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Moving Missouri to Action Addressing Maternal Behavioral Health

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Simply Strategy
Insights Articulated

MO Healthy MOMS
Resources, Support & Advocacy for Missouri's Moms

Forward

We must start by thanking the following professionals and organizations who comprise the state's leading experts in maternal and child health and well-being. None of this would be possible without their time participating in research interviews and sharing knowledge during strategy input sessions.

Given your importance to the health of Missouri's mothers, we truly value your time.

Aetna Better Health of Missouri

American Academy of Pediatrics

American College of Gynecologists and Obstetricians

Behavioral Health Response

Bootheel Network for Health Improvement

Cenpatico

Centene

Child Care Aware of Missouri

Compass Health

Cox Health

Division of Community and Public Health

Dunklin County Health Department

Empower Missouri

Hannibal Council on Alcohol and Drug Abuse

Health Policy Advantage

Home State Health

Maternal, Child, and Family Health Coalition of St. Louis

Mercy

Midwest Mind Body Health Center

Mississippi County Health Department

Missouri Delta Medical Center

Missouri Department of Health and Senior Services

Missouri Foundation for Health

Missouri Mental Health Foundation

Missouri Bootheel Regional Consortium

Missouri Primary Care Association

Missouri Telehealth Network - SHOW-ME ECHO

Center for Local Public Health Services, Missouri

MO HealthNet

Nurse-Family Partnership

Nurses for Newborns

ParentLink

Parents as Teachers National Center

Perinatal Behavioral Health Services

Postpartum Support International

Saint Louis County Department of Public Health

Saint Louis University, Department of OBGYN

SEMO School of Health and Human Services

Signature Medical Group, Strong Start Program

SSM Health, St. Mary's Hospital-St. Louis

St. Louis Regional Health Commission

Truman Medical Center- Lakewood Counseling

United States Preventative Service Task Force

Washington University School of Medicine

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Executive Summary

Missouri Maternal Behavioral Health

Moving Missouri to Action Addressing Maternal Behavioral Health

Quality medical care during pregnancy has not historically included consistent behavioral health screenings. Behavioral and mental health specifically are beginning to garner the attention of medical and academic communities as the social and economic effects of untreated disorders have become ever more apparent. Maternal behavioral health disorders affect 1 in 7 mothers at some point during or after their pregnancy making it "one of the most common medical complications during pregnancy and the postpartum period" (ACOG Committee Opinion, 2010). The American College of Gynecologists and Obstetricians recommends at least one screening during the perinatal period and the American Academy of Pediatrics recommends screening during the first, second, fourth and sixth month well-baby visits with a validated tool such as the Edinburgh Postnatal Depression Scale (Earls MF, 2010). While there is some awareness of the dangers of postpartum depression, this is but one of the many disorders that women face.

As the leaders of households and pillars of their communities, the health of mothers has a rippling effect on their families as well as the economy. Children with mothers that suffer from untreated maternal behavioral health disorders are more likely to have emotional problems, including clinical depression (Stein et al. 2014). Mothers themselves are more likely to develop a psychiatric disorder at some point in their lives and communities suffer from mothers not being able to return to the workforce as quickly (Shrivastava et al. 2015).

Despite the high prevalence and recommended steps to address maternal behavioral health disorders there is limited understanding of the spectrum and costs. "Suicide exceeds hemorrhage and hypertensive disorders as a cause of maternal mortality" (ACOG, 2010). While we know that suicide and infanticide are associated with behavioral health issues there continues to be a dearth of solutions available in our communities. Looking to national leaders and models it has become clear that Missouri's mothers who experience a behavioral health need require additional support. With funding from March of Dimes we have begun a journey to make Missouri's communities and families stronger, beginning with mothers. Regional thought leaders, family coalitions, medical professionals, clinicians, therapists, managed care companies, and state health experts were brought together to reflect and strategize on what Missouri needs to do in order to support families and assure that mothers can receive the essential care they need.

For the purposes of this report, perinatal mood and anxiety disorders and associated health concerns related to the well-being of mothers are referred to as "behavioral health." Substance use, often a component of behavioral health, for the purposes of this work, was excluded because of the breadth of additional considerations.

It is with the input of these experienced leaders that we have the following recommendations for Missouri.

1. As a **statewide, collective network, aggressively advocate** for funding for women's behavioral health needs via the formation of a collaborative intermediary organization.

   The state of Missouri is fortunate to have three maternal and child coalitions working to address maternal health needs within their communities. However, much of the state is left without support. Missouri lacks a unified voice, champion of policy, and funding or resources to support maternal and infant initiatives, including behavioral health. Funding does not exist uniformly and limited providers are able to access those resources that do exist. The subsequent and large scale changes desired by stakeholders require state-wide advocacy for funding and policy change. The first recommended step is to designate and form an intermediary organization to not only improve coordination but champion the statewide advocacy effort.

2. Provide **more resources and support to key clinical providers in women's health** and improve the network which connects them through training and technology.

