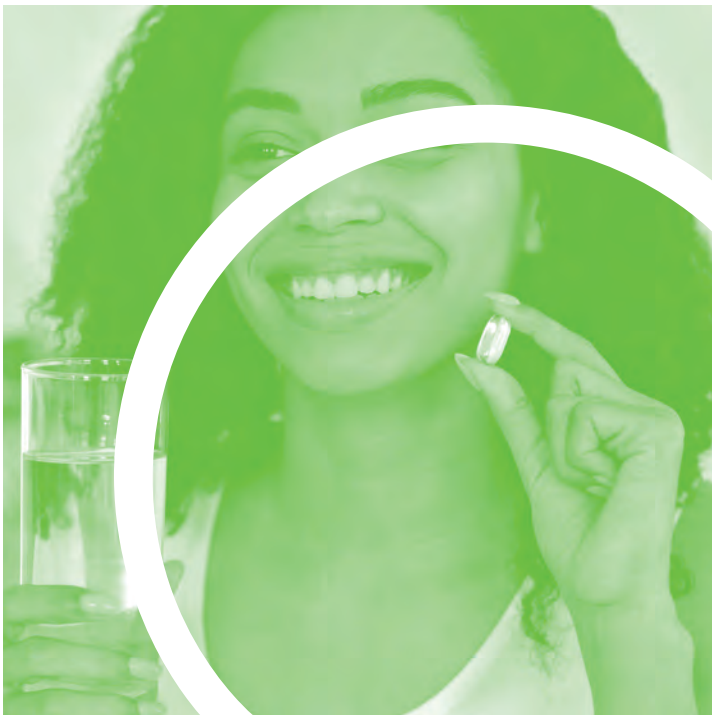

2021

Ohio Department of Health
Ohio Colleges of Medicine Government Resource Center
Ohio Chapter – American Academy of Pediatrics
March of Dimes

Healthy MOM
Healthy FAMILY
18

An IMPLICIT Interconception Care Quality Improvement Project

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Healthy Mom, Healthy Family Executive Summary

Overview

Healthy Mom, Healthy Family is a quality improvement project (QIP) designed to impact maternal and infant health and is sponsored by the Ohio Department of Health (ODH) and administered by the Ohio Colleges of Medicine Government Resource Center (GRC), in partnership with Ohio Chapter-American Academy of Pediatrics (OhioAAP) and March of Dimes. Healthy Mom, Healthy Family is based on the national network model: Interventions to Minimize Preterm and Low Birth Weight through Continuous Improvement Techniques (IMPLICIT), developed in 2003 by the Family Education Consortium Collaborative and the March of Dimes and now utilized in nine states.[1] Healthy Mom, Healthy Family builds on the quality improvement science established by the IMPLICIT Network, modified to meet the priorities and needs of Ohio families.

Background

The Ohio Infant Mortality Annual Report reveals Ohio's infant mortality rate is significantly higher than the national average. In 2018, the infant mortality rate in Ohio was 13.9 deaths/1,000 live births for Black infants and 6.9 deaths/1,000 live births for all races[2] in comparison to the same year infant mortality rate in the United States of 5.7 deaths/1,000 live births for all races.[3] Data as far back as 2009 show no significant change in the infant mortality rate for Black infants in Ohio.

Risk factors among 2018 infant deaths in Ohio revealed 42% of infants were conceived less than 18 months after a prior birth; 20% of mothers smoked during their first trimester of pregnancy; and 40% of mothers did not have first-trimester prenatal care.[2] Among women with Medicaid, 26% and 36% reported prepregnancy depression and anxiety, respectively.[4] The effect of these high-risk health behaviors and access to care on future pregnancies urges the need to provide medical care for women of childbearing age during the interconception period.[5]

A healthy mom, leads to not only a healthy family but also a healthy infant. The Ohio Pregnancy-Associated Mortality Review committee through the Ohio Dept of Health reviews all maternal deaths and makes recommendations to prevent future deaths. Half (57%) of pregnancy related deaths in Ohio from 2012-2016 were deemed preventable.[30] One recommendation that led to informing allocation of funding to this project was "the promotion of preconception health and prevention of chronic diseases during women's reproductive aged years to improve maternal health and prevent maternal morbidity and mortality and improve overall birth outcomes."[30]

Action

By the time a woman begins prenatal care, it is often too late to modify many of the high-risk health behaviors associated with poor birth outcomes.[5] The most crucial period for modifying birth outcomes is before a woman becomes pregnant, so Healthy Mom, Healthy Family focuses on four risk factors that can be addressed between pregnancies. These topics include maternal depression, tobacco use and exposure, family planning, and multivitamin use. Studies have shown mothers regularly attend their child's health care visits and are highly receptive to health advice at well-child visits.[6] By focusing on interconception health through screenings and interventions for birth mothers during well child visits 0-18 months, this QIP aims to address health behaviors and access to care that affect maternal and infant health in Ohio. The change package equips pediatricians and other primary care providers with the resources to promote interconception care and streamline processes to help mothers improve interconception health.

