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October 10, 2013

Members of the Postpartum Depression Legislative Commission,

As mandated by 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 (FY) 2013 activities related to screening for postpartum depression to the clerks of the House of Representatives and the Senate of the Massachusetts General Court.

Sincerely,

Cheryl Bartlett

Cheryl Bartlett, RN
Commissioner

Cc: Governor Deval Patrick
Secretary John Polanowicz
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

October 2013

Introduction

Under the leadership of Representative Ellen Story and in collaboration with the Massachusetts Maternal & Infant Mental Health Advisory Group as well as a diverse group of advocates across the Commonwealth, legislation was drafted specific to post partum depression (PPD) and a bill was filed in 2009. On August 19, 2010, Governor Deval Patrick signed into law *An Act Relative to Post Partum Depression, Chapter 313 of the Acts of 2010.*

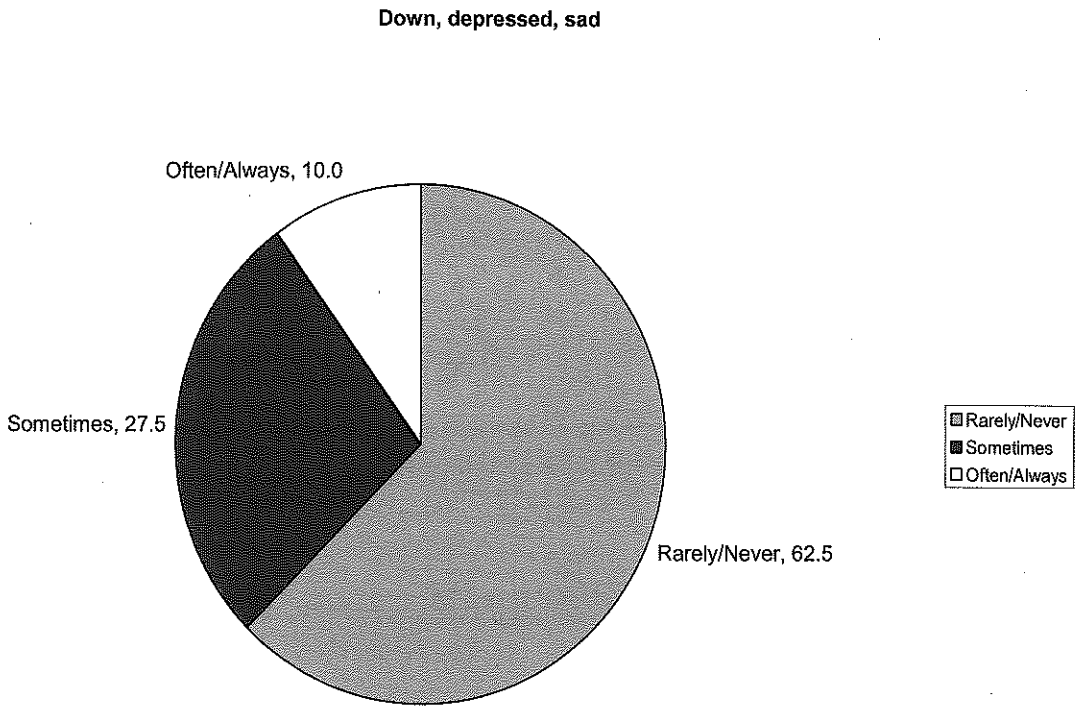
This legislation has two primary components: the establishment of a PPD Legislative Commission and a requirement that the Massachusetts Department of Public Health (DPH) promote a culture of awareness, de-stigmatization, and screening for perinatal depression. Specifically, DPH is charged with:

- 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 post partum depression; and
- Issuing an annual summary of the activities related to screening for post partum depression including best practices and effective screening tools.

This report provides a summary of activities for state fiscal year 2013.

