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ACTING COMMISSIONER

January 7, 2015

Steven T. James, Clerk  
Massachusetts House of Representatives  
Room 145, State House  
Boston, MA 02133

William F. Welch, Clerk  
Massachusetts Senate  
Room 335, State House  
Boston, MA 02133

Dear Mr. Clerk,

Per Chapter 313 of the Acts of 2010, the Massachusetts Department of Public Health is pleased to issue an annual summary of the state Fiscal Year 2014 activities related to screening for postpartum depression.

Sincerely,

Eileen M. Sullivan  
Acting Commissioner

Cc: Representative Ellen Story (PPD Legislative Commission Co-Chair)  
Senator Thomas McGee (PPD Legislative Commission Co-Chair)

# **ANNUAL SUMMARY OF ACTIVITIES RELATED TO SCREENING FOR POST PARTUM DEPRESSION**

*Massachusetts Department of Public Health*

Fiscal Year 2014

## **Introduction**

On August 19, 2010, Governor Deval Patrick signed into law *An Act Relative to Post Partum Depression*, Chapter 313 of the Acts of 2010. This legislation has two primary components: the establishment of a postpartum depression (PPD) Legislative Commission and a requirement that the Massachusetts Department of Public Health (DPH) promote a culture of awareness, destigmatization, and screening for perinatal depression.

Specifically, DPH is charged with:

- Developing standards for effective PPD screening;
- Making recommendations to health plans and health care providers for PPD screening data reporting;
- Issuing regulations that require health plans and health care providers to annually submit data on screening for post partum depression; and
- Issuing an annual summary of the activities related to screening for postpartum depression including best practices and effective screening tools.

This report provides a summary of activities for state Fiscal Year 2014.

## **PPD Pilot Programs**

The FY14 budget included language requiring DPH to conduct a PPD pilot program at Community Health Centers (CHC). Four CHCs across the Commonwealth were funded to hire part time Community Health Workers (CHW) to assist with PPD screening and referral activities. A procurement waiver was granted and the contracts were established in the second quarter of state FY14. Funding for these contracts totaled \$200,000, distributed evenly across all sites. The four CHCs include Family Health Center in Worcester, Holyoke Health Center, Lynn Community Health Center, and Southern Jamaica Plain Health Center.

Each CHC developed CHWs job descriptions, hired part-time CHWs, and implemented an outreach plan that included the following components: program objectives; target populations; outcome/output measures; program content and strategies; internal and external linkages; consumer/community input; the roles and responsibilities of CHWs; and, orientation for other agency staff about the outreach program.

The CHCs were required to submit PPD screening data to DPH on a quarterly basis. The following is a summary of the data received for the last three quarters of state FY14.

- CHCs reported 1,503 face-to-face encounters with pregnant women with 607 (40%) receiving a PPD screen
- CHCs reported 1,059 face-to-face encounters with postpartum women with 839 (79%) receiving a PPD screen
- Of the 839 postpartum women who received a PPD screen, 50 (6%) scored either a 10, 11 or 12 on the Edinburgh Postnatal Depression Scale (EPDS) or 1 – 9 on the Patient Health Questionnaire (PHQ-9) indicating mild depressive symptoms
- Of the 839 postpartum women who received a PPD screen, 48 (6%) scored either a 13 or above on the EPDS or 10 or above on the PHQ-9 indicating moderate to severe depressive symptoms
- CHCs reported 817 face-to-face encounters by a CHW with a mother
- CHCs reported 407 indirect/collateral contacts, including phone calls, were made on behalf of the mothers serviced by the program
- CHCs reported 608 referrals being made
- CHCs reported 322 completed referrals where the mother was connected to resources

Finally, the following operational measures were implemented at each CHC to support the professional capacity of CHWs.

**Operational Measure #1 - Training:** Each community health worker shall attend a minimum of 28, with a goal of 42, hours of relevant professional training per year per DPH-funded FTE and be paid while attending training.

Among the nine CHWs working under the PPD Pilot Program across the four sites, a total of 173 hours of training were provided as follows (note: the number of funded FTEs were not reported for all CHWs):

- 1 CHW received 12 training hours
- 4 CHWs received 19 training hours each
- 1 CHW received 64 training hours
- 3 CHWs received 78 training hours each

Training opportunities included participation in the intensive Community Health Worker Trainings offered at two community based agencies across the state, attendance at the annual Partners in Perinatal Health conference, and participation at multiple workshops including “Promoting Maternal & Infant Mental Health,” and “Nighttime Breastfeeding and PPD.”

