

# DESIGNING SYSTEMS TO ELIMINATE THE CONSEQUENCES OF MATERNAL DEPRESSION

Success Stories From Three States



**NICHQ**  
National Institute for  
Children's Health Quality

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# INTRODUCTION

When a mother suffers from depression, her ability to provide the care and attention that her child needs to thrive is affected.<sup>a</sup> Even though maternal depression is common, many mothers may not know help is available or may not feel comfortable asking for it. Ensuring that mothers have a strong support system can help mothers heal, improving outcomes for both moms and babies. The people who make up this support system may vary, but family advocates, public health professionals, pediatric providers, obstetricians, physicians, and early childhood educators must all understand their role in supporting the health and well-being of children and their mothers.

The following case studies highlight stories of three states that have developed successful systems for screening for maternal depression and providing appropriate follow-up treatment. Where each state began is very different, but the outcomes they share today are all very similar. In each state, pediatricians and family advocates have the skills and information they need to screen for maternal depression and provide follow-up treatment. Equally as important, each state has found a way to sustain this important work, some leveraging benefits included in the joint federal-state Medicaid program, and others relying on the support from community foundations. The bottom line for all three states is that more mothers are receiving screens and referred to services for depression, and more children and families are benefiting from healthier mothers.

## FEATURED SYSTEMS:

- > SOUTH CAROLINA
- > VIRGINIA
- > COÖS COUNTY, NEW HAMPSHIRE

## Lessons Learned

- **Cross-cutting theme 1: Take the time to build strong relationships and develop partners.** Helping more mothers get screened for depression and referred to services requires collaboration with stakeholders working across multiple systems. South Carolina, Virginia and New Hampshire all relied on strong partnerships—whether state agencies or local organizations and advocates—that helped them integrate their screening protocols into existing infrastructure; and spread, scale and sustain changes.
- **Cross-cutting theme 2: Start small and work with the people on the ground to enact change.** While not all states leveraged a quality improvement framework, all benefited from the quality improvement principle of starting small and engaging in small tests of change to lead to improvement. Central to this work was tapping frontline staff, including physicians and state health workers, and working with them to identify small changes that had the potential to make the most progress.
- **Cross-cutting theme 3: Medicaid is a critical vehicle for ensuring a child’s caregiver is screened for symptoms of depression.** Both Virginia and South Carolina utilized this program to expand access to depression screenings for mothers, which led to necessary referrals for treatment to support improved early childhood outcomes.



<sup>a</sup> View Maternal Depression: [First steps families & advocates can take to help mothers and babies thrive](#) to learn more about how maternal depression affects a mother, her child, and the rest of her family.



# SOUTH CAROLINA



**How can you spread best practices throughout an entire network of pediatricians? See how one program in South Carolina utilized a quality improvement framework to increase the identification of maternal depression in their state.**

South Carolina is home to just over five million people.<sup>1</sup> Roughly 20 percent of the state's population is under the age of 18,<sup>1</sup> with young children ages 0 to 5 accounting for slightly more than one quarter (27 percent) of this under 18 population.<sup>2</sup> Ranking 39<sup>th</sup> nationally in childhealth well-being, approximately 53 percent of children ages 3 and 4 are not enrolled in school and one in four South Carolina children live in poverty.<sup>3</sup> To support the health and well-being of these young children, South Carolina has identified Medicaid as a sustainable approach to support pediatricians in delivering care.

The South Carolina Medicaid Program (SC Medicaid) provides coverage to over one million South Carolina residents, 65 percent of whom are children.<sup>4</sup> With nearly 60 percent of all births paid for by the South Carolina Department of Health and Human Services (SCDHHS),<sup>4</sup> a large portion of South Carolina's youngest children rely on this coverage at some point in their lifetime. With this in mind, state officials and organizations dedicated to improving the health of South Carolina residents knew they had to do something to support this very large, vulnerable population.

In 2010, the state received funding through the Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant to develop a quality improvement infrastructure that would enhance the capability of the state's pediatric primary care practices to provide integrated physical and mental health services. This opportunity led to the formation of the Quality through Technology and Innovation in Pediatrics (QTIP) program, which has since evolved into a statewide program dedicated to improving health care for children in South Carolina.<sup>5</sup> Within QTIP's scope, the program was charged with improving behavioral health practices. New materials from the American Academy for Pediatrics<sup>b</sup> (AAP) were used as a template for behavioral health change. From this, South Carolina developed a strategy to screen mothers for maternal depression.

## QTIP's work on maternal depression screenings

Recognizing that identifying, diagnosing and treating maternal depression is critical for early childhood health and well-being, and building on earlier work on developmental screening, QTIP adopted maternal depression screening as a focus in 2013. With a structure and plan in place, the QTIP team thought it would be simple for their practices to begin screening new mothers. However, this was not the case.

## What is Quality through Technology and Innovation in Pediatrics (QTIP)?

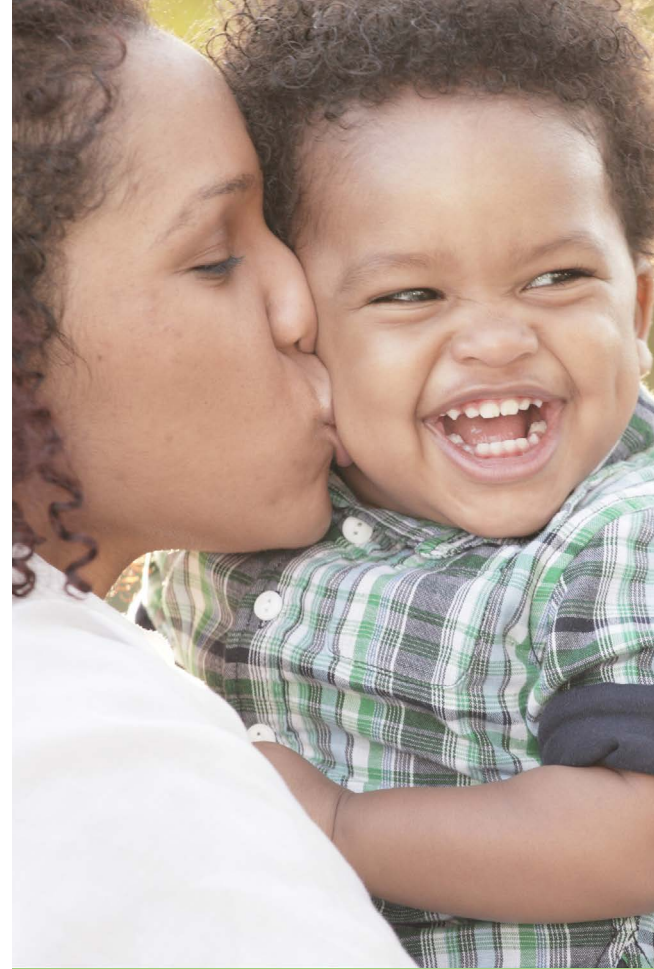
For pediatricians in South Carolina, Quality through Technology and Innovation in Pediatrics, better known as QTIP, is a longstanding program that uses quality improvement methods to spread evidence-based practices that contribute to better health outcomes for children. Since its inception in 2010, QTIP has worked with over 45 pediatric practices across the state to advance their efforts in providing value, promoting quality in pediatric care, and supporting the business side of a pediatric practice. Although QTIP supports practices' work on several different topic areas (e.g., oral health, obesity and asthma care), the program quickly became known as the driving force behind the state's work with clinicians to integrate behavioral health screenings and specifically, maternal depression screenings, into the pediatric setting.

