

Maternal Mental Health

# *Addressing the Crisis in Our Country*

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# Today's Moderator



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# About PCDC

PCDC is a Community Development Financial Institution (CDFI) that provides capital financing, expertise, and advocacy to expand primary care access and advance health equity in communities that need it most.



# Disclaimer

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).



[www.samhsa.gov](http://www.samhsa.gov)

# “Operationalizing Integration” Webinar Series Tip Sheets

**MITIGATING BURNOUT THROUGH INTEGRATED HEALTHCARE**

**IMPACT OF BURNOUT**

**Increase in error reports**  
Shanafelt et al. Ann Surg. 2010

**Increased post-discharge recovery times**  
Kassirer, Health Care Management Review, 2009

**Riskier prescribing**  
Williams, Skinner, Health Care Management Review, 2003

**Unsolicited patient complaints**  
Windsor, JAMA Internal Medicine, 2018

**Reduced empathy and professional climate**  
Brazier et al. Acad Med, 2010

High turnover, predicts intent to retire and reduce clinical hours → Turnover disrupts patient care, affects remaining team → Can impact professional and personal lives leading to declining mental health and damaging interpersonal relationships

**HOW INTEGRATION CAN MITIGATE THE IMPACT OF BURNOUT**

**Resources for Health Care Worker Well-Being: 6 Essential Elements**

Remember that trans-disciplinary connections are protective. They improve patient care and support staff communication and relations.

Examples include:

- Daily huddles
- Weekly meetings
- Treatment planning sessions

The goal is to create space, collaborate, share information, and problem solve together, moving towards an integrated strengths based approach.

**COLLABORATIVE CARE MANAGEMENT 101**

**STEPPED STRATEGIES FOR INTEGRATION<sup>1</sup>**

**In-Patient BH Care**

**Specialty Behavioral Health Care**

**Collaborative Care**  
Practice-based BHP and psychiatric consultant on PCP's treatment team

**Primary Care Panel Management**  
Systematic screening for common BH conditions  
Population-based care finding and follow up  
Practice-based BHP for PCP hand-off, brief follow up

**Primary Care Provider**  
Identifies patients needing BH care  
Makes diagnosis, initiates treatment, prescribes medications  
Provides continuity in team-based care

BH = Behavioral Health  
BHP = Behavioral Health Provider  
PCP = Primary Care Provider

**Principles of Collaborative Care<sup>1</sup>**

- Patient-Centered Team.** The patient, primary care, and mental health providers collaborate effectively using shared care plans that incorporate patient goals.
- Population-Based.** A registry is used to facilitate engagement and outcome tracking in a defined group of patients at the caseload and clinic level.
- Measurement-based Treatment to Target.** Progress is measured regularly, and treatments are actively changed until clinical goals are achieved.
- Evidence-Based Treatments.** Providers use treatments that have research evidence for effectiveness.
- Accountable.** The care team is accountable to the patient and other care team members for quality of care and clinical outcomes, not just the volume of care provided.

**COLLABORATIVE CARE FOR VARIOUS BEHAVIORAL HEALTH CONDITIONS<sup>1</sup>**

**Established Evidence-Base**

- Depression**
  - Adolescent Depression
  - Depression, Diabetes, and Heart Disease
  - Depression and Cancer
  - Depression in Women's Health Care
- Anxiety**
  - Post Traumatic Stress Disorder
- Chronic Pain**
- Dementia**
- Chronic Substance Use Disorder**
- Bipolar Disorder**

**MATERNAL MENTAL HEALTH CONSIDERATIONS**

**Burden of Untreated Perinatal Mood and Anxiety Disorders (PMADs) in the United States**

**PREVALENCE**  
Most common complication of pregnancy and childbirth

**ECONOMIC**  
Average cost per affected mother-child dyad: \$31,800

**PERSONAL**  
Associated with poor birth and early childhood outcomes, substance use challenges, suicide, lost wages, families under stress.

**Perinatal Mood and Anxiety Disorders Defined**  
Perinatal: Anytime during pregnancy through the first year postpartum

**Conditions:**

- Depression
- Anxiety
- Panic Disorder
- Bipolar Disorder
- Post Traumatic Stress Disorder
- Obsessive Compulsive Disorder
- Postpartum Psychosis

**Inequities in Maternal Mental Health Care and PMADs in Historically Marginalized Populations**  
Research shows that marginalized populations are 2x more likely to experience a perinatal mood and anxiety disorder due to:

- Unconscious and conscious racism
- Cultural differences in engaging with medical systems
- Limited evidence
- Unequal access
- Underreported symptoms
- Lower rates of screening and treatment

**High-Level Solutions to Address the Burden of Untreated PMADs in the United States**

<b>Policy</b>	<b>Infrastructure</b>	<b>Health Care System</b>
Support policies to expand insurance eligibility, enrollment, and provider and services covered	Incentive providers to practice in low resource areas	Encourage the creation of multi-disciplinary teams and team based coordinated care processes
Provide patient navigation to insurance and alternative providers	Widen providers' care area potential	Have mental health providers consult with obstetricians
	Provide flexibility by offering extended hours or after-hours care	Screen for PMADs, report quality measures, and use maternity mental health safety bundles

**PROVIDING EQUITABLE AND RESPONSIVE CARE**

**Defining Equity**

**Equality:** Everyone gets the same—regardless if it's needed or right for them.

**Equity:** Everyone gets what they need—understanding the barriers, circumstances, and conditions.

**Equity with a twist:** Everyone gets the treatment or care that is right for them.

**Responsiveness:**

- The intentional and consistent decision providers make to see, respect, and celebrate the aspects that make each person unique.
- An acknowledgment of a patient's intersectional existence in the world and how this shapes their experiences.

