Assessing the System of Care for Screening, Referral, and Treatment of PMADs in Vermont

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Executive Summary

Starting in 2019, the Vermont Department of Health and the Department of Mental Health partnered on the Screening, Treatment, & Access for Mothers & Perinatal Partners grant (STAMPP), a 5-year effort to improve the mental health and wellbeing of pregnant and postpartum people in Vermont, and their children and families, by developing and sustaining a coordinated system of mental health supports for pregnant and postpartum people. As part of the evaluation of STAMPP, the state contracted with the Vermont Child Health Improvement Program (VCHIP) to conduct a qualitative evaluation to assess the state of PMAD screening, referral, and treatment systems following STAMPP policy changes as well as provider experiences with education and consultation supports implemented under the program. VCHIP conducted semi-structured, in-depth interviews with 28 people working in perinatal health across the state in spring 2023 to ask them about their experiences with these topics. Key findings and recommendations that emerge from the study include:

- **Several sites had implemented effective systems of care for PMAD screening, referral, and treatment, often with a champion elevating this issue within a practice.** Some practices incorporated these efforts into larger initiatives related to social/emotional health, while others had targeted quality improvement efforts to improve PMAD screening.
    - Recommendation 1: Ongoing, targeted efforts are needed to spread effective solutions and continue progress made in the last five years. Engaging a champion in practice-based efforts can be useful in targeted quality improvement initiatives.
- **Functional systems of care and care teams are crucial to PMAD identification.** Interviewees described workflows in pediatrics, obstetrics, family medicine, and behavioral health settings and highlighted areas in which workflows specific to each setting type both supported and hindered identification of PMADs.
    - Recommendation 2: Given advantages and challenges of screening in different settings, invest in education and resources to proliferate PMAD screening in all settings where pregnant people, new parents, and babies receive health care.
- **Existing referral networks are essential to moving screened patients into services, and team-based care and closed loop referrals can support referral systems.** "Warm hand-offs" to PMAD services were described as essential, and many rely on personal referral networks built up over time. Settings with embedded social workers or mental health providers on site or within network generally described having an easier time with referral to treatment than those that need to coordinate with outside practices.
    - Recommendation 3: Primary and obstetrics care teams should include social workers, care coordinators, and others who facilitate referrals and create or access up-to-date lists of available mental health providers and other needed services. Teams should map existing gaps in referral networks and identify community needs. Workflows should include not only navigation to services but also follow-up to ensure patients are receiving recommended treatment.
- **Integration of PMAD screening, referral and treatment into electronic health records is beneficial but is a challenge to set up and maintain.** Benefits of easily including patient resources through portals, peer-to-peer communication, and shared plans of care were balanced against challenges of workflow and confidentiality concerns.
    - Recommendation 4: Support providers in implementation and improvement of electronic systems to track PMAD screening and referral, remove barriers to tracking and sharing

results between provider organizations, and help organizations identify and fix gaps in consistent data management. Increase direct entry of screening results into electronic systems by providing hardware (e.g. tablets) and software (user-friendly apps) to pregnant people and new parents where there are seen.

- **Workforce shortages are a nearly universal challenge in referral and treatment for PMADs.** Inadequate supply of mental health providers was a consistent theme, but interviewees also reported that access issues in primary care and obstetrics were challenges to effective PMAD treatment.
    - Recommendation 5: Invest in mental health workforce development, both through efforts to bring new providers into the field and specialized PMAD training to existing workforce. Take care to recruit providers who mirror the population they will serve. Reform episode of care/reimbursement to accommodate complexities of PMAD support provided by obstetrics providers.
- **Coordinated care teams, both across sites and within sites, support access to services and can overcome challenges gaining entry into mental health care.** Some organizations had internal teams with embedded social workers or care coordinators to manage patients' different needs; others described creating community-level coalitions to help patients and families access services.
    - Recommendation 6: Invest in practice-based care teams and foster collaborations across local/regional health and human service groups to meet the needs of all pregnant patients and families at the time and in the place that is right for them.
- **The COVID pandemic disrupted patterns of care but expanded use of telehealth for PMAD screening.** Some reported that the shift to telehealth made screening more challenging, while others commented that it expanded access for people in rural areas or who had transportation challenges.
    - Recommendation 7: Continue to promote telehealth as a viable option, particularly for residents in rural areas, work to incorporate screening practices in telehealth workflows, and encourage providers to ensure patients have a meeting space appropriate for a telehealth visit.
- **Patient factors also influence care sought and received, though system efforts can overcome some of these individual factors.** In general, patients complete PMAD screenings, though stigma, language barriers, literacy challenges, different cultural norms, and, ironically, mental health conditions were all mentioned as factors that can inhibit PMAD screening and treatment.
    - Recommendation 8: To design systems that meet patient needs, efforts should be made to hire staff with lived experience and who are more similar (in terms of race, culture, gender identity, etc.) to the patients they are helping. Peer-to-peer support and PMAD support groups may help to normalize treatment for individuals less comfortable with one-on-one treatment in a clinical setting. Invest in written and web-based materials that are accessible to all pregnant people, including people who speak a language other than English and who have lower levels of literacy and health literacy.
- **Respondents who had experience with UVM's Perinatal Psychiatric Consultation Service consider it to be a crucial resource for them, but many working in perinatal health or with new parents were unaware of this resource.** Personal connections to the consulting providers were a theme among those who use the service. Most who did not use or were not aware of the service welcomed information about accessing it.
    - Recommendation 9: To achieve broader use of this valuable service, it is recommended that the consultation service is advertised in more settings. Efforts should be made to outreach to

providers across the state, with trusted members of the provider community sharing clear guidance on the services provided and examples of successful assistance rendered.

- **While preferences for topics and modes varied, nearly all respondents noted the importance of both basic and ongoing advanced training in PMAD.** Interviewees welcomed both basic training for everyone working with pregnant people or new parents as well as more advanced training for those focusing on PMAD. Offering affordable, accessible education in a variety of modalities, as well as making training available on an ongoing basis to serve new hires, were important to interviewees.
    - Recommendation 10: Continue efforts to educate all individuals who care for pregnant people and new parents. Education should be accessible (provided in different modalities) and offered at levels suited for provides needing various levels of breadth and depth. Use both local peer experts as well as offering access to national and international educational programs to bring evidence-based information on screening and treatment of PMAD to an array of Vermont providers.
- **Participants noted the value of patient education materials that are targeted to particular populations or geographic areas.** Although a number of interviewees were familiar with statewide *Support Delivered* materials and several described sharing *Help Me Grow* information with families, when asked about patient-facing education, interviewees most often described the need for information to include local resources and be tailored to meet the needs of specific populations.
    - Recommendation 11: Support communities in their development and dissemination of information providing available resources tailored to specific population needs.

