

# Maternal Mental Health: State of the State in California and Beyond

A follow up report  
on the Implementation of the  
2017 California Maternal Mental Health  
Task Force Report



December 2019

*Issued to the California Legislature, Health and Human Services Agency,  
Stakeholders and the Public*

## PREFACE & ACKNOWLEDGEMENTS

This report, “A Status Report on the Implementation of the California Maternal Mental Health Strategic Plan,” is a follow up to the report issued by the California Task Force on Maternal Mental Health Care in April 2017 [A Report from the California Task Force on the Status of Maternal Mental Health Care: A Strategic Plan](#). The report contained a detailed overview of maternal mental health, and a state strategic plan, as well as specific recommendations for state and national stakeholder groups.



*This report provides an update on the implementation of the strategic plan as well as other efforts which have occurred in the state or nation to advance maternal mental health screening, diagnosis, and treatment.*

**THIS REPORT IS DESIGNED TO BE READ ELECTRONICALLY WITH HYPERLINKS TO REFERENCES**

### Background on the California Task Force on Maternal Mental Health

At the urging of the California Legislature through [Assembly Concurrent Resolution \(ACR\) 148](#), the California Task Force on Maternal Mental Health Care was formed to study maternal mental healthcare for pregnant and postpartum women experiencing depression, anxiety, and other maternal mental health (MMH) disorders in the state. The Task Force was established to evaluate:

- (1) barriers to screening and diagnosis;
- (2) access to treatment for mothers with private vs. public health insurance; and
- (3) evidence-based and emerging treatment models that are scalable.

The Task Force report noted:

*“Addressing Maternal Mental Health is the shared responsibility of doctors, hospitals, insurers, policymakers, government agencies, and communities. Together, stakeholders can take steps to prevent MMH disorders and close gaps in care. The Task Force urges stakeholders to commit to improving MMH by the year 2025.”*

**With effort by all of these stakeholders, California has made significant strides, yet significant work is still warranted and stakeholders seem as willing as ever to**  
**keep up the momentum**

## ACKNOWLEDGEMENTS:

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This report was written by Joy Burkhard, MBA, Executive Director with support from Alice Lu, MBA.



## Maternal Mental Health Disorders

Maternal mental health (MMH) disorders such as depression, anxiety, and other psychiatric illnesses represent the most common complication associated with pregnancy and childbirth. These disorders affect up to 1 in 5 mothers, or approximately 100,000 women in California each year yet research suggests that most women remain undiagnosed and untreated. Untreated MMH disorders can have devastating impacts on not only a mother's health and functioning, but on her and/or her partner's absenteeism and presenteeism rate in the workforce, her baby's health and development, and overall family stability. As noted in the Task Force report, untreated maternal depression is costly to a family and to society, costing California up to \$2.25 billion dollars per year. (Note this cost has been updated via a new report issued in 2019 by Mathematica. See below for additional detail.)

## Background & Objective of This Implementation Status Report

With funding from the California HealthCare Foundation, 2020 Mom facilitated distribution of the report including communicating with state and national organizations with the aim of prompting action relative to the applicable stakeholder recommendations from the April 2017 Task Force report. This "Status Report" provides an overview of the responses received from said organizations and an overview of the progress made toward meeting the general goals and recommendations set by the Task Force. The report also provides additional recommendations not previously identified by the Task Force.

## Summary of Barriers, Recommendations & Implementation Progress

Following are the barriers and recommendations from the Task Force Report.

### BARRIER 1

Providers lack guidelines, referral pathways, capacity, and support to screen and treat.

#### Recommendation 1

*California Ob/Gyns and other obstetric providers should be prepared to serve as the 'home base' for MMH and should immediately adopt the screening and treatment guidelines of ACOG and the Council on Patient Safety in Women's Health Care.*

#### Recommendation 2

*Though Ob/Gyns and other obstetric providers must serve as the "home base" for education, screening, treatment and referral, all health care providers must be in a position to screen and*

*detect MMH disorders and when needed, refer women back to their Ob/Gyns or other local treatment programs.*

### **Recommendation 3**

*Leaders from boards and/or education and advocacy organizations should develop certification boards for mental health providers who wish to be recognized as MMH specialists by the year 2021*

### **Recommendation 4**

*Provider-to-provider reproductive consult program(s) should be piloted immediately and the results reported to the legislature in order to promulgate a new statewide provider resource to be implemented by the year 2021*

### **Recommendation 5**

*Insurers should develop MMH case management programs to oversee women's treatment access, reporting back to the Ob/Gyn.*

## **BARRIER 2**

Medical and mental health insurance and health delivery systems and providers are not integrated.

### **Recommendation 6**

*In order to lay the groundwork for provider behavioral health integration, medical insurers should first bring mental health in-house, include mental health benefits in all medical care benefit contracts, and expand medical provider contracts to reimburse for MMH services.*

## **BARRIER 3**

Ob/Gyn screening rates are not measured and reported.

### **Recommendation 7**

*National accrediting and measurement bodies should develop and adopt HEDIS measure(s) for screening and treatment of MMH disorders by the year 2021.*

## **BARRIER 4**

Women don't receive adequate MMH support and education.

### **Recommendation 8**

*The California Department of Public Health (CDPH) should develop a culturally and linguistically appropriate statewide public awareness campaign to normalize and destigmatize MMH disorders after treatment shortages have been addressed, and before the year 2022.*

### **Recommendation 9**

*Local communities should form new or employ existing coalitions to address MMH, including correcting local treatment shortages/referral pathways, disseminating educational materials and awareness campaigns, and improving support resources for mothers.*

#### **Recommendation 10**

*Family-friendly policies and resources which aim to reduce maternal stress should be considered by employers, communities, and the state legislature.*

#### **Recommendation 11**

*Churches, community centers, business and others serving women who are pregnant or in the postpartum period should be aware of MMH disorders, their prevalence and symptoms, and be prepared to assess for trouble and refer to an Ob/Gyn or another community resource.*

### **BARRIER 5**

Stakeholder groups lack a framework or road-map for coordinated change.

#### **Recommendation 12**

*Stakeholder groups, such as state agencies, the insurance community, the hospital community, the employer community, funders and health care provider trade associations, should use the framework developed by the Task Force to guide efforts to close gaps in MMH care.*

## **REPORT ORGANIZATION AND REFERENCES**

This report further identifies progress made to address maternal mental health at a state and national level to improve access to effective and timely interventions in California. The report and is laid out in three Sections:

**Section 1: Significant California Action**

**Section 2: Significant National Action**

**Section 3: Task Force Report Stakeholder Action Request Responses**

**Section 4: Remaining Gaps and Conclusion**

This report includes references by hyperlinks and is meant to be utilized electronically. For an electronic copy of the report, visit [2020Mom.org](http://2020Mom.org) and search “California Implementation Report”.

