

Partnership Health Plan of
California
Annual Perinatal Symposium
2026



**Comprehensive Care
Throughout the Perinatal
Period**

Colleen Townsend, MD
Regional Medical Director

Liezel Lago
Program Manager



Logistics

Wi-Fi access back of your nametag

Restrooms Fairfield: to the right as you exit the room and through the lobby

Lactation Room: contact Liezel

Charging Station

Continuing Education

- The AAFP has reviewed Comprehensive Care Through the Perinatal Period and deemed it acceptable for up to 6.00 Live AAFP Prescribed credit(s). Term of Approval is from 04/13/2026 to 04/13/2026. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
- Providers approved by the California Board of Registered Nursing, Provider Number CEP16728, for 6.00 contact hours.
- **Must Complete Survey and quiz** at the end of the day and Liezel will follow up with certificates via email
- Materials will be available after the meeting: the slides and recording will be posted to the Partnership Website. Registered Attendees will receive an email with the website information once posted.

Conflict of Interest

- All presenters have signed a conflict-of-interest form and have declared that there is no conflict of interest and nothing to disclose for this presentation.



Regional Offices



Mission:

To help our members, and the communities we serve, be healthy.

Vision:

To be the most highly regarded managed care plan in California.

Partnership HealthPlan of California has received two accreditations from the National Committee for Quality Assurance (NCQA), a national leader in health care quality.

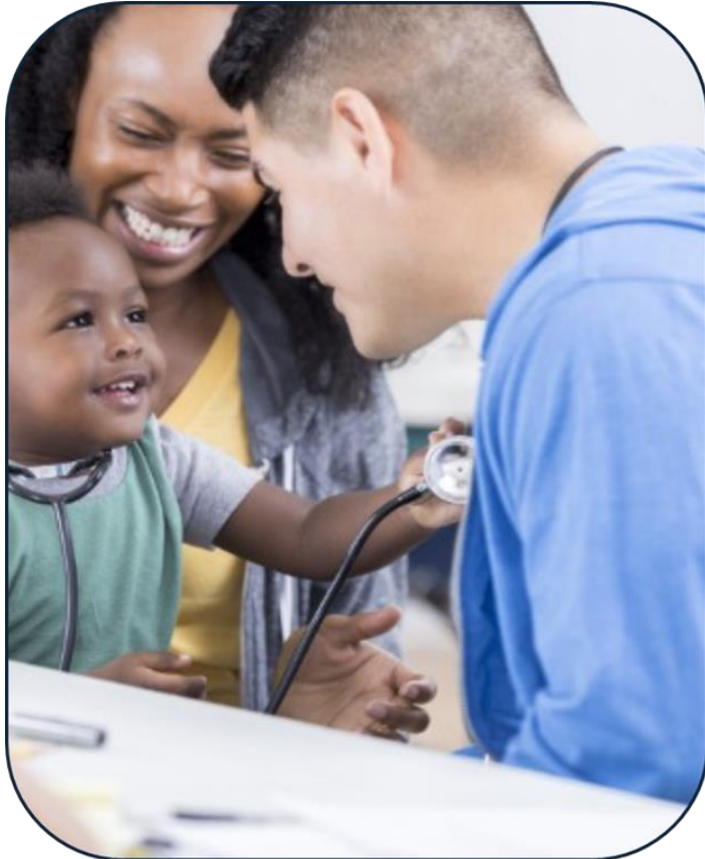
These accreditations recognize our commitment to:



- Delivering high-quality, member-centered care
- Building an internal culture that supports health equity
- Collecting and using data to address cultural and linguistic needs
- Identifying and reducing health disparities
- Improving quality of care for all communities we serve

Our NCQA Accreditations reflect our mission to help our members, and the communities we serve, be healthy.





- County organized health systems that are state sponsored health care services
- Includes primary and specialist health care and behavioral health services
- Preventive care and chronic disease management
- Inpatient and emergency care
- Medications through a state-wide program call Medi-Cal Rx

Today's Agenda and Objectives

8:45 – 8:50 a.m.	Opening Remarks	Colleen Townsend, MD
8:50 – 9:25 a.m.	Maternal Morbidity and Mortality Report: Understanding Factors that Impact Outcomes	Folo Akintan, MD, PhD, MS
9:30 – 11 a.m.	Recognizing and Responding to Perinatal Mental Health Conditions	Megan Kelly, PsyD, PMH-C
11:00 a.m. – 12:15 p.m.	Substance Use Disorders in Pregnancy	Lisa Rodelo, MD
12:15 – 1 p.m.	Lunch	
1-2 p.m.	Foundations in Perinatal Nutrition Care	Lauren Amos, MS, RD LDN
2-3 p.m.	Timely Comprehensive Care	Open Door Perinatal Team
3 p.m.	Partnership Benefits for Perinatal Members Reflections and Closing	Colleen Townsend, MD

Objectives of the Symposium

- Understand factors that influence morbidity and mortality for Partnership members in the perinatal period
- Identify common mood disorders that occur during and after pregnancy and integrate tools that support individuals to access the resources in the perinatal period
- Understand how our experiences and background impact how substance use disorder is addressed in perinatal populations
- Integrate tools for health education and referral to nutrition therapy during and after pregnancy
- Understand barriers and successes for the implementation of the comprehensive assessments, timely initial prenatal visits and coordination of care across a community
- Enhanced awareness of utilization of Partnership perinatal benefits
- Connect with colleagues

Improving Maternal Health Outcomes with Data Directed Initiatives

Maternal Morbidity and Mortality Report:
Understanding Factors that Impact
Outcomes



**Folorunso (Folo)
Akintan, MD, MPH, MBA**

Partnership HealthPlan
Epidemiologist



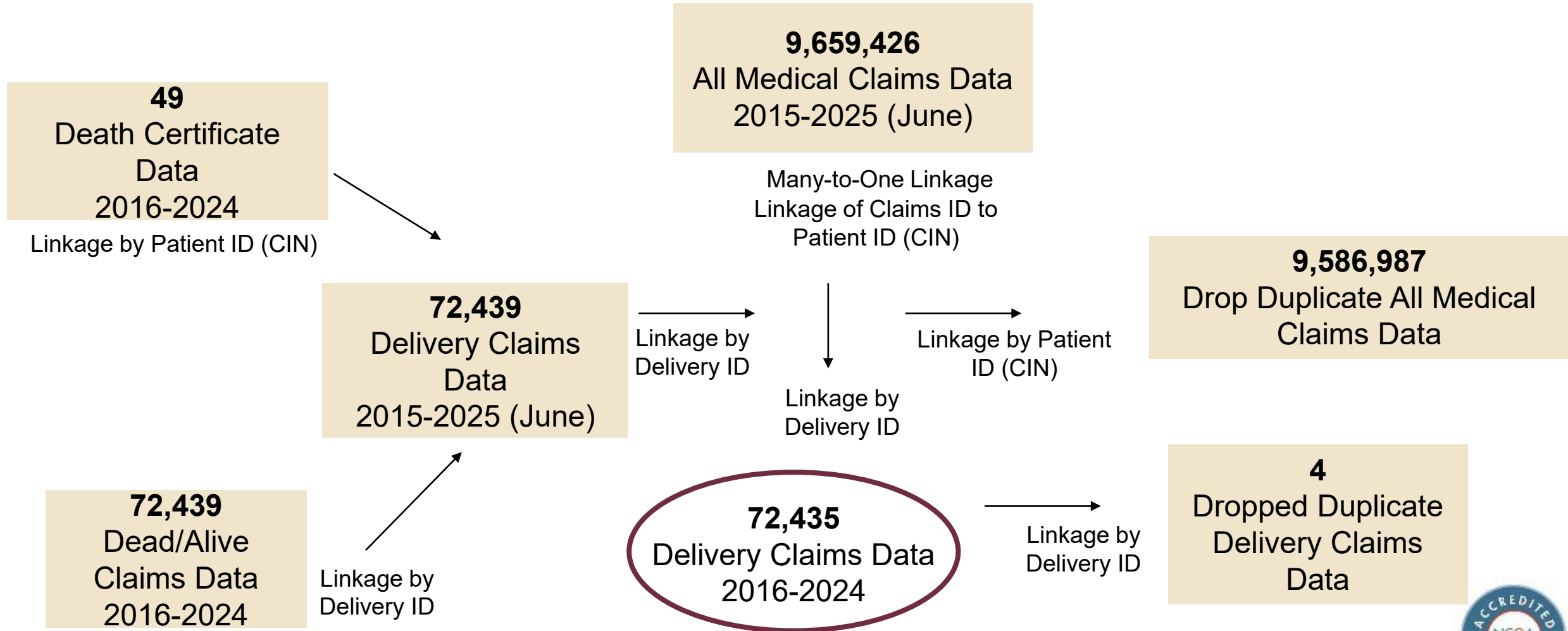
Study Question:

- What are the quality improvement interventions to be implemented by Partnership based on predicted health outcomes, both morbidity and mortality, of maternal population in all 24 counties served while addressing disparities?

Background Methodology:

- Maternal mortality using the death review
- Maternal morbidity using the severe maternal morbidity (SMM) Maternal morbidity Obstetric Comorbidity Index (OBSCOMI/OCI Scoring)

Methodology: Data Linkage 2016-2024 - Unduplicated



Limitation: 2016-2024 Data Linkage - Unduplicated



Background Definitions:

California Pregnancy Mortality Surveillance System (CA-PMSS) defines **pregnancy-related deaths** as deaths during pregnancy or within one year of the end of pregnancy from causes directly related to or worsened by pregnancy or its management, **excluding accidental or incidental causes (suicide, homicide, drug overdose, or other injury).**

In 2006, the **California Department of Public Health (CDPH)** established [California Pregnancy-Associated Mortality Review \(CA-PAMR\)](#)

CA-PAMR — now part of the [California Pregnancy-Associated Review Committee \(CA-PARC\)](#) to:

- Review deaths of pregnant or recently pregnant Californians **within one year after pregnancy.**
- Each death is examined using a **health equity framework**, considering factors like **social determinants of health, discrimination, and racism.**

(For information on how these deaths are identified and tracked, visit [California Pregnancy Mortality Surveillance System \(CA-PMSS\).](#))



Background Definitions (Continued):

World Health Organization (WHO): Maternal mortality is the death of a woman **whilst pregnant or within 42 days of delivery or termination of pregnancy, from any cause related to, or aggravated by pregnancy or its management**, but excluding deaths from incidental or accidental causes. Maternal mortality causes can be divided into direct or indirect causes.

Center for Disease Control and Prevention (CDC) / National Center for Health Statistics identifies maternal deaths in death certificate:

- Not pregnant within past year
- **Pregnant at time of death**
- **Not pregnant, but pregnant within 42 days of death**
- **Not pregnant, but pregnant 43 days to 1 year before death**
- Unknown if pregnant within the past year

The California Pregnancy Mortality Surveillance System

NVSS - Maternal Mortality - FAQ

California Pregnancy-Associated Mortality Review (CA-PAMR)



Pregnancy-Associated Death:
Death of a woman during pregnancy, at delivery, or within one year postpartum, regardless of cause, location of pregnancy, or pregnancy outcome. **A broader category of maternal death.**

Maternal Mortality



Maternal Death

Pregnancy-Related Death:
Death of a woman during pregnancy, or within one year of the end of pregnancy from causes related to or aggravated by pregnancy or its management, excluding deaths from incidental or accidental causes, i.e., suicide, homicide, drug overdose, or other injury.

Death of a woman **while pregnant or within 42 days of delivery or termination of pregnancy, irrespective of duration or site of pregnancy, from any cause related to or aggravated by pregnancy or its management, excluding deaths from incidental or accidental causes.**
These could be Direct or Indirect causes of Maternal Mortality.

Direct

Indirect



Maternal Mortality



Maternal Death

Death of a woman **while pregnant or within 42 days of delivery or termination of pregnancy, irrespective of duration or site of pregnancy**, from any cause related to or aggravated by pregnancy or its management, excluding deaths from incidental or accidental causes.
These could be direct or indirect causes of maternal mortality.

Direct cause of maternal mortality is the death of a woman caused by obstetric complications or interventions, misdiagnosis, improper management and their consequences.



Direct



Indirect

Indirect cause of maternal mortality is the death of a woman caused by pre-existing underlying disease or by pregnancy-induced aggravation of pre-existing conditions.

Maternal Death Case Review

- **Demography:** Race X patient X2 a Partnership member, completed 12th grade, never married, works in a restaurant
- **Medical History:** A 35+-year-old woman with obesity and prior history of deep veinous thrombosis, presented for a procedure to “deliver products of conception, external approach”. Six weeks after discharge died at residence within hours of pulmonary embolism
- **Autopsy:** Placenta tissue retention in uterus in a morbidly obsessed patient with left ventricular hypertrophy, hepatosplenomegaly and peptic ulcer disease
- **Final Cause of Death:** Pulmonary embolism
- **Place of Death:** Community

Maternal Mortality and Morbidity Report

The CDPH California pregnancy mortality surveillance system data is compiled from:

- Vital statistics and administrative data (CDPH: Birth Statistical Master File)
- California comprehensive master birth file
- California fetal death statistical master file
- Death statistical master file
- California comprehensive master death file
- California Department of Health Care Access and Information, formerly the Office of Statewide Health Planning and Development: Patient discharge data
- Emergency department data
- Ambulatory surgery data, coroner / medical examiner investigations, autopsy, and toxicology
- Hospital discharge summary
- Medical records
- Expert committee case review results

Methodology:

Death Review

Death Review Data

- Delivery Claims
- Medical Claims
- Dead/Alive Members
- Death Certificate
- ~~Medi-Cal Connect~~

Severe Maternal Morbidity (SMM)

SMM Review Data

- Medical Claims Data
- Delivery Claims Data

Obstetric Comorbidity Index (OBSCOMI / OCI) Scoring

OBSCOMI Data

- Delivery Claims Data

Methodology: California State (CDPH) Days-to-Die Categories

California Pregnancy-Related Deaths
2008-2016 (N=608)

	% of Maternal Deaths	Days	Obstetric & Pediatric Category	Weeks
	18% (n=109)	Pregnant	Pregnant and Dead	#
	% of Maternal Deaths	Days	Obstetric and Pediatric Category	Weeks
100%	83% (n=412)	Within 24 Hours	At Birth	One Day
		Within 6 Days	Early Perinatal	One Completed Week
		Within 7-42 Days	Late Perinatal	6 Weeks
82%	17% (n=87)	Within 43-365 Days	Postpartum	Within 3 Months or Postpartum
			Up to One year	3 Months-One Year

All Related Maternal Deaths

Pregnancy-related deaths excludes accidental or incidental causes (suicide, homicide, drug overdose, or other injury) [CA-PMSS](#)
[California Pregnancy-Related Deaths, 2008-2016](#)



Methodology: Partnership Days-to-Die Categories

Partnership All Maternal Deaths
2016-2024 (n=49)

% of Maternal Deaths	Days	Obstetric and Pediatric Category	Weeks
26.5%	Within 24 Hours	At Birth	One Day
	Within 7 Days	Early Perinatal	One Completed Week
	Within 8-42 Days	Late Perinatal	6 Weeks
	Within 43-84 Days	Postpartum	Within 3 Months or Postpartum
73.5%	Within 85-364 Days	Up to One year	3 Months-One Year

All Associated Maternal Deaths

Limitation: Missing final cause of death, no pregnancy-related death category, all maternal deaths



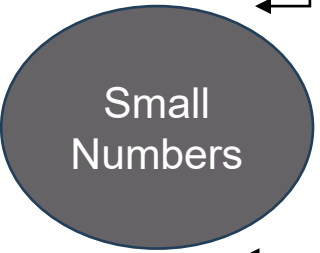
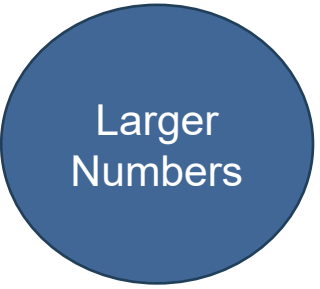
**Methodology:
Prediction**

Partnership 7 Disease List and Scores

1	High Risk Characteristics	Maternal age > 35 Twin/multiple pregnancy Delivery BMI > 40 Preterm birth (< 37 weeks)
2	Mental	Major mental health disorder Substance use disorder
3	Chronic Heart -Endocrine-Renal Disease	Chronic renal Cardiac disease, preexisting Preexisting diabetes mellitus Gestational diabetes mellitus Chronic hypertension Preeclampsia without severe features or gestational hypertension Preeclampsia with severe features Pulmonary hypertension
4	Preexisting Bleeding & Anemic Disorders	Anemia, preexisting Bleeding disorder, preexisting
5	Other Chronic Disease	HIV/AIDS Gastrointestinal disease Asthma, acute or moderate/severe
6	Autoimmune Disease	Systemic lupus erythematosus Neuromuscular disease Thyrotoxicosis Connective tissue or autoimmune disease
7	Uterus	Placental abruption Placenta accreta spectrum Placenta previa, complete or partial Uterine fibroids Previous cesarean birth

Larger Numbers

Small Numbers





Partnership Maternal Mortality and Morbidity Report Results: Maternal Death vs. Demographics



Results of Maternal Mortality by Race 2016-2024

N=72,121 Live Births

Race	Maternal Deaths Rate per 100,000 Live Births	Number of Maternal Deaths (N/n)
Black	7 per 100,000 Live Births	n=5
American Indian/Alaskan Native (AIAN)	8 per 100,000 Live Births	n=6
Hispanic	14 per 100,000 Live Births	n=10
Asian	0 per 100,000 Live Births	n=0
Native Hawaiian and Pacific Islander	1 per 100,000 Live Births	n=1
White	32 per 100,000 Live Births	n=23
Other/Unknown	6 per 100,000 Live Births	n=4
Total Live Births	72,121	N=49



Results of Maternal Mortality 2016-2024

N=72,437 Births by Race:

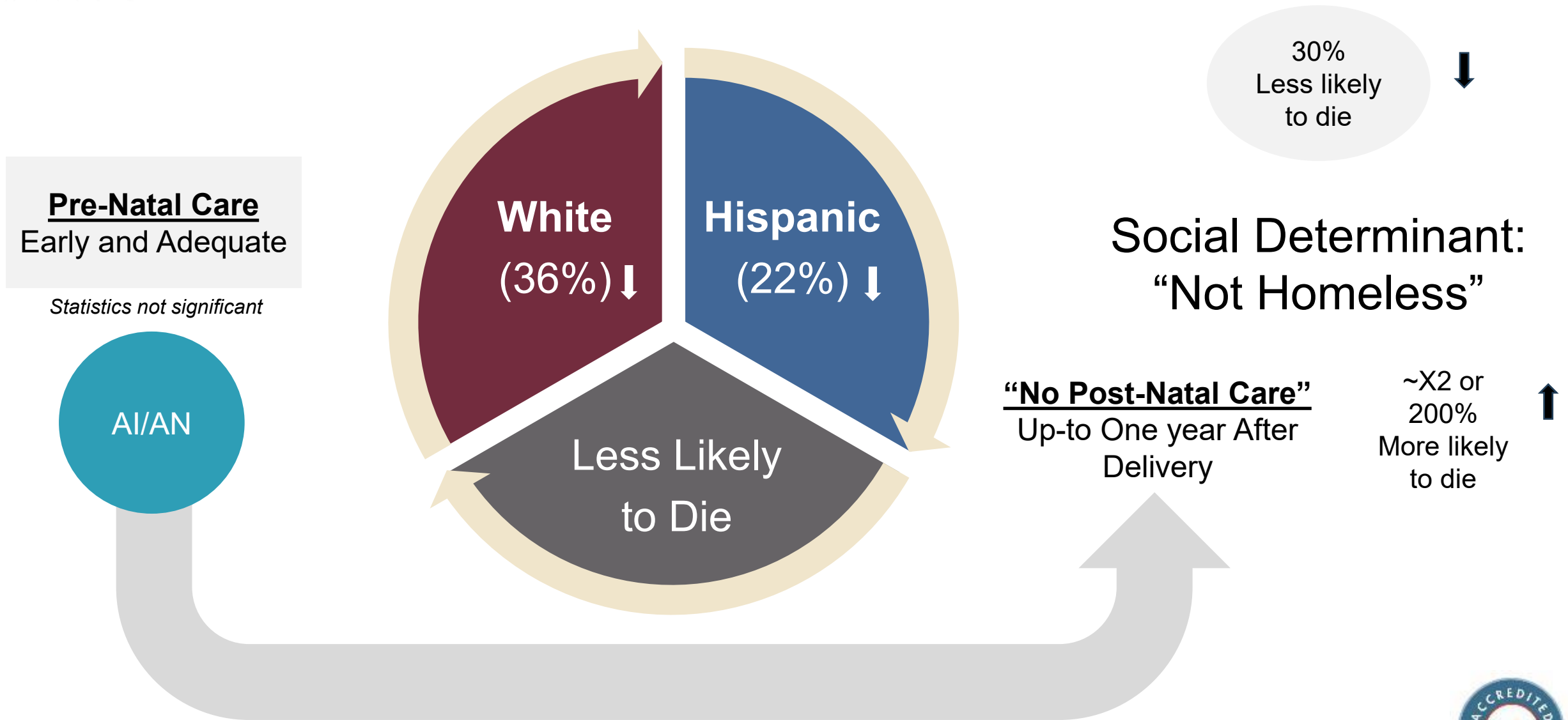
Race	Maternal Deaths Rate per 100,000 Births 2016-2024	Births by Race	Number of Maternal Deaths (N/n)
Black	138 per 100,000 Black Births over 9-year Period	3,630	n=5
American Indian/Alaskan Native (AI/AN)	259 per 100,000 AIAN Births over 9-year Period	2,317	n=6
Hispanic	39 per 100,000 Hispanic Births over 9-year Period	25,442	n=10
Asian	0 per 100,000 Asian Births over 9-year Period	2,282	n=0
Native Hawaiian & Pacific Islander	80 per 100,000 N. Hawaii/P. Islander Births over 9-year Period	1,247	n=1
White	85 per 100,000 White Births over 9-year Period	27,044	n=23
Other/Unknown	38 per 100,000 Other/Unknown Births over 9-year Period	10,475	n=4
Total Births		72,437	N=49



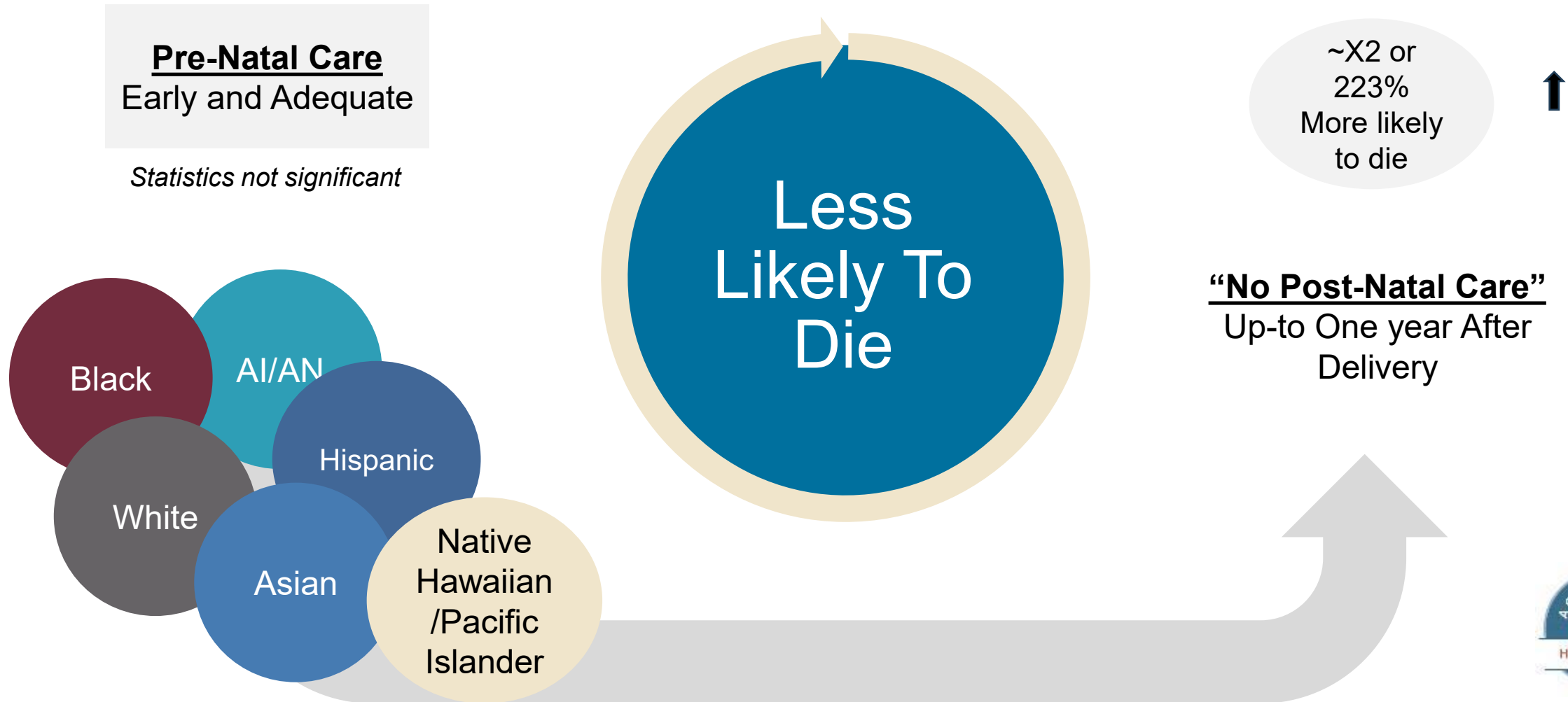


Partnership Maternal Mortality and Morbidity Report Results: Maternal Death Versus Social Determinants of Health





