little or too much

I: loss of interest in things previously found pleasurable

G: excessive feelings of guilt

E: low energy

C: poor concentration

A: appetite-increase or decrease

P: psychomotor retardation; moving or responding very slowly

Depression can occur during pregnancy as well as postpartum. The DSM V puts more strict time frames on when a depressive episode can be called postpartum depression. In practice, we tend to give this diagnosis if the episode occurs within the first year postpartum.

Patient Health Questionnaire-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Not at all 0	Several days 1	More than half the days 2	Nearly every day 3

1. Little interest or pleasure in doing things
2. Feeling down, depressed or hopeless
3. Trouble falling or staying asleep or sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down
7. Trouble concentrating on things such as reading the newspaper or watching television
8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual
9. Thoughts that you would be better off dead, or of hurting yourself

PHQ-9 scoring

Score	Severity
0-4	None-Minimal
5-9	Mild
10-14	Moderate
15-19	Moderately Severe
20-27	Severe

CoCM inclusion

- Score is approximately >10
- Or if inclusion is clinically indicated

Question 9

- Further assess acuity of ideation to determine if CoCM is appropriate

Edinburgh Postnatal Depression Scale (EPDS)

Since you are either pregnant or have recently had a baby, we want to know how you feel. Please place a CHECK MARK (✓) on the blank by the answer that comes closest to how you have felt IN THE PAST 7 DAYS—not just how you feel today.

Question stems

1. I have been able to laugh and see the funny side of things
2. I have looked forward with enjoyment to things
3. I have blamed myself unnecessarily when things went wrong
4. I have been anxious or worried for no good reason
5. I have felt scared or panicky for no good reason
6. Things have been getting to me
7. I have been so unhappy that I have had difficulty sleeping
8. I have felt sad or miserable
9. I have been so unhappy that I have been crying
10. The thought of harming myself has occurred to me

EPDS scoring

Score	Severity
7-13	Probable minor depression
14-19	Probable major depression
19-30	Probable severe depression

CoCM inclusion

- Score is approximately 10-18
- Or if inclusion is clinically indicated

Question 10/J

- Further assess acuity of ideation to determine if CoCM is appropriate

Perinatal anxiety

Generalized anxiety disorder (DSM V):

- Excessive anxiety and worry occurring most days for at least 6 months, about a number of events or activities
- Difficult to control the worry
- Anxiety or physical symptoms cause clinically-significant distress or impairment in social, occupational or other important areas of

Anxiety associated with three (or more) of the following (with at least some symptoms having been present for more days than not for the past 6 months):

- Restlessness, feeling keyed up or on edge
- Being easily fatigued
- Difficulty concentrating or mind going blank
- Irritability
- Muscle tension
- Sleep disturbance

Perinatal anxiety tends to be specific to certain topics, usually the health and safety of the baby, and we tend to make the diagnosis if symptoms have been present for 1–2 weeks (vs. 6 months). There is no formal DSM V designation for perinatal anxiety, but it is at least as common as perinatal depression.

Generalized Anxiety Disorder-7 (GAD-7)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Not at all 0	Several days 1	More than half the days 2	Nearly every day 3

1. Feeling nervous, anxious, or on edge
2. Not being able to stop or control worrying
3. Worrying too much about different things
4. Trouble relaxing
5. Being so restless that it is hard to sit still
6. Becoming easily annoyed or irritable
7. Feeling afraid, as if something awful might happen

