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June 30, 2016

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

William F. Welch
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 Fiscal Year 2016 activities related to screening for postpartum depression.

Sincerely,

Monica Bharel, MD, MPH
Commissioner
Department of Public Health

Cc: Representative Ellen Story (PPD Legislative Commission Co-Chair)
Senator Joan Lovely (PPD Legislative Commission Co-Chair)

Charles D. Baker
Governor

Karyn Polito
Lieutenant Governor

Marylou Sudders
Secretary

Monica Bharel, MD, MPH
Commissioner

FY16 Summary of Activities Related to Screening for Postpartum Depression

June 2016

Massachusetts Department of Public Health

Legislative Mandate

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

The postpartum depression (PPD) Legislative Commission "*shall file an annual report at the end of each state fiscal year with the governor and the clerks of the house of representatives and the senate, who shall forward the same to the joint committee on public health and the joint committee on financial services, along with recommendations, if any, together with drafts of legislation necessary to carry those recommendations into effect. The special commission may file such interim reports and recommendations as it considers appropriate.*"

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 Fiscal Year 2016.

PPD Pilot Programs

The FY16 budget included language requiring DPH to continue the PPD pilot programs at Community Health Centers (CHC) in four sites across the Commonwealth. A procurement waiver was granted and the contracts were reestablished in the third quarter of FY16. 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 four CHCs included the Family Health Center in Worcester, Holyoke Health Center, Lynn Community Health Center (LCHC), and Southern Jamaica Plain Health Center (SJPHC).

The CHCs are required to submit PPD screening data on a quarterly basis to DPH for the time period services were provided. The following is a summary of the data received from Holyoke Health Center, Lynn Community Health Center, and Southern Jamaica Plain Health Center. The Family Health Center in Worcester has not submitted the required data reports as of June 1, 2016.

- CHCs reported 564 face-to-face encounters with pregnant women with 191 (34%) receiving a PPD screen.
- CHCs reported 274 face-to-face encounters with postpartum women with 247 (90%) receiving a PPD screen.
- Of the 247 postpartum women who received a PPD screen, 26 (11%) 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 247 postpartum women who received a PPD screen, 19 (8%) 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 338 face-to-face encounters by a CHW with a mother.
- CHCs reported 516 indirect/collateral contacts, including phone calls, were made on behalf of the mothers serviced by the program.
- CHCs reported 24 referrals being made.

In the spring of 2016, a Master's level student from Tufts University conducted an evaluation of the PPD Pilot Programs. Activities included a survey of mothers participating in the program at Southern Jamaica Plain Health Center and key informant interviews with PPD Pilot Program staff at the Family Health Center in Worcester, Southern Jamaica Plain Health Center, and Lynn Community Health Center. Holyoke Health Center did not to participate in the evaluation.

Key results from the survey include:

- There were 51 women who completed the survey between February 23, 2016 and March 31, 2016 at Southern Jamaica Plain Health Center. The women surveyed were predominately non-Hispanic White, between the ages of 30 and 39, with an income over $70,000 a year. Most of the women also had a college education or higher and had private employer-sponsored health insurance. Sixty nine percent of the women surveyed reported being screened for PPD with 18% of these women reporting being screened both prenatally and postpartum.

- Southern Jamaica Plain Health Center *From the Beginnings Program* also provides infant feeding support, emotional support, connections to resources, and infant soothing support. Of the

services provided, surveyed women ranked the infant feeding support as the most useful, closely followed by general emotional support and connections to resources.

- Most women were very satisfied with the services provided by the *From the Beginnings* staff. For example, 90% of the women stated that they would be likely to ask a *From the Beginning's* staff member for help for depression. Furthermore, 97% of women trusted the CHWs to act in their best interest and 87% felt that the CHWs understood their concerns.

- The women surveyed reported feeling comfortable seeking out care for mental health concerns. Almost 90% of women stated that they were very comfortable or somewhat comfortable discussing depression with their family and friends. In addition, 85% of women knew where to find mental health services in their communities and 90% felt comfortable accessing mental health services in their communities.

- Eight three percent of women surveyed said that they would be likely to ask their healthcare provider for help. Only 6.5% of women said that they would be somewhat unlikely or very unlikely to approach their healthcare provider for mental health help. Furthermore, all women surveyed reported trusting their healthcare provider to act in their best interests and 91% of women felt that their healthcare provider understood their concerns.

Key results from the key informant interviews include:

- According to physicians, one of the greatest challenges to implementing universal screening in the health centers is time constraints. There are many other "competing demands for both staff and the women".