Visit <https://msp.scdhhs.gov/qtip/> to learn more.

<sup>b</sup>View [Addressing Mental Health Concerns in Primary Care](#) to learn more about resources and tools clinicians can use to implement mental health care in practice.

**Early challenges to adoption and implementation.** Making changes to an organization's workflow, especially busy pediatric offices, is not an easy task. Even though participating practices understood the critical importance of diagnosing maternal depression, changing their routines in a short period of time was difficult. One of the early challenges that practices faced was the timing of doing these screens. If a pregnant woman qualifies for South Carolina Medicaid, she is eligible to receive health insurance benefits during her pregnancy and through 60 days after delivery.<sup>6</sup> Practices found it challenging to identify maternal depression within this 60-day period. Time and cost were other major barriers to practices adopting screenings as part of their regular workflow. At the time, pediatricians were unsure if and how they could bill for their time to administer screenings.

**The turning point for QTIP practices.** QTIP's quality improvement collaborative helped practices work through these issues. Despite the challenges, one pediatrician found a way to integrate screenings for maternal depression into his care practices. During a QTIP Learning Collaborative meeting, pediatrician Kevin Wessinger, MD, shared his strategies for conducting these screens within his own practice routine. His use of data to show the impact of these screening was particularly effective. Wessinger showed that more mothers were receiving the care they needed to treat depression (e.g., via referrals to their obstetricians and connections to walk-in clinics) and the practice was generating new revenue from the Medicaid reimbursement. By sharing his quality improvement cycles, experience and data with colleagues, Wessinger helped other pediatric offices accept the importance of adopting office-wide policies that address maternal depression. Since pediatric practices frequently work in isolation from one another, the learning collaborative provided an opportunity for Wessinger to share his experiences with others, resulting in an uptake of postpartum depression screenings across the state. Hearing the story of one influential colleague who successfully navigated the barriers to implementation helped other pediatricians connect the dots so they could implement screenings in their own practice.



## Financial Tools to Support Providers

Health care providers will be the first to explain the challenges involved with administering numerous health assessments in the 15- or 30-minute well-child visit. Beyond the barrier of the time it requires to administer screenings, physicians and other providers need to be reimbursed for the assessments they are completing. When QTIP began their work to screen for maternal depression during the well-child visit, it wasn't always clear how practices could be reimbursed for their time. Initially in 2013, practices used CPT code 99420; however, in 2017, CPT code 96161 was created. This gave QTIP practices and providers another essential tool for supporting this work since they could now be reimbursed for each assessment.



# Key Takeaways from South Carolina's Efforts to Leverage Medicaid Funding

Wessinger is a champion for maternal depression screenings in South Carolina. Because of the formal structure of QTIP, Wessinger could measure the effect of his work and share his strategies with other pediatricians, ultimately helping spread his work throughout the state. The QTIP team continued to encourage practices to implement postpartum screenings through the QTIP site visits and at future learning collaboratives. This continued focus helped improve South Carolina rates of maternal depression screenings over time (73 percent increase in the number of individuals screened from 2013–2014 and a 282 percent increase from 2013–2016 (prior to code changes)).



Below are four key elements that have contributed to both South Carolina's and QTIP's overall success.

## How did Kevin Wessinger, MD, integrate screenings into his workflow?

Making use of the quality improvement framework provided by QTIP, Wessinger began implementing Plan-Do-Study-Act (PDSA) cycles with his team to figure out how to integrate screenings into his workflow. Wessinger started small: one family and one staff member. He figured out which strategies worked, and which didn't. He explained the neuroscience of early child brain development and the impact of a mother's health on her child, so his colleagues could understand why this work was important. Once his practice understood the importance of screening, he explained how they could bill for their time. These two key factors—explaining the science and explaining how to bill for screenings—helped bring his colleagues on board.

**1. Strong Partnerships.** Although QTIP officially formed in 2010, the program may not have succeeded without previous strong partnerships between SCDHHS and the local chapter of the AAP. With the encouragement and support from O. Marion Burton, MD, the Chief Medical Director of SCDHHS at the time, and Francis Rushton, Jr., MD, pediatrician and past president of South Carolina's American Academy of Pediatrics chapter (SCAAP), staff from SCDHHS wrote the original federal grant that funded QTIP. The existence of these partnerships between the private and public health care sectors helped catalyze South Carolina's journey to support pediatricians, mothers, and families to improve children's health outcomes.

**2. Mutually Reinforcing Activities.** The early partnership between SCDHHS and the SCAAP continued throughout the life cycle of the grant funding (2010–2015) and still exists. The QTIP program is now fully supported by SCDHHS but receives content oversight from the SCAAP. At the most basic level, QTIP plans Learning Collaborative meetings to align with the SCAAP Annual Chapter meetings. This not only allows for program leadership to connect with one another in-person, it demonstrates the importance of strong partnerships and organizational alignment to program participants. At the strategic level, QTIP Program Staff, state Medicaid leadership, and the SCAAP leadership have quarterly meetings to discuss program progress, barriers, and solutions for providing pediatric care.

Another reason for QTIP's success is its work to ensure the state's Medicaid priorities are supported by program activities. For example, if SCDHHS wants to improve rates of breastfeeding in the state, QTIP provides the leadership, content expertise and technical support to practices so they can work on improving breastfeeding rates in their practices/communities. As QTIP practices continue to focus on integrating maternal depression screenings into the pediatric well-child visit, SC Medicaid will remain fully supportive of these efforts.

