



***Moving on Maternal Depression (MOMD) Change Package:
Improving Perinatal Depression Screening and Follow-up Services and
Reducing Racial/Ethnic Disparities***

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Section 1: Why

Maternal Mental Health Conditions Are a Leading Cause of Pregnancy-Related Deaths

The rate of maternal mortality in the U.S. is three times greater than any other developed country, and it is rising.¹ More moms are dying today than 20 years ago. In Pennsylvania, the rate has doubled since 1994, increasing to 14 deaths per 100,000 live births during pregnancy or within 42 days after pregnancy.²

In the U.S. and Pennsylvania, **maternal mortality rates are about 3x higher for Black women than for white women.**³ These racial disparities exist regardless of education and social economic status, and are mainly due to systemic racism.⁴

In regard to pregnancy-related deaths up to one year after birth,⁵ the leading causes include cardiovascular conditions, hemorrhage, infection, embolism, cardiomyopathy, **mental health conditions** (e.g., depression, anxiety, affective disorders with psychotic episodes and psychosis, and substance use disorder), and preeclampsia and eclampsia.⁶ Half of these deaths occur in the postpartum period.⁷ And over 60% of the deaths are preventable due to factors, such as missed warning signs, misdiagnosis, ineffective treatments, and lack of coordination between providers.⁸

Perinatal depression is the #1 complication during pregnancy and the postpartum period, affecting 1 in 7 women. 10-20% of pregnant women will experience a major depressive disorder during the postpartum period, and maternal suicide exceeds other medical causes of maternal mortality, such as hemorrhage and hypertensive disorders.⁹ Maternal depression and anxiety also have an effect on child and adolescent development.¹⁰

Mood disorders are significantly more prevalent among Black women due to stressors of lifelong systemic racism. However, perinatal depression is often unrecognized because the changes in sleep, appetite, energy, and motivation levels along with other symptom changes are commonly attributed to “normal” postpartum changes.

¹ [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(16\)31470-2/fulltext?code=lancet-site](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)31470-2/fulltext?code=lancet-site)

² https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm?s_cid=mm6818e1_w

³ <https://www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm>

⁴ <https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html> and <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1470581/> and <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5657505/>

⁵ <https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm>

⁶ <https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/mmr-data-brief.html>

⁷ https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm?s_cid=mm6818e1_w

⁸ <https://www.cdcfoundation.org/sites/default/files/files/ReportfromNineMMRCs.pdf>

⁹ <https://www.acog.org/-/media/project/acogorg/clinical/files/committee-opinion/articles/2018/11/screening-for-perinatal-depression.pdf> and <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5957550/> and <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5177526/>

¹⁰ <https://jamanetwork.com/journals/jamapediatrics/article-abstract/2770120>

Cultural bias and stigma also impact the mental health identification and treatment rates. Cultural influence and stigma associated with mental health may prevent a mother from seeking the help they need if they experience mood or anxiety disorders. A birthing person may also feel isolated within their own interpersonal relationships, lacking practical and emotional support system because they “feel different.”

Due to the disproportionate impact of maternal health disparities, the gaps in depression screening and follow-up, and the impact of systemic racism, this MOMD Change Package is focusing on best practices to improve maternal depression screening and follow-up and reduce racial disparities.

Opportunity to Improve Maternal Depression Screening and Follow-Up Services

There is a significant opportunity to improve universal screening for perinatal depression – only 20% of mothers report symptoms to a healthcare provider.¹¹ This is amplified across Black women and women who have low-income, leading to disparities.¹²

Based on the Pennsylvania Performance Measures, where the Managed Care Organizations (MCOs) audit a random selection of charts, the weighted average across the Physical HealthChoices MCOs in 2019 was as follows:¹³

Prenatal Period

- 74% for prenatal depression screening when any type of screen was used, *but only 47% for prenatal depression screening when using a validated screening tool*
- 80% for follow-up services (evaluation, treatment, or referral) among those who screened positive during the prenatal period

Postpartum Period

- 77% for postpartum depression screening, *but only 60% for postpartum depression screening when using a validated screening tool*
- 89% for follow-up services (evaluation, treatment, or referral) among those who screened positive during the postpartum period

(Member-level data (e.g., race, ethnicity, and location) are not publicly available for these measures.)

This data suggests an opportunity to improve the use of validated screening tools and to understand the degree to which follow-up evaluation or referral is resulting in treatment.

¹¹ <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2018/11/screening-for-perinatal-depression.pdf>

¹² <https://www.nationalpartnership.org/our-work/resources/health-care/maternity/listening-to-Black-mothers-in-california.pdf>

¹³ http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/communication/s_002206.pdf

The Pennsylvania Department of Human Services' claims-based analyses of Current Procedural Terminology (CPT) codes indicate lower depression screenings rates compared to the above PA Performance Measures. However, it is likely the screens are being under-reported with the CPT codes. Claims-based analyses of mental health diagnostic codes are likely under-reported for Black and Hispanic populations as well. **Overall, there is an opportunity to improve documentation of data related to perinatal depression screening and follow-up.**

Claims-based data analyses also suggest the percent of Black pregnant women who received prenatal care is less than white pregnant women. Other analyses with Healthcare Effectiveness Data and Information Set (HEDIS) measures and chart reviews suggest this disparity exists for postpartum care as well.

In the future, the updated **Obstetrical Needs Assessment Form (ONAF)**¹⁴ may be the best way to track prenatal and postpartum depression screening and follow-up.

