Region 7

Maternal Health ECHO® Session 4

Supporting Maternal Mental Health

Sept. 22, 2026

Who We Are

- Nonprofit, nonpartisan educational institution based in Topeka.
- Established in 1995 with a multi-year grant from the Kansas Health Foundation.
- Committed to convening meaningful conversations around tough topics related to health.

Hello!

Avanthi Chatrathi, M.P.H.

Analyst

Kansas Health Institute

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Agenda

1. **Welcome**
2. **Didactic** — Supporting Maternal Mental Health
3. **Panel Discussion** — Region 7 Panel Discussion
4. **Problem of Practice Presentation and Discussion**
5. **Whole-Group Share Out**
6. **Cohort Announcements**
7. **Closing**

Region 7 Maternal Health ECHO®

Region 7 Maternal Health ECHO

Overarching Objectives

- **Use** actionable strategies to engage mothers and community voices in shaping service delivery and evaluation.
- **Build** networks across Region 7 to share practices, resources and data-informed insights.
- **Leverage** community-based approaches (e.g., collaboration with community health workers (CHWs), doulas) with clinical systems.
- **Identify** and share strategies to address region-specific maternal health barriers (e.g., access, transportation, trauma).

Region 7 Maternal Health ECHO Sessions

Session 1 | June 23

Enhancing Regional Collaboration and Resource Sharing

Session 2 | July 28