As the state develops future efforts to address PMADs, overarching themes to help guide that work include:

1. Systems to address PMAD—including referral networks, patient resources, workflows, etc.—are localized and need to be tailored to specific patient populations and practice sites.
2. Team-based care, especially models that embed or co-locate social workers or mental health counselors, are effective approaches to addressing multiple challenges in the screening and referral system.
3. Increased attention to PMAD in recent years has been helpful in elevating this issue, but ongoing education is needed to continue to raise awareness and develop champions.
4. Even if screening and referral systems reach full potential, ongoing workforce shortages tied to limited mental health provider supply means treatment access will still be a challenge.

Introduction

Perinatal mood and anxiety disorders (PMAD) are common, treatable mental health conditions that often go undiagnosed, leading to unnecessary disease burden, poor perinatal outcomes, and individual and societal costs. In Vermont, PMADs affect over a quarter of pregnant and postpartum people.[1] The toll of untreated PMADs is extensive and affects the adults experiencing PMAD, their young children's short and long-term health, and the health and wellbeing of their families; the broader social system also feels the effects of PMADs through employment outcomes, health and welfare costs, and high morbidity among the population.[2]

Starting in 2019, the Vermont Department of Health and the Department of Mental Health partnered on the Screening, Treatment, & Access for Mothers & Perinatal Partners grant (STAMPP), a 5-year cooperative agreement funded by the Health Resources Services Administration (HRSA). The goal of STAMPP was to improve the mental health and wellbeing of pregnant and postpartum people in Vermont, and their children and families, by developing and sustaining a coordinated system of mental health supports for pregnant and postpartum people. Key objectives for the project included increasing the capacity of health care providers, human services workforce, and others to screen, diagnose, and treat or support pregnant and postpartum people, as well as increasing access to comprehensive maternal depression educational information and referral resources. To meet these objectives, activities conducted under STAMPP included targeted quality improvement to support health care practices in screening, referral, and treatment processes; support for peer-to-peer provider consultation services; training and professional development for health and human services providers; and creation of high impact educational materials for consumers, among others.

In addition to federal and state comprehensive evaluations of the impact of STAMPP activities on program goals, the state contracted with the Vermont Child Health Improvement Program (VCHIP) to conduct a qualitative evaluation to assess the state of PMAD screening, referral, and treatment systems following STAMPP policy changes as well as provider experiences with education and consultation supports implemented under the program. This work was funded through supplemental federal STAMPP funds and complements other state and federal evaluation work. This report summarizes the results of the qualitative evaluation.

Methods

In Spring 2023, VCHIP conducted semi-structured, in-depth interviews with 28 people working in perinatal health across the state. The initial sampling frame was compiled based on recommendations from people working on STAMPP implementation (including those at the state, VCHIP, and the University of Vermont Medical Center) as well as researchers' assessment of actors involved with the perinatal and early childhood health and social services system across the state. Participants were selected through purposeful sampling to represent diverse experience with STAMPP initiatives, geographic regions, practice settings, and patient populations. The research team contacted potential participants by email with an introduction to the project and invitation to participate. Nearly all (93%) invited to participate accepted and were interviewed. Our final sample included front-line clinicians, community workers, and state/county employees working in obstetric (n=9), pediatric (n=5), both

[1] I Platt, E Pendl-Robinson, E Dehus, S O'Niel, D Vohra, K Zivin, M Kenny, L Pentenrieder. *Estimating the Costs of Untreated Perinatal Mood and Anxiety Disorders in Vermont.* Mathematica Policy Research and Vermont Department of Health. May 2023. Available at: https://www.mathematica.org/publications/societal-costs-of-perinatal-mood-and-anxiety-disorders-in-vermont

[2] Ibid.

obstetric and pediatric (n=1), mental health (n=6), or other community (n=7) settings or programs serving pregnant people or new parents.

Interviews took place between February and May 2023, lasted between 30-60 minutes, and were conducted in groups ranging from one to three people, with participants who work at the same organization having a joint interview when schedules allowed. Prior to the interview, the research team explained the purpose of the project, use of the information, and confidentiality policy; participants were given the opportunity to ask questions, and oral consent for participation was obtained. All interviews took place via video conferencing (Zoom) and were recorded for notetaking purposes only, after consent to record for such purposes was obtained from participants. Prior to the study's initiation, the study team sought IRB approval from the University of Vermont Research Protections Office, which determined that the study did not meet the federal regulatory definition of research requiring IRB review and approval under 45 CFR 46.102(d) and therefore did not require IRB review and approval.

Interview topics included PMAD screening, referral, and treatment practices; PMAD education participation, topics, and modalities; and experience with peer-to-peer perinatal psychiatric consultation services. Interview content was structured to provide feedback on core initiatives of STAMPP. Questions also asked about whether and how the pandemic affected care processes and how future efforts could improve current systems. A copy of the interview guide is included as Appendix 1.

Interviews were coded by multiple team members, first using preliminary analysis to develop codes and then using NVivo software 1.7.1 to apply codes and identify themes. In the first stage of analysis, a team member reviewed interview notes, summarized key points by interview, and drew out detailed and overarching themes. These overarching and detailed themes served as the initial basis for coding. All interview transcripts were then uploaded to NVivo and coded by hand by a second team member. During this process, codes were refined. Coded transcripts were then analyzed to assess frequency and patterns of themes. This report summarizes overarching and detailed themes, providing quotes or examples throughout to elaborate or support findings. To maintain anonymity of respondents, and because we did not ask participants their gender identity or pronoun preference, we use "they/them" pronouns throughout, even when referring to comments from an individual participant.

Results

Screening, Referral, and Treatment of PMADS

Several sites had implemented effective systems of care for PMAD screening, referral, and treatment, often with a champion elevating this issue within a practice.

Practices had varied approaches to addressing PMADs, but several had incorporated steps to address this health issue into their regular systems or workflows. Some practices (such as those participating in the DULCE (Developmental Understanding Legal Collaboration for Everyone) program, were regularly screening for a range of social/emotional issues and incorporated PMADs in these larger efforts. Others had undertaken targeted efforts to address PMADs.

Interviewees from several obstetrics practices described quality improvement projects their sites had undergone to set-up screening, brief intervention, and referring practices that would work for them. Some of these had occurred prior to STAMPP and others were a result of quality improvement support offered through the grant. Several noted the positive impact of having established processes and workflows on their ability to provide PMAD services consistently. Interviewees noted that having things

"built in" to their system—for example, through recording, visit structure, or provider-to-provider communication—is essential to supporting screening and referral.

Some respondents described the importance of a provider championing this work, resulting in some cases from personal experience, interest, or a continuing education project. Others talked about how important it was to get the entire practice staff involved. They called out the roles of providers, nurses, support staff, as well as extended members of the care team (e.g., social workers, family specialists, community health team partners) as each being crucial to keeping PMAD work top-of-mind. Conversely, at sites that have struggled to engage all staff or have not yet integrated standardized screening into visits, interviewees were less confident that all PMAD-related needs are being met.

Together, participants' collective experience highlighted the effectiveness of targeted efforts to improve the system of care for PMADs. However, as detailed below, even effective systems still face challenges.

Recommendation 1: Ongoing, targeted efforts are needed to spread effective solutions and continue progress made in the last five years. Engaging a champion in practice-based efforts can be useful in targeted quality improvement initiatives.

