The Commonwealth of Massachusetts

Executive Office of Health and Human Services

Department of Public Health

250 Washington Street, Boston, MA 02108-4619



CHARLES D. BAKER

Governor

KARYN E. POLITO

Lieutenant Governor

MARYLOU SUDDERS

Secretary

MONICA BHAREL, MD, MPH Commissioner

**Tel: 617-624-6000**

**www.mass.gov/dph**

October 7, 2019

Steven T. James

House Clerk

State House Room 145

Boston, MA 02133

Michael D. Hurley

Senate Clerk

State House Room 335

Boston, MA 02133

Dear Mr. Clerk,

Pursuant to Chapter 313 of the Acts of 2010, the Massachusetts Department of Public Health is pleased to issue a summary of Calendar Year 2018 activities related to screening for postpartum depression (PPD).

Sincerely,

Monica Bharel, MD, MPH

Commissioner

Department of Public Health

Cc: Representative James O’Day (PPD Legislative Commission Co-Chair)

 Senator Joan Lovely (PPD Legislative Commission Co-Chair)

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**CY18 Summary of Activities Related to Screening for**

**Postpartum Depression**

**October 2019**

**Legislative Mandate**

The following report is hereby issued pursuant to Chapter 313 of the Acts of 2010 as follows:

The Department of Public Health “*shall issue regulations that require providers and carriers to annually submit data on screening for postpartum depression. Following the receipt of data, the commissioner of public health shall issue an annual summary of the activities related to screening for postpartum depression, including best practices and effective screening tools. The department shall annually file the summary with the commissioner of public health and the clerks of the house of representatives and the senate not later than June 30; provided, however, that the first report is due not later than June 30, 2011.”*

**Introduction**

On August 19, 2010, Chapter 313 of the Acts of 2010, An Act Relative to Postpartum Depression, was signed into law. 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, de-stigmatization, 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 postpartum 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 Calendar Year 2018.

**PPD Regulations - 105 CMR 271.000**

*An Act Relative to Postpartum Depression, Chapter 313 of the Acts of 2010* charged DPH to issue regulations that require carriers and health care providers to annually submit data on screening for PPD. Understanding statewide PPD screening patterns and outcomes through relevant data reporting to DPH is intended to improve the detection of this prevalent condition and facilitate treatment for mothers in need of help.

The PPD Regulations (105 CMR 271.000) were promulgated in December 2014 and require annual reporting by a provider that conducts or oversees screening for PPD, using a validated screening tool, during a routine clinical appointment in which medical services are provided to a woman who has given birth within the previous six months. The regulation also applies to a carrier that receives a claim for this PPD screening.

TheProviders responsible for adhering to these regulations are OB-GYNs, Family Medicine Practitioners, and Advanced Practice Nurses including Nurse Midwives and Nurse Practitioners, and Physician Assistants, who practice in a family medicine/OBGYN setting.

Providers can report their PPD Screening data to DPH through an annual written report or through claims codes. Data collection began in CY2015. Providers are able to submit an annual written report to DPH by March 1 for the previous calendar year using the “Annual PPD Data Reporting Form” available on the DPH webpage dedicated to PPD at: <http://www.mass.gov/eohhs/gov/departments/dph/programs/family-health/postpartum-depression/ppd-regulations-on-screening-reporting-requirements.html>

Alternatively, Providers are able to use the HCPCS code of S3005 (Performance Measurement, Evaluation of Patient Self-Assessment, Depression) with a diagnostic range Z39.2 (Routine Postpartum follow up, formerly ICD9 V24 - Screening for Postpartum Depression) and with a modifier as a mechanism for reporting PPD screening.

|  |  |  |
| --- | --- | --- |
| Servicing Provider | Modifier for use with a positive PPD screen | Modifier for use with a negative PPD screen |
| OB-GYNs, Family Medicine Practitioners, Advanced Practice Nurses including Nurse Midwifes and Nurse Practitioners, & Physician Assistants | U1 | U2 |

Depending on the private carrier, the service code is set to pay at zero or at $0.01. Private carriers have been accepting this service code from the servicing providers identified above, and are reporting it directly to the All Payer Claims Database (APCD) at the Center for Health Information and Analysis (CHIA) as required under the PPD Regulations. Effective May 16, 2016, MassHealth began paying perinatal care providers for the administration of standardized depression screening during pregnancy and the postpartum period utilizing the above mentioned HCPCS code.