"Deep equity means working towards outcomes in ways that model dignity, justice, and love without re-creating harm in our structures, strategies, and working relationships."  
Change Element<sup>1</sup>

"Equity is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically."  
World Health Organization<sup>2</sup>

**Social Determinants and Intersectionality<sup>3</sup>**

**TRUNK AND BRANCHES: social determinants**

**LEAVES: health and well-being**

**ROOTS: structural determinants**

**SOIL: cultural determinants**

Click on the tree for more on Intersectionality: Amplifying Impacts on Health Equity

**Structural Determinants of Health:** Policies and institutional practices that determine the allocation of societal resources.

**Social Determinants of Health:** Conditions in which people are born, live, learn, work, play, worship and their age, which affects a wide range of health functioning and quality of life outcomes and risks.

**Quality and use of services:** The safety, effectiveness, patient-centeredness, timeliness, efficiency, and consistency of healthcare and other social resources that people use.

**Health and wellness:** Well-being experienced by various individuals and groups.

## “Mitigating Burnout through Integrated Healthcare”

tip sheet can be accessed here:  
<https://www.pcdc.org/resources/operationalizing-integration-mitigating-burnout-through-integrated-healthcare-tip-sheet/>

## “Collaborative Care Management 101”

tip sheet can be accessed here:  
<https://www.pcdc.org/resources/operationalizing-integration-collaborative-care-management-foundations-tip-sheet/>

## “Maternal Mental Health Considerations”

tip sheet can be accessed here:  
<https://www.pcdc.org/resources/operationalizing-integration-system-level-opportunities-to-improve-maternal-mental-health-tip-sheet/>

## “Providing Equitable and Responsive Care”

tip sheet can be accessed here:  
<https://www.pcdc.org/resource/operationalizing-integration-collaborative-care-management-foundations-tip-sheet/>

# "Integration at Work" Webinar Series Tip Sheets

### QUALITY IMPROVEMENT TIPS FOR INTEGRATED CARE SETTINGS

**TYPES OF INTEGRATION**

<b>Coordinated Care (off-site)</b> Level 1: Minimal Collaboration Patients are referred to a provider at another practice site, and providers have minimal communication. Level 2: Basic Collaboration Providers at separate sites periodically communicate about shared patients.	<b>Co-located Care (on-site)</b> Level 3: Basic Collaboration Providers share the same facility, but maintain separate cultures and develop separate treatment plans for patients. Level 4: Close Collaboration Providers share records and some system integration.	<b>Highly Integrated Care</b> Level 5: Close Collaboration Providers develop and implement collaborative treatment planning for shared patients but not for other patients. Level 6: Full Collaboration Providers develop and implement collaborative treatment planning for all patients.
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### INTEGRATION CONTINUUM

Key Domains of Integrated Care	Preliminary	Intermediate	Advanced
Screening, Referral to Care, Follow-Up (FU)	Response to patient self-report of general health concerns and/or general medical conditions (GMC).	Systematic screening for unmet general health concerns & proactive health education to a representative address list factors.	Analysis of patient population to identify severity of medical complexity and/or high-risk status for proactive assessment/feedback.
Facilitation of referrals and FU	Referral to external primary care (specialty and subspecialty).	Formal collaborative agreement with external PC sites to facilitate referral that includes engagement and communication expectations.	Enhanced referral protocols to create a clearly integrated off-site PCPC with automated data sharing and accountability for engagement.
Ongoing Care Management	Formal or informal FU of patients related to acute & medical specialty care.	Some ability to perform FU of general health appointments, encourage use of appointments.	Use of tracking tool to monitor treatment response and outcomes over time at individual and group level, coaching and practice by.



**"Quality Improvement Tips For Integrated Care Settings"** tip sheet can be accessed here: <https://www.pcdc.org/resource/integrating-on-at-work-quality-improvement-tips-for-integrated-care-settings/>

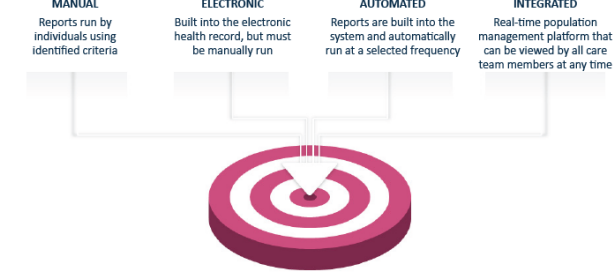
### PREVENTIVE SCREENING IN INTEGRATED CARE

**START YOUR JOURNEY WITH THE PREVENTIVE SCREENING ROAD MAP:**

1. Understand your patient population
2. Define your priorities and select screening tools
3. Define care team member roles and responsibilities
4. Operationalize the screening process
5. Provide education, training, and cross-training

**TYPES OF REGISTRIES TO HELP MEET YOUR SCREENING GOALS:**

- MANUAL:** Reports run by individuals using identified criteria
- ELECTRONIC:** Built into the electronic health record, but must be manually run
- AUTOMATED:** Reports are built into the system and automatically run at a selected frequency
- INTEGRATED:** Real-time population management platform that can be viewed by all care team members at any time



**"Preventive Screening in Integrated Care"** tip sheet can be accessed here: <https://www.pcdc.org/resource/integrating-on-at-work-preventive-screening-tips-for-integrated-care/>