   Not only do primary care and OBGYN providers lack staff, time, and financial incentive to provide recommended behavioral health screenings to every mom, many lack the network of specialized providers and wraparound services that provide key support. Furthermore the "art and science" of screening is itself a skill needed by more types of providers, such as the professionals within women's health offices and others in direct contact with mothers. Along with enhanced and expanded training, technology is another a tool that should be leveraged in connecting a statewide network, delivering training and connecting providers.

3. **Normalize behavioral health** for mothers and their support systems.

   To ensure the resources and support providers put in place are put to use by the 1-in-7 mothers in need, her level of comfort around discussing her behavioral health as well as equipping her network to be alert and aware of the prevalence of such common maternal behavioral health issues must be addressed. Normalizing maternal behavioral health, awareness of resources, and facilitating a tuned-in and supportive network, is the final piece of this puzzle.

Immediate Next Steps Recommended

1. Reconvene participants in multiple modes – in person and virtually – to review plan.

2. Form statewide steering council with a short term charge–to designate a statewide intermediary and funding source. Participants should include regional coalition leadership as well as providers to represent clinical care, social services and public health.

   The Council would define and establish the intermediary organization with the initial charge of the following:

a. Develop policy priorities
b. Conduct due diligence into establishing a network framework
c. Develop a three year strategic plan prioritizing the insights and strategies contained herein

Detailed Report and Recommendations
Insights & Strategies

1. **Stronger advocacy for women's behavioral health is needed from a collective statewide network.**

    A. Increase policymakers' awareness of societal impact of perinatal behavioral health

    B. Increase care to uninsured mothers

2. **Provide more resources and support to clinical providers in women's health** and improve the network which connects them through training and technology.

    A. Increase the capacity and capabilities of the provider team

    B. Support providers in redefining and improving care coordination across every touch point

    C. Utilize technology to increase connectivity

3. **Add programs and broaden existing resources to increase maternal support.**

    A. Increase mom's comfort discussing behavioral health with provider and support system

    B. Widen mom's support system

Strategies

1. Statewide Advocacy

A. Increase policymakers' awareness of societal impact of perinatal behavioral health

- Develop a policy agenda
- Communicate policy objective to policymakers in a unified voice

A policy agenda that includes economics and the effects of untreated behavioral health on Missouri must be established, and leadership from a statewide intermediary is key to facilitating this. Key policy agenda items may include developing policies regarding extending care/coverage for mothers postpartum and inter-conception, increased reimbursement for providers, as well as expansion of provider types reimbursed for screening, quality measures for behavioral health and funding for statewide programs.

Advocacy tactics should include coordination and analysis of data and utilize real stories from Missouri mothers in communications with policymakers.

Partners Needed to Move Forward

Statewide leaders, regional coalitions and provider groups will be needed to develop a complimentary role for the new intermediary to the coalitions' current responsibilities and devise a scope which fills gaps in statewide programs.

B. Increase care to uninsured mothers

- Increase education of mothers through non-traditional avenues identified by community agencies
- Identify the best opportunity to extend medical and behavioral health care for mothers beyond the 60 days postpartum coverage currently provided through Medicaid for Pregnant Women (MPW)

According to Kaiser Family Foundation, more than 40% of Missouri births are to mothers on Medicaid. Without Medicaid expansion, this group faces severe difficulties in obtaining care after pregnancy for themselves, at the time period where behavioral disorders such as postpartum depression are most likely to present. The discontinuation of care can also compound the difficulty of accessing affordable medication that mothers may have found success with while on Medicaid for Pregnant Women. Additionally, after 60 days, when postpartum Medicaid coverage ends there are increased challenges to obtaining family

planning as mothers become uninsured again. Without insurance women are less likely to interact with medical professionals outside of visits for their children or for emergencies. Despite the fact that pediatricians are encouraged to screen mothers at the first, second, fourth and sixth month well-baby visits, there is a lack of awareness around the reimbursable CPT codes as well as education and training around proper screening techniques.

Extending coverage to mothers, whether it be through expanding CHIP or expanding services under Uninsured Women's Health Services (1115 Waiver), must be addressed. Until this time, Missouri must rethink how they are reaching and educating mothers outside of doctors' offices. Local agencies and coalitions must lead the charge in advocating for non-traditional education and communication models--whether they be in informal conversations in hair salons, at daycare or through statewide PSAs displayed at local businesses, Missouri's mothers need more.

Partners Needed to Move Forward

A strong advocacy presence will not only be the responsibility of the new intermediary but also will require the participation of the wide variety in women's health providers, public health professionals, and associations which represent them, as well as support from payers including MO HealthNet and MCOs.

