Deliverable 9A.8 Provider Survey Report

Contract: MED 178: Florida Medicaid Drug Therapy Management Program

Project 9A: Understanding the Pregnancy and Birth Outcomes of Women with Serious Mental Illness Compared to Women without Serious Mental Illness in the Florida Medicaid Program

Prepared by:

Kai Stauffer LeMasson, Assistant Director of the Florida Medicaid Drug Therapy Management Program, Department of Mental Health Law and Policy

June 2016

Executive Summary

The purpose of the Provider Survey was to assess Florida Medicaid providers' attitudes, knowledge, and experience providing care and treatment to pregnant women with a Serious Mental Illness (SMI). This deliverable is meant to complement the Project 9A.9 Database Study on maternal and birth outcomes, and provide insight into the perspectives of providers and the treatment context for maternal mental health conditions.

Methodology

A provider survey was developed by the Florida Medicaid Drug Therapy Management Program for Behavioral Health and reviewed and refined by three psychiatric providers and three OB/GYN providers. The survey contains 29 questions: 25 closed-ended questions and four open-ended questions.

Survey Participants

A total of 107 Florida providers completed the survey: 32 OB/GYNs, 26 Nurse Midwives, 24 Psychiatric ARNPs, 21 Psychiatrists, and four other provider specialties. Fifty-two surveys were completed online and 55 surveys were returned in the mail.

Key Findings

The survey results indicate that a majority of providers felt knowledgeable and capable of managing maternal mental health conditions (65 to 75 percent), however, they also reported conflicting information and encountered challenges such as:

- Limited medical/nursing school training in maternal mental health.
- Working in office/clinic settings where there are no policies and/or procedures for conducting mental health screenings and treating maternal mental health conditions.
- Lack of experience prescribing psychotherapeutic medications such as antipsychotics to pregnant women with SMI.
- Sporadic care coordination of patients primarily due to a lack of available mental health providers who were willing to treat pregnant patients, an inability to reach providers directly by phone, and a lack of time in their practice for care coordination activities.

Although the majority of providers felt that psychiatrists should be primarily responsible for treating maternal mental health conditions, they also said that the biggest challenge for them was a lack of available mental health providers, and among those providers that would treat pregnant women, getting timely appointments for patients.

Other challenges providers reported included weighing the risks and benefits of prescribing psychotherapeutic medications during pregnancy and ensuring that their patients adhered to treatment recommendations and kept scheduled appointments.

Overall, there were negligible differences in the survey results between provider specialties and between medical doctors and advanced practice nurses.

Conclusions and Recommendations

The survey results suggest that there is a need to increase the capacity of providers to better serve pregnant and postpartum women with a SMI. Potential areas of action include:

- Developing and updating a list of providers and community mental health resources by AHCA region.
- Providing statewide and regional trainings on evidence-based screening and treatment for maternal mental health conditions and establishing office protocols for care coordination.
- Establishing a statewide provider hotline to support provider-patient treatment decisions.
- Engaging the newly formed Florida Perinatal Mental Health Workgroup and Collaborative in coordinating these efforts.

Introduction

There have been few studies examining medical providers' perspectives and experiences caring for pregnant women with Serious Mental Illness (SMI). Of the five studies identified through a literature search, two focused on OB/GYN providers' perceptions of treating women with perinatal depression (Byatt, et al., 2013; Palladino, et al., 2011). These studies found that OB/GYNs did not systematically screen for perinatal depression or feel comfortable managing depression treatment in pregnancy due to a lack of knowledge and training. In addition, providers reported a lack of communication and care collaboration between community mental health providers and OB/GYNs about patients. The OB/GYN providers expressed frustration that the psychiatric providers did not consult with them regarding treatment and would at times refuse to prescribe psychotherapeutic medication to pregnant women.

Palladino et al., (2011) also found that OB/GYNs' decisions and behaviors in managing and treating depression were shaped by numerous factors such as knowledge, training, time constraints, and views of mental illness and treatment. It was also found that OB/GYN perceptions of their roles and responsibilities as an obstetric care provider were sometimes at odds with treating perinatal depression, because they believed the role of a mental health provider was to treat depression. However, another study found that psychiatrists were reluctant to prescribe psychotherapeutic drugs during pregnancy, but were much more comfortable doing so during the lactation period (Cantalinio, et al., 2014). One in four said they always/generally recommended discontinuing psychiatric drugs in pregnancy. Interestingly, when different medical specialists were asked about their perceptions of the use of psychotropic medications in pregnancy, all specialists (including OB/GYNs) with the exception of psychiatrists overestimate the teratogenic risk of these medications in pregnancy (Cantalinio, et al., 2014). It is not known how this overestimation of risk translates into treatment recommendations and decision-making between patients and their providers.

In this current survey project (9A), we sought to understand the maternal mental health treatment and services environment in Florida Medicaid. We surveyed Florida providers' attitudes, knowledge and training, and general experiences treating pregnant women with SMI. The goal of the survey was to understand the perspectives and experience of different provider specialties including obstetrics/gynecology and psychiatry and the challenges they encounter in their everyday practice in the treatment of this patient population. These results will inform the goals and objectives of the Florida Perinatal Mental Health Workgroup to enhance care for pregnant and postpartum women with SMI in Florida.