Result: Socio-Demographic Characteristics – Prenatal / Postnatal



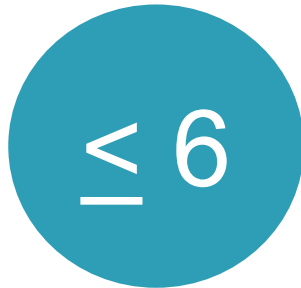


Partnership Maternal Mortality and Morbidity Report Results: Social Determinants of Health and Obstetric Comorbidity Index (Risk) Final Model

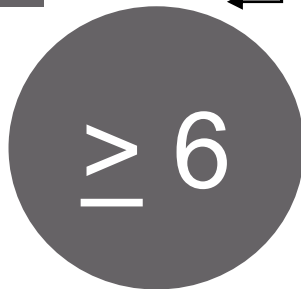


Results: Obstetric Comorbidity Index (OBSCOMI / OCI) Score

Low Risk Score



High Risk Score



Total Score	Frequency	Percent (%)
0	55,009	75.94
1	821	1.13
2	7,657	10.57
3	6,527	9.01
4	785	1.08
5	1,268	1.75
6	139	0.19
7	149	0.21
8	41	0.06
9	18	0.02
10	10	0.01
11	8	0.01
12	1	0
14	1	0
15	1	0

99.5%

0.5%

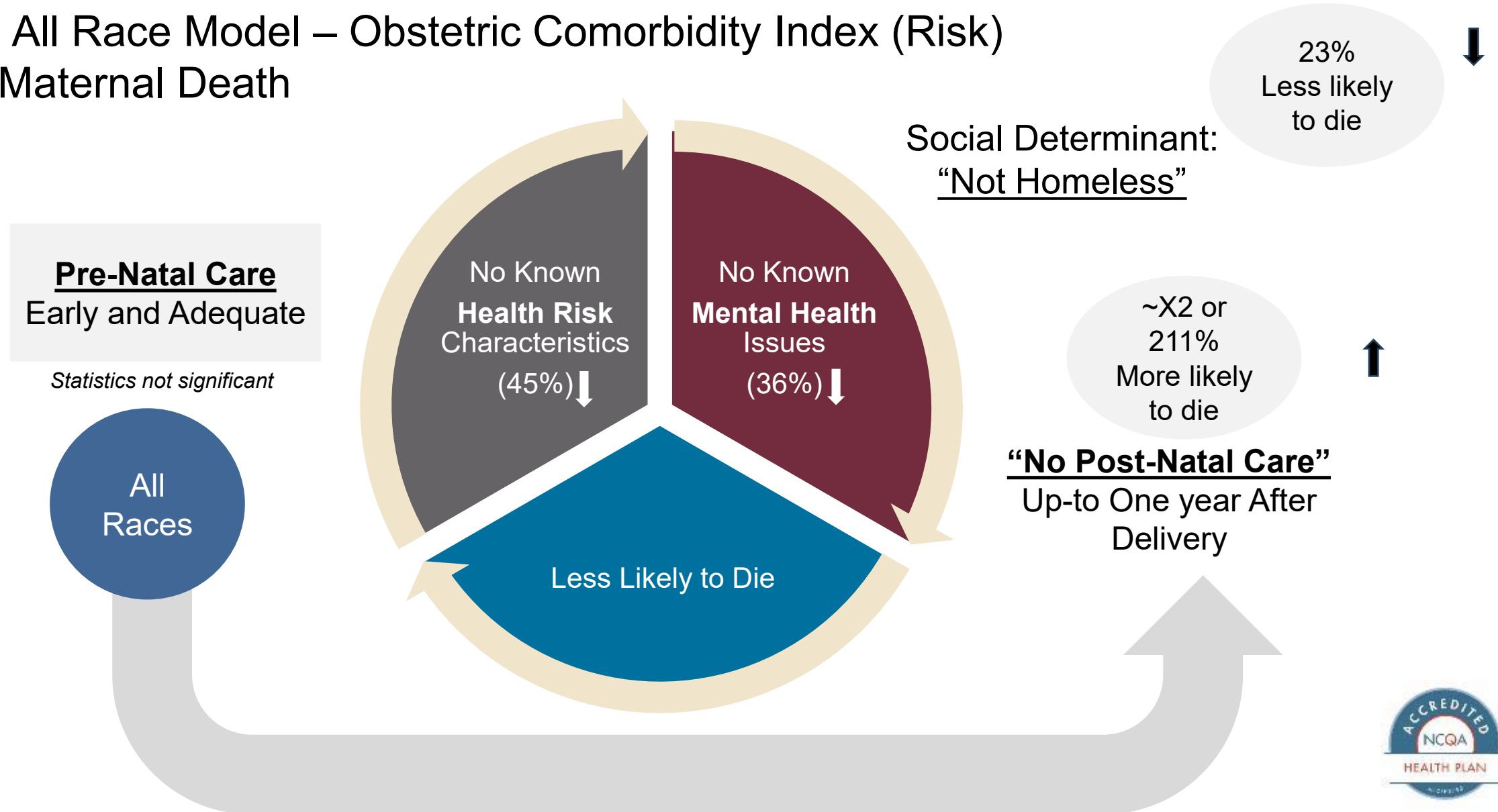
368 mothers
over 9 years

40 mothers
per year

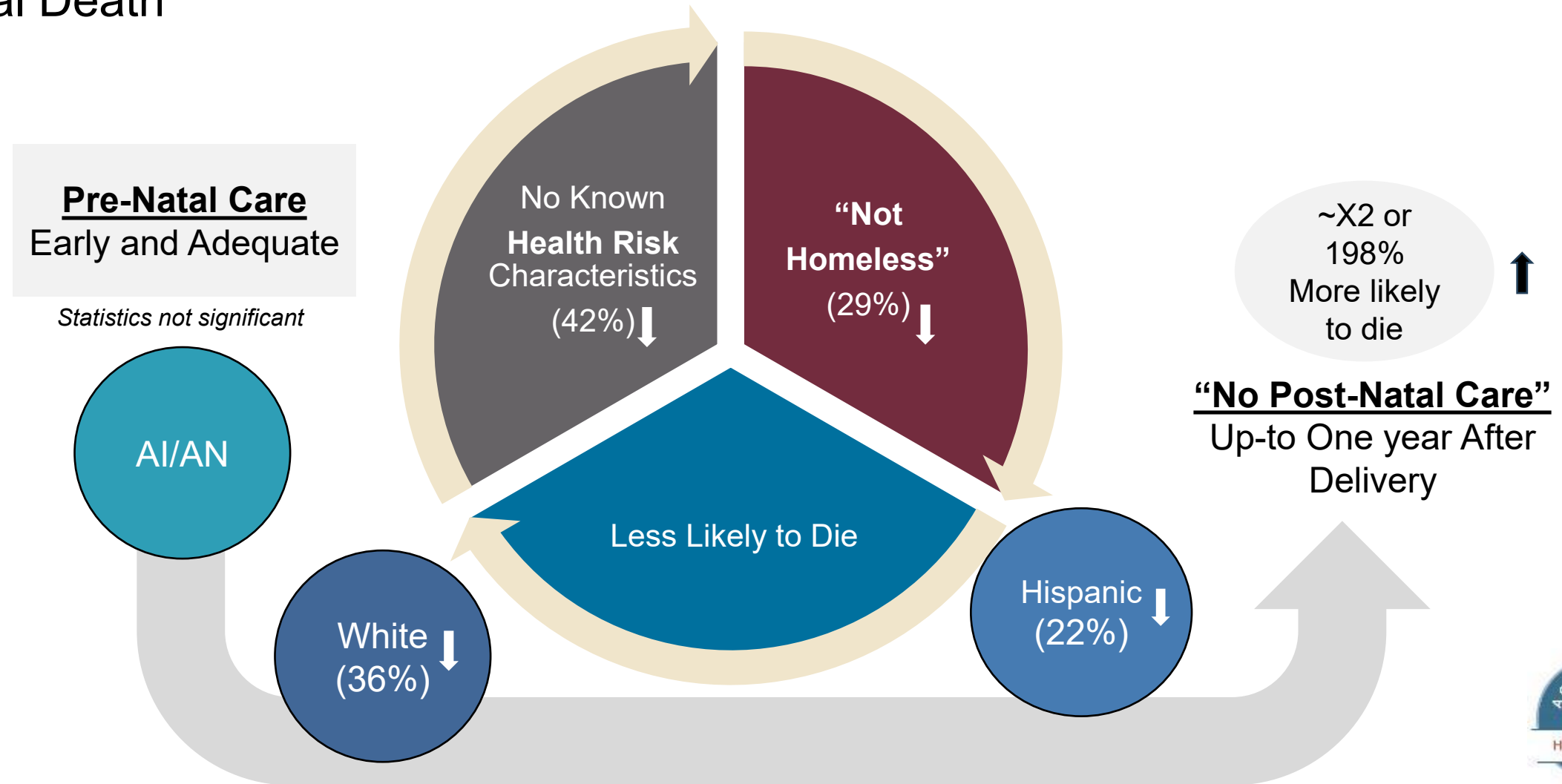
Limitation:
Small number
data analysis



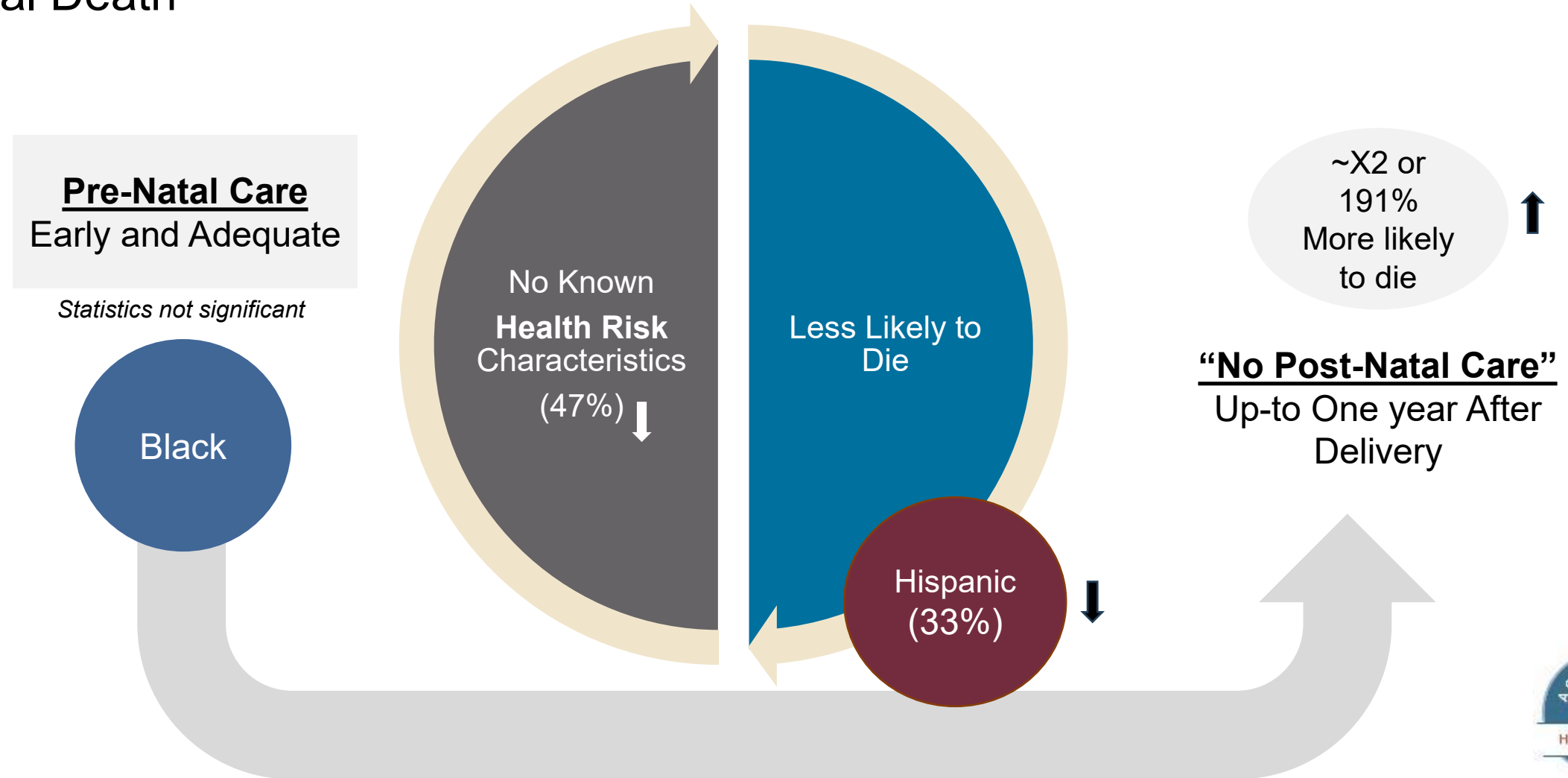
Result: All Race Model – Obstetric Comorbidity Index (Risk) Versus Maternal Death



Result: AI/AN Model – Obstetric Comorbidity Index (Risk) Versus Maternal Death



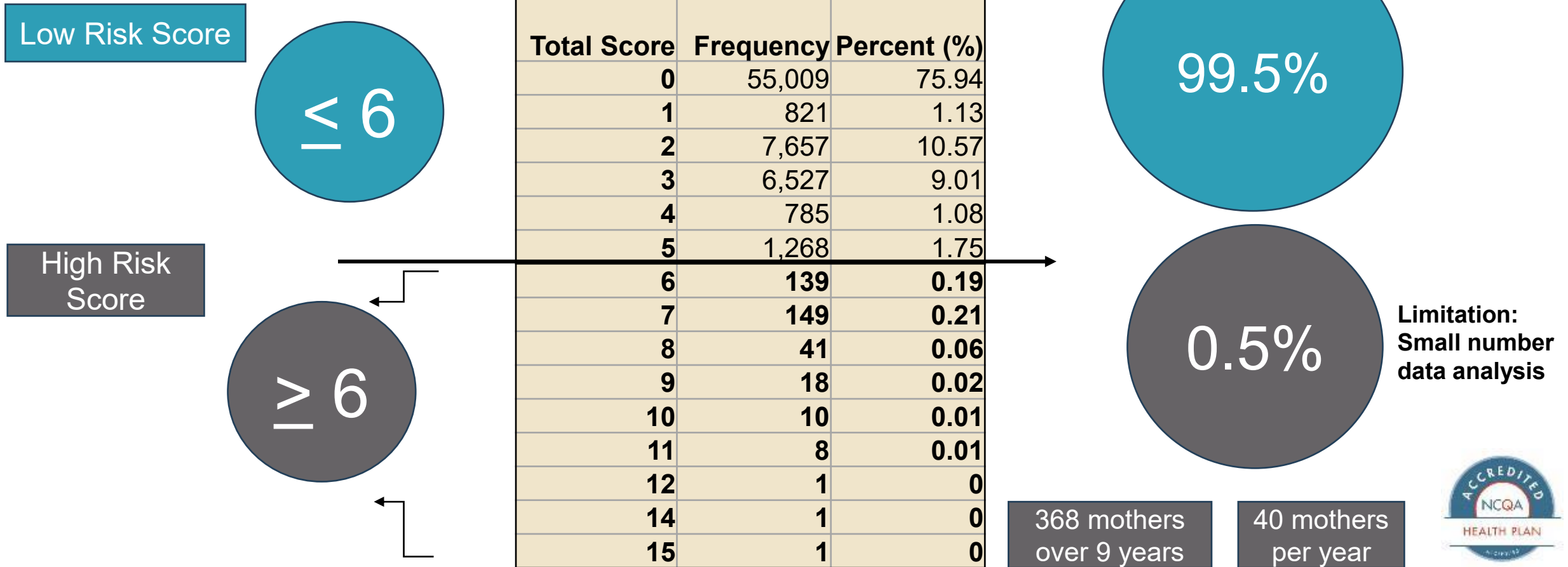
Result: Black Model – Obstetric Comorbidity Index (Risk) Versus Maternal Death



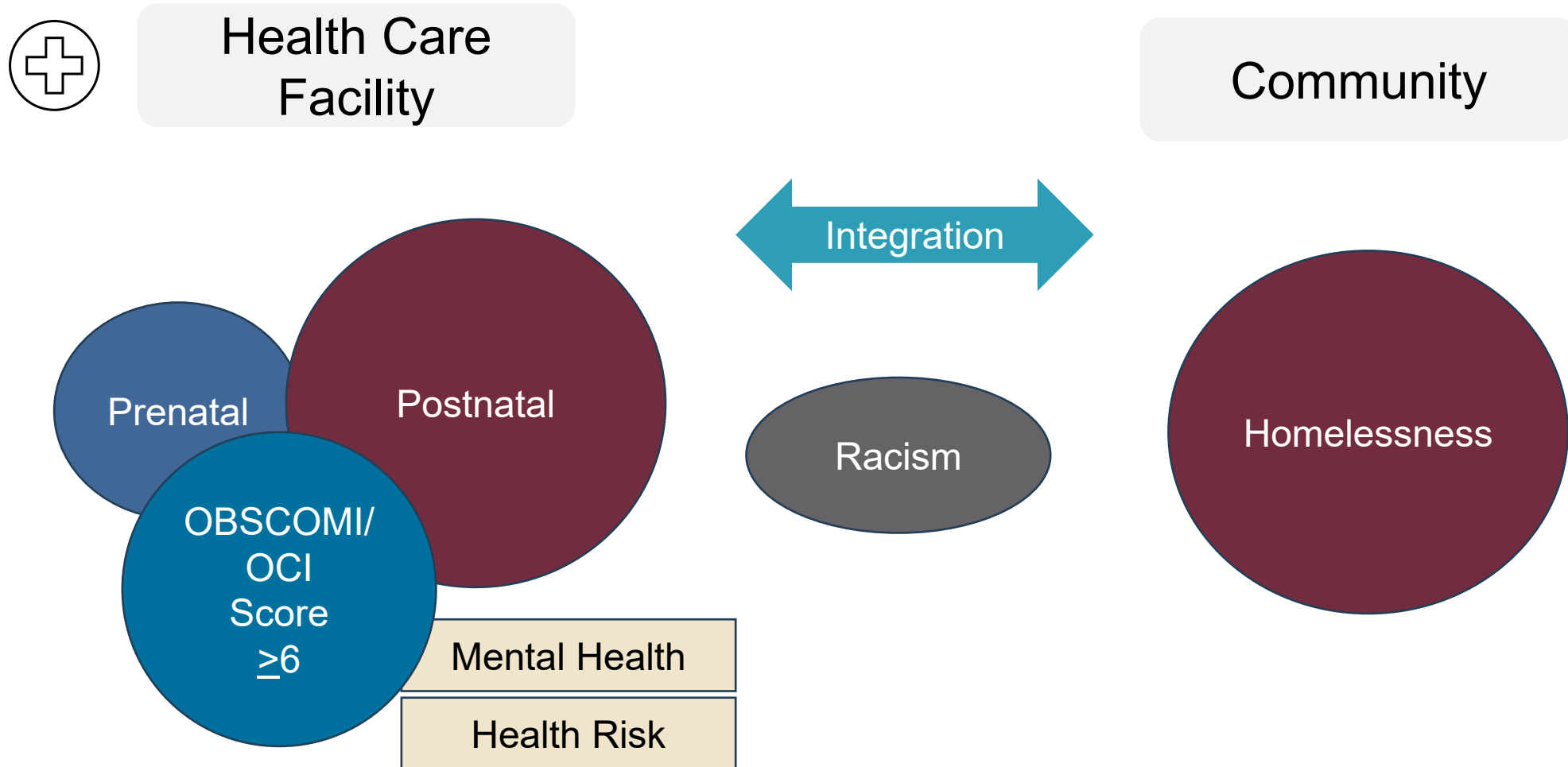
Results: Prediction

Obstetric Comorbidity Index (OBSCOMI/OCI) Scores
Predicting Five Disease and Procedure List
CDC Severe Maternal Morbidity (SMM)

Results: Obstetric Comorbidity Index (OBSCOMI/OCI) Score



Summary Result: Levels of Intervention



Questions?

Contact Folorunso Akintan (Folo) MD MPH MBA

fakintan@partnershiphp.org

Thank you!



Result: Socio-Demographic Characteristics

Analysis of Maximum Likelihood Estimates							
Parameter		DF	Estimate	Standard	Wald	Pr > ChiSq	Exp(Est)
				Error	Chi-Square		
Intercept		1	-6.4716	0.2622	609.3076	<.0001	0.002
Odds Ratio Estimates							
Effect					Point Estimate	95% Wald	
						Confidence Limits	
MEMBER ETHNIC: WHITE vs AMERICAN INDIAN					0.360	0.146	0.888
MEMBER ETHNIC: HISPANIC vs AMERICAN INDIAN					0.222	0.079	0.628
MEMBER ETHNIC: BLACK vs AMERICAN INDIAN					0.624	0.188	2.071
MEMBER ETHNIC: HAWAIIAN NATIVE/PACIFIC ISLANDER vs AMERICAN INDIAN					0.431	0.051	3.633
NOT HOMELESSNESS vs HOMELESSNESS					0.297	0.152	0.580
NO POSTNATAL vs ANY POSTNATAL					2.005	1.103	3.642

Result: Socio-Demographic Characteristics – Prenatal/Postnatal

Odds Ratio Estimates			
Effect	Point Estimate	95% Wald Confidence Limits	
		NO PRENATAL vs ANY PRENATAL	0.936
NO POSTNATAL vs ANY POSTNATAL	2.234	1.235	4.042
Effect	Point Estimate	95% Wald Confidence Limits	
		MEMBER ETHNIC: ALL RACES -NO PRENATAL vs ANY PRENATAL	1.42
MEMBER ETHNIC: WHITE -NO PRENATAL vs ANY PRENATAL	1.044	0.31	3.512
MEMBER ETHNIC: HISPANIC -NO PRENATAL vs ANY PRENATAL	1.222	0.155	9.648
MEMBER ETHNIC: BLACK -NO PRENATAL vs ANY PRENATAL	1.843	0.205	16.522
MEMBER ETHNIC: HAWAIIAN NATIVE/PACIFIC ISLANDER -NO PRENATAL vs ANY PRENATAL	<0.001	<0.001	>999.999
MEMBER ETHNIC: AMERICAN INDIAN -NO PRENATAL vs ANY PRENATAL	4.798	0.874	26.346
MEMBER ETHNIC: ASIAN –N/A because there were no deaths	NA	NA	NA

Result: All Race Model – Obstetric Comorbidity Index (Risk) Versus Maternal Death, The Event (1)

Analysis of Maximum Likelihood Estimates							
Parameter		DF	Estimate	Standard	Wald	Pr > ChiSq	Exp(Est)
				Error	Chi-Square		
Intercept		1	-6.6386	0.2038	1060.745	<.0001	0.001
Odds Ratio Estimates							
Effect					Point Estimate	95% Wald	
						Confidence Limits	
OBSTETRIC COMORBIDITY INDEX (RISK) NO MATERNAL RISK CHARACTERISTICS vs MATERNAL RISK CHARACTERISTICS					0.455	0.248	0.836
OBSTETRIC COMORBIDITY INDEX (RISK) NO MATERNAL MENTAL HEALTH ISSUES vs MATERNAL MENTAL HEALTH ISSUES					0.364	0.17	0.779
OBSTETRIC COMORBIDITY INDEX (RISK) NO MATERNAL POSTNATAL CARE vs MATERNAL POSTNATAL CARE					2.113	1.204	3.709
Parameter		DF	Estimate	Standard	Wald	Pr > ChiSq	Exp(Est)
				Error	Chi-Square		
Intercept		1	-6.7875	0.1619	1756.754	<.0001	0.001
SOCIAL DETERMINANTS OF HEALTH NOT HOMELESSNESS vs HOMELESSNESS					0.228	0.121	0.43

Result: AI/AN Model – Obstetric Comorbidity Index (Risk) Versus Maternal Death

Analysis of Maximum Likelihood Estimates							
Parameter		DF	Estimate	Standard	Wald	Pr > ChiSq	Exp(Est)
				Error	Chi-Square		
Intercept		1	-6.2814	0.2909	466.2283	<.0001	0.002
Odds Ratio Estimates							
Effect					Point Estimate	95% Wald Confidence Limits	
MEMBER ETHNIC: WHITE vs AMERICAN INDIAN					0.326	0.133	0.803
MEMBER ETHNIC: HISPANIC vs AMERICAN INDIAN					0.183	0.066	0.509
MEMBER ETHNIC: BLACK vs AMERICAN INDIAN					0.534	0.162	1.759
MEMBER ETHNIC: HAWAIIAN NATIVE/PACIFIC ISLANDER vs AMERICAN INDIAN					0.343	0.041	2.867
OBSTETRIC COMORBIDITY INDEX (RISK) NO MATERNAL RISK CHARACTERISTICS vs MATERNAL RISK CHARACTERISTICS					0.422	0.224	0.794
OBSTETRIC COMORBIDITY INDEX (RISK) NO MENTAL HEALTH ISSUES vs MENTAL HEALTH ISSUES					0.39	0.18	0.849
NO POSTNATAL vs ANY POSTNATAL					2.098	1.157	3.803

Result: AI/AN Model -Obstetric Comorbidity Index (Risk) Versus Maternal Death

Analysis of Maximum Likelihood Estimates							
Parameter		DF	Estimate	Standard	Wald	Pr > ChiSq	Exp(Est)
				Error	Chi-Square		
Intercept		1	-6.2368	0.2688	538.443	<.0001	0.002
Odds Ratio Estimates							
Effect					Point Estimate	95% Wald	
						Confidence Limits	
MEMBER ETHNIC: WHITE vs AMERICAN INDIAN					0.358	0.145	0.883
MEMBER ETHNIC: HISPANIC vs AMERICAN INDIAN					0.22	0.078	0.624
MEMBER ETHNIC: BLACK vs AMERICAN INDIAN					0.617	0.186	2.047
MEMBER ETHNIC: HAWAIIAN NATIVE/PACIFIC ISLANDER vs AMERICAN INDIAN					0.413	0.049	3.483
OBSTETRIC COMORBIDITY INDEX (RISK)					0.417	0.221	0.784
NO MATERNAL RISK CHARACTERISTICS vs MATERNAL RISK CHARACTERISTICS							
SOCIAL DETERMINANTS OF HEALTH					0.292	0.149	0.572
NOT HOMELESSNESS vs HOMELESSNESS							
NO POSTNATAL vs ANY POSTNATAL					1.983	1.091	3.605