**PPD Data Collected through Claims Codes & Linkage with APCD**

**Background:** Chapter 313 of the Acts of 2010, An Act Relative to Postpartum Depression, called for submission of data on postpartum depression (PPD) screening to examine the frequency and scope of PPD among new mothers in Massachusetts. PPD defined as depression occurring within 12 months after giving birth, includes feelings of sadness, hopelessness and anhedonia—the loss of interest in previously pleasurable activities. PPD is an important public health issue with profound long-term consequences for mothers and families if left untreated, including impaired mother-infant bonding, delayed social and cognitive development in children, and increased risk of maternal suicide and infant death. It is recognized that greater than 50% of mothers with PPD are not identified and thus do not seek help from a health care or mental health professional.

**Methodology:** All Payer Claims Database (APCD) collected by the Center for Health Information and Analysis (CHIA) were linked to the Massachusetts birth certificate data for calendar years 2015 and 2016 CHIA has created a new APCD Master Patient Index (MPI) that assigns a single unique surrogate key to each person, regardless of how many different insurance carriers have submitted data about the person. APCD Data obfuscation begins by processing Member Eligibility (ME) data through CHIA’s data intake application called FileSecure which is deployed as on-premise software at the data submitter. FileSecure prepares Member Eligibility data for use in the APCD MPI. All legacy APCD data submitted to CHIA prior to the FileSecure application deployment has been prepared and securely hashed using the exact same logic that FileSecure uses to process newly submitted data. The birth certificate data were also standardized and hashed using the same logic. First name (hashed), last name (hashed), date of birth (hashed), and zip code (5 digit) were used in APCD MPI matching scoring. CHIA’s MPI solution employs a probabilistic approach that uses these fields to generate a score that represents how well a record matches to another record. When two records are compared, each field is given a CHIA-assigned weight based on whether the field values being compared agree, disagree, or if either of the fields is empty. Techniques used to accommodate minor variations such as misspellings and digit transpositions cannot be applied to hashed data. The weights from each field comparison are summed to determine the total record score. If the record score exceeds the CHIA-defined threshold, the records are considered a match and are linked together as a single entity (person). Records linked together are assigned a surrogate key known as a Member Enterprise ID, or MEID for short.

**Results:** During January 2016 and Dec 2016, there are 69,998 unique deliveries from birth certificate, of which 48,732 (69.6%) were linked to an APCD claim. The numbers of women screened for PPD within 6 months after delivery ranged from 28 in December 2016 to 594 in June 2016 (Figure 1). Since CHIA only link women who gave birth in 2016 to APCD records in 2016, the percentages of deliveries linked to APCD continuously decreased from January (77.0%) to December (62.5%). During January 2016 and December 2016, 5,879 (12.1%) out of 48,732 deliveries were screened for PPD and 634 (10.8%) had a positive screen.

The proportion of women who were screened for PPD was higher among white non-Hispanic (13.6%) and Asian (14.6%) compared to 8.1% and 9.7% among Hispanic and black non-Hispanic, respectively. The proportion of PPD screening was lower among women who were covered by Medicaid compared to others (8.9% vs. 15.0%). A higher proportion of screening was seen among women with higher levels of education and the percentage of screening increased with education level (Table 1).

When we look at the results of screening, Hispanic (15.3%) had higher positive proportion compared to white non-Hispanic (10.3%), Black non-Hispanic (10.4%), and Asian (8.3%). Among Puerto Rican women who received screening, 67 out of 301 are positive (22.3%). The positive proportion was higher among women who were covered by Medicaid than those on private insurance (14.1% vs. 8.9%). The positive percentage of screening decreased while women’s education level increased (Table 2).