**3. Direct Line of Communication.** Since the QTIP program is housed in the state's Medicaid office, participating pediatricians are presented with an unprecedented opportunity to maintain open lines of communication with SC Medicaid leadership. For instance, leadership from the state's Medicaid office typically attend QTIP's Learning Collaborative meetings, allowing for pediatricians to meet and converse with their Medicaid officials. This unique structure is equally beneficial to SC Medicaid. SCDHHS can maintain ongoing relationships with the pediatric community via the QTIP initiative, allowing Medicaid officials to understand firsthand the successes and barriers to administering pediatric care and, in the case of maternal depression, providing screenings. When service providers and program administrators have a platform to support direct lines of communication, they are in a position to share and receive real-time feedback about patient care that ultimately benefits mothers and children.

**4. Foundation of Quality Improvement.** Wessinger's presentation helped promote and operationalize how maternal depression screening can work in a pediatrician's office. As such, the role of quality improvement in South Carolina's work was invaluable. QTIP provided Wessinger with support and guidance around how to apply quality improvement methods to his work (e.g., implementing PDSA cycles, collecting and presenting data). In turn, Wessinger assumed the role of a pediatric champion for maternal depression screenings. By sharing his tangible strategies and showing what outcomes were possible, he helped spread this evidence-based practice to other South Carolina communities.



## What are pediatricians in South Carolina doing now to screen for maternal depression, and how are they billing for it?

**Most common screening tools used:** Edinburgh, PHQ 9, SWYC

**Frequency of screens:** Pediatricians in South Carolina administer screens according to the guidelines set forth by Bright Futures/AAP.<sup>c</sup>

**Who can do the screening?** Practices in South Carolina utilize all staff members to their full ability. For instance, some practices ask their front desk staff to hand out the maternal depression screen for the clinical staff to review. This allows the screening to be completed and reviewed prior to the pediatrician starting the visit.

**How do they bill for the screen?** Practices can bill using the CPT code 96161, which allows for caregiver-focused, standardized health-risk assessments that benefit the child to be administered.<sup>7</sup>

## Summary

The state of South Carolina is at the forefront of supporting pediatricians, mothers and families to screen for maternal depression. The infrastructure necessary to support providers with implementation is in place and the relationships between key partners required to advance this work are strong. With nearly a decade of achievements and lessons learned, public health professionals and family advocates across the country can use South Carolina as an example of how to make the identification and treatment of maternal depression a state-wide priority.

<sup>c</sup> view the AAP/Bright Futures Recommendations for Preventive Pediatric Health Care here: [https://www.aap.org/en-us/documents/periodicity\\_schedule.pdf](https://www.aap.org/en-us/documents/periodicity_schedule.pdf)

# VIRGINIA



**How can we ensure women receive maternal mental health services when screenings are not a requirement for providers to complete? See how Virginia leverages Medicaid to increase the opportunity for women to receive maternal mental health screenings.**

While states can choose to implement Medicaid differently, they can also learn from each other and adopt similar designs that may best meet their residents' needs. The Commonwealth of Virginia's success at incentivizing maternal mental health services through Medicaid reimbursement represents a potential model for states that are seeking to improve maternal and child health through maternal mental health screenings.

Virginia is home to 8.5 million people<sup>1</sup> and in 2018, just over 12 percent of residents were enrolled in Medicaid.<sup>8</sup> The population of Medicaid enrollees in Virginia prior to Medicaid Expansion was young. In 2018, 75 percent of members were children or a combination of parents, caregivers and pregnant women.<sup>9</sup> In addition, Medicaid covered nearly one third of all Virginia births in 2018.<sup>10</sup> On January 1, 2019, Virginia expanded their Medicaid program so that more adults with low income could receive quality health care coverage.<sup>8</sup>

In parallel to Virginia's efforts to expand Medicaid coverage to more individuals, the Commonwealth also demonstrates an understanding of the intersection of maternal mortality, racial disparities and maternal mental health. In June 2019, Virginia Governor Ralph Northam announced his goal to eliminate racial disparities in the Virginia maternal mortality rate by 2025. Included in his call were measures to incorporate perinatal anxiety into mandated information shared with patients.

Given that Medicaid covers such a large number of children and families, the recent Medicaid Expansion, and Virginia's goal to eliminate racial disparities in maternal mortality, improving health and behavioral health care services for Virginia's Medicaid population has the potential to directly impact early development and well-being.



## How does Virginia provide maternal depression screenings through Medicaid?

The Virginia Department of Medical Assistance Services (DMAS) is the state agency that provides and regulates Medicaid coverage to eligible members through both managed care and fee-for-service delivery systems. Most Virginians enrolled in Medicaid receive coverage through Managed Care Organizations (MCOs). MCOs contract with DMAS to provide health and behavioral health care to their enrolled members. Virginia has two managed care programs: Medallion 4.0 (M4.0) and Commonwealth Coordinated Care (CCC) Plus. DMAS provides coverage for maternal mental health screenings and treatment under Medicaid benefits administered through these programs, in addition to their fee-for-service BabyCare Program.

## Medallion 4.0

Most pregnant and postpartum women in Virginia receive care under the M4.0 managed care program. MCOs that participate in this program offer maternal mental health screenings to women through their care coordination teams and reimburse providers who conduct maternal mental health screenings for their patients. Should a member have a positive screen for a condition such as postpartum depression, all M4.0 MCOs reimburse for an array of mental and behavioral health benefits that are available as treatment options.

MCO care coordination teams are staffed by qualified professionals (at least one behavioral health expert) who are trained to assess for medical and behavioral health risks and coordinate services. All six M4.0 MCOs have high-risk maternity programs that can offer support for women deemed at risk for adverse pregnancy and postpartum outcomes. All pregnant and/or postpartum women are screened by their MCO for risk status during their pregnancy and are referred to the MCO's care coordination team as needed and requested by the member. Many MCOs also include maternal mental health screening indicators for various perinatal mood disorders in their general risk assessments. Further, all MCOs offer screens specifically for maternal mental health indicators to all pregnant and postpartum members enrolled in their plan.

M4.0 MCOs reimburse for these screenings when conducted by a provider. MCOs use their own reimbursement practices, including appropriate CPT codes and provider settings. Despite a variety of provider types and settings, all MCOs reimburse for this service.

## Commonwealth Coordinated Care Plus

The second managed care program administered through DMAS is CCC Plus. This program provides benefits to individuals with complex medical needs and relies on care coordination teams to identify and refer members to services, as well as coordinate members' overall care. All pregnant or postpartum woman enrolled in CCC Plus are assigned a care coordinator (e.g., a licensed nurse, clinician or behavioral health specialist) who oversees their individual care plan and administers health risk assessments.