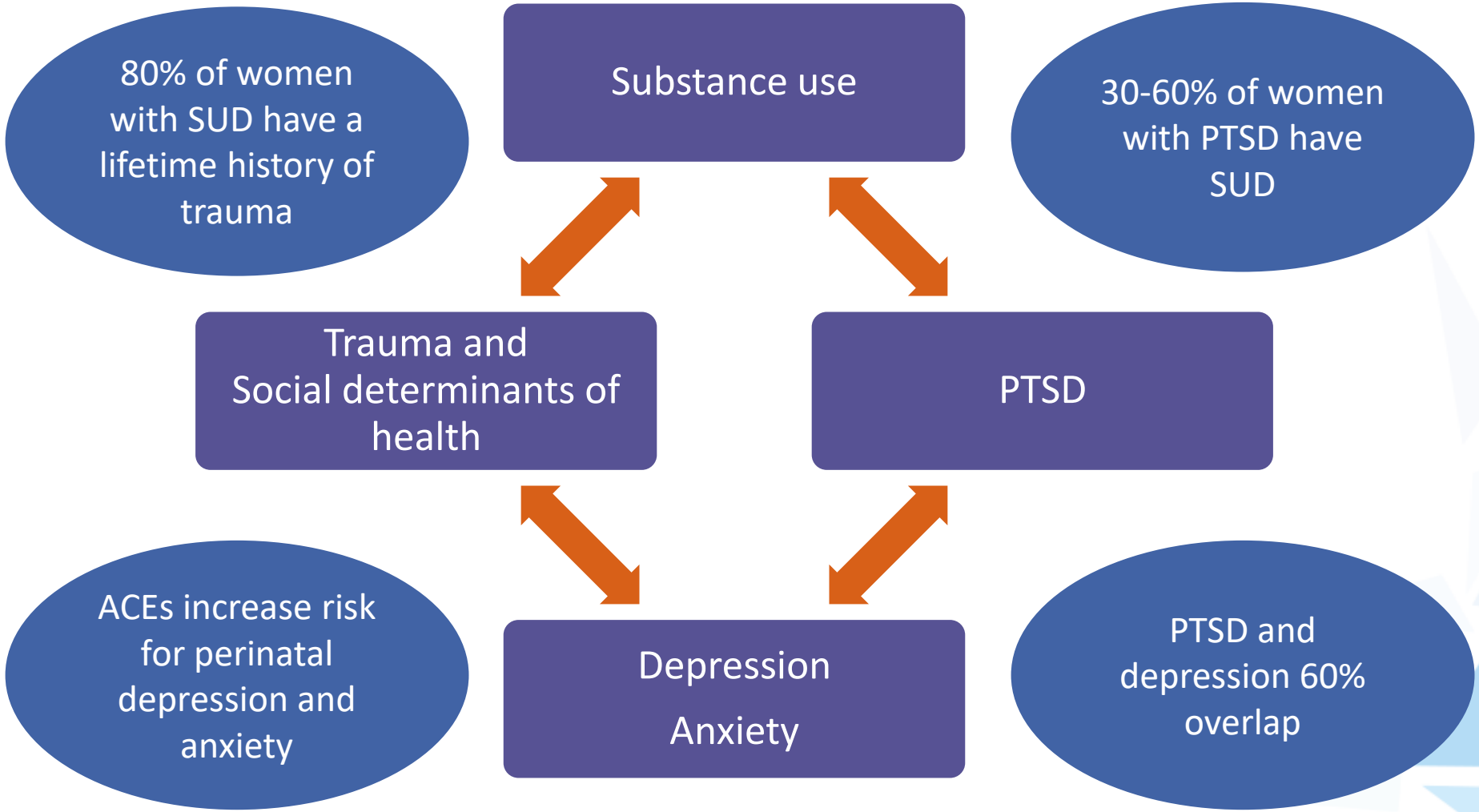
GAD-7 scoring

Score	Severity
0-9	None to Mild
10-14	Moderate
15+	Severe

CoCM inclusion

- Score is approximately 10+
- Or if inclusion is clinically indicated

Perinatal illness often presents as comorbid conditions



Michigan Clinical Consultation & Care (MC3)

- Two umbrella services working together:
  - Perinatal services
  - Pediatric services

- Offers psychiatry support to health care providers in Michigan who are managing patients with behavioral health concerns