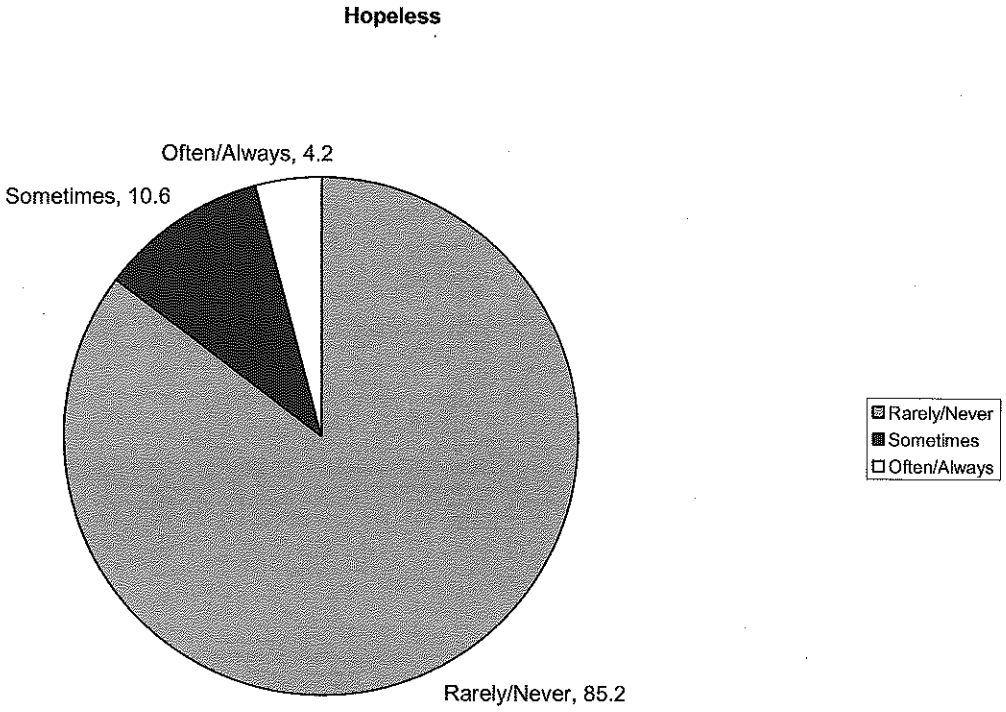
PRAMS – PPD Data

In 2013, DPH released the 2009-2010 Report for the Massachusetts Pregnancy Risk Assessment Monitoring System (PRAMS). This survey asks a set of three questions related to post partum depression. Of the nearly 1,400 mothers surveyed in 2010, 27.5% reported "sometimes" feeling down, depressed or sad and 10.0% reported "often" or "always" having these feelings.



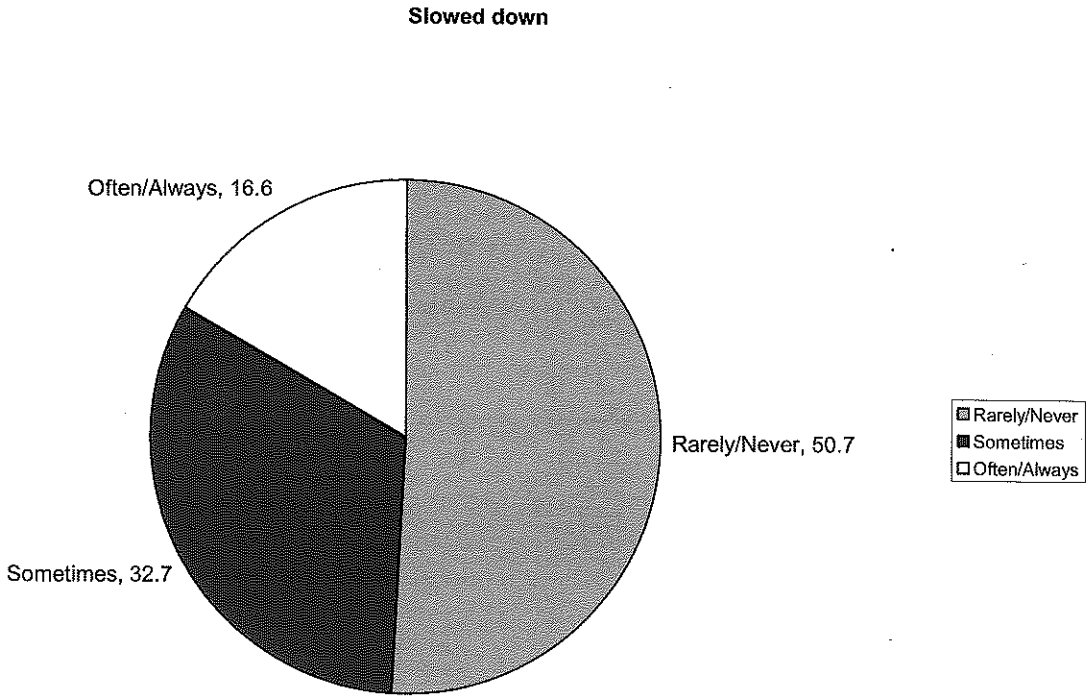
The occurrence of "often" or "always" feeling down, depressed, or sad was most prevalent among those living at or below 100% of the federal poverty level (16.3%).

