Video Transcript: High Impact Practice Set (HIPS) for Outpatient Settings: Respond to Mental Health Conditions to Improve Maternal Health

Sydney Pelley:

Welcome, everyone. My name is Sydney Pelley and I'm with the Reproductive Health National Training Center, and I'm so excited to welcome you to today's webinar focused on High Impact Practices to Respond to Mental Health Conditions and Improve Maternal Health Outcomes. The RHNTC developed the high impact practice set that we're going to discuss today in collaboration with the American College of Obstetricians and Gynecologists. This set is adopted from work developed by the Alliance for Innovation on Maternal Health, or AIM. First, a few announcements. Everyone on the webinar is muted and we'll have time for questions at the end, so please type any questions into the chat at any time. A recording of today's webinar, the slide deck, and transcript will be available on rhntc.org within the next couple of days. To view closed captioning, click the CC icon at the bottom of your screen. Your feedback is extremely important in helping us to improve our work. Please take a second to open the evaluation link that's in the chat and consider completing the evaluation in real time. In order to obtain a certificate of completion or CEUs, you have to complete the evaluation and you must be logged into rhntc.org when you do it.

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I'm so happy to introduce our speakers today. Meg is a senior clinical consultant at the Reproductive Health National Training Center and is a certified nurse midwife. She has been a hospitalist and outpatient care midwife over the past 15 plus years. Meg directed the Title X program in the US Virgin Islands for about 10 years before joining the RHNTC. We also have Danielle Jones today and she is a patient advocate who works with MoMMA's Voices, a patient advocacy coalition that amplifies the voices of those who have experienced pregnancy and childbirth complications to ensure that they are activated as partners with providers and researchers to improve maternal health outcomes. Danielle is a dedicated advocate for more services and supports to address racial disparities in mental health care for BIPOC families. She serves as a volunteer for the Perinatal Mental Health Alliance for People of Color and the Single Mother Cohort in her community. Chris Raines is an adjunct professor in the Department of Psychiatry at the University of North Carolina Chapel Hill. She's both a women's health nurse practitioner and psychiatric nurse practitioner. At UNC she helped develop an integrated perinatal mental health model within the OB-GYN high risk clinics and founded the UNC Perinatal Depression Support Group. She was a member of the team instrumental in opening the first inpatient perinatal psychiatric program in the US. She's a co-author of the AIM Maternal Mental Health Safety Bundle upon which the high-impact practices we will discuss today are

based. Ms. Raines currently serves as the board chair emeritus for Postpartum Support International and maintains a private practice.

Our intention is that by the end of this webinar you'll be able to describe the impact of mental health conditions on maternal health, including its impact on racial disparities in maternal morbidity and mortality. Describe the high-impact practices, HIPS, that sexual and reproductive health providers can implement to respond to mental health conditions for improved health outcomes. And describe at least two resources that sexual and reproductive health providers can use to implement high-impact practices to respond to mental health conditions.

So we'd like to take a minute to see where the group is in terms of our confidence to do the first two objectives before we dive in. So we're going to launch a poll, please rate your confidence from one to five where one is not confident at all and five is very confident on the following objectives. Okay, great. I think we can share the results. It looks like about the majority of people, about 58% of participants are about a three for the first objective. And it looks like we're pretty evenly split for the second objective at around a two or a three. Hopefully by the end of this webinar we can get those numbers up a little bit. But thank you so much for participating and let's dive in. Meg, over to you.

Meg Sheahan:

Thanks, Sydney. So, the United States is in the midst of a maternal health crisis. We have the highest maternal mortality rate of any industrialized nation in the world. Our rate is far greater than our peer countries. It's more than two and a half times the rate of France, the next country down on this list, and it's 14 times higher than that of New Zealand.

This graph here depicts maternal mortality rates by race and Hispanic origin from 2019 through provisionally September 2023. And there's a lot to take in here. First of all, the overall rate of maternal mortality is rising, and I actually feel that the alarming rate of increase isn't well captured in this slide because the relatively short span of time is presented over a long x-axis on this graph. But the rise is driven largely by the precipitously rising rates in Black, Hispanic, and American Indian or Alaska Native individuals. The maternal mortality rate of Black individuals, which is the purple line here, is three times the rate of white individuals, and even more so the rate of Asian Non-Hispanic individuals, which are the red and green lines respectively. And the rates of American Indian and Alaska Natives peak through the shocking orange line up there at the top. Rates spiked during the acute phase of the COVID-19 pandemic in 2021 as a result of tremendous disruptions in provision of an access to care, slow maternal vaccine uptake, and worsening racial health inequities. And we see that rate, that spike go down in 2022, which signifies a move away from pandemic-related poor maternal health outcomes, but we can't be lulled into thinking that our overall rate trend over time is going down. It isn't. This is really just a return to a baseline of sorts, but that baseline is still higher than pre-COVID rates. Not shown here, but something that's very important is that women who live in rural America are about 60% more likely to die from pregnancy related causes.