Functional systems of care and care teams are crucial to PMAD identification.

Screening workflows and systems of care to support identification of PMADs (that is, knowing what to do, when to do it, and how to do it) are important facilitators of people receiving needed help. Interviewees described workflows in pediatrics, obstetrics, family medicine, and behavioral health settings and highlighted areas in which workflows both supported and hindered identification of PMADs.

Pediatrics: Respondents noted that screening for PMADs in pediatric primary care can be successfully added into existing visit workflows due to several factors. First, screening is a regular component of many pediatric visits, with workflows set up for (and patients accustomed to) conducting screening. In addition, pediatricians have frequent visits with families following the arrival of a new baby, providing multiple opportunities for screening and family interaction; they also follow families for an extended period, allowing screening to occur for a longer period (in at least one practice, up to 12 months). Child health providers are often seen as a safe space for families, which could lead to more open responses to screening questions, and interviewees stated that no-show rates for pediatric visits are lower than postpartum visits. Lastly, pediatric practices are often well-connected to family-focused services.

However, PMAD screening in pediatrics also has its challenges. Parents are not patients of the practice, making charting, billing, and other office visit mechanics difficult. At least one interviewee described how connecting adults to services may be a stretch for practices that are used to working within the childhood system. Some new parents may also be reluctant to complete PMAD screenings at a child's visit if they answered the same or similar questions during a recent obstetric visit. In addition, screening in pediatrics will miss PMADs that appear during the prenatal period, prior to the pediatrician's engagement with the family.

Obstetrics: Many interviewees working in obstetrics indicated that they routinely screen for PMADs at specific intervals before and after a baby's birth. Several obstetric providers named the specific visits at which they screen using a validated tool (though the specific visit and tool varied across practices). They

also described informal screenings that occur in-between these pre-set screening intervals. For example, one OB provider described:

> *"Formally, screening happens very consistently in our nurse midwifery group at the 16-week visit. They get an EPDS [Edinburgh Postnatal Depression Scale] there to fill out in person, and we go over it with them, and then screening also happens postpartum at the 2- and 6-week visits, and that is also where our group is lucky. We're very consistent with that. And those are like formal screenings that we actually, you know, collect and put numbers in the computer….I would say our practice is really excellent at sort of informal screening, too. I mean, I think we are consistently checking in with people's mental health, and you will see a lot of referrals come out of conversations with people not necessarily just triggered by a screening."*
>
> *– OB Provider*

However, this same provider noted that it had taken time for their practice to achieve this consistent screening. Others described how workflow is interrupted when they are short-staffed or when they have staff turnover. A provider from another office described that there is so much to cover in both early prenatal and postpartum visits that they don't want to spend the whole visit checking boxes with new parents. As a results, PMAD screening may be skipped. Several obstetric providers mentioned higher rates of no-shows at postpartum visits and reflected that it was therefore more difficult to screen in the postpartum period compared to prenatal visits.

Family medicine: A few interviewees reported that although they were not aware of the family medicine practices they work with screening specifically for PMADs, family medicine providers do often routinely screen adult patients for depression using validated tools. Positive screens may alert providers to perinatal concerns that they refer to a member of their care team or to an outside resource. Multiple respondents noted that relatively few family medicine practitioners in the state deliver babies anymore and may spend limited time working in perinatal health.

Other settings: PMAD screening also occurs at parent-child centers, home visiting programs, and crisis centers, according to interviewees. Like providers working in primary care and obstetrics, in some cases, interviewees described the use of standardized tools to identify mental health concerns and in others, assessing pregnant person, partner, and new parent mental health through more open-ended dialogue. One interviewee from a parent-child center said:

> *"The [Home visitor]and I do not currently use an actual tool like the Edinburgh scale, or anything, but we are screening and assessing families every time we meet with them, or do a home visit, with the understanding of what is expected and typical….And then, of course, we're always asking questions about sleep and mental health."*
> - *Social services provider*

Mental health-providing interviewees described taking extra care to monitor clients during pregnancies and recent births to identify PMADs. These assessments were typically made without the use of screening tools, as patients were already under care for related or other mental health conditions.

Across settings (and even within a practice), however, there was some variation in provider comfort level with PMAD screening.

Recommendation 2: Given advantages and challenges of screening in different settings, invest in education and resources to proliferate PMAD screening in all settings where pregnant people, new parents, and babies receive health care.

Existing referral networks are essential to moving screened patients into services, and team-based care and closed loop referrals can support referral systems.

Interviewees who conduct screening described the importance of knowing where they could refer and which clinicians had availability. Although some said patients were left to find their own appointments, many described how treatment was more likely to occur if the primary or obstetrics team helped patients find care. Many said that a warm hand-off (making the connection from the patient to the mental health provider) was essential, since simply giving patients a name to call often did not lead to follow up. Several noted that care coordination and personal introductions were crucial for people during the tumultuous perinatal period, when new parents are juggling competing demands and have limited bandwidth to take on additional tasks.

> *"Being able to navigate to counselors and people who can have openings for our patients, we would like to do that as soon as possible. We don't want it to linger and so having the availability of people within a week or two ends up consuming a lot of my time. [A lot of my time is spent] on the care coordination and resource navigation, and my feedback to our county has been that if we are prioritizing this population, we need to be able to triage them with our designated agencies and other places."*
> - *OB provider*

Many respondents described a referral system that was largely dependent on personal relationships or provider networks. Interviewees explained that they had built up referral networks over time based on personal relationships. For instance, a person working in an obstetrics office said:

> *"I knew [the mental health provider] already, and you know, knew how to access her a little bit better, but I think that it was really helpful, for the other clinicians in my office to like, meet her and know her and hear about the referral service…."*
> - *OB provider*

And referencing a local, independent obstetrics provider, a mental health clinician noted:

> *"I work closely with [the obstetrics provider]. I have a relationship with people there. So you know a couple of them, I think, feel like it's easier for them to reach out to me."*
> - *Mental health provider*

Other mental health providers similarly noted that many of their referrals are through word of mouth or existing relationships versus more formal referral pathways or advertising.

Social workers in particular were described as having the most resources and largest networks, as respondents indicated they had more time than some other providers to build relationships and establish networks. Providers who had personal networks in place described systems in which they felt confident that their referrals were seen, as they trusted their network to follow through on the referral.

This pattern was especially true for “red flag” cases in which a screening provider felt a patient needed follow up quickly.

In addition to personal referral networks, team-based care and inter-practice collaboration were themes in respondents’ description of successful referral systems. Interviewees who worked in settings with embedded social workers or mental health providers generally described having an easier time with referral to treatment than those that need to coordinate with outside practices. In these practices, respondents indicated that social workers provide an initial referral and can conduct brief intervention, which sometimes provided a sufficient level of care for the patient. Respondents also indicated that many patients are comfortable with the level of engagement that embedded social workers provide, as they may be reluctant to enter what they perceive as “the mental health system.” [See page 13 for additional related findings.] Respondents also indicated that initial referral was ideally suited to social workers’ training, as they know of a range of resources and are adept at getting to know patients’ family and social situations.