2. Increase support of providers

A. Increase the capacity/capabilities of the OBGYN provider team

- Through advocacy, address the reimbursement model to encourage wider screening capabilities
- Expand maternal behavioral health screening capacity of teams both in clinical and wraparound settings
- Establish a state-wide behavioral health referral network with toolkits
- Ensure *all* staff are comfortable conducting behavioral health screenings
- Improve provider understanding of HIPAA and overcome obstacles associated with the legal and necessary sharing of information

Screening every woman appropriately requires substantial resources. As more providers become reimbursed to providing screening, education on the *art and science* of screening as well as increased attention to cultural competency must accompany this change. A behavioral health referral network can be utilized to train clinicians, which could help reduce the workload of physicians. Additionally a behavioral health referral network can be used outside of education and training as a way for providers to share how they utilize their staff in an efficient way, such as through social workers or other intake workers providing screenings to ensure the recommended screening takes place. This type of peer-to-peer education is just one of the recommendations from the American Congress of Obstetricians and Gynecologists (ACOG) in the recently released Maternal Mental Health Bundle.

Going to a women's health provider should not be the only opportunity that women have to be screened. Without providing additional support and mandating screening, providers will be trapped having nowhere to refer women. The support from clinicians in wraparound services such as nurse home visiting programs or Women, Infant, & Children's (WIC) offices could also be trained on screening by the behavioral health network to help to ensure that any issues will be brought to the attention of a healthcare provider.

Continued advocacy support is needed for efforts like HB1695, which failed in 2016, which would have enabled reimbursement from MO HealthNet of LPCs and LCSWs for behavioral health screenings.

Partners Needed to Move Forward

Providers will work closely with the intermediary to access recommended trainings and toolkits from the state-wide behavioral health network. Policy advocates will work with providers to push for the expansion of providers eligible to screen.

B. Support providers in redefining and improving care coordination across every touch point

- Study, test and promote best practice care coordination models
- Offer patients co-located services

Care-coordination has been shown to be a best practice and without a statewide database and accessible patient records, questions of follow up and referrals are often left unknown, leaving mothers at risk. Co-located services, true medical home models, and group prenatal care programs are just a few promising models showing effectiveness in allowing mothers to access their care with unprecedented ease, increasing appointment attendance, adherence, and improving birth outcomes. Such coordination and co-location also enhances the quality of care from providers because they have greater insight into their patients' care and medical history. Innovative providers should be incentivized to help bring those models to greater scale and share best practices across the state.

Partners Needed to Move Moving Forward

A new intermediary or aligned stakeholder group should pursue the resources needed to align public and private health providers and insurers as well as childcare and transportation services so that the appropriate model of care-coordination and co-location can become a reality for more Missouri mothers.

C. Utilize technology to increase connectivity

- Assess effective forms of communication and adapt medical communication to fit community need
- Expand telehealth network and expertise to include maternal behavioral health

Ever changing technology demands that the medical profession find creative and appropriate technological tools. Such tools may allow providers new ways to communicate safely and securely with clients and new apps may enable clients to stay more organized, feel supported, and have access to resources. Technology not only empowers clients, but also can be utilized to support clinicians by providing them appropriate referral networks and resources.

With a shortage of providers, utilizing current telehealth and expanding their expertise to include maternal behavioral health is essential for providers with limited referral options in the wake of concerning screenings. Without such support, screening becomes ineffective.

Partners Needed to Move Forward

Stakeholders should explore the expansion of current telehealth networks' capacity, including those of hospital systems, Missouri Health Connection (MHC), the Missouri Telehealth Network (MTN) and its Extension for Community Healthcare Outcomes (ECHO). The intermediary should lead evaluation of communication methods and coordinate with government stakeholders on the adoption of new tools.

3. Increase Maternal Support

A. Widen mom's support system

- Catalog informal and formal systems that can be communicated as avenues of support
- Utilize and increase access to technology to promote additional resources
- Address barriers to care such as transportation and child care

Without a robust network of support, mothers will continue to face difficulties in addressing their maternal behavioral health needs. Expectations around motherhood can be overwhelming and mothers need broader community support. Public health and community outreach agencies need insight and funding to devise communication strategies to reach them through preferred and accessible channels. Additionally, outreach should include connectivity to the places where mothers spend their time, whether that be in churches, early childhood centers, social media, or online. Support is powerful both in person and in virtual communities. Ensuring mothers have access to technology enables them to communicate with medical professionals and find resources in their communities as well as a way to connect with warm-lines and communities of mothers via social media that can provide peer support.

Support systems look different in every community just as barriers to care vary by community. Regardless, all communities should have access to a universal crisis line.

Two prominent barriers to care are transportation and child care. Creative solutions and synergies with state-wide agencies, like Childcare Aware, should be explored as should assessing the capability of various transportation models throughout Missouri. Informal networks or shifting to a medical home model may be more feasible and effective for some communities, but support and resources are needed to help communities develop and implement solutions.

Partners Needed to Move Forward

Identifying what supports are needed in every community must be decided by experts in the field, local stakeholders, and the intermediary to become a part of the policy agenda. Community assessments led by local organizations will direct the intermediary in the best ways to reach mothers.