## **THE LANDSCAPE IN CALIFORNIA AND BEYOND**

Since the Strategic Plan for Maternal Mental Healthcare was issued in 2017, the following notable changes and in field have occurred in California and nationally.

### **Section 1: Significant California Action**

## Part 1: State Reports

The following reports were issued by various entities referencing maternal mental health or mental health in California, since November 2017:

### MIHA Report of Mothers' "Symptoms of Depression During and After Pregnancy"

In 2018, the California Department of Public Health consolidated results into a [new report](#) related to maternal mental health from its Maternal Infant Health Assessment (MIHA) survey. The data was also included in the 2017 California Maternal Mental Health Task Force report.

### Mathematica: Cost of Untreated Maternal Mental Health Disorders

In 2019 [a study conducted by the research firm Mathematica](#) with funding from three foundations, including the California Health Care Foundation, estimated the cost of untreated perinatal mood and anxiety disorders (also known as Maternal Mental Health Disorders) in California at \$2.4 billion for all births in 2017. This includes costs incurred due to medical interventions, low-income health care, welfare payments, work absenteeism, and lost productivity over a six-year period, from the mom's pregnancy through the child's first five years of life.

## **The cost to California of not treating Maternal Mental Health Disorders was 2.4 Billion in 2017**

### UC Merced Report on Top Causes of California Maternal Mortality

The UC Merced and Michigan State University [study](#) found that drug overdoses were the second leading cause of death, only second to all medical complications related to birth, and that suicide was the seventh leading cause. Note, the California Task Force on Maternal Mental Health did not address substance use directly, but did note that this is an important "overlapping issue" on pg 4 of the report:

"The Task Force acknowledged there are many important and overlapping issues that deserve further exploration by others. Those issues include intimate partner violence, substance use, mental health of partners, including fathers; and special populations (e.g., military families and incarcerated women)."

***Suicide was the 7th leading cause of maternal death.***

### State Report on Maternal Suicide

The California Department of Public Health (CDPH) in partnership with the California Maternal Quality Care Collaborative (CMQCC) and the Public Health Institute (PHI) released its first [Maternal Suicide Report](#) in September 2019. The report was based on the findings of the California Pregnancy-Associated Mortality Review (CA-PAMR) Committee. Here are the Committee's findings:

***"Suicide is highly preventable."***

## In the CA-PAMR Pregnancy-Associated Suicide Cohort (99 women):

The majority of the women (83%) died in the late postpartum period, or 43-365 days following the end of pregnancy: 36% died between 43 days and 6 months and 47% died more than 6 months postpartum.



Mental health conditions were highly prevalent: 62% of women had reported mental health conditions before becoming pregnant and 25% had new onset conditions noted during or after pregnancy. Nearly a quarter of women (23%) had a reported family history of mental health conditions.



Depression (54%), psychosis (24%), and bipolar disorder (17%) were the most prevalent diagnostic impressions identified. Substance use, including alcohol and tobacco, was a common co-occurring condition with all mental health disorders.



Nearly one-third (32%) of women used illicit drugs (methamphetamine, cocaine, heroin) or abused prescription opioids during or after pregnancy; heavy alcohol use was noted in 17% of women. Substance use was identified as a precipitating factor to the suicide in 29% of women.



Approximately 85% of women had one or more psychosocial stressors documented near the time of their deaths (e.g., interpersonal conflict with partner, financial hardship, exposure to violence as a child or adult).



Half (51%) of the women had a good-to-strong chance of suicide preventability with missed opportunities to intervene.



### The report also identified several other key findings:

**“Pregnancy-associated suicide prevention requires better coordination between primary obstetric care providers and psychiatric and mental health professionals.”**

***“While the suicide ratio for pregnancy-associated deaths is notably lower than that among other reproductive-age women, this is a time of intense engagement with the medical system, so there are multiple opportunities for recognition and treatment, and preventing suicide.”***

***“Women who died by suicide within one year of pregnancy were more likely to be adolescents at the time of their first birth and receive less than adequate prenatal care during their most recent pregnancy.”***

“Approximately 85% of the women who died by suicide while pregnant or within a year of pregnancy had one or more psychosocial stressors documented. Interpersonal conflict, substance use, financial hardship, exposure to violence as a child or adult, and recent reproductive loss were particularly pervasive.”

**Implications for other states and tracking suicide:**

“...Because the rate of suicide is lower among women who were pregnant within the year prior to death than that among reproductive-age women who were not pregnant within the prior year, determining pregnancy-relatedness becomes very challenging. An alternative that is under discussion nationally is to understand that the definitions of the term, ‘pregnancy-related’, may not fit well with mental health disorders and to simply use timing to define ‘pregnancy-associated deaths from suicide.’”

**California Listening to Mothers Survey**

California conducted its first state version of the “[Listening to Mothers Survey](#),” conducted by the National Partnership for Women and Families, published in 2018.

**The *Listening to Mothers* surveys focus the discussion of maternity care on those who care about it the most: mothers themselves.**



The survey included the questions from the Patient Health Questionnaire for Depression and Anxiety (PHQ-4) a research-validated, widely used screening tool for depression and anxiety. Respondents



completed the questions with reference to “in the past 2 weeks” (i.e., in the postpartum period) as well as, among prenatal topics, “during your recent pregnancy.”

**Key findings include:**

**One woman in five screened positive for anxiety prenatally (during pregnancy), and 1 in 10 screened positive for anxiety postpartum.**

**About 1 in 10 screened positive for depression prenatally, and this figure dropped several percentage points in the postpartum period.**

**About 1 in 10 scored as experiencing moderate psychological distress and about half that as experiencing severe distress during pregnancy.**

**The postpartum measure for psychological distress resulted in levels that were about half that of prenatal distress.**

**With the exception of postpartum anxiety, there was a tendency for a higher proportion of women with Medi-Cal coverage to screen positive for the conditions during pregnancy than women with private insurance, and this achieved significance in the case of prenatal depression.**

**Many women reported receiving counseling or treatment for emotional or mental well-being. Women were more likely to receive such help if they had positive screens or with increasing severity of psychological distress. However, most women facing apparent challenges with these conditions did not receive standard types of help.**

**There was a tendency for higher proportions of Black women to screen positive and have symptoms of anxiety and depression and to score as having greater severity of psychological distress at both time periods in comparison with other racial/ethnic groups.**