Systemic Racism is a Public Health Crisis, Affecting Maternal Depression Screening and Follow-up Rates

Black, brown, and indigenous populations have endured centuries of institutionalized harm and racism in the United States. Various social factors, such as community conditions, inadequate access to quality medical providers, lack of unbiased medical providers who are representative of the Black and brown communities they serve, unaffordable housing, inequitable school funding, incarceration, food insecurity, and socioeconomic factors, influence a person's social mobility and determinants of health.

Communities of color have faced systemic barriers to achieving equity in these areas. As a result, racial discrimination over the lifespan has had detrimental effects on mental health and birth.

Historically, health care workers have exercised power imbalances that lead to barriers in women and birthing people of color achieving bodily autonomy, birthing with dignity, and holistic wellness.

Black, Hispanic, Native American, and Asian communities have reported discrimination and bias in healthcare settings. For example, 10% of Black women vs. 1% of white women reported unfair treatment from their hospital stay, such as delivery staff invalidating their decisions about their birth, lack of communication during labor, and pressure to have medical interventions.¹⁵

¹⁴ <https://www.whamglobal.org/resources#OB-Needs-Assessment-Form>

¹⁵ https://cdn.americanprogress.org/content/uploads/2019/04/30133000/Maternal-Infant-Mortality-report.pdf?_ga=2.264466383.1305843431.1599069094-438336308.1599069094

Research has shown that there is a correlation between implicit bias or attitudes towards a group of people based on stereotypes and lower quality of care. Racism, not race itself, influences the patient-provider relationship, treatment, and diagnosis decision-making. Health care workers are prone to making incorrect assumptions that Black patients “feel no pain,” are “strong Black women,” or have “tougher skin.” Biases also present themselves with assumptions of the patient’s support system, economic status, insurance, and additional intersecting stereotypes beyond race.

In the face of systemic barriers, Black communities have exercised their resiliency through community and culturally driven solutions, such as family and birthing centers, advocacy for wellness and safety, and organizing intergenerational approaches for self-determination.

Section 2: Implementing Depression Screening and Follow-up

Implementation Strategies and Tactics

Step 1: Identify champions at all roles and levels of care (administrators, physicians, students, nurses, social workers, community health workers, medical assistants, advance practice providers, and front desk staff/receptionists) who can display enthusiasm and gain buy-in from their colleagues and peers by doing the following:

- Setting clear expectations to staff regarding implementation
- Actively promoting the value of the innovation
- Discussing barriers and answering questions with other colleagues
- Communicating strategies/challenges with leadership
- Showing appreciation for the efforts and contributions of others
- Following the new workflows and protocols to set an example
- Keeping the project a priority and protecting its resources
- Ensuring that the innovation is implemented in the face of organizational inertia

Step 2: Before developing a quality improvement plan, form a multi-disciplinary quality improvement team and provide a structure for the team by:

- Developing a common purpose
- Establishing norms for the team
- Developing relationships among team members
- Defining roles for team members
- Defining procedures for making decisions
- Preparing for and running a team meeting
- Following a common methodology for doing their work

For guidance on forming a team to work on a quality improvement plan, please see <https://www.whamglobal.org/list-documents/148-applying-qi-principles/file>.

Step 3a: Once a quality improvement team is established, start to create and continuously modify a quality improvement (QI) plan for depression screening and follow-up with a 30-60-90 day action plan.

A **quality improvement (QI) plan** is defined as a single document that is used to:

- Prioritize and describe a problem, with baseline data and a specific, measurable, achievable, realistic, and time-bound (SMART) objective related to prenatal depression screening and follow-up and postpartum depression screening and follow-up¹⁶
- Diagram the “current condition” with a process map or workflow related to the problem and SMART objective (see Step 3b for guidance)
- Identify the root cause of the problem
- Select and incorporate changes into the current process or workflow to address the root cause, creating a “future condition” workflow or process
- Use the MOMD quality measures, prenatal depression screening and follow-up and postpartum depression screening and follow-up,¹⁷ to monitor whether the changes are moving towards the SMART objective
- Create a 30-60-90 day action plan to implement the “future condition” and a data collection plan for the MOMD quality measures

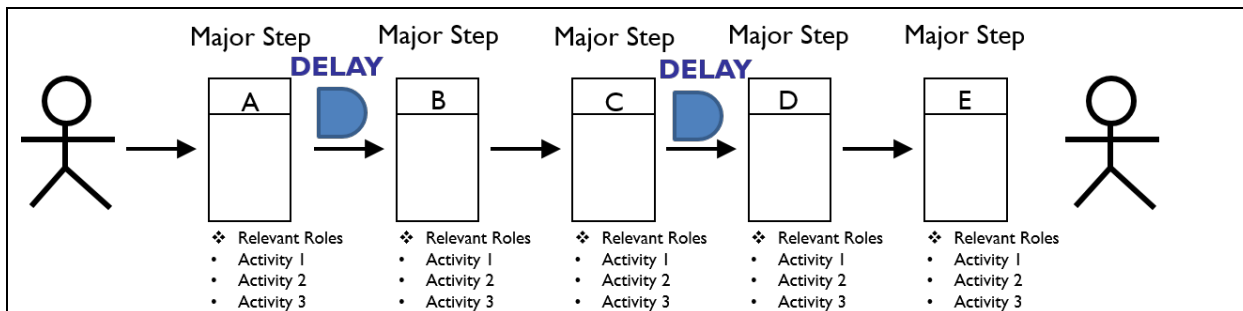
For guidance on developing a QI plan, please use the QI Plan template and other “Quality Improvement” resources available here: <https://www.whamglobal.org/resources>.

Step 3b: To understand the “current condition,” create a workflow of a prenatal/postpartum office visit, pediatric office visit, and telehealth visit depicting the steps (e.g., pre-visit preparation, check-in, rooming, vitals, exam, and discharge), roles (e.g., receptionist, MA/RN, and CNM/NP/Physician/PA), activities, and non-value added time (e.g., delays).