MC3: two types of perinatal services

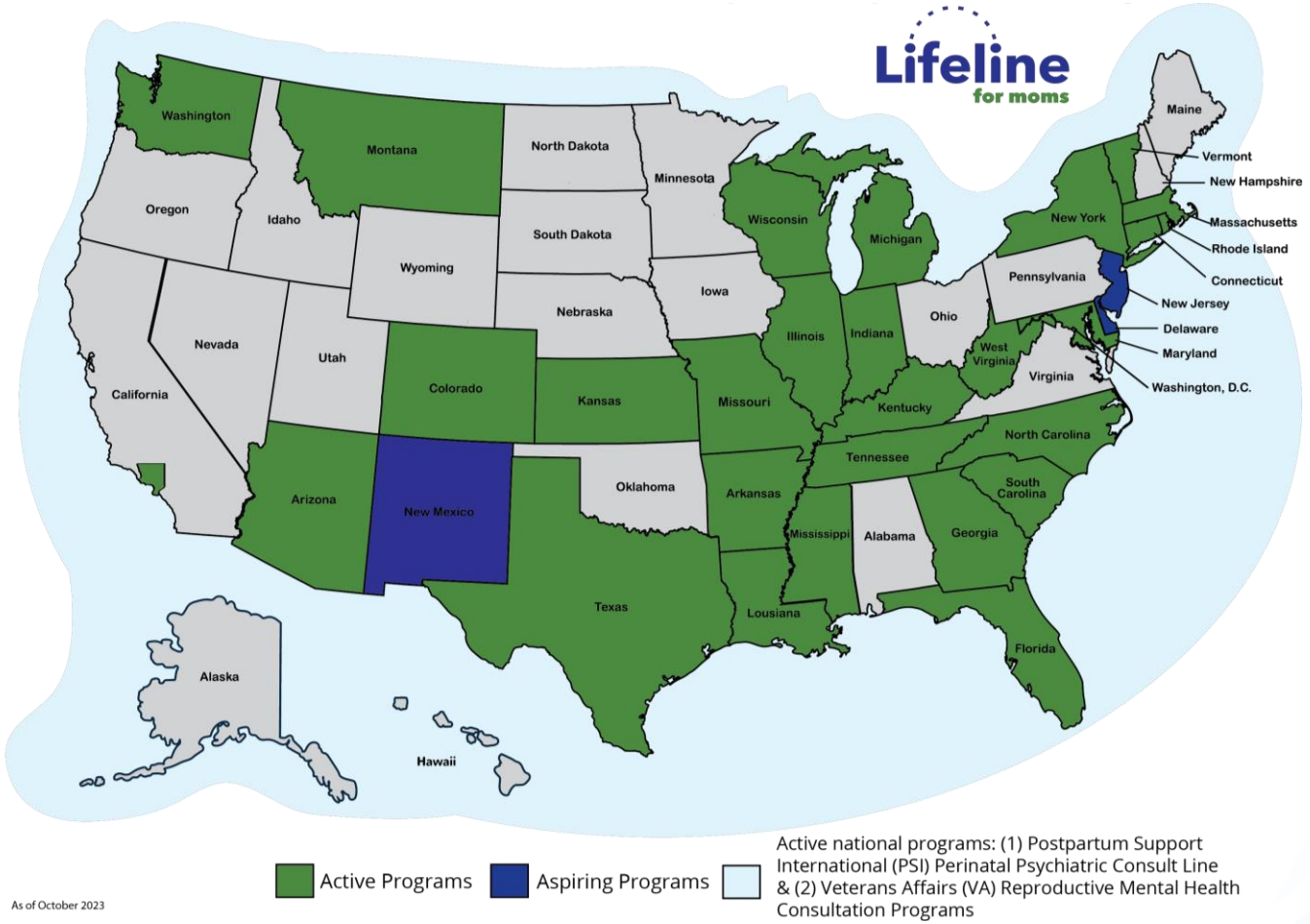
Provider consultations

- Same-day psychiatric consultations for providers caring for perinatal patients
- Trainings, webinars, and toolkits
- Statewide in Michigan
- No cost; DHHS funded

Patient care (Collaborative Care Model)

- Same day and free access to virtual:
  - Screening for risk and needs
  - Brief counseling (6-8 sessions)
  - Case management (resources)
  - Care coordination (with OB provider)
  - Symptoms monitoring up 12 months postpartum
- Available in select Michigan counties
- No cost; DHHS funded

National Network of Perinatal Psychiatry Access Programs



MC3 perinatal patient care (Collaborative Care Model): connecting via QR code

Provider informs patients of our service and flyers hanging in office

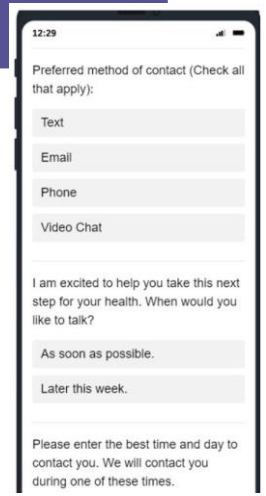
Patient scans QR code on site or at home