> "Mothers frequently turn to their pediatricians for advice about how best to care for their children. That advice need not be limited to the children that have already been born; it can and should be extended to the child who is not yet conceived."[7]

Model for Improvement Guideline

This list will serve to identify main content areas for this Quality Improvement (QI) collaborative and initial steps to get your team started on the right foot.

Who needs to know about this QI project?

- Teams can vary, but a project champion is crucial
- Notify those involved in the process to complete the patient assessment
- May include front desk, residents, nurses, MAs and/or rooming staff
- Identify someone for data collection and/or Electronic Health Record (EHR) extract

Key components for doing the project?

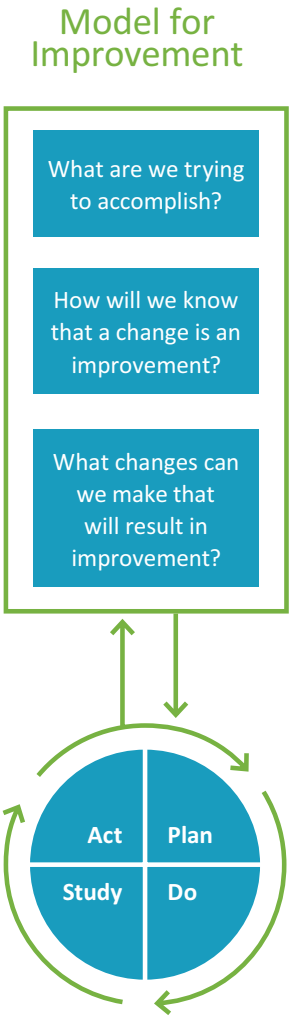
- Ask patients some simple questions to complete the data collection form and identify risk factors
- Reinforce or advise on healthy behaviors
- Administer assessments for positive screenings
- Provide education materials, referrals or other interventions

How to prepare for QI data?

- Recommend identifying a data lead at your site responsible for data submission
- Collect data on every patient who meets eligibility criteria
- Submit data on a monthly basis

Quality Improvement model

- Sites will do small tests of change utilizing the Institute for Healthcare Improvement's (IHI) Model for Improvement
- Plan-Do-Study-Act (PDSA) cycles of your choosing will be completed
- QI coaching is available for assistance
- Aggregate and site-specific data will be reviewed to demonstrate if changes are resulting in improvement



Lessons Learned

- Posters and room cards help serve as visual reminders for a new process

Source: Adapted from the IHI Model for Improvement. *http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx*

Healthy Mom, Healthy Family Overview Algorithm

ASK

Ask birth mothers 18 years or older that opt-in about depression & anxiety symptoms, tobacco and multivitamin use and family planning.

ADVISE

Educate mom about desired healthy behaviors and respond to maternal mental health needs.

- Advise mom about risks of untreated postpartum depression and anxiety.
- Advise mom to quit using tobacco products.
- Advise mom on why it is important to take a multivitamin with folic acid.
- Advise mom about healthy 18 month birth spacing.

ASSESS & ASSIST

Identify readiness for change and assist.

- Assess mom's need for care and advise on options of care.
- Assess mom's readiness to change.
  - How important is quitting tobacco?
  - How confident is she about quitting?
  - Is mom willing to quit?
- Assess mom's willingness to take a multivitamin and provide her a sample.
- Assess mom's future plans and discuss family planning and birth control options.

Discuss options for care and referral

Provide educational material

Document positive screens in child's EHR

ARRANGE

Arrange for mom to follow up with Quitline, PCP, OB/GYN, family planning center or specialist to receive interconception care via a referral or screening note.

Focus Area: Depression and Anxiety

Up to 20% of new moms have postpartum depression, and approximately 80% of new moms are affected by baby blues. Postpartum depression is the #1 problem new moms experience after having their babies. Know that postpartum depression can happen up to one year after delivery. The American Academy of Pediatrics and American College of Obstetrics and Gynecology recommend universal postpartum depression screenings of all new mothers and the use of community resources and referrals for treatment and to support mother and child.[8]

Goal

Educate mothers about the effects of untreated depression and anxiety on healthy pregnancies and birth outcomes and provide resources and/or referrals to help mothers access appropriate services.