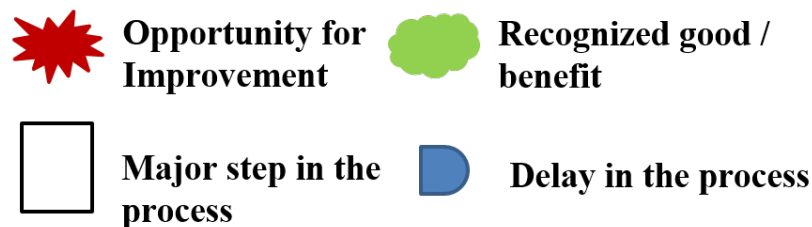
A blank template of a workflow is provided below. This template relates to understanding the “current condition” before identifying how to change it with roles and activities for depression screening and follow-up. (Refer to Step 5, the “Future Condition,” for suggested roles for depression screening and follow-up.)

¹⁶ See the specifications for the MOMD quality measures here <https://www.whamglobal.org/data-collection>

¹⁷ See the specifications for the MOMD quality measures here <https://www.whamglobal.org/data-collection>



Process Map Symbols



The Appendix also includes a generic example of a completed “current condition” workflow. To create a “current condition” workflow for your setting, the PA PQC recommends to have staff observe and document what actually happens, starting from the patient’s perspective. The draft of the “current condition” workflow can then be reviewed and edited by others who perform the roles and activities.

Mapping out “current condition” workflows with the team enables the entire team to see how their role connects to the entire process. It also enables the team to see how new activities can be incorporated into their unique setting/context and day-to-day roles.

The “current condition” workflow can also be reviewed by patients and family members to verify whether it matches their experience as well (see step 4).

Step 4: Community Engagement: Organize a focus group, conversation, or community listening and action planning session with patients and community members to inform the following decisions:

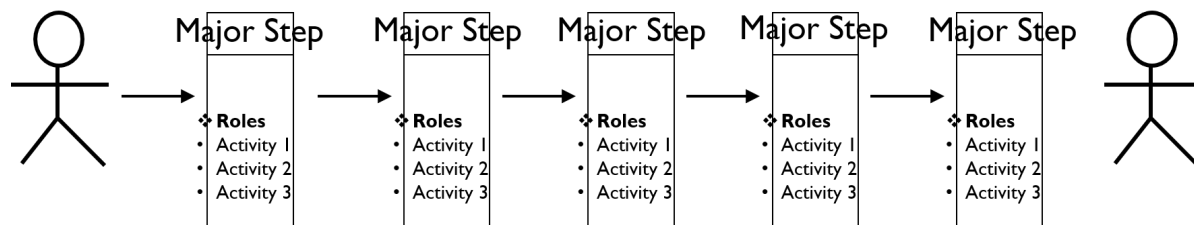
- which validated screening tool is used;
- how and when it is introduced and discussed with patients;
- how to tailor educational materials to meet patients’ health literacy, language, and cultural needs;
- how to best develop workflow protocols in a patient-centered manner; and
- which community-based resources to involve or refer to perinatal mental health support.

It is critical to obtain feedback and input from patients and community members when adding new services, such as depression screening and follow-up. This step almost always occurs in other industries that create services or products for consumers. Patients are the

only people who can advise on where, how, and when to incorporate new services in a respectful, non-judgmental, and culturally appropriate way that increases patient satisfaction.

Step 5: In the “current condition” workflow that was diagramed in Step 3, identify where to incorporate the new depression screening and follow-up steps, roles, and activities to create the “future condition” workflow by involving those who do the work and incorporating the community feedback from Step 4.

Please see below for a blank template of a workflow.



Note: the workflow template is intentionally blank since the details are meant to be created by the healthcare organization with frontline providers and patient/community input.

For example:

- The patient completes the PHQ-2 when the other health screens occur (e.g., self-administered screens via patient portal, kiosks, tablets, or clipboards prompted by receptionists/front desk staff)
- The rooming providers (e.g., the RN or MA) review the PHQ-2 results. If PHQ-2 > 2, then the rooming providers administer or ask the patient to complete the full-screen (e.g., the PHQ-9 or Edinburgh Postnatal Depression Scale)
- The Physician/CNM/CRNP/PA interprets the full-screen results, and if positive, conducts an assessment with follow-up questions and comorbidity screens (e.g., the MDQ) to inform the diagnosis

The Appendix also includes a generic example of a completed “future condition” workflow. This “future condition” workflow is not meant to be copied to create your “future condition” workflow since it should be based on your specific workflow and reflect decisions made by those who do the work and the community.

For telehealth visits, consider sending the screens prior to the telehealth visit (e.g., mail or patient portals) so the provider can review the results before the telehealth visit just like a regular office visit work flow.

Step 6: Create non-judgmental key messages¹⁸ for the office/telehealth visit team to use in each part of the future condition workflow.

Even when a validated screening tool is used, the way the screening is introduced, framed, and administered can make it effective or ineffective.

The key messages and where and when screenings occur should be informed by patient focus groups (Step 4) to ensure they are easy to understand, are being done in a culturally competent way, and are creating a safe, trusting environment.

Step 7: Determine whether, and if so, how to incorporate mental health screening and follow-up information from community-based organizations.

For example, information, such as screening tool name, screening date, screening score, referral, and follow-up date, could be shared between the community-based organizations and healthcare organizations, with information sharing consents in place. In this example, the healthcare team would need to have a process in place to ascertain which community resources the patient is working with by asking the patient or receiving a notice from the community resource that the healthcare team's referral was successful.