Notably, 75% of pregnancy-related suicide deaths occur in the postpartum period, with 53%, or a little more than half, occurring between seven and 365 days postpartum. So this really underscores the important role of outpatient sexual and reproductive health teams who see many clients who are in this timeframe and the crucial need not to miss the opportunity to

screen for and respond to mental health conditions. Negative consequences of mental health conditions can be averted if perinatal mental health conditions are detected and treated, especially when that's done early. But despite the availability of validated screening instruments and effective treatment, perinatal mental health conditions remain underdiagnosed and untreated or undertreated. So these are the reasons that we've come together today, to learn more about how we can improve our services around mental health conditions and improve maternal health outcomes. So with this, I'm very happy to pass it over to you, Danielle. Thank you.

Danielle Jones:

Thank you so much, Meg. So hi, everyone. My name is Danielle and I am a single mother of two kids. My son Corbin is 10, and my daughter Caia, but we call her Wisdom, is two years old. I'm a licensed mental health counselor, a doula, and a podcaster, and I have a certification in perinatal mental health, and I'm also a patient family partner with MoMMA's Voices. Next slide, please.

I'm also the owner of Place of Wisdom, Maternal and Family Wellness Center. So I've been in the field of mental health for about 10 years and I shifted my focus to maternal mental health after my experience with depression during the pregnancy of my son. So while pregnant with my son, I moved away from his father and back to my hometown to be closer to family. And I was really anxious during the beginning part of my pregnancy because I just wasn't sure what to expect. I was becoming a new mom, I didn't know what I was doing. I had support from my family and friends, and I was also living with my mom at the time, so I had a lot of her support, my sisters were always around, so I was able to really get through that during that time pretty well. In 2021, I became pregnant with my daughter. And so this time again I found myself going through another breakup with their father and experiencing an unexpected, and at that time, an unwanted pregnancy, and I was experiencing depression all over again. But this time it was more severe. I was depressed, I was anxious, I was isolating because I was now living on my own. My family was not around as much. I didn't have as much support. I still had to parent my son. I had to show up for him. I also was experiencing some passive suicidal ideation. I didn't necessarily want to hurt myself, but I was having thoughts that things would be easier if I wasn't alive. I remember having this thought while lying in the bed with my son as he was falling to sleep. But I knew he needed me, I knew that the baby I was carrying needed me, and that is what prompted me to get some support. That was a really scary time for me because I never had those thoughts before. I remember calling my provider and telling them that I wanted to get back on medication because at one point previously I had taken medication for my depression and anxiety. I never explained to them why I wanted to get back on my medication, nor was I ever asked further follow-up questions as to what had changed and why I was choosing to get medication. During my appointments, I was met with general questions of how was I doing. My providers would mention mental health, but then they would quickly say something like, "Oh, well you already know about mental health because you're a counselor." So I felt dismissed in those moments. They would then proceed to ask me about my private practice and about my clients that I was serving and how things were going in my business at that time. So I felt disconnected, I felt unheard, and I felt like I wasn't really cared about. I never felt like I could share what was really going on with me because it seemed as though they expected me to be okay. I felt disconnected, and I just felt like I was going through the motions of attending my appointments as I felt like they were also doing the same with me of just going through the motions while I was there. I knew it was time for me to get help when I received a call home from school about my son's behavior. I had never experienced that before, and I realized that

my son was experiencing a different version of me. I was sad, I was irritable, I was yelling more, I was withdrawn, and it was having an impact on my son, and I knew that I needed to get help so that he wouldn't have to struggle as I was struggling. I remember sitting in my bathroom one evening and I was crying 'cause I was so overwhelmed, and my son came in and he said, "Mom, it's gonna be okay." And he gave me the biggest hug. I decided that that was my time to reach out for some help. I remember reaching out to the National Maternal Mental Health Hotline for some support because I was struggling. I also decided to go back to counseling so that I would have someone to help me through what I was going through. But the one thing I never did was tell my providers what I was experiencing because I just did not feel safe. I did not feel connected to them, and I did not feel like they really cared about what was happening with me mentally and emotionally. So what I want moms and family members and providers to know and take away from my story, what I hope you will take away is that the titles or the degrees of your family members, they don't matter.

And so, oh, you can go forward to the next slide, I'm sorry.