Survey Methodology

Survey Instrument

The survey instrument was designed to assess providers' attitudes, knowledge, and experience providing care to pregnant women with a SMI. Since there were no established surveys related to

this topic, we constructed the survey with input from both obstetric/gynecologic and psychiatric providers. Six providers reviewed an initial draft of the survey and made suggestions regarding question content and format. This was an iterative process and there were multiple drafts of the survey before a final survey was agreed upon by the reviewers. The final version of the survey was approved by the Agency and contained 29 questions (25 closed-ended questions and 4 open-ended questions). Among the 21 closed-ended questions, there were four questions for which a response of "yes" prompts the respondent to explain their response in greater detail. The survey assessed the following:

- Practice specialty and background
- General knowledge and experience treating psychiatric disorders in pregnancy
- Understanding of the risks and benefits of psychotherapeutic medication in pregnancy
- Office or clinic policies for screening and treating pregnant women with SMI
- Care coordination

Survey respondents had the option of completing the survey by mail or over the internet. The survey format and questions were the same for the mailed and internet-based versions of the survey. Having two options for completing the survey, gave potential respondents greater choice and flexibility in responding to the survey and was designed to increase response rates.

Data collection

Data collection was based on a modified Dillman approach (also known as the Total Design or Tailored Design Method [TDM]) for mail and internet surveys to enhance provider response rates (Dillman, 1978, 2000). The TDM is the standard for designing mail, telephone, and internet-based surveys, and has been modified to address the unique challenges of conducting surveys with physicians (Field, et al., 2002; Thorpe, et al., 2008; VanGeest, et al., 2007). We employed many of the elements of TDM for achieving a high response rate including:

- Designing a respondent-friendly, short questionnaire (29 questions).
- Personalizing all correspondence regarding the survey.
- Providing return envelopes with first-class stamps.
- Sending reminders and replacement surveys.

One thousand surveys were mailed to a representative sample of Florida Medicaid providers in the specialties of OB/GYN and psychiatry (250 each to nurse midwives, OB/GYNs, psychiatric nurses, and psychiatrists). Thirty-eight surveys (6 percent) were returned due to an incorrect address. If a correct address was located, the survey was resent to the provider. In addition, a mass email was sent through Constant Contact to 2,969 Florida Medicaid providers inviting survey participation, followed by a reminder email two weeks later. This email contained a link to the online survey hosted on *Qualtrics*. The open rate for the mass email blasts were 17 and 19 percent, respectively. Three Florida Healthy Start Coalitions also sent an email to their local list of OB/GYNs and nurse midwives regarding the survey and included a link to the internet-based survey in *Qualtrics*. A total of 107 providers completed the survey: Fifty-two surveys were

completed online and 55 surveys were returned in the mail. The response rate was 5 percent (the number of completed surveys divided by the number of providers contacted by mail/email).

The data was compiled in a Microsoft Excel file and analyzed using *IBM SPSS Statistics, Version 22*. For the open-ended response options, thematic analysis was used to identify the main themes in the data.

Survey Results

Survey Participant Characteristics

Table 1 provides the demographic characteristics of the providers that participated in the survey (N = 107). Obstetricians/gynecologists and nurse midwives made up a higher percentage of those that completed the survey (55 percent), than psychiatrists and psychiatric nurses (42 percent). Seventy-one percent of the respondents were female, and 29 percent were male. The age of providers ranged from 29 to 78 years old with a mean age of 54.8 (*SD* = 10.1). The majority of survey participants were experienced providers, with a mean of 22.9 years in practice as a licensed medical provider (*SD* = 11.3).

Table 1. Survey Participant Characteristics

	N	%
Practice specialty (n = 107)		
OB/GYN	32	29.9%
Nurse Midwife	26	24.3%
Psychiatrist	21	19.6%
Psychiatric Nurse	24	22.4%
Other	4	3.7%
Biological Sex (n = 105)		
Male	30	28.6%
Female	75	71.4%
Race-Ethnicity (Choose all that apply) (n = 104)		
White, Non-Hispanic	79	76.0%
Black, Non-Hispanic	6	5.8%
Asian, Pacific Islander	8	7.7%
American Indian, Alaskan Native	2	1.9%
Other	9	8.7%
Hispanic (n = 90)	8	8.9%
Age in Years (n = 102)		
< 40	5	4.9%
40 – 49	28	27.4%
50 – 59	33	32.3%
60 +	36	35.2%
Years as a Licensed Provider (n = 98)		
< 10	10	10.2%
10 – 19	31	31.6%

20 – 29	30	30.6%
30 +	27	27.5%

Practice Characteristics

Table 2 provides information on the survey participants' practice environment, whether the practice provides services to Medicaid patients, and the practice policies/protocols for screening and treating pregnant women with serious mental illness. Approximately 4 out of 5 providers said their practice accepted Medicaid patients. When asked if their malpractice insurance had a clause that limited them from prescribing psychotherapeutic medication to pregnant women, 55 percent said "no", and 41 percent were uncertain and selected the response option "I don't know."

Providers were also asked about their office policies and protocols in treating women with SMI. Eighty-three percent said their office or clinic did not have a policy for managing this population. In addition, 69 percent said their office or clinic did not have a protocol for mental health screening in pregnancy.