Upon a woman's enrollment into CCC Plus, the care coordination team will administer a set of screenings to assess the woman for different health risks, including perinatal mood disorders. Based on these initial screening results, CCC Plus care coordinators will utilize these screenings to refer for appropriate treatment services. This care plan is reassessed at least annually, providing regular opportunities for the woman to receive screenings for mental health services. If the woman is identified as at risk for a perinatal mood disorder, the care coordination team is trained to connect her to appropriate treatment.



## Reimbursement through M4.0 and CCC Plus

While providers in Virginia are not required to screen for maternal depression, MCOs that participate in M4.0 and CCC Plus are required, by contract with DMAS, to include coverage for postpartum depression screening for their members. Reimbursement rates are negotiated between MCOs and providers, and all MCOs have their own policies for how the screenings are covered. Oftentimes, MCOs develop their service plans to align with screening guidelines set forth by the American Academy of Pediatrics (AAP), so that providers can be reimbursed for a maternal depression screening under the child's Medicaid benefit (and therefore, during a pediatric well-child visit). However, not all MCOs provide reimbursement under the child's Medicaid benefit and even those that do have varying reimbursement criteria. To understand the specific requirements and reimbursement rates for these services, DMAS encourages providers and individuals to connect with each MCO to learn more. When changes to covered services are made, DMAS is responsible for notifying providers through state Medicaid memos and through the MCOs.

Despite the varying requirements and reimbursement rates, the financial incentive offered to providers through their MCOs elevates the importance of screening for maternal mental health during pregnancy, immediately after giving birth, and throughout the early childhood years. In addition, by including coverage for depression screening in standard contract language, DMAS sets the expectation that all pregnant and postpartum women covered by Medicaid should have the opportunity to receive screenings for maternal mental health.



## BabyCare Program

In Virginia, all Medicaid members receive benefits under the state's Fee-For-Service (FFS) benefit, typically for 30-45 days, before being enrolled into one of the two managed care programs noted previously. High-risk pregnant and postpartum women with an FFS benefit are eligible for the state's BabyCare Program. The BabyCare Program has three main components:

1. Expanded prenatal services for pregnant women;
2. Behavioral risk screenings; and
3. Case management services for high-risk pregnant women and infants (up to age 2).

To address the second component, pregnant and postpartum women receiving coverage under the BabyCare Program will work with their provider (physician, physician assistant, or nurse practitioner) to complete the Behavioral Health Risks Screening Tool for Pregnant Women and Women of Childbearing Age.<sup>11</sup> This tool uses the 3-Question Edinburgh Postnatal Depression Scale to detect indicators for perinatal and postpartum depression<sup>12</sup> with the goal of identifying and assisting members at risk for adverse mental health outcomes, and to identify infants at risk for developmental issues secondary to their mother's risks.

Once members are enrolled into managed care, the MCOs provide programs that mirror those of BabyCare to ensure continuity of care for members and, in some cases, provide additional services.

## Reimbursement through the BabyCare Program

Providers are eligible to be reimbursed for administering the Behavioral Health Risks Screening Tool for Women of Childbearing Age.<sup>11</sup> Using CPT code 96160, a provider may be reimbursed under the mother's benefit up to four times per member. Under CPT code 96161, the provider is eligible to be reimbursed through the child's benefit, up to four times per year for the child's first 2 years of life. Both CPT codes (96160 and 96161) allow for providers to receive \$2.63 per assessment.



## Key Takeaways from How Virginia Leveraged Medicaid Funding to Support Health Equity

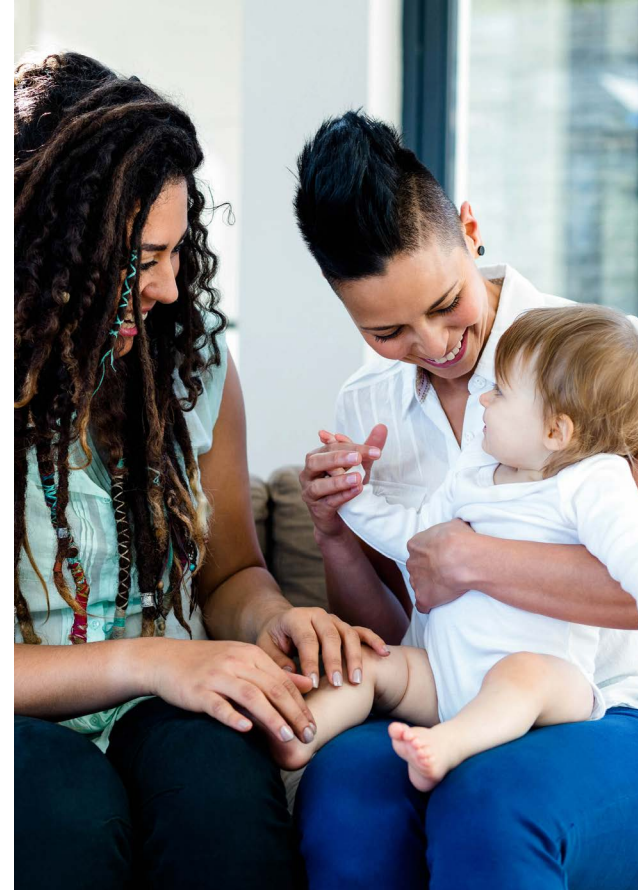
When a mother suffers from mental health concerns, her entire family is affected. The following are five key takeaways from Virginia's work to leverage Medicaid funding to support mothers and families.

**Utilize existing state and federal infrastructure to interrupt the cycle of poverty.** Medicaid financing provides essential health benefits to the most economically disadvantaged individuals living below the federal poverty level, including children and families. The program also plays an important role in preventing future economic hardship. As Richard Reeves, PhD, at the Brookings Institution highlights in his paper *The Effects of Maternal Depression on Early Child Development and Implications for Economic Mobility*, "poverty increases the risk of depression, which can weaken attachment between mom and baby and therefore slow early child development. A weaker developmental start increases the risk of poor educational outcomes, which in turn heightens the risk of future poverty."<sup>13</sup> This cyclical effect and growing body of evidence that poor maternal health outcomes can put a child at risk of adverse health consequences heightens the important role Medicaid can play in screening for adverse maternal mental health outcomes.