B. Increase mom's comfort discussing BH/MH with provider and support system

- Normalize and increase visibility of discussion of maternal behavioral health throughout the community

- Expand curriculum of prenatal classes offered in the community to include discussion of maternal behavioral health

- Hold providers accountable to successful, best practices in culturally competent screenings

Best practices tell us that screening for maternal behavioral health must take place in a system that "ensures accurate diagnosis, effective treatment, and appropriate follow up" (US Preventative Services Task Force, 2016). However; this is far from the reality due to a multitude of factors, including the fact that oftentimes women don't make regular appointments due to the many barriers they face in seeing their provider. As a community we need to look beyond provider encounters and overcome current societal messages that deter mothers from being honest about the struggles they face. Strong and supportive community messages beginning at a younger age, greater emphasis on behavioral health in prenatal education, and provider accountability in consistent and appropriate screenings will help mothers to feel supported rather than judged.

Partners Needed to Move Forward

The intermediary should explore a statewide campaign aimed at normalizing maternal behavioral health displayed in areas that mothers frequent. Providers, whether they be clinicians or educators in schools and hospitals will partner with the campaign, so as to be aligned with the message. Lastly, funding should be allocated to ensure standardization in the implementation of best practices to ensure that effective screening is being practiced in facilities around the state.

Appendix

Approach

1. Learning and Inquiry

Primary Research
Simply Strategy was engaged by the Greater Missouri Chapter of the March of Dimes to facilitate data-collection and discussion during its one-day Perinatal Mood and Anxiety Disorder (PMAD) training session in August 2014. Design utilized both quantitative and qualitative methodologies.

Three *research objectives* were explored during the PMAD facilitated discussion.

- Develop an understanding of the variety of issues facing perinatal women and their service providers across the State of Missouri as well as identifying any resource gaps which exist.
- Regionally, identify formal or informal provider networks for mood disorder treatment and referral.
- Assess the extent to which stakeholders are interested in participating and committing to ongoing collaboration toward the goal of creating a regional network.

Participants

- Among participants, a large portion came from either non-profit organizations (44%) or government and public health departments (41%).
    - Home visitor (administrator, training, educator, doula, nurse) – 31%
    - Public health nurse – 24%
    - Non-profit administrator – 11%
    - Trainer/Educator – 11%
    - Social worker – 10%
    - State administrator - 7%
    - Physician, hospital-based clinician – 3%
    - Behavioral health provider – 2%
- More than half of the participants came from the Central region. Participants from St. Louis City or County and the Eastern region together comprised another 30%. The Southeast region only had two representatives present.
- The sample is not representative of all regions or all organizations and is therefore not generalizable.

    - Quantitative survey administered through an Audience Response System (ARS)
    - Qualitative exercises completed in small groups
    - N = 110

Summary Findings

- The majority of participants felt least somewhat or moderately knowledgeable about both general and perinatal mental health issues, yet 66% had not previously received any training. It is worth continuing to explore what people know, what they want to know, and where they currently get their information.
- Among participants, 47% felt their organization had little or no knowledge of perinatal mental health issues; only 33% felt that their organization was moderately or extremely knowledgeable of perinatal mental health issues.
- The top three influencers of access to perinatal mental health services were identified as cost, transportation, and insurance, all of which are more practical concerns as compared to awareness or stigma.
- The availability of specialized providers, problems with Medicaid, and the screening of perinatal women were cited as the biggest gaps to perinatal mental health services. Many of the gaps are intertwined and require further exploration.
- More than half of the organizations being represented had no mechanism for follow-up after a referral was made, meaning that there is no way to know if women are actually receiving treatment.
- The overwhelming majority of participants,95%, felt that their organizations do not have the resources they need to meet the perinatal mental health needs of their communities.
- At least 88 participants were interested in continuing to collaborate with other members of the Missouri perinatal mental health community. Another 16 individuals were not sure, but did not say no. Ten individuals were specifically interested in leadership roles moving forward.

Literature Review

To augment what was learned in the primary research and to have a basis for comparison, a literature review was conducted.

Key insights

Maternal Behavioral Health Impacts the Health of the Entire Family

- Decreased motor tone, more abnormal reflexes, lower activity levels, less robustness and endurance, increased irritability, and inferior orientation have been found in fetuses of mothers with higher depression or anxiety scores. (Field et al; Abrams et al; Lundy; Lundy et al; Field et al) (Alder et al. 2007)
- Elevated depression scores at 32 weeks gestation and major depression diagnosed at any time during pregnancy have been related to neonatal intensive care unit admissions. (Chung et al; Misri et al) (Alder et al. 2007)
- Depression after childbirth affects a woman's feelings about herself and her relationships with her new baby, her partner, older children, and her wider family. (Tsivos et al. 2011)