### **The California Workforce Development Commission Report**

The [report “Meeting the Demand for Health”](#) the final report of the California Future Health Workforce Commission (February 2019), the report notes the most looming health care provider shortages the state faces are in Primary Care and Mental Health. The California Future Health Workforce Commission (“Commission”) shared these compelling facts:

**Two-thirds of California adults with a mental illness do not receive treatment.**

**Primary care physicians now provide over half of all mental health treatment, yet they receive limited formal psychiatric education or experience during their training.**

**In California, Emergency Department visits resulting in an inpatient psychiatric admission increased by 30% between 2010 and 2015. Studies suggest that more timely access to outpatient treatment and specialized psychiatric crisis services could reduce the need for inpatient care.**

**There is significant maldistribution in the availability of behavioral health services. The Inland Empire and the San Joaquin Valley have the lowest provider-to-population ratios in the state for almost every category of behavioral health provider; in contrast, the Bay Area has over three times more psychiatrists than those two regions on a population basis.**

**45% of psychiatrists and 37% of psychologists are over age 60.**

**The Commission recommended that California:**

**Develop a psychiatric nurse practitioner program that recruits from and trains providers to serve in underserved rural and urban communities to help address access gaps in behavioral health by treating over 350,000 patients over five years.**

**Expand the number of primary care physician and psychiatry residency positions, yielding an increase of 1,872 primary care physicians and 2,202 psychiatrists by 2030. In conjunction with**

**priorities 7 (maximize role of nurse practitioners) and 9 (psychiatric nurse practitioners), this recommendation would eliminate California’s projected shortage of primary care physicians and psychiatrists.**

**Scale the engagement of community health workers, promotores, and peer providers through certification, training, and reimbursement, broadening access to prevention and social support services in communities across the state. Community health workers and promotores (CHW/Ps) and peer providers can help meet increasing demand for team-based integrated primary and behavioral health care, drawing on lived experience to support better outcomes for all and to promote recovery and self-sufficiency for people with mental illness and substance use disorder.**

**Expand funding for educational capacity, stipends, and scholarships to strengthen the size, distribution, and diversity of the behavioral health workforce.**

### **California’s Current and Future Behavioral Health Workforce**

A similar report was issued by the University of California at San Francisco (UCSF) the year prior (February 2018) which was specific to mental health: [California’s Current and Future Behavioral Health Workforce](#).

The report highlighted the same shortages and needs and also recommended:

**Supporting team-based models of care in which psychiatrists provide advice and education about medications to primary care physicians, physician assistants (PAs), and nurse practitioners (NPs) either in person or virtually via telehealth technology.**

**Possible models for expanding access to behavioral health training in underserved regions of California include providing clinical training in these regions and expanding access to didactic education via distance learning. Training programs in underserved areas could focus on recruiting students from these areas and could provide financial aid to those who agree to practice in these areas upon graduation.**

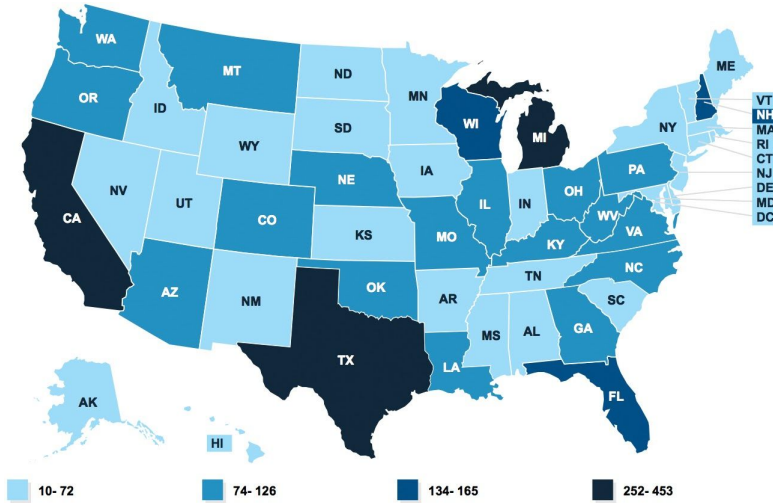
**To implement improved access to mental health care, the authors note policymakers could leverage funding from the following programs:**

- [Mental Health Services Act \(MHSA\) Workforce Education and Training grants](#) for psychiatry residency programs and Psychiatric Mental Health Nurse Practitioner (PMHNP) education programs.
- [Song Brown](#) special programs grants through the California Office of Statewide Health Planning and Development (OSHPD), which provide funds to primary care residency programs and primary care physician assistant (PA) and nurse practitioner (NP) programs to enhance training on high priority health care needs.

### **Interactive State Map Illustrating Psychiatrist and Ob/Gyn Shortages**

Since California’s Task Force issued the state strategic plan for Maternal Mental Health, the California Health Care Foundation (CHCF) published these [interactive doctor shortage area maps](#), which illustrate significant current shortages of maternal mental health care providers including, Ob/Gyns and general psychiatrists.

The map below, from the initial [Maternal Mental Health Task Force Report](#) illustrates the U.S.'s overall Mental Health shortage areas, noting California and Texas face the highest number of shortage areas, which [remain the same](#) in 2019.

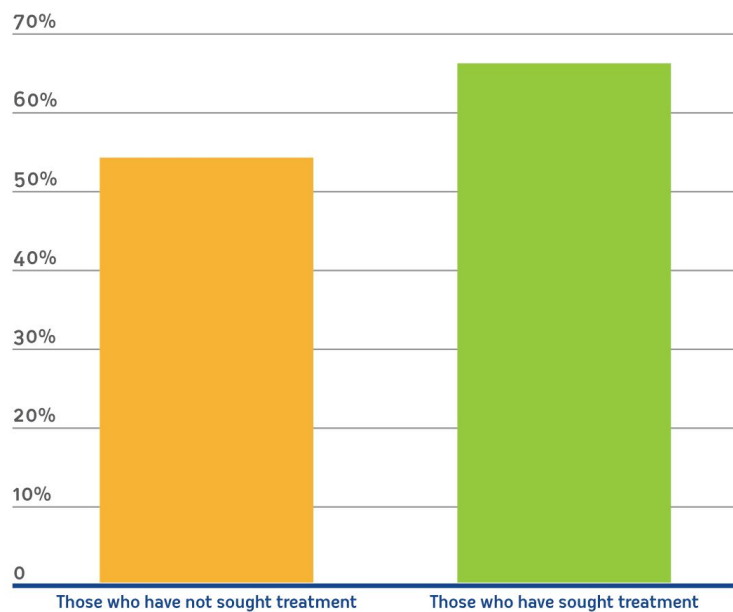


### [California Health Policy Survey \(2018\)](#)

The [California Health Policy Survey](#) by the Kaiser Family Foundation and the California Health Care Foundation noted:

**Among health issues, Californians' top priorities are ensuring people with mental health problems can get treatment (49% say it is "extremely important").**

## Most Californians think there's a lack of available mental health care—especially if they've tried to get it



Percentage who say people with mental health conditions in California are not able to get the services they need.