Table 1. Women’s Characteristics by Status of PPD Screening, Jan 2016 -Dec 2016, MA

|  |  |
| --- | --- |
|   | **Screened** |
|  | **No** |   | **Yes** |
|   | **N** | **%** |  | **N** | **%** |
| ***Race/Ethnicity* ƚ** |  |  |  |  |  |
| White NH | 24,081 | 86.4 |  | 3,779 | 13.6 |
| Black NH | 5,241 | 90.3 |  | 560 | 9.7 |
| Hispanic | 8,892 | 91.9 |  | 786 | 8.1 |
| Asian/PI NH | 3,444 | 85.4 |  | 587 | 14.6 |
| AIndian | 192 | 89.7 |  | 22 | 10.3 |
| Other NH | 247 | 86.7 |  | 38 | 13.3 |
| Unknown | 756 | 87.6 |  | 107 | 12.4 |
| ***Insurance* ƚ** |  |  |  |  |  |
| Medicaid | 21,617 | 91.1 |  | 2,121 | 8.9 |
| Other | 21236 | 85.0 |  | 3758 | 15.0 |
| ***Education* ƚ** |  |  |  |  |  |
| <HS | 4,547 | 92.0 |  | 393 | 8.0 |
| HS/GED | 8,336 | 90.7 |  | 850 | 9.3 |
| Some College/Associate Degree | 12,132 | 88.6 |  | 1,563 | 11.4 |
| Bachelor Degree | 9,013 | 85.9 |  | 1,479 | 14.1 |
| Graduate Degrees | 7,689 | 84.8 |  | 1,380 | 15.2 |
| ***Preterm Birth*** |  |  |  |  |  |
| No | 39,340 | 87.9 |  | 5,426 | 12.1 |
| Yes | 3,456 | 88.5 |  | 450 | 11.5 |
| ***Plurality* ƚ** |  |  |  |  |  |
| Singleton | 42,083 | 88.0 |  | 5,742 | 12.0 |
| Multiple | 770 | 84.9 |  | 137 | 15.1 |
| ***Parity* ƚ** |  |  |  |  |  |
| 1 | 18,046 | 86.8 |  | 2,733 | 13.2 |
| 2 | 14,469 | 87.3 |  | 2,104 | 12.7 |
| 3+ | 10,183 | 90.8 |  | 1,034 | 9.2 |
| **Married ƚ** |  |  |  |  |  |
| No | 17,897 | 90.3 |  | 1,927 | 9.7 |
| Yes | 24,956 | 86.3 |   | 3,952 | 13.7 |

ƚ P<0.01

Table 2. Women’s Characteristics by Results of PPD Screening, Jul 2015-Jun 2016, MA

|  |  |
| --- | --- |
|   | **Screen Results** |
|  | **Negative** |   | **Positive** |
|   | **N** | **%** |  | **N** | **%** |
| ***Race/Ethnicity* ƚ** |  |  |  |  |  |
| White NH | 3,391 | 89.7 |  | 388 | 10.3 |
| Black NH | 502 | 89.6 |  | 58 | 10.4 |
| Hispanic | 666 | 84.7 |  | 120 | 15.3 |
| Asian/PI NH | 538 | 91.7 |  | 49 | 8.3 |
| AIndian | 18 | 81.8 |  | 4 | 18.2 |
| Other NH | 35 | 92.1 |  | 3 | 7.9 |
| Unknown | 95 | 88.8 |  | 12 | 11.2 |
| ***Insurance* ƚ** |  |  |  |  |  |
| Medicaid | 1,440 | 86.6 |  | 222 | 13.4 |
| Other | 3805 | 91.5 |  | 355 | 8.5 |
| ***Education* ƚ** |  |  |  |  |  |
| <HS | 336 | 85.5 |  | 57 | 14.5 |
| HS/GED | 719 | 84.6 |  | 131 | 15.4 |
| Some College/Associate Degree | 1,374 | 87.9 |  | 189 | 12.1 |
| Bachelor Degree | 1,360 | 92.0 |  | 119 | 8.0 |
| Graduate Degrees | 1,272 | 92.2 |  | 108 | 7.8 |
| ***Preterm Birth*** |  |  |  |  |  |
| No | 4,842 | 89.2 |  | 584 | 10.8 |
| Yes | 400 | 88.9 |  | 50 | 11.1 |
| ***Plurality*** |  |  |  |  |  |
| Singleton | 5,119 | 89.2 |  | 623 | 10.8 |
| Multiple | 126 | 92.0 |  | 11 | 8.0 |
| ***Parity*** |  |  |  |  |  |
| 1 | 2,433 | 89.0 |  | 300 | 11.0 |
| 2 | 1,905 | 90.5 |  | 199 | 9.5 |
| 3+ | 900 | 87.0 |  | 134 | 13.0 |
| ***Married* ƚ** |  |  |  |  |  |
| No | 1,635 | 84.8 |  | 292 | 15.2 |
| Yes | 3,610 | 91.3 |   | 342 | 8.7 |