Maternal Behavioral Health Can Have Effects Which Last a Lifetime

- Exposure to highly stressful events in pregnancy increases a woman's risk of developing psychiatric disorders across her lifetime. (Talge et al. 2007)
- The onset of depression negatively impacts the manner in which a mother takes care of her infant, negatively influences her quality of life, and prevents her from resuming her job, thus affecting the economic productivity of women and family. (Shrivastava et al. 2015)
- Longitudinal studies have shown that prenatal depression is associated with increased risk of child emotional problems, including clinical depression in late adolescence. (Stein et al. 2014)
- Maternal depression can contribute to intergenerational transmission of socio-economic disadvantage, making an impact on the child's quality of life and future life prospects. (Johnston et al. 2001, Bauer et al. 2015)

Mothers in Missouri have Limited Access To Care

- More than 45% of uninsured Missourians earn less than 138% of the federal poverty level, making it virtually impossible to get treatment (missourihealthmatters.com)
- MO Healthnet for Pregnant Women only provides medical coverage for mothers for 60 days postpartum so many mothers are without coverage at a critical time. (http://dss.mo.gov/fsd/mpreg.htm).
- While many organizations deal with related issues (e.g., general mental health, substance abuse, postpartum depression, family strengthening or crisis intervention) fewer organizations specifically target mental health as it relates to pregnant mothers and caregivers. (visionforchildren.org)

Aside from guiding the process ahead, this secondary research informed a fact sheet that was compiled and has been a tool to communicate the impacts and importance with those less familiar with the issue.

Individual Depth Interviews

In-depth interviews were conducted among clinicians, coalition leadership and community health leaders to more specifically inform problem areas, understand regional differences, confirm previous learnings and gain insight on Missouri mothers. Stakeholders were also solicited for suggestions of other experts needed to participate in planning sessions to ensure state-wide inclusivity and professional representation.

2. Planning Process

Persona Development

Personas of three Missouri mothers were created to illustrate the common experiences of different maternal journeys in Missouri. Personas are character profiles that reflects personality traits, core values, behaviors and life experiences of a targeted population

segment. Additionally, the personas included the experiences mothers encounter as they interact with the healthcare and public sectors, providers and their own support system.

Journey Mapping

A journey map is a visualization of a person's journey through an experience. A maternal behavioral health journey map was created to depict the touchpoints—places or situations where women come into contact with a provider or system—throughout their pregnancy and onto postpartum and interconception care.

The barriers identified in the personas and subsequently as problem points on the journey map informed the objectives utilized in strategic input sessions. Problem points were unmet or urgent needs that exacerbate barriers or gaps in cares or systems.

Strategic Input Sessions

Key stakeholders were invited to attend one of two strategic planning sessions in February of 2016. Twenty-four regional or statewide leaders attend the session held in Columbia; twenty attended the other in Cape Girardeau.

Facilitated discussions were conducted regarding these objectives:

1. Engage and widen mom's support system
2. Increase mom's comfort discussing BH/MH with provider and support system
3. Ensure all providers are comfortable conducting BH/MH screenings
4. Increase the types of providers qualified and incentivized to provide BH/MH screening
5. Understand and overcome all barriers to attending prenatal, 2-week, 6-week and annual check-ups (environmental and behavioral)
6. Improve care coordination across every touch point
7. Utilize technology to increase connectivity
8. Increase care and services to mom during inter-conception period
9. Increase policymakers' awareness of societal impact of perinatal behavioral health

Fact Sheet

Request copies from the March of Dimes.

Personas

Tiffany

- 24 years old
- Rural Missouri
- 3rd pregnancy
- On Medicaid for Pregnant Women
- History of PPD

Tiffany has two children at home, a 4 year old and a 2 year old. They share both a house and a car with her mom, who helps watch the kids if she's home during Tiffany's shifts as a server. Between transportation issues and her irregular hours at a restaurant, it's hard for Tiffany to be consistent with picking up her birth control at the health department so she's not totally shocked to discover she's pregnant.

After applying online for Medicaid for Pregnant Women, she finally receives her card after almost six weeks. She sees her health care provider for her first prenatal appointment at 19 weeks. Her OBGYN is located at the hospital about 40 minutes away in an adjacent county, but Tiffany really wants to continue with this doctor who delivered her last baby and is familiar with her.

At her first appointment, the doctor brings up her previous bout with the Baby Blues after delivery, and suggests they be on alert and ready to tackle it this time. Tiffany appreciates her concern, and fears that battle again, but tells her doctor she knows it's just something every mom has—her mom did, her friends did, and she will again.

Hopefully it won't be any worse, but she doubts there is much she can do about it. After all, she will only be able to take a few weeks off of work, and she can barely afford birth control once her Medicaid ends, much less any other visits or medications. Her doctor voices understanding, and just tells Tiffany they can talk about it if it's a bigger issue after the baby comes.