Table 2. Practice Characteristics of Survey Participants

	N	%
Practice Environment (n = 107)		
Private Practice	40	37.4%
Group Practice	13	12.2%
Hospital-Based Practice	14	13.1%
Academic-Teaching Center	11	10.3%
Community Health Center/FQHC	6	5.6%
Community Mental Health Center	12	11.2%
Public Health Department	4	3.7%
Other	7	6.5%
Does your practice accept Medicaid Patients? (n = 104)		
Yes	83	79.8%
No	21	20.2%
Does your malpractice insurance contain a clause that limits you from prescribing psychotherapeutic medication to pregnant women? (n = 103)		
Yes	4	3.9%
No	57	55.3%
I Don't Know	42	40.8%
Does your office or clinic have a protocol for mental health screening in pregnancy? (n = 102)		
Yes	25	24.5%
No	70	68.6%
I Don't Know	7	8.8%
Does your office or clinic have a policy regarding treating pregnant		

women with serious mental illness? (n = 103)		
Yes	7	6.8%
No	85	82.5%
I Don't Know	11	10.7%

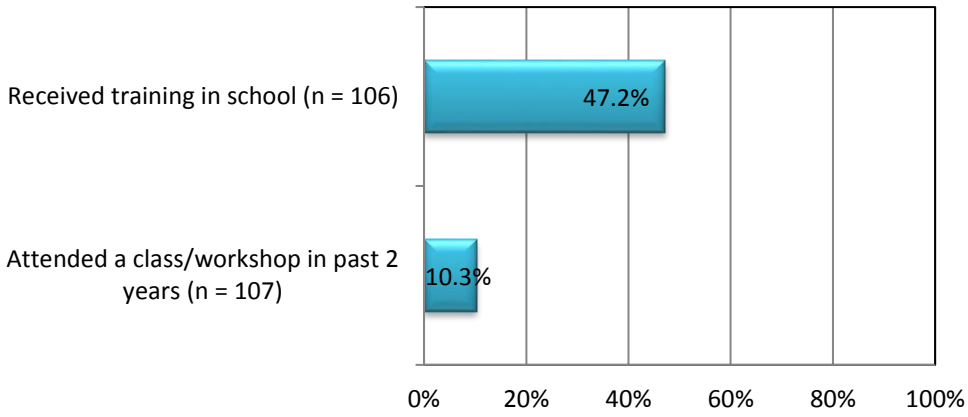
Providers' Background, Training, and Experience Treating Pregnant Women with SMI

Figure 1 depicts the providers' reported training in medical/nursing school and more recent training through workshops/classes in treating pregnant women with SMI. Forty-seven percent of providers reported they received training during school and/or internship/resident programs in treating this population. These providers were then asked about the adequacy/quality of their training:

- The majority (73 percent) said their training in treating pregnant women with SMI was minimal, limited, or very basic (e.g., lecture, briefly discussed).
- Only 11 percent said their training was very good or excellent.

To assess more recent training experiences, providers were asked if they had attended a class or workshop on prescribing psychotherapeutic medications in pregnancy. Approximately 1 in 10 indicated they had attended a class or workshop.

Figure 1. Provider Training and Preparation for Treating Pregnant Women with SMI



To determine providers' overall experience and treatment encounters, they were asked "in any given year, how many pregnant women with serious mental illness do you typically treat?" Provider experience was highly variable, with responses ranging from seeing 0 to 100 pregnant women with SMI in a given year (*mean (X)* = 15.7; *SD* = 24.2). Forty-three percent of providers had considerable experience treating this population, reporting they treated on average more than 10 pregnant patients with SMI a year.

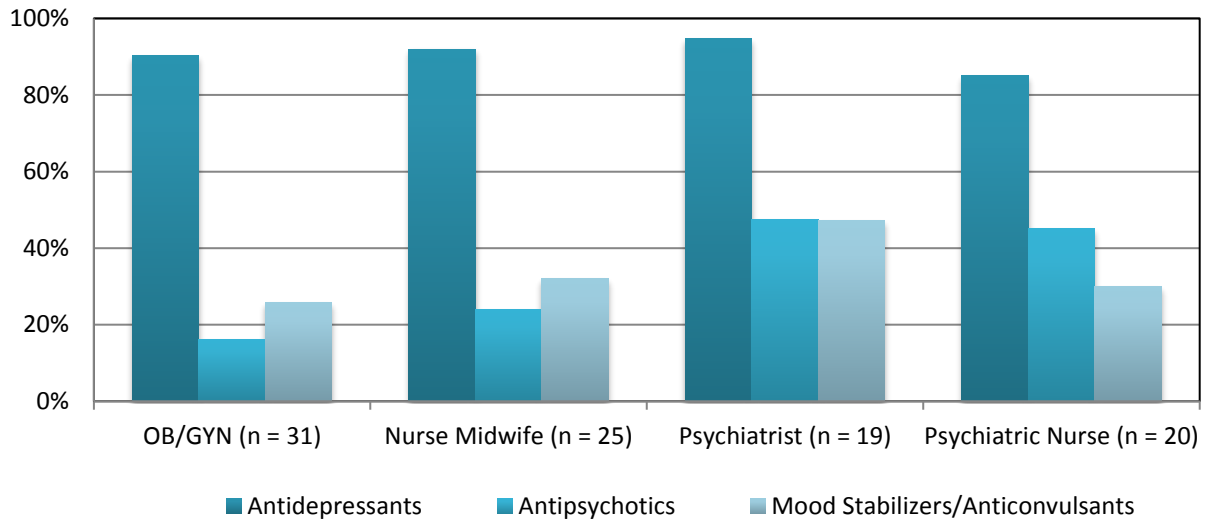
Providers were asked about whether they had experience in prescribing antidepressants,

antipsychotics, and mood stabilizers/anticonvulsants during pregnancy (See Figure 2):

- The vast majority of providers across specialties reported they had prescribed antidepressants to women during pregnancy (average of 91 percent).
- A minority of prescribers reported they prescribed antipsychotic or mood-stabilizer/anticonvulsant medication to pregnant women (16 to 47 percent).