At a minimum, reach out to community-based agencies to ask for their feedback on the healthcare team's maternal depression screening and follow-up protocols and to identify how these community agencies can encourage pregnant and postpartum women to go to their prenatal and postpartum appointments, where the screens would be documented in the health care setting.

Step 8: Create an organizational suicide risk response policy, using guides, such as the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) card¹⁹ or other patient manage tools from the Suicide Prevention Resource Center.²⁰

Step 9: Create a follow-up protocol, using the scores of the depression screen to inform follow-up actions (see Step 1 in "Maternal Depression Follow-up Services")²¹

Step 10: Configure EHRs to use their functionality to notify providers of a positive screen and, and to use their order set functionality to allow providers to click on the notification to place an order for a referral to the behavioral health team (depending on the EHR functionality and follow-up protocols/resources)

¹⁸ Other examples of scripts: <https://www.health.state.mn.us/docs/people/womeninfants/pmad/ppdguide.pdf>

¹⁹ <http://www.sprc.org/resources-programs/suicide-assessment-five-step-evaluation-and-triage-safe-t-pocket-card>

²⁰ <http://www.sprc.org/settings/primary-care/toolkit>

²¹ <https://www.mcpapformoms.org/Docs/AdultProviderToolkit12.09.2019.pdf>

Step 11: Create a data collection, documentation, and measurement plan for the MOMD prenatal and postpartum depression screening and follow-up measures, and stratify by race/ethnicity (Non-Hispanic White, Non-Hispanic Black, Hispanic, and Other) to make continuous improvements and close gaps in disparities (see Section 3).

Please see the specifications for the MOMD quality measures here <https://www.whamglobal.org/data-collection>.

Ensure that this information for Medicaid recipients is being documented in the updated OB Needs Assessment Form (ONAF) at the first prenatal visit, at the 28-32 week prenatal visits, and at the postpartum visit.²²

Also consider outcome measures, such as depression response and remission²³ and/or assessment scales (e.g., Post Bonding Questionnaire²⁴ or Barkin Index of Maternal Functioning²⁵) stratified by race/ethnicity.

Step 12: Train and educate providers on protocols for mental health screening, documentation, diagnosis, and treatment to ensure that the providers feel comfortable diagnosing and treating pregnant women with mental health disorders, with the understanding the second or third treatment trial/step may require specialists if the first line treatment is not effective.

Step 13: Go live with the protocol, and disseminate the stratified performance data to staff and leadership each month.

Screening Protocols

Step 1: In an OB, pediatric, or primary care office visit, screen all pregnant and postpartum people universally for depression with a validated pre-screen, the PHQ-2 (either the Likert or yes/no version).^{26*}

If positive (PHQ-2 > 2 with Likert version or any yes with yes/no version), administer a validated, self-reported full-screen screen (e.g., Edinburgh Postnatal Depression Scale (EPDS)²⁷ or PHQ-9²⁸) in a culturally relevant way at least once during the prenatal period, ideally in each trimester, and at the 3/6 week, 6 month, and 12 month postpartum visits.

²² <https://www.whamglobal.org/resources#OB-Needs-Assessment-Form>

²³ <https://www.ncqa.org/hedis/the-future-of-hedis/hedis-depression-measures-for-electronic-clinical-data/>

²⁴ <https://sundspyskologerna.se/files/Brockington-et-al-2006-PBQ-validation-pdf.pdf>

²⁵ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3003914/>

²⁶ <https://www.med-ig.com/files/noncme/material/pdfs/LI042%20IG%20tools.pdf>

²⁷ <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/practicing-safety/Documents/Postnatal%20Depression%20Scale.pdf>

²⁸ <https://www.uspreventiveservicestaskforce.org/Home/GetFileByID/218>

For well-child visits, screen the mom at the 1 month, 2 month, 4 month, and 6 month visit.²⁹

Please see Step 5 in “Implementation Strategies and Tactics” for guidance on where, when, and by whom the pre-screens and full-screens could be conducted. As indicated in Step 5, involve the routine providers who have existing perinatal care relationships with the pregnant/postpartum person. Completing step 4 in “Implementation Strategies and Tactics” can also help ensure it is being done in a “culturally relevant way.”

** Providers may choose to start with a full-screen (e.g., the EPDS or PHQ-9) instead of starting with the PHQ-2 pre-screen. The PA PQC **strongly encourages** providers to simultaneously screen for anxiety with a validated screening tool (e.g., the GAD-7³⁰).*

Step 2: If the depression screen is positive (PHQ-9 > 9 or EPDS > 9,³¹ screen for other co-morbidities, such as:

- suicidality,
- anxiety (e.g., Perinatal Anxiety Screening Scale (PASS), Anxiety Disorder – 13, EPDS anxiety subscale, or GAD-7),
- bipolar disorder (e.g., MDQ),
- domestic violence and sexual assault history (e.g., Hurt, Insult, Threaten and Scream (HITS), Partner Violence Screen (PVS), Abuse Assessment Screen (AAS), Woman Abuse Screening Tool (WAST)),
- substance misuse (e.g., the 4ps, 4Ps Plus, 5Ps, modified 5Ps which also includes tobacco, emotional health, and domestic violence, NIDA Quick Screen, Substance Use Risk Profile Pregnancy (SURP-P) Scale, ASSIST, TICS, and NIDA-modified ASSIST),³² and
- SDOH screens with validated questions for Healthcare access and affordability, Childcare, Clothing, Employment, Financial strain, Food insecurity, Housing instability/homelessness, Transportation, and Utilities.³³

²⁹ https://brightfutures.aap.org/Bright%20Futures%20Documents/MSRTable_InfancyVisits_BF4.pdf