**Operational Measure #2 - Supervision:** Each CHW shall receive a minimum of one hour of supervision during every two-week period.

Among the nine CHWs working under the PPD Pilot Program across the four sites, a total of 96.25 hours of supervision were provided as follows (note: the number of funded FTEs were not reported for all CHWs):

- 1 CHW received 7 supervision hours
- 1 CHW received 7.25 supervision hours
- 3 CHWs received 18 supervision hours each
- 4 CHWs received 64 supervision hours each

## **Early Intervention Partnerships Program (EIPP) – PPD Screening**

The Massachusetts Early Intervention Partnerships Program (EIPP) is a high-risk maternal and newborn screening, assessment and service system. Implemented in 2003, EIPP has demonstrated capacity for the early identification of maternal and infant risk factors and linkages to services to prevent or mitigate poor health and/or developmental outcomes. Through a variety of interventions and strategies to foster continuity of care, EIPP works to address the complex physical, emotional, and environmental health needs of pregnant and postpartum women who may not be eligible for other programs such as Healthy Families.

EIPP provides home visiting and group services to over 550 families annually by a maternal child health (MCH) team that includes a MCH nurse, a mental health clinical professional, and a community health worker (CHW). EIPP provides maternal and infant health assessment and monitoring; health education and guidance; screening and appropriate referrals; and, linkage with Women, Infants and Children (WIC) nutrition program and other resources.

Program eligibility data collected during the first face-to-face encounter for all 6,292 EIPP participants enrolled between state FY03-FY14 indicates a high need population (note: mothers may meet more than one eligibility criteria):

<b>Percent</b>	<b>Eligibility Criteria</b>
84%	High level of stress
57%	Inadequate food or clothing
46%	History of depression including postpartum depression
40%	Homelessness or housing instability
22%	Tobacco use
22%	Current high risk pregnancy
12%	Substance abuse in the home
9%	Maternal age 20 years or younger with at least two children, including the current pregnancy or infant
8%	Violence in the home
7%	Pregnant woman with a previous poor birth outcomes (still birth or neonatal death; baby less than 1000 grams)
3%	Maternal age 21 or 22 years old with at least three children including the current pregnancy or infant
2%	Pregnant woman beginning prenatal care in the third trimester
2%	Postpartum woman who had inadequate or no prenatal care (Kotelchuck Adequacy of Prenatal Care utilization Index)
.01%	Hepatitis B positive

At intake, and at key stages of program engagement, all EIPP participants receive a Comprehensive Health Assessment (CHA) that assesses the social, emotional and physical well-being of the pregnant woman, mother and infant in the context of their family. This CHA includes a PPD screen. Mothers who screen positive for depression are then supported in accessing mental health services including counseling and support groups.

## **Massachusetts Home Visiting Initiative (MHVI)**

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act of 2010. This legislation is designed, at a minimum, to make quality affordable health care available to all Americans. A provision within the Act called the Maternal, Infant, and Early Childhood Home Visiting Program, provides \$1.5 billion nationally over five years to states, tribes, and territories to develop and implement one or more evidence-based maternal, infant, and early childhood home visiting model(s).

The Affordable Care Act and the Maternal, Infant and Early Childhood Home Visiting Program provision provides an unprecedented opportunity for states, tribes, and territories to improve health and development of high need children and families. In the spring of 2010, DPH was appointed by the Governor to be the lead agency on the Maternal, Infant, and Early Childhood Home Visiting Program, now known in Massachusetts as the MA Home Visiting Initiative (MHVI).

DPH and state partners developed and submitted a state plan to the federal government, in accordance with the specifications required by the legislation. Massachusetts was awarded both formula funding and competitive funding, providing the MHVI approximately \$9.05 million-\$10.66 million annually for five years.

MHVI is currently entering its fourth year of implementing the grant, funding evidenced-based home visiting programs including Parents as Teachers (PAT), Early Head Start, Healthy Steps, Healthy Families America, and Healthy Families Massachusetts. Depression screening is conducted with all program participants at key stages of program involvement and data is currently being analyzed by the MHVI Evaluation Team. Screens should be conducted within two months of enrollment, within two months of delivery, and at 6-month intervals. In the last three quarters of federal FY14, 59% of expected screenings for depressive symptoms were completed within the appropriate time frame.