Interviewees within pediatric primary care indicated that screening was most effective when pediatric and obstetric providers can work as a team, sharing screening results and discussing patients. Several respondents who work within larger health networks described easier referral processes than independent practices, many of which indicated that connections with the UVMMC system have lapsed in recent years.

While longstanding referral networks, embedded supports, and team or network-based care promoted effective referrals, respondents also noted many challenges to making referrals for PMADs.

Several interviewees noted particular challenges making referrals for behavioral or maternal health support if pregnant people or new parents do not reside in Vermont, are insured by an out-of-state plan, or receive a portion of their care in bordering states. One noted the rurality of Vermont made it a hard place to live: “…you’re over an hour to the birthing center…and where are you finding work? And what mass transportation is available?” resulting in yet another trigger for mood disorders.

In addition, unfortunately, referral loops are not always closed, and referring providers do not always receive updates from the providers to whom they have referred. For example, one pediatric provider described how she does not hear back from obstetric providers she has shared concerns with, saying, “Given the mom's not our patient, we don't get feedback from the OB team. So that's you know, expected.” Instead, they are “touching base with the moms when they come back in.”

Similarly, obstetrics does not always hear back from psychiatry:

> *“…I'll refer to [a mental health provider]. But then, if that person decides to cancel that visit, for whatever reason, then they kind of fall off. You know I don't know that they necessarily cancel that visit unless I take the time to go back and look at the chart, which sometimes I do, and sometimes I don't because I’m just hoping, you know. Okay, they're getting into [mental health care]….”*
>
> - *OB Provider*

A home health provider expressed concern with patients being left to reach out on their own.

> *“We don't know always if the patients contacted that person. We generally try to make the phone call with the patient while we're there, but it's not it's not always answered. So then we don't know exactly what happens. Do they call back? And the*

patient doesn't answer, does the patient just not return their call? Or they decided they're not interested, things like that."

- *Home health provider*

Recommendation 3: Primary and obstetrics care teams should include social workers, care coordinators, and others who facilitate referrals and create or access up-to-date lists of available mental health providers and other needed services. Teams should map existing gaps in referral networks and identify community needs. Workflows should include not only navigation to services but also follow-up to ensure patients are receiving recommended treatment.

Integration of PMAD screening, referral and treatment into electronic health records is beneficial but is a challenge to set up and maintain.

Interviewees involved in direct patient care frequently referenced the impact of electronic health records (EHRs) on how they screen, seek advice, refer, and treat patients and families. One interviewee described how they could easily add educational materials and resources to their EHR to share with patients. Others talked about how they used the EHR to communicate with colleagues in their organization. In some cases, they referenced formal or informal shared plans of care and in others they talk about using the EHR for messaging other providers and seeking consultations.

> *"There is some screening that occurs through the OB's office that is shared with us….We round in the nursery Monday through Friday, so we usually get that through the shared plan of care…If moms have a history of depression or anxiety, and if they're on meds or not. And so then we put that in our newborn admission notes, so that it's there for all of us to be aware of… when we log into the baby's chart, and then it links over to the mom's chart so we can see their share plan of care, and they have that with every mom, and it's a pretty standardized form…."*
>
> *– Pediatric provider*

However, even practices that reported using EHRs effectively within their workflow described challenges. The interviewee cited above also said that if mental health concerns are noted in a confidential section of the pregnant person's medical record, they are not available for the baby's care team to review and consider as they assess the baby's well-being.

Several interviewees described challenges navigating between paper and electronic forms. With some patients completing forms electronically prior to the visit and others completing them on paper in the office, staff must manage multiple workflows. Providers may not remember to review electronic results before meeting with the patient, and staff may fail to enter paper results into the EHR following data collection. Additionally, at least one provider talked about their practice's EHR prompting completion of electronic forms as part of certain visits, but not others. Providers suggested giving patients tablets to use in the office so all results were captured electronically in the same place. One described that Dartmouth had made this change and was frustrated their organization had not.

"We may be missing the highest priority thing in terms of the screening [in]the electronic health record. It's really, it's clunky. And I think most of us are using Epic. We do not have good interfaces, which is just nuts. We should be able to hand people, an iPad. Dartmouth is doing it. We've asked for it. It's just it's silliness that we're doing this on paper that then [a member of the care team's name] is looking at it….That would be helpful using our technology more smartly if you will, to get that information."

– Mental health provider

Recommendation 4: Support providers in implementation and improvement of electronic systems to track PMAD screening and referral, remove barriers to tracking and sharing results between provider organizations, and help organizations identify and fix gaps in consistent data management. Increase direct entry of screening results into electronic systems by providing hardware (e.g. tablets) and software (user-friendly apps) to pregnant people and new parents where there are seen.

Workforce shortages are a nearly universal challenge in referral and treatment for PMADs.

Interviewees consistently talked about inadequate mental health provider supply and problems accessing mental health care. According to interviewees across the state, there are too few mental health clinicians at all levels. They described how it would be useful to have more people embedded in their practices to provide immediate support, more community-based mental health clinicians to provide general mental health care, more perinatal mental health specialists to provide targeted interventions, and more psychiatrists to help patients with complex needs. A mental health provider indicated that the practice is able to meet demand, but only because it does not do any outreach or advertising of its service to broaden its reach. They speculated they would be "inundated" if they advertised more and added that although they had created information about their specialized PMAD services, "to be perfectly candid, we haven't sent it out because we are concerned what that would mean…this [PMADs] is not something we want to have people on a waitlist for."

Respondents described multiple implications of workforce shortages. For example, some noted that enthusiasm for screening was subdued due to a sense that there was nowhere to send people who screened positive. Others mentioned social workers doing brief intervention for patients who ideally would be referred on to longer-term care. Interviewees also described a system that works reasonably well for the highest acuity (who may already be linked to care) and lowest acuity (who could be served by social supports or brief interventions) but misses people with moderate PMAD.

Notably, workforce issues also were mentioned in the context of primary and obstetrics care. One provider in a rural area described challenges due to lack of obstetricians in their area, which hinders coordination as patients seek pregnancy care outside their referral region. Without the benefits of provider familiarity and shared systems, referrals from obstetrics providers outside their region were not happening with much frequency.

One obstetrics provider described how they're managing people with more severe postpartum concerns, and managing people longer, because they are unable to get appointments elsewhere. Specifically, they expressed the difficulty of transitioning patients out of postpartum care due to limited access to primary care providers who could continue to monitor patients with lower-acuity mental health problems or who were uncomfortable managing patients with higher level needs. As a result, their social worker was working through their lunch and calling people after hours from home, and the practice was seeing patients for a year or more after their child's birth.