Although psychiatrists and psychiatric nurses had more experience prescribing antipsychotic and mood stabilizing/anticonvulsant medications during pregnancy than OB/GYN doctors and nurse midwives, less than half of psychiatric providers reported having experience prescribing these medications during pregnancy (30 to 47 percent).

Figure 2. The Percentage of Providers with Experience Prescribing Psychotherapeutic Medication

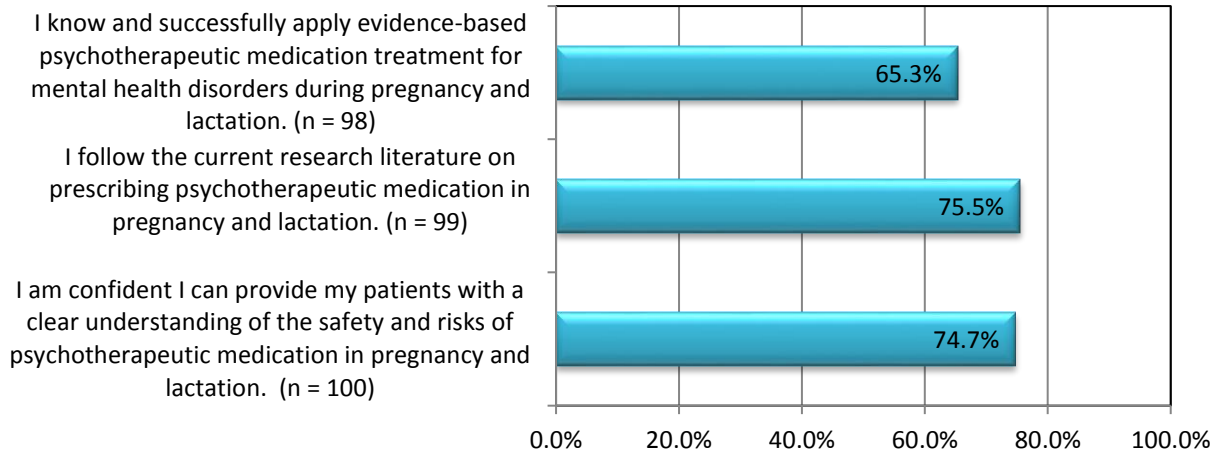


Providers' Knowledge of Evidence-Based Practice and Confidence in Providing Treatment

Figure 3 provides survey results regarding providers' knowledge and confidence in treating pregnant women with serious mental illness:

- 65 percent reported they usually or always were aware of and successfully able to apply evidence-based psychotherapeutic medication treatment for pregnant and lactating women.
- 75 percent reported they followed the current research literature in prescribing psychotherapeutic medication to pregnant/lactating women and were confident they could explain to patients the risk and benefits of these medications.

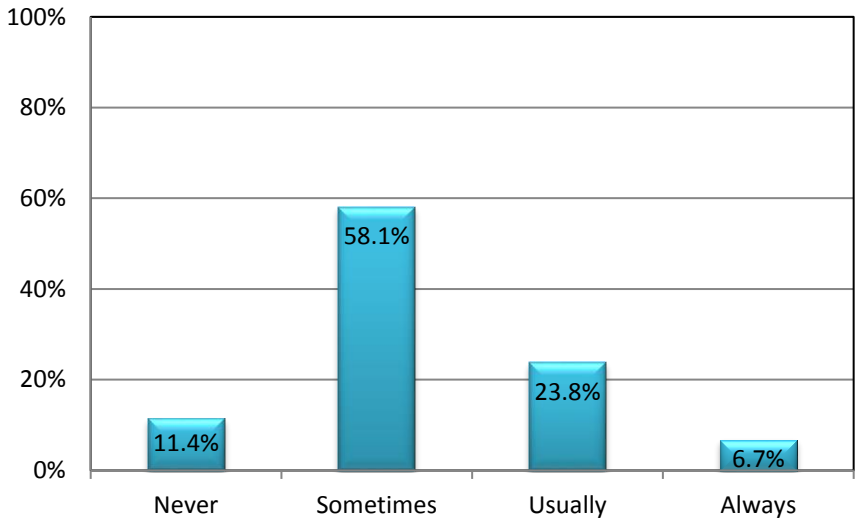
Figure 3. Providers' Self-Reported Knowledge and Confidence Treating Pregnant Women with SMI



Providers' Experiences with Care Coordination

Providers were asked about their experiences of care coordination between themselves and other providers when treating pregnant women with SMI, specifically how often it occurs when treating this patient population (See Figure 4). The results indicate that providers do not perceive care coordination to be the norm with each patient. The majority of providers reported that care coordination sometimes occurs (58 percent). An additional 11 percent reported that care coordination never occurs.