Michelle

- 22 years old
- City of Kansas City, MO
- 2nd pregnancy
- On Medicaid for Pregnant Women
- No known behavioral health history
- Smoker

At Michelle's first appointment with her provider at the FQHC, all she can talk about is how excited she is to be almost 5 months along with another baby! She already has a 1 year-old daughter at home, and is really loving motherhood, despite some major stressors in her life. When asked, she explains that between her daughter, the bus schedule, and everything else she has happening, she just couldn't make it in for a prenatal appointment any sooner.

As is standard practice at their clinic, Michelle's health care provider conducts a behavioral health screening at her 24 week appointment. Despite the fact that Michelle doesn't have a documented history of maternal or postpartum depression, her prenatal care team knows she does have a history of living with chronic stressors such as unstable housing, intermittent food insecurity, and at least one incidence of domestic violence.

Michelle's behavioral health screening score doesn't indicate a need for further screening or referral, and her behavioral health is not addressed again during the course of her prenatal care. After delivery, while Michelle packs her bags in preparation for discharge, she tells the nurse that her home may or may not have all the utilities up and running, it's always a week-by-week situation. As she leaves the hospital with her 1 year-old and 3 day-old in tow, she realizes she will not see her health care provider or the clinic staff again for a while, as there is not a strong likelihood she will load up both kids on the bus just for a "check-up" at 6 weeks postpartum. She will have to remember to call the clinic to see if someone will renew her birth control pill prescription that she was using before she became pregnant.

Jenny

- 33 years old
- Chesterfield, MO
- Privately insured by her law firm
- First pregnancy
- History of anxiety

Jenny has battled fertility issues for two and half years to get pregnant, and is almost more nervous than happy when she learns she is. At 12 weeks, her fertility specialist tells her that she can begin seeing her regular OB/GYN for the rest of her prenatal care. She sees her OBGYN at 14 weeks, and is as diligent about her prenatal care as she is her job as an attorney. Despite an internal fear of what this pregnancy and the hormones will do to her anxiety, she doesn't mention it to her doctor--even when prompted, she maintains her smile and confidence. After all, she has worked so hard for this baby, she sure can't complain. It's about the baby now, and she'll figure it out, she always does.

Her doctor doesn't complete a formal behavioral health screening, he trusts his gut and doesn't have any concerns about Jenny or her baby. Everything continues to proceed normally, and Jenny delivers a healthy baby at 40 weeks via c-section. She returns for her 2 week check-up, and her doctor immediately notices her very flat affect as she describes the usual routine of little sleep and frustration with newborn cues. He asks her about her general health and mood, and she quickly insists she's got everything under control and heads out. Her doctor assumes she must be getting enough support at home, and makes a note to follow-up again at the 6 week check-up—what more can he do if she insists she's fine?

Jenny shows up right on time to her daughter's 1 month check-up. The pediatrician immediately notices her withdrawn attitude, and an almost fearfulness of her baby. Jenny does not tell the pediatrician that the baby cries "constantly" and only calms down when her mom or husband holds her. Assuming that Jenny's primary care physician has noticed her symptoms, the pediatrician keeps her focus on the baby. When Jenny returns from the doctor her husband excitedly asks how the baby is doing, and Jenny hands him some paperwork. The baby begins to cry as it is feeding time. Jenny becomes frustrated, pushes the baby at her husband and walks away. He is left to wonder if this is something all mothers go through, and doesn't want to force the issue and make her feel like a bad mom.