I want you to know that the titles of your family members and your patients don't matter, right? See them as a regular individual. I wanted to just be seen as a person without my title of a mental health counselor, or without my title of having a certification in perinatal mental health or without my title of being a doula. Perinatal mental health does not discriminate, and I hope that's something that you will remember. That it doesn't matter about your race, your age, your profession, your religion. Yes, I am a mental health counselor, but I can still experience depression, anxiety, and passive suicidal ideation as I did during the pregnancy and the postpartum period with my daughter. I hope that providers will ask more questions beyond the basic questions of just how are you doing, beyond the basic assessments that are presented at perinatal appointments. Spend time actively engaging with your clients, with your patients. A few questions on a standardized assessment can't capture everything. Ask more questions to really build that connection. So ask questions like, have you eaten today? Have you showered? Are you bonding with your baby? How are you feeling about this pregnancy? Those simple questions can open up a world of what that mom is dealing with and give you more insight into what's going on. If my providers would have had a longer conversation with me and asked just the simple questions of are you bonding with your baby? Or how are you feeling about this pregnancy? They would have learned that at that time I was struggling with going through an unwanted pregnancy. I was struggling to bond with my baby because I was sad that I was becoming a single mother again. That all of that was really taking a toll on my mental and emotional health, and that was my reality that I was dealing with every single day. So overall, I just wanted to be seen. And so I wanna encourage everyone to just see me, right? See her, see the moms in your life and your practices. See them beyond their titles, beyond their knowledge, and beyond what's presented on a basic screening tool. Spend time and ask questions beyond just general, how are things going? Take the time to really open up that space to get a better idea and picture of what that mom is dealing with on a daily basis. So I just wanna thank you all for listening to my story, and I hope that this helps you to interact with your family members and your patients in brand new ways. So I'm gonna turn it back over to you, Meg.

Meg Sheahan:

Thank you, Danielle. Thank you so much for sharing your story and your experiences.

Danielle Jones:

Yes, you're welcome.

Meg Sheahan:

So, why focus on mental health specifically in the outpatient sexual and reproductive health setting? Well, there are a few good reasons. Sexual and reproductive health providers are highly likely to encounter clients with mental health conditions. Also, SRH settings including Title X agencies are often clients only or usual source of care. So if your clients don't receive care in connection to resources and services from your clinic, from you, they might not receive them at all. Addressing mental health is an important component of preconception care which SRH providers offer, so it fits right in. SRH providers often see clients within a year of pregnancy or the late postpartum period, which is a vulnerable time, and it's a critical time for supporting maternal mental health. And SRH settings are highly engaged with clinical and social service providers and other community partners, so they're able to provide effective referrals and linkages to care. SRH providers have an important role and an important opportunity to support clients in achieving their reproductive and broader life goals and supporting mental and overall health, so there's just a lot of opportunity here.

This is a lot. So if you're wondering where to begin, we've got some guidance for you. The High Impact Practice Sets are a series of five evidence-based practices to address the leading known causes of preventable severe maternal morbidity and mortality in the United States. The RHNTC and ACOG work together to adapt patient safety bundles created by the Alliance for Innovation on maternal health to the outpatient sexual and reproductive health setting. The High Impact Practice Sets are building blocks, or you could think of them as sort of a roadmap, to improving maternal health outcomes and reducing maternal mortality.

As I just mentioned, the High Impact Practice Set series addresses the leading known causes of preventable severe maternal mortality and morbidity in the United States. And these include hypertension, cardiac conditions, substance use disorders, mental health conditions, and the postpartum transition. To support programs in implementing the high-impact practices on each topic, the RHNTC offers a package. And that package includes a webinar like this one, a job aid like the one that you see on this slide, and a measurement tool, which I'll explain in a bit.

Each High Impact Practice Set is structured around what we call the five Rs, and this is how the Alliance for Innovation on Maternal Health structures their patient safety bundles. So, the high-impact practices are grouped into practices that support readiness to address the issue, recognition and prevention of the issue, response to the issue, reporting and systems learning, and respectful care. So to carry this conversation forward, Chris, I'm gonna pass it over to you now. Thank you.

Chris Raines:

Thank you so much, Meg. And sorry, my ears kind of popped. And thank you all for the opportunity to be here and really talk about perinatal mood disorders, which is my passion, and to spread the word. It makes me extremely grateful. And really, readiness is why you're all here today, right? Because you want to understand what you can do within your practices to really make them ready to give them the, to be proactive in regard to perinatal mental health.

Knowledge is power for both our clients and ourselves, and understanding what the specific nuances of perinatal mood disorders combined with detection, assessment, and care gives us all the ability to support our clients in an evidence-based, racially equitable way. But none of us know exactly how to do that, right? I mean, we can't all know everything. So by developing and maintaining a set of referral sources, you can help support the client, plus develop relationships with your referral sources so that you can be aware of all the services that are available in your area, which really gives your clients a leg up. Because not only you're their provider, but you're providing a team support, which is really, really important. And, you know, as I think back on and listen to Danielle's story, it is so important to understand what readiness is and to understand how we can get ourselves ready so that we can ask the questions that nobody asked Danielle. So that she doesn't have to, our patients don't have to feel isolated and there's judgment there. So it's really important to be able to do that. Next slide.

So when we think about caring for people, what is the first thing that we need to do? In my opinion, I think we need to look at barriers. Barriers are set up to stop us from doing what we need to do, and that's what stops us from screening and treating perinatal patients. In a study conducted in 2013 by Nancy Byatt, it was a really important study for me to read because it looked at the different barriers, but it looked at it from different types of situations. So it looked at what are the barriers that perinatal providers have and looking at what are the conditions. Why are we not, why are we not screening? Why are we not treating? And the barriers to what the providers said was it was the lack of provider training. There was need for effective communication skills among providers to really assess the mental health needs of their client, lack of standardized protocols for screening and care, and very limited referral sources. And if these things had been put into place, Danielle might have been able to get the help she needed a little bit quicker. Next slide.