Since Virginia expanded Medicaid in early 2019, over 296,000 low-income citizens now have access to medical and behavioral health benefits (as of July 1, 2019). About 60 percent of those members are adult women who can now access care that addresses their behavioral health needs prior to becoming pregnant, should they choose to expand their families. Virginia hopes that providing care prior to conception will help women access the treatment they need to support healthy pregnancy outcomes, which will also positively impact their families.

In addition, providers caring for children can align with expert recommendations to not only offer, but also seek reimbursement for maternal depression screenings. Should a member receive a positive screen, all Medicaid members in Virginia can also access behavioral health treatment. Virginia's longstanding dedication to develop and improve programs that leverage Medicaid funding to reimburse providers for maternal mental health screenings and treatment sets a strong example for how other states may begin to break the cycle of poverty and poor health outcomes.

***Capitalize on the strengths of existing departments and organizations to grow your impact.*** DMAS credits their successful provision of maternal mental health services to their comprehensive statewide collaboration. DMAS participates in many statewide stakeholder groups, working with sister agencies like the Virginia Department of Public Health, the Virginia Department of Social Services, the Virginia Department of Behavioral Health and Developmental Services, and state maternal mental health advocates. Each stakeholder provides a diverse set of perspectives and shares feedback regarding provision of services to Virginians. For example, DMAS represents the public payer perspective and can provide useful information on Medicaid reimbursements to stakeholders with the goal of improving mental health outcomes and promoting health equity for low-income citizens across the Commonwealth.



DMAS is currently involved in a Maternal Mental Health Stakeholder group with their sister state agencies, including the Virginia Department of Health, advocacy groups such as Postpartum Support Virginia, and multiple providers. This collaborative group is working toward building a statewide resource guide for providers in the state. The resource guide will be a useful tool to teach providers how critical maternal mental health is, and what resources are available to their patients. By collaborating with a group of stakeholders that all share a common vision, Virginia has been able to accelerate their efforts to support maternal mental health.

***Think outside of the box to ensure all eligible individuals receive care.*** The BabyCare program helps pregnant and postpartum women receive the coverage and services they need, regardless of their enrollment in a managed care program. The BabyCare Program allows women to receive wrap-around services, including screenings for maternal depression, enabling providers to identify depressive symptoms and thus help women receive treatment as early as possible. The existence of this program and the fact that it reimburses providers for these screenings sets the precedent in Virginia that every pregnant and postpartum woman and mother deserves to receive care.

*Incorporate mental health care into a statewide response to address racial disparities in maternal care and mortality.*

In June 2019, Virginia Governor Ralph Northam announced his goal to eliminate racial disparities in the Virginia maternal mortality rate by 2025, saying, “a critical component of improving maternal health outcomes is the elimination of the racial disparity we are seeing in Virginia and across the nation.” Governor Northam made this announcement during a ceremonial bill signing of House Bill 2546, which codifies the Maternal Mortality Review Team in Virginia, and House Bill 2613, which adds perinatal anxiety to the list of information providers must give patients.

Through this statewide goal, Virginia will develop a comprehensive plan to address the complex racial disparities that exist in medical and behavioral health care for pregnant and postpartum women in the Commonwealth. Including an expansion of how the state addresses maternal mental health outcomes in this initiative demonstrates Virginia’s commitment to holistically supporting its citizens and its understanding of the value mental health screening and treatment has in improving outcomes for mothers and their children.



## Summary

The Commonwealth of Virginia is fortunate to have the leadership and buy-in from key state agencies that support the need for maternal mental health screenings and treatment. DMAS provides financial incentives throughout all of its service delivery systems for providers to screen for maternal depression, presenting the Commonwealth with an opportunity to interrupt the cycle of poverty by making accessible mental health screening and treatment to low-income citizens. The alignment of policies with evidence-based practice and the integration of language that supports reimbursement for maternal depression screens into state contracts set Virginia up to serve as a model for other states and communities who wish to leverage Medicaid funding to support the health of mothers and children.



# NEW HAMPSHIRE

**What happens when a state cannot utilize their Medicaid funding to support screenings for maternal depression? In Coös County, New Hampshire, a coalition of early childhood organizations got creative to make sure that their families were receiving the mental health services they needed.**

Coös County is New Hampshire’s northernmost county. Sharing a border with Maine, Vermont and Canada, Coös is recognized as New Hampshire’s largest county, yet it has historically been home to the fewest number of residents compared to the state’s other nine regions. Living in one of the most rural areas in New Hampshire, residents of Coös County experience higher rates of poverty than residents of other counties. Of these residents, roughly 1,200 are under the age of 6. Realizing the strong link between maternal health and a child’s health, the Coös Coalition for Young Children and Families saw an opportunity to improve services and systems for children and families in their community.

## What is the Coös Coalition for Young Children and Families?

In a small New England state, it is oftentimes the dedication and hard work of local organizations and advocates that lead to real change in a community. In 2012, a group of organizations representing health care, mental health, education, child welfare and family services formed the Coös Coalition for Young Children and Families (Coalition). With a mission to promote optimal health and development for children birth through 5 the Coalition identified four main topic areas, all of which were already being worked on by the organizations involved in the Coalition. These topic areas would remain their primary areas of focus for the next several years:

1. Developmental screening
2. Maternal depression screening
3. Evidence-based curricula for home visitors to support children’s social and emotional development
4. Evidence-based curricula for early childhood providers to support children’s social and emotional development

With all members on board to work on these four areas, the Coalition was optimistic that it would soon see an increase in the number of maternal depression screenings administered, and that more mothers and families would receive the care they need.

Visit <https://investincooskids.net/> to learn more about the Coalition



## Coalition’s work on maternal depression screenings

The Coalition’s four priority areas were carefully selected through a strategic planning process. They were coming off a successful launch of their initiative with health clinics to integrate developmental screenings into their workflow, and they were eager to begin working on maternal depression. Since all coalition members already understood the evidence for how maternal depression affects young children, they thought it would be a simple task to onboard health care clinics in this work. However, Coalition staff soon realized that this was not going to be the case.

## How the Coalition Supported Widespread Implementation

Since state Medicaid funding was not available to encourage providers to screen for maternal depression, the Coalition needed to get creative and develop an implementation strategy that could be spread and scaled. Below are five critical strategies they used to spread this work to practices throughout the county.