Figure 4. ***How often is there care coordination between an OB/GYN provider and a psychiatric provider in the treatment of pregnant women with mental health conditions?*** (n = 105)



Providers were also asked to identify any barriers they had experienced in coordinating care for pregnant patients with SMI (See Table 3). Many of the barriers providers reported overlapped with their responses to the question about the challenges they encountered when caring for pregnant women with SMI. Four themes were identified in the data:

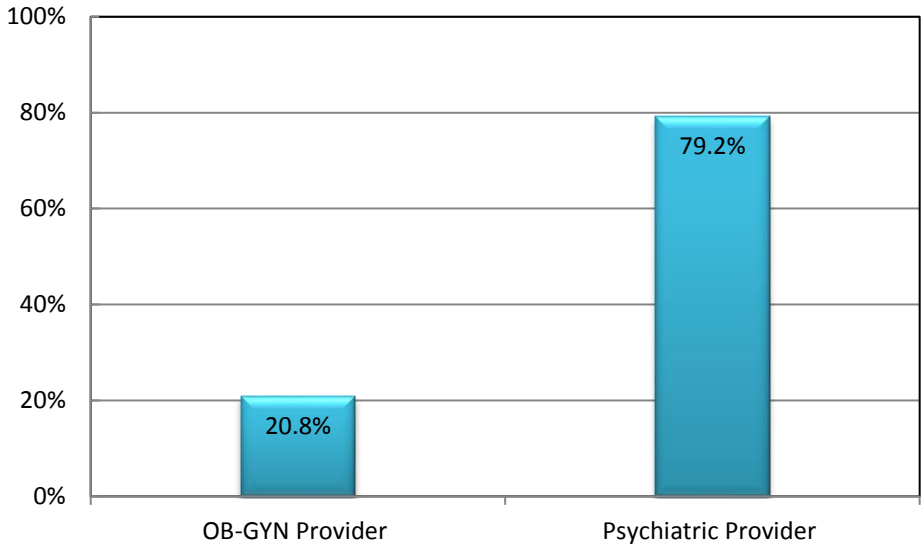
1. *Lack of Access to Mental Health Providers*. OB/GYNs and nurse midwives said this was the main barrier to care coordination – finding psychiatrists and mental health providers to treat pregnant women with SMI. In other words, there were no providers to work with in coordinating care for their patients.
2. *Providers Unwilling to Treat OB Patients with SMI.* Providers, particularly OB/GYNs and nurse midwives, speculated that psychiatrists did not want to treat this patient population out of fear and concerns regarding lawsuits and malpractice.
3. *Poor Communication and Provider Availability*. Providers said that poor communication and lack of provider availability was a barrier to care coordination as they had difficulty reaching providers by phone and/or getting them to return phone calls.
4. *Lack of Time.* Providers said that they did not have adequate time in their schedule to coordinate care for their patients.

Table 3. Providers' Perceived Barriers to Care Coordination

Themes	Examples
Lack of Access to Mental Health Providers	Lack of psychiatrists and counseling services, problems getting timely appointment
Psychiatric Providers Unwilling to Treat OB Patients with SMI	OB/GYN providers believed that psychiatric providers did not want the responsibility of caring for pregnant women with SMI out of fear of lawsuits and malpractice
Poor Communication and Provider Availability	Problems communicating with providers – providers are not available, do not returns calls
Lack of Time	No time in the provider's schedule to discuss the patient's case with other providers.

Surveyed providers were asked which provider – the OB/GYN or psychiatric provider – was mainly responsible for managing mental health conditions in pregnancy (See Figure 5). The majority of providers said the psychiatrist was primarily responsible for managing mental health conditions in pregnancy (79 percent). However, 1 in 5 said that it was the OB/GYN who was primarily responsible for managing mental health conditions in pregnancy (21 percent).

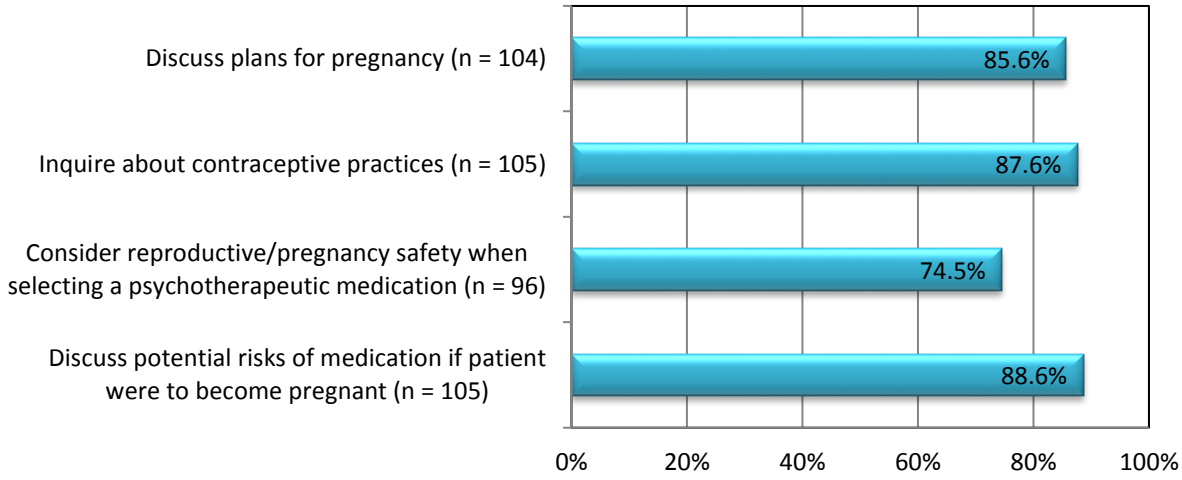
Figure 5. ***"Who is primarily responsible for managing mental health conditions in pregnancy?"*** (n = 96)