Secondly, the PRAMS survey also asks how often mothers have felt hopeless in the post partum period. Overall, 4.2% of mothers reported that they "often" or "always" felt hopeless and 10.6% of mothers reported they "sometimes" felt hopeless in the post partum period.



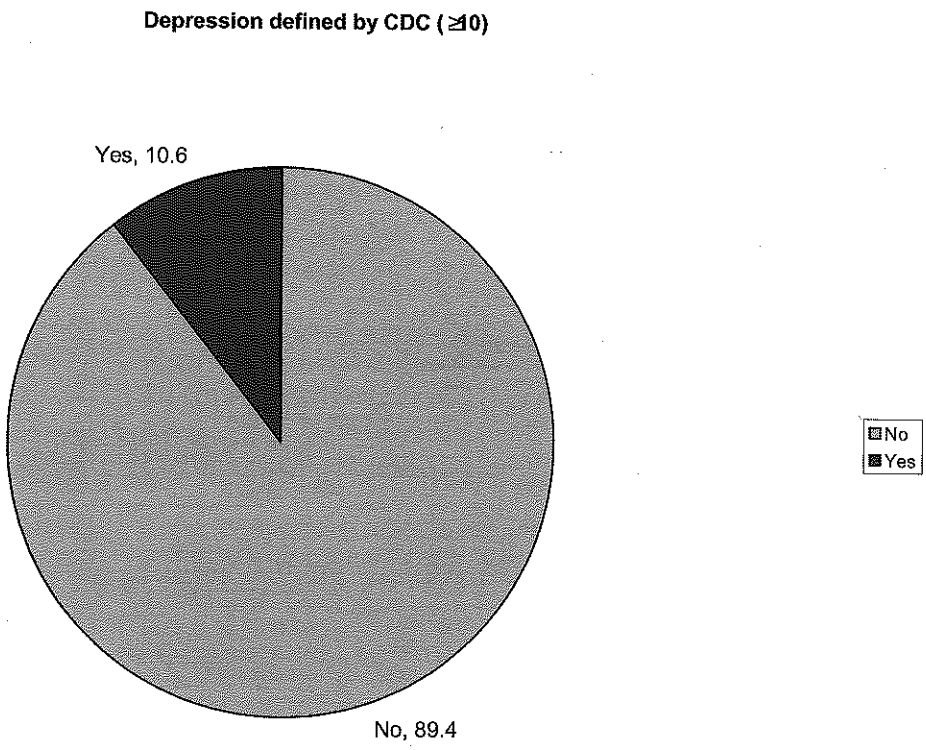
Similar patterns were observed with regard to feeling hopeless as well as with feeling down, depressed, or sad, with the most prevalent groups of mothers reporting "often" or "always" feeling hopeless being among those living at or below 100% of the federal poverty level (6.6%) and those with less than a high school education (11.9%).

Lastly, the PRAMS survey asks how often mothers have felt slowed down in the post partum period. Overall, 16.6% of mothers reported that they "often" or "always" felt slowed down and 32.7% reported "sometimes" feeling slowed down in the post partum period.