### INTEGRATION AT WORK

**LABS AND HEALTH INDICATORS: AN INTEGRATED CARE OPPORTUNITY**

<b>Primary Care Providers (PCP):</b> Provide information to BH colleagues about "red flag" symptoms a client may mention that should get a referral for labs or other health indicator testing such as: dizziness when standing, trouble breathing, excessive tired, numbness, etc. Keep BH colleagues updated on fluctuations in client labs and health indicators. Convey acute and long-term implications of health behaviors that may be related to lab results in order to facilitate collaborative care planning and alignment on shared treatment goals. Follow through on care for referred clients and follow up with BH provider to connect around reasons for referral.	<b>Behavioral Health Providers (BH):</b> Refer clients for labs or other health indicator testing when "red flag" symptoms are expressed and provide a warm hand-off to PCP. Engage with clients about their experience receiving lab and health results. Offer supportive coping mechanisms if needed. Connect with PCP for updates on what client lab results indicate. Collaborate on care plans, modifying shared treatment goals to ensure client is comprehensively supported. Recommend ways PCP colleagues can supportively provide health guidance and information to clients.
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**Key ways Behavioral Health providers are critical partners within integrated care:**

- Improve the skills of primary care providers to recognize behavioral disorders.
- Improve the skills of providers to recognize how behavioral health conditions may manifest as physical symptoms.
- Promote greater adherence to treatment regimens for chronic conditions.
- Help patients understand the ways that emotions can affect how they feel physically.
- Establishing responsive "person centered" goals to manage both physical and behavioral conditions.

**POLICY CONSIDERATIONS**

- Include details on specific task oriented staff activities
- Convene stakeholders from throughout organization to develop PC-BH policies and recommendations
- Incorporate feedback even after policies are drafted as input is key to understanding how a process gets carried out in real time
- Ensure all guidance is either broad enough for or can specifically account for differences between disciplines. For instance: PCP may focus on specific clinical markers; BH may focus on social and emotional markers. Good policy and directives would account for both.

Contact us to discuss how our services can help your care teams. Email: [ccp@pcdc.org](mailto:ccp@pcdc.org)  
This resource was developed in partnership with the Center of Excellence for Integrated Health Solutions.

**"Promoting Successful Collaboration in Integrated Care Settings"** tip sheet can be accessed here: <https://www.pcdc.org/resource/integrating-on-at-work-promoting-successful-collaboration-in-integrated-care-settings/>



### Considering Cost and Yield in Partnership Equations

Integrated care partnerships can be complex, with different organizations and team members holding different visions. Part of taking an advanced lens on partnerships is determining the cost (input of time, energy and resources) and the yield (client impact, positive staff experience, increase in revenue, etc.) and understanding if shifting or transitioning a partnership is necessary. When the cost is HIGHER than the yield, applying concepts on the wheel to the right can be supportive to recalibrate. When the cost is LOWER than the yield, it is still critical to have methods in place, such as those within the wheel, to keep a forward trajectory where your partnerships remain in a low cost high yield equation.

**"Integrating Care Partnerships"** tip sheet can be accessed here: <https://www.pcdc.org/resource/integrating-on-at-work-components-of-successful-integrated-care-partnerships/>

# Audience Demographics Poll

## Do you work in a:

- Primary care setting
- Behavioral health setting
- Integrated care setting

## Are you working primarily as a:

- MD/DO
- Nurse Practitioner/Registered Nurse
- Physician Assistant
- Medical Assistant
- Therapist
- Social Worker
- Care Manager
- QI Manager
- Informatics
- Other

## Please rate your current skills and comfort in discussing maternal mental health, associated Federal legislation, and models for implementation.

- Very Low
- Low
- Moderate
- High
- Very High

# Today's Presenters



**Adrienne Griffen, MPP**  
Executive Director  
**Maternal Mental Health Leadership Alliance**



**Joan Kenerson King, RN, MSN**  
Senior Consultant  
**The National Council for Mental Wellbeing**



# Accidental Advocate



UNITED NATIONS



POSTPARTUM SUPPORT INTERNATIONAL



# About MMHLA

Maternal Mental Health Leadership Alliance (MMHLA) is a nonpartisan 501(c)3 nonprofit organization dedicated to improving the mental health of mothers and childbearing people in the United States by focusing on policy and equity.

**Founded in 2019**

We advocate for national policies that provide universal, equitable, comprehensive, and compassionate mental health care during pregnancy and the year following pregnancy.

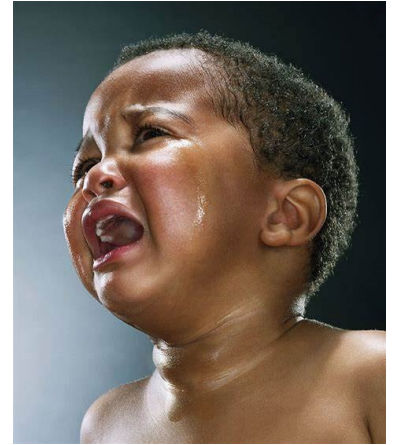
[www.mmhla.org](http://www.mmhla.org)



# The Happiest Time in a Family's Life...



# Not Always!



# Just the Facts:

## **FACT #1**

The United States is in a maternal mortality crisis.

## **FACT #2**

Mental health conditions are the leading cause of maternal deaths.