Consideration of Reproductive Health

The survey also assessed the extent to which survey participants discussed family planning and contraception with their patients, and took this into consideration when prescribing psychotherapeutic medications (See Figure 6**).** A majority of providers discussed patient plans for pregnancy (86 percent), asked patients about their contraceptive practices (88 percent), considered the reproductive safety of medications (75 percent), and discussed the risks of medication with patients (89 percent). Providers in psychiatry were just as likely as their counterparts in OB/GYN and midwifery to discuss family planning and contraception with their patients.

Figure 6. ***When you are treating women of reproductive potential, do you…?***



Treatment Challenges

Providers were asked about the primary treatment challenges they encounter in treating pregnant women with SMI**.** Table 4 provides the five main themes that were identified from provider responses to this open-ended question:

- *Lack of Access to Mental Health Care and Resources.* The most common challenge providers reported, especially among OB/GYNs and nurse midwives, was in referring their patients to psychiatrists and other mental health professionals. Providers reported their patients had difficulty getting an appointment with a psychiatrist or other mental health professional in a timely manner, and that there were limited community mental health resources for their patients.
- *Weighing the Risks and Benefits of Psychotherapeutic Medication in Pregnancy*. Providers reported that one of their biggest challenges was weighing the risks and benefits in treating mental health conditions during pregnancy with psychotherapeutic medications. Providers were equally concerned about the safety of psychotherapeutic medications in pregnancy and about the mother's mental health and risk of decompensation if not taking psychotherapeutic medication.
- *Patient Adherence to Treatment Recommendations.* The role of the patient was reported to be a treatment challenge, particularly taking medications as prescribed and keeping scheduled appointments.
- *Provider Communication/Collaboration.* Providers, particularly OB/GYNs and nurse midwives reported little or no communication with mental health providers and finding psychiatrists who were willing to collaborate in their patient's care.
- *Patient Comorbid Substance Abuse.* Providers also indicated that comorbid substance abuse presented a treatment challenge, especially in the context of a lack of access to psychiatric providers.

Table 4. ***What are the primary treatment challenges you encounter in caring for pregnant women with serious mental Illness?***

Themes	Examples
Lack of Access to Mental Health Care and Resources	Lack of available psychiatrists and counseling services, problems getting timely appointments, long wait times, inadequate community resources for mental health
Weighing the Risks and Benefits of Psychotherapeutic Medication during Pregnancy	Balance the mental health needs of mothers versus the safety of the fetus, explaining the risks and benefits of treatment to patients and their families, limited options for treatment with safe medications, breastfeeding
Patient Adherence to Treatment Recommendations	Adherence to medications, skipping appointments, being unwilling to seek mental health treatment, patient and family concerned over the safety of medications, stigma
Provider Communication/ Collaboration	Lack of communication with mental health providers, finding a psychiatrist with whom to collaborate and prescribe for OB/GYN
Comorbid Substance Abuse	Use of illicit drugs during pregnancy

Summary and Conclusions

A total of 107 providers completed the survey: 32 OB/GYNs, 26 Nurse Midwives, 24 Psychiatric ANRPs, 21 Psychiatrists, and four other provider specialties. Fifty-two surveys were completed online and 55 surveys were returned in the mail.

The following is a summary of the main survey results:

Practice Environment

- Survey participants worked in many different practice environments, most commonly working in private practice (37 percent).
- 80 percent of survey participants reported they provided medical services to Medicaid recipients.
- The majority of provider offices/clinics did not have policies and/or procedures for screening mental health conditions in pregnancy (69 percent) and treating pregnant women with SMI (83 percent).

Background and Training

- The vast majority of providers had minimal training in caring for pregnant women with SMI.
- 47 percent received maternal mental health training in their medical/nursing classes and/or internship/residence programs. However, 73 percent said that training was limited and/or very basic.
- 10 percent had received additional training in the past two years in prescribing psychotherapeutic medication to pregnant/postpartum patients.

Experience Treating SMI during Pregnancy

- Experience treating SMI during pregnancy was variable across providers.
    - On average, providers treated 16 pregnant women with SMI a year.
- 91 percent of all providers had prescribed antidepressants during pregnancy.
- Less than half of providers, including psychiatrists and nurse midwives, had prescribed antipsychotics and mood stabilizing/anticonvulsant agents during pregnancy (16 to 47 percent).

Provider Knowledge of Evidence-Based Practice and Confidence in Providing Treatment

- Between 65 and 75 percent of all providers reported they had stayed current with the maternal mental health literature, felt they were able to apply evidence-based psychotherapeutic medication management, and were able to provide their pregnant patients with a clear understanding of the safety and risks of psychotherapeutic medication.
- A small but sizable minority of providers (between 25 and 35 percent) reported they were

not confident in their knowledge and application of evidence-based practice and treatment for maternal mental health conditions.