Result: Black Model -Obstetric Comorbidity Index (Risk) Versus Maternal Death

Analysis of Maximum Likelihood Estimates							
Parameter		DF	Estimate	Standard	Wald	Pr > ChiSq	Exp(Est)
				Error	Chi-Square		
Intercept		1	-6.4852	0.2359	756.0326	<.0001	0.002
Odds Ratio Estimates							
Effect					Point Estimate	95% Wald Confidence Limits	
MEMBER ETHNIC: WHITE vs BLACK					0.578	0.218	1.53
MEMBER ETHNIC: HISPANIC vs BLACK					0.349	0.118	1.032
OBSTETRIC COMORBIDITY INDEX (RISK) NO MATERNAL RISK CHARACTERISTICS vs MATERNAL RISK CHARACTERISTICS					0.463	0.229	0.934
SOCIAL DETERMINANTS OF HEALTH NOT HOMELESSNESS vs HOMELESSNESS					0.298	0.142	0.628
NO POSTNATAL vs ANY POSTNATAL					1.792	0.937	3.426

Result: Black Model -Obstetric Comorbidity Index (Risk) Versus Maternal Death

Analysis of Maximum Likelihood Estimates

Parameter	DF	Estimate	Standard	Wald	Pr > ChiSq	Exp(Est)
			Error	Chi-Square		
Intercept	1	-6.6629	0.2838	551.2344	<.0001	0.001

Odds Ratio Estimates

Effect	Point Estimate	95% Wald Confidence Limits	
MEMBER ETHNIC: WHITE vs BLACK	0.623	0.236	1.647
MEMBER ETHNIC: HISPANIC vs BLACK	0.332	0.112	0.98
OBSTETRIC COMORBIDITY INDEX (RISK) NO MATERNAL RISK CHARACTERISTICS vs MATERNAL RISK CHARACTERISTICS	0.47	0.233	0.948
OBSTETRIC COMORBIDITY INDEX (RISK) NO MENTAL HEALTH ISSUES vs MENTAL HEALTH ISSUES	0.537	0.207	1.39
NO POSTNATAL vs ANY POSTNATAL	1.907	1.001	3.634

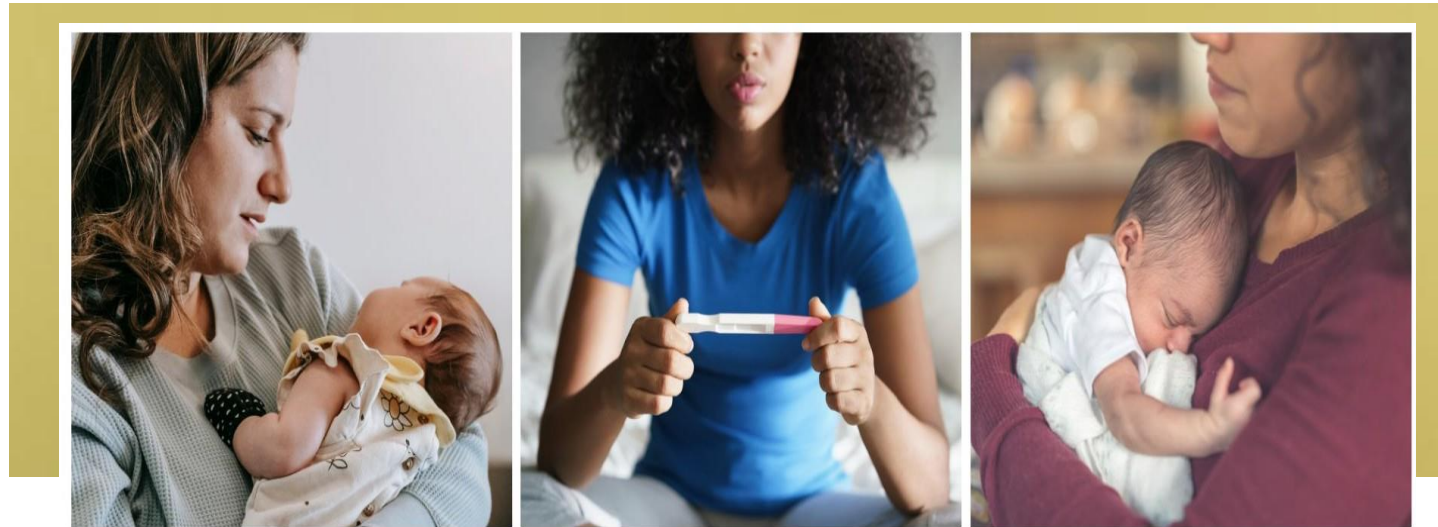
Result: Hispanic Model – Obstetric Comorbidity Index (Risk) Versus Maternal Death

Analysis of Maximum Likelihood Estimates							
Parameter		DF	Estimate	Standard	Wald	Pr > ChiSq	Exp(Est)
				Error	Chi-Square		
Intercept		1	-6.5124	0.2816	534.901	<.0001	0.001
Odds Ratio Estimates							
Effect					Point Estimate	95% Wald Confidence Limits	
MEMBER ETHNIC: WHITE vs HISPANIC					1.569	0.722	3.408
OBSTETRIC COMORBIDITY INDEX (RISK) NO MATERNAL RISK CHARACTERISTICS vs MATERNAL RISK CHARACTERISTICS					0.428	0.203	0.899
OBSTETRIC COMORBIDITY INDEX (RISK) NO MENTAL HEALTH ISSUES vs MENTAL HEALTH ISSUES					0.61	0.228	1.629
SOCIAL DETERMINANTS OF HEALTH NOT HOMELESSNESS vs HOMELESSNESS					0.264	0.12	0.578
NO POSTNATAL vs ANY POSTNATAL					1.557	0.777	3.122

Result: White Only Model -Obstetric Comorbidity Index (Risk) Versus Maternal Death, The Event (1)

Analysis of Maximum Likelihood Estimates							
Parameter		DF	Estimate	Standard	Wald	Pr > ChiSq	Exp(Est)
				Error	Chi-Square		
Intercept		1	-6.4684	0.3312	381.5397	<.0001	0.002
Odds Ratio Estimates							
Effect					Point Estimate	95% Wald	
						Confidence Limits	
OBSTETRIC COMORBIDITY INDEX (RISK) NO MATERNAL RISK CHARACTERISTICS vs MATERNAL RISK CHARACTERISTICS					0.519	0.204	1.318
OBSTETRIC COMORBIDITY INDEX (RISK) NO MATERNAL MENTAL HEALTH ISSUES vs MATERNAL MENTAL HEALTH ISSUES					0.963	0.281	3.301
SOCIAL DETERMINANTS OF HEALTH NOT HOMELESSNESS vs HOMELESSNESS					0.229	0.097	0.539
OBSTETRIC COMORBIDITY INDEX (RISK) NO MATERNAL POSTNATAL CARE vs MATERNAL POSTNATAL CARE					1.245	0.546	2.842

Recognizing and Responding to Perinatal Mental Health Concerns



- April 13, Megan Kelly, PsyD, PMH-C PSI-CA Training Committee Chair, PSI-CA

Educational Objectives

- Identify perinatal mental health concerns and risk factors across birthing and non-birthing patients
- Learn interventions to validate and support clients experiencing distress
- Incorporate a culturally responsive approach to care
- Effectively engage with resources & referrals across health systems
- Mitigate provider self-care and burnout

What are Your Goals for Today?

What are you hoping to get out of today?

What is one word to describe your
interest and experience with perinatal
mental health?

What are PSI and PSI-CA?

Postpartum Support International (PSI) was founded in 1987. Its purpose is to increase awareness among public and professional communities about the emotional changes that birthing people experience during pregnancy and postpartum.

The California Chapter of PSI was founded in 2020, and our mission is to promote equity and inclusion in awareness, prevention, and treatment of mental health issues related to pregnancy, childbearing and parenting in California.

2026 PSI Annual Conference in Los Angeles June 24-28!



Overview - Signs & Symptoms

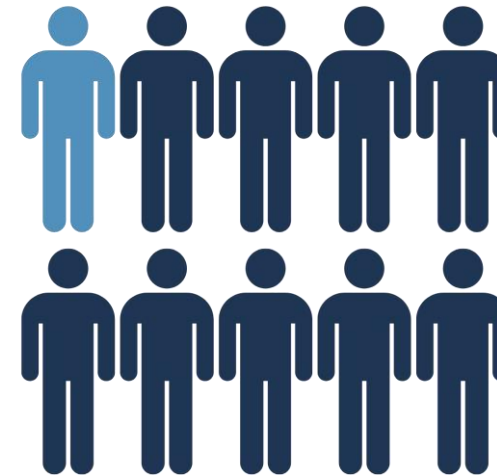
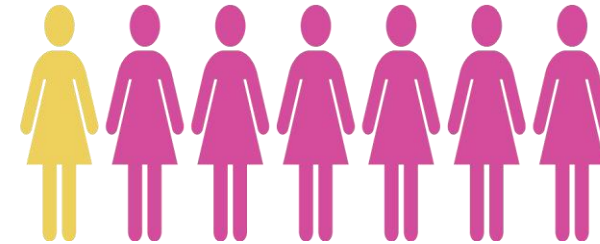
Perinatal Mental Health Disorders

- **Terminology: Perinatal and Postpartum:**
 - Time period from pregnancy to 1 year after birth of child.
 - Popularized as ‘postpartum depression,’ but much broader
 - Terms include: Perinatal Mood and Anxiety Disorders (PMADs) and **Perinatal Mental Health Disorders (PMHD)**
- **Lack of education in Mental Health Space:**
 - **Currently no therapist board mandates training in PMH** -> mandate HIV/AIDS, sexuality, aging/long term care, child development, interpersonal violence

Perinatal Mental Health Disorders

- **1 in 5 nationally for birthing parents, more likely 1 in 3 in California**
 - Data misses miscarriages and abortions, adoption and partners
 - Parental self-report is fraught due to stigma attached to mental health/mood disorders and fear of CFS involvement
- **Different from the ‘Baby Blues’ (more on this later)**
 - Baby blues only lasts until **2 weeks postpartum**
- **Impact and Environmental Context:**
 - Impact on attachment between parent/child, parents’ relationship, long-term consequences to children and families
 - Rising rates of [Maternity Care Deserts](#)
 - [2025 DHCS Birthing Care Pathways, 75% of women DO NOT receive treatment in California](#)

- **1 in 5** mothers experience serious depression (**PPD**) or anxiety (**PPA**) during pregnancy or postpartum.
- **1 in 10** fathers experience depression before or after the birth of their child.
- **1-2** mothers out of **1,000** might have a serious condition called postpartum psychosis (**PPP**).



Three U's of Dad's & Non-Birthing Parents and Postnatal Paternal PMH

- **Under-screened**
 - Onset often around 3-6 months postpartum, also OCD, anxiety, etc.
- **Under-diagnosed (1 in 10)**
 - 10.4 – 14% in United States
 - Pre/postnatal care geared towards Mother/Child dyad
 - Low self-report due to stigma attached to mental health/mood disorders
- **Untreated**
 - **Lack of education and focus** on research surrounding PMH symptomatology in men (i.e. often referred to as ‘paternal depression’)

Consider The Whole Family Experience

- **Fathers, Partners, and Co-parents** (often overlooked and underscreened, but have similar and unique risk factors too)
- **Same-Sex Partners and Adoptive Parents** (can face unique invisibility or exclusion in medical settings)
- **Grandparents & Extended Family** (experience caregiver stress, grief, helplessness)
- **Siblings** (may experience fear, confusion, jealousy, or increased caregiving demands at home)



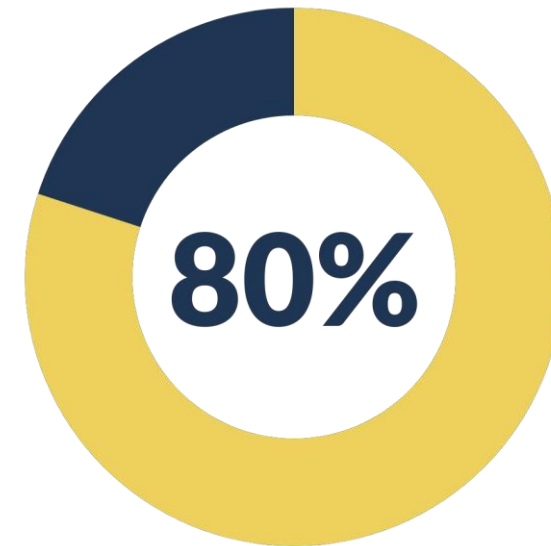
The Specifics: Recognizing Baby Blues

Baby Blues

- Thought to be response to hormonal shifts
- About 80% of birthing women
- More linked to hypomania than depression
- Lasts only about two weeks after birth

Symptomatology

- Anxious/Overwhelmed
- Sad/Mood swings/Loss of appetite
- Tearful/Crying spells
- Difficulty sleeping
- Waxes and wane/not clinically severe
- Resolves on its own



Perinatal Mental Health Disorders - Diagnosis



- Postpartum Depression (**PPD**)
- Postpartum Anxiety (**PPA**) & Panic Disorder
- Obsessive-Compulsive Disorder (**OCD**)
- Bipolar Disorder
- Postpartum Post-Traumatic Stress Disorder (**PTSD**)
- Postpartum Psychosis (**PPP**)
- Perinatal Substance Use

Perinatal Depression Symptomatology



- Difficulty sleeping
- Trouble coping/overwhelm
- Loss of appetite (more common) or overeating
- **Sadness/Tearfulness or Anger/Rage**
- Feeling numb (just going through the motions)
- Poor concentration
- Fear of being left alone or social isolation
- Commonly comorbid with anxiety
- Difficulty connecting to baby/feeling like the baby is theirs
- Forgetfulness
- Feelings of failure

*In **fathers**, more often includes hyperfocus on work, irritability, agitation, increase in risky behavior/substance use*

Postpartum Anxiety Symptomatology

- **Excessive worry/preoccupation with fears, what-ifs, safety**
(calling/seeing pediatrician frequently)
- Sleep issues (sometimes complete inability to sleep)
- Feelings of guilt and shame
- Panic attacks can progress to panic disorder, challenges leaving the house or caring for the baby
- Inability to relax, restlessness
- Overly concerned what others think
- Overwhelm
- Somatic complaints (back pain, dizziness, nausea, headaches)
- Fatigue

In fathers, more likely to include irritability and increased frustration

What is Perinatal OCD?

What are Postpartum and Perinatal OCD (pOCD)?

- OCD that occurs after childbirth is called postpartum OCD
- OCD that occurs during pregnancy is called perinatal OCD

People who are pregnant, or who have recently given birth, are at an increased risk of developing OCD symptoms. Those who have OCD often experience worsening of symptoms.

How is pOCD different from OCD that occurs at other times?

- In pOCD, the obsessions and compulsions usually focus on the infant. There may be obsessions about the baby getting hurt, contaminated, or lost; and compulsive rituals involving checking, mental rituals, and seeking-reassurance.
- There may also be unwanted sexual obsessions. The person may also use excessive avoidance, such as avoiding bathing or holding the baby.

Perinatal OCD Symptomatology

- **Unwanted Obsessive Worry or Intrusive Thoughts (obsessions)**
- **Repetitive/compulsive/reassurance-seeking behavior (compulsions or behaviors)**
- Can include obsessions & compulsions or obsessions only
- Intrusive thoughts of harming baby (including sexual thoughts, common in history of sexual victimization & Pure O)
- Intrusive thoughts of harm coming to baby
- Counting/tracking (feeds, diapers, naps)
- Hand washing/excessive grooming
- **RECOGNIZE INTRUSIVE THOUGHTS AS DISTRESSING**

*In **fathers**, more commonly includes excessive work and/or budgeting*

Perinatal OCD Symptomatology (cont'd)

Who struggles with Perinatal OCD (pOCD)?

- pOCD affects about 8% of pregnant and 17% of postpartum women
- Some new fathers develop pOCD symptoms to the extent they bear caregiving responsibilities
- People with OCD who become pregnant often experience worsening symptoms during pregnancy or postpartum

Is pOCD related to depression?

- Depressed people tend to have more negative thoughts, which can develop into obsessions
- Alternatively, obsessions and compulsions can lead to depression due to the distress they cause and shame about having negative thoughts during this time

Perinatal Bipolar Disorder Symptomatology

- Depressive or **elevated mood** (euphoric and/or irritable)
- **Decreased need for sleep**
- **Rapid/pressured speech**
- Impulsivity
- Easily Distracted
- Overconfidence
- Increase in risky and/or goal-directed behavior (spending, cleaning, etc.)
- Rapid cycling common
- Anxiety more often co-morbid
- High percentage of unmedicated bipolar birthing people will have postpartum manic episode (66%)

Fathers more likely to have comorbid substance use and greater irritability/anger

Postpartum Psychosis Symptomatology

POSTPARTUM PSYCHOSIS IS RARE BUT IT IS A MEDICAL EMERGENCY REQUIRING HOSPITALIZATION DUE TO RISK OF SUICIDE/INFANTICIDE

- A person with history of Bipolar Disorder, or a previous psychotic episode is at risk
- Prolonged lack of sleep (going days without any sleep) is a risk and a warning sign
- **Waxing/waning**
- **Auditory/visual hallucinations**
- **Paranoia and/or delusions** (not connected to reality)
- **Disorganization/confusion/agitation**
- Depersonalization/derealization
- Abnormal mood/bizarre behavior
- Abnormal thought content/beliefs
- **LACK OF AWARENESS OF ABNORMAL THOUGHT CONTENT/BELIEFS**

Assumed to be first episode of Bipolar I Disorder if DSM criteria met, otherwise, severe depression with psychotic features or sleep deprivation psychosis

Only vague theories regarding postpartum psychosis in fathers

Differential Diagnosis of OCD vs. Postpartum Psychosis

Is perinatal OCD related to postpartum psychosis?

- Both can involve **thoughts of harming the baby**
- Cases of postpartum psychosis have received media attention, leading people to worry that OCD will lead to psychosis
- **Postpartum psychosis is rare**, affecting 1-2 in a thousand births. pOCD is common, about 8% in pregnancy and 18% in postpartum
- Persons with postpartum psychosis have harmed their infant, acting on their hallucination or delusion, while **pOCD is harmless**
- People with postpartum psychosis **lack insight** and believe in their hallucinations/delusions, while OCD sufferers have insight and recognize thoughts as upsetting and inconsistent with their wishes

There is no evidence that pOCD symptoms can change into postpartum psychosis

Perinatal PTSD Symptomatology

- **Experienced, witnessed, or learned of an event that involved actual or threat of death, serious injury, or sexual violence**
- Intrusive thoughts, memories or dreams/nightmares of event
- Negative thoughts/distress
- Detachment, difficulty with bonding
- Numbness, social isolation
- Hypervigilance
- Sleep disruption
- **Avoidance** of reminders of traumatic event:
 - Not returning to medical setting or appointments
 - Avoiding talking about birth or pregnancy

PTSD and Perinatal Loss

Birth/Infant Loss

- Grief
- Isolation – loss of community (*providers often ignore partners*)

Trauma

- Unexpected/late term loss or stillbirth
- Loss of control/what-ifs
- Financial stresses

Infertility/Genetic Disorders

- Repetitive cycle, loss after loss
- Stigma

PMHDs and Substance Use

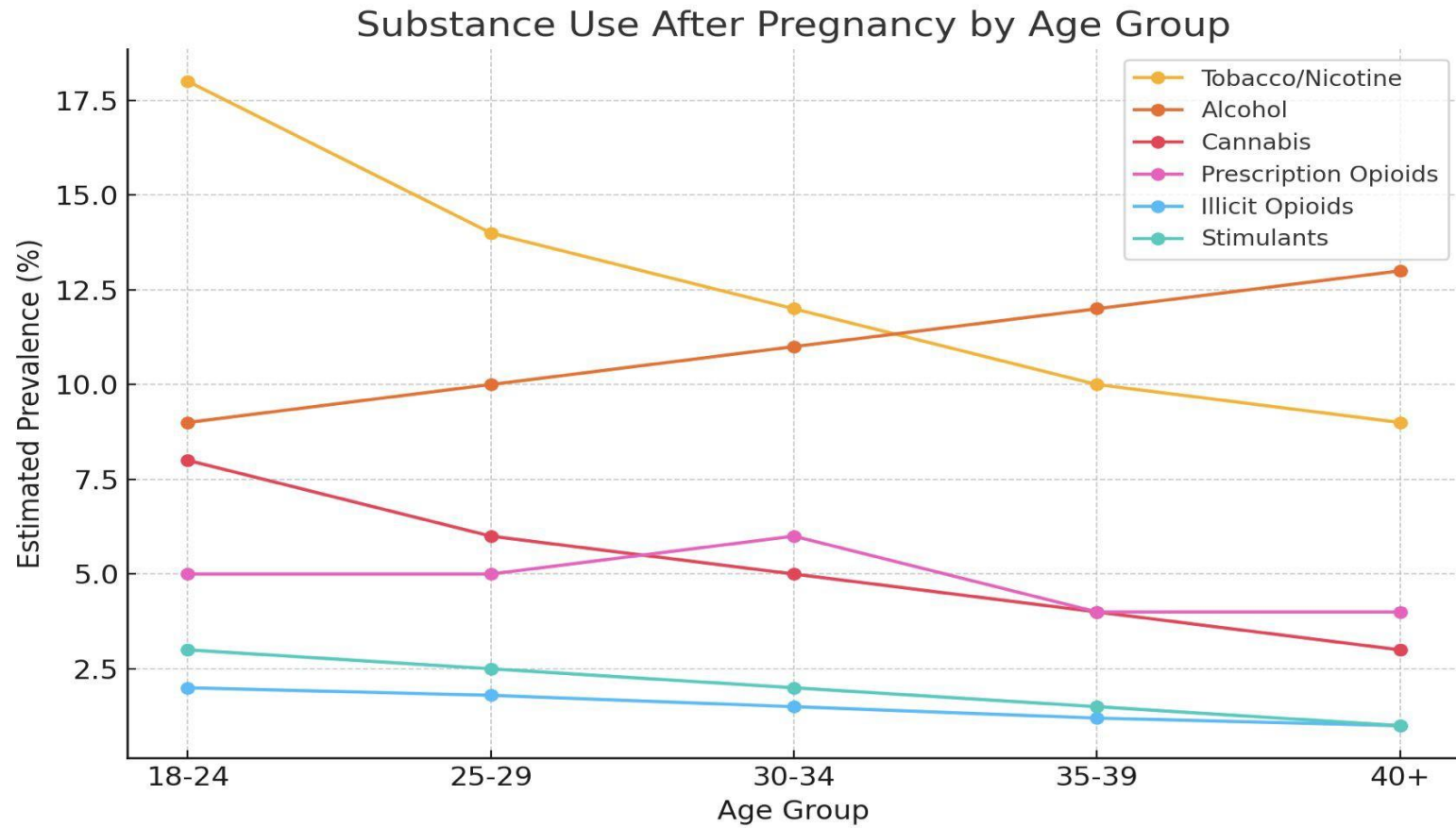
- Significant co-occurrence of mental health disorders and SUDs
- Pregnant women with poor mental health more likely to drink
- Over 30% of pregnant women in rehab screen positive for depression, over 40% experience postpartum depression
- Pregnant women with substance use disorders often have depression, anxiety and PTSD and use as self-medication
- Suicide and overdose are leading cause of death in the first year postpartum

- All parents with PMHDs should be screened for SUD and vice versa!

Most Common Substances Used Postpartum

SUBSTANCE	PREVALENCE	RISKS
Tobacco	~10–15%	SIDS & Respiratory issues
Alcohol	~8–10%	Impaired Bonding
Cannabis	~5–7%	Neurodevelopmental effects
Prescription Opioids	~4–6%	NAS, dependency
Illicit Opioids	~1–2%	Overdose, Impaired Caregiving
Stimulants	~1–3%	Preterm birth, placental abruption

Substance Use After Pregnancy by Age Group





Raising Awareness & Engagement: Practical Applications

Opportunities to Raise Awareness

- **When and How to Introduce PMHDs:**
 - Initial Consultations; Initial Calls
 - Prenatal Visits
 - Postpartum
- **Opportunities for Intervention:**
 - Validation, Empathy, Centering the Birthing Person
 - Providing resources: Text, Phone, Virtual Support
 - Working with doulas, birth workers and lactation consultants

Screening Saves Lives

- More screening means more identification of caregivers, *early on*, who may need help, which could prevent worsening of mental health symptoms (including suicidality)
- Brief screeners:
 - Edinburgh Postnatal Dep Scale (EPDS)***
 - PHQ-9 (Depression)
 - GAD-7 (Anxiety)
 - PCL-5 (PTSD)



Brief Screeners: EPDS

Edinburgh Postnatal Depression Scale (EPDS)

Date: _____ Clinic Name/Number: _____

Your Age: _____ Weeks of Pregnancy/Age of Baby: _____

Since you are either pregnant or have recently had a baby, we want to know how you feel. Please place a **CHECK MARK (✓)** on the blank by the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**—*not just how you feel today*. Complete all 10 items and find your score by adding each number that appears in parentheses (#) by your checked answer. This is a screening test; not a medical diagnosis. If something doesn't seem right, *call your health care provider regardless of your score*.

Below is an example already completed.

I have felt happy:
Yes, all of the time _____ (0)
Yes, most of the time (1)
No, not very often _____ (2)
No, not at all _____ (3)

This would mean: "I have felt happy most of the time" in the past week. Please complete the other questions in the same way.