Bridging Community and Clinical Approaches

Session 3 | Aug. 25

Removing Structural and Financial Barriers

Session 4 | Sept. 22

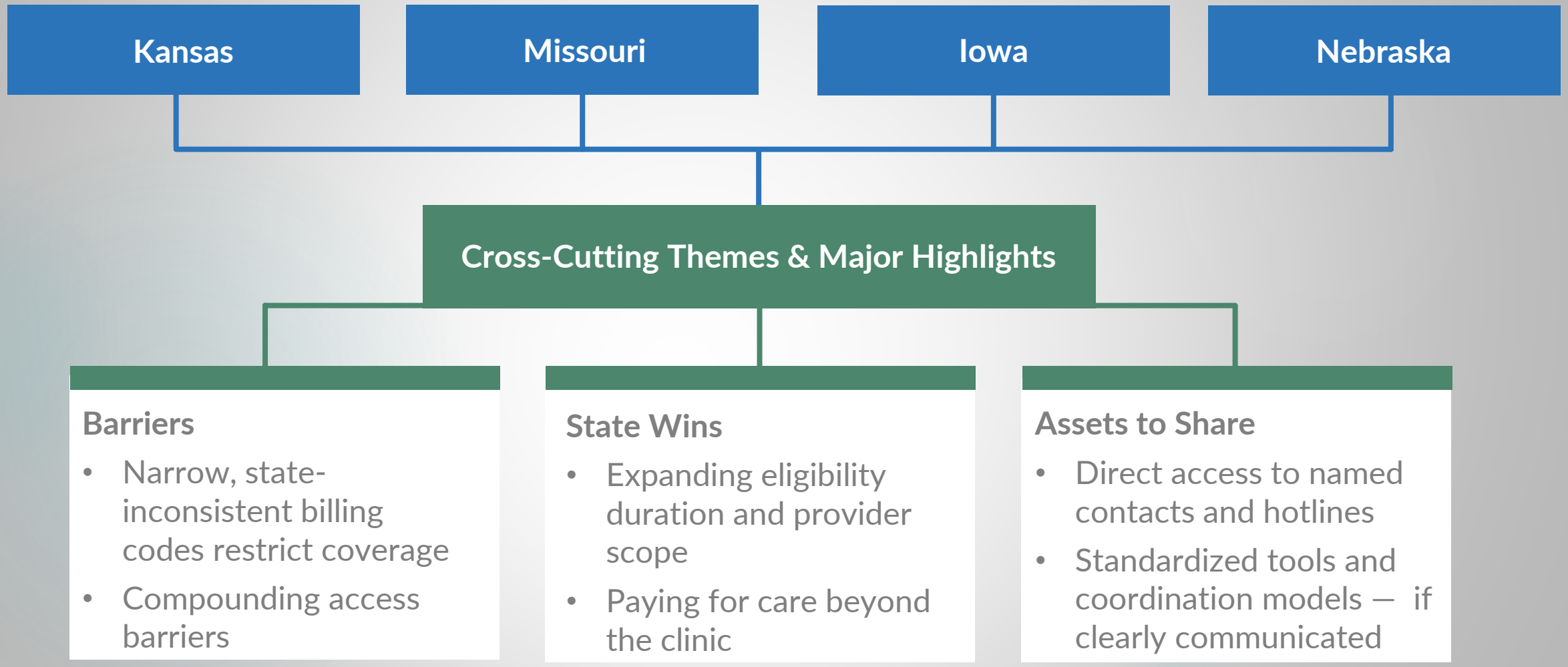
Supporting Maternal Mental Health

Session 5 | Oct. 27

Reflecting and Moving Forward Together

Session 3 Breakout Discussion Summary

Removing Structural and Financial Barriers



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Misha Raichura
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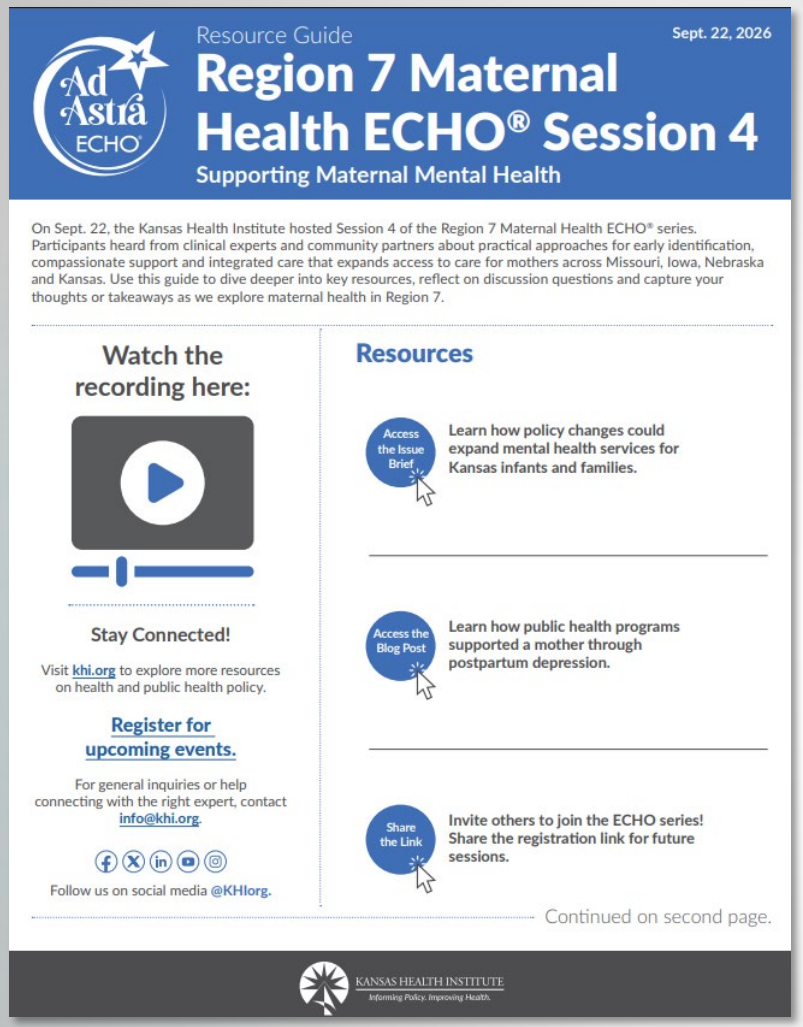
Resource Guide



Resource Guide

Sept. 22, 2026

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Continued on second page.

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Access your Resource Guide in the chat!

Didactic

Supporting Maternal Mental Health

Leigh Cook, APRN-NP

Co-Director of Reproductive Psychiatry

Nebraska Medicine

Maternal Mental Health in Practice

From a positive screen to wellbeing

Leigh Cook, APRN-NP, FNP-C, PMHNP-BC

Co-Director, Reproductive Psychiatry Program, Nebraska Medicine

Region 7 Maternal Health ECHO | Session 4 | September 22, 2026

University of Nebraska Medical Center

What I want you to leave with:

1. **It is common, it is serious, and it does not look the way people expect.**
   One in five. Often anxiety, not sadness. No demographic profile.

2. **Screening is not the intervention. The pathway is.**
   We have largely solved detection. We have not solved what happens next.