Provider Experiences with Care Coordination

- 79 percent of providers reported that care coordination between OB/GYNs and mental health providers is not typical practice for them.
- The main barriers to care coordination identified by providers were: A lack of patient access to mental health providers (e.g., long wait times, do not take Medicaid); psychiatric providers being unwilling to treat OB patients with SMI; poor communication between providers; and the lack of time in a busy practice.
- 79 percent felt that psychiatric providers should be mainly responsible for mental health care and treatment in pregnancy.

Consideration of Reproductive Health

- Most providers discussed family planning and contraception with their patients (86 and 88 percent, respectively).
- Most considered safety when prescribing psychotherapeutic medications to women of reproductive age (75 percent) and felt able to communicate the risks of medication to the patient if she were to conceive (89 percent).

Treatment Challenges

- Providers identified five primary challenges they encountered in providing care to pregnant women with SMI: 1) A lack of access to mental health care and resources; 2) Weighing the risks and benefits of medication in treatment decisions involving pregnant women; 3) Ensuring patient adherence to treatment recommendations; 4) An inability to effectively communicate and collaborate with other providers; and 5) Caring for pregnant women with comorbid substance abuse.

<u>Conclusions/Recommendations</u>

The survey results suggest that there are system, community, provider, and patient-level barriers to the treatment and management of SMI in pregnancy. First, many providers believe that psychiatrists are primarily responsible for treating mental health conditions. However, this belief is not congruent with the practice realities in which there is a shortage of mental health providers. Survey participants, primarily OB/GYNs and nurse midwives, reported that this was their biggest treatment challenge, and a primary barrier to effectively coordinating patient care. In the absence of available psychiatric providers, another mechanism of care and collaboration must be identified such as working with the patient's primary care provider.

Furthermore, the majority of providers reported that their offices/clinics did not screen for mental health conditions or have protocols in place for managing pregnant women with SMI. Thus,

screening and treatment may be left up to individual providers who may not have sufficient training to manage mental health conditions. One out of three survey participants did not feel they had the knowledge or training to apply evidence-based psychotherapeutic medication management to their pregnant patients.

Although most providers had some experience treating SMI in pregnancy, particularly major depression, the majority had not treated schizophrenia or bipolar disorder in pregnancy (this was true for psychiatrists and psychiatric ARNPs as well).

Potential areas of action include building the capacity of providers to serve pregnant and postpartum women by:

- Developing and continually updating a resource list by region of mental health providers, their treatment specialties, insurances accepted, and other community resources (e.g., peer support).
- Bringing together Florida professional societies and other entities to host and support regional maternal mental health meetings to: 1) Train OB/GYN, psychiatric, and primary care providers in evidence-based screening and treatment for psychiatric conditions in pregnancy and the postpartum; 2) Provide guidance in developing office-based mental health screening, treatment, and care coordination protocols; and 3) Address access issues, community resources, and patient education.
- Providing support and guidance in treatment decisions, particularly to OB/GYN and primary care providers, through provider hotlines and care coordination resources modeled after programs such as the Moms MCPAP Program in Massachusetts (www.mcpapformoms.org).
- Engaging the newly formed Florida Perinatal Mental Health Workgroup and Collaborative in coordinating these efforts.

References

Byatt, N., Biebel, K., Debordes-Jackson G., Lundquist, R. S., Moore Simas, T. A., Weinreb L., and Ziedonis, D. (2013). Community mental health provider reluctance to provide pharmacotherapy may be a barrier to addressing perinatal depression: a preliminary study. *Psychiatr Q,. 84*(2), 169-74.

Cantilino, A., Lorenzo, L., de Paula, J. A., and Einarson, A. (2014). Use of psychotropic medications during pregnancy: perception of teratogenic risk among physicians in two Latin American countries. *Revista Brasileria de Psiquiatria, 36*, 106-110

Dillman, D. A. (1978). *Mail and Telephone Surveys: The Total Design Method*. John Wiley: New York, NY.

Dillman, D. A. (2000). *Internet and Mail Surveys: The Tailored Design Method*. John Wiley: New York, NY.

Field, T. S., Cordoret, C. A., Brown, M. L., Ford, M., Greene, S. M., Hill, D., … Zapka, J. M. (2002). Surveying physicians: Do components of the "Total Design Approach" to optimizing survey response rates apply to physicians? *Medical Care, 40*(7), 596-605.

Palladino, C. L., Fedock, G. L., Forman, J. H., Davis, M. M., Henshaw, E., and Flynn, H. A. (2011). OB CARES--The Obstetric Clinics and Resources Study: providers' perceptions of addressing perinatal depression--a qualitative study. *Gen Hosp Psychiatry, 33*(3): 267-278. doi:10.1016/j.genhosppsych.2011.02.001. Epub 2011 Mar 31.

Thorpe, C., Ryan, B., McLean, S. L., Burt, A., Stewart, M., Brown, J. B., . . . Harris, S. (2009). How to obtain excellent response rates when surveying physicians. *Family Practice, 26*, 65-68.

VanGeest, J. B., Johnson, T. P., and Welch, V. L. (2007). Methodologies for improving response rates in surveys of physicians: A systematic review. *Evaluation and the Health Professions, 30*(4), 303-321.