1. I have been able to laugh and see the funny side of things:
As much as I always could _____ (0)
Not quite so much now _____ (1)
Definitely not so much now _____ (2)
Not at all _____ (3)
2. I have looked forward with enjoyment to things:
As much as I ever did _____ (0)
Rather less than I used to _____ (1)
Definitely less than I used to _____ (2)
Hardly at all _____ (3)

7. I have been so unhappy that I have had difficulty sleeping:
Yes, most of the time _____ (3)
Yes, sometimes _____ (2)
No, not very often _____ (1)
No, not at all _____ (0)
8. I have felt sad or miserable:
Yes, most of the time _____ (3)
Yes, quite often _____ (2)
Not very often _____ (1)
No, not at all _____ (0)
9. I have been so unhappy that I have been crying:
Yes, most of the time _____ (3)
Yes, quite often _____ (2)
Only occasionally _____ (1)
No, never _____ (0)
10. The thought of harming myself has occurred to me: *
Yes, quite often _____ (3)
Sometimes _____ (2)
Hardly ever _____ (1)
Never _____ (0)

When and Where to Screen

- PMHDs can occur any time during pregnancy or **up to a full year after birth**
- After the first three months, most common time is after **return to work** or after **abrupt weaning**
- Without treatment, symptoms can continue long after the first postpartum year
- Suggested screening guidelines:
 - Regularly during pregnancy and at delivery
 - At six-week postpartum visit, and
 - After first six weeks, at **each pediatric visit** during the first year

Language of PMHDs

- “No one has ever felt as bad as I do” *helplessness*
- “I have made a terrible mistake” *anxiety*
- “I am all alone and no one understands” *isolation and withdrawal*
- “I am a failure as a parent/partner” *guilt, poor self-esteem*
- “I will never be myself again” *hopelessness*
- “I’m losing it” *despair*
- “I am on an emotional roller coaster” *mood changes*
- “I want to cry all the time” *tearfulness*
- “Everything feels like a huge effort” *no energy*
- “I feel like I’m in a fog” *disorientation, confusion*
- “Sometimes I think everyone would be better off without me”
suicidal thinking

Adapted from MMHN, 2018

Ways to Provide Validation & Empathy

Often, the most powerful thing one can do is listen and offer simple words:



- “This is so hard—you’re not alone in feeling this way.”
- “You are doing an amazing job, even if it doesn’t feel like it.”
- “It’s okay to need support; none of us is meant to go through this by ourselves.”
- “Can I sit with you for a few minutes?”
(presence can matter more than advice.)
- “Would it help to take a break?”
- **Other examples?**

Addressing Shame and Silence

Transition to Motherhood (*Matrescence*) involves dialectics and contradictions:



Honor family or cultural traditions *and* navigate external expectations of motherhood

Balance individual needs and finding identity as a mother with community messages and practices

What other beliefs, myths, expectations are you aware of?

Unrealistic Expectations of Parenthood

- **Unrealistic expectations related to shared caretaking**
 - **Equal caretaking** for baby/household (overnight, after work)?
- **Unrealistic expectations related to loving child**
 - Assumption of **immediately falling in love** with child/role
- **Financial Responsibility**
 - Increased pressure for promotion, raise
 - **Impact of family leave** - does partner take theirs?
- **Lack of self-care (“I should be able to do it all, without help!”)**
- **Balancing sleep deprivation (risk factor) and work**

Myths of Parenthood

- **Good parent vs. Bad parent, i.e. WHAT NOT TO SAY**
 - Good parents don't get depressed! (or anxious, or traumatized, etc.)
 - You're having/had a baby, you can't be depressed!
 - But the baby is healthy, focus on that!
 - Birthing parent as a “candy wrapper” rather than a human being
 - Provider bias towards cis-gender, heterosexual, partnered moms and babies
 - “Is Dad babysitting today?”
 - “Where's Dad today?”
 - “Where's Mom today?”
 - “Are you Mom or are you Dad?”

Consequences of Myths of Parenthood

- **Stigma - “good parents don’t get depressed/anxious”**
- **Shame - “must be my fault”**
- **Lack of outreach for help**
 - Lying on screening tools
 - Think this is just how new parenthood really is
 - Common experience is “I’m a terrible parent” rather than “I’m depressed/anxious”
 - Mistrust of healthcare providers (especially among marginalized communities)
 - Fear of Child Protective Services



Treatment Referrals & Resources

Referrals: Clinical Treatment Options

ALWAYS have patient cleared medically to ensure symptoms not due to or exacerbated by medical condition (thyroid, anemia or vitamin D deficiency)

- Individual psychotherapy (nurture the nurturer):
 - Recommend therapists trained in PMH
 - Interpersonal Psychotherapy (IPT) - validated
 - Cognitive Behavioral Therapy (CBT) - validated
 - Dialectical Behavior Therapy (DBT) - helps with dysregulation
 - Harm Reduction/Motivational Interviewing (for SUD)
 - Eye Movement Desensitization & Reprocessing (EMDR) for trauma
 - Parent/child dyadic therapy, to improve disrupted bonding
- Psychopharmacology if moderate/severe (reproductive psychiatrist)

Other Intervention Options

- Psychoeducation about PMH (and **lifestyle factors** that contribute to symptoms)
- Peer support (individual or group)
- Lifestyle case management
 - Troubleshooting sleep challenges
 - Getting additional family or doula support/**sharing caregiving responsibilities**
 - Food/nutrition/**sunlight**
 - **Exercise**/getting moving
 - Socializing/**pleasurable activities**

PSI Resources for Parents

- **PSI Helpline: 1-800-944-4773 (4PPD) and National MMH Hotline:**The Hotline is available to text or call 24/7. 1-833-TLC-MAMA
- **PSI Support Groups on Smart Patients Forum:**
For those affected by PMHDs to connect with peers in a safe, supportive environment. Over 50 groups for different demographics and circumstances, including pregnancy, postpartum, adoption, partners, birth trauma and loss. Includes a [group for parents struggling with substance use/misuse](#).
- **Chat with an Expert: Connect with other parents and talk with a PSI mental health expert about resources, symptoms, and treatment options.**
 - *first Mondays for Dads,*
 - *every Wednesday for Moms*

PSI Resources for Parents (cont'd)

- [PSI Peer Mentor Program](#): This program pairs individuals in need of support with a trained volunteer who has also experienced and fully recovered from a Perinatal Mood Disorder (PMD)
- [Provider Directory](#): Online directory of trained perinatal providers.
- [Perinatal Mental Health Discussion Tool](#): For parents to identify PMHD symptoms to discuss with their provider.
- Social Media: [Facebook page](#) and [private group](#), [Instagram](#) and X, and our new app, [Connect by PSI](#).

PSI Resources for Providers

- **Perinatal Mental Health Certification (PMH-C)**: Creates a structure for professional education and evaluation and a standardization of training and experience.
- **Perinatal Prescriber Consultation Line**: For medical professionals who are prescribers and have questions about mental health care related to perinatal patients.
- **Membership**: PSI members (clinicians, physicians, survivors and advocates) around the world receive benefits including:
 - Discounts on training and the annual Conference
 - Online **Peer Consultation Groups** for psychotherapists (including one in Spanish and one for providers of color), prescribers and doulas
 - Email listservs for providers and prescribers (International and within California)

- **[Perinatal Mental Health Alliance for People of Color](#)**

(PMHA-POC):

A program within PSI, created to fill a gap in support services for professionals and communities of color.

- **[PSI California Chapter \(PSI-CA\):](#)**

Furthers the mission of PSI on a statewide level.

- Bimonthly newsletter
- Short PMH trainings
- State-level legislative advocacy
- Scholarships for PSI training

Check our [website](#) for more information and to connect with your state chapter for collaboration, education, support, and advocacy.

National Suicide Prevention Lifeline

- Dial **988**
- [suicidepreventionlifeline.org](https://www.suicidepreventionlifeline.org)

Crisis Text Hotline (24/7)

- Text **HOME** to **741741**

Domestic Violence Hotline

- **800.799.7233**
- Text **START** to **88788**

Maternal Mental Health Hotline

- **800.852.6262 (24/7 – HRSA)**



You are not alone.
You are not to blame.
With help, you will be well.



Cultural Context & Risk Factors

Cultural Considerations

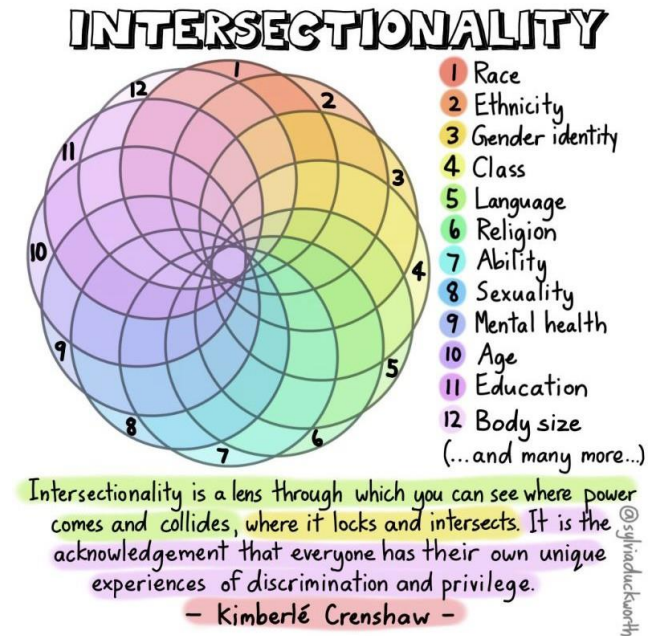
- **Underdiagnosis and Misdiagnosis:** Clinicians unfamiliar with **culturally specific expressions of distress** (e.g., somatic complaints rather than emotional language) may miss postpartum depression or anxiety.
- **Bias in Health Systems:** Racial and ethnic minorities, especially Black and Indigenous women in the U.S., face higher rates of miscommunication, dismissal of symptoms, and **poorer maternal outcomes** due to systemic bias.
- **Language Barriers:** Limited English proficiency can hinder screening, psychoeducation, and treatment engagement.

Cultural Considerations (cont'd)

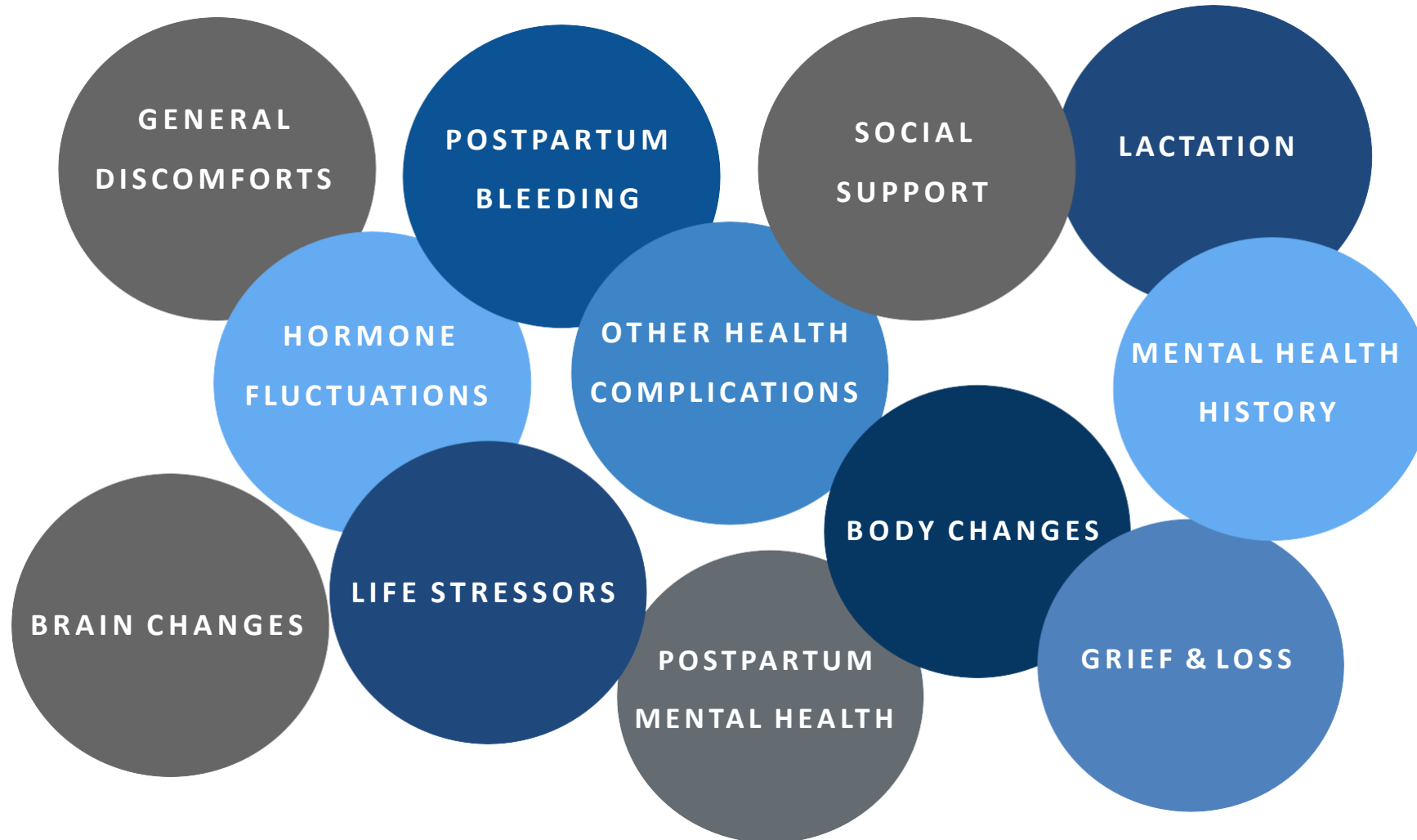
- **The Perinatal Health Alliance for People of Color (PMHA or Alliance)** was founded in February 2017.
- The **Alliance** is bridging the gap in perinatal mental health support services for birthing persons, providers, and communities of color.
- Within PSI, the **Alliance** is continuing to bridge the gap in PMH support services by expanding its reach to the **LatinX and Spanish-speaking community** with our Alliance Spanish & Cultural Program.

Intersectional Risk Factors in PMH

- What is **intersectionality**
 - crossroads of race/ethnicity/immigration status, gender, sexual identity, disability/neurodivergence
- How does intersectionality create a risk factor in CA
 - implicit bias and systemic racism
 - causes **chronic stress** in marginalized groups
 - American Indian and BIPOC higher rates of PMH: rates 3-4x higher



Challenges During Postpartum:



Psychosocial Risk Factors

- Personal or family **history** of depression, anxiety, or PPD
- Pregnancy or delivery **complications**
- Miscarriage or infant **loss**
- Baby **feeding** complications
- **Abrupt** discontinuation of breastfeeding
- Lack of culturally relevant support
- **Lack** of support from family or friends
- **Financial** stress or poverty
- Marital or relationship **stress**
- History of trauma
- Having **twins** or **multiples**



Contributors to PMHDs

- **Hormones (changes affect all birthing and caregiving parents)**
 - Estrogen - large increase during pregnancy, rapid decrease in estrogen and progesterone after birth/while breastfeeding
 - Testosterone decrease in cohabitating fathers in 3rd trimester
 - Increased oxytocin/prolactin/cortisol in all new parents when caregiving
- **Brain changes associated with caregiving may contribute**
 - Significant brain changes in birthing people help with attunement
 - Brain changes also in partners who spend time caregiving
 - Greater brain changes [positively associated with postpartum depression in fathers](#)
- **History of mood or anxiety disorder**
- **Postpartum psychosis link to Bipolar Disorder or first manic episode**

Contributors to PMHDs (Cont'd)

Psychosocial factors

- Work or financial stress
- Relationship dissatisfaction/**lack of empathy by partner**
- Planned pregnancy vs. unplanned
- Prior pregnancy/infant loss, infertility journey, pregnancy or birth complications
- **Colicky** or sick baby (NICU), temperament mismatch
- Lack of social/family support
- **Feeding complications** or abrupt cessation of breastfeeding
- Personality issues (**perfectionism, people-pleasing**, Type A)
- Recent life stressors (move, loss of loved one, etc.)

Contributors to PMHDs (Cont'd)

Adverse Childhood Experiences (ACEs) - Understanding the impact of childhood trauma

A checklist of common childhood traumas that are positively associated with health and mental health challenges, such as:

- childhood emotional neglect or severe poverty
- loss of a parent
- parent with mental health or substance abuse challenges
- physical, psychological or sexual abuse

A high ACE score is positively correlated with perinatal mental health and substance use

Biologic Risk Factors For Women

- **Family/Personal History Mental Health Concerns**
- **Family/Personal History of Thyroid Illnesses:** Postpartum thyroiditis and anxiety similarities in sx
- **Inflammation and Metabolites**
 - Cedars Sinai studies 2021/2022: inflammation correlates, marker in plasma
 - [Japanese study plasma metabolic disturbance 2023](#)
- **Premenstrual Syndrome (PMS) and Premenstrual Dysphoric Disorder (PMDD):** Correlation between history of pain/mood issues and PMHDs
- **Shorter or longer break between children**
 - WHO recommends 18-24 months minimum, Mayo recommends not more than five years
- **Other Biological Factors**
 - Onset of PMHDs often occur after cessation of breastfeeding
 - low Vitamin D, iron, circadian rhythm, sleep dysfunction/sleep issues

Additional Biologic Factors For Men

- **Cohabiting with gestating partner**
 - Men generally experience a drop in testosterone a month before birth, increase in estrogen
 - Lower testosterone creates higher empathy in fathers
- **Pre/Post Birth**
 - Higher testosterone/lower cortisol in fathers correlates to poor paternal parenting and vice versa
 - Oxytocin correlated to stimulatory play – 30 sample study showed nasal oxytocin just prior to labor increased paternal motivation.

Additional Non-Conforming Biologic Factors for Trans-men/Gender

- Additional likelihood of **prior mood and anxiety disorders** in this demographic
- Impact of Testosterone
 - Cessation of testosterone and rebound to estrogen
 - **Minimal research** on fertility time period of moving into gestating parent.
- Pre/Post Birth
 - Unknown impact on biochemical mood of moving out of gestating parent to restarting testosterone
 - If chest-feeding, then risk for PMH onset at cessation

- **Increased Risk Among LGBTQ+ Women:** Research indicates that they are 50% more likely to experience stress and depression during pregnancy
- **Higher Rates of Postpartum Depression:** LGBTQ+ women are more likely to screen positive for postpartum depression
- **Elevated Mental Health Challenges:** LGBTQ+ women in the U.S. face disproportionately high rates of trauma and mental health issues, yet they are less likely to seek medical care.

Barriers to Accessing PMH Treatment for LGBTQ+

- **Discrimination and Stigma:** LGBTQ+ often encounter discrimination in healthcare settings, leading to mistrust and avoidance of care
- **Lack of Provider Competence:** Many healthcare providers **lack training in LGBTQ+ health issues**, resulting in inadequate or insensitive care
- **Systemic Heteronormativity:** Medical forms and practice assumptions **alienate LGBTQ+ patients**
- **Fear of Legal and Social Repercussions:** Concerns about PMH diagnoses leading to child removal or employment discrimination deter LGBTQ+ from seeking help
- **Geographical and Financial Barriers:** Access to LGBTQ+ - competent care is limited geographically and financially



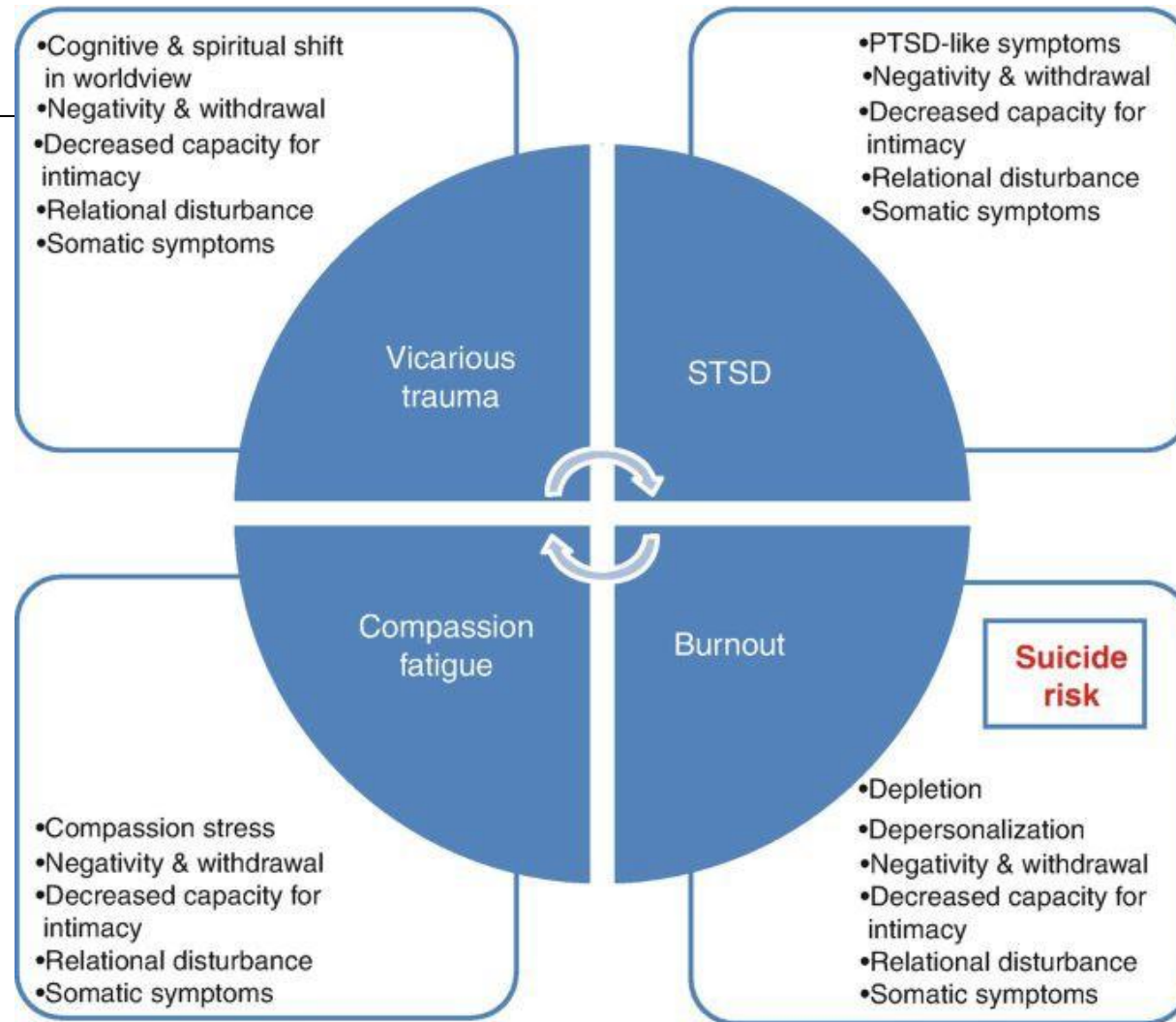
Provider Self-Care & Burnout

Caring for the Caregiver: Burnout, Compassion Fatigue & Vicarious Trauma

Key Points:

- **Burnout:** Emotional exhaustion, depersonalization, and reduced sense of accomplishment.
- **Compassion Fatigue:** Emotional residue from bearing witness to others' suffering.
- **Vicarious Trauma:** When clients' traumatic stories begin to alter your worldview.
- **Cultural Load:** Additional emotional labor for health workers serving their own or marginalized communities.

Burnout in Community & Providers



(Hategan et al, 2020)

Self-Care: Putting It Into Practice



Create A Self-Care Action Plan



TAKEAWAYS & THANK YOU

“What is one word that reflects what you are taking from today?”

Thank you for the work you are doing!

Summary and Takeaways

- **PMHDs are extremely common**, especially among underserved populations, but also very *put-together* parents
- Parents often **underreport symptoms** or avoid help - stigma and lack of recognition that they have a PMHD
- **Intrusive thoughts are normal** but extremely upsetting in anxiety and OCD, and should be treated as routine
- Postpartum psychosis is a rare **psychiatric emergency** and requires immediate action to avoid tragic consequences. Hospitalization and medication is needed
- **PSI can help** with support for parents and by providing culturally competent training for providers.
- With knowledgeable and compassionate treatment, most parents with PMHDs **will recover quickly** and completely.



PSI Branded Materials

Your department can purchase bulk PSI-branded items to give to patients and increase awareness and access to postpartum and perinatal mental health support and resources



PSI Branded Items for Purchase:

Organizations can order a bulk order from here (under "**PSI Chapters/Swag Catalog**"- and the drop down has many items, including "PSI Imprinted Items").

<https://postpartum.app.neoncrm.com/np/clients/postpartum/catalog.jsp?catalog=2>

Example pricing:

\$16 for 10 PSI stress hearts, \$45 for 50 PSI pens, \$50 for 60 PSI magnets

So, it would be \$250 for 500 Magnets, if you ordered a bulk amount for providers to pass out to patients, at a single location.





Behavioral Health Services in Partnership HealthPlan Perinatal Services

- Behavioral health services are essential for pregnant and post partum individuals
- Perinatal services programs can provide these services internally/ with embedded behavioral health using Z codes.
 - MSW, LCSW, PhD, MFTs
- Using Z codes for behavioral health services
 - Z6300 initial assessment (30 minutes) with additional time (Z6302)
 - Z6304 individual antenatal follow up
 - Z6306 group antenatal or post-partum
 - Z6308 postpartum assessment/treatment /intervention
- Health educators CAN provide behavioral health education
 - Most/all Partnership members have risks for mood disorders but may not “screen” in
 - Initial comprehensive assessment (Z6300) – includes screening for mood disorder AND risk factors
 - Codes for health educators: Z6406 (follow up prenatal) and Z6414 (Post-Partum)



Additional Behavioral Health Resources

- Post Partum International – (800) 944-4773
- Modified Edinburgh Postnatal Depression Scale (EPDS) See attached.
- Recommended reading:
 - Down Came the Rain by Brooke Shields
- Health Resources and Services Administration (HRSA) Maternal and Child Health resources:
 - Hotline: (833) 852-6262 (TLC-MAMA)
 - <https://mchb.hrsa.gov/programs-impact/national-maternal-mental-health-hotline>
- American Association of Medical Colleges
 - <https://www.aamc.org/about-us/mission-areas/health-care/maternal-mental-health>



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Substance Use Disorders in Pregnancy

Lisa Rodelo MD

Family and Addiction Medicine

Deputy Health Officer Contra Costa Health

At the end of this discussion, participants will have an understanding of:

1. A broad overview of how SUD impacts pregnancy/ post partum
2. The benefits of recognizing / addressing SUD during pregnancy
3. How individuals' bias may impede the intention to support the care of an individual with SUD in pregnancy.
4. Evidence based tools in screening/ and addressing SUD in pregnancy– SBIRT/ first steps to Motivational Interviewing
5. Review Partnership specific resources for accessing SUD services by region

(Treatment not addressed in depth today, slides from last year available)

How big is the problem?

