PERINATAL MENTAL HEALTH SUPPORT IN COMMUNITY HEALTH CENTERS: A PILOT PROGRAM

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Grant Background

- How this program originated

- Obtained state funding with the help of the Massachusetts Postpartum Depression Commission, Chaired by Rep. Ellen Story

- Lost funding in 9C cuts last fall
Why Community Health Centers?

- Largest primary care network in the state
- Patients are disproportionately low-income, publicly insured, or uninsured
- Gateway to many types of care
- Opportunity to impact perinatal mental/emotional health by integrating support into existing systems of care
Need for these programs: Prevalence of perinatal depression

- Perinatal depression affects between 1 in 7 and 1 in 5 women (Wisner et al. 2013)

- Prevalence is higher for disenfranchised women
  - Rates are nearly twice as high among lower income women of color (Chaudron et al. 2010 and Sacher 2001)
  - 40-60% of women in poverty experience PPD (Issacs 2006).
  - 26-32% of teen mothers experience PPD (Troutman & Cutrona 2009). One study of 1000 adolescents found 48% experienced postpartum depression. (Beck & Watson-Driscoll 2006).
  - Moms recovering from substance abuse are 6X more likely to have PPD (Ross & Dennis 2009).
  - DV and trauma history increase risk (Ross & Dennis 2009).
Need, cont’d: Risk Factors

- Myriad factors such as poverty and lack of social support can increase the risk for perinatal depression.

- Economic disenfranchisement, social isolation, lack of family support, and lack of access to mental and physical health services may create life stress that contributes to and/or worsens PPD symptoms (Tempelton 2008).

- Some research shows that these factors are predictors of PPD even after controlling for other demographic variables (Segre 2007).
Need, cont’d: Barriers to seeking and receiving treatment

- Our patients face many barriers!
- Lack of access to healthcare services, limited insurance coverage, childcare needs, and financial constraints (Goodman 2009)
- Stigma, idea that PPD is a “personal weakness”, unwillingness to disclose negative feelings to a healthcare provider, fear that children will be taken away (Sampson 2014)
- Cultural barriers: PPD “doesn’t exist in my community”
Need, cont’d: Screening

- Lower income women of color receive less frequent screening and treatment for postpartum depression (Beck 2001)
- If women in these demographics experience symptoms of PPD, they are more likely to minimize or ignore them because of other life stressors, shame, or stigma. (Dennis 2006)
Need, cont’d:
Why integrate services?

- Lower barriers and increase timely access to care
- We meet people where they are—literally! At their clinic appointments or with home visits.
- Reduce stigma
- Studies show that ongoing communication, onsite childcare, and integration with obstetric services increase PPD treatment rates (Beck, 2001 and Dailey 2011)
- Most effective approach to addressing PMADs is a collaborative, multi-disciplinary, integrated one
FAMILY HEALTH CENTER OF WORCESTER

Overview

- As of fiscal year 2013, 18,000 patients were enrolled at FHCW for primary care
- We provide multifaceted care in a family practice setting
  - Primary care, comprehensive prenatal care, mental health counseling, same-day walk-in, comprehensive HIV care, Suboxone Program; lab, pharmacy, radiology, U/S, mammography, HBAs, SNAP
  - WIC; 14 locations in Worcester County including school-based health services in the Worcester Public schools
- Services in 37 languages
- Prenatal Care: we see between 360-380 women per year with approximately 300 FHCW women giving birth at UMass Memorial in Worcester
Our CHWs are “OB Advocates” who are assigned to pregnant women at their initial intake between 8-10wks

Advocate is matched with a woman through pregnancy, birth, and 2 years postpartum

Provide prenatal education and support; home visits as needed

Serve as a resource for food insecurity, transportation, and housing issues

Available 24/7 for labor and delivery support as doulas

Does regular depression and tobacco screening (smoking cessation); provides anticipatory guidance RE: postpartum contraception and PP mood issues
FAMILY HEALTH CENTER OF WORCESTER: The OB Advocates

- Sussana Twi
- Luz Spanish
- Ha Vietnamese
- Fatima Portuguese
FAMILY HEALTH CENTER OF WORCESTER

Successes

- During grant period 401 postpartum women, and have made 196 referrals to counseling or other community resources

- Supported: Baby Café, Centering Pregnancy

- PHQ-9 screening (electronic) throughout pregnancy and PP at newborn/6-week PP visit, 3 months, 6 months, 9 months, and 1 year. Completed by OB Advocates; all medical assistants also trained to do PHQ-9, results shared with provider prior to visit; scores 10+ shared with advocates for closer f/u
  - On-site immediate mental health services available
  - MCPAP Program

- OB advocate weekly supervision with mental health provider
LYNN COMMUNITY HEALTH CENTER: Overview

- Target populations: children and their families, the poor, minorities, non-English speaking, teens, and the frail elderly.

