Hospital Quality Institute©
Leadership in quality and patient safety

Perinatal Mental Health Learning Community

HOSPITAL CASE STUDY

▪ Marshall Medical Center

This is one of three hospital case studies developed by Hospital Quality Institute as part of the two-year Perinatal Mental Health (PMH) Learning Community (2020-2021). The case studies showcase hospitals that have demonstrated exemplary levels of maternal mental health integration achieved through committed leadership and purposeful action.

I. Background

Marshall Medical Center is an independent, nonprofit community health care provider located in the heart of the Sierra Foothills between Sacramento and South Lake Tahoe. The medical center includes Marshall Hospital, a fully accredited acute care facility with 125 beds in Placerville; several outpatient facilities in Cameron Park, Placerville, El Dorado Hills, and Georgetown; a group of primary and specialty care physicians known as the Marshall Physician Clinic Services, including internal and family medicine, OB/GYN, cardiology and rheumatology; and many community-health and education programs. Approximately 500 birthing families deliver at Marshall Medical Center every year.

Mary Ann Gulutz came to work for Marshall Medical Center in 2016. In her previous position at a hospital in New York, the obstetric nursing unit she managed was an early adopter of screening for postpartum depression. Mary Ann suffered a case of postpartum depression herself in the past and brought special compassion to this work.

II. The Team

Core team members at Marshall Medical Center included:

- Mary Ann Gulutz, MS, RN-C, birth center director
- Christine Parker, RN, IBCLC, manager of various protocols including referrals for substance use, postpartum depression, neonatal abstinence syndrome management, and bereavement
- Michelle Cherry, MD, physician champion - obstetrician in the birth center, active in protocol and referral development

III. The Tools

In collaboration with the regional public health department, in 2019 the team at Marshall Medical Center developed a patient brochure to offer lactation consultation programming and to address postpartum anxiety and mood disorders. In 2021, the brochure was expanded into a Pregnancy & Postpartum Resource Guide for families in the community. The easy-to-read

guide focuses on resources and referrals for a variety of family needs during and following their pregnancies and includes a section on signs/symptoms and resources for postpartum depression and anxiety. This was an important part of the development of the overall protocol for postpartum depression and anxiety screening. The guide is now given to patients in the OB offices, on the birthing unit, and at the pediatrician's office. This guide functions as a "living document" and is being updated annually, or as needed. The current edition is posted on HQI's PMH Learning Community website, as an example for others who may wish to develop something similar.

Screening via the Edinburgh Postnatal Depression Scale (EPDS) began in 2019, completed by mothers at their OB visits in the first trimester and as indicated throughout pregnancy. The screening is done again at about 24 hours after delivery and/or prior to discharge and then at the four-to-six-week postpartum OB check-up. In addition, pediatricians, lactation consultants and OB physicians are encouraged to give the EPDS screening whenever the history or current assessment indicates a need.

IV. The Timing

Marshall Medical Center joined HQI's PMH Learning Community in April 2020 with the intent to refresh and retool the approaches to staff education and screening. As the COVID-19 pandemic spread, the team's ability to continue prenatal classes became compromised, so a video session was recorded and posted on the hospital website, including a tour of the unit to help moms prepare for their delivery.

V. The Training

HQI's virtual staff training on maternal mental health in the hospital setting provided an opportunity to standardize the knowledge and awareness among the existing team members as well as new hires. More than 50 staff members completed the virtual training during the months of May-July 2020. The training was given a very favorable review by nurses and physicians alike, acknowledging that much of the material was already "known" but that this was a perfect refresher to empower excellent care. Obstetricians and pediatricians were asked to complete the same training with the goal of standardizing approaches across disciplines and the continuum of care. Referral criteria and algorithm processes were added to the public health referral protocol used by staff and physicians as a guide to ensure a positive outcome for new mothers.

VI. The Teaching

In subsequent months, discussion groups based on online modules were facilitated at staff meetings, which helped nurses integrate the learnings and discuss with each other the screening techniques and various experiences of screening postpartum patients. This helped increase their comfort level with the process.