Screening Tools

Patient Health Questionnaire 2: 2-Question Screen (PHQ-2) and Patient Health Questionnaire 9: Depression Screener (PHQ-9) can be used to screen for depression and can take less than 5 minutes. *https://www.phqscreeners.com/*

General Anxiety Disorder 2: 2-Question Screen (GAD-2) and General Anxiety Disorder 7: Anxiety Screener (GAD-7) can be used to screen for anxiety and can take less than 5 minutes. *https://www.phqscreeners.com/*

Edinburgh Postnatal Depression Scale (EPDS) can be used to screen for depression and anxiety. The EPDS was developed for screening postpartum women and can take less than 5 minutes. *https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/help-me-grow/professionals/Edinburgh-Postnatal-Scale*

Treatment Options

The "baby blues" can be treated with self-care and psychosocial support, while postpartum depression and anxiety usually require treatment. Treatment options include self-care, anti-depressant/anxiety medications, support groups, individual or group counseling or hospitalization. Postpartum psychosis is rare and requires hospitalization.

The American Academy of Pediatrics encourages sharing these considerations with breastfeeding mothers:[9]

- Avoid long-acting forms of medications.
- Try taking medication at time-of or immediately following breastfeeding (best timing can depend on the medication). Most anti-depressants and anxiolytics are safe to use while breastfeeding.
- Watch the baby for unusual signs and symptoms (e.g., sleepiness, irritability, and other potential or known effects of the medication).
- When possible, choose a medication that will expose the baby to the least amount of the medication.

Intervention

Patients with untreated depression or anxiety should be encouraged to follow up with a PCP or mental health professional. For mothers who express thoughts of suicide, follow operational guidelines in place and/or refer to the National Suicide Prevention Crisis Lifeline.

The Suicide Prevention Crisis Lifeline and Textline provides 24/7 access to crisis counselors who provide free and confidential support and/or advice when someone has an immediate need. Additional resources can be found at: *https://mchb.hrsa.gov/national-maternal-mental-health-hotline* or by calling the HRSA Maternal Mental Health Hotline: 1-833-943-5746 (1-833-9-HELP4MOMS).

Suicide Prevention Crisis Hotline:
988 or
Text 'HOME' to:
741-741

Documentation and Billing

Document positive screenings and interventions at every well-child visit from birth to 18 months in the child's EHR. Screenings for maternal depression can be billed to the child's health plan through Medicaid.

Resources

The Ohio Department of Mental Health and Addiction Services provides mental health contacts and services available by county. This community information includes consultation, treatment, and peer support services. *https://mha.ohio.gov/get-help*

Patient Outreach & Encouragement for Moms (POEM), a program of Mental Health America of Ohio, offers a free maternal mental health support program in Ohio.
https://mhaohio.org/get-help/maternal-mental-health/for-professional/

See Appendix for additional resources

Focus Area: Tobacco Use and Vaping

In 2019, more than 24% of Ohio women smoked.[10] This number increased to 40% for those with an income less than $25,000.[11] In addition, more than 1 in 3 non-smokers who live in rental housing are exposed to second-hand smoke.[12] If women quit smoking or vaping during pregnancy, it is important to discuss that they should not relapse after giving birth. Recent data has shown that women perceive e-cigarettes as safer alternatives to tobacco cigarettes though e-cigarettes also deliver nicotine which can have harmful effects on both mother and baby.[13]

Goal

Educate mothers about the effects of tobacco use and vaping on healthy pregnancies and birth outcomes, the dangers of secondhand smoke, and provide resources and/or referrals to help mothers access appropriate services.

Counseling

The 5 A's model for treating tobacco use and dependence is a brief counseling intervention and evidenced-based smoking cessation program designed to help you hold that conversation with mothers, encouraging them to quit. The 5A's can be used by any health care professional and implemented as part of a routine visit in 5-15 minutes.

- **Ask** the mother about her smoking status at the first visit and follow up at subsequent visits.
- **Advise** the mother who smokes to stop by providing advice to quit. Provide her with information about the risks of continued smoking to her family and herself.
- **Assess** the mother's willingness to attempt to quit smoking at each visit. Quitting advice, assessment, and motivational assistance should be offered at subsequent care visits.
- **Assist** who is interested in quitting by providing specific, self-help smoking cessation materials. Offer direct referral to the Ohio Tobacco Quit Line to provide ongoing counseling and support.
- **Arrange** follow-up visits to track the progress of the mother's attempt to quit smoking. For current and former smokers, smoking status should be monitored and recorded, providing opportunities to congratulate and support success, reinforce steps taken toward quitting, and advise those still considering a cessation attempt.

To learn more about the Ohio Tobacco Quit Line, or to enroll in the program call:

1-800-QUIT-NOW

(1-800-784-8669)

or visit:

http://ohio.quitlogix.org

Intervention

Based on the mother's willingness to quit, referrals can be made to the Ohio Tobacco Quit Line, a free tobacco quit line counseling service for uninsured Ohioans, Medicaid recipients, pregnant women, and members of the Ohio Tobacco Collaborative, or parents can be encouraged to seek care with their PCP for further resources.