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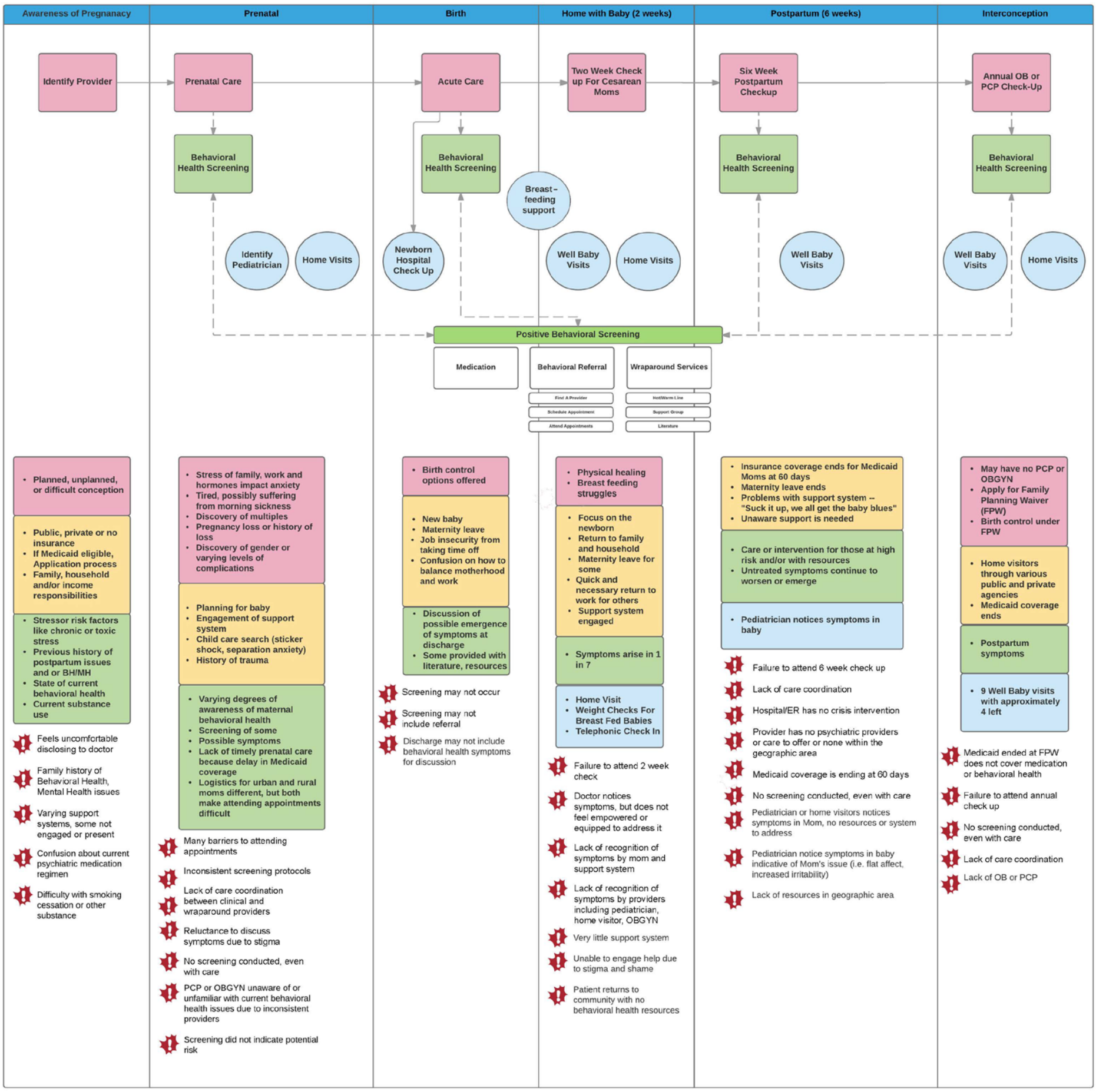
Maternal Behavioral Health Journey Map

A visualization of a mother's journey through pregnancy as it relates to her behavioral health. It describes the activities she undertakes and problem points she encounters.



Key: = Maternal = Infant = Environmental = Behavioral Health = Care Coordination = Problem Point

BH/MH = Behavioral Health/Mental Health

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ACOG Patient Safety Bundle

Glossary

Behavioral Health: Mental health is a level of psychological well-being, or an absence of a mental illness (Nami.org). Behavioral health a state of mental/emotional being and/or choices and actions that affect wellness. Substance use and misuse are one set of behavioral health problems, other problems include (but are not limited to) serious psychological distress, suicide, and mental illness. Such problems are far-reaching and exact an enormous toll on individuals, their families, communities, and the broader society. (SAMHSA)

For the purposes of this report, perinatal mood and anxiety disorders and associated health concerns related to the well-being of mothers are referred to as "behavioral health." Substance use, often a component of behavioral health, for the purposes of this work, was excluded because of the breath of additional considerations.

CenteringPregnancy: CenteringPregnancy brings 8-10 women all due at the same time together for their care. Centering group prenatal care follows the recommended schedule of 10 prenatal visits, but each visit is 90 minutes to two hours long - giving women 10x more time with their provider (centeringhealthcare.org)

CHIP: Medical coverage source for individuals under age 19 whose parents earn too much income to qualify for Medicaid, but not enough to pay for private coverage. Children's Health Insurance Program coverage varies from state to state, but all states' CHIP plans cover routine check-ups, immunizations, doctor visits, prescriptions, dental care, vision care, hospital care, laboratory services, X-rays and emergency services. Some states also cover parents and pregnant women. In Missouri of the children eligible for CHIP, 85% use CHIP. Due to Medicaid not being expanded, parents often find that their children can be covered through CHIP, but they themselves do not qualify for Medicaid. (healthcare.gov) (Investopedia.com)

Co-location: Offering multiple medical services at the same facility as a way to have greater control over patient referrals and follow up. For example, the co-location of therapy or counseling services in an OBGYN's offices.

Extension for Community Healthcare Outcomes (ECHO): Our goal is to use videoconferencing technology to provide education, training and engagement opportunities to primary care providers concerning specific disease states or conditions that are chronic, costly, common and complex. The goal is to improve patient access and health outcomes as well as reduce overall cost for care of patients.

ECHO creates ongoing learning communities where primary care clinicians receive support and develop the skills they need to treat specific conditions. Specialists serve as mentors and colleagues, sharing their medical knowledge and expertise with primary care clinicians. (medicine.missouri.edu)

Family Planning Waiver: Uninsured Women's Health Services Program, formerly referred to as the Family Planning Waiver, is healthcare coverage for women's health services to

uninsured women ages 18 up to but not including age 56. Coverage is limited to family planning and testing and treatment of sexually transmitted diseases.