**1. Rely on existing relationships as a starting point for new work.** The Coalition's long-term goal was to have practices screen for maternal depression up to age 6 during the well-child visit. To achieve this big goal, staff had to start small. Instead of reaching out to every pediatric provider in the county and encouraging providers to begin implementing screens, the Coalition started with one Federally Qualified Health Center (FQHC), with which they already had a strong relationship through previous work together. Their existing relationships with FQHC providers enabled Coalition staff to have more candid conversations about how to actually integrate screenings into the pediatric visit. By focusing on relationships that were already strong and taking the time to identify challenges and create solutions together, the Coalition had more evidence to present to other practices when it was time to begin spreading this work.

**2. Work with pediatric staff to understand their challenges and identify consistent messaging about the importance of this work.** An early challenge to administering maternal depression screenings during the well-child visit was how to document the screening in the medical chart. Given that the child was the primary patient, a physician administering a depression screen on the mother during the child's visit was not able to easily access the mother's chart. With two different patient charts (one for the child and one for the mother), physicians expressed concerns around where they should be entering results of the screen, and if or how they would be able to follow-up with the mother about her results.

Coalition members worked with both administrative staff and providers within the FQHC to understand their concerns and help identify strategies for working with two different patient charts. Their conversations illustrated that FQHC staff needed more evidence and information before agreeing to change their workflow.

In response, the Coalition reframed their messaging to administrative staff and providers to help them really understand the significance of adding the depression screen to their workflow. Two tactics the Coalition used include:

- i. **Reminders to staff about the American Academy of Pediatrics (AAP) recommendations for maternal depression screening.** This affirmed the importance of implementing screenings<sup>14</sup> by relying on existing evidence from a nationally recognized professional association, ultimately saving the Coalition time and effort from having to gather the evidence on their own.
- ii. **Comparing the impact of maternal depression on a child's health to that of other environmental factors (for example, smoking).** The Coalition explained how maternal depression is an environmental factor that impacts a child and, just like any other environmental factor, physicians should be doing screens during the visit. Like the AAP statement, this comparison supported the message that maternal depression screenings are critical for children's health.

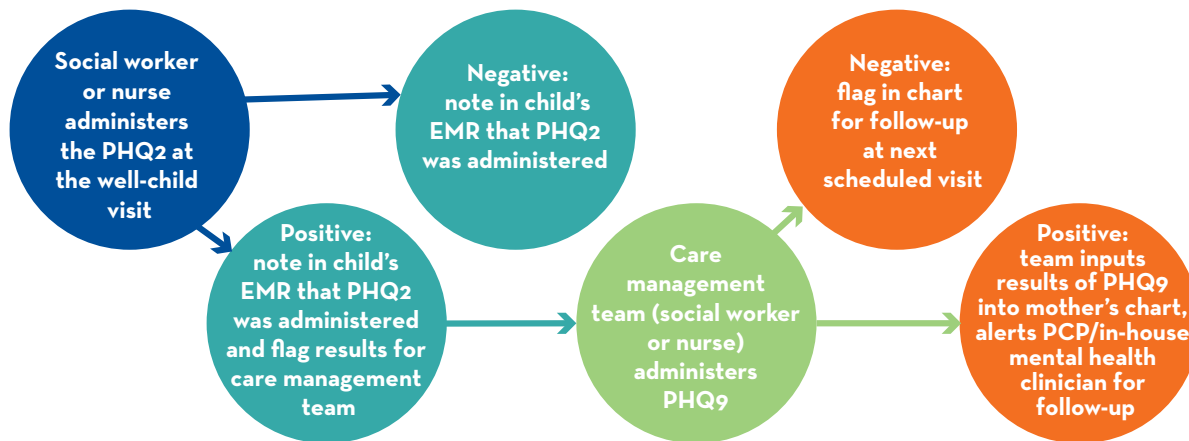
Over time, the Coalition successfully used these two strategies in their conversations with FQHC staff to convince them to incorporate screenings into their workflow.

The American Academy of Pediatrics recommends new mothers be screened five times for postpartum depression: once during pregnancy and again at their baby's well visits at 1, 2, 4, and 6 months of age.<sup>d</sup>



<sup>d</sup> view the AAP/Bright Futures Recommendations for Preventive Pediatric Health Care here: [https://www.aap.org/en-us/documents/periodicity\\_schedule.pdf](https://www.aap.org/en-us/documents/periodicity_schedule.pdf)

**3. Develop a structure for incorporating screenings into a well-child visit.** The conversations with FQHC staff purposefully did not include expectations for how FQHC staff should incorporate screens into the well-child visit, and what they should do if a screen shows up positive for depression. Instead, the Coalition recognized FQHC staff as the experts in their own daily routines and worked with them to develop a plan that would be easy and efficient for physicians and administrative staff to implement. Eventually, the FQHC identified the following process for screening a mother for depression:



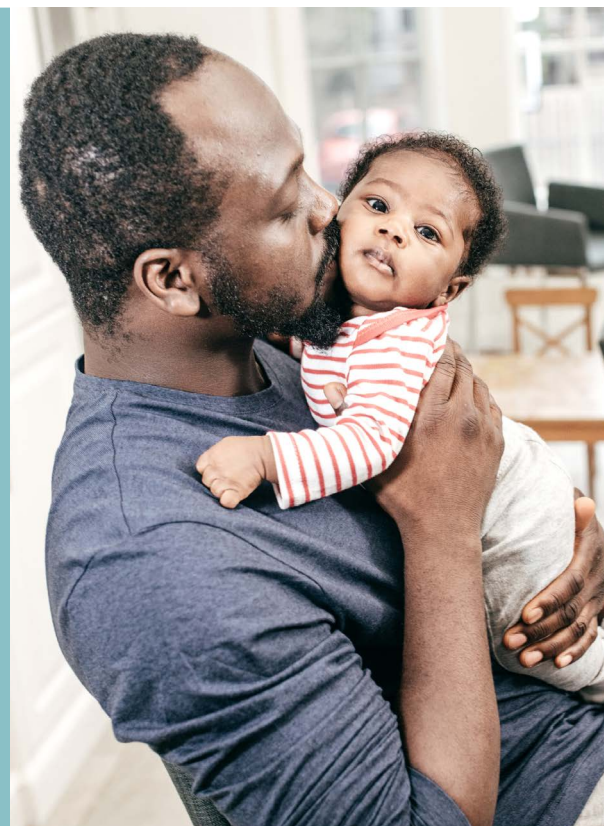
As illustrated above, this FQHC identified a process for screening and follow-up that best fits their unique needs. If an FQHC staff member, usually a social worker or a nurse, administers the PHQ2 to a mother and that screen comes up positive, staff will flag the results within the child’s electronic medical record and alert the FQHC’s care management team. The care management team is typically a team of nurses who then meet with the mother to administer the PHQ9. If a mother screens positive on the PHQ9, a member of the care management team works with her to schedule an appointment with her primary care physician (if she has one), or an in-house mental health clinician, or provides a referral to a mental health clinic in the area.