 **ƚ** P<0.01

\* P<0.05

**PPD Data Collected through Written Reports**

For calendar year 2018, 2 Annual PPD Data Reporting Forms were received, 1 form from an insurance carrier and 1 form from a medical practice. Results from those sites include:

* The insurance carrier reported no postpartum patient encounters or screens during this time period
* The 1 practice reported screening 860 (93.0%) of 926 postpartum patients seen
* The practice reported using the Patient Health Questionnaire -9 (PHQ-9) to screen women for PPD.
* Overall, 53 women (7.0%) screened positive for PPD

**PPD Pilot Programs**

The FY19 budget included language requiring DPH to continue the PPD pilot programs at Community Health Centers (CHC) in three sites across the Commonwealth. A procurement waiver was granted and the contracts were reestablished in the second quarter of FY19. Funding for these contracts totaled $200,000, distributed evenly across all sites. This funding allowed the CHCs to continue to employ part time Community Health Workers (CHW) to assist with PPD screening and referral activities. The three CHCs included the Family Health Center in Worcester, Holyoke Health Center, and Lynn Community Health Center (LCHC).

The CHCs are required to submit PPD screening data on a quarterly basis to DPH for the time period services were provided. However, Holyoke Health Center did not submit the contract required quarterly reports; rather the agency submitted one report at the end of the fiscal year. In addition, Holyoke Health Center did not submit the contract required documentation ensuring the CHW receives the required training and supervision.

The following is a summary of the data received from Lynn Community Health Center and the Family Health Center in Worcester.

* CHCs reported 458 face-to-face encounters with pregnant women with 363 (79.3%) receiving a PPD screen.
* CHCs reported 698 face-to-face encounters with postpartum women with 218 (31.2%) receiving a PPD screen.
* Of the 219 postpartum women who received a PPD screen, 4 (1.8%) 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 219 postpartum women who received a PPD screen, 5 (2.3%) 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 320 face-to-face encounters by a CHW with a mother.
* CHCs reported 745 indirect/collateral contacts, including phone calls, were made on behalf of the mothers serviced by the program.
* CHCs reported 661 referrals being made with 499 (75.5%) referrals completed.

**Pregnancy Risk Assessment Monitoring System (PRAMS)**

Since 2007, DPH has monitored the health of women and children in the Commonwealth with the Massachusetts Pregnancy Risk Assessment Monitoring System (PRAMS), an ongoing survey of new mothers. The survey asks a set of two questions related to the experience of postpartum depression (PPD). Based on the most recent data available (2017, N=1,399), an estimated 10.7% of mothers in Massachusetts experience PPD symptoms always or often, 27.9% experience PPD symptoms sometimes, and 61.4% experience PPD symptoms rarely or never (Figure 1).

PRAMS data from 2017 suggests some Massachusetts mothers are more likely to report experiencing PPD symptoms. Compared to White non-Hispanic mothers (7.7%), Black non-Hispanic mothers (18.7%) and Asian non-Hispanic mothers (14.5%) were more likely to experience PPD symptoms often or always. Similarly, higher prevalence of PPD symptoms was observed among mothers with less than a high school education (17.2%) and high school education (15.6%) compared to mothers with a college education (7.1%). Although higher prevalence of PPD symptoms was observed among who are not married (14.3%) compared to mothers who are married (8.9%), this difference was not statistically significant after adjusting for maternal race/Hispanic ethnicity and education.

