REPRODUCTIVE LIFE PLANNING AND DEPRESSION SCREENING/REFERRAL
The Healthy Start Interconception Care Learning Community (ICC LC) is a partnership that equally includes:

1. All Healthy Start grantees, as well as consumers and providers from Health Start Communities

2. An Expert Work Group of 18 leaders in women’s health, primary care, public health, quality improvement, and Healthy Start

3. The Maternal and Child Health Bureau, Health Resources and Services Administration (MCHB-HRSA); and

The quality improvement change projects initiated through the ICC LC included healthy weight, family planning, case management, screening assessment, maternal depression, and primary care linkages.

The Metro Louisville Healthy Start Program elected maternal depression in the first cycle and reproductive life planning in cycle II and III as its change projects.
Perinatal Depression

Engagement of At-Risk Women in Mental Health Services
Core Component of Healthy Start

- Direct outreach and client recruitment
- Health education
- Case management
- Depression screening and referral
- Interconceptional care services
Why It’s Important

- Depression affects between 10% and 25% of expectant and post-partum mothers
- Rates can be higher among at-risk groups
- Rates of depressive symptoms are estimated to be as high as 35% in African American women
Risk Factors Associated with Depression

- History of mood disorders
- History of alcohol dependence
- Life stress
- Poor marital relationships
- Low social status, lack of social support or absence of community network
- Unplanned pregnancy
Relationship between Depression and Gestational Problems

- Elevated fetal activity
- Delayed prenatal growth rates
- Placental abnormalities
- Epidural analgesia
- Elevated baseline fetal heart rate
- Altered fetal cerebral circulation
- Caesarian delivery and admission to neonatal care
Link between Depression and Fetal Morbidity and Mortality

- Increased risk of preeclampsia
- Low birth weight
- Premature birth
- Spontaneous abortion
Infants of depressed mothers:

- Are less likely to form secure attachments
- Are more likely to exhibit avoidant or disorganized behavior
- Experience compromised interactions between mother and infant
- Are at higher risk for problems later in life, including developmental delays and behavioral problems
- Are more likely to be neglected or abused
Two Core Healthy Start Measures

1) Healthy Start projects “facilitate health providers’ screening of women participants for risk factors, including perinatal depression; and

2) Healthy Start projects must report the percentage of women requiring a referral who receive a completed referral
Earlier Analysis

- (2006) Dr. Kanotra analysis revealed that only 7.3% of women who had screened positive for depression and who were referred for mental health services (assessment and possible treatment) actually made and or kept the appointment.

- Subsequent research project: to identify barriers and systems issues.
Findings of that Study

Personal barriers:
- Denied that problem existed
- Had breastfeeding/medication issues
- Had limited access to childcare or transportation
- Lack of funds
- Negative prior experience
- Cultural issues

System Barriers: Fragmented and Stigmatizing
ICC-LC (Interconceptional Care Learning Collaborative)

- **Aim:** All HS women who need mental health services will have access to culturally competent providers
- **Change:** Strong working relationships with two mental health providers
- **Measures:** Increase the rate of completed referrals for mental health services to 25% (from baseline of 7.3%)
Collaboration with Seven Counties

- October 2009; SCS was invited to be on the ICC–LC Home Team
- HS and SCS’s HELP Team engaged in a pilot of in-home mental health therapy
- Healthy Start nurses screen for depression (*during pregnancy and post-partum*)
- Referrals made to HELP team
- HELP team reaches out to Healthy Start participants
Results

Successful Engagements through Partnership with Seven County Services

GOAL 25.0%


7.3% 49.0%

Total Referrals during pilot project: 239 (117 or 49% were successfully contacted)
Results

Change in Edinburgh Depression Scale Scores Among Referred Mothers (n=15)*

Statistically significant reduction in depression (t=3.50, df=14, p<0.002)
The Metro Louisville Healthy Start Program, Cycle II
Interconception Care Committee
Subgroup: Family Planning and Reproductive Life Plan Development

Members; Latacha Stallard, RN, BSN; Patricia P. Brodie RN, MSN
Tenoeda Shavers, Community Health Services Assistant;
Cece Briggs, Administrative Assistant
Tasks of the Subgroup:
1. Literature review of reproductive life planning.
2. Review of reproductive life plan formats that had been implemented, reviewed and are evidence-based.
3. Adaptation of formats for the identified needs of Metro Louisville Healthy Start program participants.
4. Development of protocols for the use of the adapted reproductive life plan format.
Over 50 relevant articles were examined and a selected bibliography of 12 sources were utilized. Generally, throughout the literature, a reproductive life plan (RLP) is defined as a plan that incorporates a person’s intentions about the number and timing of pregnancies and is based on the person’s personal values and life goals.