³⁰ <https://med.dartmouth-hitchcock.org/documents/GAD-7-anxiety-screen.pdf>

³¹ <https://www.uspreventiveservicestaskforce.org/uspstf/document/evidence-summary-primary-care-screening-for-and-treatment-of/depression-in-adults-screening>. The EPDS' cutoff score of 13 or greater is associated with a sensitivity (true positive) of 0.67 to 1.00 (depending on the study) and a specificity (true negative) of 0.87 to 0.99 with the English version. Among these studies, the study with low-income Black women found a sensitivity of 0.81 and a specificity of 0.96. In comparison, the EPDS' cutoff score of 10 or greater is associated with a sensitivity of 0.63 to 0.84 and a specificity of 0.79 to 0.90 with the English version, and the study with low-income Black women found a sensitivity of 0.84 and specificity of 0.81. The PHQ-9 with a cutoff of 10 or greater, which is consistently used, is associated with a 0.75 sensitivity and a 0.91 specificity for the postpartum population.

³² <https://www.whamglobal.org/list-documents/50-sud-screening-presentation/file>

³³ <https://sirennetwork.ucsf.edu/tools-resources/mmi/screening-tools-comparison>

To reduce the time it takes to complete these comorbidity screens, the following pre-screen questions could be used prior to these full co-morbidity screens:

- *Suicidality*: If 1 or higher response to PHQ-9 question #9, or 1 or higher response on EPDS question #10, or patient volunteers thoughts of suicide
- *Anxiety*: Do you worry more than most people or have attacks of anxiety?
- *Bipolar*: Has there ever been a period of at least four days when you were so happy or excited that you got into trouble, or your family or friends worried about it, or a clinician said you were manic?
- *Family violence*: Do you feel safe in your current relationship? Does your partner put you down or try to control what you can do? In the past year, have you ever been hit, pushed, restrained or choked during an argument?

Step 3: If the depression screen indicates thoughts of suicide (1 or higher response positive response to PHQ-9 question #9, or 1 or higher response on EPDS question #10) or if the patient volunteers thoughts of suicide, follow the policy for suicide risk response (see Step 8 in “Implementation Strategies and Tactics”).

Step 4: If the depression screen is positive (PHQ-9 > 9 or EPDS > 9), the trained physician/CNMs/CRNPs/PAs conducts an **assessment to make a diagnosis using standard ICD-10 codes (e.g., F05 Delirium due to known physiological condition, F30 Manic episode, F34.1 Dysthymic disorder, and F32.9 Major depressive disorder, single episode, unspecified³⁴).**

Maternal Depression Follow-up Services

Step 1: Connect patients to mental health and/or other culturally relevant community services through warm handoffs or integration models.

- **If the depression screen is negative (PHQ-9 < 10 or EPDS < 10) but indicates risk for developing postpartum depression (e.g., PHQ-9 score 5-9 or EPDS score 7-9), offer preventive resources, such as community programs and resources similar to approaches studied for Black and Latina women, such as “Mothers and Babies” based on cognitive-behavioral therapy and “Reach Out, Stand Strong, Essentials for new mothers” (ROSE) based on interpersonal therapy.³⁵**
- **If the depression screening is positive (PHQ-9 > 9 or EPDS > 9), use one of the following options to engage patients in mental health treatment and culturally relevant community services:**

³⁴ <https://www.acog.org/practice-management/coding/coding-library/coding-for-perinatal-depression>

³⁵ <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/perinatal-depression-preventive-interventions>

- **Option 1:** Through shared decision making, refer patients with a diagnosis of depression to a specialty behavioral health treatment provider and community resources.
If needed, obtain consent to share mental health information between the treating providers for continuity of treatment and to close the feedback loop, following PA information sharing laws.³⁶
- **Option 2:** Provide a warm handoff from the maternal health care provider (OB/GYN, PA, NP, CNM), pediatrician, or primary care provider to a trained behavioral health care manager (i.e., a trained SW, RN, MA, or LPC) on the maternity care team who:
 - provides initial and follow-up contacts using motivational interviewing and behavioral activation skills;
 - connects patients to community resources
 - re-administers the depression severity screen (PHQ-9) to track improvement and inform adjustments to treatment plan (e.g., 50% or greater decrease in initial PHQ-9 score or remission (PHQ-9 < 5) from depression symptoms);
 - prioritizes cases and presents cases during weekly systematic case review meetings with a multi-disciplinary team including a consulting psychiatrist to identify recommended changes to the treatment plan; and
 - works with the patient to implement the treatment plan options (e.g., antidepressants and/or cognitive behavioral therapy) through shared decision making.
- **Option 3:** Provide a warm handoff from the maternal health care provider (OB/GYN, PA, NP, CNM), pediatrician, or primary care provider to a behavioral health consultant (i.e., a LCSW, LPC, or other therapists) on the maternity care team.
- **Options 4:** Connect patients to evidence-based home visiting programs³⁷ to provide a wide array of resources to help eliminate the barriers which could be preventing people from accessing behavioral health treatment, connect patients to community resources, work with families, and offer social and emotional support.

³⁶ <https://www.pacode.com/secure/data/055/chapter5100/s5100.32.html>

³⁷ <https://homvee.acf.hhs.gov/>

For all referrals to mental health providers and community services, develop a process to close the loop on whether the person was able to successfully connect to the referred service.

- PA 211 (<https://www.pa211.org/>), Aunt Bertha (<https://www.auntbertha.com/>), or other electronic lists can be searched to find services based on needs and location. The Pennsylvania Department of Human Services is developing a Statewide Resource & Referral Tool that will allow providers to generate referrals and receive a report of the outcome of each referral through a closed-loop mechanism with a network of community services related to social determinants of health.³⁸ EHRs could also be configured to create electronic referral requests and orders with trackable fields (e.g., open and closed status).