So another part of this study was what they found was what were the perceived barriers from the clients? And I think this is really important. Because as a provider myself, I understand where my barriers are, but I really have to stop and step back and understand what the barriers to my clients are. What her team found was that clients were afraid to disclose what they were experiencing for fear of CPS referral, being labeled a bad mom, and being judged. This was what surprised me though, was that clients really perceived a lack of empathy and understanding of what they were going through. They felt that their providers weren't really listening to what they said, they weren't being heard, and if they had a prior diagnosis of a mental health issue, say anxiety or depression, a lot of times providers felt like that kind of got them off the hook because they didn't really have to look at it, they could pass that along. And providers labeled anxiety and then kind of left it at that. I have seen this really in my own practice as I, my practice is working specifically with perinatal patients during pregnancy and in the postpartum period. And I had a mom that came to me in the postpartum period. She was, she was a newly delivered mom. She was in the hospital. What happened was she was in the hospital, she was like 24-hours postpartum, and she was complaining of shortness of breath and chest pain. And with that she carried a diagnosis of anxiety. So the providers and the healthcare team really looked at that well, she has anxiety, of course she's gonna have chest pain and shortness of breath. So they continued to treat her for her anxiety for over four days until somebody really stopped and listened to the patient when she said, "This isn't what my anxiety feels like, there's something else going on." They did a CT scan and found that she had a ruptured diaphragm and most of her intestinal organs were up in her chest. So that's what was causing, and of course she went to emergency surgery. But think of the trauma that mom went through. Think of how she felt not being heard and that just contributes to the mistrust of the

medical community. This is a real true story and a patient of mine. So listening to what the patient said. Another quote that I have from a patient is, "Instead of listening to me, once they knew I had anxiety, I was dismissed with the assumption that that's what my symptoms were contributing to." So we really have to listen. Next slide.

So what do we do? How do we ready our environments? What is it that we need to do to make sure that these things aren't happening? To make sure that stories like Danielle's and this patient, you know, that we are really meeting the needs from a nonjudgmental, equity based environment. So the first thing that we need to do is really examine our own biases and our own judgments concerning mental health. Interestingly enough, I have a client that is in the healthcare field and treats pregnancy and works with newborn babies. And she talks about postpartum depression, she talks about postpartum anxiety with all of her patients. She does a great job with that. But when she started having symptoms herself after the birth of her first child, she didn't understand what it was and she didn't understand how difficult and how threatening it can be. And so it really has given her, it opened her eyes into that she had judgment around this too. And I think that that's the important part of this, is that we really have to think about how we're thinking about it because we cannot provide a safe and nonjudgmental and equity-based environment if we are not normalizing mental health, if we are not understanding how we feel about it. You know, mental health is a common complication of pregnancy. Understanding that it is time limited and we have evidence-based, successful treatment options can go a long way in decreasing the stigma. Screening needs to become a vital routine, a routine vital sign, just like blood pressure and weight, and we need to establish protocols that will help normalize this process. I think back to, you know, to what Danielle said, and there were no kind of systems that were put in place to help with that. And in order to be able to do that, we need to use validated screening tools. Next slide.

So the next that we come to is recognition and prevention. And by using evidence-based and validated screening tools, we can recognize clients that are having difficulty. It also gives us a great starting point for productive conversation. Using culturally relevant tools to determine structural and social drivers of health give us the opportunity to provide resources that align with our clients' health literacy, cultural needs, and language proficiency. And I thought what Danielle said was really important. Perinatal mood disorders, I call it an equal opportunity employer, because it doesn't matter who you are, it doesn't matter, like she said, your wealth, your status, your anything, it strikes everybody. Next slide.

So here are the evidence-based screening tools that we have. I don't know how many of you guys use the Edinburgh. The Edinburgh is one of the ones that we've had for quite a few years and it was developed in the UK. John Cox developed it. So the word usage of it is a little bit strange, but it really does kind of capture what we need it to capture. The second one that we have seen used is the Patient Health Questionnaire, the PHQ-9, and also the Generalized Anxiety Disorder, the GAD-7. There's a couple of important parts of these, so we'll talk about that. Next slide.