RLP’s were viewed as an interconception care tool and strategy to support the reduction of poor birth outcomes.
Preconception care was defined by the Centers for Disease Control in 2006 as a series of interventions that aim to identify and modify biomedical, behavioral, and social risks to a woman’s health or pregnancy outcome through prevention and management. The CDC encourages the inclusion of men in preconception planning (2006). Recommendation 1, titled “To Improve Preconception Health and Health Care,” states that all women, men, and couples should have a reproductive life plan.
Interconception care is a subset of preconception care, defined as care and counseling between pregnancies building on important information learned from the previous pregnancy.
Attempts to implement reproductive life planning have not been successful for most women, especially minority women and men.

Some of the most important contributions to implementing a reproductive life plan include:

- Education of health care providers (nurses, doctors, social workers, etc.)—use of a life course perspective.

- Health literacy—understand information provided and using it to do something different.

- Daily encounters—teaching-learning moments at diverse contacts. It’s a conversation and talk is cheap!
1. PC² You Decide. Association of Reproductive Health Professionals
2. GHI HMO Reproductive Life Plan
3. You’re a Busy Teenager, Utah Department of Health
4. Voices of Appalachia Healthy Start, Whitley County, Kentucky
   (Adapted from N.C. and the Florida Dept. of Health’s Healthy Start Program)
Common elements and substantive content were identified in the six plans:
- Family planning goals
- Educational goals
- Goals to deal with challenges and barriers: emotional and physical health, substance use and abuse, financial issues, lack of support system, family/partner violence.

A decision was made by the subgroup to combine the brevity of the Voices of Appalachia format and the visual and language elements of the NC and AZ formats. Copies of the final document are available as a handout.
**TO violentlyquent**

**Family Planning**

**AIM**

Establish consistent assessment and data collection tools and protocols for Louisville Metro Healthy Start Community Health Nurses and Resource Workers to improve family planning services for all program participants and to encourage personal decision-making that supports the health of the family.

**SUBTOPIC/CHANGE PROJECT**

*Advance Use of Tools and Data Collection Methods*

Effectively collect information regarding Healthy Start Participants’ actual use of family planning methods.

**CHANGE**

A tool (and protocol) for family and career planning (a Reproductive Life Plan) was developed.

HS Nurses and Resource Workers were trained on the protocol for the new Reproductive Life Plan.

As of mid-May 2011 34.4% of current Healthy Start participants had a Reproductive Life Plan.
PDSA Model

PLAN

An ICC-LC II subcommittee reviewed the literature on reproductive life planning. Work began with the CDC's recommendation regarding the value of this type of planning, extended to the consideration of 50 articles, as well as networking with other Healthy Start Programs, and consultation with ICC-LC II subject matter experts. The result is a one-page, user-friendly document that generates a second copy for the record and a primary copy for the family.

DO

Reproductive Life Plan (RLP) forms in duplicate (carbon) format were made available to Healthy Start staff who were trained on the protocol. The Metro Healthy Start data system was modified to track clients with RLPs, and record their choice of birth control. RLPs are initiated in the prenatal period, and a review and update occurs in the first postnatal visit. The Healthy Start nurses take the lead in working with families in completing the RLP, and the Healthy Start Resource Workers play a critical role in removing barriers and encouraging HS participants to adhere to their plan.

ACT

In reviewing progress and results, the value of the Reproductive Life Plan and accompanying protocol was affirmed. However, several ideas for improving the process were identified, and will be incorporated into ICC-LC III. Enhanced strategies include:

- Providing additional education to Resource Workers and Participants about different methods of birth control (increasing the chances that participants make a well informed choice)
- Increasing the frequency of the nurse's visit to quarterly
- Providing on-line, refresher training for nurses and resource workers
- Tracking the actual use of the chosen method of birth control (identifying and responding to any barriers and making revisions to the plan as appropriate).

STUDY

Assessment of the implementation process includes an analysis of the electronic data related to the number of plans completed, whether a decision about birth control has been made, and the type of birth control method chosen. It also includes feedback from program participants at the time of the home visits and feedback from the HS Nurses and Resource Workers engaged in the implementation.
“After I had my third child I was like, where am I going to go from here? How am I going to raise my kids as a single mother? But Healthy Start really helped me think about my future.”