Several mentioned potential solutions to workforce challenges. For example, multiple respondents said it would be useful to have more doulas trained in PMAD to help pregnant people and new parents and to make people in these support roles more accessible to all families. Others described how support groups or group visits might help patients who are unable or unwilling to find one-on-one professional help. Of note, interviewees described how it would be particularly beneficial to have providers with whom patients could relate. Providers who identified as queer, spoke the same language, were of the same race, and came from similar cultures or countries of origin were all examples shared.

Interviewees from regions with larger teams and more integrated systems voiced fewer concerns with staffing shortages. When mental health specialists were part of the obstetrics department's team, it was possible to get patients timely services. Similarly, when communities had dedicated time to establish a network of independent groups that came together to triage cases, they were able to find care to meet patients' needs. Several interviewees also talked about social workers, care coordinators, and family specialists funded through the Vermont Blueprint for Health's Community Health Team and Women's Health Initiative (now called the Pregnancy Intention Initiative) or through DULCE funding alleviated some of their staffing issues.

Recommendation 5: Invest in mental health workforce development, both through efforts to bring new providers into the field and specialized PMAD training to existing workforce. Take care to recruit providers who mirror the population they will serve. Reform episode of care/reimbursement to accommodate complexities of PMAD support provided by obstetrics providers.

Coordinated care teams, both across sites and within sites, support access to services and can overcome challenges gaining entry into mental health care.

All interviewees referenced the importance of teamwork to screening, referral, and treatment. Some talked about how their organizations had internal resources to manage patients' different needs, enabling "warm hand-offs," and others described creating community-level coalitions to help patients and families access services.

One interviewee described how their community had come together to create a team made up of people from a number of local health and human service organizations. Together they were able to identify how best to serve each pregnant person or new parent given the current available resources. They noted other regions would benefit from similar collaborations. In their words:

> *"When you have that many people working together, like somebody's program has capacity. We're able to figure it out, which is really nice, because if it was just coming to us, we can't serve everybody and not everybody makes sense to be coming to us.*

You know it makes more sense to be part of the nursing program or going to VDH, to WIC."

- Social services provider

As discussed earlier, embedded social workers and care coordinators are crucial to well-managed care for PMAD. Several interviewees noted that pediatric DULCE sites were particularly adept at helping new parents with mental health concerns. Through formal and informal screening, care teams are able to identify family needs and provide support. One pediatric provider had the following to say:

"We have helped moms get to a place so they can work on their mental health and get to a better place. I could not do this without [social worker and family specialist]. I mean there is absolutely no way as a clinician going in those visits that I would have time or ability or capacity to do what they do like. I totally rely on these guys to help get moms where they need to be…it's having this team from initial screening to early hand-off and referral…."

– Pediatrics provider

An obstetrics provider described the accessibility of social workers to themselves and to their patients.

"I have both their [social workers] work cell phones so I can call them during the day, and I could call them from a patient room if I needed to. They are very accessible, and frequently, when I send them messages, referrals, they get back to me within the same day with a plan….If you have a patient who's never engaged in with mental services or counseling. It's sometimes a little bit of a big lift to ask them to engage, now that they're postpartum, and they feel busy, and they feel the burden of time. So I think what's been really helpful in particular is our Women's Health Initiative social workers, because they're extremely accessible over phone and text message. But say for most that's kind of a level of engagement that many are comfortable with….That's often the first thing to say. Well, what if I had one of our social workers give you a call tomorrow to check in, and they can check in the next day or the next week, and that's often a good like an extremely positive middle ground that many are accepting of."

– OB provider

The provider went on to describe how social workers were always part of the referral process for them:

"They [patients] always pass the social worker on the way to whatever happens next, no matter what, sometimes just the social worker. But if it's psychiatry, I get the social worker involved to just to make sure that if you know, you never know when you place a referral to the psychiatrist, if it's going to be like 10 weeks until they're seen. So the social worker is the good kind of touchpoint regardless."

– OB provider

Other interviewees similarly described social workers and people in similar roles as able to provide brief intervention and help patients navigate to other services. Interviewees also described how members of a larger care team could extend the services delivered by a medical or mental health provider by talking

over the phone or by meeting pregnant people and new parents in their homes and other locations of their choosing (e.g., a parent-child center).

A mental health provider embedded in primary care stated "the primary care providers oftentimes reach out to us to see what our availability is. Are they an appropriate referral? If we're full, what can they do in the meantime?" When asked how this process worked within their practice, they noted they had an upcoming meeting to "smooth out that process" since it seemed to work better in some situations than others. For instance, primary care providers were sometimes setting unrealistic expectations about when the mental health provider would have time to see them or were having front desk staff schedule mental health appointments for uninterested patients, resulting in visit no-shows.

Recommendation 6: Invest in practice-based care teams and foster collaborations across local/regional health and human service groups to meet the needs of all pregnant patients and families at the time and in the place that is right for them.

The COVID pandemic disrupted patterns of care but expanded use of telehealth for PMAD screening.

Interviewees described how the onset of the recent pandemic had influenced workflow. Care team members were no longer onsite for consultation. Further, visits at which PMAD screening had previously occurred became telehealth visits, and it became a challenge to get screenings done. One interviewee also mentioned that it was hard to know if telehealth visits were happening in private or if a partner was nearby, making it more challenging to ask sensitive questions.

However, telehealth opportunities that resulted from COVID removed barriers to needed specialty services for some patients. One person from an obstetrics site outside of Chittenden county offered the following:

> *"Having the opportunity to [use] telehealth has been critical for people, you know, who don't have transportation. It's hard to get away. It's going to Burlington. It just seems like Mars, you know, just impossible. But [telehealth] access, I think, is critical to keep offering. You know the telehealth options, you know just in terms of that connection with them."*
> *– Mental health provider*

A mental health provider noted telehealth has "for a lot of people, made treatment a lot easier" and added this was especially true for people with new babies, for whom getting to an appointment could be a challenge.

Many described how mental health concerns had increased in numbers and severity during COVID, making it even more of a challenge to meet all patients' needs. Interviewees talked specifically about anxiety caused by rules barring partners from joining pregnant people at visits and new parents feeling depressed from isolation at a time they wanted to share their baby with friends and family. However, at least one interviewee remarked that COVID forced enhanced collaboration. Groups came together to work with families in crisis and identified work that could be done by team members who were able to maintain in-person visits and work that could be done remotely, by others.

Recommendation 7: Continue to promote telehealth as a viable option, particularly for residents in rural areas, work to incorporate screening practices in telehealth workflows, and encourage providers to ensure patients have a meeting space appropriate for a telehealth visit.

Patient factors also influence care sought and received, though system efforts can overcome some of these individual factors.

Interviewees described that in general, most patients completed PMAD screenings as directed. However, according to at least one interviewee, pregnant people or new parents may be reluctant to complete screening tools if they have pre-existing mental health conditions, thinking "me answering these questions, it isn't going to change that fact that I have depression or anxiety." An interviewee also noted that patients sometimes did not see the value of responding to the screening at later visits since no one had ever followed up with them about the results of their earlier screens.