Interconception: As used in this report, considered the time in-between pregnancies

Intermediary: Referred to in this report as a connecting organization working across the state to connect the regional efforts, coordinate efforts and advocate for women's health policy.

Medical Home Model: Today's medical home is a cultivated partnership between the patient, family, and primary provider in cooperation with specialists and support from the community. The patient/family is the focal point of this model, and the medical home is built around this center. These guidelines stress that care under the medical home model must be accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. (HRSA.gov)

PMAD: Perinatal Mood and Anxiety Disorder: Perinatal Mood and Anxiety Disorders have been identified in women of every culture, age, income level and ethnicity. Research shows that Perinatal Mood and Anxiety Disorders can appear during pregnancy or days or even months after childbirth, and does not usually resolve without treatment (Woolhouse H. et al. BJOG 2014). Although the term "Postpartum Depression" is often used, there is actually a spectrum of disorders that can affect mothers during pregnancy and postpartum. These include: Depression/Anxiety in Pregnancy, Postpartum Depression, Perinatal Panic Disorder, Perinatal Obsessive-Compulsive Disorder, Postpartum Posttraumatic Stress Disorder, Perinatal Bipolar Disorder, Postpartum Psychosis (Postpartum Support International.)

Show-me Healthy Babies: A new program entitled Show-Me Healthy Babies (SMHB) under the authority of the Federal Children's Health Insurance Program (CHIP) and the State Children's Health Insurance Program (SCHIP) created in 2014. SMHB is established as a separate CHIP for any low-income pregnant woman and unborn child with household income up to 300% of the federal poverty level (FPL). The purpose is to provide pregnant women with access to ambulatory prenatal care and an opportunity to connect individuals to longer-term coverage options for the baby. Targeted low-income pregnant women and unborn children will receive a benefit package of essential, medically necessary health services identical to the MO HealthNet for Pregnant Women benefit package. However; those without Missouri resident status including undocumented immigrants are ineligible for a postpartum follow-up. (dss.mo.gov)

Wraparound Services: Support services provided outside the primary medical office, by community partners, social support agencies, or other entities not directly connected to the provider but ideally linked through a referral network. Such services may include breastfeeding support, home visiting, or counseling, among others.

About the Authors

Simply Strategy
Insights Articulated

Since 2008, Simply Strategy has been utilizing the consistent model of research first, combined with efficient project management, to lead and manage multi-faceted teams. Our methodology -- inquiry, insight, ideation and implementation -- has produced successful results for clients in the public health, managed care, business, and healthcare service sectors. Passionate about the necessity of inquiry as a foundation to any program, plan, or campaign, Simply Strategy serves a range of mid-sized organizations to Fortune 500s who value an articulated strategy formed from true insight. ***Simply Strategy's multi-disciplinary team conducted the inquiry and learning process, developed materials, coordinated communication, led the planning process and completed the analysis and strategic outline.***

Health Policy Advantage

Health Policy Advantage provides policy analysis, consultation, and strategic development support to healthcare related entities and providers and was an ideal collaborator on examining the pregnancy journey of Missouri women. Susan Kendig, HPA Principal, served as co-chair of the Council on Patient Safety in Women's Health Maternal Mental Health Patient Safety Bundle. ***In addition to ensuring alignment to national best practices and policies, Health Policy Advantage provided both a legal and medical lens to the process as well as supported with session facilitation and analysis.***

MO Healthy MOMS
Resources, Support & Advocacy for Missouri Moms

Maternal Behavioral Health

An idea born as a way to emphasize mothers at the center of families' health, MO Healthy Mothers could grow to encompass research, programs, advocacy and support for the health and well-being of Missouri's mothers. While initially funded through a March of Dimes contract, this initiative hopes to engage collaborators that span both the geography of the state and the disciplines that touch families.

Maternal Behavioral Health is the first targeted area for this endeavor; future areas of interest may include:

- Smoking cessation
- Inter-conception Health
- Intimate Partner Violence
- Expansion of Medicaid, CHIP, and/or safety net programs

Funding

The March of Dimes works to end premature birth, birth defects, and other problems that threaten babies, by helping mothers to have healthy full-term pregnancies that lead to healthy babies. While March of Dimes is known for its focus on the baby, it recognizes that healthy babies begin with the health of mothers. Alarmed that one in seven mothers experience postpartum depression (PPD) following the birth of a child, but only 15 percent of those women will receive treatment, the March of Dimes advocates nationally with its allies from the American College of Obstetricians and Gynecologists (ACOG) to promote legislation, awareness and support to increase access to screening and treatment. ***The March of Dimes funded this state-wide Maternal Behavioral Health coordinating effort and thanks all agencies and individuals who participated.***