The 2017 PRAMS data also suggests that some Massachusetts mothers are less likely to be screened for PPD during their postpartum visit. Overall, 86.5% of mothers reported that their health care providers asked if they were depressed (proxy for PPD screening). Compared to White non-Hispanic mothers (89.4%), Hispanic mothers (79.3%) and Asian non-Hispanic mothers (83.6%) were less likely to be screened for PPD. Similarly, lower prevalence of PPD screening was observed among mothers with less than a high school education (74.1%) and high school education (80.7%) compared to mothers with a college education (90.4%).

**Early** Intervention Parenting Partnerships **(EIPP) – Social Connectedness & PPD Screening**

The Early Intervention Parenting Partnerships (EIPP) Program is a home visiting program for expectant parents and families with infants who are high need due to practical barriers (e.g., low financial resources, housing instability), emotional and/or behavioral health challenges (e.g., depression, substance use), or other stressors (e.g., immigration-related stress). The goals of EIPP are to:

* Connect families with local resources;
* Provide and build families’ social support;
* Appropriately engage families in health care systems;
* Provide parenting education;
* Promote positive parent-child attachment and healthy child development; and
* Support families experiencing multiple stressors to prevent child social and emotional delays, and link with Early Intervention (EI) services where appropriate.

EIPP provides home visiting and group services to over 300 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 parental and infant health assessment and monitoring; health education and guidance; screening and appropriate referrals; and linkage with WIC and other resources. Programmatic performance measures and parental and infant outcomes range from improved management of alcohol, tobacco and other drugs, improved parenting skills, improved emotional health, increased rates of exclusive breastfeeding, increased attendance at postpartum visits, and improved nutrition.

Data on the 353 EIPP Participants enrolled during CY18 include the following select eligibility criteria (participants may meet more than one):

**Percent Eligibility Criteria**

85.0% High level of stress

59.2% Inadequate food or clothing

52.4% History of depression including postpartum depression

37.7% Homelessness or housing instability

13.9% Less than a 10th grade education

12.5% Tobacco use

7.6% Substance abuse in the home

2.3% Violence in the home

At enrollment 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 participant and infant in the context of their family. This CHA includes both a Social Connectedness utilizing a three question survey and a PPD screen utilizing the Edinburgh Postnatal Depression Scale (EPDS).

In calendar year 2018, the results of a Social Connectedness Screen and a PPD Screen at 2 months postpartum are below:

Participants who screen positive for depression are then supported in accessing mental health services including counseling and support groups. In 2018, 100% of the EIPP participants identified with depression and/or a mental health disorder were connected to mental health services including individual counseling, support groups and/or couples/family counseling. Barriers to accessing mental health services included language, stigma, transportation, and lack of insurance for undocumented participants.

**Massachusetts Home Visiting Initiative (MHVI)**

Since the spring of 2010, DPH has been implementing the Maternal, Infant, and Early Childhood Home Visiting Program, a federally funded program for states, tribes, and territories to develop and implement one or more evidence-based maternal, infant, and early childhood home visiting model(s). Massachusetts’ program is known as the MA Home Visiting Initiative (MHVI).

In September 2018 DPH was awarded $7.2 million in federal funds ($200,000 of which was earmarked for an updated statewide Needs Assessment), marking the ninth year of funding. MHVI funds evidenced-based home visiting programs including Parents as Teachers, Early Head Start, and Healthy Families America.

Depression screening is conducted with all program participants and data are ~~is~~ analyzed for all 24 home visiting programs on a quarterly basis and with the annual report to the federal funding agency, the Health Resources and Services Administration (HRSA), each October. Screens are conducted within three months of enrollment and updated in compliance with model fidelity.

In federal FY18, 83% of expected screenings for depressive symptoms were completed within three months of enrollment.