## **FACT #3**

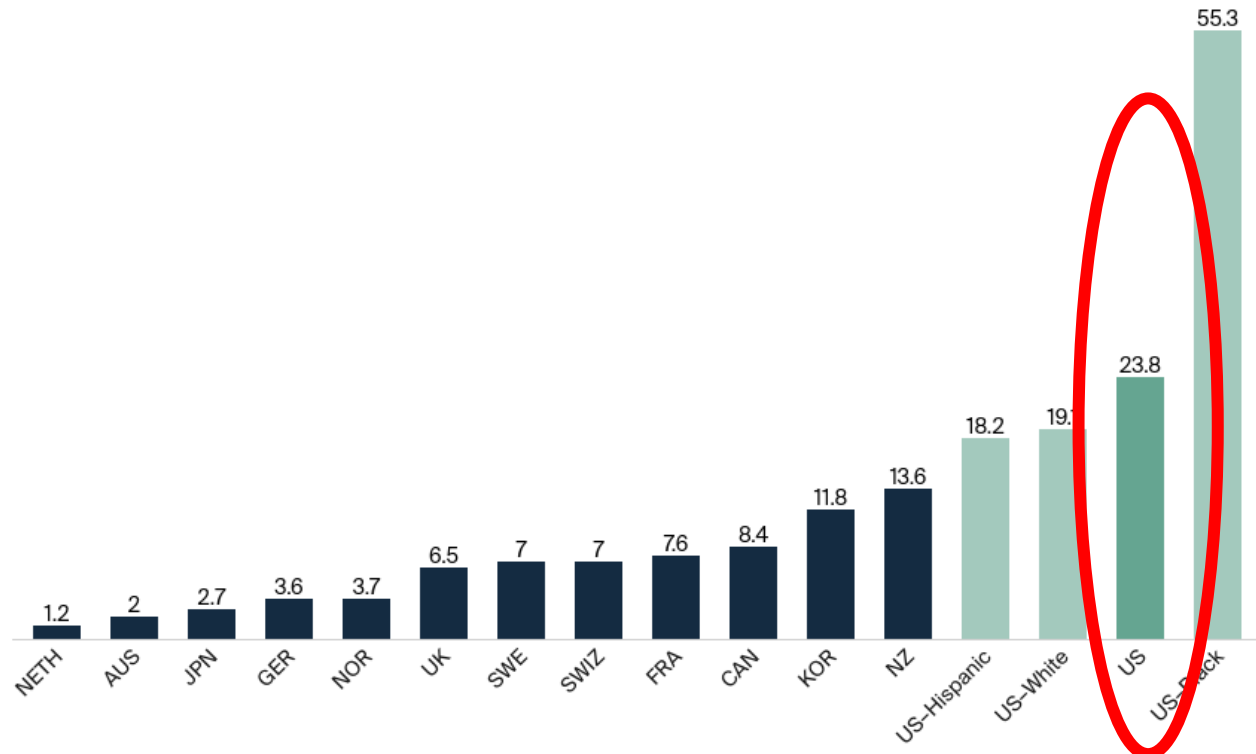
Together we can save the lives of new mothers.