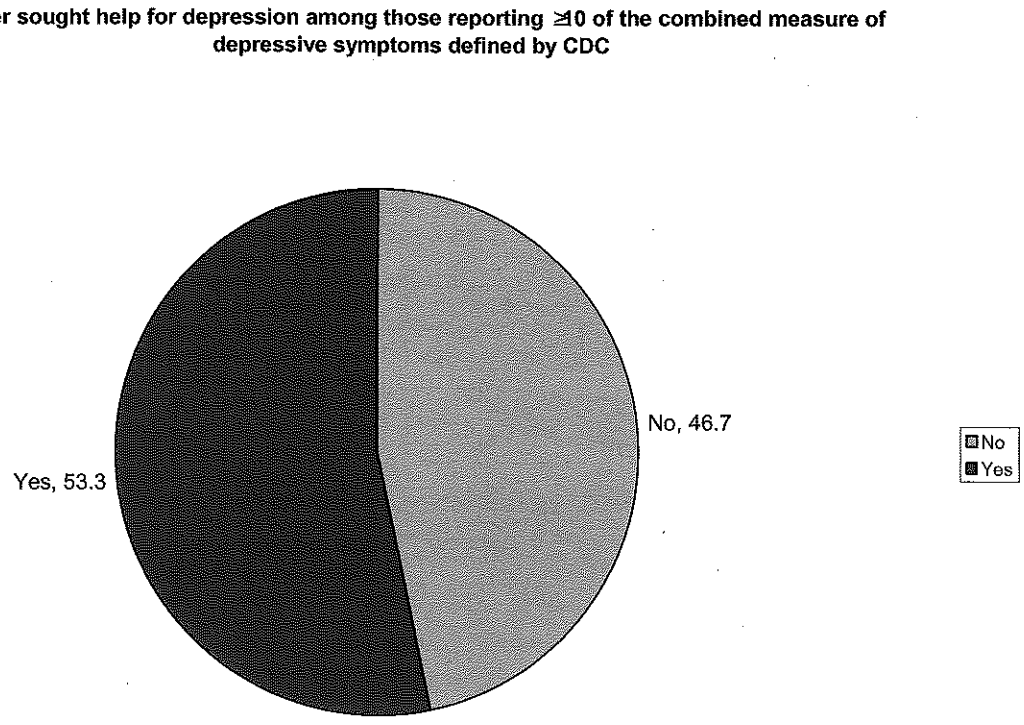


The Centers for Disease Control and Prevention (CDC) recommend summing the three related depression questions together (feeling depressed, hopeless or slowed down) with a score ranging from 1 to 5 for each question (always=5, often=4, sometimes=3, rarely=2, never=1) and using a cut off of ≥10 as an indication of post partum depressive symptoms.

Using this algorithm, 10.6% of mothers surveyed in Massachusetts experienced post partum depression.



Among all mothers, regardless of the frequency of feeling depressed or reporting a loss of interest, 12.6% of them sought help for depression in the time since their babies had been born. Among mothers reporting frequent experiences of depressive symptoms (those who have a depression symptom score ≥10), only about 53.3% reported that they had sought help for depression.



Citation: Massachusetts Department of Public Health. Massachusetts Pregnancy Risk Assessment Monitoring System (PRAMS) Data; 2010.

Massachusetts Home Visiting Initiative (MHVI)

On March 23, 2010, the President 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). Of this total amount, a portion was designated "formula funding" and was allocated to states and territories based on the percentage of children ages 0 – 8 living below 100% of the federal poverty level. The remaining funding was available to states on a competitive basis.

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, in collaboration with state partners, the Executive Office of Health and Human Services (EOHHS), Executive Office of Education (EOE), Children's Trust Fund (CTF), the Department of Children and Families (DCF), Department of Early Education and Care (EEC), the Department of Transitional Assistance (DTA), and the Office of MassHealth, formed a committee to work on applying for and implementing the MA Home Visiting Program.

First, DPH and partner agencies conducted a statewide needs assessment identifying which communities in MA were high-need based on data collected at the city and town level on numerous maternal, infant, and early childhood data indicators (per federal requirements). The 17 high-need communities are (in alphabetical order): Boston, Brockton, Chelsea, Everett, Fall River, Fitchburg, Holyoke, Lawrence, Lowell, Lynn, New Bedford, North Adams, Pittsfield, Revere, Southbridge, Springfield, and Worcester.

Once the high need communities were identified, 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 MA Home Visiting Initiative approximately $9.05 million - $10.66 million annually for 5 years.