Providers may also wish to explore new funding vehicles to create a tele psychiatric consultation and care coordination services for moms similar to MA Child Psychiatry Access Program (MCPAP) for Moms.³⁹

Financing

Sustain the maternal depression screening and follow-up services with financing strategies, such as value-based payment models that include HEDIS prenatal/postpartum depression screening and follow-up quality measures and/or through billing codes:

- Depression screening billing codes include 96127 (brief behavioral assessment)⁴⁰ and 96161 (caregiver focused)⁴¹ (see PA DHS EPSTD guideline in footnote)
- Behavioral health integration codes include 99492, 99493, and 99494 for Option 2 and 99484 for Option 3 under step 1 in “Maternal Depression Follow-up Services”⁴²

The above CPT procedure codes are listed on the Medicaid Fee Schedule.⁴³ Depression screening codes can be billed by hospital-based medical clinics, independent medical clinics, CRNPs, PAs, Physicians, and CNMs. The Integration codes can be billed by hospital-based medical clinics, independent medical clinics, CRNPs, PAs, and Physicians.

³⁸ https://www.media.pa.gov/pages/DHS_details.aspx?newsid=565

³⁹ <https://www.mcpapformoms.org/>

⁴⁰ https://aims.uw.edu/sites/default/files/Basic_BHI_Coding_0.pdf and <https://www.acog.org/practice-management/coding/coding-library/coding-question-postpartum-depression-screening>

⁴¹ <https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20MAP/MAB2020052602.pdf>

⁴² https://aims.uw.edu/sites/default/files/Basic_BHI_Coding_0.pdf

⁴³ <https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Care%20for%20Providers/MA-Fee-Schedule.aspx>

Section 3: Closing Gaps in Racial Disparities

Closing Gaps in Racial Disparities with Anti-Racism Strategies

Establish systems to accurately document self-identified race, ethnicity, and primary language.

- Organize and provide system-wide staff education and training on how to ask demographic intake questions.
- Ensure that patients understand why race, ethnicity, and language data are being collected.
- Ensure that race, ethnicity, and language data are accessible in the electronic medical record.
- Evaluate non-English language proficiency (e.g. Spanish proficiency) for providers who communicate with patients in languages other than English.
- Educate all staff (e.g. inpatient, outpatient, community-based) on interpreter services available within the healthcare system.

Analyze how existing institutional policies are facilitating or alleviating racial disparities. Analyze the impact of new institutional policies on people of color, with a racial equity impact assessment tool (e.g., Race Forward’s impact assessment tool⁴⁴).

Prioritize a comprehensive, person-centered approach by engaging Black communities in meaningful conversations about the emotional, mental, and physical harm and how it is being corrected at the institution.

Offer Black pregnant/postpartum people, and communities of color expansive birthing choices:

- Integrate collaborative community care by building trust, relationships, and referral networks with community resources, such as community-based doulas, hospital-hired doulas, perinatal community health workers (CHWs), birth workers, board-certified midwives, community birthing centers, and planned at-home births.⁴⁵
- Promote accessible literacy and education that is grounded in the linguistic and cultural characteristics of ethnic communities.
- Implement Culturally and Linguistically Appropriate Services (CLAS) (beyond computer-based translations) to promote health equity and support for families whom English is not their first/preferred language.

⁴⁴ <https://www.raceforward.org/practice/tools/racial-equity-impact-assessment-toolkit#:~:text=A%20Racial%20Equity%20Impact%20Assessment,a%20proposed%20action%20or%20decision>

⁴⁵ A statewide advisory group will be created to advance policies related to certifying and reimbursing Doulas and Perinatal CHWs. Other policy efforts are focusing on licensing Certified Midwives since only Certified Nurse-Midwives are currently licensed in PA.

Provide staff-wide education on perinatal racial and ethnic disparities and root causes annually.

- Implement training, assessment, and re-assessment of organizations’ systemic racism and individuals’ implicit bias
 - Examples of implicit bias trainings include AccessMatters’ Cultivating Awareness of Racial Microaggressions training
 - Examples of anti-racist trainings include Soul Focused Group’s “Enterrupting Racism Now”; Undoing Racism: The People’s Institute for Survival and Beyond; and Antiracist Training by Felicia Savage Friedman & Martin Friedman.
 - For trainings, use pre and post evaluations that assess process and outcome measures, including patient experience, patient outcomes, and changes in the trainees’ knowledge, attitudes, beliefs, and behaviors.
- Use the [Racial Equity Glossary](#) to promote language around understanding systemic racism
- Offer ongoing trainings of cultural humility model – the continued interpersonal sensitivity of cultural differences to combat racism and power imbalances in healthcare system. This should be integrated in educational programs for staff.
- Establish a service-learning component in which mental health providers, nurses, and physicians work in under-resourced communities to have an on-the-ground understanding of lived experiences of individuals.
 - Service-learning or additional staff trainings should be regularly monitored and evaluated by patient interviews, surveys, and local/state health departments.

Engage clinicians in understanding their own unreconciled triggers/traumas that may manifest itself in how they treat patients.⁴⁶

Build a culture of equity, including systems for reporting, response, and learning, and apply resources towards identified problems.

This includes creating a culture where people feel comfortable reporting these incidents and reinforcing this culture through education (displaying posters, promoting provider conversations, etc.)

Establish a mechanism for patients, families, and staff to report inequitable care and episodes of miscommunication or disrespect, and ensure a timely and tailored response and action to each report of inequity or disrespect.