Documentation and Billing

Document positive screenings and interventions at every well-child visit from birth to 18 months in the child's EHR. Screenings for tobacco use can be billed to the child's health plan through Medicaid.

Resources

The Ohio Partners for Smoke Free Families provides resources designed to support healthcare professionals in implementing or improving tobacco cessation services within their organization. *http://ohiosmokefreefamilies.org/*

The American Academy of Family Physicians' "Ask and Act" tobacco cessation program encourages family physicians to ASK all patients about tobacco use, and then to ACT to help them quit. More details can be found at *http://www.aafp.org/patient-care/public-health/tobacco-nicotine/ask-act.html*

See Appendix for additional resources

Focus Area: Multivitamin/Folic Acid

Nutritional needs change as women move through their child-bearing years and beyond. Benefits of taking folic acid during pregnancy occur by 4 weeks gestation, before most women know they are pregnant. All women benefit from taking a multivitamin, regardless of pregnancy intention, to build strong bones, prevent against heart disease, and strengthen hair, skin and nails.

Goal

Educate mothers about the benefits of multivitamin use for healthy pregnancies and birth outcomes and provide resources and/or referrals to help mothers access appropriate services.

Nearly half of all pregnancies are unplanned... **AND** of those unplanned pregnancies, nearly half of the women **were** using contraception.[21]

Counseling

- Describe benefits of multivitamin use for all women of child-bearing age, regardless of pregnancy intention.
- Recommend 400 micrograms of folic acid daily for all women of childbearing age.[14, 15]
  - This increases to 4mg daily if mom has had a child with a neural tube defect.
- Encourage moms to begin taking folic acid before conception.[16]
- Encourage 200-300mg/day of DHA to support development of baby's brain and eyes and encourage heart health for mom.[17]
- Talk about adverse effects and remind moms that too many vitamins and minerals can be harmful to them and their unborn babies.
- Health Disparity: Neural tube defects are more likely in children born to Hispanic/Latina women.[18, 19, 20]

Intervention

For moms currently not taking a multivitamin:

- Provide the multivitamin sample distributed through the IMPLICIT project.
- Discuss over the counter (OTC) and prescribed options for vitamins
- If using OTC, discuss important details to focus on when selecting an option available at a local store or online

Taking folic acid prior to and during early pregnancy prevents serious birth defects, such as neural tube defects.

Important nutrients for women:

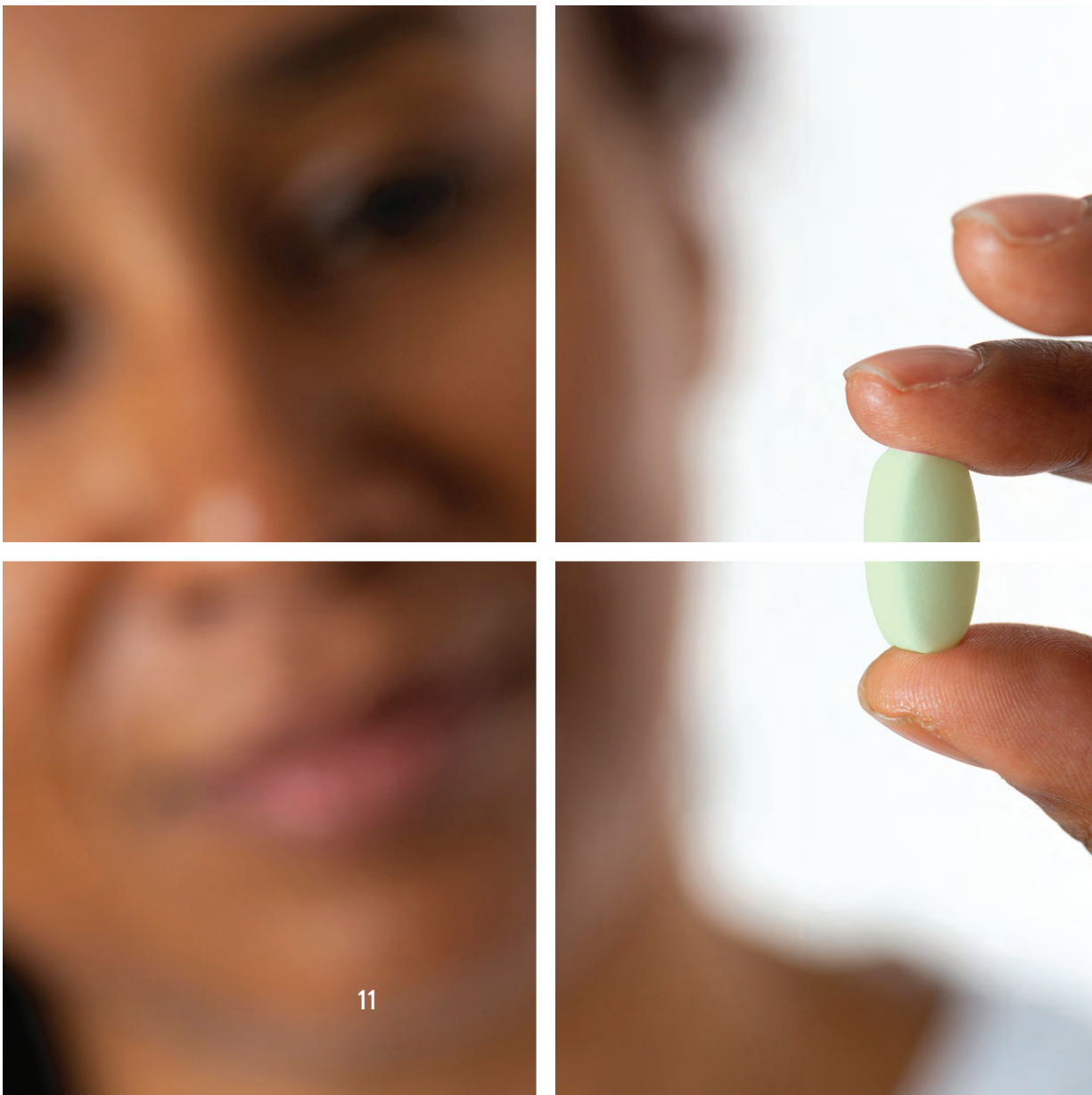
1. Folic Acid
2. Iron
3. Calcium
4. Vitamin D
5. DHA