Source: California Health Policy Survey, 2018 (Kaiser Family Foundation/California Health Care Foundation)

## **Section 1: Significant California Action, Continued**

### **Part 2: State Legislation**

Several notable bills sponsored by grassroots advocacy organizations were signed into law in 2018 and 2019: AB 2193, AB 3032, AB 1893 and AB 845. Assembly Bill (AB) 1676 is pending in the current two-year bill cycle.

#### **ACR 180: Maternal Mental Health Awareness Month 2018**

Also of note, was the introduction of [Assembly Concurrent Resolution \(ACR\) 180](#) which redeclared May Maternal Mental Health Awareness month in CA, in 2018. Though [ACR 105](#) (2010) declared May “Perinatal Depression” Awareness month in CA in perpetuity, Assemblymember Marie Waldron a leader in the Legislative Women’s Caucus recognized that re-declaring the awareness month in 2018 would help to educate assembly members before the three bills introduced in 2018 were heard and voted on, on the assembly floor.

#### **AB 1893: Maternal Mental Health Federal Funding**

[Assembly Bill \(AB\) 1893](#) was introduced by Brian Maienschein-R, to provide clarity and direction to state agencies as to the expectation that the state apply for federal funding provided through the federal [Bringing Postpartum Depression Out of the Shadows Act](#), which was signed into law as a part of the 21st Century Cures Act in 2016.

The federal law authorized the Health Resources and Services Administration (HRSA) to make grants to states to establish, expand, or maintain maternal mental health treatment programs including enabling real-time psychiatric consultation. Grants were to be made to at least three states and give priority to states proposing to expand or enhance screening for maternal depression in primary care settings, including obstetric providers. The program is authorized for four years and allocated \$20 million over four years.

**The California Department of Public health was the named agency in AB 1893 to apply for federal funding. The agency applied but was not one of the seven states that received grants. According to representatives at HRSA, additional rounds of funding could be available in the future.**

### **AB 2193: Maternal Mental Health Screening and Insurer Program Development**

Assembly Bill 2193 (2018), also introduced by Brian Maienschein-R, was effective July 1, 2019. It requires health insurers to develop maternal mental health programs and requires obstetric providers to screen or confirm each patient has been screened for MMH disorders using a validated screening tool at least once during the perinatal period (pregnancy through the first year postpartum).

*As initially introduced, AB 2193 required health insurers to develop case management programs for MMH disorders (consistent with Task Force Recommendation 5), assisting patients and their screening providers with finding in-network behavioral health treatment and providing assistance overseeing implementation of the treatment plan. This portion of the bill was removed and replaced by a more general requirement for insurers to create maternal mental health programs, in order to remove opposition to the bill by the California Association of Health Plans.*

Such a case management service may remain a valuable means for reducing the burden of screening providers and unwell patients to identify in-network treatment options. Connecting patients with timely and adequate mental health care remains a significant opportunity.

An example of such a program is the [California Health and Wellness Medi-Cal Managed Care plan case management program](#).

Case management programs could be particularly valuable for PCPs and patients seeking mental health coverage, as patients are often unable to find adequate in-network care. In a [report by Milliman Inc.](#), published in December 2017, data analyzed from 42 million patients and found that in 2015 California patients were more than seven times as likely to get treatment for mental health conditions from providers outside their insurance plan's network as patients seeking medical care. The analysis also showed that insurers in California paid primary care providers almost 28 percent more for office visits than they paid behavioral health providers.

### **Assembly Bill 3032: Hospital Maternal Mental Health Training and Education**

[Assembly Bill \(AB\) 3032](#) introduced by Jim Frazier-D was signed into law in 2018. The law becomes effective January 1, 2020. This bill requires maternity care hospitals to train clinicians who provide care to the hospital's patients, in the signs and symptoms of the range of maternal mental health disorders. The law also requires hospitals to inform patients of the same, including any local treatment options.

### [Assembly Bill 845, Maternal Mental Health MD Education](#)

In 2019, Brian Maienschein-D introduced another bill, [Assembly Bill 845](#) that encouraged the California Medical Board (“The Board”) to create training in the range of maternal mental health disorders and treatment options.

**In November 2019, a letter to the California Medical Board and the California Hospital Association (CHA) was sent by advocacy organizations to urge the Medical Board and CHA Member Hospitals to ensure provider education *distinguishes between intrusive thoughts and psychosis.***

**Intrusive thoughts are unwanted recurring thoughts, often in the perinatal period, of harm coming to the baby at the mother’s hands.**

**Research released this year (2019) indicates up to 50% of women will suffer from intrusive thoughts and confirms they are at no higher risk of harming their babies.**

**Until MDs are adequately aware of this fact, they may inappropriately send mothers to Emergency Rooms and/or call Child Protective Services. As the cases which have made news headlines illustrate, these actions generally do not lead to a mother receiving treatment, and may heart-breakingly result in her children being removed from her home when she was at no increased risk of harming her children.**

**A story published in November 2019 highlights this gap, which perpetuates the problem of women not wanting to seek help. Such fears are particularly pervasive in women of color.**

### [Assembly Bill 577, Maternal Mental Health Continuity of Care CMA](#)

In 2019, Susan Eggman-D introduced [AB 577](#) to provide women diagnosed with a maternal mental health disorder extended Medi-Cal coverage from 60 days postpartum to, through one year postpartum. This bill was sponsored by the American College of Obstetrics and Gynecology (ACOG), District IX. The bill was amended after being introduced to no longer extend coverage to women, but to require insurers to continue coverage for women whose providers terminate from the insurer’s network through one year postpartum. In 2019 ACOG also championed a successful budget appropriation effort to provide funding for MediCal coverage through the first year postpartum.

### [Assembly Bill 1676, Maternal and Child Mental Health PCP Telepsychiatry Consultation](#)

In 2019, Brian Maienschein-D introduced this fourth Maternal Mental Health bill. This bill, featured a model from the state of Massachusetts, the Massachusetts Child Psychiatry Access Program (MCPAP) and the “MCPAP for Moms” program, which provides real-time consultations to pediatricians with child psychiatrists and obstetricians with reproductive psychiatrists. Access through a state facilitated reproductive psychiatry consultation program is recognized as the gold-standard, as such a form of this bill will likely be reintroduced in 2020.