- Leveraging the voices of patients can positively influence the patient-provider relationship, and empower them to validate and speak on their experiences.
- Gather feedback from patients using self-reported tools such as:
 - **Mother’s Autonomy in Decision Making (MADM)** instrument to assess the women’s autonomy and role in decision making during maternity care

⁴⁶ <https://www.birthplacelab.org/about/>

- **Mothers on Respect index (MORi)** to assess the women's experiences of respect and self-determination when interacting with their maternity care⁴⁷
- Consider including prenatal care questions, such as “how much has racism impacted your care,” and create a method for patients to report this type of trauma and harm.

Engage diverse patient, family, and community advocates who can represent important community partnerships on quality and safety leadership teams as Patient and Family Advisors, including the team that is continuously improving the maternal depression screening and follow-up processes.

For tactics and guidance on engaging patient, family, and community advocates on healthcare teams, please see the PA PQC webinar recording⁴⁸ and presentation.⁴⁹

Seek expertise from diverse community advocates or partnerships that have buy-in and trust built with individuals of the community. Community partners can have mental health resources to help patients make informed choices and foster holistic care.

- Engage women of color-led groups and community advocates in sharing information about the importance of engaging in mental health care to bridge gaps of stigma and access.
- Expand access to perinatal mental healthcare through telehealth, self-love coaching, meditative services, art therapy, and other expanded forms of mental wellness.

Providing safe spaces for mothers to be vulnerable can allow them to safely recognize the signs and symptoms of mood disorders and how systemic racism and gender discrimination impact their mental wellness.

Increase awareness about the community resources among all providers in each healthcare organization and system across outpatient and inpatient settings. This is also an opportunity to reinforce community resources and the importance of attending prenatal/postpartum visits in a culturally appropriate way.

- Leverage the MCOs’ and DHS’ SDOH resources, and incorporate online lists of community resources (e.g., Aunt Bertha, postpartumpgh.org, United Way 211, and the PA DHS Resource & Referral Tool in 2021⁵⁰) into day-to-day provider prenatal and postpartum workflows, and close the loop on referrals.
- Include new perinatal team roles, such as CHWs, doulas, family advocates, home visiting programs (e.g., Physical Health MCOs offer at least 2 home visits after delivery), CRSs, etc.

⁴⁷ <https://www.birthplacelab.org/tools/>

⁴⁸ <https://prh1.webex.com/recordingservice/sites/prh1/recording/75f6fc78a31042fc9f923ab5651bfa6a/playback>

⁴⁹ https://www.whamglobal.org/images/PAPQC/PA_PQC_Patient_and_Family_Engagement_Webinar.pdf

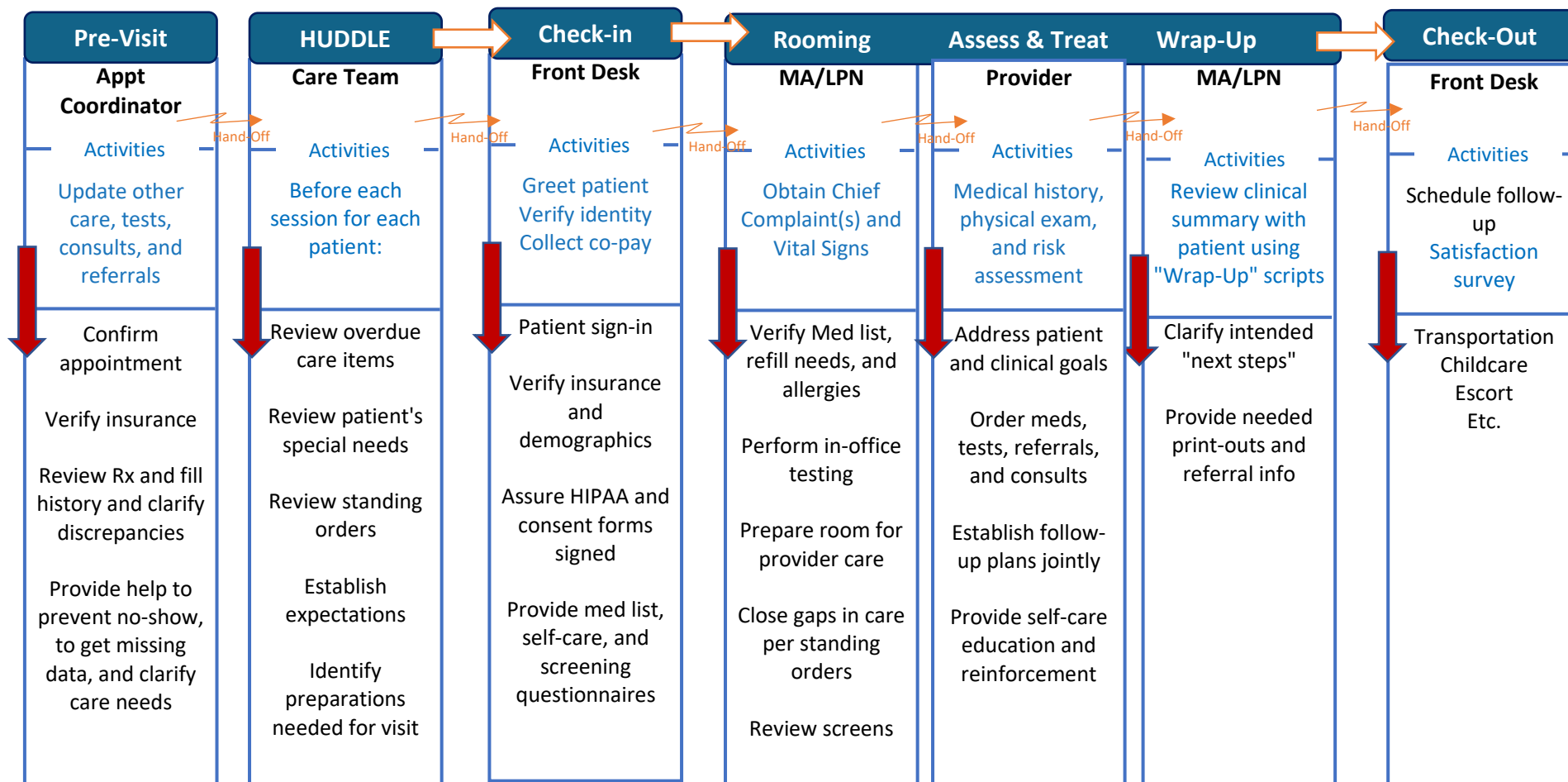
⁵⁰ https://www.media.pa.gov/pages/dhs_details.aspx?newsid=645