**Welcome Family**

The Welcome Family program offers a universal, one-time nurse home visit to mothers with newborns and their families, regardless of age, income, or other criteria in five Massachusetts communities. The goal of Welcome Family is to promote optimal maternal and infant physical and mental well-being and provide an entry point into a system of care for families with newborns in Massachusetts. The visit is conducted within 8 weeks postpartum, lasts approximately 90 minutes, and is conducted by a nurse with maternal and child health experience. All services are provided at no cost to families. The primary focus of Welcome Family is the mother and her newborn, but any caregiver is eligible for a visit, including fathers, grandparents, adoptive, and foster parents.

During the visit, the Welcome Family nurse assesses the following six areas. Each area includes screening, brief intervention, education, and referrals to services as needed.

* Maternal emotional health, including a depression screen
* Maternal and infant nutrition, including breastfeeding
* Unmet health needs
* Intimate partner violence
* Substance use
* Maternal and infant clinical assessment

The nurse also spends time addressing the family’s questions or concerns. Participants receive a Welcome Family bag with gifts and information to support mom and baby. In addition, participants receive a follow-up phone call to inquire about the outcome of the referrals made during the visit and assess the need for any additional referrals.

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

Welcome Family is available to families living or giving birth in five communities: Fall River, Boston, Lowell, Holyoke, and Springfield. During 2018, 1,756 PPD depression screens were offered during Welcome Family visits. There were 307 positive PPD screens, of which 181 received a referral to services. Families who did not receive a referral received brief interventions by the Welcome Family Nurse if the family declined a referral.

*“I had some concerns about postpartum depression and being able to talk to the nurse about it helped a lot. I had never had postpartum depression previously so it was helpful to learn more about it from the nurse.”-Welcome Family Participant*

**Additional Activities and Products**

In CY18, additional activities were conducted and products were developed with the goal of supporting health care providers and health plans as DPH collaboratively implements the PPD Legislation.

1. In partnership with the PPD Legislative Commission subcommittee focused on community resources, DPH maintains and updates the web page dedicated to PPD on the DPH website with additional resources. It can be viewed at: <https://www.mass.gov/postpartum-depression>
2. At the request of the Department of Children and Families (DCF), DPH continues to provide quarterly PPD trainings to DCF social workers at their training center in Southborough.
3. At the request of the Boston Public Health Commission, a presentation on maternal mental health and maternal mortality in Massachusetts was conducted by DPH on February 22, 2018.
4. DPH worked collaboratively with the Department of Corrections on finalizing the Standards of Care for pregnant inmates that include a provision requiring PPD screening as required under the *Act to Prevent Shackling and Promote Safe Pregnancies for Female Inmates* signed into law in 2014.
5. DPH continues to make available free to the public the brochure entitled “Being a Mother is Hard Job” through the Massachusetts Health Promotion Clearinghouse at <http://massclearinghouse.ehs.state.ma.us/category/CHILD.html>
6. In collaboration with Judge Baker Children’s Services, DPH has completed work to assess, define, and standardize the EIPP model across all vendor sites.
7. DPH has funded Tufts University over the next three years to evaluate the effectiveness of the program.
8. DPH participated in the quarterly PPD Legislative Commission Meetings and the annual PPD Awareness Day event at the State House.
9. DPH Maternal Mortality & Morbidity Review Initiative published a Bulletin on maternal mortality and substance use in CY2018.

**Planned Next Steps**

During the next calendar year, DPH plans to:

1. Continue to offer and conduct training to DCF Social Workers on PPD and the impact of infant development at their training center.
2. Continue to provide training and technical assistance to providers and carriers on the PPD Regulations requiring annual reporting of data on screening for PPD.
3. Continue to 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 and support the mechanism for CHIA to share this PPD Screening data with DPH who can then analyze and report to the Legislature as required under the PPD Legislation.
4. Support the recently funded PPD Pilot Programs at the three Community Health Centers in implementing universal PPD screening at their sites.
5. Continue to participate in the quarterly PPD Legislative Commission Meetings.
6. 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.
7. Continue MHVI and Welcome Family service provision to ensure 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.