## [Senate Bill \(SB\) 83. Paid Family Leave Extension](#)

[Senate Bill \(SB\) 83](#) was signed into law in June 2019. Effective July 1, 2020, it extends the duration of paid family leave from six to eight weeks. The California Disability Insurance (SDI) program is available to care for a seriously ill family member and bond with a child within one year of the birth of placement through foster care or adoption. California was the first state in the nation to create a paid family leave program in 2004.

*The American College of Obstetrics and Gynecology (ACOG) advocates for at least 6 weeks of paid leave for mothers to care for newborns and recover from childbirth.*

## [Section 1: Significant California Action, Continued](#)

### [Part 3: Additional State Action](#)

## [California Department of Public Health Awareness Materials](#)

In May 2019, during Maternal Mental Health Awareness month, the Maternal Child Health Division of the California Department of Public Health (CDPH) developed maternal mental health [awareness materials](#), including a two-page fact sheet for mothers, providers, and families including the PSI warmline to call for support. The CDPH also created an awareness video that other organizations can share. (Note that CDPH was encouraged to develop an awareness campaign in the initial Maternal Mental Health Task Force report issued in 2017.)

Maternal, Child & Adolescent Health  
**mcah**  
| MATERNAL MENTAL HEALTH

**Feeling anxious or depressed?**

Many women experience depression and anxiety during pregnancy and after having a baby.

What every new mom and mom-to-be need to know

**One in five California women** has symptoms of depression during or after pregnancy.

**Symptoms**

Feelings of depression after pregnancy, also known as baby blues, are common, last about two weeks and are considered normal. Symptoms can also occur during pregnancy or any time during your baby's first year. But if your symptoms last longer than two weeks, are severe or get worse, please talk with someone you trust and see your health care provider.

- ▶ Anxiety and/or nervousness
- ▶ Sadness
- ▶ Excessive crying
- ▶ Mood swings
- ▶ Difficulty concentrating
- ▶ Lack of interest in things you typically enjoy
- ▶ Changes in sleeping or eating habits
- ▶ Excessive worry about your baby
- ▶ Feelings of guilt or inadequacy
- ▶ Difficulty accepting motherhood

**See your doctor right away if you have:**

- ▶ Thoughts of harming yourself or your baby
- ▶ Panic attacks
- ▶ Fear that you can't take care of your baby
- ▶ Baby blues lasting longer than two weeks
- ▶ Irrational thinking, such as seeing or hearing things that are not there

**NEED HELP RIGHT NOW?**  
Call 1-800-944-4773 or text 503-894-9453  
Postpartum Support International to find local resources

**WATCH OUR VIDEO:**  
[www.cdph.ca.gov/MaternalMentalHealth](http://www.cdph.ca.gov/MaternalMentalHealth)

Maternal, Child and Adolescent Health | Center for Family Health | California Department of Public Health | FACT SHEET  
MAY 2019

**Reach:** This multi-media campaign included social media posts in May as well as e-mail newsletters. The campaign reached 2,765 e-mail addresses with one-third of recipients opening it. The video was viewed 619 times with 1,378 visits to the MCAH Maternal Mental Health web page. Social media analytics were unavailable.

**Awareness campaigns through advocacy organizations can be quite impactful. [TheBlueDotProject](#) hosts an annual Maternal Mental Health awareness campaign the first week of May and in 2019 generated 18 million social media impressions and over 36,000 website visits.**



### **[Postpartum Support International State Chapter](#)**

In November 2019, notice was shared with advocacy organizations and individual advocates that a state chapter of [Postpartum Support International \(PSI\)](#) would be established. The chapter will be run by elected volunteers who will set the state agenda. Postpartum Support International is best known for providing in-person provider training in local communities, and also providing a web-based training in conjunction with 2020 Mom. PSI also hosts a vetted [list of providers who are trained in maternal mental health](#) available to those who call the PSI warm line, and which is now available on the PSI website. Postpartum Support International also currently maintains a list of [support groups](#) in the state.



**There are several non-profits in the state addressing maternal mental health, most notably Maternal Mental Health Now serving Los Angeles county, 2020 Mom a national non-profit which is based in California, and Postpartum Health Alliance serving San Diego and surrounding areas.**

### **[Department Of Health Care Services Issues Bulletins on Billing](#)**

In November of 2018 ([bulletin 533](#)) and in July of 2019 ([bulletin 526](#)) the California Medicaid Agency, the Department of Health Care Services (DHCS) announced billing guidelines for maternal depression screening and for coverage of services to prevent maternal depression respectively. The guidelines read:

#### **Depression Screenings for Select Recipients Are Now Reimbursable**

Effective for dates of service on or after December 1, 2018, depression screening is reimbursable under Medi-Cal as an outpatient service. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment options including referral to mental health specialists and appropriate follow-up.

## Billing Codes

The following chart lists procedure codes that must be used when billing for depression screening:

Recipient Category	Positive Depression Screen	Negative Depression Screen
Pregnant or postpartum	G8431 with modifier HD	G8510 with modifier HD
Age 12 and older, not pregnant or postpartum	G0444 with modifier KX	96127

### Pregnant or Postpartum Recipients

Providers of prenatal care and postpartum care may submit claims twice per year per pregnant or postpartum recipient: once when the recipient is pregnant and once when she is postpartum. Screens that are positive for depression must be billed using HCPCS code G8431 (screening for depression is documented as being positive and a follow-up plan is documented) and modifier HD. Screens that are negative for depression must be billed using HCPCS code G8510 (screening for depression is documented as negative, a follow-up plan is not required) and modifier HD.

### Postpartum Depression Screening at Well-Child Visits

Providers of well-child care may submit claims for a maternal depression screening up to four times during the infant's first year of life. Bright Futures recommends screening for maternal depression at the infant's one-month, two-month, four-month and six-month visits, with referral to the appropriate provider for further care if indicated. Screens that are positive for depression must be billed using HCPCS code G8431 and modifier HD. Screens that are negative for depression must be billed using HCPCS code G8510 and modifier HD. When a postpartum depression screening is provided at the infant's well-child visit, the screening must be billed using the infant's Medi-Cal ID. The only exception to this policy is that the mother's Medi-Cal ID may be used during the first two months of life if the infant's Medi-Cal eligibility has not yet been established.