# FACT #1

**The United States is in a  
Maternal Mortality Crisis**

# Maternal Mortality

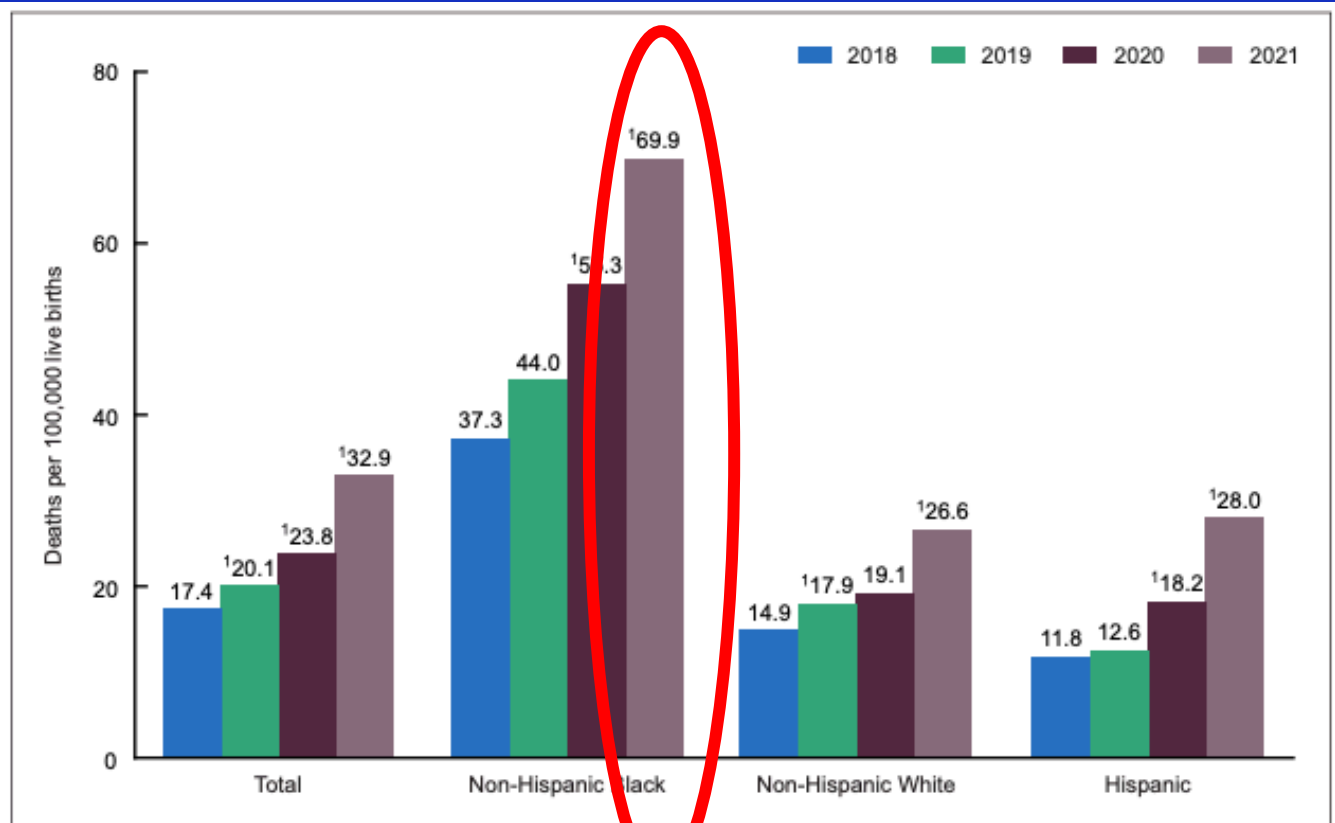
Deaths per 100,000 live births



Maternal mortality:  
Deaths per  
100,000 live births

U.S. maternal mortality rate  
**IS THE WORST**  
of all developed countries

# U.S. Maternal Mortality



Number of maternal deaths in the U.S.  
**DOUBLED**  
during the pandemic

**2018: 658**

**2021: 1,205**

Women of color were disproportionately impacted



# U.S. Maternal Mortality

## COVID

**25% of deaths in 2020-2021**

Women of color disproportionately impacted

### **Social determinants of health**

Worked frontline jobs

Lived in more crowded homes

Faced challenges accessing the internet,  
having privacy, accessing healthcare

## MENTAL HEALTH

**22% of deaths in 2017-2019**

**SUICIDE + OVERDOSE**  
leading cause of death

For all groups except  
non-Hispanic Black women

## **FACT #2**

**Mental Health Conditions are the  
Leading Cause of Maternal Deaths**

# The Facts

- Mental health conditions are **THE MOST COMMON** complication of pregnancy and childbirth
- Suicide and overdose combined are the **LEADING CAUSE** of maternal mortality

# Maternal Mental Health (MMH)

**1 in 5**

Number of pregnant/postpartum people impacted by MMH conditions

**1 in 3**

Number impacted in high-risk groups

**75%**

Of those impacted, remain untreated

**100%**

Of maternal deaths due to MMH conditions are preventable

**\$14 billion**

The annual cost of MMH conditions



# Parents at High Risk

People with a history of mental health conditions

People who have experienced trauma

Parents who lack social support, especially from their partner

Individuals of color

Individuals who live in low-income neighborhoods

Parents with a baby in the NICU

Military mothers and spouses; Veteran Women

Immigrant parents



Sources:  
CDC Foundation, 2021  
Taylor et al., 2019  
Maxwell et al., 2018  
MacDorman et al., 2021  
Cherry et al., 2016  
Guintivano et al., 2018  
Smorti et al., 2019

# Why Should We Care: Impact on Mother

## Women with untreated MMH during pregnancy are more likely to:

- Not have adequate prenatal care
- Have poor nutrition
- Use substances (alcohol, tobacco, drugs)
- Experience physical, emotional, sexual abuse

## Women with untreated MMH postpartum are more likely to:

- Be less responsive to baby's cues
- Have fewer positive interactions with baby
- Experience breastfeeding challenges
- Question their competence as mothers

# Why Should We Care: Impact on Baby

## Children born to mothers with untreated MMH are at higher risk for:

- Low birth weight or small head size
- Pre-term birth
- Stillbirth
- Longer stay in the NICU

## Children living with mothers with untreated MMH are at higher risk for:

- Excessive crying
- Impaired parent-child interactions
- Behavioral, cognitive, or emotional delays
- Adverse Childhood Experiences

# Cost of Untreated MMH Conditions

## UNTOLD COSTS

Impact on relationships with partner, other children

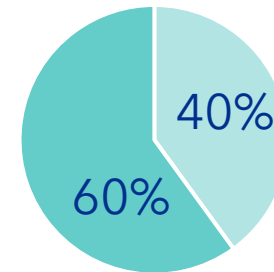
No other children



## SOCIETAL COSTS

\$32,000 per parent/child dyad

**\$14.2 billion**



Per parent cost  
\$19,520  
Lost wages and productivity

Per child cost  
\$12,480  
Treating impact



# A National Priority

Institute for Medicaid Innovation

Recent survey and focus group

Identify the most important topics in women,  
gender, and maternal health

#1 issue:

**MATERNAL MENTAL HEALTH**



Federal policymakers



State policymakers



Medical health plans



Maternal health leaders

# FACT #3

# Together We Can Save Lives

# Federal Legislation: Grants to States

## Bringing Postpartum Depression Out of the Shadows Act of 2015

- Elevated a successful state program from Massachusetts
- Provided grants to 7 states to replicate this program
- 30 states and territories applied
- Funded FY2018-2022

## Into the Light for Maternal Mental Health and Substance Use Disorder Act of 2022

- Reauthorized and expanded the program
- 12 states received a total of \$12 million
- Funded FY2023-2028

# Federal Legislation: Maternal Mental Health Hotline



- 24/7 Voice and Text
- English and Spanish
- 60+ other languages
- Mental health providers
- Maternal-child health providers
- Certified peer specialists
- Launched Mother's Day 2022
- 70% calls; 30% texts
- ~1,000 people/month

# White House Blueprint for Addressing the Maternal Health Crisis



- Access
- Systems of Care
- Data
- Workforce
- Support Systems

## GOAL

- The U.S. will be the best country in the world to have a baby
- Whole of government strategy
- Coordinated efforts from multiple federal agencies

## MATERNAL MENTAL HEALTH

- Extend Medicaid for a full year postpartum
- Launch a postpartum depression public awareness campaign
- Address perinatal addiction and substance use disorder
- Increase funding for the National MMH Hotline and state grants
- Launch the Department of Defense (DoD) reproductive behavioral health consultation service