- Other challenges include the delays associated with getting psychiatric appointments, language and cultural barriers, confusing referrals processes, and a perceived lack of maternal interest in seeking help.

- The PPD Pilot Program has alleviated some challenges for physicians. Physicians stated that pre-implementation of the program, they attempted to universally screen women; however, there was no system in place to ensure that women were screened and follow-up with these women. Following implementation of the PPD Pilot Program, the care provided was more coordinated and they could create follow-up systems.

Recommendations:

- Currently, there are many inconsistencies in the data reporting. Each health center has a different definition of what each data element means. The definitions of what a contact with a pregnant or postpartum woman means must be standardized across all four health centers in order to standardize the results.

- Each health center has implemented the Pilot Program differently. As such, each health center has a different screening, referral, and follow-up system. Therefore, it is recommended that the program model be assessed, defined, standardized, and documented, and that an operations manual is produced.

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.

The Providers 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/

Alternatively, Providers are able to use the HCPCS code of S3005 (Performance Measurement, Evaluation of Patient Self-Assessment, Depression) with a diagnostic range 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 carrier, the service code is set to pay at zero or at $0.01. 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.

For calendar year 2015, 66 Annual PPD Data Reporting Forms were received. The results include:

- Fifty six sites reporting using the Edinburgh Postnatal Depression Scale (EPDS), six sites reported using the Patient Health Questionnaire -9 (PHQ-9) and 4 sites reporting using the Postpartum Depression Screening Scale (PDSS) to screen women for PPD.

- There were 8,748 patients reported screened for PPD during 10,248 visits.

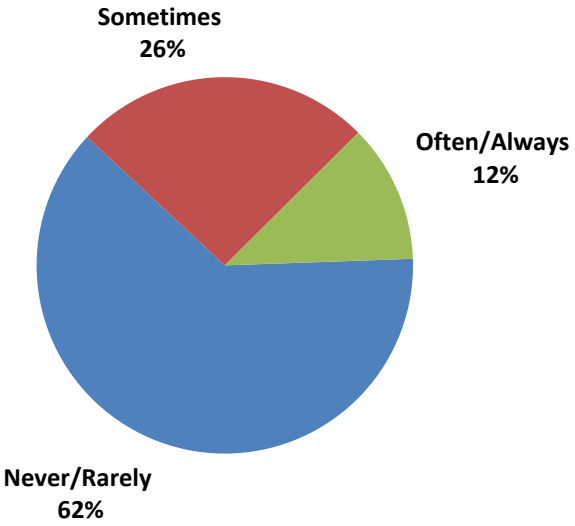
- A total of 85.35% patients seen were screened for PPD. Of those, 552 screened positive for PPD.
- Overall, 6.3% of women screened positive for PPD, but there were large variations by site. For example, many sites with a small number of patients reported 0.0% of women screening positive for PPD, while 3 sites reported ≥20.0% women screening positive.
- Sixteen sites had a PPD prevalence of ≥ 10% of the population screened.
- Another 17 sites had a PPD prevalence between 5-10% of the population screened.

DPH continues to work with the All Payer Claims Database (APCD) at the Center for Health Information and Analysis (CHIA) to define the process to access the claims utilizing the S3005 claims code. An IRB application has been submitted and is pending review and approval.

Pregnancy Risk Assessment Monitoring System (PRAMS)

In 2016, DPH will release the 2012-2013 data for the Massachusetts Pregnancy Risk Assessment Monitoring System (PRAMS). This survey asks a set of two questions related to PPD. Of the nearly 3,000 mothers surveyed, 11.9% of mothers reported always or often having postpartum depressive (PPD) symptoms, 25.6% reported sometimes having these depressive symptoms, and 62.5% reported never or rarely having PPD symptoms (Figure 1).

Figure 1. Frequency of self-reported postpartum depressive symptoms, MA PRAMS, 2012-2013



All mothers should be screened for PPD. However, PRAMS data suggested some Massachusetts mothers are more likely to report experiencing PPD symptoms. Compared to White non-Hispanic mothers, Asian non-Hispanic and other non-Hispanic groups have a higher prevalence of PPD symptoms, while Hispanic mothers have lower prevalence of PPD symptoms. Mothers with less than college education and mothers who are not married have higher prevalence of PPD symptoms compared to mothers who completed college and compared to mothers who are married.

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 after a one year planning process by an Expert Working Group, EIPP provides services to women with an identified maternal or infant risk factor and links them to services to improve health and 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.

EIPP provides home visiting and group services to over 500 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 WIC and other resources. Programmatic performance measures and maternal 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.