Tiffany Brown & baby Jaylen
Louisville Metro Healthy Start Participants

“Healthy Start has helped me think about my future, and what it is I want to do in life. Now I know what my focus needs to be, and within the next five years I plan to be where I want to be.”

RaSheedah Lanier & baby Kenndel
Louisville Metro Healthy Start Participants
MEASURES

Increase the number of participants who have a Reproductive Life Plan from 0 to 25%.
Increase in the number of women/couples who have identified a preferred method of birth control.

Participants with a Reproductive Life Plan

<table>
<thead>
<tr>
<th>Month</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Sept 2010</td>
<td>11.4%</td>
</tr>
<tr>
<td>Oct-Dec 2010</td>
<td>21.6%</td>
</tr>
<tr>
<td>Jan-Mar 2011</td>
<td>29.1%</td>
</tr>
<tr>
<td>Apr-mid 2011</td>
<td>34.4%</td>
</tr>
</tbody>
</table>

Self-Reported Choice of Birth Control Method

- Other 40.1%
- The Pill 11.4%
- Surgical Sterilization 20.8%
- Implanon 8.4%
- Mirena IUD 5.9%
- Male Condom 5.9%
- Injection 2.0%
- Nuva Ring 2.0%
- Ortho Evra Patch 2.0%
- Paragard IUD 1.5%

(OTHER INCLUDED VARIATIONS INVOLVING THE FOLLOWING: Depo, Tubal Ligation, Essure, Hysterectomy, and 'Decision Pending')
participants w/ reproductive life plan

- 2010: 23%
- 2011: 65%
- 2012: 81%
Connecting the Dots

Unintended pregnancy, depression, drugs, and alcohol: Four Horsewomen of the apocalypse or Opportunity for partnership and prevention?
Prevention Through Partnering

The Seven Counties and Healthy Start Experience

Key Factors for Success

• Screening, assessment, referral and follow up
• Teamwork between agencies and intra-agency
• Education for staff and persons served
• Data collection, analysis and evidence-based practices
What we know

• Women who enroll in the Healthy Start Program have the highest risks in our community for infant mortality and morbidity.
• Women enrolled in Healthy Start are routinely screened for alcohol, drug and tobacco use.
• Smoking marijuana and/or tobacco products are reported by a high percentage of enrollees, comparable to the depression rates.
According to the preliminary data for 2011, National Vital Statistics Report (CDC&P), the national neonatal mortality rate (infants under age 28 days) was 4.04 per 1,000 live births in 2011, which was also not significantly different than 2010. The national post neonatal mortality rate (infants aged 28 days-11 months) decreased by 4.3% from 2.10 deaths per 1,000 live births in 2010 to 2.01 deaths per 1,000 live births in 2011.

The mortality rate of black infants remains at 2.2 times the rate of white infants.
According to several news articles in 2012 (USA Today, Courier Journal etc.) Kentucky has seen its hospitalizations for drug dependent (substance exposed) infants increase from 29 in 2001 to 730 in 2011. . . .these infants are neonates born to addicted mothers.
What we do

- Refer women to Project Link for services and/or for inclusion in a database without individual identifiers.
- Accept referrals from treatment programs such as the JADAC intensive outpatient program, Volunteers of America and others.
- Support Healthy Start participants in each person’s recovery path as she directs us.
- Partner with Seven Counties Services Perinatal Depression Team.
- Assist program participants to develop reproductive life plans.
More of what we do

- Continually educate ourselves to prevention and treatment resources available for women enrolled in Healthy Start.
- Refer to available tobacco smoking cessation programs offered at Public Health and other agencies. Encourage use of the tobacco cessation hotline.
- Educate program participants regarding the effects of alcohol and drug use on fetal development and newborns, as well as on their own health.
What more can we do?

- Examine the data available, statewide, regionally, and locally, and improve linkages to meet the need.
- For Healthy Start, focus on consistency, evidence-based practice, and capitalize on the strength of serving multigravida women and home visitation services.
- Triangulate home visitation services that include mental health services (such as the 7 Counties Perinatal Depression Services Team), substance use/abuse services, and inter-conceptional services such as Healthy Start offers.
Consider...

- Do we need a Kentucky Infant Mortality and Morbidity Reduction State Plan that can address the issues of racial disparity and drug impacted infants?
- How can the Affordable Healthcare Act help?
- How can we better link services, share resources, and assess successful outcome?
- What funding is available for improved linkages?
What do we have to lose if we don’t keep trying?