Overall rates of use in pregnancy

(National Survey on Drug Use and Health 2023)

- 5% used illicit drugs in the past month
- 5% used tobacco in past month
- 5% binged on alcohol in past month

- *15% of pregnant individuals meet criteria for an SUD prior to getting pregnant*

Effect of income on rates of use within past month while pregnant

- Marijuana:
 - Below poverty line: 11 %
 - One to two hundred percent of poverty line: 3%
 - Above two hundred percent of poverty line: 2%
- Daily tobacco:
 - Below poverty line: 11 %
 - One to two hundred percent of poverty line: 9%
 - Above two hundred percent of poverty line: 4%
- Alcohol:
 - Below poverty line: 5% used
 - One to two hundred percent of poverty line: not listed
 - Above two hundred percent of poverty line: 9% (opposite trend)

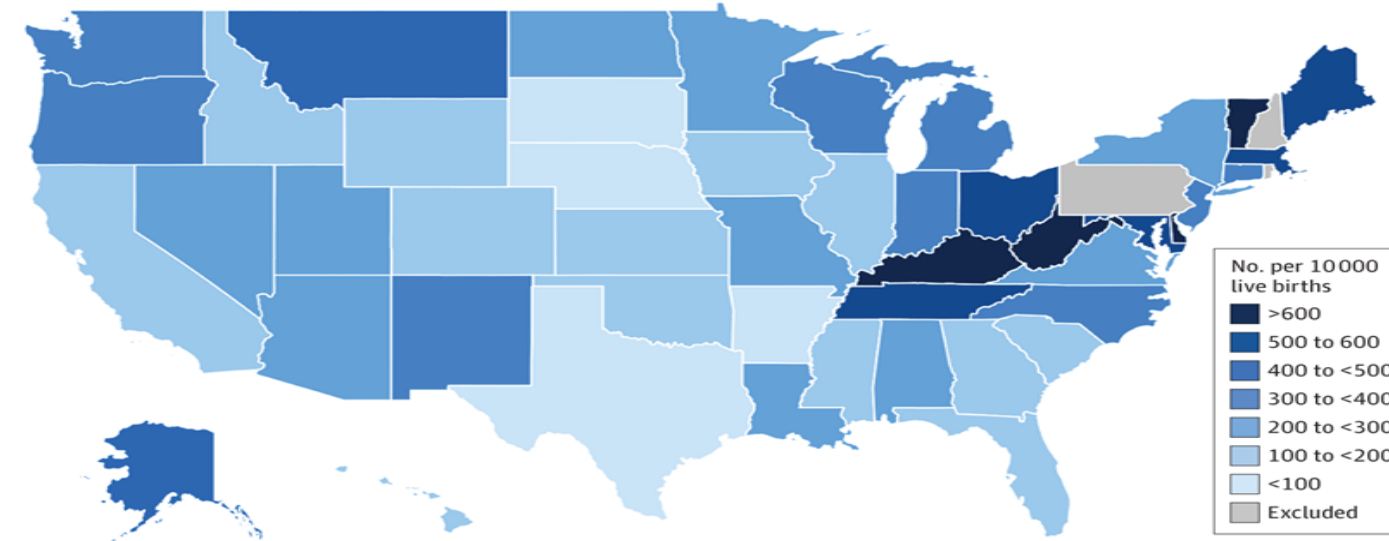
- 8.4% of all pregnant women used any alcohol in past month
 - 4.8% have binged during past month
 - 1.7% report heavy alcohol usage during past month
-
- Compared to non-pregnant rates: 49.8%, 26.0%, and 5.9% respectively

National Medicaid Data: Opioid Use Disorder in Pregnancy⁷

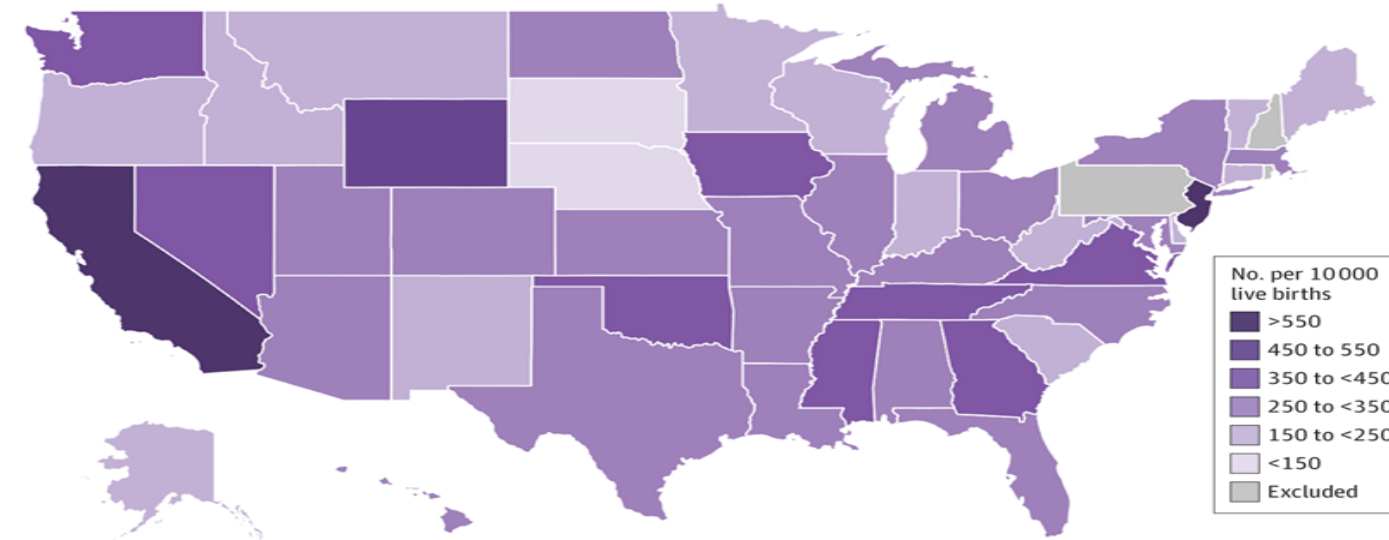
2016-2018
Beginning of
fentanyl
epidemic

N = 96 309

A Rates of opioid use disorder among pregnant people



B Rates of severe maternal morbidity among pregnant people with opioid use disorder



- [Prenatal Substance Use](#)
 - By county or region
 - Stratifies by age, income, race, rural/urban, etc.
 - <https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Prenatal-Substance-Use.aspx>

Prenatal Substance Use

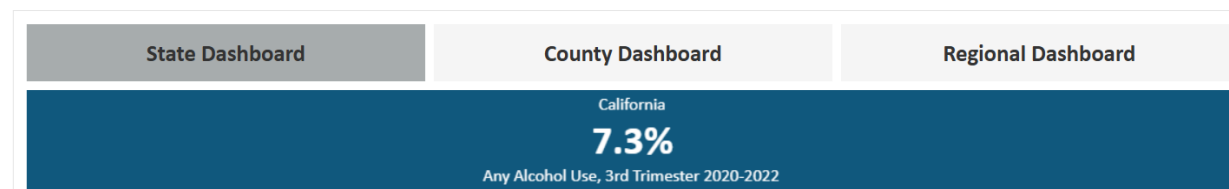
Welcome to the California prenatal substance use dashboard based on state-, county-, and regional-level data for 2013–2022. Here you can see data at a glance, obtain more details for indicator subcategories, as well as download data for your own analyses.

[About the Data \(PDF\)](#)

[Download Data \(CSV, 3.5 MB\)](#)

[Frequently Asked Questions](#)

[Dashboard Instructions](#)



- **First- what is it NOT?**
 - Not just **tolerance** to a substance
 - Not just **dependence** on a substance
 - Not a character defect (lazy, stupid, violent)
 - Not selective
 - Not something people choose for themselves
 - **Explore your own feelings about this one!**

- What has your experience of addiction been like in your *personal* life?
 - Family/loved ones
 - Self

How do you feel about these past experiences *today*?

- Anger
- Sadness
- Frustration
- Disgust
- Shame
- Pride?
- Awe?

So- what is addiction then?

Medical disease model:

Repeated **exposure** to a substance



Biochemical **molding and adaptation** of the brain's pathways

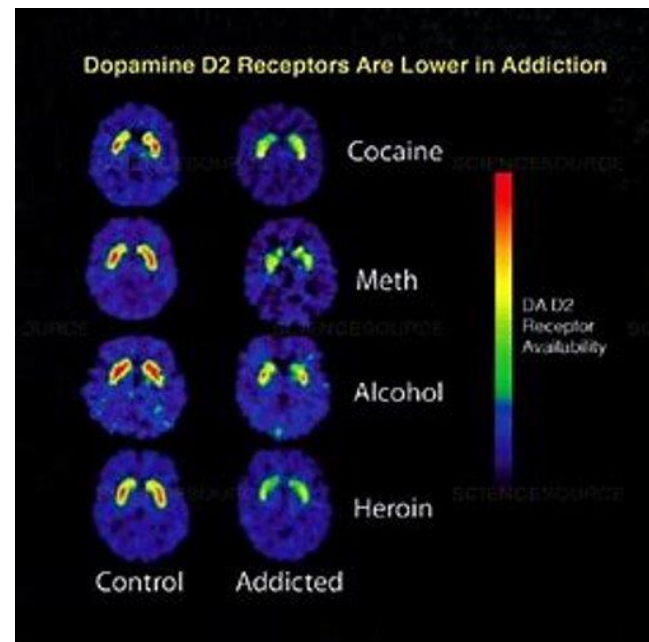
What kind of medical disease?

- Chronic (mild, moderate, severe)
- Relapsing/remitting
- Terminal if unaddressed

Repeated **exposure** to a substance



Biochemical **molding and adaptation** of the brain's pathways:

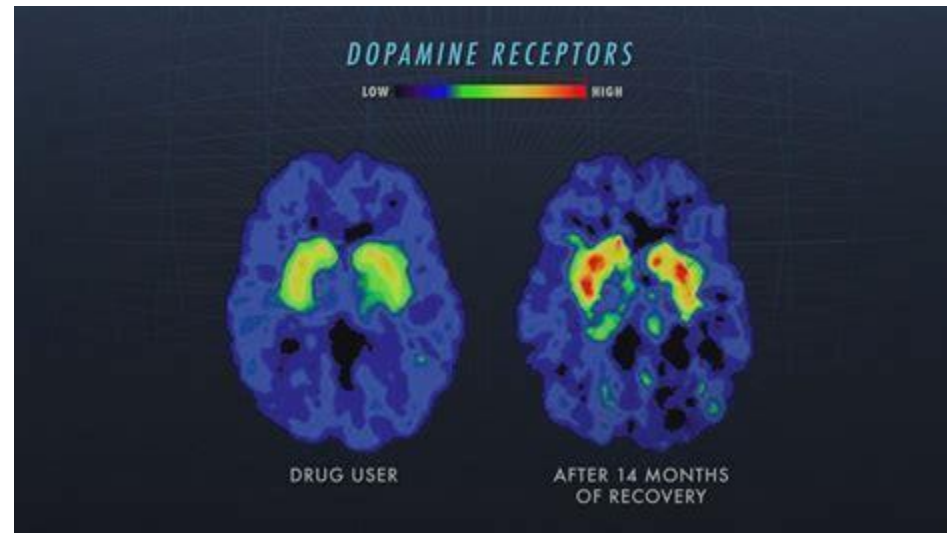


Neuroplasticity gone awry



maladaptive behavior!

But it can be reversed



What are your feelings around recovery?

- Use disorder "in remission" or "resolved"?
- Sobriety from one substance but not another
- Relapses
- "My recovery needs to come first"
 - How do you feel about that in personal settings?

Why is recovery so complicated??

- Substance use is no longer to get high, but to feel normal
 - Blunting of reward response if uses
 - Highs get progressively less fun
 - Reinforcement of punishment if no use
 - Lows are terrible, worse than prior to disease
 - We'll come back to this later...

Example: the opioid-addicted brain

Positive effects with initial use	Negative effects of non-use after build-up of tolerance
↑ Dopamine – feel good	↓ Dopamine - dysphoria
↑ Opioid peptides – pain relief	↓ Opioid peptides- pain, hyperalgesia
↑ Serotonin – peacefulness, feel-good	↓ Serotonin - dysphoria
↑ GABA - calmness	↓ GABA – anxiety, panic

(G Koob PhD “Common Elements of Neuroplasticity of Addiction” presentation CSAM 2013)

- Defining addiction is hard
 - Highly variable presentations
 - Differing meanings depending on setting
 - Medical
 - Recovery community
 - Public
- 11 criteria exist for diagnosing a use disorder
 - All but 2 are behavioral
 - Tolerance and dependance \neq addiction!!

TABLE 2.

DSM-5 Criteria for Substance Use Disorder

Criterion	Severity
Use in larger amounts or for longer periods of time than intended	Severity is designated according to the number of symptoms endorsed: 0-1: No diagnosis 2-3: Mild SUD 4-5: Moderate SUD 6 or more: Severe SUD
Unsuccessful efforts to cut down or quit	
Excessive time spent using the drug	
Intense desire/urge for drug (craving)	
Failure to fulfill major obligations	
Continued use despite social/interpersonal problems	
Activities/hobbies reduced given use	
Recurrent use in physically hazardous situations	
Recurrent use despite physical or psychological problem caused by or worsened by use	
Tolerance	
Withdrawal	

SUD, substance use disorder

Adapted from Diagnostic and Statistical Manual of Mental Disorders, fifth edition.²³

“4 C’s”

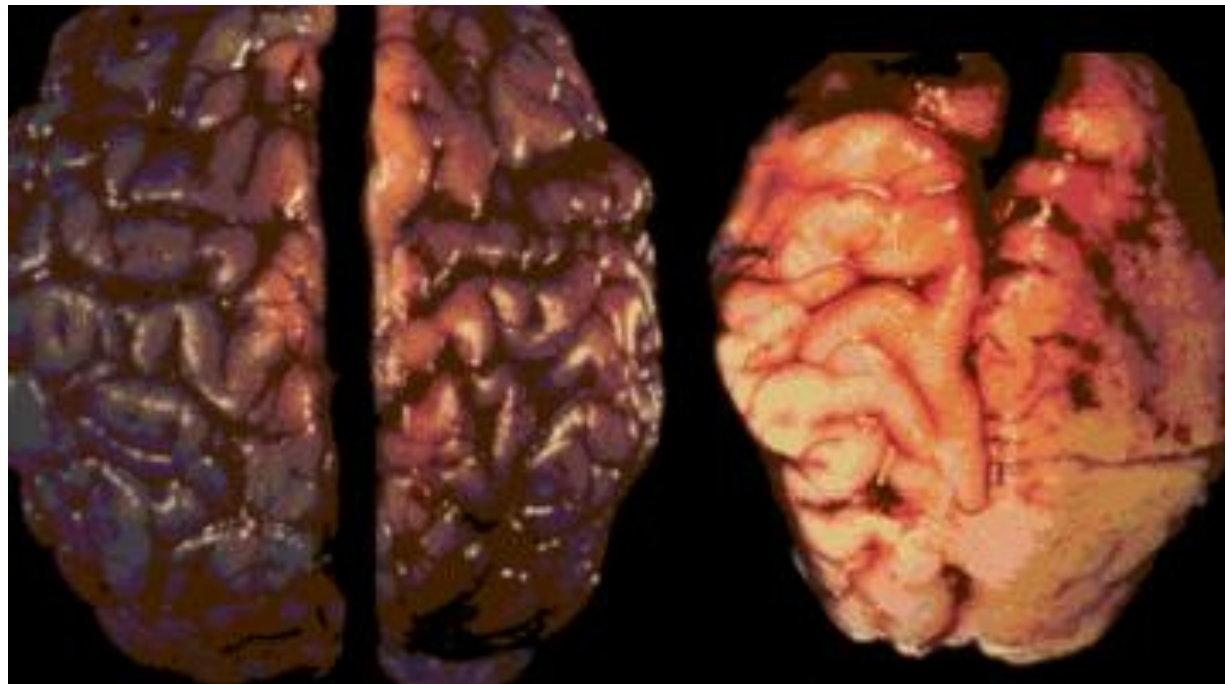
- Controlled by the substance
- Compulsion to use
- Continued use despite harm
- Cravings during periods of abstinence

- In health care settings:
 - Limit stigmatizing language
 - No longer characterized as “abuse”
 - “Clean” vs “dirty” connotes a quality that is not medical
- In the community:
 - Terms can mean something completely different to different people
 - Addiction, recovery, sobriety, clean vs. dirty, etc.

- Perinatal risks:
 - SAB, low birth weight, abruption, PPRM, preterm delivery, abnormal placentation, IUFD
- Neonatal/childhood risks:
 - Respiratory problems, SIDS, behavioral problems
 - Girls: increased risk of substance use in adolescence
 - Boys: increase in oppositional defiant disorder (8)

- Withdrawal can be fatal
 - Imperative to detect/prevent withdrawal
 - Mimics other syndromes (htn, psychosis, etc)
 - Restlessness, agitation, tremor, fever, sweating, hallucinations, HTN, tachycardia, seizures

Fetal alcohol syndrome



- ~40,000 live births in US per year
- Umbrella term that describes the range of effects:
 - Growth delay, sensory problems, behavioral and learning issues, abnormal facial features
- No cure, only prevention
 - Dose response relation

- Similar to alcohol
 - Withdrawal can be fatal- similar to etoh
 - Consider risks of taper vs. continuing
 - Risk of NAS vs. likely higher risk of destabilization, seizures

- Methamphetamines, cocaine, many new designer drugs
- Withdrawal unpleasant but not fatal
- Mood disorders very common (uphill battle due to severe dopamine dysregulation)

- Pregnancy risks:
 - Preterm labor
 - Placental abruption
 - Fetal growth restriction
 - Hypertensive disorders
 - Psychosis
 - Nutritional/dental problems

- Suspected linkage to:
 - Lower birth weight
 - Increased risk of SIDS
 - Increased childhood respiratory problems
 - **Childhood cognition problems**
- Data seems confounded by tobacco use
- "No safe amount"

- Preterm labor
- Pre-eclampsia
- Placental abruption
- Low birth weight
- Non-reassuring fetal status
- Perinatal mortality

- Neonatal opioid withdrawal syndrome
- Prematurity
- Neural tube defects
- Microcephaly
- Neurobehavioral deficits
- SIDS

- Overdose
- Use disorders
- Cognitive risks
- Bowel function problems
- Hyperalgesia

- Can cause fetal distress, premature labor
 - Increased oxygen consumption by both mother and fetus
 - Increased sympathetic tone

Here's my pitch...



Pregnancy is our chance to intervene for *mothers*:

- Increased motivation
- Increased encounters with health care
- Increased general support from the community

- A primary risk factor for SUDs = history of ACEs
 - By treating a pregnant mom, you are in effect trying to "break the cycle" by preventing future ACES for her children

OK, so what do I do?

But first... what are my own biases?

- What have been your *professional* experiences of SUD?
 - Negative?
 - Positive?

- *The more addiction you treat the more frequently you will see the positive, generational effects*

- **Screening**
- **Brief Intervention**
- **Referrals**
- **Treatment**

- When? Before, during, and after pregnancy!
 - **Repeated** screening encouraged due to stigma/hesitation to admit use
 - *Recall- 15% of pregnant individuals meet criteria for an SUD prior to getting pregnant*

First- what are we screening for?

- Risky use!
 - **Not a diagnosis** of a use disorder, but means should be evaluated for one
 - **Can be done by anyone**
 - Written or verbal

 - *Recall- diagnosis made by 11 criteria*
 - *Must be done by licensed clinician*

- Screening should be universally offered
- Be especially vigilant if risk factors present:
 - Older age (alcohol), younger age (all others)
 - Income or housing instability
 - Lack of social support
 - At risk for trafficking
 - Sex worker
 - Family history, especially alcohol (4x increased risk)
 - Repeated encounters with criminal justice system
 - Prior children not currently in care
 - Partners/support persons who are using
 - Late to care, missed appointments
 - History of SUDs in past

- Intake questionnaires
- Urine toxicologies
- **Ask (use screening tools)**
 - Opinion: Providers should ask in addition to non-licensed staff (patients may be more comfortable divulging to me after several visits, as opposed to stranger on the phone)
- **Screening tool plus utox more effective at detection than either alone**
 - Both are standard of care

1. Did either of your **Parents** have problems with alcohol or drug use?
2. Do any of your friends (**Peers**) have problems with alcohol or drug use?
3. Does your **Partner** have a problem with alcohol or drug use?
4. Before you were pregnant did you have problems with alcohol or drug use? (**Past**)
5. In the past month, did you drink beer, wine or liquor, or use other drugs? (**Pregnancy**)

- Can be less threatening way to approach patient
- Gives some collateral information about their lives

NIDA Quick Screen: super easy!

National Institute on Drug Abuse quick screen

In the past year*, how often have you used the following:	Never	Once or twice	Monthly	Weekly	Daily or almost daily
1. Alcohol, four or more drinks per day					
2. Tobacco products					
3. Prescription drugs for nonmedical reasons					
4. Illegal drugs					

* For pregnant women, ask about substance use since the woman became pregnant.

Modified from: National Institute on Drug Abuse (NIDA). The NIDA Quick Screen. Available at: <https://www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf> (Accessed on September 21, 2016).

- Motivational Interviewing
 - Heavily supported by evidence
 - Can be done effectively in 5 minutes
 - Takes pressure off clinician

NOT data gathering!

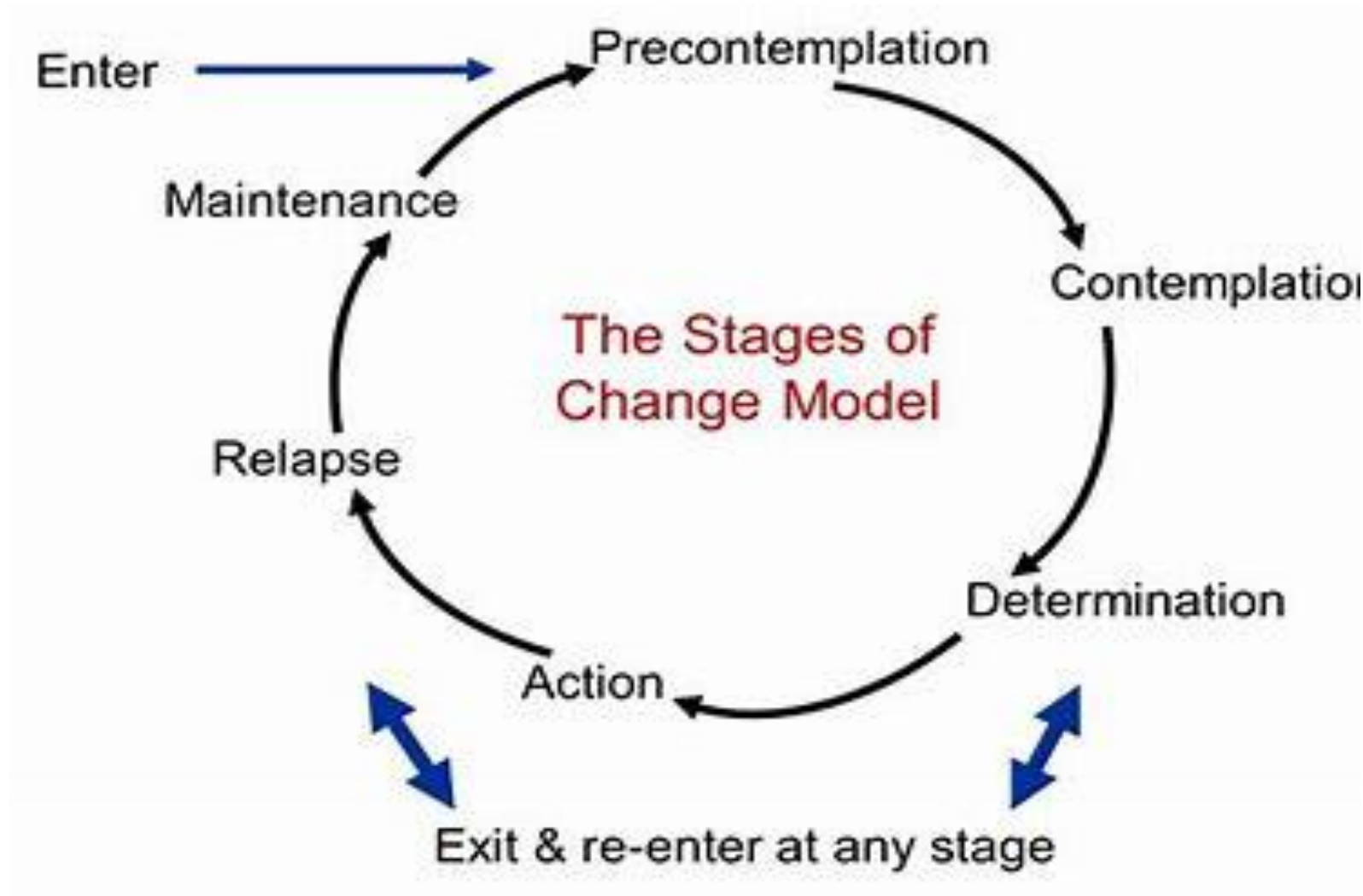
NOT persuading!

