

TEAM UP Memo: Identifying and Tracking High-Risk Families during the Prenatal-Postpartum Transition

November 2021

I. Context and Opportunity Statement

Screening for psychosocial risk in pregnancy is an important component of comprehensive prenatal care. The American College of Obstetrics and Gynecology (ACOG) recommends screening occur at least once per trimester.^{1,2} Factors such as stress, intimate partner violence, housing instability, and lack of social support have been shown to increase risk for poor birth outcomes and depression in the prenatal and postpartum periods, with previous history of depression being one of the biggest risk factors for postpartum depression (PPD).³⁻⁷

PPD is exceedingly common, particularly in under resourced communities where upwards of 48% of mothers report elevated depressive symptoms in the postpartum period.⁸ The impacts of PPD on both the caregiver and child are well established. Caregivers with PPD may be less responsive to their infant and experience feelings of intense sadness, anxiety, or despair that prevent them from performing daily tasks.⁹ PPD may also cause caregivers to experience issues sleeping and lower likelihood to seek preventive medical treatment.^{10,11} Children of caregivers with depression are more likely to experience delays in language development and challenges with attachment, social-emotional development, learning, and adjustment to school or other social situations.^{12,13}

Given the documented link between PPD and child outcomes, the American Academy of Pediatrics (AAP) recommends screening for PPD as a routine part of well child visits in the newborn period and advocates coordination of care between pediatric and prenatal providers for caregivers with prenatally diagnosed maternal depression.³ Screening for caregiver depression is a component of TEAM UP's approach to universal developmental and behavioral screening. Additionally, TEAM UP has established prenatal-postpartum transition care as a core component of the clinical model with the goal of identifying prenatal patients with current elevated psychosocial risk or anticipated risk postpartum, communicating this risk to the child's pediatric provider, and ensuring linkage to essential services for the caregiver(s).

Evidence suggests that PPD can be addressed and even prevented by a variety of psychosocial interventions that increase social support and problem solving.¹⁴⁻¹⁷ TEAM UP is in a strong position to not only identify and refer patients with an elevated symptoms to treatment, but also prevent the development of significant symptoms in caregivers through the kinds of brief intervention that the integrated BHCs and CHW/FPs have been trained to deliver.

Within the prenatal-postpartum transition workflow, health centers will identify prenatal patients at risk for PPD or currently in crisis, using factors including a positive prenatal depression screen and history of prior depression, communicate the risk to the child's pediatric provider, and provide navigation support to access treatment, both within the health center and surrounding community. DCF involvement, substance abuse, homelessness, or other risks identified by the clinicians caring for the patient may also be included within the health center's criteria for psychosocial risk.

II. Goals of memo

This memo is intended to achieve two goals:

1. Describe the background, rationale, and available evidence base to support TEAM UP's approach to prenatal-postpartum transition care.
2. Provide a summary of learnings from experience establishing prenatal-postpartum transition programming within Cohort 1 health centers.

III. Guiding Principles

We relied on the following guiding principles in establishing minimum standards for prenatal-postpartum transition care.

- Evidence-based
 - The recommendation to establish prenatal-postpartum transition care with a minimum process of identifying prenatal patients at risk for PPD or currently in crisis, communicating this risk to the child's pediatric provider, and ensuring navigation support and access to treatment is based on a review of the evidence pertaining to prevention and management of PPD and implications of unmanaged PPD on child outcomes and family wellbeing. Available evidence is summarized in Section IV below, with citations in Section VII.
- Feasible to Implement and Sustain Long-term
 - As a core component of the TEAM UP model, minimum standards for prenatal-postpartum transition care were established with implementation feasibility and sustainability in mind. Health centers will determine the specifics of implementation (e.g., timeline, tasks, responsible parties, etc.) based on their local context and environment.
- Use of Data to Monitor Implementation
 - Unlike with other clinical workflows, prenatal-postpartum transition care often centers on the caregiver. Due to limitations to the data we can collect per Intuitional Review Board (IRB) approval, data documented in the caregiver's chart are not included in the data sets collected as part of the TEAM UP evaluation. Given this, data reports created by the BMC evaluation team will not include information on behavioral health care delivered directly to the caregiver, even in cases where such visits are delivered within the integrated pediatric setting. Pertinent available data are limited to the PCP and BHC BH plans, which both include 'parent/caregiver mental health concern' as a key issue. Nonetheless, TEAM UP implementation and evaluation teams are on hand to collaborate individually with health centers to determine alternative options for guiding implementation and monitoring progress. Some examples of ways in which Cohort 1 health centers monitored implementation of this workflow are detailed in Section V below.
- Commitment to Co-development
 - Programming for prenatal-postpartum transition care is a developing component of the TEAM UP model. While there are limitations to the data available through the TEAM UP evaluation to monitor implementation progress, we are committed to working with

health centers individually to support implementation. Additionally, we are committed to soliciting feedback from health centers on the implementation process, facilitators, barriers, and outcomes. This feedback will be used to expand our experiential knowledge and collectively advance this component of the model.