Resources

Multivitamin/mineral Supplements - Fact Sheet for Professionals:
https://ods.od.nih.gov/factsheets/MVMS-HealthProfessional/

Multivitamin/mineral Supplements - Fact Sheet for Consumers:
https://ods.od.nih.gov/factsheets/MVMS-Consumer/ (English)
https://ods.od.nih.gov/factsheets/MVMS-DatosEnEspanol/ (Spanish)

Folic Acid & Gestational Diabetes Post Cards, Brochures, Fact Sheets, & Posters
https://www.cdc.gov/ncbddd/folicacid/materials/factsheets.html



Focus Area: Family Planning

Ideal family planning for most women includes 18-month spacing between pregnancies to reduce the risk of delayed prenatal care and adverse birth outcomes, including preterm birth, low birthweight and neonatal morbidity.[22] Ongoing health problems such as developmental delays, asthma, and vision and hearing loss are also frequently associated with adverse birth outcomes of children.[23]

Birth spacing is important in preventing adverse birth outcomes as it allows mothers to build up supplies of folic acid and nutrients; heal from infection and inflammation during pregnancy;[24] and seek care and management of pre-existing conditions such as hypertension, diabetes and obesity.

Goal

Educate mothers about the role ideal birth spacing plays in healthy pregnancies and birth outcomes and provide resources and/or referrals to help mothers access appropriate family planning services.

Birth spacing of less than 6 months increases preterm birth by about 40%.[26]

Counseling Intervention

Identify the mother's pregnancy intentions.

- One Key Question® can be used to routinely ask mom about her interest or plans to become pregnant.[25] This simple tool can be used to begin the conversation around family planning and the recommended 18-month spacing between pregnancies.
  - Providers can ask: "Would you like to become pregnant?" and offer four responses: Yes, No, Ok Either Way, Unsure.[25]

Explore pregnancy intentions & birth control experiences and preferences.

- Encourage a healthy 18-month spacing between pregnancies.
  - Providers can ask: "What questions can I answer for you about family planning and birth control options?"
- After initial conversations on family planning, it is suggested to reiterate or confirm pregnancy planning intentions at every well-child visit from birth to 18 months.

Provide educational handout, screening note and/or encourage mom to follow up with a PCP, OB/GYN, or local family planning center to discuss or receive birth control and family planning assistance.

Many Black women lack access to quality contraceptive care and counseling, including being less likely than white or Latina women to receive postpartum contraception — or when they do did receive it, being less likely to receive a highly effective method.[27, 28]