NOT fixing!

Think of it as "dancing" (moving together) vs. "wrestling" (moving in opposition)

- Goal is to have patient do the work of:
 - developing discrepancy between actions and goals
 - working through ambivalence about change
 - progressing through stages of change

Stages of Change



- Use your OARS!
 - Open-ended que
 - Affirmations
 - Reflections
 - Summarizations



- Open ended questions:

“Where are you at with cutting down on meth?”

“What does the meth do for you?”

“What concerns you about your meth use?”

“What are some reasons you might want to quit?”

- Affirmations:

“You’ve done great cutting back. Where do you want to go next with this?”

“You’re already showing what a great mom you are just by coming to your visit today”

- Reflections

"I don't know if I can handle this" -->

"You're feeling really overwhelmed right now"

"I just want to do what's best for my baby" -->

"You want to do the best thing for your baby"

- Summarizations

"So you're a bit scared, but you're willing to work really hard. You want to learn more about treatment, and I'll give you a few resources today"

- Medication

- Withdrawal management
- Prevention of cravings
- Maintenance during recovery

- Behavioral Health

- Structured recovery programs:
 - Residential medical → residential non-medical → intensive outpatient → weekly/prn outpatient
- Peer support: 12-step, Lifering, etc
- Psychotherapy + psychiatric care
- Social work, Enhanced Care Management, etc

But first...

- You have to get her to come back
 - Trust building
 - Lots of questions and fear
 - Internalized stigma on top of experienced stigma

Be a “**soft place to land**” when a mother screens positive

- She likely already feels guilty
- She likely already knows she should quit

Create a safe space where she can be honest with you without feeling judged

- Even if her decisions seem counterintuitive, meet her where she’s at
- Be patient; here’s why:

So when you meet her:

- Don't be offended or surprised if she used prior to visit in order to be present
- If in withdrawal:
 - Unrelenting panic state
 - Dysphoria; unable to see the light and end of tunnel yet
 - Physically ill, syndrome varies by substance
 - Likely labile mood, cranky or sad

You will change lives by listening with compassion



Substance Use Disorder (SUD) Services in the Partnership Network

- SUD in primary care / prenatal practices office-based medication assisted therapy for opioid use disorder, alcohol use disorder, or other disorders
- Can be provided in a PCP practice to which the member is not assigned for primary care
 - Billing codes:
 - F11.x for Medication Assisted Therapy for Opioid Use Disorder
 - F10. x for Medication Assisted Therapy for Alcohol Use Disorder
- Substance Use services are available either through providers contracted through Partnership (7 Wellness and Recovery counties) or through county-based programs





Perinatal SUD Services

Women's Recovery & Resiliency Services – Shasta County (Outpatient): (530) 245-6411

Provides parenting skills development and case management. On-site childcare is available. Serves Shasta County members.

Ujima Family Services The Rectory – Contra Costa (Residential): (510) 263-3134

Services are provided for pregnant and parenting women and their children up to the age of 12.

Ujima Family Services Hope Solano (Outpatient): (707) 558-8500

Program offers evidence-based services to promote recovery from drug and alcohol use for pregnant, postpartum, and parenting women and men with children.

Women's Recovery Services (WRS) – Sonoma (Residential): (707) 527-0412

WRS's treatment approach includes addresses health problems, mental health and trauma as part of a recovery process.

Tule House – Lake County (Residential): (707) 263-3116

Tule House is a family centered treatment program that allows women to bring their children who are 12 and under to live with them at the facility.

Bright Heart Health in all 24 counties for mental health and SUD/MAT: **(800) 892-2695**

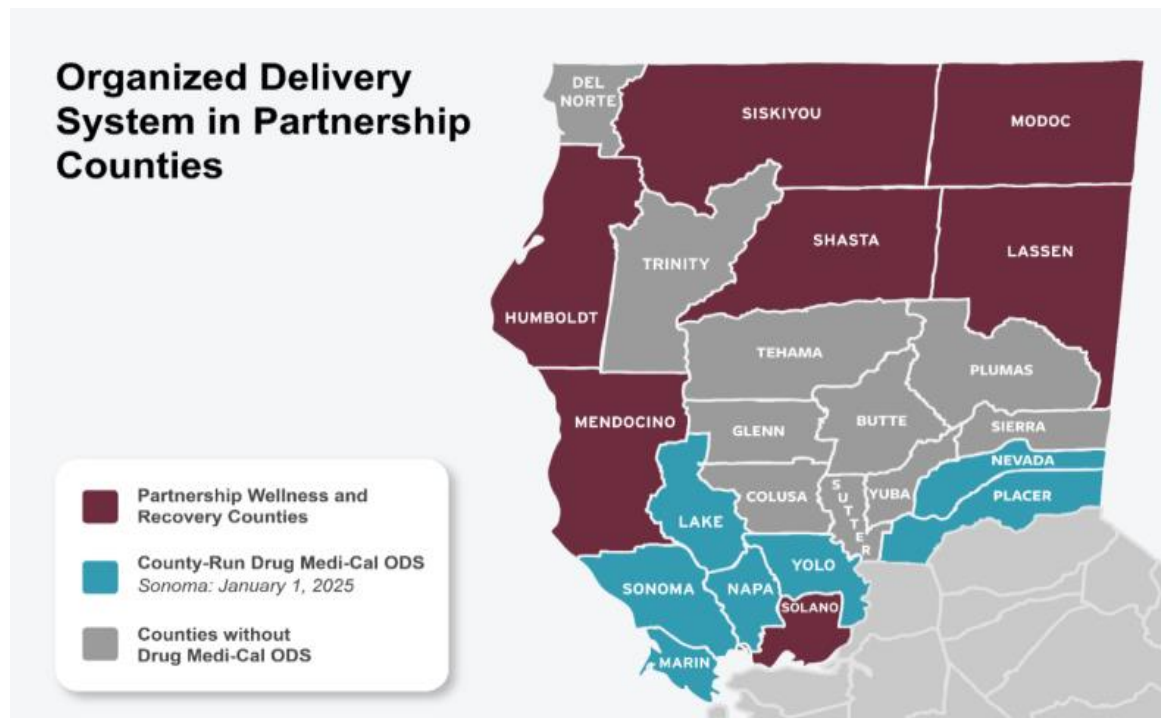
- Visit the online virtual clinic at: <https://www.brighthearthealth.com/contact-us/>



Partnership and the Wellness and Recovery Program

On July 1, 2020, Partnership began administering SUD services to Medi-Cal beneficiaries in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties.

Organized Delivery System Counties



Key Components of the Benefit

- Full continuum of services
- Central access line
- Standardized medical necessity criteria – ASAM
- Care coordination across systems
 - Primary care
 - Mental health
 - Substance use

Accessing Services



Behavioral Health Access Line

- Members may be referred or can self-refer to Partnership Behavioral Health at (855) 765-9703 to be screened and connected to a service provider.



Direct Referrals

- Connecting directly to a Partnership SUD service provider is also appropriate in Wellness and Recovery Counties.



Authorizations in Wellness and Recovery Counties

- The only level of care requiring authorization is **residential** and can be obtained by the residential treatment provider



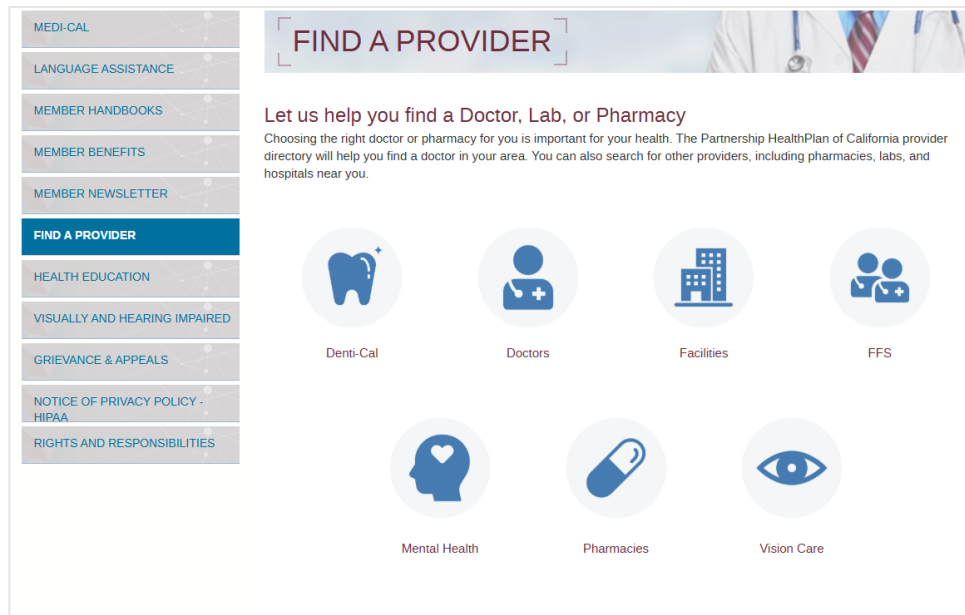
Transportation

- Transportation services are directly coordinated by Partnership's Transportation Services and can be requested by members and providers.

Additional SUD Resources

- Partnership behavioral health SUD webpage
- Information about benefit
- Links to webinars on SUD

○ <http://www.partnershiphp.org/Providers/BehavioralHealth/Pages/Substance-Use-Disorder-Services.aspx>



The screenshot shows a navigation menu on the left with options like 'MEDI-CAL', 'LANGUAGE ASSISTANCE', 'MEMBER HANDBOOKS', 'MEMBER BENEFITS', 'MEMBER NEWSLETTER', 'FIND A PROVIDER' (highlighted), 'HEALTH EDUCATION', 'VISUALLY AND HEARING IMPAIRED', 'GRIEVANCE & APPEALS', 'NOTICE OF PRIVACY POLICY - HIPAA', and 'RIGHTS AND RESPONSIBILITIES'. The main content area features a 'FIND A PROVIDER' header with a search bar and a list of service categories: Denti-Cal, Doctors, Facilities, FFS, Mental Health, Pharmacies, and Vision Care. A descriptive paragraph explains the purpose of the directory.

FIND A PROVIDER

Let us help you find a Doctor, Lab, or Pharmacy
Choosing the right doctor or pharmacy for you is important for your health. The Partnership HealthPlan of California provider directory will help you find a doctor in your area. You can also search for other providers, including pharmacies, labs, and hospitals near you.

- Denti-Cal
- Doctors
- Facilities
- FFS
- Mental Health
- Pharmacies
- Vision Care

Partnership Provider Directory – Search by Specialty/Substance Use

- <https://providerdirectory.partnershiphp.org/Provider/BasicSearch/>

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Foundations of Perinatal Nutrition Care

Lauren Amos, MS, RD, LDN



Disclosures

Presenter: Lauren Amos, MS, RD, LDN

Relationship: Full-time employee of Zipongo Inc.

This presentation is focused on evidence-based practices and the current medical literature. All clinical recommendations are based on peer-reviewed data accepted within the profession as adequate justification for patient care. My presentation today includes information regarding Foodsmart, which is developed by my employer.

Objectives

- Describe evidence-based nutrition recommendations during pregnancy and postpartum.
- Identify common misinformation related to nutrition during pregnancy.
- Identify and utilize reputable, accessible patient-facing resources (websites, apps, and tools) to support nutrition education during and after pregnancy.
- Identify common barriers to achieving optimal nutrition during pregnancy and postpartum, such as food access and economic constraints.
- Describe resources that support overcoming these barriers.
- Recognize clinical and behavioral indicators that warrant referral to Registered Dietitian (MNT) and Certified Diabetes Educator (CDE) services.
- Describe cultural factors that influence food choices and nutrition access during pregnancy.
- Identify culturally appropriate counseling approaches and resources.

- Nutrition during the perinatal period influences **maternal health, fetal development, and postpartum recovery.**
- Adequate nutrition supports **prevention and management** of conditions such as gestational diabetes, hypertensive disorders, anemia, and excessive or inadequate weight gain.
- **Social determinants of health** significantly influence nutritional status.
- Evidence-based nutrition guidance and timely referral can **improve outcomes and reduce disparities.**
- Interdisciplinary collaboration strengthens **perinatal nutrition care.**

Special Considerations During Pregnancy

- Healthy Weight Gain & Increased Energy Needs
- Increased Nutrient Needs
- Food Safety
- Alcohol & Caffeine Consumption
- Managing Symptoms



- Recommended weight gain depends on pre-pregnancy BMI
- **General Increased Calorie Needs:**
 - No added energy needs in **1st trimester**
 - Additional ~300 daily calories **2nd trimester**
 - Additional ~450 daily calories **3rd trimester**

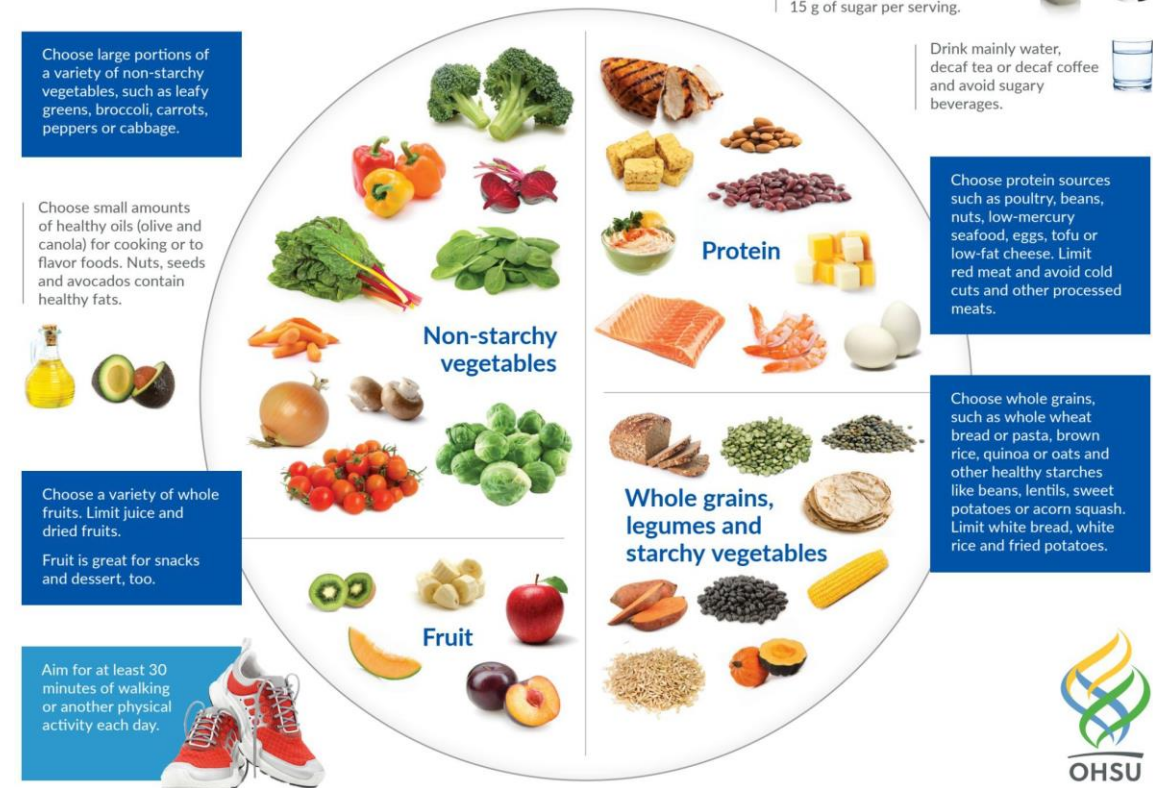
Pre-pregnancy weight	Recommended weight gain
Underweight (BMI below 18.5)	28 to 40 lbs. (about 13 to 18 kg)
Healthy weight (BMI 18.5 to 24.9)	25 to 35 lbs. (about 11 to 16 kg)
Overweight (BMI 25 to 29.9)	15 to 25 lbs. (about 7 to 11 kg)
Obese (BMI 30 or more)	11 to 20 lbs. (about 5 to 9 kg)

Source: Institute of Medicine and National Research Council

Increased Nutrient Needs

- A well-balanced diet is important to meet nutrient needs
 - **Iron:** lean meats, dark green veggies, fortified cereals, beans, peas, lentils
 - **Folic Acid:** Dark-green veggies, beans, peas, lentils
 - **Iodine:** seafood, low-fat dairy, eggs
 - **Choline:** Eggs, lean meats, beans, peas, lentils
- Daily prenatal vitamin

My Pregnancy Plate



Choose large portions of a variety of non-starchy vegetables, such as leafy greens, broccoli, carrots, peppers or cabbage.

Choose small amounts of healthy oils (olive and canola) for cooking or to flavor foods. Nuts, seeds and avocados contain healthy fats.

Choose a variety of whole fruits. Limit juice and dried fruits. Fruit is great for snacks and dessert, too.

Aim for at least 30 minutes of walking or another physical activity each day.

Choose 2 to 3 servings of nonfat or 1% milk or yogurt (cow, soy or almond). A serving is 8 oz. Choose yogurt with less than 15 g of sugar per serving.

Drink mainly water, decaf tea or decaf coffee and avoid sugary beverages.

Choose protein sources such as poultry, beans, nuts, low-mercury seafood, eggs, tofu or low-fat cheese. Limit red meat and avoid cold cuts and other processed meats.

Choose whole grains, such as whole wheat bread or pasta, brown rice, quinoa or oats and other healthy starches like beans, lentils, sweet potatoes or acorn squash. Limit white bread, white rice and fried potatoes.

Non-starchy vegetables

Protein

Whole grains, legumes and starchy vegetables

Fruit



Food Safety During Pregnancy

Immune system changes increase the risk of foodborne illness for both mother and baby

- Pregnant women should avoid these foods during pregnancy:
 - Do not drink or eat raw or **unpasteurized milk, cheese or juice**
 - Do not eat **raw or undercooked meat, eggs, and fish** (raw sushi, meat spreads, pâté)
 - Avoid eating **lunch meats, hot dogs, cold cuts**, etc. unless heated to 165°F
 - Avoid **refrigerated pate, meat spreads or deli salads**. Shelf-stable options are safe to eat

- **Nausea**

- Eat small, frequent meals
- Limit fried or greasy foods
- Eat high-protein snacks throughout the day
- Plain crackers

- **Heartburn**

- Eat small, frequent meals
- Limit spicy, greasy, acidic and fried foods
- Walking after meals

- **Constipation**

- Choose foods high in fiber
- Drink plenty of water
- Regular physical activity

Common Nutrition Misconceptions

- **You're eating for two**
 - Calorie needs aren't doubled during pregnancy but increased by ~300-400 based on gestation
- **Seafood isn't safe to eat during pregnancy**
 - Choose options low in mercury (salmon, cod, chunk light tuna, sardines)
- **Prenatal vitamins replace a healthy diet**
 - Eating a variety of foods is important to meet nutrient needs
- **Caffeine isn't safe**
 - Generally Limit caffeine to 200 mg daily - encourage to discuss with provider
- **Alcohol and pregnancy**
 - There is no safe amount of alcohol during pregnancy



Postpartum Nutrition Considerations

- **Breastfeeding Energy Recommendations**
 - Additional ~350 daily calories for exclusively breastfeeding mothers
 - Healthcare providers should work with postpartum women to determine appropriate dietary supplements - specifically iodine and choline
- Support sustainable, realistic eating patterns for **all postpartum mothers**
 - Eat more whole foods (fruits, vegetables, whole grains, beans, legumes, lean proteins)



Postpartum Period & Weight Loss

- General recommendations encourage postpartum mothers to wait until at least 6 weeks before embarking on a weight loss journey
- Healthy weight loss goals should aim to return to pre-pregnancy weight by 6-12 months postpartum
- Encourage mothers to wait until cleared by health care provider to begin physical activity

- **Food insecurity**

- Food insecurity increases risk of:
 - Poor gestational weight gain
 - Micronutrient deficiencies
 - Gestational diabetes complications

- **How to screen for food insecurity**

- Ask neutral, non-stigmatizing screening questions (Hunger Vital Sign)
- “In the past 12 months, were there times you worried whether your food would run out before you got money to buy more?”
- “Did the food you bought not last, and you didn’t have money to get more?”

Overcoming Barriers to Optimal Nutrition: Economic

- Connect patients to resources such as WIC, SNAP, and community food programs
- Provide realistic, budget-conscious nutrition guidance.
 - <https://www.nutrition.gov/topics/food-security-and-access/nutrition-budget>
- Refer to an RD or community support services when additional support is needed

Barriers to Optimal Nutrition: Access

- Transportation
 - Limited access to grocery stores or WIC/SNAP offices
 - Reliance on public transport or rides from others
- Geography
 - Living in “food deserts” with few supermarkets
 - Limited availability of fresh fruits, vegetables, and culturally appropriate foods
 - Time Constraints
 - Long work hours, multiple jobs, childcare responsibilities
 - Less time for grocery shopping or meal prep

- **Nutrition Guidance May Not Reflect Cultural Foods**
 - Traditional nutrition education (e.g., MyPlate) often centers on common American foods
 - Patients may struggle to translate guidance to culturally familiar meals
- **Language & Health Literacy**
 - Limited English proficiency can make nutrition recommendations harder to understand
 - Access to bilingual providers or interpreters improves patient engagement and outcomes
- **Navigating the Health System**
 - Patients may not know how to find culturally or linguistically aligned providers
 - Tools such as **provider directories and translation services** can help connect patients with appropriate care
- **Implications for Care**
 - Adapt nutrition guidance to include culturally relevant foods
 - Utilize interpreter services and bilingual providers when available

Referral to a Registered Dietitian

- Referral to an RD ensures **personalized, evidence-based nutrition care** for perinatal patients
- Clinical Concerns: Gestational diabetes, abnormal weight gain, hyperemesis, preeclampsia, chronic conditions
- Nutritional Needs: Micronutrient deficiencies, restrictive diets, complex postpartum/lactation needs
- Social & Behavioral Factors: Food insecurity, access barriers, cultural or literacy considerations
- Support for Behavior Change: Meal planning, goal-setting, or difficulty following nutrition guidance

Member Path to Foodcare Optimization



Accessing Medical Nutrition Therapy and Nutrition Education in the Partnership Network

- Primary care or perinatal services practice: Community registered dietitian (RD) or certified diabetes care specialist in person or via telehealth, is a covered Partnership benefit
 - Health educators CAN provide nutrition education throughout pregnancy
 - RD/nutritionist and health educators in Federally Qualified Health Center (FQHC) / Tribal health center (THC) / Indian Health Service (IHS) practices in a PHPS program eligible for prospective payment system reimbursement
 - PHPS providers use Z codes for nutrition-related perinatal services
 - Health educators: Z6406 (follow up prenatal) and Z6414 (postpartum) – ONLY after Z6300 (initial comp assessment)
 - RDs and nutritionists: Z6200/02 (antenatal initial), Z6204/Z6206 (antenatal follow up individual/group), postpartum: Z6208 (individual) Z6206 post partum (group)
 - RD / nutritionist in FQHC / THC /IHS practices are a prospective payment system eligible service

Accessing Medical Nutrition Therapy and Nutrition Education in the Partnership Network

- Specialty services medical nutrition therapy (MNT) within the Partnership network – referral coordinators can direct referrals via an eRAF or faxing for MNT using the provider directory and the Partnership provider portal.
 - The Northern California Center for Wellbeing in Sonoma County
 - As You Are Nutrition in Napa County
 - FoodSmart

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Timely, Comprehensive, Pregnancy Care in Rural Communities

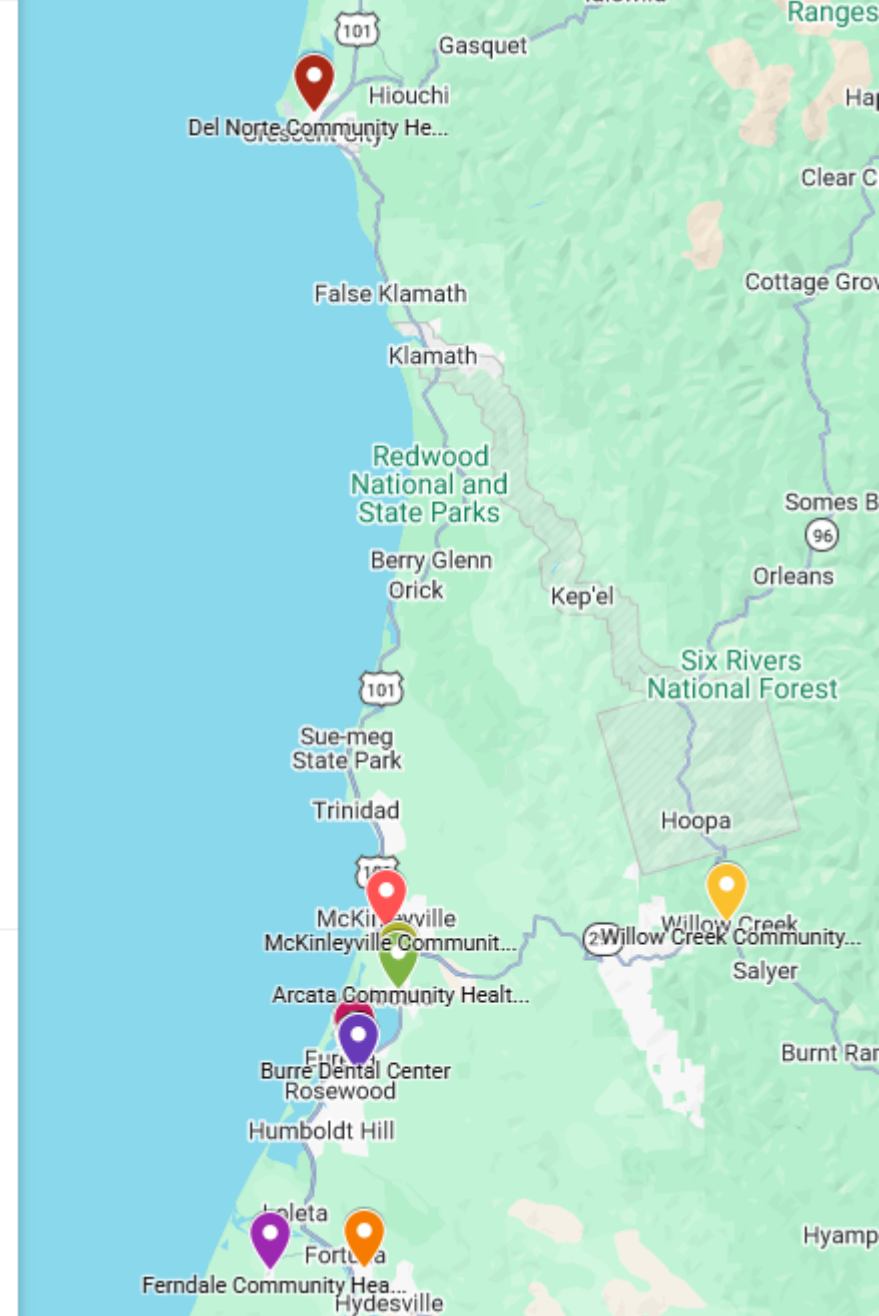
Operational Lessons

opendoor
Community Health Centers

April 13, 2026

Locations

-  Burre Dental Center
-  Del Norte Community Health Center
-  Eureka Community Health & Wellness Center
-  Ferndale Community Health Center
-  Fortuna Community Health Center
-  McKinleyville Community Health Center
-  Redwood Community Health Center
-  Telehealth & Visiting Specialist Center
-  Willow Creek Community Health Center
-  Arcata Community Health Center
-  Plaza Community Health Center
-  Open Door Rx