3. **Every role in this room owns a piece of that pathway.**
   The gaps are between us, not inside any one of us.

The Most Common Complication of Childbirth

And the one people are least prepared to name

1 in 5	experience a mood or anxiety disorder in pregnancy or the first year postpartum
~75%	of those affected receive no treatment at all
12 mo	of risk after birth, with onset possible at any point in that window

It is not just postpartum depression

- Anxiety is at least as common as depression, and often the presenting complaint
- Perinatal OCD: intrusive thoughts of harm to the baby, in a parent terrified to tell anyone
- Birth-related PTSD, bipolar unmasked postpartum, and postpartum psychosis

Prevalence and treatment-gap figures: Policy Center for Maternal Mental Health and MMHLA fact sheets, 2026.

A Mortality Issue

~1 in 4

pregnancy-related deaths have a mental health condition, including suicide and overdose, as the underlying cause - accounts for approx. 27.7 % in 2022 CDC MMRC

~85%

of pregnancy-related deaths are determined to be preventable - a large share occur between 43 and 365 days postpartum (after 6 week visit)

The cost of doing nothing is not neutral

- Untreated perinatal mood and anxiety disorders: approximately $14.2 billion for one year of births, about $32,000 per untreated mother-infant pair
- Associated with preterm birth, low birth weight and preeclampsia risk
- Effects on infant attachment, child development, and the other parent

Sources: CDC MMRC data as summarized by MMHLA (2026) and the Policy Center for Maternal Mental Health; Mathematica cost analysis.

We fixed detection. We did not fix what happens next.

Four places people fall out of the pathway

DISCLOSURE

Stigma, fear of losing custody, and the belief that this is just what everyone feels. Many people score low on purpose.

NEXT STEP

A positive screen lands in a 15-minute visit with no protocol attached. The provider knows something is wrong and not what to do by Friday.

THE WAIT

Psychiatry is booked months out across most of Region 7, and further in rural counties. The referral is made, and nothing happens.

THE HANDOFF

Referral made is not care received. Nobody owns the space between the OB, the therapist, the plan and the pediatrician.

Three Principles That Change Outcomes

1

Safety first, and safety overrides the score

A low total with a positive self-harm item is still an emergency. Always ask directly. Screening answers often do not tell the whole story.

2

Treat, do not just refer

Stepped care: start what can be started now and make referral one track rather than the only track.

3

Match the need, not just the number

The score tells you severity. It does not tell you what the person needs.

Step 1: Ask about safety, every time

Ask directly: thoughts of suicide or self-harm | thoughts of harming the baby | hallucinations, paranoia, confusion, not sleeping at all, escalating agitation

EMERGENCY *act now*

Plan or intent, thoughts of harming the baby, or any sign of psychosis or mania

- Do not leave the person alone; activate the emergency pathway: ED, mobile crisis or 988
- Same-day psychiatric evaluation, involve a support person, document the safety plan

URGENT *same or next day*

Passive thoughts without plan or intent; significant distress but safe right now

- Collaborative safety plan, means-safety counseling, warm handoff where possible
- Consult an access line to start a plan without waiting for a psychiatry slot, involve support

Step 2: Stratify then start

MILD — **Support and watchful waiting**

Psychoeducation, therapy and peer support, and a re-screen on the calendar in 2 to 4 weeks

PHQ-9 5-9 | GAD-7 5-9 | EPDS ~10-12

MODERATE — **Initiate treatment now**

Therapy referral and/or a first-line SSRI started by the front-line provider, with an access-line consult; refer to psychiatry but begin treatment while waiting

PHQ-9 10-14 | GAD-7 10-14 | EPDS ~13-14

SEVERE — **Prioritized psychiatry plus a bridge**

Expedited referral, strongly consider medication now, consider higher level of care, and reassess safety at every contact

PHQ-9 15+ | GAD-7 15+ | EPDS ~15+ or marked impairment

PHQ-9 and GAD-7 bands are the standard published ranges. EPDS severity splits are less standardized; replace with your program's validated thresholds before clinical use.

Step 3: Match the need and run the tracks in parallel

SOCIAL *Housing, food, money, transportation, childcare, IPV*

Social work, case management, community health workers, 211 and local navigation. Often the biggest and fastest lever, and it should never wait on psychiatry.