QR code leads to screen to complete name/phone number and how best to reach

BHC gets alert via text. BHC texts back to connect and arrange time for e-screen

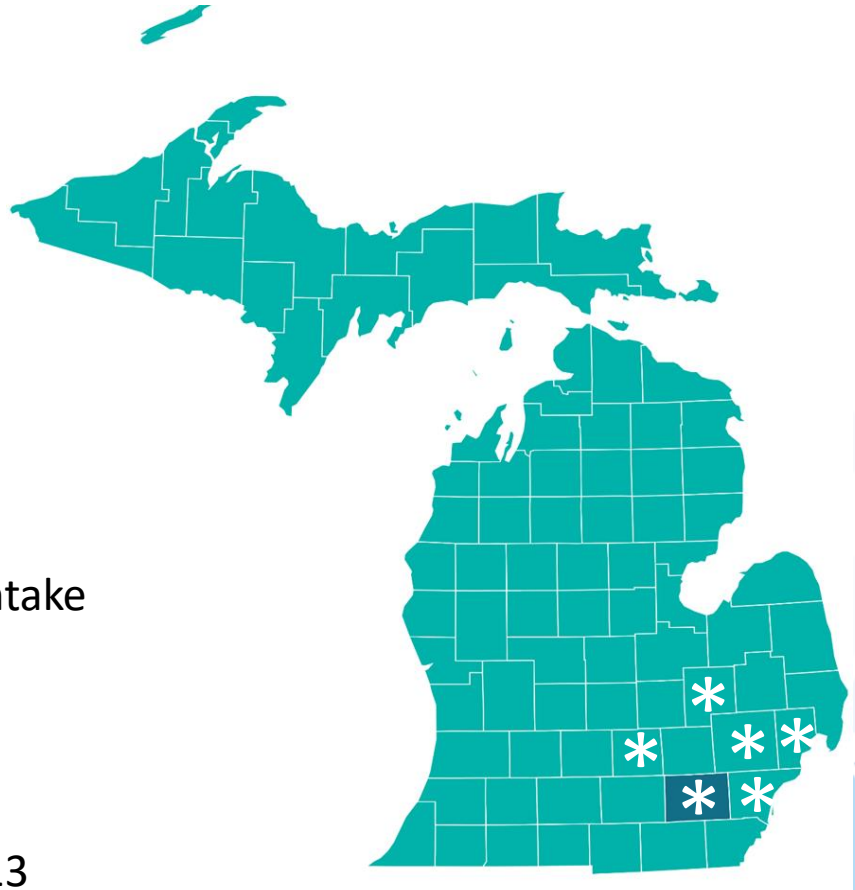
Patient and BHC do e-screen (risks/needs) together