In addition to funding evidence-based home visiting programs, MHVI is also providing enhancements to home visiting programs, such as Welcome Family and Moving Beyond Depression, to bolster program delivery and enhance statewide systems of care for children and families. In the last three quarters of federal FY14, 64 referrals were made to MBD as a result of screening for depressive symptoms conducted in MHVI home visiting programs.

### **Welcome Family (WF) – Universal PPD Screening**

During state Fiscal Year 2013, MHVI established a planning committee comprised of state and community stakeholders to develop a new program called Welcome Family (WF) that serves as an entry point for families into the larger system of care for women, infants and their families.

WF is a program that offers a universal, one-time nurse visit to mothers with newborns and their families. The visit is held within 8 weeks postpartum, lasts approximately 90 minutes and is conducted by a nurse with maternal and child health experience. All services are free.

The primary focus of WF is the mother and her newborn. The father of the baby, partners, family and friends are encouraged to participate in WF services with the permission of the mother. During the visit, the WF nurse assesses key focus areas including:

- maternal emotional health, including a PPD screen
- maternal and infant nutrition, including breastfeeding
- unmet health needs
- interpersonal violence
- substance use, including tobacco
- maternal and infant clinical assessment

Following the assessment, the nurse answers any questions and provides additional support and referrals as needed. All families participating in the program are given a WF bag that contains a swaddling blanket, water bottle, picture frame magnet, infant book, developmental toy, and nutrition guide. All mothers who have received a WF visit also receive a follow-up phone call to inquire about the outcome of the referrals made during the visit and ask if there are any additional needs or referrals required.

Marketing and outreach activities are conducted at the community level to identify and recruit mothers with newborns who are eligible for WF services. Relationships are fostered with potential referral sources in the community including OB-GYNs, midwives, birth hospitals, pediatricians, WIC, and others as appropriate.

Beginning in September 2013, two Welcome Family pilot sites began providing services to mothers of newborns in the communities of Boston and Fall River. Between 9/1/13 and 6/30/14, the Boston Public Health Commission and Fall River People Incorporated Welcome Family programs conducted 208 and 149 visits, respectively, in which a postpartum depression screen was offered.

In state FY14, two additional communities (Lowell and Lawrence) were awarded Welcome Family contracts with a service provision start date of July 1, 2014. A contract with Harvard Catalyst is in place to conduct an extensive evaluation of program services.

### **Moving Beyond Depression (MBD) – PPD Treatment Services**

Moving Beyond Depression/In-Home Cognitive Behavioral™ (MBD) is an evidence-based program that provides 15 In-Home Cognitive Behavioral Therapy™ (IH-CBT; Ammerman et al., 2007) sessions to women with clinical depression, delivered by a clinical masters-level social worker or equivalent mental health professional. The MBD team is augmented by doctoral-level clinicians with experience in CBT and perinatal depression who serve as supervisors.

MBD is uniquely and specifically adapted to meet the needs of mothers in home visiting, and addresses issues common to this population including trauma, relationship problems, and poverty. In MBD, therapists and home visitors work together to help mothers recover from depression and optimally benefit from home visiting. As demonstrated in a clinical trial, MBD

has been found to be highly effective in reducing depressive symptoms and their associated clinical complications.

Starting in October 2013, MHVI began implementing the Moving Beyond Depression program to pregnant women and mothers who are 1) experiencing clinical depression, and 2) who are also participants in the already contracted MHVI home visiting programs in the 17 identified communities: Boston, Brockton, Chelsea, Everett, Fall River, Fitchburg, Holyoke, Lawrence, Lowell, Lynn, New Bedford, North Adams, Pittsfield, Revere, Southbridge, Springfield, and Worcester. To date, a total of 162 referrals have been made to MBD with 115 assessments completed. Eighty-five women were enrolled in MBD with twenty-one women successfully completing treatment to-date.

MHVI currently has contracts in place with three mental health agencies that are collectively providing MBD to mothers in home visiting programs in the greater Springfield, Holyoke, Fitchburg, Leominster, Worcester, Revere, and Chelsea communities. Over the course of the summer and fall of 2014, MHVI is expanding MBD to cover mothers participating in other home-based programs and in additional communities. MHVI is also contracting with a fourth mental health agency to expand coverage to the southeastern part of Massachusetts. MHVI will continue working to expand MBD to ensure statewide coverage.