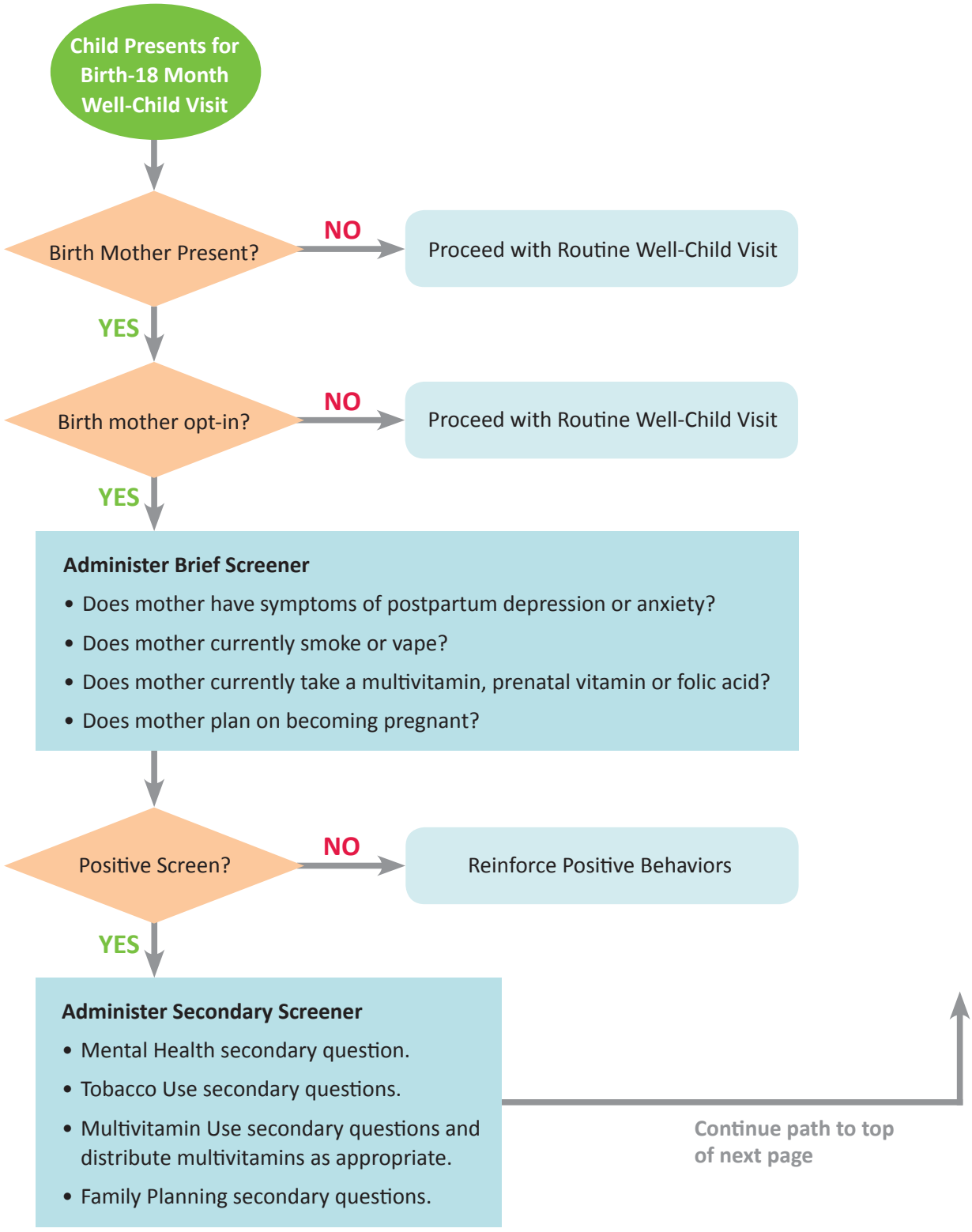
Resources

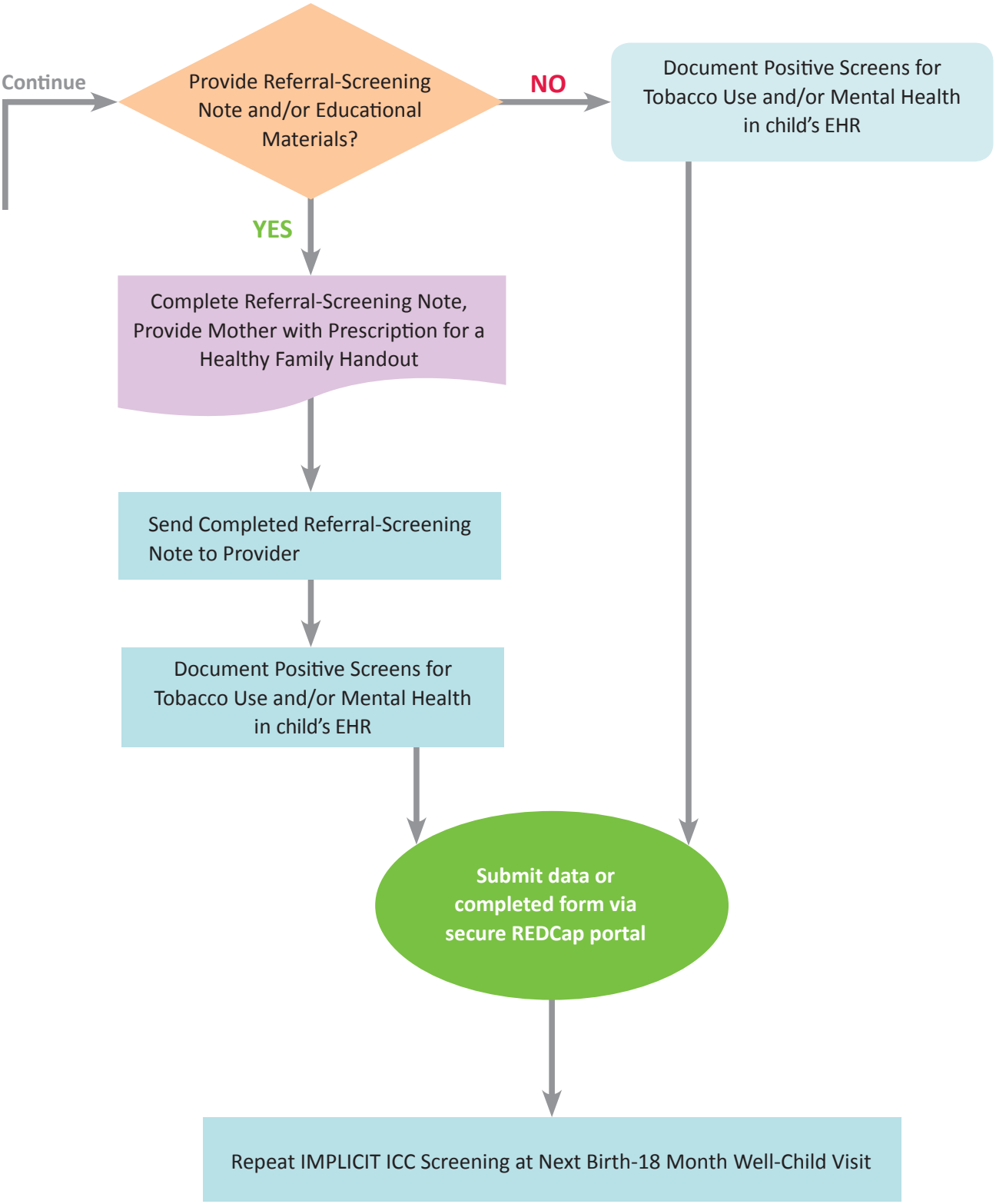
The March of Dimes offers online tips, resources and planning guides for moms interested in pregnancy planning and interconception health.
https://www.marchofdimes.org/pregnancy/planning-your-pregnancy.aspx

The Ohio Department of Health Reproductive Health and Wellness Program (RHWP) provides family planning resources with a focus on those in greatest need and priority populations. Local and online family planning centers and services can be determined and accessed via an online portal based on patient zip code. Fees are based on family size and income with no residency requirements and no one denied access to services.
https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/reproductive-health-and-wellness-program/welcome/

See Appendix for additional resources

Healthy Mom, Healthy Family Workflow




Continue
Provide Referral-Screening Note and/or Educational Materials?
NO
Document Positive Screens for Tobacco Use and/or Mental Health in child's EHR
YES
Complete Referral-Screening Note, Provide Mother with Prescription for a Healthy Family Handout
Send Completed Referral-Screening Note to Provider
Document Positive Screens for Tobacco Use and/or Mental Health in child's EHR
Submit data or completed form via secure REDCap portal
Repeat IMPLICIT ICC Screening at Next Birth-18 Month Well-Child Visit

Appendices

Depression and Anxiety

Prevalence, onset, symptoms and treatment of baby blues, postpartum depression and postpartum psychosis.

Type/Prevalence/Onset	Symptoms