## What happens when the child’s primary caregiver isn’t the mother?

As the Coalition began working with more pediatric clinics throughout the county, clinicians and other providers started to ask what they should do when the mother isn’t at the pediatric visit. For example, many children were accompanied by a grandparent, father, or other primary caregiver. In these situations, staff wanted to know if they should still administer a screening for depression.

The Coalition recognized these concerns, especially since they understood that typically, if a primary caregiver in a child’s household is depressed, it is not uncommon for others in the family to also experience depressive systems.

After some discussions, the Coalition and clinic staff decided that the ultimate focus of their work was to support the child’s health. If a child’s health was being impacted by a caregiver (mother, father, grandparent or other family member), it was important for providers to recognize caregiver depression. Today, the Coalition encourages providers to screen all primary caregivers for depression during the well-child visit.



**4. Help More Mothers Access Treatment.** By leveraging their connections with the community, the Coalition helped the FQHC care for mothers who screened positive for depression. A shortage of mental health providers in the county meant that if a mother was diagnosed with depression, she may sit on a months-long waiting list before receiving care. This was a challenge for staff at the FQHC because they didn't want to identify a mother's depression and have nowhere to send her. As a response, the Coalition immediately referred to one of their key partners. In the early stages of their work, the Coalition was very intentional to invite leaders in the community who held decision-making power. One of these leaders was a strong advocate for mental health and the Deputy Director for the community's mental health organization. Through this connection, the mental health organization agreed to fast-track all maternal and caregiver referrals for depression so that these mothers could receive the help they needed without having to wait months for an appointment.

**5. Address funding.** The percentage of patients screened for depression is one of the 12 performance measures that all FQHCs are required to report in order to maintain their status as an FQHC, and therefore maintain their funding. This funding incentive positioned the FQHC as a strong partner for starting this work because it eliminated reimbursement as a barrier against uptake. Moreover, staff were more interested in tackling this issue because it aligned with the work they were already required to do.

## Key Takeaways from the Coalition's Success

The Coalition was the driving force behind the county's work to recognize and integrate maternal depression screens into the well-child visit. The Coalition's achievements reflect the success of multiple strategic decisions, including:

### *Bringing key decision makers to the table, from the start.*

Part of the Coalition's success stems from successfully recruiting the key decision makers in the community from the very beginning. Having the Deputy Director of the county's primary mental health organization involved in the early conversations, where physicians identified wait times as a key barrier for implementing screens, led to an immediate decision to fast track all referrals. What could have been a barrier to the long-term success of this work was immediately addressed because the right people were involved early on.



## Where are they now?

Since this initial work with one FQHC back in 2012, the Coalition has expanded their reach to more health clinics in the county. In addition, they have also begun to work with the Family Resource Center and the Head Start community.

### **The role of the Family Resource Center in screening for maternal depression**

The Family Resource Center in Coös administers the county's home visiting program, which presents another opportunity to reach children and families. As part of the home visiting contract, home visitors were already administering the Edinburgh Postnatal Depression Scale during the child's first year of life. After working with members of the Coalition, the Family Resource Center expanded their focus on mental health by integrating the PHQ2 assessment into the home visitor's program. Now, home visitors administer the PHQ2 annually, up until the child turns 6. The Coalition's role in this process helped the Family Resource Center identify and implement a new process for mental health screenings.

### **The role of Head Start in screening for maternal depression**

By now, members of the Coös community recognize the Coalition as a leader and thought partner for addressing maternal and caregiver depression. The local Head Start center approached the Coalition for guidance on how to address the increasing number of caregivers that were showing signs of depression. Head Start staff didn't know how to start this conversation so the Coalition helped them understand how to use the PHQ2 screener with their families. Eventually, this Head Start center incorporated the PHQ2 as part of their intake process and, in 2018, the center had 122 children enrolled in their program and staff had screened 134 caregivers. Next steps for the Coalition are figuring out how to capture data on the number of families referred to services and the number of families who receive services.



**Strategically selecting priorities.** Every organization has their own reporting requirements, goals and strategic priorities they need to follow to stay true to their mission. Understanding an organization’s strategic priorities and meeting them where they are is fundamental to making any sort of progress in this work. For the Coalition, this meant having a strong understanding of the partners they were working with before asking them to change their processes. Going to health centers prepared with suggestions for how this work could build on what they were already doing made all the difference.

**Strategically framing the data conversation.** It’s one thing to collect data on the number of patients you see and screens you administer; it’s another thing to turn this data into a story that energizes partners and helps remind them why this work is important. Using data to tell the story of your work isn’t easy, but the Coalition recognized it as an important tool to keep their partners involved. By slightly changing messaging from, “the number of depression screens we administered,” to, “we administered this many depression screens, which has impacted this many children under the age of 8, and allowed us to do xyz,” the Coalition is redirecting everyone’s focus back to the children and reminding everyone of the reason they started this work in the first place.

**Having a plan to spread this work across the county.** The Coalition’s decision to start this work with one FQHC was integral to their success. They took the time to identify the major barriers that were preventing mothers to be screened for depression, and then worked with staff to develop solutions that eliminated these barriers. Once the Coalition saw progress from one FQHC, they started working with another clinic. When this clinic began experiencing success, they moved to yet another practice in the community. When expanding their reach from one clinic to multiple clinics in the area, the Coalition was in the position to share lessons learned from their work throughout the county. The Coalition understood the steps it took to integrate maternal depression screens into a well-child visit and worked closely with every clinic to adopt and adapt strategies that would work for each individual location. This well-planned process facilitated the Coalition’s successful work to ensure more mothers and caregivers were screened for depression and ultimately, improve the health of young children in their county.

## Summary

Despite not having funding from the state’s Medicaid office, the momentum the Coalition has built around recognition and treatment of maternal depression is truly remarkable. This rural community identified a significant challenge affecting children and families, took the time to build relationships with key partners and organizations, and ultimately found a way to work together to develop solutions that met the unique needs of each organization, child and family. Should other communities across the country want to better support their own mothers, children, and families affected by depression, the Coalition has outlined critical components that can make this work a success.