After e-screen, start MC3 direct care with BHC

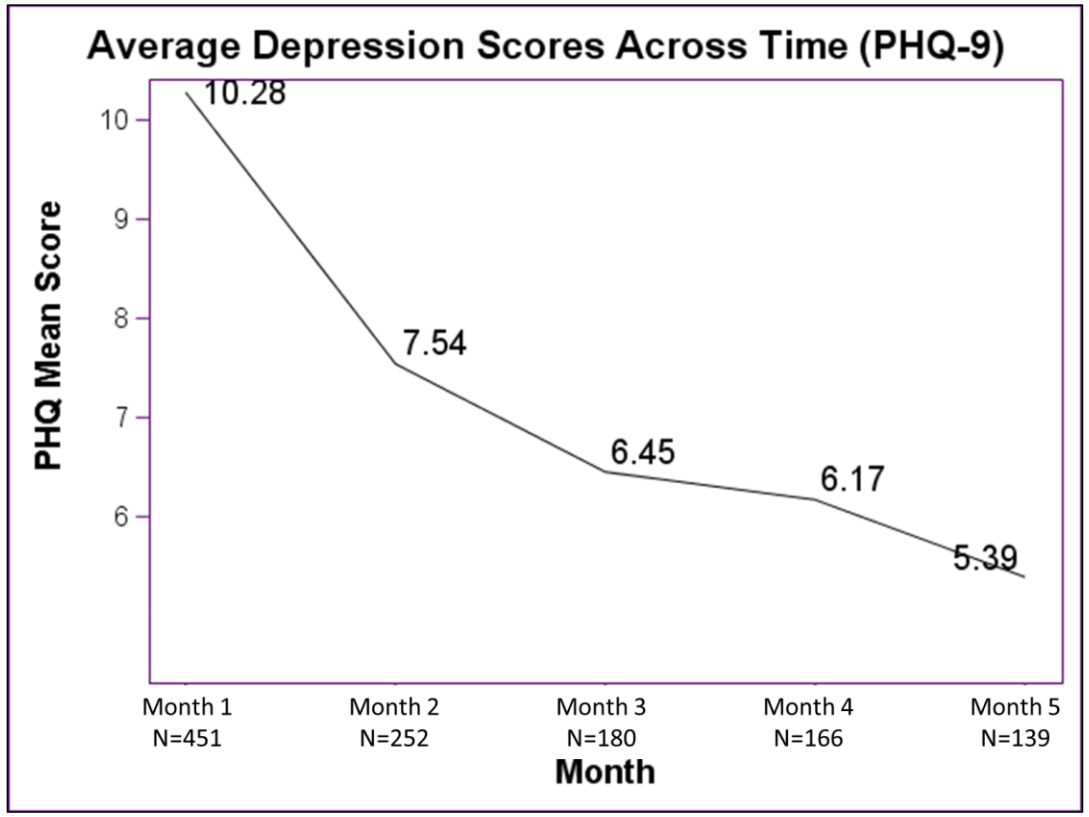


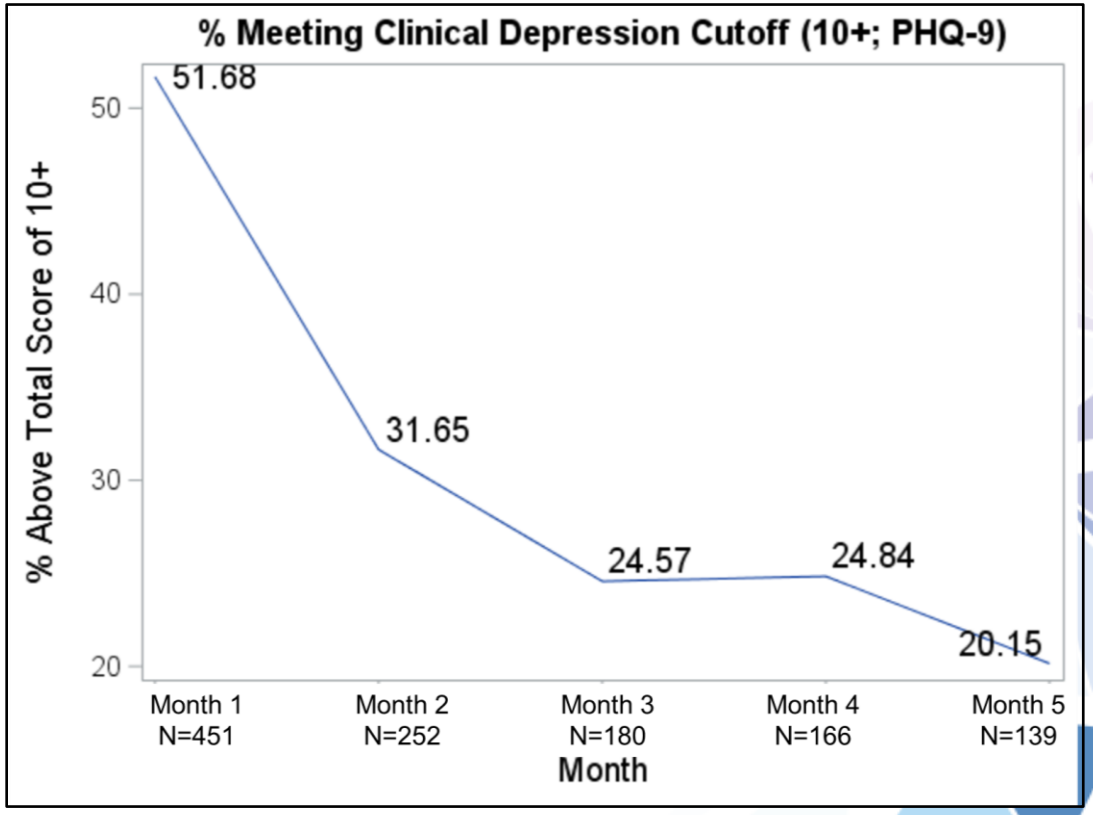
MC3 perinatal CoCM data: 2022-2023

- **541 women referred**
  - 496 engaged (94%)
  - 407 received therapy (75%)
- **Demographics**
  - 30% Black/African American
  - >50% Medicaid insured or uninsured
  - 30% substance use disorder risk, 16% active use on intake
  - 20% intimate partner violence risk
- **1216 therapy sessions**
  - Phone: 739, Video: 451, Text: 154, Email: 64, Other: 13
- **Average number of sessions per patient: 6.7**