Some interviewees described how stigma surrounding mental illness may influence the care patients seek. They described how some patients may find it hard to seek mental health support in general and others may be particularly wary of expressing their struggles with mental health during a period they think parents are supposed to be focused on the arrival of a new baby and associated joy. One reflected, "New parents are bringing their kids in. But are they getting the care for themselves, right?"

A social worker described how some providers need to work on how they present behavioral health care so that it feels less stigmatizing. They said some patients feel defensive when it is suggested they see the care team's social worker or express concern they are going to be reported for substance use.

Interviewees noted patient hesitations to ask questions or seek help are often a result of language or literacy barriers. Pregnant people and families who do not speak or read English fluently may be less likely to understand what providers and written materials are saying or how to articulate what they are feeling in a way that the provider understands. An interviewee who works with many New American families said:

> *"There's so many times where somebody will like say all the things in an appointment, and the parent is like nodding and saying yes, and then the care Provider will say like, do you have any questions? The family says, No, we don't have any questions. And then, like 2 days later, I follow up, and we have this long conversation, and there's so many questions."*
>
> *– Social service provider*

Another remarked how "Mental health in general means many things to different cultures" and that providers needed to help people with PMADs "make sense of what that means in their culture."

Patients with lower levels of education and health literacy, no matter what their background, may have trouble understanding medical terminology and instructions. Some patients may feel rushed when answering standardized screening tools or not understand why they are being asked questions about their mental health during a pediatric visit.

One mental health clinician interviewed suggested that the cost of counseling may be a barrier for some individuals. Another said that some individuals in the military choose to pay out-of-pocket (and consequently seek less frequent help) out of concern that an insurance claim might be connected to mental health diagnosis and jeopardize their employment.

Recommendation 8: To design systems that meet patient needs, efforts should be made to hire staff with lived experience and who are more similar (in terms of race, culture, gender identity, etc.) to the patients they are helping. Peer-to-peer support and PMAD support groups may help to normalize treatment for individuals less comfortable with one-on-one treatment in a clinical setting. Invest in written and web-based materials that are accessible to all pregnant people, including people who speak a language other than English and who have lower levels of literacy and health literacy.

PMAD Education and Consultation Services

Respondents who had experience with UVM's Perinatal Psychiatric Consultation Service consider it to be a crucial resource for them, but many working in perinatal health or with new parents were unaware of this resource.

The provider-to-provider Consultation Service offered through the University of Vermont Medical Center (UVMMC) was described as a useful resource by everyone who knew about it. Discussing treatment options, medication management, and determining if additional support was warranted were among popular issues discussed. Many also talked about using the Consultation Service as they waited to get their patients in for appointments with specialty care providers. Interviewees were impressed with how quickly they heard back from the service (noting they typically heard within a day of calling) and with the content of the calls.

One obstetrics provider talked about how they used the Consultation Service to feel confident they had created a good plan of care.

> *"I just like need to talk to somebody to reassure me that what I'm doing is correct, and that's what they would they do. And I think for me, I did have a feeling afterwards of being like, okay good. That was really reassuring. And I'm glad I have a plan."*
>
> *– OB provider*

This same provider noted a little reluctance talking over the phone, wishing there was more formal documentation from the consultant so it didn't look like they were "being a cowboy" with their treatment plans.

Providers noted that perinatal mental health has become a very specialized field and appreciate access to experts in this area. An obstetrics provider spoke about their appreciation for access to specialists, saying:

"I feel so lucky to work in a place like here in Vermont. We take care of people like they are our neighbors because they are, or they are members of our family. And whether it's this consultation support, or any specialty to be able to pick up the phone and talk with a specialist at UVM or Dartmouth, and get fabulous guidance about what to do next. We're so lucky to have the resources that we have here, and to take care of people the way that we do in general, when there's an acute need and a burning question that we have to answer. So appreciate it [the Consultation Service] for that."

– Mental health provider

They also said it would be helpful to receive feedback about how their group was using the service:

"I don't know what you're seeing in terms of data. And those referrals from our team. It would be interesting to look at that, you know? Again, I think that these are the kind of data that would be helpful to know. How many referrals are we making? What are those referrals for? Is this really a good referral? Is this a good use of our expert, the expertise, or are there gaps that we could be filling locally that we just don't realize, because you know, providers are in a vacuum trying to do the best that they can on that day for that person."

– Mental health provider

Some interviewees referenced using the official Consultation Service phone number, but more described reaching out directly to the nurse midwife/psychiatric mental health nurse practitioner and pediatric psychiatrist who currently run the program. Personal connections were a theme among those who use the consult service. Several talked about having known the nurse midwife/psychiatric mental health nurse practitioner for a long time and would "default" to "go ask [the nurse midwife/psychiatric mental health nurse practioner]" when they had questions about PMAD treatment. Those within the UVM Health Network described the benefits of being able to direct message these local experts though their shared EHR.

Others were unfamiliar with the service or had little experience with it. Several said they knew there was a number to call but had trouble finding the number or didn't always remember this was an available resource. Others still mentioned they made use of other similar services, like Child Psychiatry Access Program, or called providers at Dartmouth for support. One suggested more advertising of the service should be done, and several asked for more information (which was shared through email after the interview).

Recommendation 9: To achieve broader use of this valuable service, it is recommended that the consultation service is advertised in more settings. Efforts should be made to outreach to providers across the state, with trusted members of the provider community sharing clear guidance on the services provided and examples of successful assistance rendered.

While preferences for topics and modes varied, nearly all respondents noted the importance of both basic and ongoing advanced training in PMAD.

Interviewees described how it is beneficial for everyone working with pregnant people and families with new babies to have a baseline understanding of PMADs as well as opportunities to learning about evolving guidelines and updated recommendations when they are released. Practices described training their entire staff, from reception up through physicians, in PMADs. In one interviewee's words, "I do think education is always great, because it empowers the, you know, the providers and staff who are caring for people." Another described how important it had been to create a common understanding of PMAD and the value of "getting in and supporting families" in their community. A non-clinical provider remarked:

> *"I don't have a clinical background, but I at least have like some language to use with the families, and then I can help them process questions and create questions to bring to their appointments. So I do think that the more like medical and clinical language and information is helpful [for non-clinical providers]."*
>
> *– Social services provider*

Interviewees described how offering education in a variety of modalities is appreciated; in-person experiences are rich, fostering a sense of community and shared goals; live, web-based offerings reach more people since they can be offered to people from across the state without the burden of travel; and asynchronous learning is the most convenient so individuals can fit education into their busy schedules. ECHO-model trainings (which require ongoing, real-time participation) were often described as a challenging model given provider schedules. Interviewees recommended making participation easier by recording and archiving web-based training, allowing people to attend a session even if they are unable to commit to a whole series, and offering different versions of trainings on similar topics. Interviewees appreciated trainings that were held locally, did not cost a lot of money, and earned them continuing education credits.