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Maternal depression is common, and it has a clear impact on the health of children. South Carolina, Virginia, and Coös County, New Hampshire are three examples that show how it is possible to implement maternal depression screenings during a well-child visit. Maternal depression is one critical example of a policy change that everyone can promote to address children and family health. Whether you are a community partner, family advocate, health care provider or state official, we hope these examples provide you with ideas and strategies for leveraging funding and partners to prioritize the health and well-being of children, mothers and families across the country.

The project team that developed this brief extends their gratitude to the partners from each state who enthusiastically donated their time and effort to carefully articulate the programs they are leading. We hope these case studies illustrate their tireless efforts, energy and dedication to supporting young children and families.

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# REFERENCES

- <sup>1</sup> QuickFacts: New Hampshire; Coos County, New Hampshire; Virginia; South Carolina. Suitland, MD: United States Census Bureau; 2019. <https://www.census.gov/quickfacts/fact/table/NH,cooscountynewhampshire,VA,SC/PST045218>. Accessed May 1, 2019.
- <sup>2</sup> Child population by age group in the United States. Baltimore, MD: The Annie E. Casey Foundation Kids Count Data Center; 2018. <https://datacenter.kidscount.org/data/tables/101-child-population-by-age-group#detailed/2/31,42,48/false/871,870,573,869,36,868,867,133,38,35/62,63,64,6,4693/419,420>. Updated August 2018. Accessed May 1, 2019.
- <sup>3</sup> Children's Trust of South Carolina. Child Well-Being Matters in South Carolina. <https://scchildren.org/wp-content/uploads/Child-Well-Being-Matters-in-South-Carolina-Infographic-web.pdf>. Updated February 2019. Accessed May 1, 2019.
- <sup>4</sup> Amick B. Medicaid in 2019. <http://www.scaap.org/wp-content/uploads/2019/01/Amick-Medicaid-In-2019.pdf>. Powerpoint presented at 2019 CATCH Meeting, January 18-19, 2019; Charleston, SC.
- <sup>5</sup> Quality Through Technology & Innovation in Pediatrics. South Carolina Healthy Connections Medicaid. <https://msp.scdhhs.gov/qtip/>. Accessed May 1, 2019.
- <sup>6</sup> Chen A, Hayes E. Q&A on Pregnant Women's Coverage Under Medicaid and the ACA. National Health Law Program. <https://healthlaw.org/resource/qa-on-pregnant-womens-coverage-under-medicaid-and-the-aca/>. Published September 5, 2018. Accessed May 1, 2019.
- <sup>7</sup> Moore K, Hays B. New codes, new payment opportunities for 2017. Fam Pract Manag. 2017; Jan-Feb;24(1):7-11. <https://www.aafp.org/journals/fpm/explore/online/cpt-update-2017.html>. Accessed May 1, 2019.
- <sup>8</sup> Norris L. Virginia and the ACA's Medicaid expansion. HealthInsurance.org. <https://www.healthinsurance.org/virginia-medicaid/>. Published November 2, 2018. Accessed May 1, 2019.
- <sup>9</sup> Virginia Department of Medical Assistance Services. 2019 Medicaid at a Glance. [http://www.dmas.virginia.gov/files/links/221/2019%20MAG%20Draft%20\(01.07.2019\).pdf](http://www.dmas.virginia.gov/files/links/221/2019%20MAG%20Draft%20(01.07.2019).pdf). Updated January 7, 2019. Accessed May 1, 2019.
- <sup>10</sup> Kaiser Family Foundation. Births Financed by Medicaid. <https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&sortModel=%7B%22collid%22:%20%22Location%22,%22sort%22:%20%22asc%22%7D>. Accessed May 1, 2019.
- <sup>11</sup> Lent M. Virginia's BabyCare Program: Working to Improve Birth Outcomes through Medicaid. National Academy for State Health Policy. <https://nashp.org/wp-content/uploads/2018/12/Babycare-VA-Fact-Sheet.pdf>. Updated November 2018. Accessed May 1, 2019.
- <sup>12</sup> Virginia Department of Medical Assistance. Provider Manuals. [https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual!/ut/p/z1/jY8xC8lwFIR\\_i0NH-15sFXGLqENRcJHGt0gqMS20SUmjwX9v0UnQ6m-13fHdwQCCAjLxVWvrKGI3\\_kizU7ZPOVsi2-F6w5AnfLrqzQS3KeRPAL-II9A\\_QGAhudzoF9IBqRrW7zecFMk-cw3k1EU55eKr6-PS-7ZbRBhhCCHW1upaxWfbRPipUtrOg3gnoW0OAsdU3AMfPQAM03sk/dz/d5/L2dBISEvZ0FBIS9n-QSEh/p0/IZ7\\_JP4A1B01M0EF10A3A5D01M20D3=CZ6\\_JP4A1B01M0EF10A3A5D01M20L4=LA0=Ejavadoc.include.path\\_info!QCPVAPProviderManualsPortletView.jsp=#/Z7\\_JP4A1B01M0EF10A3A5D01M20D3](https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual!/ut/p/z1/jY8xC8lwFIR_i0NH-15sFXGLqENRcJHGt0gqMS20SUmjwX9v0UnQ6m-13fHdwQCCAjLxVWvrKGI3_kizU7ZPOVsi2-F6w5AnfLrqzQS3KeRPAL-II9A_QGAhudzoF9IBqRrW7zecFMk-cw3k1EU55eKr6-PS-7ZbRBhhCCHW1upaxWfbRPipUtrOg3gnoW0OAsdU3AMfPQAM03sk/dz/d5/L2dBISEvZ0FBIS9n-QSEh/p0/IZ7_JP4A1B01M0EF10A3A5D01M20D3=CZ6_JP4A1B01M0EF10A3A5D01M20L4=LA0=Ejavadoc.include.path_info!QCPVAPProviderManualsPortletView.jsp=#/Z7_JP4A1B01M0EF10A3A5D01M20D3). Accessed July 13, 2019.
- <sup>13</sup> Reeves RV, Krause E. The Effects of Maternal Depression on Early Childhood Development and Implications for Economic Mobility. The Brookings Institution. [https://www.brookings.edu/wp-content/uploads/2019/01/ES\\_20190131\\_Reeves\\_Maternal\\_Depression2.pdf](https://www.brookings.edu/wp-content/uploads/2019/01/ES_20190131_Reeves_Maternal_Depression2.pdf). Published January 2019. Accessed May 1, 2019.
- <sup>14</sup> Earls MF, Yogman MW, Mattson G, et al. Incorporating recognition and management of perinatal depression into pediatric practice. Pediatrics. 2019;143(1):e20183259.