THERAPY *Wants to talk; adjustment, grief, birth trauma, stress*

Behavioral health or teletherapy referral, perinatal-specific groups, and Postpartum Support International groups and helpline.

MEDICATION *Moderate or higher symptoms, prior good response, preference*

Front-line providers can start first-line treatment in uncomplicated cases. Psychiatry for the complex: bipolar, psychosis, polypharmacy, treatment resistance.

The Bridge: Perinatal Psychiatry Access Programs

The most evidence-backed answer to "psychiatry is booked out for months"

A free provider-to-provider consultation line, staffed by perinatal psychiatrists, so the front-line provider can start or adjust treatment themselves. Pioneered as MCPAP for Moms and now replicated in more than twenty states.

What they do

- Real-time or same-day psychiatric consultation for the treating provider
- Resource and referral navigation for the patient
- Provider training and toolkits
- Some offer direct telehealth assessment

Why it works

- Multiplies a scarce workforce instead of rationing it
- Keeps care where the patient already is, which matters most rurally
- Reserves specialty appointments for genuinely complex cases
- Builds lasting front-line capability

Where Region 7 Stands

Four states, four different answers to the same question

KANSAS	Kansas Connecting Communities provider consultation line: consultation, resource and referral, and direct telehealth assessment. 800-332-6262, weekdays.
MISSOURI	Maternal Health Access Project, a statewide access program. Providers enroll free for same-day psychiatrist consultation and care coordination. 844-538-2279.
IOWA	No operational statewide line yet. Recent federal maternal health investment is being directed toward building one.
NEBRASKA	No statewide access line. Providers rely on PSI's national consultation program, free but by appointment, and on regional specialty referral.

Everywhere: 988 | Maternal Mental Health Hotline 1-833-TLC-MAMA | PSI Consult Line 1-877-499-4773

Bringing it Together

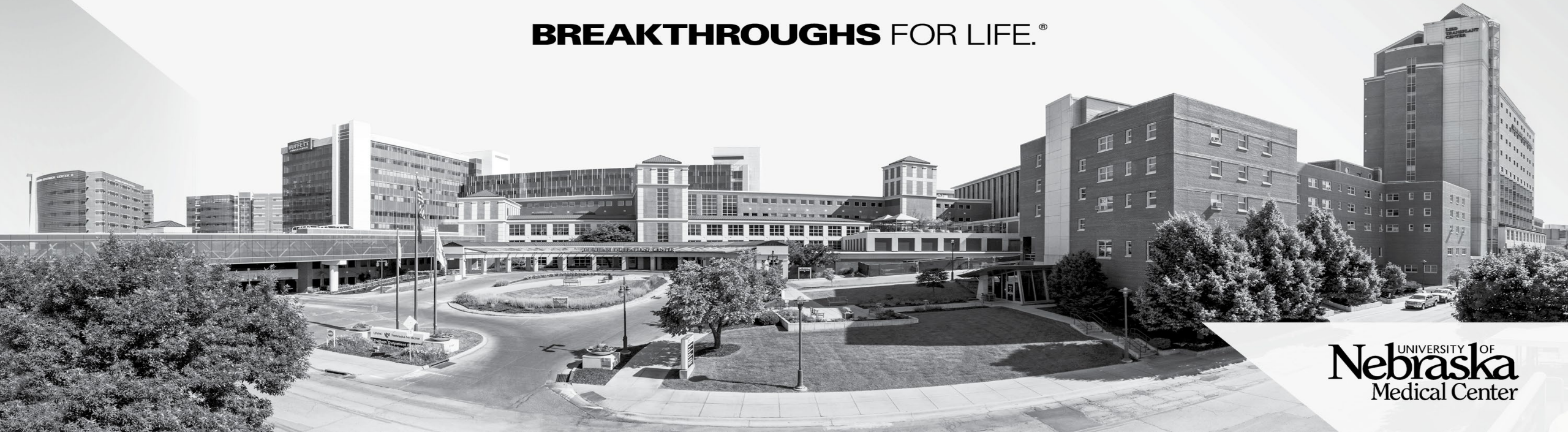
The gaps are between roles, so the fixes are too

Clinical teams	Never let a screening protocol go out without a written pathway attached.
Public health and MCH	Use the touchpoints you already own: WIC, home visiting, well-child visits.
Payers and health plans	Pay for collaborative care, peer support, and 12 months of coverage.
Policy and legislative	An access line is cheap infrastructure with a documented model.
Community organizations	Peer support reaches people who will never call a clinic.
All of us	Say it out loud: a lot of people feel this way, and it is treatable.