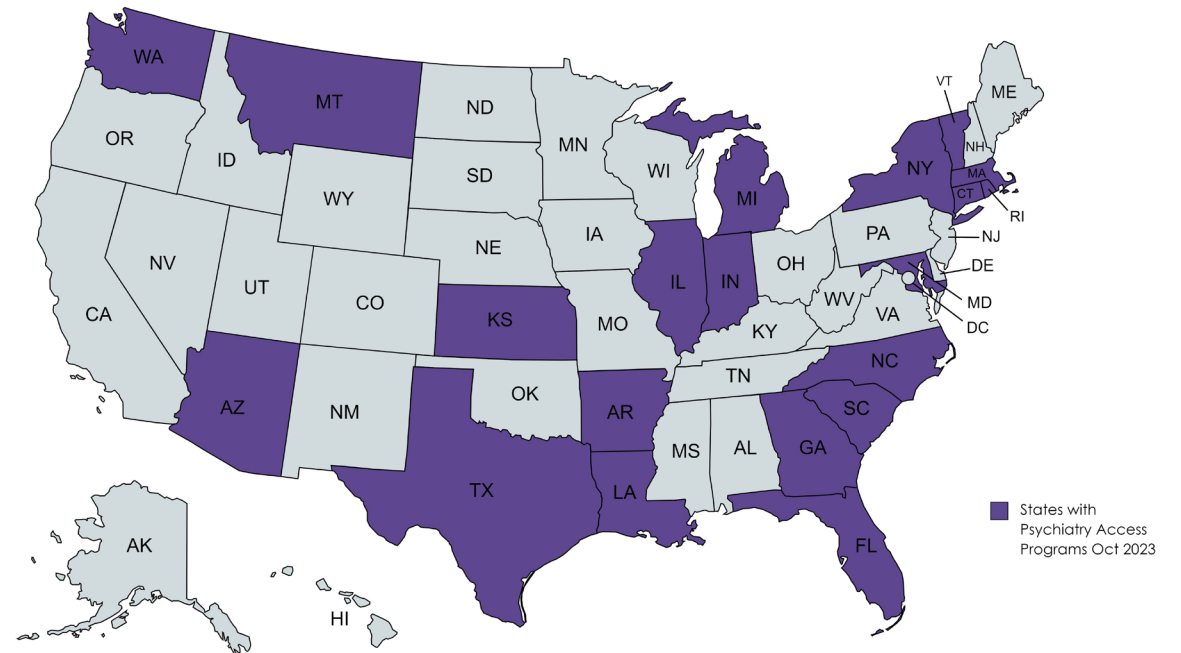
# State Legislation and Initiatives

- Coalitions or Task Forces
  - Proclamations or Resolutions
  - Awareness Campaigns
  - Screening Requirements
  - Educational Requirements
- Intensive Treatment Programs
  - Medicaid extension
  - Maternal Mortality Review Committees
  - Perinatal Quality Collaboratives

# Psychiatry Access Programs

## Population-based programs at the state level:

- Education for frontline providers
- Real-time psychiatric consultation
- Resources and referrals



Created with mapchart.net

# Perinatal Maternal Mental Health (PMH) Education and Screening Project

A multi-year collaborative effort to ensure that all pregnant and postpartum people are educated about and screened for PMH disorders and connected with resources for recovery.

## Phase I

Synthesize existing screening guidelines into a cohesive approach focused on **WHEN** to provide patient education and screening.

## Phase II

Address barriers to screening:

- Lack of education for frontline providers
- Reimbursement for frontline providers
- Resources for those impacted by PMH disorders
- Screening tools: comprehensive, updated, culturally relevant



# The Good News

- MMH conditions are often **TEMPORARY** and **TREATABLE**
- Pregnant/postpartum people are engaged in the healthcare system
- Parents, babies, and families can recover
- There are evidence-based prevention and treatment options
- Resources for providers and parents



“

Mothers are the heart and soul of every life they touch. In them lies the beauty, depth, and grandeur of life.

— *Jane Clayson Johnson*

# Practice Change Works: Montana Maternal Mental Health and Substance Use Disorder Act of 2022

# **The Meadowlark Approach**



# Why a Different Approach to Care?

- The number of Montana children in foster care more than doubled between 2011 and 2016; out of more than 3,200 children in foster care in 2016, 64% were removed from the home for reasons related to parental substance use.
- Before 2016 access to SUD treatment was minimal for pregnant women: only 6% of Montana's state-licensed substance use disorder treatment programs served pregnant women or young families.
- Mental illness and SUD are prevalent in Montana across all demographic groups, including pregnant women.
- Screening and treatment for prevalent mental illnesses were not routine in prenatal and post-partum care.



# Brief History & Partnerships: A New Standard of Pregnancy Care

- The Meadowlark Initiative was established in 2017 by the Montana Healthcare Foundation (MHCF).
- In 2019, the Montana Department of Public Health and Human Services (DPHHS) formed a funding partnership with MHCF to support the initiative. DPHHS funding is supported by a HRSA grant.
- MHCF and DPHHS lead the initiative with technical assistance from the National Council for Mental Wellbeing.
- Child and Family Services Division partners with the Meadowlark Initiative to decrease foster care placements and support families.
- Healthy Mothers/Healthy Babies partners with Meadowlark grantees in supporting the development of community teams and partners with the PRISM for Moms line.
- JG Research and Evaluation supports data collection and evaluation activities for grantees.

# The Meadowlark Initiative

**Integrating prenatal care and behavioral health to improve maternal and neonatal outcomes**

The Meadowlark Initiative brings together clinical and community teams to:

- **PROVIDE** the right care at the right time for women and families.
- **IMPROVE** health outcomes for mothers and babies.
- **KEEP FAMILIES TOGETHER** and children out of foster care.



# System of Care

Clinical and community teams collaborate to provide **integrated prenatal and behavioral health care and coordinate community-based support and services** that families need.