### Counseling to Prevent Perinatal Depression is Now Reimbursable

Effective for dates of service on or after February 12, 2019, and consistent with the U.S. Preventive Services Task Force recommendation, Medi-Cal will now reimburse individual and/or group counseling sessions for pregnant or postpartum women with certain depressive, socioeconomic and mental health related risk factors. These risk factors include perinatal depression, a history of depression, current depressive symptoms (that do not reach a diagnostic threshold), low income, adolescent or single parenthood, recent intimate partner violence, elevated anxiety symptoms and a history of significant negative life events.

Up to a combined total of 20 individual counseling (CPT codes 90832 and 90837) and/or group counseling (CPT code 90853) sessions are reimbursable when delivered during the prenatal period and/or during the 12 months following childbirth. Modifier 33 must be submitted on claims for counseling given to prevent perinatal depression.



## THE LANDSCAPE IN CALIFORNIA AND BEYOND

### Section 2: Significant National Action

#### HEDIS Measure Under Development

Co-funded by the [California Health Care Foundation](#) and the [ZOMA Foundation](#), a National Committee for Quality Assurance (NCQA) “Healthcare Effectiveness Data and Information Set” (HEDIS) measure is under development to monitor how often obstetric providers are screening for maternal depression. HEDIS measurement occurs through health insurers. The measure will look for screening during pregnancy and the postpartum period and for a follow-up encounter at least once in 30 days when there is a positive screen.

The final measures will be published in *HEDIS 2020 Volume 2: Technical Specifications for Health Plans* in July 2019, pending final approval from NCQA’s Board of Directors. Health plans would then have the opportunity to report the first-year measures in 2020, based on performance for measurement year 2019. Read more about the proposed measures, [here](#).

#### Board Certification in Perinatal Mental Health for Mid-Level Providers

In September 2018, Postpartum Support International (PSI) launched the Perinatal Mental Health (PMH) board certification for psychotherapists, prescribers, and affiliated professionals such as doulas and lactation consultants, referred to as a [PMH-C](#). In its first year, 25 psychotherapists, one affiliated professional and no prescribers in California became PMH board certified.



### [Complimentary Telepsychiatry Consultation Launches Nationally by the Non-Profit, PSI](#)

In June 2018, Postpartum Support International (PSI) launched a free [Perinatal Psychiatric Consult Program](#) for medical prescribers who have questions about mental healthcare for pregnant and postpartum women. Providers may call a phone line or fill out a web-based form on their inquiries, and receive a return call from an expert perinatal psychiatrist within 24 hours. In its first year, only 7 inquiries were made by prescribers in California and 100 inquiries total from the US; approximately 2 inquiries per week across the nation.

### [ACOG Defines the Fourth Trimester](#)

In May 2018, the American College of Obstetrics and Gynecology (ACOG) released [committee opinion number 736](#) redefining postpartum care. The committee's recommendations and findings were as follows:

#### **Recommendations and Conclusions**

“The American College of Obstetricians and Gynecologists makes the following recommendations and conclusions:

- To optimize the health of women and infants, postpartum care should become an ongoing process, rather than a single encounter, with services and support tailored to each woman's individual needs.
- Anticipatory guidance should begin during pregnancy with development of a postpartum care plan that addresses the transition to parenthood and well-woman care.
- Prenatal discussions should include the woman's reproductive life plans, including desire for and timing of any future pregnancies. A woman's future pregnancy intentions provide a context for shared decision-making regarding contraceptive options.
- **All women should ideally have contact with a maternal care provider within the first 3 weeks postpartum. This initial assessment should be followed up with ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth.**
- The timing of the comprehensive postpartum visit should be individualized and woman-centered.
- The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being.
- Women with pregnancies complicated by preterm birth, gestational diabetes, or hypertensive disorders of pregnancy should be counseled that these disorders are associated with a higher lifetime risk of maternal cardiometabolic disease.

- Women with chronic medical conditions, such as hypertensive disorders, obesity, diabetes, thyroid disorders, renal disease, mood disorders, and substance use disorders, should be counseled regarding the importance of timely follow-up with their obstetrician–gynecologists or primary care providers for ongoing coordination of care.
- For a woman who has experienced a miscarriage, stillbirth, or neonatal death, it is essential to ensure follow-up with an obstetrician–gynecologist or other obstetric care provider.
- **Optimizing care and support for postpartum families will require policy changes. Changes in the scope of postpartum care should be facilitated by reimbursement policies that support postpartum care as an ongoing process, rather than an isolated visit.”**



**A related press release issued by ACOG in April 2018, notes:**

“Timely follow-up is particularly important for women with chronic medical conditions. The initial assessment should be followed up with ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth. This visit should serve as a transition to ongoing well-woman care and the timing of the visit should be individualized, woman-centered and the follow-up should include a full assessment of the following:

- **mood and emotional well-being**
- infant care and feeding
- sexuality contraception and birth spacing
- sleep and fatigue
- physical recovery from birth
- chronic disease management
- health maintenance

**[The USPSTF Recommends Interventions to Prevent MMH Disorders](#)**

In September 2018, The United States Preventive Services Task Force (USPSTF) recommendation of [counseling as an effective intervention in preventing maternal depression](#). Specifically, the USPSTF cited that cognitive behavioral therapy or other evidence-based counseling improves outcomes for depressed perinatal women.

### [The American Academy of Pediatrics Reaffirms Position on Maternal Depression](#)

In January 2019, the AAP reaffirmed its position on screening for perinatal depression during well child visits in its report titled “[Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice.](#)”

### [The American Medical Association Addresses Maternal Depression](#)

In November 2017, the American Medical Association (AMA), the country's leading physician group [called for more routine depression and anxiety screenings](#) in new and expectant moms.

### [The American Psychiatric Association Issues Position on Maternal Mood and Anxiety Disorders](#)

In December 2018, the American Psychiatric Association (APA) issued a [position on screening and treating MMH disorders](#). The APA recommended more frequent screening for mood and anxiety disorders than other Associations; a total of 6 screens throughout the perinatal period including two screenings during pregnancy, including once early in pregnancy to detect pre existing psychiatric disorders, and once later in pregnancy.

### [FDA Approves First PPD Drug Treatment](#)

**In March 2019, the intravenous (IV) drug [Zulresso \(brexanolone\)](#) was approved by the Food and Drug Administration (FDA), and is the first and only drug specifically indicated for the treatment of postpartum depression.** The drug must be administered in an inpatient setting and the patient kept inpatient for several days. Though commonly accepted that the drug is a breakthrough, as of November 2019, only one hospital in California, UC Davis is providing the service/accepted insurance inpatient rates.