One in five. Three in four untreated. Nearly all of it preventable.

University of Nebraska Medical Center℠

BREAKTHROUGHS FOR LIFE.®



University of Nebraska Medical Center

Region 7 Panel Discussion

Meet the Panelists

Keslee Fout, M.P.A

Maternal and Child Behavioral Health Director

Kansas Department of Health and Environment

Rinda Davis, B.S.N., M.P.H, R.N

Assistant Director of Health

Springfield-Green County Health Department, MO

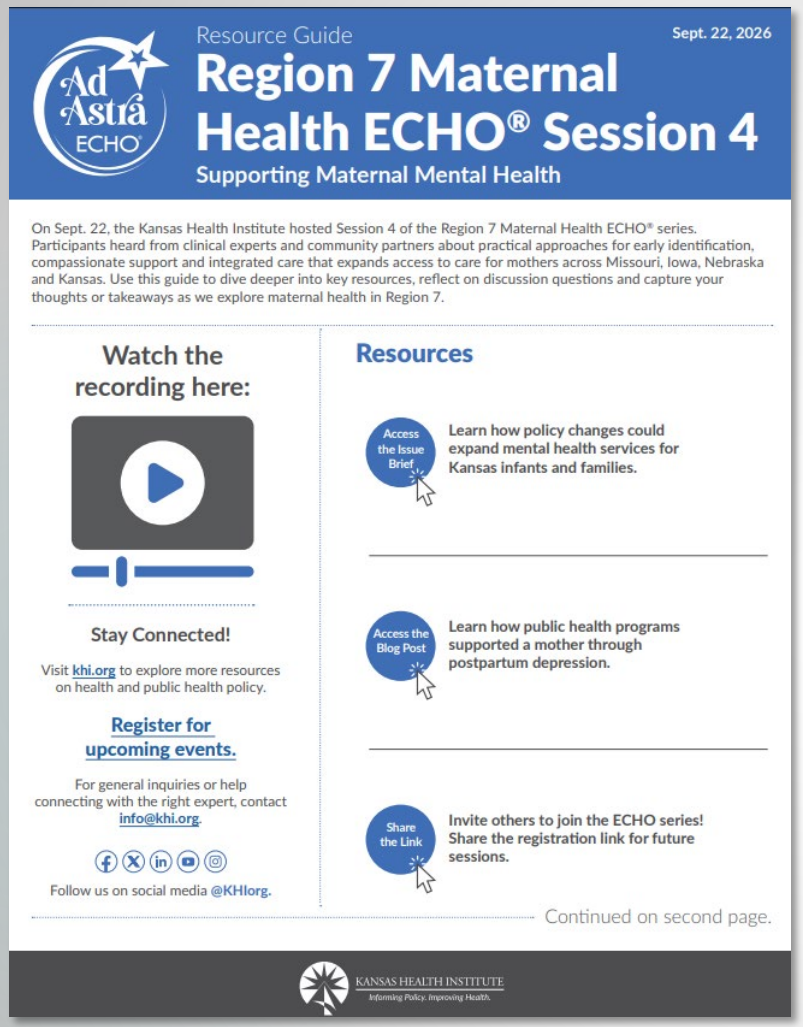
Laura Hanna-Bergen, C.N.M. P.M.H.N.P

Certified Nurse-Midwife and Psychiatric Mental Health Nurse Practitioner

University of Iowa Health Care

Next Steps

Resource Guide



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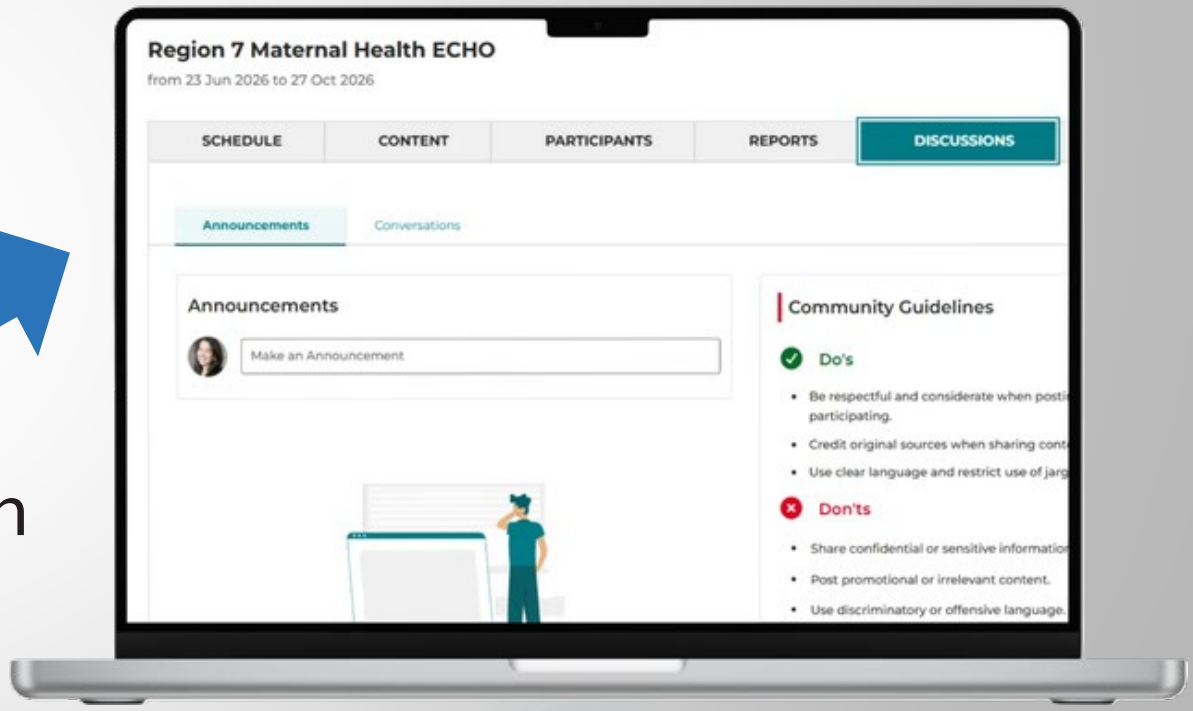
Your Turn to Share — Cohort Announcements

Share what's happening in your world:

- Events
- Initiatives
- Publications
- Anything else!

Come off mute, use the chat or post in the iECHO discussion board.