- Over 90% of patients live at or below 200% of the federal poverty level, and over 50% are best served in a language other than English. 57.1% are minorities. 31.7% are immigrants or refugees.

- Over 400 new patients per month since 2006.

- 55% of staff are non-white. 55% of staff are bi/multilingual.

- 2012-2014: 16.6-18% of deliveries at LCHC were teens (DPH).

- 2013 – city of Lynn had 106 teen births. LCHC served 66 of these teen mothers 62% (DPH).

- Help uninsured patients obtain health insurance
LYNN COMMUNITY HEALTH CENTER: Grant-related Activities

- CHWs help with practical needs – referrals for housing, foodstamps, daycare, home visitors, parenting classes
- BH imbedded in OBGYN, pediatric, all primary care teams – same day or next day access.
- Home visits as needed with CHW and psychologist.
- PHQ-9 throughout pregnancy and every 6 months in medical setting.
- EPDS at 6 week PPV and 4 month well baby visit in pediatrics and 3 primary care teams.
LYNN COMMUNITY HEALTH CENTER: Successes

- CMs obtained certifications as CHWs & see women up to 1 year postpartum (instead of 6 weeks)
- High risk meetings 2x/month with CMs, nurse manager, high risk nurse, psychologist.
- EPDS put in EMR.
- All medical teams/providers in pediatrics, OBGYN, and 3 primary care teams trained to do EPDS and screening at 4 month well baby visit, and refer patients to CHWs.
- One CHW obtained Certification as a lactation consultant and another is working to obtain this.
LYNN COMMUNITY HEALTH CENTER: Successes, cont’d

- From Jan – June 2014, there have been 663 prenatal and PPD screenings.

- At least 85% of patients who delivered at LCHC in 2013 had at least 1 PPD screening during that time period using a standard tool.

- Jan-April 2015: 110 EPDS screens.

- Home visit case with mother with agoraphobia.
Southern JP Health Center: Overview

- Serve over 12,000 patients in Jamaica Plain and surrounding communities
- Over 50% of our patients are Latino. Bilingual staff.
- Affiliate of Brigham & Women’s Hospital and Partners HealthCare
- Connects patients with services such as food assistance, domestic violence assistance and tobacco cessation programs.
- Community partnerships and a focus on prevention
- Health equity and social justice frameworks
Southern JP Health Center: Grant Activities

- Primary staff: CHW and CPD/CLC
- Integration of our services into pediatrics
- Screening with EPDS
- Feeding support, emotional support, help with baby-related concerns
- Home visits
- Mental Health
- Collaborate with Perinatal Case Manager
Southern JP Health Center: Successes

- Saw over 240 patients. Avg 5.26 contacts per patient.
- We created a service that pulled departments together
- Complete integration of perinatal support: Provided continuity of care through prenatal into pedi
- Raised awareness about perinatal emotional complications
Southern JP Health Center: Successes

- Universal screening with EPDS and documenting in EMR
- Lactation! Home visits!
- Increased timely access to MH service
- Lots of emotional support
- Anecdote
Southern JP Health Center: Challenges

- Created a new initiative and hired 2 new staff
- Getting buy-in from providers
- Follow-up screens
- Documenting and creating systems
- Cultural competency
Common Successes

- Screen all patients with EPDS or PHQ-9
- Increase timely access to Mental Health services
- Use collaborative, integrated, team-based approach
Common Challenges

- Expanding the services to fill the need – space is limited!
- EPDS is not always culturally relevant
- Provider time
- Funding
Group Discussion

- **BREAK UP INTO GROUPS for 10 minutes**
  Envision an adaptation of one of the interventions presented that could be implemented in your setting.

- Each group will report back one thing that you can take back to your site/practice and implement
References