Given the roles of the people interviewed, it is not surprising that everyone had some sort of personal experience with PMAD training. Experience included descriptions of what they had learned in school, workshops and trainings, webinars, ECHO series, Grand Rounds, reading, and podcasts. Many found the trainings offered through Postpartum Support International (PSI) to be particularly helpful, though some mentioned that costs for ongoing PSI training were prohibitive. Interviewees also described learning from colleagues and local experts like the nurse midwife/psychiatric mental health nurse practitioner and pediatric psychiatrist who staff the perinatal consultation service. Some interviewees recalled trainings they had attended in great detail (including if it had been sponsored by STAMPP funding) and others furnished more basic descriptions.

Interviewees noted that topics and scope of focus needed vary depending on individuals' roles. For instance, one interviewee described people in primary care needing to know "what to look for and where to go with it" while behavioral health providers needed to know current best practices. Interviewees suggested the utility of overviews and brief trainings as well as in-depth curriculums that resulted in PMAD-focused certifications. Several interviewees talked about building expertise and establishing themselves or others as specialists in PMAD. For example, one referenced PSI certification, saying:

> *" I actually have talked with our clinical director, [name] about, you know, sort of doing the next steps to have like that certification, if that's something that would be*

beneficial to the department or the hospital to have…the letters after my name, or to say, "oh, we have a certified perinatal mood clinician here." I'm already paying for other licenses and things that I need, so I don't want to pay for another thing. But, however, if that would benefit the hospital, I certainly would."

– Mental health provider

When talking about handling PMADs in obstetrics, another said:

"What are we going to do? It's so hard. It feels very heavy right now, just being able to get people what they need. And that's part of my like push to, to kind of further my education, because I feel like I have some amount of comfort in being able to care for people. But I feel like I'm really stretching myself and doing a lot of self-learning, and it doesn't quite feel adequate. And I think if you asked all of my colleagues, we would all feel the same like, yeah, we've dabbled in this. It was like a minuscule part of our education. It really wasn't enough."

– OB provider

Interviewees suggested many topics for trainings, including those listed in Table 1.

Table 1: Suggested topics for future PMAD education	
General introduction to PMAD	Trauma informed care
Whole family care/identifying and helping perinatal partners who need it	Engaging nursing and other staff in screening, referral, & treatment
Grief and loss	Case examples/first-hand descriptions of PMAD
Abortion support	Introduction to Guideline updates
Fertility issues	Role of nursing staff
Cooccurring substance use disorder	Components of care (and other PSI offerings)
Medication management during pregnancy & breastfeeding	Different types of evidence-based therapies for PMAD treatment
Non-pharmaceutical approaches to PMAD management	Treatment of new & pre-existing mental health disorders beyond depression & anxiety (e.g., bipolar, obsessive compulsive, sleep disorders)
Disparities in health & health care (e.g., impact of race on maternal health)	Gender-affirming care

Many described "101" style trainings that would provide an overview of PMADs. Interviewees noted that many patients with PMAD had experienced some form of trauma, and that providers should be better equipped to address these patients' care. Education focused on the use of medications during the perinatal period was also mentioned by many of the people interviewed. Interviewees described that providers often felt ill-equipped to treat patients on medications, particularly stimulants. A mental health clinician described how some providers are supportive of patients who continue to take stimulants through pregnancy and breastfeeding and others are not. They described that without appropriate provide knowledge and support, patients can be left feeling ashamed about their mental health disorder.

Interviewees stressed that training needed to be ongoing. Established providers benefit from new ideas and the opportunity to learn from others. Also, one community-based interviewee noted that due to high rates of staff turnover, there should be regular opportunities to learn about PMADs.

> *"… because you know the nonprofit world and the human services world is a revolving door. I'm always going to have the need to train new folks. It's not like they're going to stay."*
>
> *- Social services provider*

Recommendation 10: Continue efforts to educate all individuals who care for pregnant people and new parents. Education should be accessible (provided in different modalities) and offered at levels suited for provides needing various levels of breadth and depth. Use both local peer experts as well as offering access to national and international educational programs to bring evidence-based information on screening and treatment of PMAD to an array of Vermont providers.

Participants noted the value of patient education materials that are targeted to particular populations or geographic areas.

Although a number of interviewees were familiar with statewide *Support Delivered* materials and several described sharing *Help Me Grow* information with families, when asked about patient-facing education, interviewees most often described the need for information to include local resources and be tailored to meet the needs of specific populations. They suggested a mix of written and visual materials focused on how to find professional and peer support that would be accessible to people with limited English or reading skills and talked about how rather than handing pregnant people materials, providers should go through them during the visit. One interviewee said:

> *"Very often we're really working to get them connected in a personal way. I want you to talk to this person at [a community action group]. I want you to talk to this person at the [parent child center]. I want you to talk to this person at Early Head Start. Like we're trying to do really warm hand offs. And in this small community, and because we have these coalitions, we know each other. That is more effective, I think, for our patients."*
>
> *– Mental health provider*

Interviewees described how education should be convenient (e.g. available online), interactive and be geared to reach partners in addition to pregnant/birthing parents. Interviewees noted how general information (e.g. parenting skills) and specific topics (e.g., harm reduction strategies relating to substance use during breastfeeding) were useful to have on hand. At the same time, interviewees stated that patients are often overloaded with information and pamphlets, particularly at early prenatal visits, so universal patient education materials may get lost in the shuffle.

Recommendation 11 Support communities in their development and dissemination of information providing available resources tailored to specific population needs.

Looking Ahead

The rich findings from this qualitative study led to a range of recommendations for the state to consider as it develops future efforts to address PMADs. While we have detailed them in order to provide a comprehensive assessment of the state of the screening, referral, treatment, consultation, and education systems in the state, here we draw out overarching themes to help the state prioritize and structure future efforts.

First, interviews revealed that systems to address PMAD—including referral networks, patient resources, workflows, etc.—are localized and need to be tailored to specific patient populations and practice sites. Successful micro-systems each operate somewhat distinctly, and sites that are still struggling to address PMADs frequently flagged the challenge of adapting tools and resources to their particular needs. While statewide efforts offer advantages of scale and consistent standards, a model that enables local communities to individualize their initiatives may ultimately be more effective.

Second, team-based care, especially models that embed or co-locate social workers or mental health counselors, are effective approaches to addressing multiple challenges in the screening and referral system. Practices or systems in which providers from multiple disciplines and varied training backgrounds work together generally reported more success in adopting screening and referral systems into their workflows. These practices were able to overcome barriers such as physician discomfort with treating PMADs (by having mental health professionals on hand), delays or time-consuming communication in making referrals (in that coworkers were on hand or easily reachable for referrals), and workforce limits (by being able to treat lower acuity cases in house). These sites also reported higher awareness of PMADs within the practice and overall commitment to prioritizing this issue. Payment systems to support and expand team-based care can help build on these successful models.

Third, increased attention to PMAD in recent years has been helpful in elevating this issue, but ongoing education is needed to continue to raise awareness and develop champions. Perhaps reflecting our sampling frame, most people we spoke with for this study were aware of the importance of PMADs to a range of outcomes for families and the health care system. However, even within this highly activated sample, there was variation in provider comfort level with PMADs; even those whose practices were largely dedicated to this area indicated a need for ongoing education. Ongoing education can also be an effective route to developing champions to develop site-specific initiatives, which interviews showed was a helpful approach to establishing functional systems. Resources to support a range of education topics and modalities can address this need.