### [A Federal Maternal Mental Health Interagency Task Force to Issue a Report in 2020](#)

On December 20, 2019 President Trump signed the federal [budget bill](#) diverting government shutdown and funding a Maternal Mental Health interagency Task Force. [House Report 116-62](#) details the request, requiring the Secretary of Health and Human Services to convene agencies such as the Surgeon General, Health Resources and Services Administration (HRSA), the Centers for Medicare and Medicaid Services (CMS), the Office of Women’s Health and others to determine what role each should play in awareness, screening, diagnosis and treatment. The report must be issued to Congress by Wednesday June 17, 2020.

*This federal appropriations effort was spearheaded by the non-profit organization 2020 Mom, whose leaders noted much like no one particular provider type has been responsible for maternal mental health, which has lead to women falling through the cracks, no one federal agency has taken a leadership role in defining and adequately addressing maternal mental health.*

### [Patients Win a Class Action Law Suit Against National Insurer for Denial Behavioral Health Care](#)

On March 5th, 2019, a Judge in the Northern California District Court published an opinion in the cases of David Wit, et al., and Gary Alexander, et al., v. United Behavioral Health (UBH). Wit and Alexander (hereinafter *Wit*) represented plaintiffs in a class-action suit against UBH (operating as OptumHealth Behavioral Solutions). The plaintiffs asked the court to find for them on two grounds:

- (1) that UBH **breached its fiduciary duty** under ERISA (the Employee Retirement Income Security Act of 1974) by failing to properly administer the plaintiff’s health benefits plans, -and-
- (2) that UBH **arbitrarily and capriciously adjudicated and denied claims for coverage by using overly restrictive Guidelines.**

## What are Clinical Practice and Level of Care Guidelines?

Clinical Practice Guidelines are defined by the Institute of Medicine as follows:

**Clinical practice guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.**

**(Institute of Medicine, 1990)**

Guidelines are comprehensive and are issued by third-party organizations and define the role of specific diagnostic and treatment modalities in the diagnosis and management of patients. The statements contain recommendations that are based on evidence from a rigorous systematic review and synthesis of the published medical literature.

These guidelines are not fixed protocols that must be followed, but are intended for health care professionals and providers to consider along with their patients.



Unlike medical clinical practice guidelines (CPGs) there are no general mental health CPGs developed by professional associations such as the American Psychiatric Association, the American Psychological Association and/or the American Medical Association. Milliman, Inc. a consulting firm has developed [mental health care guidelines referred](#) to MCG Behavioral Health Care Guidelines which must be purchased.

***Clinical practice guidelines for the treatment of maternal mental health disorders have not yet been developed by professional associations. Guidelines do exist for other specialized behavioral health services, such as eating disorders.***

### Level of Care Guidelines

Similarly, guidelines note what level of care is warranted at what points along a continuum of outpatient and inpatient care. For example, the [American Society of Addiction Medicine](#) (ASAM) has created level of care guidelines used by treating providers and insurance companies alike.



## Of Note:

### Medical Doctor Training and Tests

There has been much discussion about whether Medical Doctors are adequately trained to screen for, recognize and treat maternal mental health disorders. California's Task Force on Maternal Mental Health recognized the key role of two primary types of MDs, Ob/Gyns and other Obstetricians, and Psychiatrists including "Reproductive Psychiatrists." A copy of the Task Force report issued in April 2017, and specifically the Task Force's recommendations for the testing boards boards and professional societies was sent to these organizations requesting a response.

### Reproductive Psychiatry

Currently there is no requirement that psychiatrists receive training in reproductive mental health though examinations from the American Board of Psychiatry and Neurology (ABPN) does include content related to maternal mental health.

Further, there is no board certification for a Reproductive Psychiatry subspecialty, as there is in child psychiatry for example. In order to create such a board, The American Council for Graduate Medical Education (ACGME) would need to set standards for Reproductive Psychiatry Fellowship training. These accreditation standards are needed for the American Board of Medical Specialties (ABMS) to establish an official subspecialty of Reproductive Psychiatry. Only if a subspecialty were to be approved by ABMS can the American Board of Psychiatry and Neurology (ABPN) develop a subspecialty certification for Reproductive Psychiatry.



To begin to close these gaps, in late 2019, the [National Curriculum in Reproductive Psychiatry](#) website, funded by the ABPN was launched in an effort to bring optional training to general psychiatrists.

### Ob/Gyns and Maternal-Fetal Medicine Specialists

The American Board of Obstetrics and Gynecology (ABOG) has created examination content for Ob/Gyns and high risk Maternal-Fetal Medicine (MFM) Ob/Gyns. The content primarily focuses on depression. ABOG sets more comprehensive requirements for Maternal-Fetal Medicine (MFM) doctors, also known as perinatologists, who specialize in high-risk pregnancies. Board examinations for MFM specialists include formulating a plan of management for MMH disorders, including depression, bipolar disorder, and schizophrenia including psychotic disorders.

The ABOG annual Maintenance of Certification (MOC) process replaces a more general continuing education requirement, and it includes a segment on maternal mental health diagnoses/disorders. There are also optional articles Ob/Gyns can read available through the MOC learning center. ABOG noted "Within the realm of our role as a certifying organization, we will continue to work toward efforts that translate into

supportive practice environments for women who need screening and treatment for conditions related to maternal mental health.



## THE LANDSCAPE IN CALIFORNIA AND BEYOND

### Section 3: Task Force Report Stakeholder Action Request Responses

To address **BARRIER 5** Stakeholder groups lack a framework or road-map for coordinated change, the Task Force created specific [stakeholder recommendations](#).

*Stakeholder groups, such as state agencies, the insurance community, the hospital community, the employer community, funders, and health care provider trade associations were encouraged to use the framework developed by the Task Force to guide efforts to close gaps in MMH care.*



After the Task Force Report was issued in April 2017, the stakeholder recommendations applicable to various organizations were distributed requesting a response. The tracking grid in the Appendix notes which organizations responded and includes an excerpt or full response.

## APPENDIX

### Stakeholder Response Tracking Grid

<https://docs.google.com/spreadsheets/d/1bAOGKhFjuN7TrLGc9TgcMIncGnQDDHLSVysnusmgRT0>

## THE LANDSCAPE IN CALIFORNIA AND BEYOND

### Section 4: Remaining Gaps, Recommended Actions and Conclusion

While significant strides have been made in California and Nationally to address maternal mental health since the [2017 California Maternal Mental Health Task Force report](#) was issued, additional action is necessary, including a significant focus on build up of accessible treatment.