So most of you have seen the Edinburgh. The Edinburgh is a 10-scale, self-administered, validated tool to look at how patients are feeling to really help to identify different spots or different areas that they're having difficulty with. The reason I like the Edinburgh is because it has four questions. Number four, five, and six really deal with anxiety. And from a provider's perspective, what I normally see is patients don't come in with depression, they come in with

anxiety and insomnia. So I wanted a tool that really kind of measured that anxiety part of it. But one of the things I want you to really take away from this is the Edinburgh is a tool, it is a screening tool. And, you know, being able to use this as a tool, so many people have said, "I don't know how to ask the question." I do a lot of training with home health visitors and they say, "I don't know what to say. I don't know how to ask the question." This gives you the icebreaker. This is an icebreaker. So if you have somebody that scored a three on number four, then you can say, "Well, so tell me about your anxiety. Tell me a little bit about how you're feeling. What are some things that you might be worried about?" What it does is it helps you open up the conversation and ask the questions so that people can give you the answers they need. When you're depressed or anxious and you go to a provider, you're not gonna just spill out how you're feeling because you want it to be a safe environment. This gives you a way to do that. When you're scoring the Edinburgh, you look at it, the scores are zero to three, zero being the best you've ever felt, three being the worst you've ever felt, and then you grade it on that. And usually a score of 10 or above is a positive screener. But I caution people to think about that and to really look at the screener. Because you can have somebody that answers three on number 10 and zero to the rest of them, and that to me is a positive screen. So number 10 is the suicidal ideation or the thoughts of harming themselves. Next slide.

So PHQ-9 is used a lot of times, I think pediatricians use this in their offices a lot. The nice thing about the PHQ-9, it's also a self questionnaire and you can circle the numbers, but it does correlate with the DSM-5, which is how we look at diagnoses. So that gives them a way of kind of looking at what the diagnosis might be. The only problem with the PHQ-9 is it doesn't really assess for anxiety. So if you're using this, you want to sure that you're using the GAD-7 also to really capture that anxiety component. Next question. Next slide, sorry. Next question.

And so when we think about why does this happen? You know, Meg talked earlier about how many patients go untreated and unrecognized, and the numbers were really pretty staggering. Cox out of UNC did a study in 2013 looking at what are the prevalences around screening. How many people got screened, how many didn't, and what was that, what were the treatment options? And what they found were that up to 50% of birthing persons go unrecognized, meaning they never got screened. And of the patients that got screened, 85% of the people, the 50% that did get screened, the patients that were screened positive, up to 85% of those patients never received treatment. And the other patients that did get treatment, the majority of them, sometimes up to 95%, did not get treated adequately with the right medication or with the right therapy modalities and also not to remission of symptoms. So it's important to remember that, that these numbers are slightly better in 2024, but they're not great. And so this is why we really have to provide education and decrease the stigma around screening. Next slide.

So what can we do? What is it that we can do?

When we think about a response, we want to initiate a mental health response policy and protocol that is culturally relevant and responsive to clients' values and needs. This is exactly what was not in place for Danielle. We want to offer reproductive life planning discussions and resources, including access to full range of contraceptive options for which the client is medically eligible. And in our kind of political climate now, this is hard and we have to kind of look at that, but we really want to look at activating an immediate suicide risk assessment and response protocol. Next slide.

So what does that mean? What does a protocol for mental health emergencies mean? Well, what it means is looking out when someone comes in in crisis or when someone comes in with certain types of conditions, when, you know, when do we activate this protocol? So, and by establishing protocols, we can reduce stress by knowing when to activate it and for what reasons. Is the patient actively suicidal or are they overwhelmed and having intrusive thoughts? There's an example of this from, part of the example of this is another patient out in, I think it was in California. But she was three months postpartum. She went in to her OB provider. She was starting to have scary thoughts and she felt like she needed to be seen and get treated. So she went in to get treated, talked to the OB provider, and told her what she was feeling, that she was having these really scary thoughts about her baby and she was afraid. She didn't think she was gonna act on 'em, but she was really concerned and she was having difficulty sleeping and she wasn't sure what to do, so she thought she needed to come in and be seen. The problem was, is that there were no established protocols, there was no emergency plan for emergencies, so this provider was not aware of what intrusive thoughts were and missed, decided that this was probably a psychosis. Ended up sending her to the emergency room, called the sheriff. She went to the emergency room. She was there for 18 hours, separated from her breastfeeding infant, was evaluated and determined not to be psychotic, and was discharged home. Unfortunately, the ED did not treat her symptoms, because EDs don't do that, or put in a referral for this mom. So this mom asked for help, went to where she was supposed to do, got sent away, and never got the treatment that she needed. So part of what's important to understand is what are intrusive thoughts and what is psychosis? And intrusive thoughts can be scary thoughts, and they sound horrible. But how you can distinguish between those is that patients are often very afraid of them, they're seeking help for them, they don't know what's going on. A psychosis can be intrusive thoughts, just like other mothers have. Part of the statistic is over 80% of moms or birthing persons will have some form of an intrusive thought, so they're very common. When it moves into psychosis it takes on a different flavor and it has usually some type of religious connotation to it, or it's somebody's telling me to do something. So it's not just a thought, it's more of kind of a command. So when you have that, how do you activate it? When do you activate it then, the plan? And you want to notify family, talk about emergency department, and evaluate suicide intent. Next slide.