The MA Home Visiting Initiative (MHVI) is currently entering its second year of implementing the grant. In addition to funding evidence-based home visiting programs, the 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.

Welcome Family (WF) – Universal PPD Screening

During state fiscal year 2013, the DPH Massachusetts Home Visiting Initiative (MHVI) established a planning committee comprised of state and community stakeholders to develop a new program called Welcome Family (WF) that would serve 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 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 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 will assess 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

Following the assessment, the nurse will answer any questions and provide 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 will 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.

In FY13, two contracts were established with community based agencies to pilot WF in Fall River and Boston. It is anticipated that WF services will begin in both communities in FY14. Harvard Catalyst has also been contracted with to conduct an extensive evaluation of program services.

Moving Beyond Depression (MBD) – PPD Treatment Services

During state fiscal year 2013, DPH MHVI has been working to establish contracts with mental health providers to provide the Moving Beyond Depression/ In-Home Cognitive Behavioral Therapy™ 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. It is anticipated that these contracts will be in place and services will begin in FY14.

Moving Beyond Depression™ (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.

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 needs and strengths, 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 15th 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 2013, additional activities have been conducted and products have been developed with the goal of supporting health care providers and health plans as we collaboratively implement 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. At the request of multiple community-based providers, a power point presentation that offers an overview of PPD and a background on the work conducted in response to the PPD legislation has been prepared and disseminated. This presentation is available on the DPH PPD webpage.

3. A power point presentation entitled "The Intersection of Public Policy, Public Health & the Nonprofit Sector: Massachusetts Postpartum Depression Initiative" was delivered at the annual Association of Maternal Child Health Programs (AMCHP) on February 11, 2013 in Washington, DC. This presentation was conducted in collaboration with Massachusetts State Representative Ellen Story and Liz Friedman of Motherwoman.

4. A power point presentation entitled "Maternal Post Partum Depression (PPD): Awareness, Identification and Response" was delivered at the Children's Trust Fund 20th Annual View from All Sides Conference on November 2, 2012. This presentation was conducted in collaboration with Barbara Prindle-Eaton from the Cape Cod Child Development Program and Mary Wilson from the Barnstable Council for Family & Community Engagement.

5. A single service code (S3005 with a diagnostic range V24) has been identified and agreed upon by health plans across Massachusetts to be used as a mechanism for reporting PPD screening by providers in their networks. The service code is set to pay at zero or at $0.01 depending on the health plan. The health plans have reconfigured their systems to accept this service code and will be reporting it directly to the All Payer Claims Database (APCD) at the Center for Health Information and Analysis (CHIA).

6. Stakeholders have been engaged in the development of the PPD regulations. DPH is working diligently to finalize the regulations and propose to the Public Health Council. Following the proposal, the draft will go through the public process, allowing for further public consideration and comment. .

Planned Next Steps

The DPH tasks for the next fiscal year include:

1. Promulgate the regulations requiring health care providers and health plans to annually submit data on screening for PPD.

2. Work with the APCD at CHIA to identify and collect the specific data elements from insurance claims with the service code S3005 attached. Once identified and collected, establish a mechanism to share this PPD Screening data with DPH who can then analyze and report to the Legislators as required under the PPD Legislation.

3. Begin service provision of WF in Fall River and Boston with a focus on universal PPD screening, conduct periodic site visits with approved vendors to ensure program fidelity, and evaluate program effectiveness in identification of need and referral into services.

4. Establish the MBD contracts, train mental health clinicians in required curriculum, begin service provision, conduct periodic site visits with approved vendors to ensure model fidelity and evaluate program effectiveness in reducing depressive symptoms among participating women.

5. At the request of the Massachusetts Behavioral Health Partnership, participate in a working group to explore the expansion of Massachusetts Child Psychiatry Access Project (MCPAP) services so that psychiatric consultation services are also made available to health care providers treating women with PPD.

6. Continue to work with health plans in Massachusetts to identify and resolve logistical and system configurations issues so that other providers, such as pediatricians and mental health providers, can be phased into the PPD screening data reporting process.

7. Develop a mechanism for the collection and analysis of PPD screening data collected from health care providers and health plans.