This simple system has been shown to **reduce newborn drug exposure, improve maternal and neonatal outcomes, and reduce the need for foster care placement.**







# The Meadowlark Initiative: Screening

The Meadowlark Initiative provides **routine screening for mental illness and substance use disorders** to all women during prenatal and postpartum appointments as a new standard of pregnancy care.

Women with any concerns identified through screening are offered evaluation and treatment options immediately.

Of the 10,000 deliveries in Montana each year, **Meadowlark care providers now screen more than 6,000 pregnant women** for substance misuse, depression, and anxiety.



# Universal Screening

- Depression and anxiety: from 10% before Meadowlark to 70% (and above) after.
- Adoption of the AUDIT C plus 2:
  - Prior to Meadowlark 40% of sites screened for substance use in a standardized way.
  - 90% of sites not only screened during the grant period but continue to screen after the grant period ends.
- Using standardized tools for screening for social determinants.
- Screening is the beginning---clear response pathways and, ultimately culture change.

# Adapting to Change



*Things are different in our practice now; we are all paying attention to things we didn't see before. Because we have a full team, because we ask more questions, we are finding out new things, dealing with loss, approaching both parents...things are changing for all of us.*

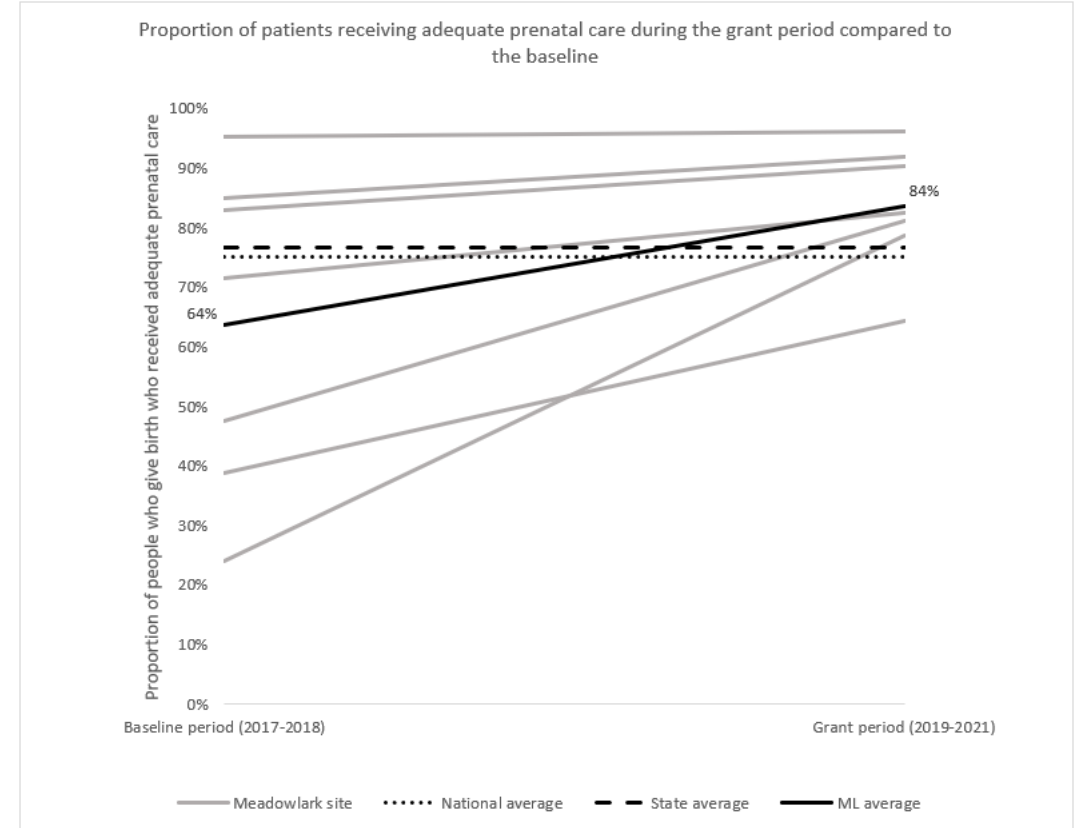
# Impact: Patients

More women are receiving adequate prenatal care

*I think they're making more of their OB appointments, because if they don't make it then I call them, and not just call them, because normally, to me, if you don't come for your OB appointment, it's because something's going on, not because you don't give a damn about your baby.*

– Care Coordinator

Note: Grey lines represent individual Meadowlark grantees. Only grantees with baseline and grant period data are included.