Lastly, even if screening and referral systems reach full potential, ongoing workforce shortages tied to limited mental health provider supply means treatment access will still be a challenge. As in many areas, Vermont faces greater demand for PMAD services than capacity to treat. Access to treatment for higher acuity cases is particularly challenging. Interviewees offered many ideas to address this issue, including expanded awareness of consultation services; increased numbers of embedded social workers, case managers, or family specialists; development of a robust postpartum doula service; and

engagement of adult primary care in PMAD initiatives. These ideas are all actionable short-term solutions to consider, given the time to train and recruit mental health specialists in PMAD.

Vermont has made great strides in developing systems of care to address PMAD, with multiple examples of highly effective practices, networks, or communities. Replicating the lessons learned from these examples while addressing the ongoing challenges in the system will require focused effort and resources.

Appendix 1: 2023 STAMPP Evaluation Interview Guide

This document is the interview guide for the VCHIP qualitative evaluation of Vermont's activities and outcomes under the STAMPP project. Interviewees include representatives from:

- Obstetrics-based or focused providers (including nurse midwives, social workers, nurse managers, clinical coordinators, physicians, and other providers)
- Primary care-based or focused providers (including physicians, family specialists, care coordinators, and psychiatric nurse practitioners, among others)
- Mental health-based or focused providers (including administrators from designated agencies and providers)
- Other collaborators involved with STAMPP development or implementation in the state

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Interviewer introductions: names, role at VCHIP, etc.

We are interviewing individuals who work with expecting and new parents or are engaged with the state's Screening, Treatment & Access for Mothers & Perinatal Partners (which we call STAMPP) project to learn more about how perinatal mood and anxiety issues (PMADs) are supported in Vermont. We are trying to glean a richer understanding of how STAMPP, supported by VDH and DMH, has impacted providers' delivery of care and the health care system for supporting screening, referral, and treatment. We have questions that focus on PMAD screening, referral, and treatment, PMAD education, and the Perinatal Mood and Anxiety Consultation Service offered through UVMMC. We are interviewing people from various places and positions and know that some individuals will have more to say about some topics than others. We have some questions to guide our time but we hope this can be an open discussion and invite you to bring up ideas and concerns we can bring to stakeholders.

This work is being completed under a grant from the state as part of its evaluation of STAMPP. We will be recording this meeting only for our own note-taking purposes. This interview, as well as others conducted for this project, will be the basis of analysis that synthesizes themes and findings across interviews. That analysis will be written up as a report to the state and may be publicly available. We will not identify you by name in the report. Any comments shared during this interview will be used anonymously and attributed only by general role (e.g., "obstetrics provider" or "stakeholder"). Do you have any concerns or questions about this project or the use of information? Do we have your permission to start recording?

Participant background:

Can you tell us a little about yourself—what you do, where you work, for how long, etc.

Part 1: Screening, Referral, and Treatment

[For OB/Primary care]: We are interested in how your **screening, referral and treatment** of perinatal mood and anxiety disorders currently works. Can you describe your screening practices?

[For MH]: We are interested in how you perceive **screening, referral and treatment** of perinatal mood and anxiety disorders to currently work. Can you describe your perception of screening practices in OB and primary care?

[Stakeholders] Can you describe your perception of typical screening practices?

Probe: Do [OB/PCP: insert "you"] [MH/stakeholder, insert "OBs and PCPs"] routinely screen for PMAD? How/what tools do [OB/PCP, insert "you'] [MH/stakeholder, insert "OBs and PCPs] use? When do [you/OBs or PCPs] screen/how frequently do [you/OBs or PCPs] screen? Have [you/OBs or PCPs] done screening via telehealth?

What are the challenges to screening?

Probe: How comfortable do [you/OBs or PCPs] feel screening for PMAD?

Probe: What is your perception of patient comfort or response to PMAD screening?

Probe: How useful or difficult to use are current screening tools?

Probe: Are there challenges related to telehealth?

Other probes: Reimbursement; time

What happens with positive screens?

Probe: Please describe your referral or treatment process, either as a referring or receiving provider.

Probe: How are positive screens assessed during telehealth visits handled? Does this change if the patient indicates suicidal ideation?

What challenges do you [OB/PCP, insert "experience"; MH/stakeholder, insert "perceive"] referring people to services?

What are the challenges to treatment?

Has [OB/PCP, insert "your"; MH/Stakeholder, insert "your area or health system's"] screening, referral and treatment practices changed in the last 5 years? How?

Probe: What changes occurred due to the pandemic?

Have you engaged in any formal or informal quality improvement activities in this area? If yes, what kind and with whom?

Have you seen any improvements? What?

If not (or few), what are the obstacles to improvement?

What else should we know about the state of PMAD screening, referral, and treatment in your area?

Part 2: PMAD Education:

Have you engaged in PMAD **education** in the last few years? Education activities may include PSI training, attending grand rounds, lunch and learns, or sessions with Sandy Wood or Sarah Guth.

If so, please describe.

Do you know if these were supported by STAMPP funding?

What was good about the education/training?

What topics do you feel are most needed for education/training activities?

What could be done to improve education/training opportunities for practitioners? Topics? modalities? Time and timing?

Are there things you'd like your partners to learn (what and who?)?

Have you used any patient education materials related to PMAD? If so, which ones? If not, why not?

Probe: Are you aware of the Support Delivered products? What is your opinion on the usefulness of these products? Do you have suggestions for improvement or expansion?

Part 3: Perinatal Psychiatric Consultation Service

[OB/PCP/MH: "Have you used" [Stakeholders: "Are you aware of"] the **Perinatal Mood and Anxiety Consultation Service**? Probe: This is the service through which Sandy Wood and Sarah Guth can provide peer-to-peer consultation services on PMAD-related questions.

[OB/PCP/MH providers:]

If you have used it, please describe how and when?

How long ago? How often?

Was the response efficient enough to be helpful?

Was the response thorough enough to be helpful?

Did you feel equipped to provide next steps in care for the patient?

Did the patient still need to be referred to psychiatry following the peer-to-peer consult?

How could the service serve you better?/What would you like to see change about it?

If you haven't used it or haven't used it in the last few years, why?

What would need to change for you to start using it (for those who haven't)

[Stakeholders:]

How well used do you perceive this service is? Do you have an opinion of who finds it useful and who does not?

Probes: Do you believe the service is efficient in its operation? Thorough?

Probe: Do you believe the service helps patients get treatment more efficiently, or do you believe it slows things down?

Probe: Do you feel the service is sufficient to support providers in caring for pregnant people with PMAD?

What changes do you suggest to the consultation service?

Closing questions/moving ahead:

If you were in charge of asking for funding to support more work in the PMAD area, what would you ask for?

In your opinion, what aspects of the system of care for PMAD are working well in the state? What needs improvement?

Is there anyone else from your community you recommend we talk to about this project?