Appendix A: Women's Reproductive Health and Serious Mental Illness: A Survey of Florida Providers

Instructions: We know your time is valuable so have created a brief survey comprised of 29 questions to understand your background and experience treating pregnant women with serious mental illness during pregnancy. Please select the best response option. For the open-ended questions, please provide a detailed, explanatory response.

Thank you for completing the survey! We appreciate your time and effort!

1. Please indicate your practice specialty.
   - ☐ Obstetrics/Gynecology
   - ☐ Psychiatry
   - ☐ Other:_____

2. Please indicate your highest level of education and training.
   - ☐ APRN/Advanced Practice Registered Nurse (ARNP, CNP, CNS, CNM)
   - ☐ MD/Medical Doctor

3. What best describes your practice environment? *Please choose one response.*
   - ☐ Private practice
   - ☐ Group practice
   - ☐ Hospital-based practice
   - ☐ Academic-teaching center
   - ☐ Community mental health center
   - ☐ Other:_____

4. Does your practice accept Medicaid Patients?
   - ☐ No
   - ☐ Yes

     If YES, approximately what percentage of patients has Medicaid coverage?

     Percentage:_____

5. Does your malpractice insurance contain a clause that limits you from prescribing psychotherapeutic medication to pregnant women?
   - ☐ No
   - ☐ I don't know
   - ☐ Yes

     If YES, *please explain*:_____
     _____
     _____

6. Does your office or clinic have a policy regarding treating pregnant women with serious mental illness?

- ☐ No
- ☐ I don't know
- ☐ Yes

If YES, *please explain*:_____
_____
_____
_____

7. Does your office or clinic have a protocol for mental health screening in pregnancy?

- ☐ No
- ☐ I don't know
- ☐ Yes

If YES, *please explain*:_____
_____
_____
_____

8. Did you receive training during your residency/internship program in treating psychiatric disorders in pregnancy?

- ☐ No
- ☐ Yes

If YES, how sufficient was the training? *Please explain*:_____

_____
_____

9. <u>In the past 2 years</u>, have you attended a class or workshop on prescribing psychotherapeutic medications in pregnancy?

- ☐ No
- ☐ Yes

10. On average, how many pregnant women with serious mental illness (major depression, bipolar disorders, or schizophrenia) do you treat each year?

Estimated number of patients:_____

11. Please select the psychotherapeutic medications that you have experience prescribing in pregnancy. *PLEASE CHOOSE ALL THAT APPLY.*

- ☐ Antidepressants
- ☐ Antipsychotics
- ☐ Benzodiazepines
- ☐ Mood stabilizers/Anticonvulsants

12. What are the primary treatment challenges you encounter in caring for pregnant with serious mental Illness? *Please explain*:_____
_____
_____
_____
_____
_____

13. How do you weigh the risks and benefits of psychotherapeutic medication treatment, when making treatment recommendations to your pregnant patients who have a serious mental illness? *Please explain:*_____
_____
_____
_____
_____
_____

14. In your opinion, which provider is primarily responsible for managing the treatment of mental health conditions in pregnancy?

- ☐ OB/GYN
- ☐ Psychiatrist

15. In your experience, how often is there care coordination between an OB/GYN provider and a psychiatric provider in the treatment of pregnant women with mental health conditions?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

16. Please identify any barriers you have experienced with care coordination for this patient population:_____
_____
_____
_____
_____
_____

Please indicate your level of agreement with the following statements. Please circle one response per question.

Items	*Response Options*			
17. I know and successfully apply evidence-based psychotherapeutic medication treatment for mental health disorders during pregnancy and lactation.	Never	Sometimes	Usually	Always
18. I follow the current research literature on prescribing psychotherapeutic medication in pregnancy and lactation.	Never	Sometimes	Usually	Always
19. I am confident I can provide my patients with a clear understanding of the safety and risks of psychotherapeutic medication in pregnancy and lactation.	Never	Sometimes	Usually	Always

20. When you are treating women of reproductive potential, do you routinely discuss plans for pregnancy?

- ☐ No
- ☐ Yes

21. When you are treating women of reproductive potential, do you routinely inquire about contraceptive practices?

- ☐ No
- ☐ Yes

22. When you are treating women of reproductive potential, do you routinely consider reproductive/pregnancy safety when you select a psychotropic medication, even if the patient is not planning on becoming pregnant in the near future?

- ☐ No
- ☐ Yes

23. When you are treating women of reproductive potential, do you routinely discuss potential risks if the patient were to become pregnant while on her prescribed medication?

- ☐ No
- ☐ Yes

24. How many years have you been a licensed provider in the U.S.?

Number of Years:_____

25. What is your age?

Age in Years:_____

26. What is your sex?

- ☐ Female
- ☐ Male

27. Are you Hispanic, Spanish, or Latino?

- ☐ No
- ☐ Yes

28. What is your race? *PLEASE CHOOSE ALL THAT APPLY.*

- ☐ White
- ☐ Black or African American
- ☐ Asian or Pacific Islander
- ☐ American Indian or Alaska Native
- ☐ Other:_____

29. Please let us know how we can better assist you in providing optimal care to pregnant and postpartum women with serious mental illness.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

YOU HAVE COMPLETED THE SURVEY

THANK YOU FROM THE FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION AND

THE FLORIDA MEDICAID DRUG THERAPY MANAGEMENT PROGRAM FOR BEHAVIORAL HEALTH

HAVE A GREAT DAY!