Baby Blues Affects approx. 80 percent of new mothers. Begins in first weeks after delivery and symptoms usually resolve in two weeks.	- Crying, weepiness / sadness - Irritability/frustration - Exaggerated sense of empathy - Anxiety - Feeling overwhelmed - Fatigue / exhaustion / insomnia
Postpartum Depression Affects approx. 10-20 percent of new mothers Usually begins within first two to three months postpartum or earlier if baby blues last longer than two weeks. Can occur anytime in first year.	- Frequent crying/persistent sadness - Anxiety - Fatigue/Insomnia, hyperinsomnia - Poor concentration or indecisiveness - Not feeling up to doing everyday tasks - Significant decrease or increase in appetite - Feelings of worthlessness, inadequacy or guilt - Poor bonding with baby or lack of interest for baby or family activities - Somatic symptoms (extreme focus on pain or physical symptoms) - Recurrent thoughts of death or suicide*
Postpartum Psychosis* Affects approx. 1-2 per 1,000 new mothers. Usually starts two to four weeks postpartum or earlier, but can occur anytime in first year.	- Hopelessness - Feeling agitated, angry - Anxiety - Insomnia - Paranoia / Delirium / Confusion / Mania - Auditory hallucinations/delusions (often of baby/of a religious nature) - Visual hallucinations (often seeing or feeling a presence of darkness) - Thoughts of harming or killing self, others, or the infant*
*Mothers who express thoughts of suicide or signs of postpartum psychosis, follow operational guidelines in place and/or refer to the National Suicide Prevention Crisis Lifeline: 988 or Text 'HOME' to: 741-741.	