## The following Barriers and Recommendations identified by the Task Force in 2017 have not yet been addressed or adequately addressed in California:

### BARRIER 1

Providers lack guidelines, referral pathways, capacity, and support to screen and treat.

#### Recommendation 4

*Provider-to-provider reproductive psychiatry consult program(s) should be piloted immediately and the results reported to the legislature in order to promulgate a new statewide provider resource to be implemented by the year 2021. **Not yet Implemented.** See page 14 of this report to learn of the attempt to address this gap through Assembly Bill 1676 (2019). **Legislation is expected to be reintroduced in 2020.***

#### Recommendation 5

*Insurers should develop Maternal Mental Health case management programs to oversee women's treatment access, reporting back to the Ob/Gyn. **Not yet Implemented.** The initial introduction of Assembly Bill 2193 (2018) included language requiring health plans and health insurers to develop case management services. This language was **Legislation and/or regulation should be pursued.** (See pg 13 of this report.)*

### BARRIER 2

Medical and mental health insurance and health delivery systems and providers are not integrated.

#### Recommendation 6

*In order to lay the groundwork for provider behavioral health integration, **medical insurers should first bring mental health in-house**, include mental health benefits in all medical care benefit contracts, and expand medical provider contracts to reimburse for MMH services. **Not yet implemented.** **No pending legislation or regulation, though California's Department of Managed Health Care has taken note of this recommendation.***

### BARRIER 4

Women don't receive adequate MMH support and education.

#### Recommendation 9

*Local communities should form new or employ existing coalitions to address Maternal Mental Health, including correcting local treatment shortages/referral pathways, disseminating*

educational materials and awareness campaigns, and improving support resources for mothers. **Partially in process.** Over two-thirds of county Departments of Public Health and local health jurisdictions have **prioritized MMH**. County Departments of Mental Health are beginning to look at maternal mental health, though the **Mental Health Services Oversight and Accountability Commission** should actively address use of Prop 63 MHSAs funding to address maternal mental health.



### **The following additional strategies should be deployed:**

In addition to the development of a State facilitated telepsychiatry consultation program, the creation of case management programs and continued rollout of community based maternal mental health support, **the following additional strategies are important to the future of maternal mental health in California and the U.S.:**

#### **Focus on the Range of Disorders not just Depression**

This report illustrates that many professional associations and others, including the California Department of Public Health have made significant progress to address maternal mental health, though may only use the term maternal depression or postpartum depression. Continued focus should be paid by these organizations to refer to the range of maternal mental health disorders including anxiety disorders, bipolar disorder (which if treated with antidepressants can trigger mania, putting a mother at risk for psychosis, a medical emergency).

#### **Development of Clinical Practice & Level of Care Guidelines**

As noted on pg 21, comprehensive guidelines for treatment of maternal mental health disorders have not yet been issued by any professional organizations but exist for other behavioral health disorders like eating disorders. Additionally level of care guidelines which address what outpatient or inpatient “level” of care is recommended based on a patient’s condition and prior treatment. Such guidelines will aid treating providers in treatment plan development and insurers in providing appropriate coverage. Additionally hospitals and others can use predictive modeling to make the case for additional treatment program development. These guides should be developed by professional trade associations including the Marce Society of North America as soon as possible, and no later than 2021.

## **Aggressively Build Up Treatment**

With one in eight births in the U.S. occurring in California, and with a screening mandate in place for obstetric providers, there is an urgent need to build up treatment access for maternal mental health disorders.

According to Massachusetts General Hospital's [Center for Women's Mental Health](#),

**“While we clearly see an increased interest in identifying women with perinatal mood and anxiety disorders, less attention has been devoted to how to deliver care to this vulnerable patient population. We continue to hear stories of women, even those with financial resources and/or excellent health insurance, who struggle to access care.”**

The following strategies should be deployed in California to address general mental health treatment shortages and super shortages of maternal mental health providers:

### **Follow Recommendations from Other State Reports to Address Mental Health Provider Shortages**

The state should follow recommendations noted on page 9-10 of this report to address significant existing and looming mental health provider shortage. Including:

- 1. Development of psychiatric nurse practitioner, Ob/Gyn and nurse midwife programs that recruits from and trains providers to serve in underserved communities;**
- 2. Expansion of the number of primary care physician and psychiatry residency positions;**
- 3. Scale the engagement of community health workers, promotores, and peer providers through certification, training, and reimbursement, broadening access to prevention and social support services in communities across the state;**
- 4. Expand funding for educational capacity, stipends, and scholarships to strengthen the size, distribution, and diversity of the behavioral health workforce.**
- 5. Create systems that support team-based models of care in which psychiatrists provide advice and education about medications to primary care physicians, physician assistants (PAs), and nurse practitioners (NPs) either in person or virtually via telehealth technology**

### **Deploy Maternal Mental Health Certified Peer Specialists**

Peer Support has been well recognized by the [Centers for Medicaid and Medicare Services \(CMS\)](#) and others as evidence-based in supporting those with mental illness and substance use disorders. California is the last state to create a certifying body for peers. For several years, legislation has been [vetoed](#) by California's governors. Certification should be made available as soon as possible, not later than 2021. Additionally, a [specialized maternal mental health peer support training](#) should be made available in California no later than 2021. A study will be released in early 2020 in support of such training.

### **Increase Number of MMH Specific Inpatient and Intensive Outpatient Treatment Facilities**

Including an inpatient maternal mental health program. [Just three intensive outpatient programs exist and no inpatient programs.](#) Several recent [news articles](#) highlight the need for inpatient programs unique to the needs of mothers. State and federal funding should be considered for development of such programs.

## IN CONCLUSION

This report, “Maternal Mental Health: State of the State in California and Beyond” a follow up to the report issued by the California Task Force on Maternal Mental Health Care in April 2017 [A Report from the California Task Force on the Status of Maternal Mental Health Care: A Strategic Plan](#) highlighted the significant efforts that have been implemented both in California and nationally.

The Task Force report noted:

*“Addressing Maternal Mental Health is the shared responsibility of doctors, hospitals, insurers, policymakers, government agencies, and communities.*

*Together, stakeholders can take steps to prevent Maternal Mental Health disorders and close gaps in care. The Task Force urges stakeholders to commit to improving Maternal Mental Health by the year 2025.”*

**California has made significant strides, yet significant work is still warranted and stakeholders seem as willing as ever to keep up the momentum. Mothers, Babies and Families Deserve it. And the Future of California Depends on it.**



*To learn more about California’s and the nation’s progress to close gaps in maternal mental health in the year 2020 and beyond, visit [2020Mom.org](http://2020Mom.org)*