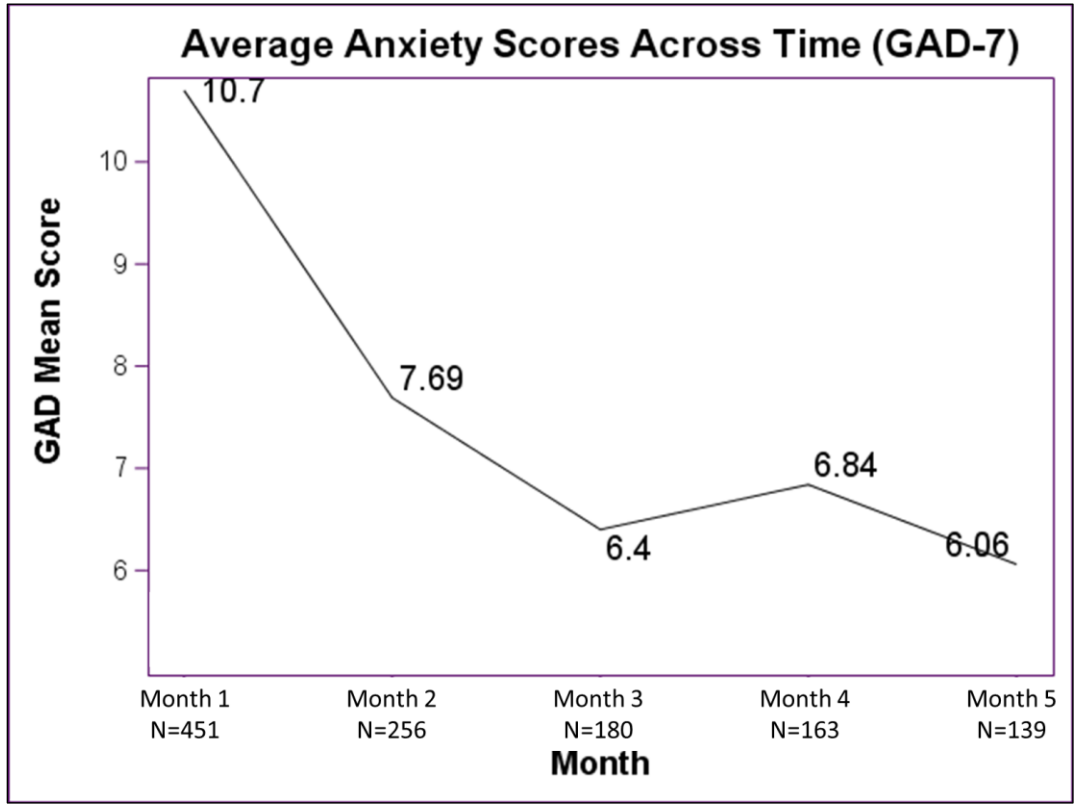


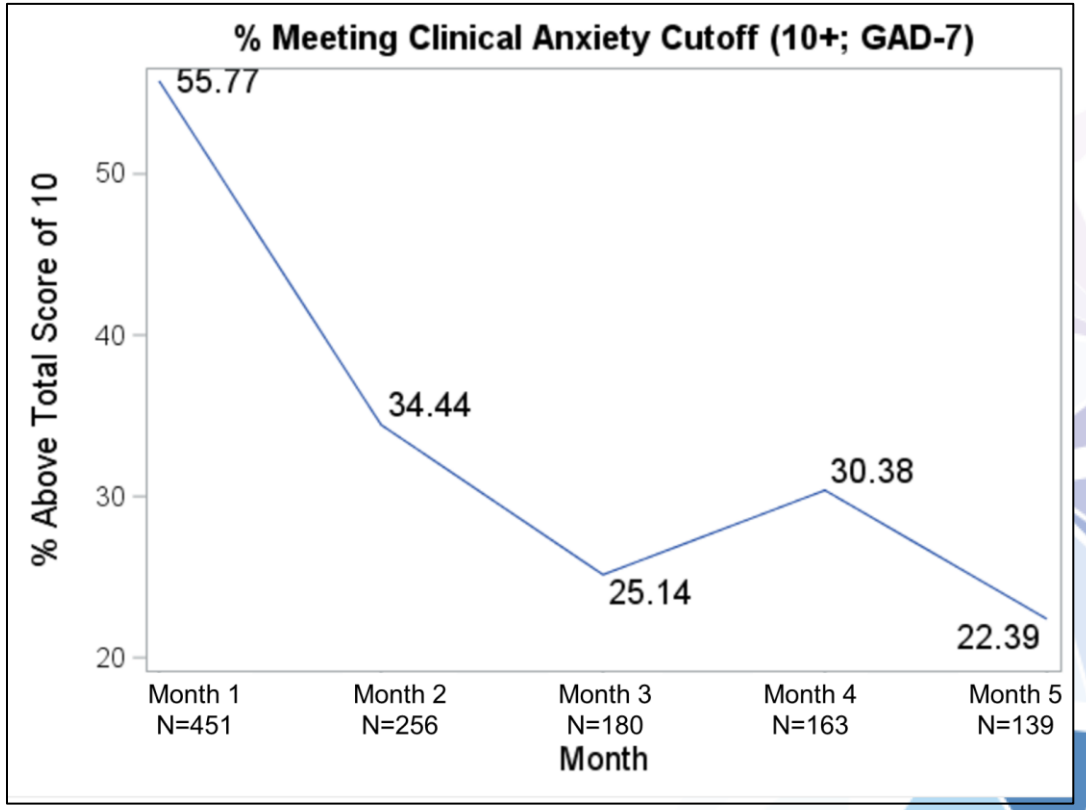
MC3 patient outcomes: depression



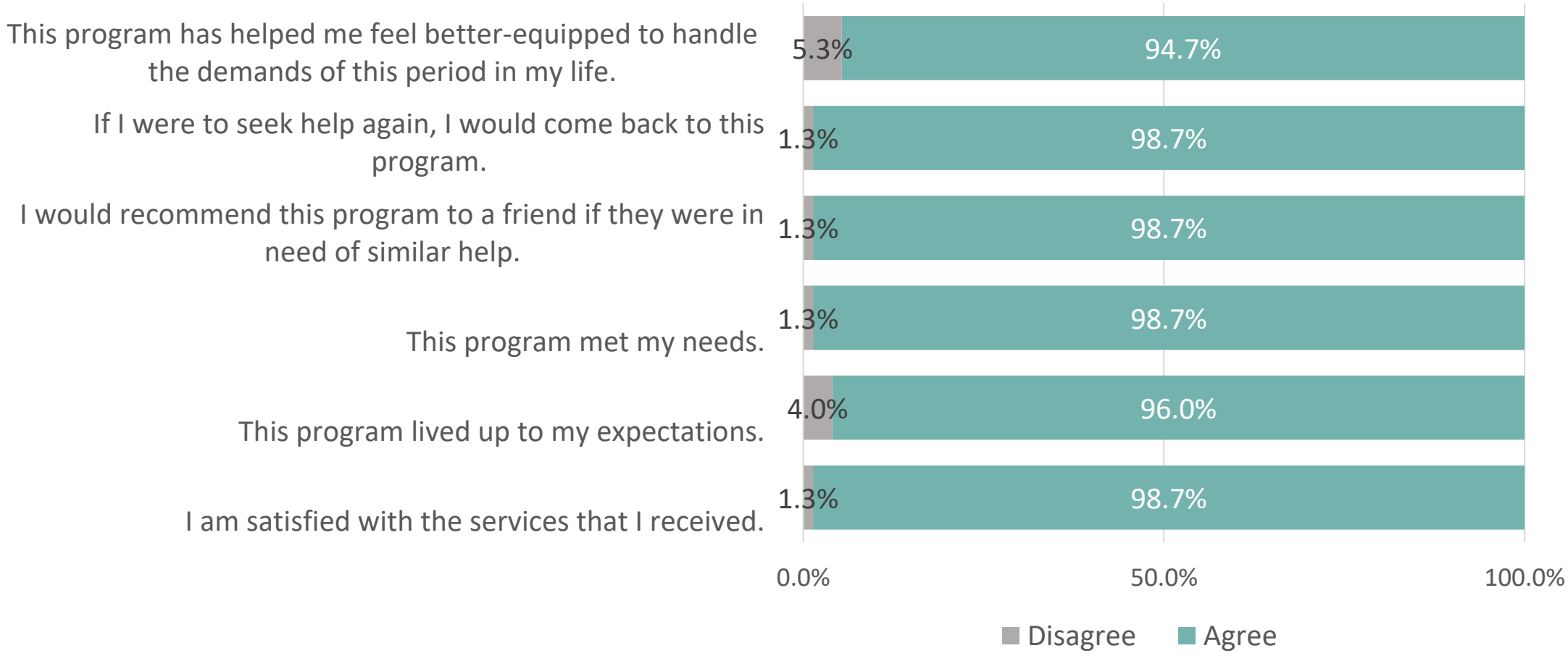


MC3 patient outcomes: anxiety





MC3 patient satisfaction

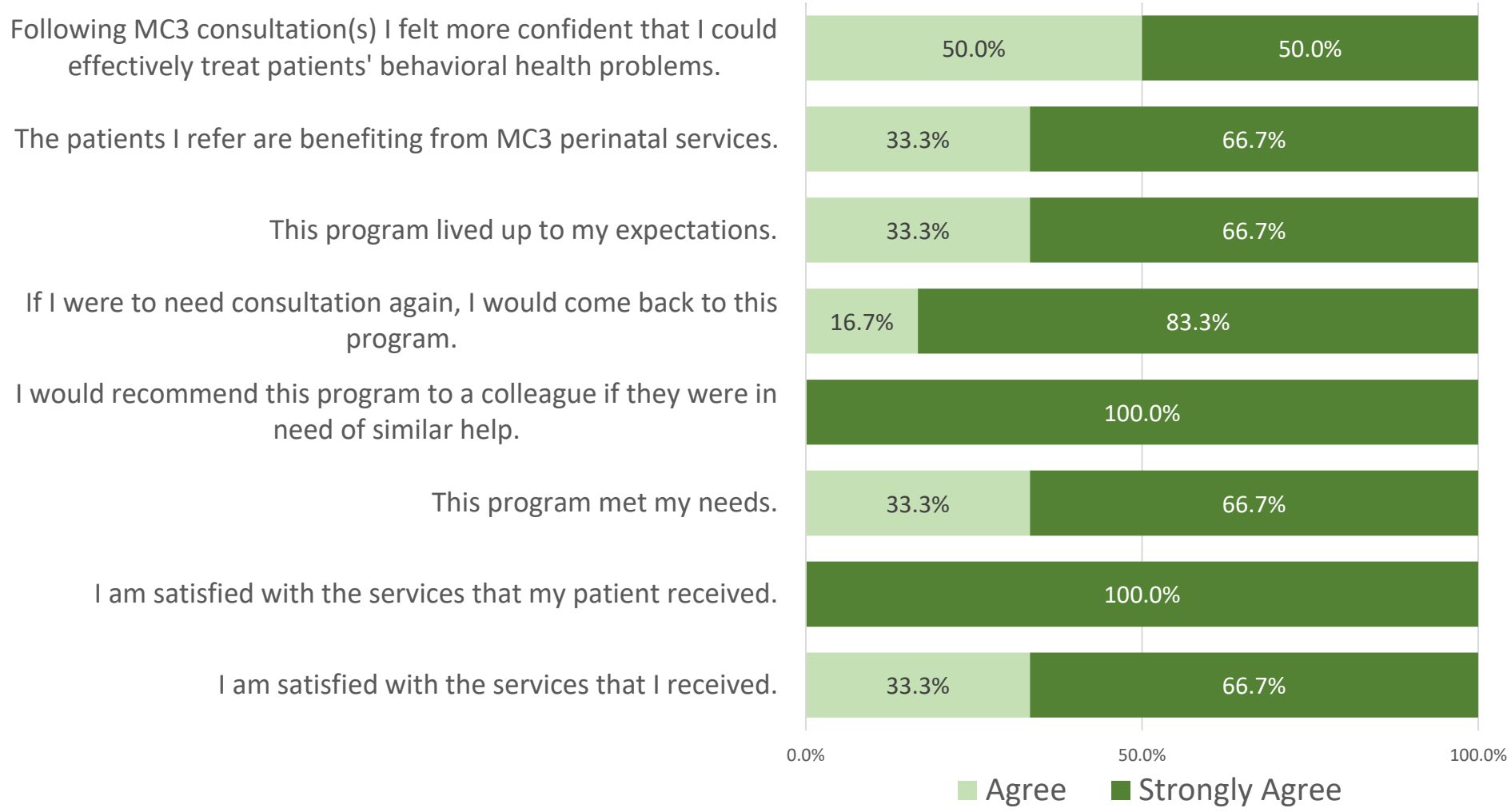


Patient testimonials

- "…The time that BHC spends **talking to me** and really **getting to know me** and the things I'm needing help with has been priceless. She has helped get me a therapist for long term, she has got my doctor to **understand my medical needs** with medication and hooked me up with getting into physical therapy … **I would recommend it to anyone in need**!"

- "For the first time, I have found someone who has a way of understanding me and helping me understand and see things in a whole new way. I am able to **take a step back and dissect how and why I'm feeling the way that I am**. BHC has been a lifesaver and is truly incredible at what she does."

MC3 provider satisfaction



Provider testimonials

- “I love that it **loops in the providers if anything comes up** as the clients are working with the BHCs. In addition, the **diverse backgrounds of the BHCs** is very appealing. Black women have shared with me that they strongly desire a black therapist- MC3 heard this and responded. They remain steady in their commitment to **representation in their staff**.”

- “I feel **more prepared to directly address mental health issues** with my patients now that I actually have an easily accessible intervention to offer them.”

Contact us

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