

TEAM UP Prenatal-Postpartum Transition Profile

Codman Square Community Health Center

November 2021

I. Workflow

CSHC Pediatric Care Coordinator Manual

II. Implementation Strategy and Set Up

Development of a Registry for Identifying and Tracking High-Risk Prenatal Patients

CSHC created a high-risk prenatal patient registry in Epic OCHIN Patient Lists to track all patients presenting for prenatal care in the OB/GYN department with elevated depression symptoms during their prenatal care. The high-risk registry included patients with (a) a positive PHQ-9 screening during the prenatal period, (b) a history of prior depression documented in the chart in a discrete History field, and/or (c) other specific risk factors for postpartum depression. Other risk factors included: housing insecurity; history of trauma; history of depression, anxiety or other mental health diagnoses; current mental health diagnoses; past or current domestic violence; past or present substance use; past intrauterine fetal demise (IUID); unintended pregnancy; teen pregnancy; limited social support; difficulty engaging in care; DCF involvement; and immigration status.

During the second implementation year, CSHC separated the registry to distinguish between patients who were medically high-risk and socially high-risk (although many patients fell into both categories).

Establishing Clinical Pathways for Caregivers Requiring BH Support

CSHC worked to establish clinical pathways for caregivers requiring further BH support alongside development of the high-risk prenatal patient registry. As a result of qualitative and observational learnings, in cases where caregiver mental health concerns and/or issues of caregiver-child attachment were present, Pediatric Integrated Clinicians (PICs) were assigned to provide short-course integrated treatment. In instances where issues of attachment were not present and the caregiver was a patient of the health center, short-course integrated treatment was delivered by a Behavioral Health Integrated Therapist (BHITs) caring for adult patients. In either instance, if longer-term treatment was needed, PICs, BHITs, and Family Partners (FPs) could present the case at an existing triage meeting to transition the patient into the BH specialty department.

Hiring a Pediatric Care Coordinator

CSHC hired a Pediatric Care Coordinator (PCC) with supplemental early childhood-focused funding made available from the Smith Family Foundation. Along with other care coordination responsibilities, the PCC maintained CSHC's high-risk prenatal patient registry, identify and track high-risk families in both the prenatal and postnatal periods, attend weekly high-risk case review meetings with the Maternal and Child Health Nurse and Clinical Champion, attend bimonthly prenatal group registrations, and attend Centering Pregnancy group meetings. The PCC served as a liaison between the prenatal and pediatric care teams supporting the transition between prenatal and pediatric care, ensuring both internal and external connections to BH care as needed.

III. Continuous Quality Improvement

CSHC tracked the following metrics as part of their process to evaluate their prenatal-postpartum transition care.

- Percent of prenatal patients screened for prenatal depression and/or with a documented history of previous depression.
- Percent of prenatal patients who were stratified as high-risk based on screening/risk factors.
- Percent of high-risk prenatal patients who were tracked through the defined clinical pathway to 'close the loop', e.g. percentage of high-risk prenatal/postpartum patients who were connected to services, percentage of high-risk prenatal/postpartum patients who stayed engaged with care for more than one contact.

Improving the High-Risk Prenatal Patient Registry

The Women's Health leadership and Pediatric BHI dyads (PICs and FPs) learned through observation that an automated report limited what information could be captured in the high-risk prenatal patient registry. Using the automated reporting features in OCHIN, CSHC was only able to gather the patients' latest PHQ-9 scores and current mental health diagnoses. Rather than pursuing the build of an automated report, CSHC decided to track patients' risk status using Epic OCHIN Patient Lists. The list of risk factors in the expanded criteria included: housing insecurity; history of trauma; history of depression, anxiety or other mental health diagnoses; current mental health diagnoses; past or current domestic violence; past or present substance use; past IUD; unintended pregnancy; teen pregnancy; limited social support; difficulty engaging in care; DCF involvement; and immigration status. Initially the Women's Health Clinical Champion managed the list, though the task was taken over by the PCC when that position was created and filled. To support more functionality, CSHC began working with Epic OCHIN to make the following social data collected during prenatal registration reportable: (1) primary language; (2) involvement of partner; (3) other social supports; (4) employment status; (5) food insecurity; (6) housing insecurity; (7) current or prior mental health diagnosis; (8) current or prior substance use; (9) current or prior domestic violence.

During the second implementation year, the high-risk prenatal patient registry was further improved. Through this work, the PCC worked to link the Early Intervention (EI) tracking registry and socially high-risk prenatal registry into a single master tracker, and ultimately developed pathways for referring families to EI during the prenatal period.

IV. Lessons Learned

Facilitators

The strong partnership between the Women's Health Clinical Champion, the Pediatric BHI Clinical Champion, and the BHI Project Manager helped expand Pediatric BHI services into the prenatal period and develop the PCC role to liaise between the two care teams

Challenges

The workflow changes and roll-out of new roles was difficult to communicate and standardize across team members. Additional challenges resulted from inconsistent support staff for the Women's Health department since there were no full-time Medical Assistants (MAs), and Family Medicine MAs rotated through an assignment, adding to the difficulty of rolling out new screening practices. The PCC's consistent presence and physical co-location between departments helped mitigate this challenge.

Impact Analysis

The PCC role developed out of a needs assessment and gap analysis across the Primary Care, Women's Health, and Pediatric BHI teams. It was important to recognize that the existing Pediatric BHI staff did not have the ability to take on both the expansion of services into the prenatal space as well as the level of tracking required to fully support high-risk families' prenatal-postpartum transition. Another important consideration for CSHC was in distinguishing between the roles of pediatric versus adult clinicians when working with caregivers in this perinatal period. With the PCC playing an important role in triaging and leveraging different resources, it proved important to more clearly define the scope of BHITs and PICs in particular, taking into consideration clinical areas of expertise, workload, and staffing ratios.