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 utilizing the Edinburgh Postnatal Depression Scale (EPDS).

Of the 493 women enrolled in EIPP between July 1, 2015 and May 31, 2016, 483 were screened for PPD at the initial visit. The results of those screens include:

- 328 women (68%) scored between 0-9 indicating no or minimal symptoms of PPD
- 59 women (12%) scored between 10-12 indicating mild depressive symptoms
- 96 women (20%) scored 13 or higher indicating moderate to severe depressive symptoms

Mothers who screen positive for depression are then supported in accessing mental health services including counseling and support groups. Between July 1, 2015 and May 31, 2016, 79.76% of the EIPP Participants identified with depression and/or a mental health disorder were connected to mental health services. Barriers to accessing mental health services included language, transportation, and lack of insurance for undocumented women.

Massachusetts Home Visiting Initiative (MHVI)

Since the spring of 2010, DPH has been spearheading 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 April 2016, DPH was awarded $6.8 million in federal funds, marking the sixth year of funding. MHVI funds evidenced-based home visiting programs including Parents as Teachers (PAT), Early Head Start, and Healthy Families America. Depression screening is conducted with all program participants at key stages of program involvement and data is analyzed for all 21 home visiting programs on a quarterly basis and with the annual report to the federal funding agency, HRSA, each October. Screens are conducted within two months of enrollment, within two months of delivery, and at 6-month intervals. In federal FY15, 79% of expected screenings for depressive symptoms were completed within the appropriate time frame.

Welcome Family

Welcome Family is a program that offers a universal, one-time nurse visit to mothers with newborns and their families, and serves as an entry point for families into the larger system of care for women, infants, 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 provided at no cost to those served by the program.

The primary focus of Welcome Family is the mother and her newborn. The father of the baby, partners, family, and friends are encouraged to participate in Welcome Family services with the permission of the mother. During the visit, the Welcome Family 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 Welcome Family bag that contains a swaddling blanket, water bottle, picture frame magnet, infant book, developmental toy, and nutrition guide. All mothers who have received a Welcome Family 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 Welcome Family services. Relationships are fostered with potential referral sources in the community including OB-GYNs, midwives, birth hospitals, pediatricians, WIC, and others as appropriate.

Welcome Family is available in four pilot communities: Fall River, Boston, Lawrence, and Lowell. During FY15, 1,127 PPD depression screens were offered during Welcome Family visits. There were 124 positive PPD screens, of which 75 received a referral to services. Welcome Family is expected to expand to two additional communities – Holyoke and Springfield – beginning July 1, 2016.

Additional Activities and Products

In FY15, 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 began the process for updating the web page dedicated to PPD on the DPH website with additional resources. It can be viewed at: http://www.mass.gov/eohhs/gov/departments/dph/programs/family-health/postpartum-depression

2. At the request of the Department of Children and Families (DCF), DPH has drafted a training curriculum on PPD specifically for child welfare workers. This training will be offered to DCF social workers at regional offices across the state during FY17.

3. DPH secured funding to reproduce the brochure entitled "Being a Mother is Hard Job." This brochure is available for free to Massachusetts residents and health care providers and can be ordered through the Massachusetts Health Promotion Clearinghouse at http://massclearinghouse.ehs.state.ma.us/category/CHILD.html

4. On Friday April 8, 2016, DPH staff conducted a workshop entitled "Both Sides Now: Enhancing the System of Care for Social and Emotional Wellness of Infants and Caregivers in Massachusetts" at the annual Association of Maternal Child Health Programs (AMCHP) conference held in Washington, DC. Information on the PPD Regulations was shared as part of this presentation.

5. DPH secured funding to assess, define, standardize and evaluate EIPP over the next several years. DPH solicited bids for a qualified vendor during FY16. The contract is expected to be awarded in late June 2016 with the planned start date of July 1, 2016.

6. DPH participated in the quarterly PPD Legislative Commission Meetings.

7. DPH continued with an ongoing evaluation process to assess the program effectiveness of the programs funded under MHVI including Welcome Family.

Planned Next Steps

During the next fiscal year, DPH plans to:

1. Work collaboratively with the four PPD Pilot Programs to assess and define the program model.

2. Offer and conduct training to DCF Social Workers on PPD and the impact of infant development at regional offices across the state.

3. Continue to update and make improvements to the PPD page on the DPH website in partnership with the PPD Legislative Commission subcommittee focused on community resources.

4. Continue to provide training and technical assistance to providers and carriers on the PPD Regulations requiring annual reporting of data on screening for PPD.

5. 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 establish a 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.

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 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.