Foster a diverse workforce that is representative of the communities you serve by implementing hiring practices to develop a diverse workforce that matches the diversity and background of the patient population.

For example, expand and finance the education and promotion of Black mental and maternal health providers within practices and institutions, and create mentorships and collaborative models to support Black providers.

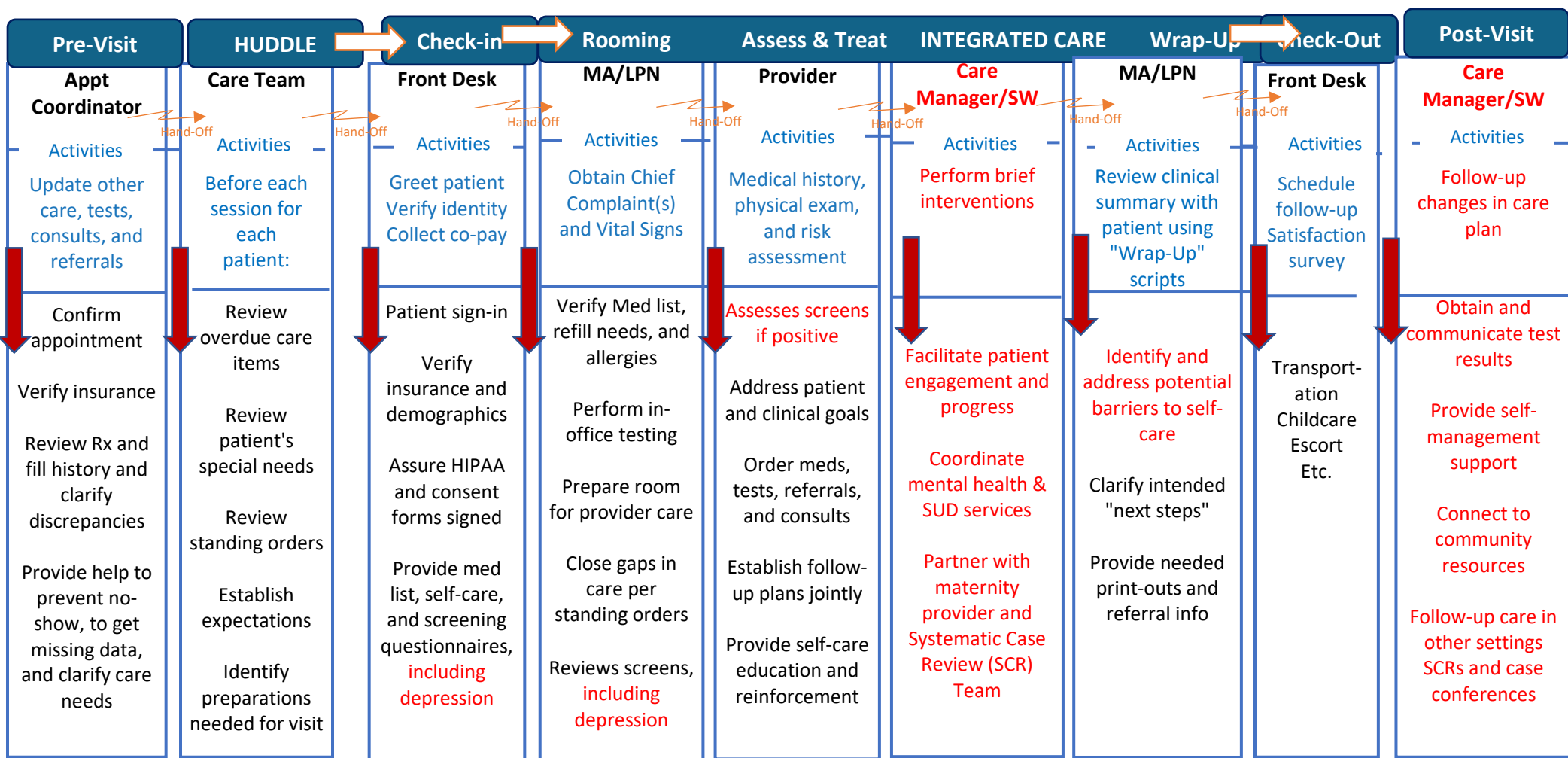
Appendix

Example of a Generic Office Visit “Current Condition” Workflow*



**Note: This is just an example and it is not meant to be copied to create a “current condition” workflow for a specific office. It is recommend for a staff to observe the office’s actual workflow from the patient’s perspective in order to diagram the actual roles and activities that occur in that office.*

Example of a Generic Office Visit “Future Condition” Workflow*



*Note: (Changes to the Current Condition are Marked in Red). This is just an example and it is not meant to be copied to create a “future condition” workflow for a specific office. “Those who do the work” at the office should be involved in identifying how to depression screening and follow-up activities to their workflow.