- Alignment with Other Contractual or Regulatory Requirements
 - Whenever possible, TEAM UP strives to align with health centers' other contractual and regulatory obligations. This is intended to streamline implementation of the TEAM UP model and contribute to its long-term sustainability.

IV. Available Evidence

The following summary reviews the pertinent literature related to identifying and addressing psychosocial risk factors and depressive symptoms in the perinatal period:

- Prenatal identification of psychosocial risk factors and depressive symptoms may mitigate the potential for later diagnosis of PPD in caregivers^{10,16-21}
 - Depression during pregnancy has been shown to be one of the strongest predictors of PPD onset, along with history of depression, low levels of social support, anxiety during pregnancy, and stressful life events experienced during the prenatal period.
 - Detection and management of depression prenatally may prevent symptoms from persisting into the postpartum period and reduce risk of caregivers developing PPD.
 - Effective models for PPD prevention among at risk individuals have included both group-based and individual psychological and psychosocial intervention, with approaches such as psychoeducation and problem solving showing positive effect on prevention of PPD regardless of previous depressive symptoms.
- Collaboration between prenatal and pediatric care environments can ensure continuity in care and risk monitoring to support caregiver and child health in the postpartum period^{18,22}
 - Prenatal care providers can support early engagement in pediatric care by referring families with increased psychosocial risk for a prenatal visit with a pediatric provider.
 - Pediatric primary care providers are often the only medical professionals engaged with the newly postpartum family within the first six weeks of birth.
 - Pediatric providers will additionally continue to engage with caregivers via well-child visits beyond the postnatal 6-week checkup and through the first six months following birth of the newborn when risk for PPD is remains high.
- PPD can be successfully managed in pediatric primary care settings²²⁻²⁴
 - The pediatric care environment can serve as a support system for caregivers by providing anticipatory guidance and brief intervention for the benefit of the child and family.³
 - Existing models to address PPD within the pediatric environment include screening for depressive symptoms, assessment of suicide and psychosocial risk, and care management with interventions such as brief counseling, psychoeducation, “motivating help seeking, engaging social supports, and referral to outside services as needed”.²⁴

V. Implementation Considerations, Informed by Cohort 1 Experience and Learnings

Given the existing demands on clinical workflows, the need for collaboration and partnership between obstetrical/gynecological (OB/GYN) and pediatric care settings, and the range in available services and practices across health centers, timelines and strategies for development and implementation of prenatal-postpartum transition care may differ. TEAM UP's BMC-based implementation and evaluation teams are available to provide technical assistance and clinical training to support each health center's work.

At the beginning of this effort with Cohort 1, members of MCPAP for Moms joined a Steering Committee meeting to present the resources they developed to support pediatric providers to screen for PPD and assist caregivers in accessing appropriate care. The MCPAP for Moms Toolkit for Pediatric Providers provides comprehensive guidance and an algorithm for use during pediatric well child visits (see Section VI).

Based on Cohort 1's experience, health centers may wish to engage a multi-pronged approach to identifying and managing high-risk families during the prenatal-postpartum transition. All Cohort 1 health centers began with development of a registry for tracking patients flagged as high-risk during the prenatal period. As part of this work, health centers individually determined criteria for identification of risk factors, unanimously settling on either a positive prenatal depression screen or history of depression as the primary indicator. Screening instruments utilized in Cohort 1 included both the Patient Health Questionnaire (PHQ-9) and the Edinburgh Postnatal Depression Scale (EPDS). Health centers determined the scoring threshold utilized to indicate high-risk status.

Collaboration with the IT teams at each health center facilitated the development of the high-risk patient registry and the necessary EMR functionality to ensure patients were appropriately flagged in the system based on the health center's determined criteria. Utilization of EMR functionality to automate steps in the development and management of the patient registry ensure standardization in the approach, create efficiencies in the process, and contribute to feasibility and sustainability.

Cohort 1 health centers also considered staffing to support prenatal-postpartum transition programming, identifying staff to manage the high-risk patient registry, and in some cases, also identifying an integrated behavioral health clinician (BHC) to support both OB/GYN and pediatric departments. These integrated BHCs were co-located between departments allowing for behavioral health consults and warm handoffs in the prenatal care setting, and greater communication and continuity of care through the postpartum period.

Additionally, some health centers established recurring meetings with identified members of both the pediatric and prenatal care teams to review high-risk patients in the registry, discuss treatment plans and referral options, and ensure regular communication between departments.

Detailed overviews of each Cohort 1 health center's programming can be found in the profiles linked within Section VI of this memo.

VI. Supporting Documents

MCPAP for Moms Toolkit for Pediatric Providers

Prenatal-Postpartum Transition Profile – The Dimock Center

Prenatal-Postpartum Transition Profile – Codman Square Community Health Center

Prenatal-Postpartum Transition Profile – Lowell Community Health Center

VII. References

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