Meet your Presenters



Casey Weiser, MD
Pregnancy Services Clinical Lead



Aila Gilbride-Read,
Administrative Director



Kate Maguire, CPHW
Comprehensive Perinatal Health Worker

Learning Objectives

1. Describe factors that influence access to pregnancy care in rural communities and strategies to improve early entry to care
2. Analyze challenges of rural “shared care” and approaches to standardization
3. Evaluate approaches to risk-stratified scheduling
4. Explain how integrating the core pillars of Partnership HealthPlan Perinatal Services (PHPS) (previously CPSP) improve standard pregnancy care



Open Door Community Health Centers

Service Area

- Humboldt & Del Norte counties (2.3 million acres)

Network

- 15 clinics and 4 mobile (2 medical, 3 dental)

Patient Volume

- >60k patients in 2025

Access Types:

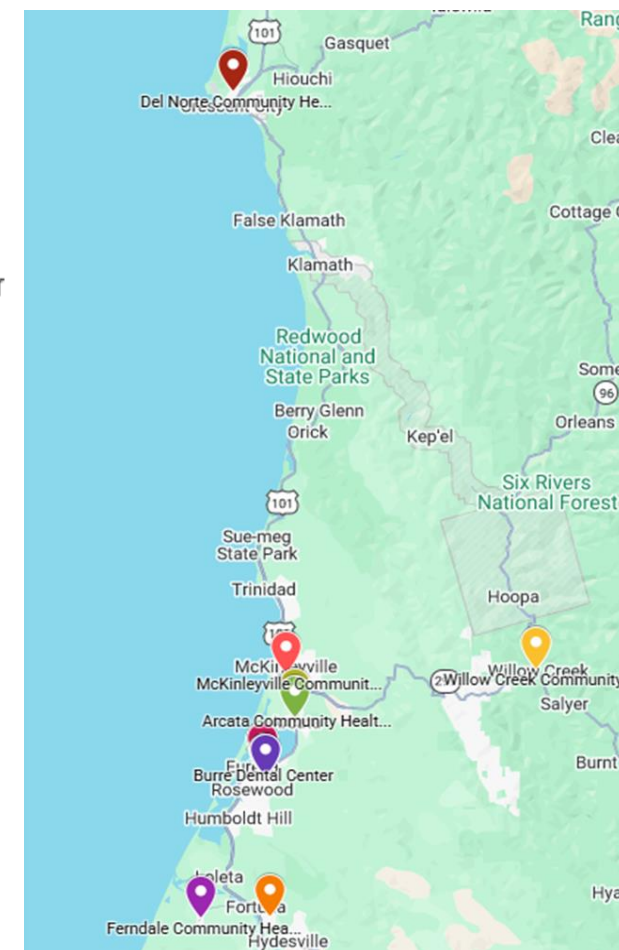
- ~ 270,000 Medical Visits
- ~34,000 BH visits
- ~34,000 Dental visits

Payor Types:

- ~174,000 Medicaid (46%)
- ~102,000 Medicare (27%)
- ~90,000 Commercial (24%)
- ~7500 Self-Pay (2%)

Locations

- Burre Dental Center
- Del Norte Community Health Center
- Eureka Community Health & Wellness Center
- Ferndale Community Health Center
- Fortuna Community Health Center
- McKinleyville Community Health Center
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- Telehealth & Visiting Specialist Center
- Willow Creek Community Health Center
- Arcata Community Health Center
- Plaza Community Health Center
- Open Door Rx



Pregnancy Services at ODCHC

Vision

Vision: Rooted in respect and partnership, every pregnant person receives holistic, equitable, compassionate, high-quality care throughout each pregnancy journey.



2 clinics, both in Northern Humboldt County

>450 deliveries in 2025



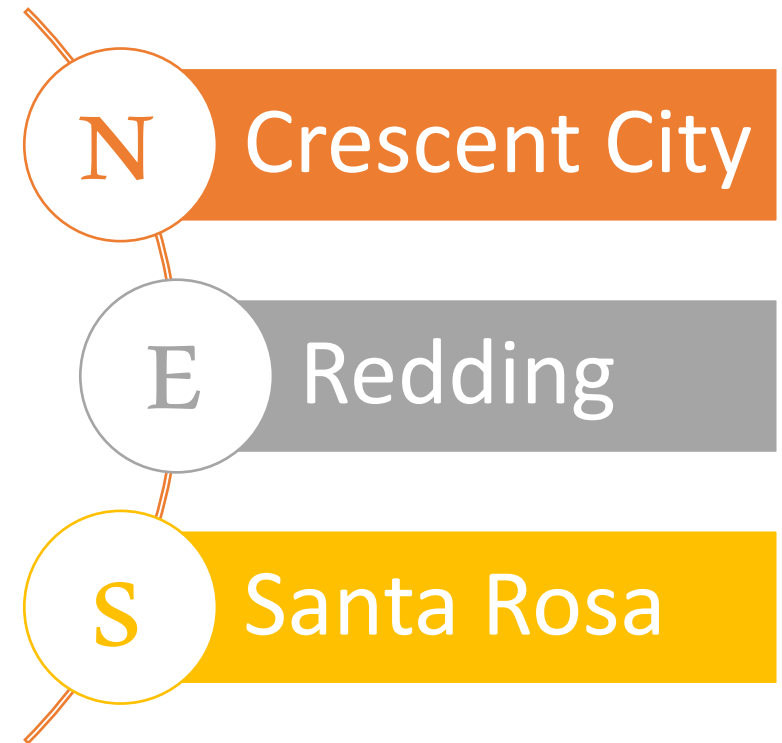
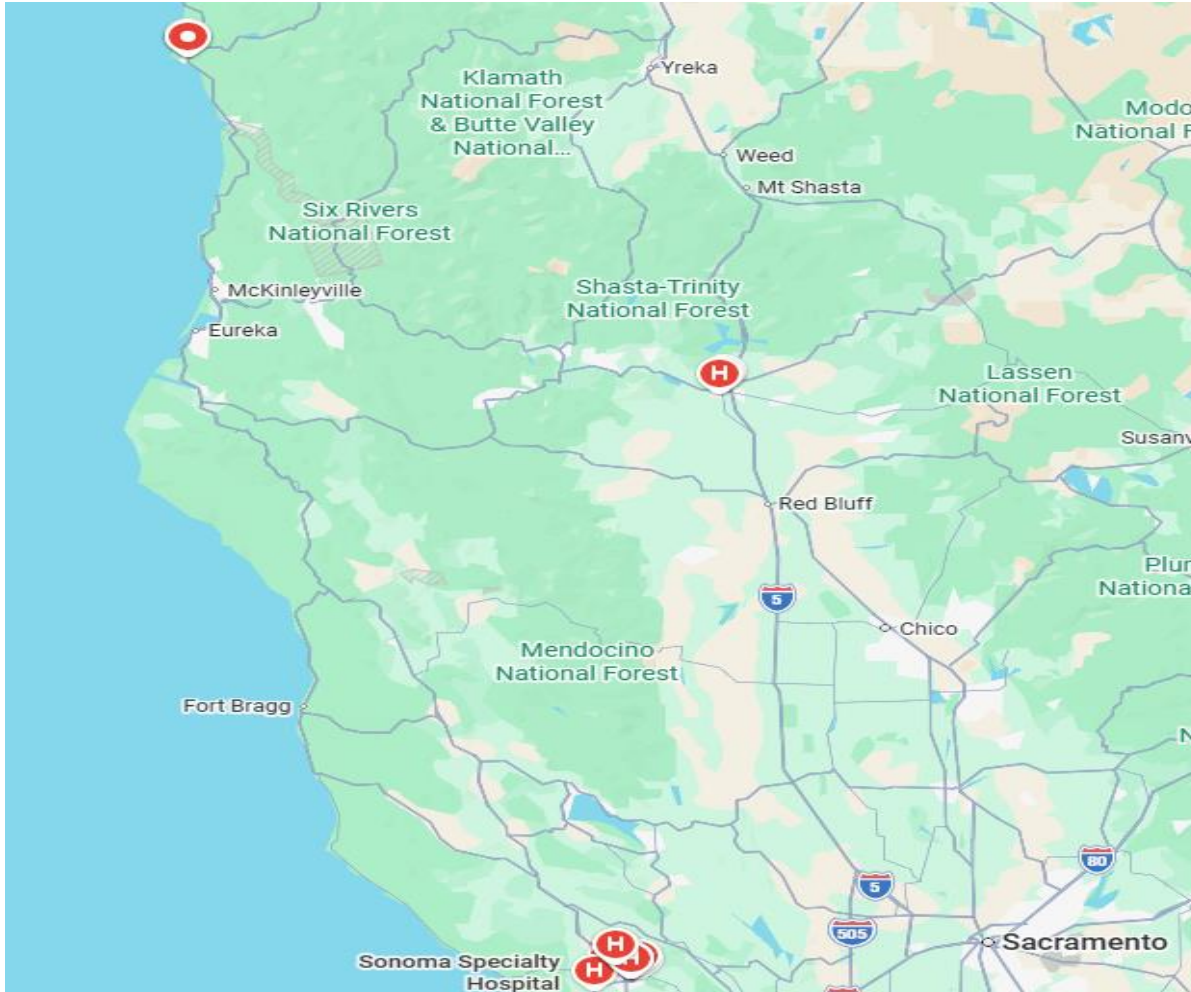
~70% covered by MediCal and/or Partnership

Timely Access to Care

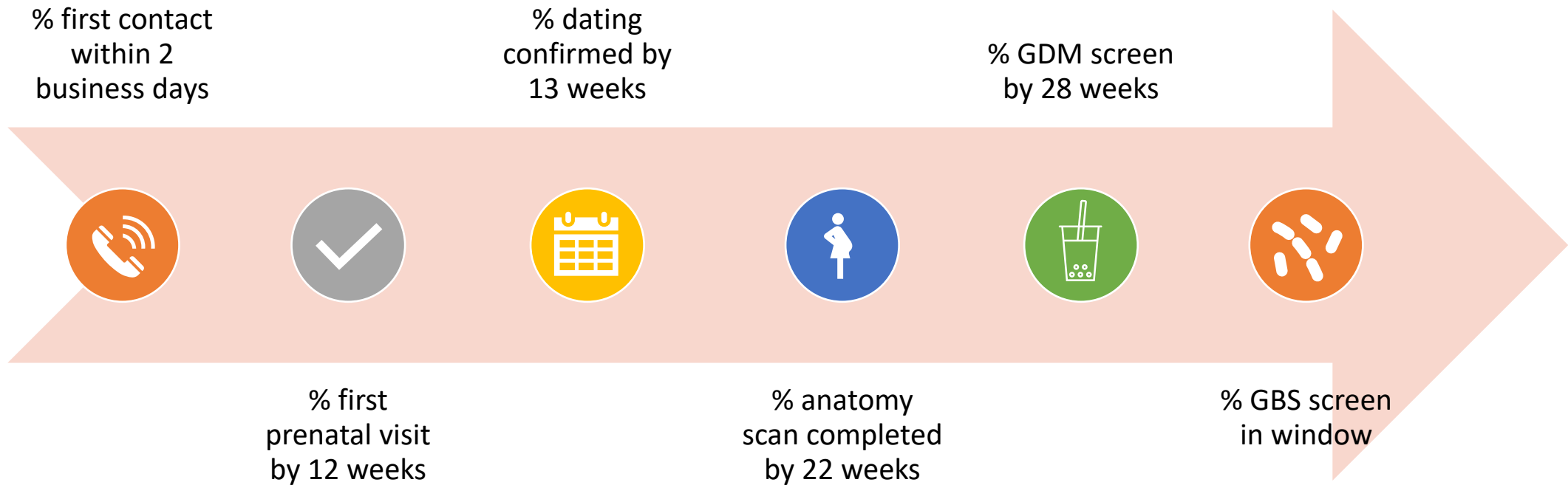


1. Geography & weather
2. Workforce shortages
3. Transportation barriers
4. Technology gaps
5. Small-town realities

Long Distance Between Hospitals



What does “timely” look like in practice?





St. Joseph Hospital
Eureka Paso a Paso (Step by Step)

Maintaining
Strong
community
partnerships to
improve timely
care




Meet the Doulas: Humboldt

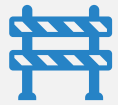
Meet local doulas and learn more about what a doula does, how a doula can support you, and make connections with resources and support through the prenatal, birthing, and postpartum process.

In person every first Thursday of the month

5-6:30pm Open Door Pregnancy Services
2350 Buhne St Eureka, CA95501

For more information:
call or text Jodie DiMinno 707 616 0930
or call Open Door Pregnancy Services 707 630 5281



Pick one real access bottleneck (geographic, scheduling, triage, referral, labs, ultrasound, transportation, language, etc.)



Write it as: “When ___ happens, we ___, which results in ___”



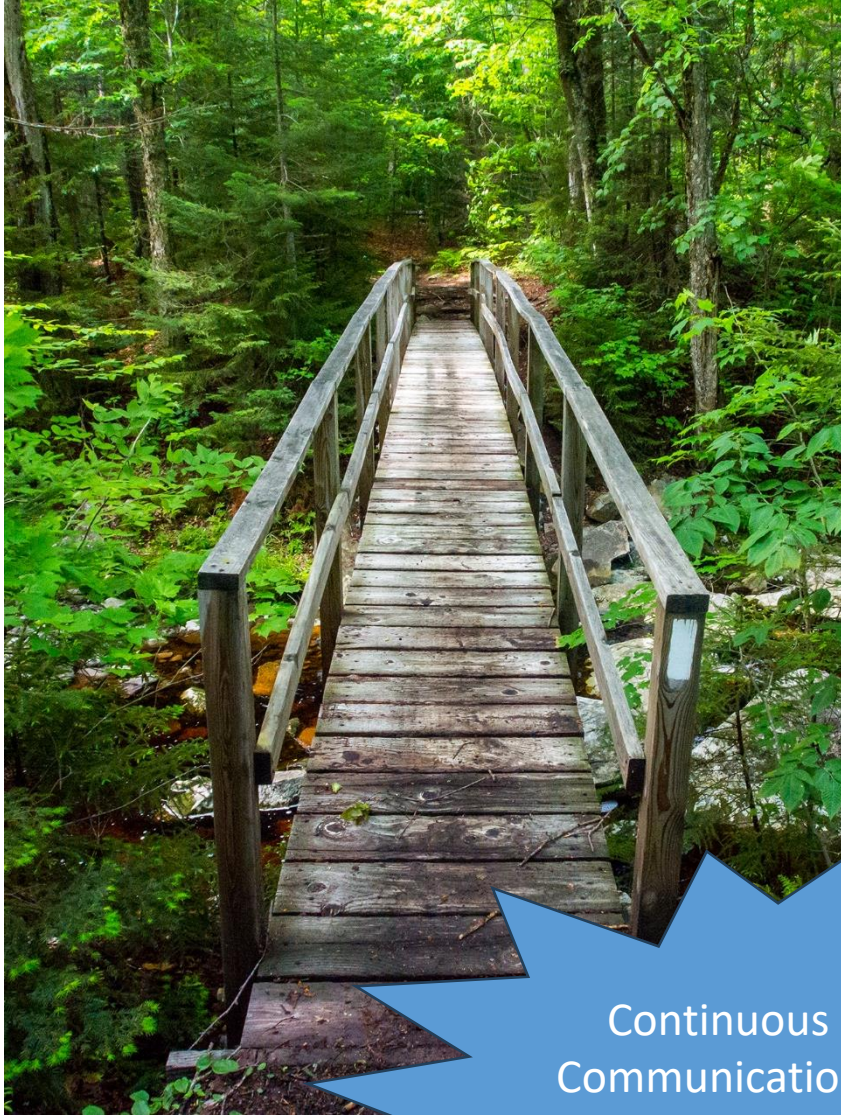
Then identify one leverage point you control (script, scheduling, role, handoff, documentation flag, etc)

Shared/Parallel Care



Sharing Care in our Rural Communities

1. Early shared care agreement and needs assessment (medical + social + structural)
2. Visit cadence and modality tailored to risk and barriers
3. Routine information exchange
4. Explicit plan for rural and SDOH barriers: Equity and respectful care embedded into shared-care workflows
5. Safety-focus with clear after-hours pathways and delivery planning
6. No postpartum “handoff cliff”



Bridging the Rural Geography Gap with Shared Care

Develop a protocol

Establish guidelines

Educate staff

Educate patients

Continuous Communication!



When ‘shared care’ becomes ‘fragmented care

- “A patient at 39w5d with no established care contacts OD hoping to be induced that day.”

Risk-Stratified Scheduling

- ✓ Build the right team
- ✓ Make meetings matter
- ✓ Between-meeting support to close care gaps



Goal: Treat scheduling as a clinical safety step, not just a calendar task

Workflow: “Patient Intake and Scheduling for High-Risk Pregnancy Conditions SOP”



Identify risk early

- Front desk script
- Simple triggers



Route quickly

- Same-day nurse review
- Tailored scheduling slots



Close the loop

- Confirm attendance
- Escalate if no-show risk

1. How far along do you think you are?
2. Any urgent symptoms today?
3. Do you have any chronic medical conditions or take any daily medications that require a prescription?



Step 1

Nurse-led intake

- RN intake call ensures accurate triage, diagnosis confirmation, and tailored scheduling

Step 2

Tailored scheduling with MD or CNM

- Risk-stratified scheduling ensures timely access based on diagnosis

Step 3

Comprehensive documentation

- Thorough EHR documentation prevents care gaps

- All of the barriers that we talked about regarding access to care are still in play.
- If they haven't engaged in care but we identified them as high-risk, we haven't gotten very far.



Case study example:

“I’m about 5 weeks pregnant. I have diabetes (A1c 7.5) and I’m on a GLP-1 injection.”

Partnership HealthPlan Perinatal Services (PHPS)/(CPSP)

Program Structure



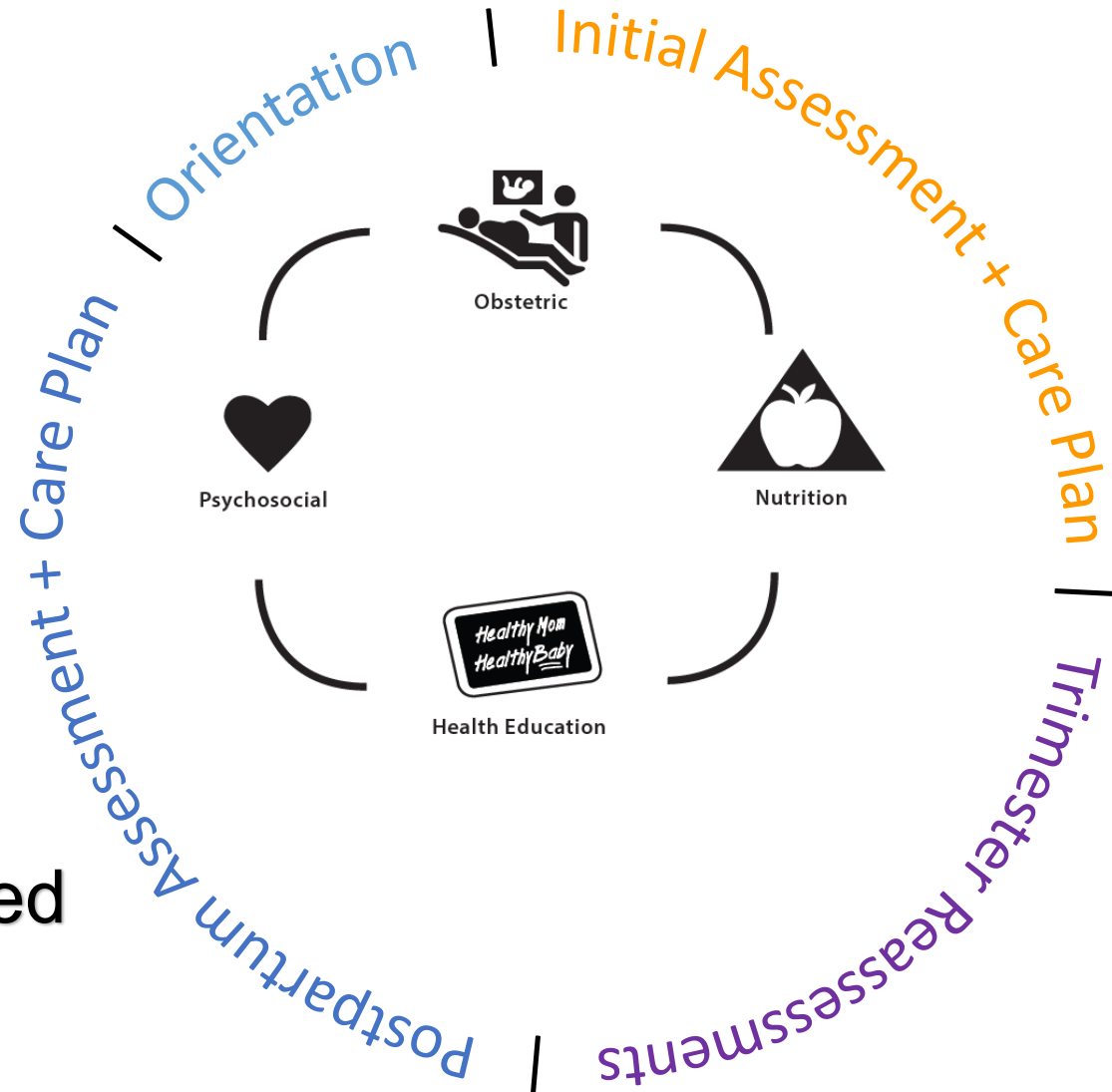
- ~40 years



- Medi-Cal



- Integrated + Team-based



“Timely” care

- Orientation provided at entry to introduce patients to services, team roles, and how to get help
- Initial assessment (Nutrition, Health Education, Psychosocial, Obstetric) completed <4 weeks of entry

Why it matters

- ✓ Gather baseline data and identify needs
- ✓ Develop Individualized Care Plan
- ✓ Provide early education
- ✓ Incentives for PHC patients





Increased attention to staffing



Standardized training



Protected visit time



Improved workflows/guides/communication tools



OCHIN Compass Rose CPSP program



Unforeseen challenges



Language barriers



Cultural preferences



Questions?