MATERNAL HEALTH DATA REGIONAL SUMMIT

Oct. 21, 2026

Oracle Innovations Campus - Kansas City, Missouri

Alongside DirectTrust Annual Conference

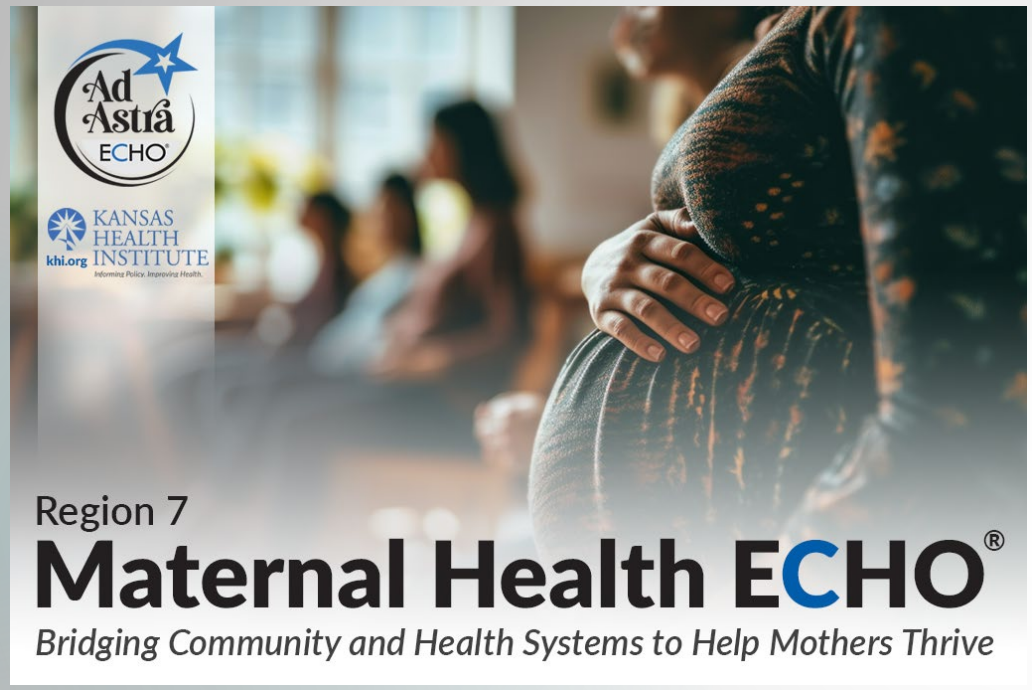
Focus on States of HHS R 7 w/ Others

Prompted by HHS ONC

- Fragmented handoffs along maternal journey
- Reflected in poor data capture, quality, flow
- Therefore, not driven by or for the person
- Data => Knowledge => Drive person-centered care
- Strategic Approach
- Outcomes matter – State officials, lived experience