So how do you evaluate suicide intent? How do you assess for this? You wanna identify risk factors. You wanna identify protective factors. One of the things that I say to my patients all the time, if they come to me and they score a three on their Edinburgh or we're discussing, you know, suicide or how they're feeling and they'll say, "Yeah, I'm having thoughts of hurting myself. I'm having thoughts." And so we discuss that. Instead of being frightened by that, we need to embrace that and be grateful that they're telling us this and say, "So tell me about it. What are you feeling? Why have you not done it? What is keeping you from hurting yourself?" And the majority of the time they'll say, "I can't do that to my children. I need to be here for my children." And so then that gives me the opening to really talk about, "Well then, what is it that you need right now? How can we, what is one thing that you need today that I can help you with that will give you back some control?" The majority of the time they'll say, "I need some sleep," or, "I need some help," or, "I need whatever." And so then we work around that trying to get them that help. But what if you have a patient that says, "I can't stay safe." And how do you handle that in your office? And I think this is really hard for a lot of providers and it's really frightening, especially if you're, you know, in a clinic that is not associated in the hospital or you're a outpatient clinic. What do you do? How do you handle this? How do you talk to the family? What are your HIPAA constraints around this? What are you allowed to talk about that you haven't?

Have you gotten permission from the patient? Well, each state is really different in their reporting laws. But however, if you are providing patient-centered care, which hopefully you have already discussed this with the patient, if you've seen the patient before and you've been able to really talk to them about information, what can be shared? Who is their emergency contact? One of the things that I do, I have a conversation at the beginning of all of my first sessions with patients and we talk about confidentiality. We talk about what my policy is. I tell them that everything we say in session is confidential and that I will not share anything with the exception is if I feel like they're gonna harm themselves or harm somebody else. But we will talk about that, the patient and I will develop a plan, and there will not be anything that I will do behind their back. If going to the hospital is what is necessary, then we discuss that, we talk about what that would look like. If the patient agrees, then that's great, we go ahead and initiate that admission. If not, then I have to let them know that I have to involuntarily commit them, which is a really hard decision to make. But my job as their provider is to keep them safe. And I've told them that and they know that already. And so doing some of that prep work can really be, can really be helpful. So you wanna document the risk level, determine the risk level and document. Documentation is huge. Next slide.

So in the suicide protocol, you want to talk about ideation, you want to talk about plan, behaviors, past attempts, intent, and this goes to what we were talking about, do you really intend to hurt yourself? What are the things that you planned to do it? Is this, you know, as Danielle said, it wasn't that she wanted to harm herself, she just needed a break. She wanted to run away. And I hear that from so many patients is that, "I just need, I wanna get in my car and turn it on and just drive until I can't drive anymore." And so by being able to allow patients to express themselves and you not being overreactive and frightened by that, you can work through a plan that will be helpful. Next slide.

And the fourth R is reporting, systems, and learning. Again, this speaks to the high-impact practices regarding perinatal mental health or any type of mental health which reduces barriers to care on the system level. It's great that we can do it from, you know, provider patient, but we have to look at it from a system level and reporting that data and the progress of readiness, recognition, and response can help to reduce barriers to care on the system-wide agenda. Next.

And so this is really my favorite part. This is the R and working on this safety bundle with the incredible group of people that I work with. To me, this was the most important part, the respectful and equitable supportive care. They come to us as experts and we need to make sure that they have all the information so they can make an informed decision. Next slide.

So when we talk about patient-centered or client-centered care, what do we mean? The NIH defined that as treating a person receiving healthcare with dignity, respect, and involving them in all decisions about their health. That means listening, that means educating, that means providing emotional support, compassionate care, and actively involving the patient. Next slide.

So it's really not as much a protocol as it is a change in culture, looking at how informed consent should be done. It should be patient centered. However, if we have not checked our own judgements and biases at the door, we might wanna push our own agenda. We might not wanna tell all the good, bad, and ugly because we don't want to scare the client and put ourselves, but we need to put ourselves in their shoes. Don't you wanna know all the

information? You would be upset with your provider if they didn't tell you something because they were afraid that you couldn't handle that information and so they were making a judgment for you, right? So that's really not what our job is. Some of the, not what our job is. And so we need to kind of stop and look at what it is that we need to let the patient know. Informed consent is probably one of my most important soap boxes is because I think that this is how we as providers help the patient understand all the research, all the good, the bad, and the ugly to help them and we support them making their decision. I have patients that might disagree with me and I allow that disagreement and we talk about that disagreement. We talk about what are the recommendations, but ultimately they make those decisions. And that is, from a liability standpoint, that's how it needs to be. And so some of the stuff that we're presenting today can feel a little bit uncomfortable, checking our own biases at the door, making sure that we're looking at our own judgments, but it really means that we're growing and that's what learning is all about. And that's why you guys are here today. And that is, I will send it back over to Meg.

Meg Sheahan:

All right, thank you. Thank you, Chris, so much. That was just a wealth, thank you. Okay, so we've got some good resources to support your implementation of these high-impact practices. We'll chat the links into these resources and they'll be in the slides that you can download off rhntc.org in just a few days.