VII. The Transformation

About mid-2021, both Dr. Cherry and Mary Ann Gulutz left Marshall Medical Center, and Christine Parker emerged as the core team member to maintain the gains of this work. Christine is known for her significant experience, skill, and passion in helping mothers and families with substance abuse and maternal mental health. Her combined focus added strength to the overall approach. The new Neonatal Abstinence Syndrome protocol allowed dyads to stay together using non-pharmacological methods (eat, sleep, and console method) to soothe infants through the withdrawal symptoms in the first five to seven days of life. Using this protocol, the birth center has successfully maintained approximately 70% of the infants with their mothers and avoided transfers to hospitals with NICU capabilities. The birth center also has a strong collaboration with the Cares Clinic, which helps pregnant mothers who are dealing with various addictions and can prescribe buprenorphine for opioid use disorder. Finally, the hospital has a perinatal bereavement program that includes referrals to ensure healing through the grief of a loss. An effort is underway to work with the emergency department (ED) to help supply women with memorable items and referrals after a miscarriage, infant, or other child loss.

The new screening and referral processes have remained in place throughout the staffing transitions and the subsequent COVID-19 waves. OB and pediatrics staff meetings are regularly used to maintain the collaboration between physicians, hospital's social services, and local public health. When a patient has a score that meets the criteria for referral, an internal social services assessment is done, the patient's physician is notified, a public health referral is submitted when indicated, and receipt of that referral is confirmed. Public health nurses follow up with the referred patients via home visits.

In January 2021 a postpartum follow-up call to all mothers was added to the hospital process. This call addresses postpartum preeclampsia, depression/anxiety, infection screening and feeding assessments. Mothers have been very receptive to the calls. Several cases of readmission due to potential preeclampsia were identified during these calls and several mothers have been helped with mental health issues.

As a result of these improvements, Marshall Medical Center was recently awarded the BETA Healthcare Group Quest for Zero: Excellence in OB, which includes extensive new mental health requirements.

Using the EPDS screening process at the birth center results in the average of two to three referrals each month. The following patient care example illustrates the application of improvements across the care continuum:

A 23-year-old patient had a fetal demise at 20.1 weeks gestation at another hospital and had a history of self-harm by cutting.

- Nine days post birth, contact was attempted by a social worker from the hospital where the patient delivered, with no results.
- 17 days after birth the patient had a postpartum check with Dr. Cherry at the Marshall Medical Center. The patient had thoughts of self-harm and her EPDS score was 23 along with a score of 2 on question 10. Dr. Cherry walked her to the ED.
- In addition to the ED visit, Dr. Cherry referred the patient to a bereavement coordinator at the hospital who facilitated further follow-up support by the program's bereavement doula and a referral to a local resource (Infant Parent Center) for grief counseling.
- Dr. Cherry reached out a week later and the patient had remained connected with the Infant Parent Center, meeting with one of the counselors weekly.
- The patient had a follow-up appointment with Dr. Cherry two weeks after the ED visit and her progress with the grieving process was encouraging.
- Two weeks later Dr. Cherry saw this patient again and the patient reported doing better while still seeing the Infant Parent Center counselor.

VIII. Key Take-Aways and Next Steps

Increased awareness and knowledge about perinatal mental health, as well as strengthened EPDS screening and referral processes, have equipped the staff at Marshall Medical Center to help patients and families lead a healthier first year. Lessons learned for continued improvement include the need to maintain collaboration between the hospital staff, obstetricians, pediatricians, ED, local public health, and local community mental health resources. The complexity of prenatal/postpartum patients' needs is especially challenging when there is fetal exposure, perinatal depression, and/or medications that may not be compatible with breastfeeding. Featuring screening results in the Epic electronic medical record aids in a systematic approach across the continuum of care.

With a goal of further improving internal and external collaboration, Marshall Medical Center will endeavor to identify all at-risk patients and connect them with available help. Additional work is underway with First Five El Dorado and Early Head Start to better identify families where a member may be suffering from anxiety and depression disorders, as well as other issues. The local public health department has been approved for a grant to develop a program connecting both low- and high-risk patients with public health nurses early in pregnancy and continuing that relationship/connection throughout pregnancy and postpartum. Planning meetings have started and will include collaboration with public health nurses, obstetricians, pediatricians, and the hospital's birth center. The strengthened connection will help better identify the patients' unique needs, begin to meet them, and develop trust for better outcomes.