Adapted from Santoro K, Peabody H. Identifying and Treating Maternal Depression: Strategies and Considerations for Health Plans. NIHCM Foundation Issue Brief. Washington DC: National Institutes of Health Care Management; 2010:3
Additional resources can be found at: https://mchb.hrsa.gov/national-maternal-mental-health-hotline or by calling the HRSA Maternal Mental Health Hotline: 1-833-943-5746 (1-833-9-HELP4MOMS).

Appendices

Tobacco Use

A Brief Summary of the U.S. Preventive Services Task Force (USPSTF) Recommendation for Counseling and Interventions to Prevent Tobacco Use and Tobacco-Caused Disease in Adults and Pregnant Women: The Evidence Behind the 5 A's Evidenced-Based Smoking Cessation Counseling Practice

Population	For adults age ≥18
Recommendation	Ask about tobacco use. Provide tobacco cessation interventions to those who use tobacco products.
Counseling	The 5 A's framework provides a useful counseling strategy: 1. Ask about tobacco use 2. Advise to quit through clear, personalized messages 3. Assess willingness to quit 4. Assist to quit 5. Arrange follow-up and support Intensity of counseling matters. Brief (5–15 minutes), one-time counseling works; however, longer sessions or multiple sessions are more effective. Consistency of counseling matters. All health care providers should implement the intervention at every visit. Telephone counseling "quit lines" also improve cessation rates.
Pharmacotherapy (treatment of diseases with drugs)	Combination therapy with counseling and medications is more effective than either component alone for the general adult population. U.S. Food and Drug Administration (USFDA)-approved pharmacotherapy includes nicotine replacement therapy, sustained-release bupropion, and varenicline.*
Implementation	Successful implementation strategies for primary health care include: • Instituting a tobacco user identification system • Promoting health care intervention through education, resources, and feedback • Dedicating staff to provide treatment and assessing delivery of treatment in staff performance evaluations
Relevant Recommendations from the USPSTF	Recommendations on other behavioral counseling topics are available at *https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/tools-and-resources-for-better-preventive-care*

*While varenicline should never be used in pregnant women, other professional organizations include recommendations for providers to assess risks and benefits of pharmacotherapy when counseling and support alone is not successful. Pregnant women should be referred to their treating provider to discuss pharmacotherapy.

Appendices

Family Planning

Reversible Methods of Birth Control

Method Options	Typical Use Effectiveness	How Long Does It Last	Administration	Possible Bleeding Changes	Common Side Effects	When Pregnancy Can Occur if Discontinued
IUD (non-homonal)	99% effective	Up to 10 years	Inserted by provider	Heavier periods that may return to normal after 3-6 months	Cramping that usually improves after 3-6 months, spotting	Immediately (Provider can remove implant at any time.)
IUD (hormonal)	99% effective	Up to 5 years, varies by product	Inserted by provider	Irregular, lighter, or no period at all	Cramping after insertion, spotting, nausea, breast tenderness	Immediately (Provider can remove implant at any time.)
Implant	99% effective	Up to 3 years	Inserted by provider	Infrequent, irregular, prolonged, or no period at all	Insertion site pain, nausea, breast tenderness	Immediately (Provider can remove implant at any time.)
Lactational Amenorrhea Method-LAM [29]	98% effective	Up to 6 months postpartum	Periods have not returned and baby exclusively breastfed	No period	Effectiveness of LAM depends on exclusively breastfeeding baby	Immediately
Shot	94% effective	Up to 3 months	Shot given by provider	Irregular or no period at all	Weight changes, nausea, breast tenderness	Immediately, but may have 6-12 month delay
Vaginal Ring	91% effective	Up to 1 month	Prescription and inserted by patient	Shorter, lighter, more predictable periods	Nausea or breast tenderness	Immediately
Patch	91% effective	Up to 1 week	Prescription and applied by patient once a week	Shorter, lighter, more predictable periods	Nausea, breast tenderness, application site reaction	Immediately
Pill (Estrogen & Progestin)	91% effective	For 1 day	Prescription and taken by patient once a day	Shorter, lighter, more predictable periods	Nausea or breast tenderness	Immediately
Pill (Progestin only)	91% effective	For 1 day	Prescription and taken by patient once a day	Shorter, lighter, more irregular periods, spotting	Breast tenderness, changes in mood, headaches	Immediately
Condom	82% effective	For 1 sex act	Buy over the counter & used with each sex act	None	Allergic reaction to latex	Immediately

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