So this job aid, again, it's available on the RHNTC website, presents high-impact practices to care for clients with mental health conditions along with resources to support implementation. So you've got the high-impact practice in the column on the left, and on the right you've got resources that are linked, hyperlinked, that you can click on and it will help you implement that practice. So this is one of, this particular job aid is one of a series of five job aids that are available. One for each of the HIPS topics that I mentioned a few minutes ago. The High Impact Practice Set is organized around the five Rs that Chris just discussed. Your agency may not be able to implement every high impact practice. That is absolutely okay. It's understandable completely. Start with the ones that make sense and are feasible in your context. We do suggest that you pay special attention to the starred high-impact practices, they've got a little star by them. We consider those key.

So next, we've got a measurement tool. It's an Excel spreadsheet and we designed it in collaboration with ACOG, and it will help you collect, well, it'll help you know which data to collect and how to use that data to track how your program responds to mental health conditions. This sheet disaggregation of data by race and ethnicity to help you identify and address disparities. And at the bottom of the tool it even plugs your data into a descriptive narrative that you can use to describe what you're doing, what your program is doing in this area.

So next, we've got the national psychiatric consultation line, or PSI HelpLine. It's a free expert consultation line specifically for medical prescribers. Through this helpline, prescribers can connect with a perinatal psychiatrist within 24 hours to receive expert advice on diagnosis, treatment, and medication management for preconception, pregnant, and postpartum individuals. Important thing to note though, this is not an emergency hotline.

Next, HRSA's National Maternal Mental Health Hotline, which Danielle also mentioned. It serves individuals and providers related to pregnancy, postpartum, and post-loss mental health. The line is staffed by licensed mental health and healthcare clinicians, certified peer specialists, and childbirth professionals. It's open 24/7/365 for calls or texts in English and Spanish, and they also offer other languages by request. This line is free and it's confidential.

There are a lot of very good resources out there. Too many for us to actually review in detail during this webinar. But these slides, and this slide with these links, will be posted on rhntc.org in a few days, after which you can access them and you can click on these links and the other links that were featured today so you've got them at your fingertips. All right, over to you, Sydney.

Sydney Pelley:

Thanks, Meg. So we would like to hear from all of you all now, so please take a few moments to chat in. What is one thing you'll do or do differently as a result of this discussion?

And as you're thinking about that question, we would like to come back to the poll for a minute to see where the group is in terms of our confidence to do these objectives. So we can go ahead and launch the poll. After attending this webinar, please rate your confidence from one to five where one is not confident at all and five is very confident to do our objectives today. Give it a couple more seconds. Okay great, I think we can close it. And it looks like our numbers have increased from our pre-webinar poll. It looks like the majority of people are at a four or even a five for both objectives, which is great to see. Thank you all for participating and please continue to send in your responses to the question posted in the chat and I'll pass it back over to you, Meg.

Meg Sheahan:

Great, thanks. So ,we've gotten some good questions, and thank you to those who have sent their questions. The first question is from Victoria. Danielle, it's for you. And the question says, "Danielle, would you recommend starting with a story to help patients open up? As you said, I feel a lot of the questions are asked, patients just answer them on a whim. They don't really connect to open up into their real lives. For me, if I disclose a personal story, maybe this will help them feel at ease to open up to a vulnerable conversation."

Danielle Jones:

Yes, you can hear me okay?

Meg Sheahan:

We can. Yeah.

Danielle Jones:

Okay. So yeah, that's a great, great question. Some self-disclosure can definitely be helpful. I would say, you know, don't necessarily like start off with it. Like, let the patient just kind of come in and get the conversation going. But, you know, being able to weave some self-disclosure into

those conversations are important. You know, find some similarities to share, right? So with me, I was onto baby number two, so something as simple as that of, you know, like I noticed this is baby number two for you. Like I also have two kids, you know, I know how it can be just getting ready for a second one while still taking care of a first one, right? That can build some rapport and build relationships and make people feel more comfortable if they know that there's some type of similarity that they share with you. I'll also say that all of my providers were white women. And so just me as a Black woman coming into that space, there's already some just hesitancy, and that's some things that Chris talked about is just that trust or me even sharing what was going on. Will they understand? Will they be able to relate? So having have known like some of their own story or just them sharing some things with me definitely could have been helpful.

Meg Sheahan:

Thank you-

Chris Raines:

If I can just add something, I don't mean to jump in, Meg, but one of the things that I always do when I see patients the first time, I ask them to tell about their birth story. I wanna hear about their birth story. And lot of times that will open up opportunities for you to kind of expand on things that they've talked about or what else might be going on.

Meg Sheahan:

I love that, that's a great suggestion. Thanks to you both for those responses. So, Chris, I think I'm gonna pass this one to you because you have a lot of experience in establishing these programs. The question is, "How do we get providers and departments that are heavily focused on time management and finances to adopt these kind of patient-centered and trauma-informed care and education practices, even though it takes longer? Any suggestions on how we can change the culture?" And that question is from Deborah. Thanks, Deborah.