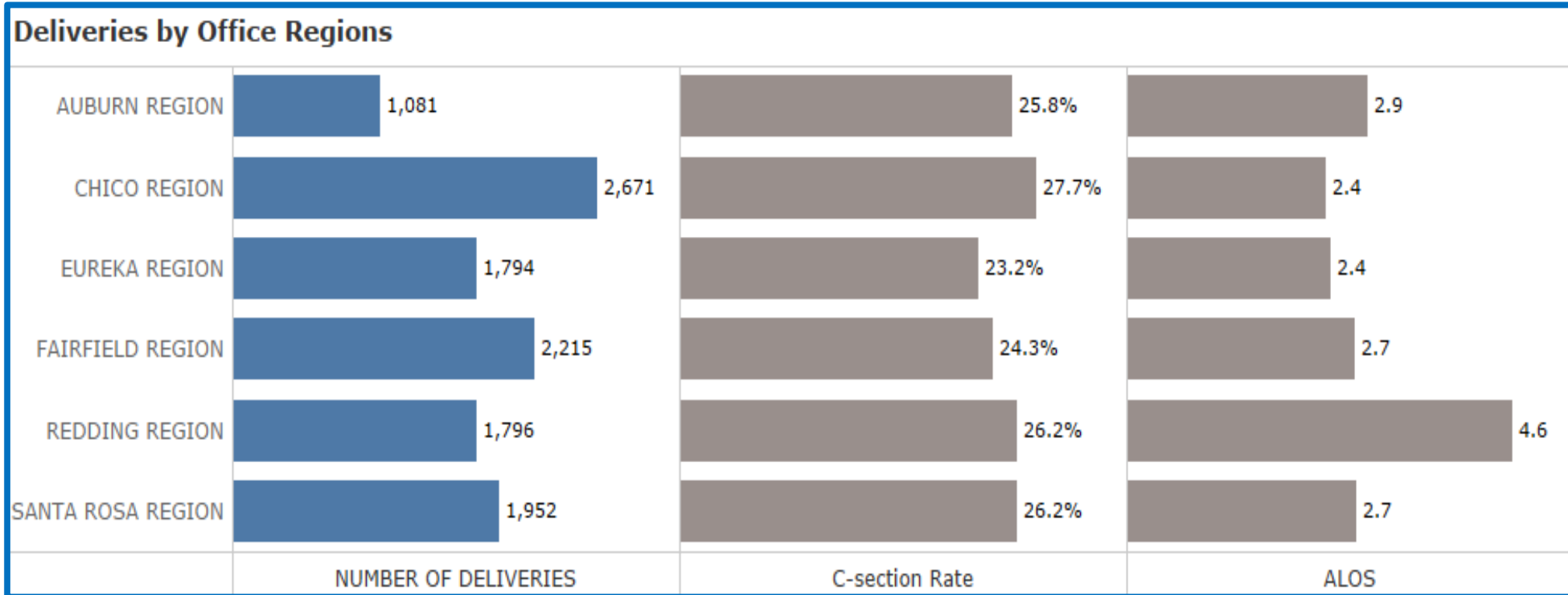
Partnership Portfolio of Perinatal Benefits and Initiatives

Colleen Townsend, MD
Regional Medical Director



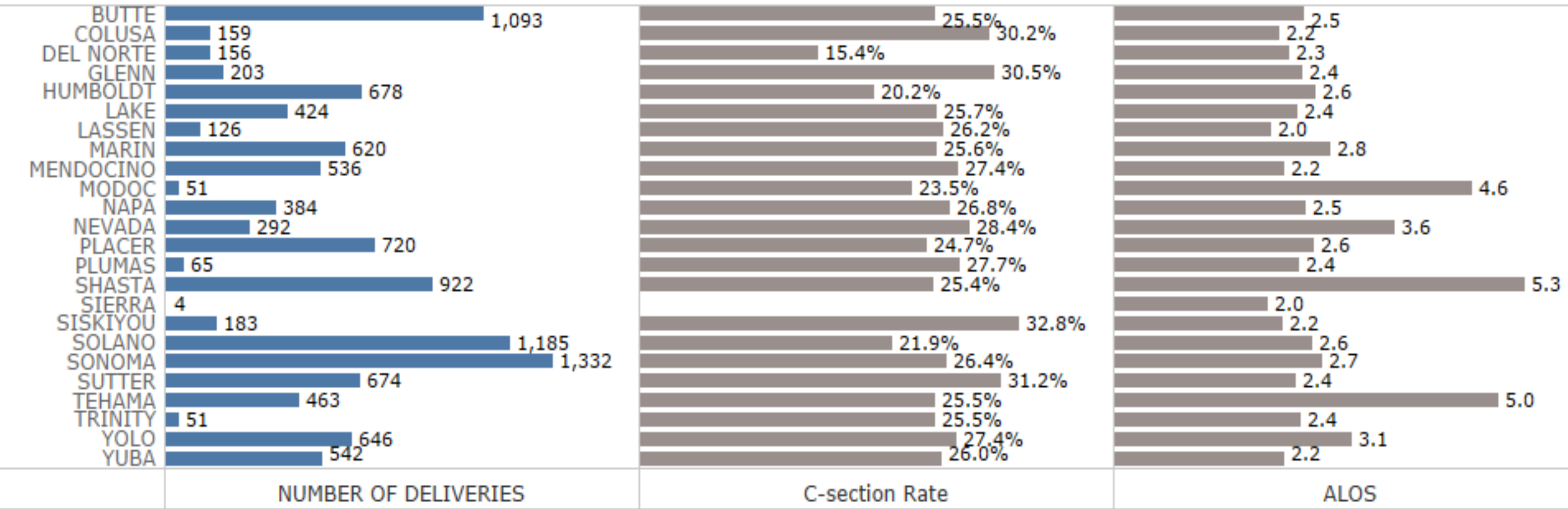
- Review Partnership perinatal population across the network
- Identify Partnership perinatal programs that aim to address poor outcomes and disparities in maternal and infant health
 - Partnership HealthPlan Perinatal Services (PHPS)
 - Doula services
 - Enhanced care management (ECM) birth equity population of focus
 - Tribal perinatal program
- Identify current Partnership education and engagement activities for provider network
- Explore current and future policy strategies to improve access and quality of perinatal services for Partnership members

Partnership Perinatal Members Served in 2025



County of Residence for Member Deliveries in 2025

Deliveries by County



Plan wide total: 11,509 deliveries

25.7% delivered by C-section

2.89 days ALOS



HEDIS Perinatal Quality Metrics

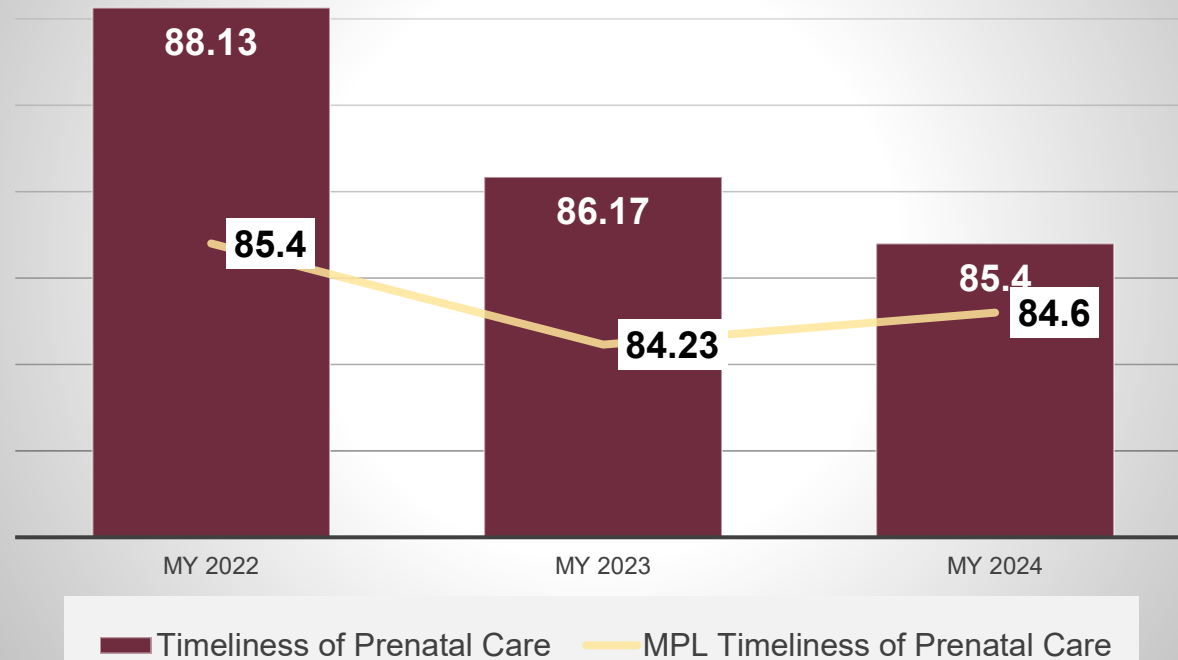
NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results

Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Women's Reproductive Health						
MY 2023	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	90.34%	73.48%	81.75%	86.86%	91.07%
MY 2024		84.43%	73.48%	81.94%	86.89%	91.85%
MY 2023	***PPC - Prenatal and Postpartum Care—Postpartum Care	86.96%	67.31%	75.18%	80.78%	84.59%
MY 2024		88.81%	68.63%	77.37%	82.48%	86.62%
MY 2023	PRS-E - Prenatal Immunization Status - Combination Rate	35.40%	7.94%	15.17%	25.81%	37.75%
MY 2024		29.36%	8.42%	15.96%	24.92%	35.60%

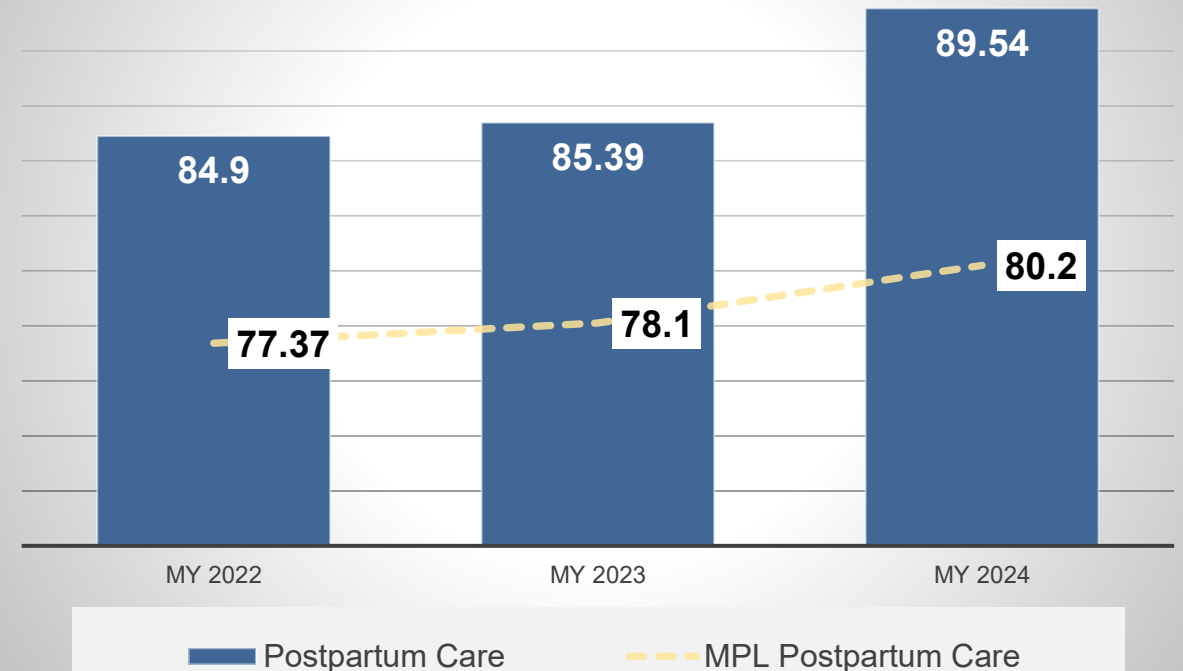


HEDIS Planwide Performance

HEDIS Planwide Performance Timeliness of Prenatal Care



HEDIS Planwide Performance Postpartum Care



Partnership Perinatal Portfolio

- **Optimizing Benefits for our Members**

- Partnership HealthPlan Perinatal Services (PHPS)
- Doula services
- ECM: Population of Focus Birth Equity

- **Quality Incentive Programs (QIP)**

- Perinatal QIP
- Hospital QIP
- ECM QIP

- **Provider Education Initiatives**

- Monthly for doulas and Case Managers
- Clinical practice outreach
- Perinatal care symposium
- County or Regional Perinatal Summits

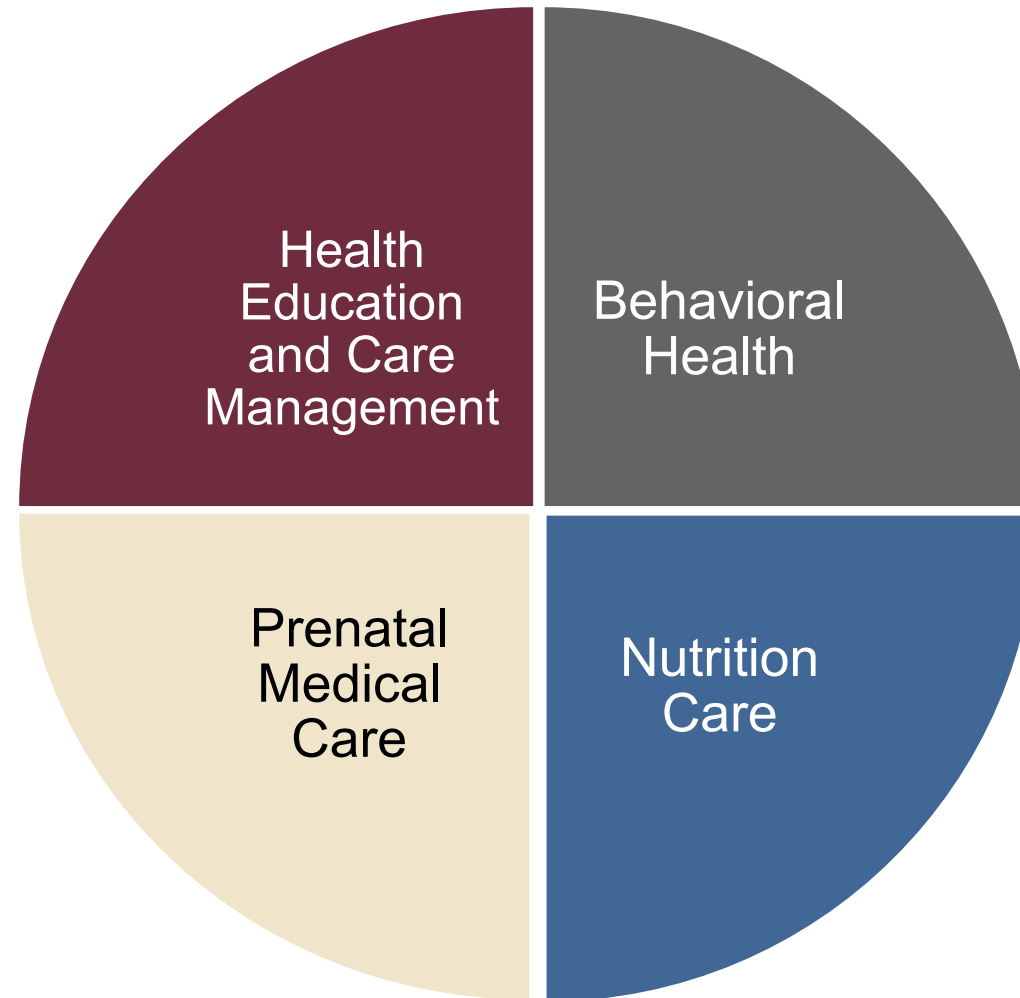
- **Policy**

- Health plan policy
- Work force development
- Regional and statewide advocacy



Four Domains of Services:

- Individual assessments and individual care plans: each trimester and postpartum
- Health education and care management during and after pregnancy
- Standardized clinical care per American College of Obstetrician and Gynecologists guidelines
- Physicians, nurse practitioner, physician assistant, nurse midwives, and licensed midwives

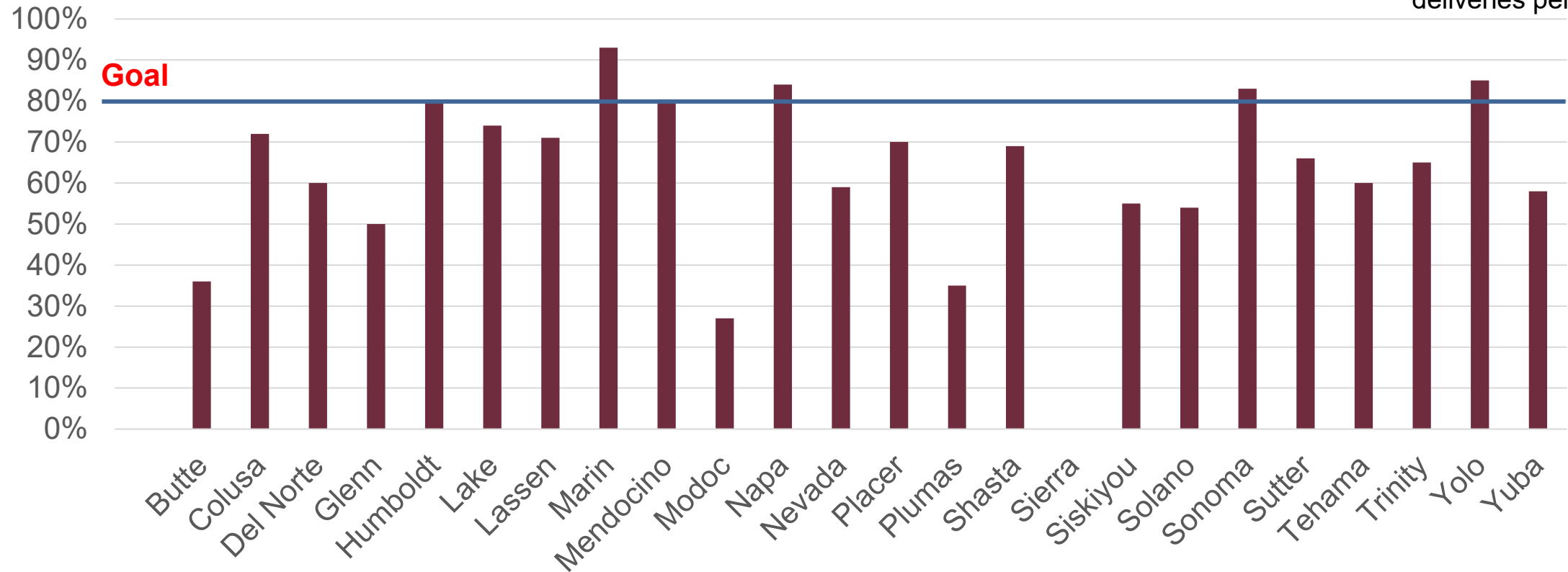


- Education perinatal case managers, comprehensive perinatal health workers, LVN, RN
- Behavioral health therapy, PsyD, LCSW, MSW, substance use disorder (SUD) counselors
- Education perinatal case manager, CPHW, RN, LVN
- Counseling and medical nutrition therapy (MNT): nutrition health coaches, RD

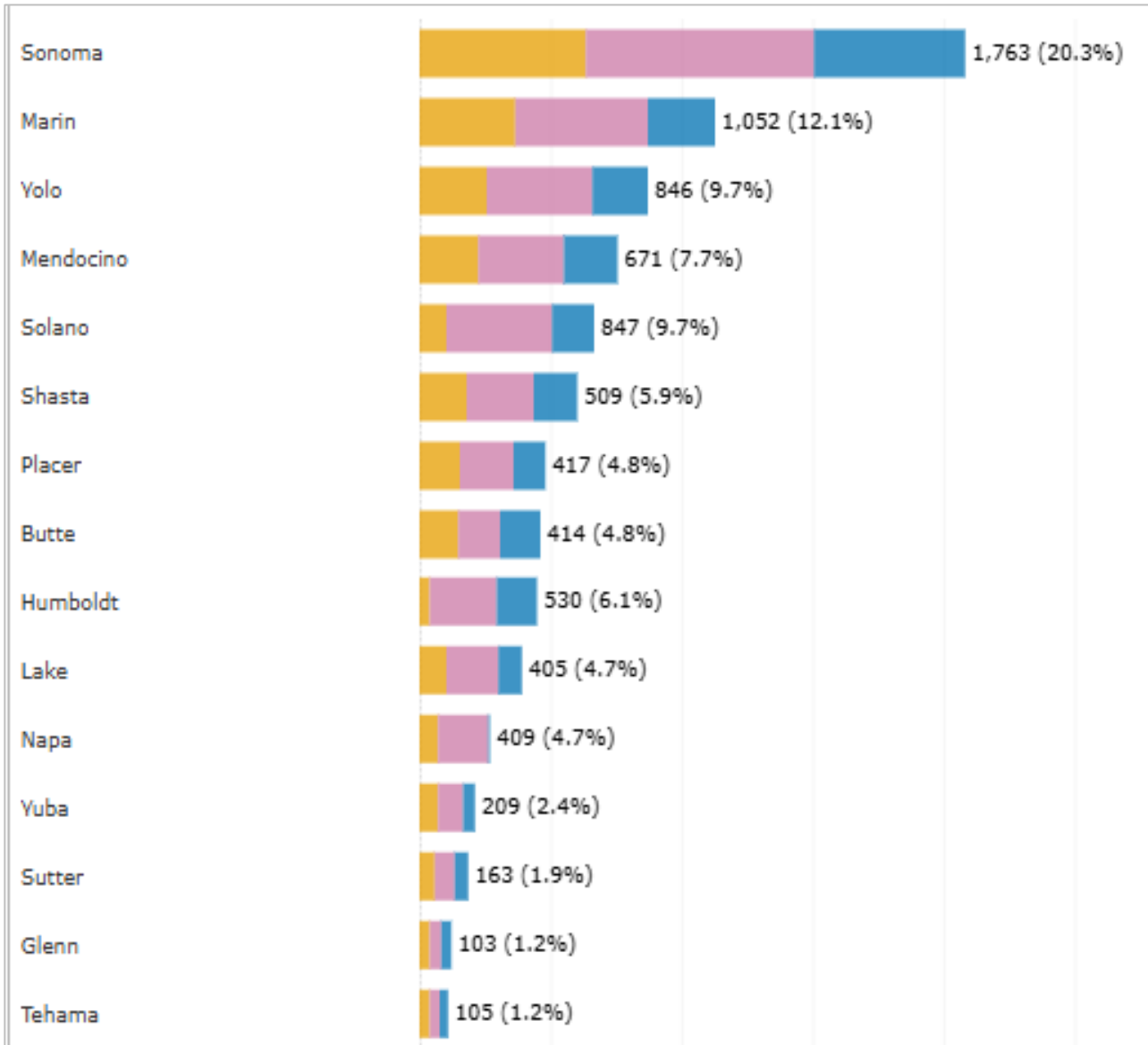
PHPS Services in Each County 2025

Percent of deliveries with at least one PHPS visit

Add volume of deliveries per county



Snapshot of PHPS Services by County (2025)



PHPS Services by Category: Plan-wide

Health Education / Care Coordination	34,289 (60%)
Nutrition	13,314 (23.3%)
Behavioral Health / Psycho-Social	9,507 (16.6%)



- **Non-clinical pregnancy support** demonstrated to improve pregnancy outcomes and satisfaction with birthing experience
- **Members are eligible for up to eight regular visits, three extended visits, and labor and delivery support**
 - No referral or formal recommendation for this service
- **Current Status**
 - 150+ contracted doulas serving members from 24 counties
 - **2025:**
 - 7500+ encounters,
 - 1200+ members, 900 Deliveries
 - 6+ visits per member average



Interested doulas can contact doulaservices@partnershiphp.org



Enhanced Care Management (ECM):

Focused case management efforts of outreach and support to prenatal practices and organizations that serve African American / Black and / or American Indian / Alaskan Native and Pacific Islander communities

ECM Enrolled Pregnant Members	
Members Served	460
Claims	2,124
Serving Providers	61

- Program focused on providers in Tribal communities to integrate and expand culturally-informed perinatal programs for health education and care coordination.
- Improve the quality of perinatal services provided to the Tribal community by training current case managers / nurses / doulas of Tribal health centers in ECM practices and policies to apply in their work with prenatal and postpartum mothers and their families.
- Funds allocated based on the volume of the Tribal community members and are dispersed as program milestones of training are met
- 15 Tribal entities in the program

- **Perinatal QIP**

- Incentives for perinatal practice for:
 - First trimester prenatal care
 - Two post-partum visits
 - Vaccines in pregnancy: Tdap and Influenza
- Year-over-year improvement in prenatal visit submission and administratively captured postpartum visits
- Areas of focus for improvement: access to timely prenatal care
 - Prenatal care access
 - Prenatal Care rates: Del Norte, Humboldt, Shasta, Solano, and Trinity
 - Focus on counties with low HEDIS rate counties and practices with 3NA > 10 days for first prenatal visit
 - Identify practice and community wide challenges with timely prenatal care

- **Fostering Connections: 2026 Clinical Provider Engagement Series**
 - Presentations with individual prenatal care organizations
 - Topics: perinatal clinical updates, data from state, county, Partnership, and practice
 - Discusses best practices for perinatal care emphasizing access / quality measures
 - 2024 – 2025 Completed 25 separate presentations
- **Annual Perinatal Care Symposium**
 - April 13, 2026
 - 2024 March addressing clinical challenges in perinatal care
 - 2024 February shuttering of maternity care
- **Perinatal Summits**
 - Convenes all provider organization type in a county or region
 - Reviews Partnership benefits and identifies local resources

- **Neonatal Airway Management**

- Two-hour hands-on experiential training to learn updated techniques and tools for airway newborn management – focuses on training labor and delivery, pediatric, emergency department, and EMS teams
 - 5 presentations, 50 participants, 4 counties

- **Basic Life Support / Obstetrics**

- Day-long experiential training to learn approaches to addressing obstetric urgencies
- For non-medical professionals who work with pregnant individuals / families – doulas, non-medical first responders, perinatal case managers
 - 9 presentations, 42 participants, 5 counties

- **Advanced Life Support / Obstetrics**

- Daylong experiential, CME eligible clinician/team training for clinicians to address obstetrical urgencies
 - 6 presentations, 65 participants, 5 counties

Tribal Perinatal Program and ECM

Monthly webinar series focused on relevant topics for Perinatal Case Managers, Doulas and Health Educators

Topic	Date
Vascular Disease	January 21, 2026
Substance Use Disorder (SUD)	February 25, 2026
Intimate Partner Violence	March 18, 2026
Infant Care	April 29, 2026
Bias and Vaccination Education	May 20, 2026
Parenting Education	June 17, 2026

The recordings to all sessions can be found online at:

<https://www.partnershiphp.org/Providers/Medi-Cal/Pages/ProviderEducationTrainingMaterials.aspx>



- **Work Force Development**

- Recruitment and retention policies include midwives and family medicine and obstetricians in the network
- Incentivize hospitals to include family medicine and midwives as eligible medical staff to provide obstetrics care

- **Leveraging advocacy through professional organizations**

- SB 669 (Partnership sponsored) passed in 2025: Allows rural hospital to have “stand by” perinatal services
- AB 55 passed in 2025: Improves access to alternative birth centers by removing specific licensing, certification, and proximity requirements

- **Maternal care focused policy program by DHCS**
 - For members who are pregnant up to 12-months post-partum who are discharged from hospital
 - Divided into two groups: High intensity and moderate intensity
- **High Intensity – Partnership Care Coordination**
 - Hospitalized while pregnant for medical condition
 - Medi-Cal Connect RSST score = high risk
 - Obstetric comorbidity index >6
 - Receiving county SUD / mental health services or with disorder not under treatment
 - Qualify for ECM
- **Moderate Intensity – Partnership HealthPlan Perinatal Services**
 - All other post-partum patients on delivery from hospital

Questions?



Thank you!

Survey Monkey QR

Please complete for
Continuing Education
Credits & Give Feedback