The program is delivered through a close partnership between home visiting programs and the agency providing the MBD/IH-CBT services. The fundamental steps of the program include:

- Home visitors administer a self-report depression screen (Edinburgh, CES-D, or equivalent) to identify mothers who may be eligible for treatment;
- The home visiting program refers the mother to the MBD therapist;
- MBD/IH-CBT clinical masters-level therapist meets with the mother in her home, conducts a thorough clinical assessment to determine eligibility , and officially enrolls her in MBD;
- Therapist provides 15 in-home IH-CBT sessions and a one-month booster to the mother; and
- Therapist and home visitor are in close communication during the course of treatment, conducting the 15<sup>th</sup> session as a joint session between the therapist and the home visitor.

Moving Beyond Depression™ was developed by Dr. Robert Ammerman & Dr. Frank Putnam at Every Child Succeeds, a regional home visiting program operated by the Cincinnati Children's Hospital Medical Center & University of Cincinnati College of Medicine in Cincinnati, Ohio.

## **Additional Activities and Products**

During state Fiscal Year 2014, additional activities have been conducted and products have been developed with the goal of supporting health care providers and health plans as DPH collaboratively implements the PPD Legislation. They include:

1. The web page dedicated to post partum depression on the DPH website continues to be updated with resources as they become available. It can be viewed at:  
<http://www.mass.gov/eohhs/gov/departments/dph/programs/family-health/postpartum-depression>
2. The PPD Pilot Program contracts at the four CHCs were established and data on the PPD Screening activities at each site was collected. Contracted agencies were supported in accessing training and technical assistance in program implementation.
3. Stakeholders were engaged in the development of the proposed PPD regulations which were presented to the Public Health Council on May 14, 2014. A public hearing was held on July 8, 2014 and written comments were solicited to allow further public consideration and comment. A total of six comments were received and revisions to the proposed PPD regulations are being considered.
4. DPH has worked diligently to finalize the PPD regulations and plans to present the final PPD Regulations to the Public Health Council for final approval.
5. At the request of the Massachusetts Behavioral Health Partnership, DPH continued participation in an advisory workgroup to the Massachusetts Child Psychiatry Access Project (MCPAP) for Moms program that provides psychiatric consultation and care coordination services to health care providers treating women with PPD.
6. At the request of the Massachusetts Department of Mental Health, DPH joined and participated in a quarterly statewide MCPAP for Moms Coordination Meeting.
7. DPH participated in the quarterly PPD Legislative Commission Meetings.
8. DPH began an ongoing evaluation process to assess the program effectiveness of the DPH funded home visiting programs including EIPP and the programs funded under MHVI including Welcome Family and Moving Beyond Depression.

## **Planned Next Steps**

The DPH tasks for the next state fiscal year include:

1. Promulgate the PPD Regulations requiring health care providers and carriers to annually submit data on screening for PPD.
2. Work with the All Payers Claim Database (APCD) at Center for Health Information and Analysis (CHIA) to collect the specific data elements from insurance claims with the service code S3005 attached. Once identified and collected, establish a mechanism for CHIA to share this PPD Screening data with DPH who can then analyze and report to the Legislators as required under the PPD Legislation.
3. Continue to support the PPD Pilot Programs at the four Community Health Centers in implementing universal PPD screening at their sites.
4. At the request of the Massachusetts Behavioral Health Partnership, continue to participate in an advisory group to the Massachusetts Child Psychiatry Access Project (MCPAP) for Moms program that provides psychiatric consultation and care coordination services to health care providers treating women with PPD.
5. At the request of the Massachusetts Department of Mental Health, continue to participate in a quarterly statewide MCPAP for Moms Coordination Meeting.
6. Continue to participate in the quarterly PPD Legislative Commission Meetings.
7. Continue to manage current EIPP contracts, ensure the provision of ongoing training, conduct periodic site visits with approved vendors to ensure program fidelity, and evaluate program effectiveness in identification of need and referral into services.
8. Continue WF service provision in Fall River, Boston, Lowell, and Lawrence, ensure the provision of ongoing training, conduct periodic site visits with approved vendors to ensure program fidelity, and evaluate program effectiveness in identification of need and referral to services.
9. Manage current and establish new MBD contracts, train mental health clinicians in required curriculum, begin and enhance service provision, conduct periodic site visits with approved vendors to ensure model fidelity and evaluate program effectiveness in reducing depressive symptoms among participating women.
10. As needed, maintain and update the DPH webpage dedicated to PPD.