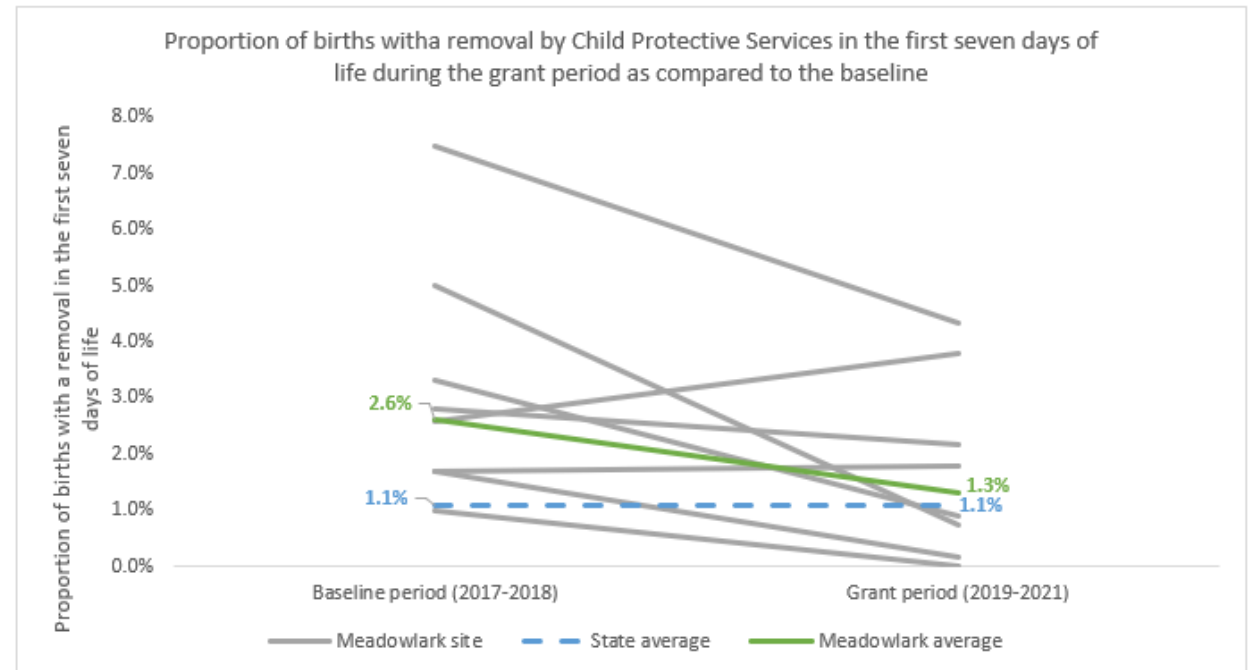


# Impact: Patients

## Fewer Family Separations

*Sometimes we didn't know all of it in the past, so I think with that relationship building, it's more transparent, right? I can tell them they're not taking this baby because grandma's moving here from Tennessee to live with them, or those kind of things, where we didn't always know all that information in the past.*

– Care Coordinator



Note: Grey lines represent individual Meadowlark grantees. Only grantees with baseline and grant period data are included.

# Impact: Patients



*I think people just don't think that like their doctor's offices where they would get help for transportation or get help for housing. And I think that might be a difference too. To the nurse, it's not relevant. But to my role, it's relevant... One of the OBs came out and they're like, "Yeah. They seem really good. They're just like a young couple." And then I get done with my appointment, I guess, with them, and they're homeless, living in a truck for four months, and using like a space heater.*

– Care Coordinator

*The big stories about women who have never taken a baby home, being able to take a baby home to parents. Then small victories in just allowing someone to talk about what postpartum depression looked like with their first child, but they never spoke about it because they were embarrassed or ashamed.*

– Care Coordinator

# Impact: Patients



*We had a lot of OBs that wanted to refer, but you don't want to just hand out the list of all the different counselors in the community and not know what they actually have to offer or what that's like.*

– Behavioral Health Provider

*Just the speed at which we're able to do it. Like I said, **that whole warm handoff approach and just knowing who they're sending people to and feeling good about that** instead of having it just be this open ended (thing).*

– Behavioral Health Provider

*I think that **it would be really hard to find one of our providers who would ever go back to not doing work like this because it just made such an impact and made their jobs so much easier, too.***

– Care Coordinator

# Post-presentation Poll

After attending this webinar, please rate your current skills and comfort in discussing maternal mental health, associated Federal legislation, and models for implementation.

- Very Low
- Low
- Moderate
- High
- Very High



# Office Hours



# Upcoming CoE Events

## **The Youth Mental Health Crisis and Opportunities for Integrated Care**

[Register for the Webinar](#) on Thursday, November 30, 2023, 1:45 pm ET

## **Equity in Action: Protecting Incarcerated Individuals Living with HIV/AIDS: Access to Equitable Care and Support**

[Register for the Webinar](#) on Thursday, December 14, 2023, 12 pm ET

Interested in an individual consultation with the CoE experts on integrated care?

[Contact us through this form here!](#)

Looking for free trainings and credits?

[Check out integrated health trainings from Relias here](#)

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# CoE Resources

- [Center of Excellence for Integrated Health Solutions](#)
- [The Meadowlark Initiative](#)
- [Montana Healthcare Foundation](#)
- [Integrating Substance Use Disorder and OB/GYN Care Brief](#)
- [Maternal, Infant, and Child Health – Healthy People 2020](#)
- [Perinatal Mental Health Alliance for People of color](#)
- [Perinatal Depression: Preventive Interventions](#)
- [WNY Postpartum Connection Inc: Directory of Mental Health and Support Services for Pregnant and Post Partum People of Color](#)



# Additional Resources

- Maternal Mental Health Leadership Alliance (MMHLA) -- [www.mmhla.org](http://www.mmhla.org)
- Postpartum Support International (PSI) -- [www.postpartum.net](http://www.postpartum.net)
- Policy Center for Maternal Mental Health ([www.2020mom.org](http://www.2020mom.org))
- National Maternal Mental Health Hotline -- 1-833-TLC-MAMA (833-852-6262) -- 24/7 voice and text support in English and Spanish.
  - Hotline staff are all highly-trained counselors, certified peer support specialists, and mental health or maternal health providers.

# Contact Us



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# References

Fawcett, E., Fairbrother, N., Cox, M., White, I. R., & Fawcett, J. M. (2019). The Prevalence of Anxiety Disorders During Pregnancy and the Postpartum Period: A Multivariate Bayesian Meta-Analysis. *The Journal of Clinical Psychiatry*, 80(4), 18r12527. doi:10.4088/JCP.18r12527

Gavin, N. I., Gaynes, B. N., Lohr, K. N., Meltzer-Brody, S., Gartlehner, G., & Swinson, T. (2005). Perinatal Depression: A Systematic Review of Prevalence and Incidence. *Obstetrics and Gynecology*, 106(5), 1071–1083. doi:10.1097/01.AOG.0000183597.31630.db

Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019 | CDC. (2022, September 26).