Chris Raines:

So did you ask, you want me to answer that, Meg? I'm sorry.

Meg Sheahan:

Yep. Yep, if you could.

Chris Raines:

I think that that's a, it's a great question and I think if I had a really good answer to it, we could probably all move to the Bahamas or something because that's the question of the day. How do we do that? How do we change that culture? I think one of the things to do is to use your nursing staff to really debrief patients or to really kind of as you're doing your intake, have some of that discussion around how are you doing, what's going on? Using the tool, using the Edinburgh tool, there's no reason why you as a support staff can't use that tool to talk about what else might be going on. And so a lot of times if you do some of that front work and then you can take that information to the provider, they're usually much more likely to be able to talk to the patient and really look at it from patient-centered and trauma-focused care. It is hard. It's

hard to meet patients where they are, but I think utilizing your support staff, utilizing your nursing staff can really be helpful to do that. Because patients a lot of times will relate more to you than they do to the provider and they'll tell you more things than they'll tell the provider. And then I would recommend that you go in with the patient and the provider and just help them share what they've been feeling.

Meg Sheahan:

Thank you.

Danielle Jones:

Can I jump in real quick?

Meg Sheahan:

Please.

Danielle Jones:

I'm sorry Meg.

Meg Sheahan:

No, yeah, please.

Danielle Jones:

Because something that came to mind for me, just having experience of working in like community mental health settings and being kind of restrained by some of those same things of just like time and money and them wanting us to see people in such short time. This may be a little bit of a rebel response, but I do think that it takes someone just being that person that's willing to just kind of put themselves out there to spend a little extra time with someone, right? Although there's that time constraint and, you know, you're kind of up against some of these rules, but just sometimes just being a human, right? We are still human at the end of the day and sometimes you just have to be willing to go that extra mile just to spend that extra time and be able to capture that impact and be able to then share that to like the higher ups basically, right? So sometimes we can't always look for the change to start at the top and then come down, sometimes we just have to be willing to make that change down here at the bottom level and then be able to share that impact outside of just a number of people that we saw. But let me explain to you more of what that impact was for that patient or that client and how that potentially has helped save their life at the end of the day,

Chris Raines:

Finding champions, finding your provider and your administrative champions that feel the way you do and helping them with you kind of push through some of those policies. Great question.

Meg Sheahan:

Thank you. Okay, so I see the time. I wonder, and I hesitate to do this, I'm on the fence. Can I throw out one more question and ask if it could be answered pretty briefly in respect of people's time, but it's an important one. The question is, "We're struggling with patients who come to triage frequently and screening positive due to a lifetime attempt, which per our policy requires an in-depth social work assessment for determination of low, moderate, or high risk for suicide. We don't have enough social workers to meet this need in OB and we've talked about suppressing the full assessment if they were recently assessed and deemed low risk. I have a lot of angst about this because you don't know when today is the day when they wouldn't be low risk. But we also don't wanna alienate patients and make them not wanna be honest because they know that they'll be in triage for hours each time because of this detailed assessment requirement. Are there any suggestions on how to address this?"

Chris Raines:

Yeah, and I think that it's a great question. And, you know, some of our hospital policies are put in place to be protective, but they're really barriers to care a lot of times. And I think that may be one of 'em. You know, my recommendation is whoever is doing it, if it's the social worker who's assessing that patient, really kind of go through the assessments that we had in this webinar of, you know, looking at the suicide assessment, what is the intent, what is their motivation? And you're right. You know, I think that's the hardest part for all of us is that we never know when it's a high risk day for someone, especially someone who has attempted before. And unfortunately the uncomfortable part of that is we can determine them low risk and they can walk out the door and be high risk because of something that happened. And so there, you know, there's no guarantee and I hear your angst, but doing a good suicide assessment really, you know, even using maybe the Columbia Suicide Scale too is another one that you can look at to really determine where their risk is today and then follow up with that patient. Follow up is the most important thing you can do. You know, reach out to them the next day, reach out to them two days. That means more to the patient than anything.

Meg Sheahan:

Thank you. I'm gonna pass it over to you, Sydney.

Sydney Pelley:

Thanks Meg. With that, we'd really like to thank you for joining us today and I hope you'll join me in thanking our wonderful speakers and presenters. As a reminder, all of the materials will be available in the next week or so in rhntc.org and we'd really like to take another moment to encourage you to please complete the evaluation. We really value your feedback and it does inform our future sessions. There are a number of ways to stay in touch with us. You can subscribe to our monthly e-news by visiting rhntc.org. You can contact us through our website, sign up for an account on our website, you can follow us on LinkedIn and X. And with that, we wanna thank you again for joining the webinar and this concludes our session today. Have a wonderful day, everyone.

Chris Raines

Thank you. Thank y'all for being here.

Meg Sheahan:
Thank you.