- Start with known use-cases, rather than data survey
- Driving toward public position / statement / pilots

Agenda / Registration

Up Next

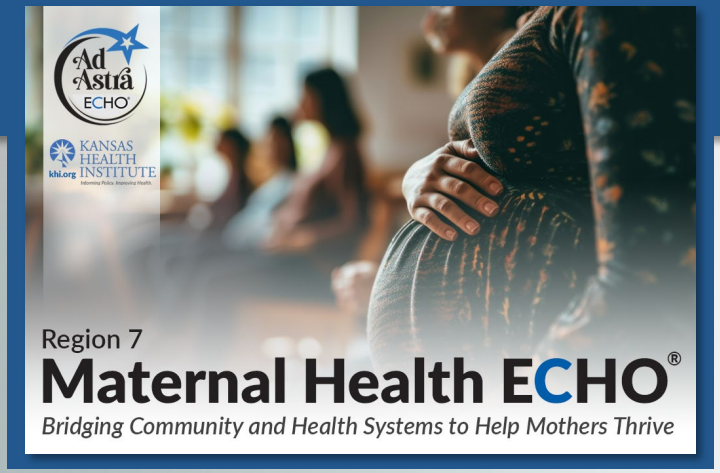


Session 5

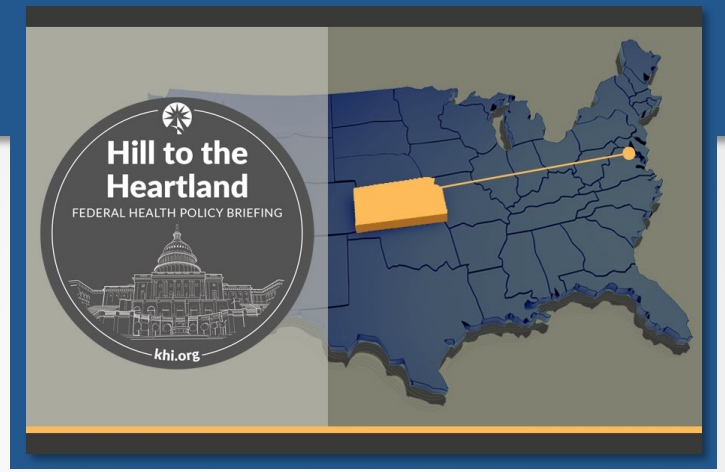
Reflecting and Moving Forward Together

Oct. 27, 2026

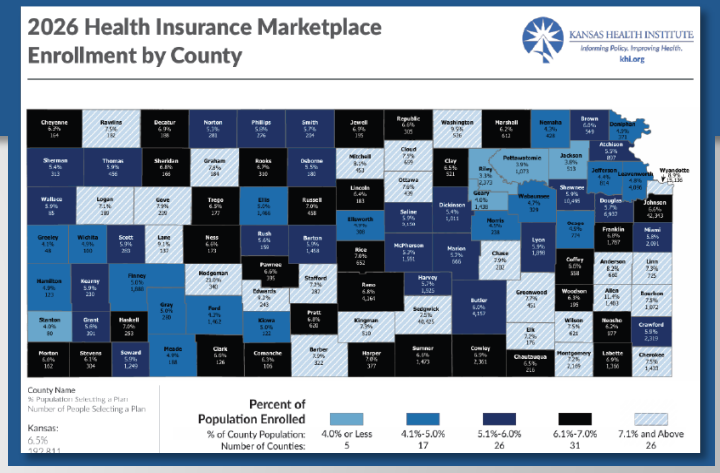
Explore More Resources at khi.org



Upcoming Events



Federal Policy Updates



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