MURIEL BOWSER
MAYOR

January 9, 2024

The Honorable Phil Mendelson
Chairman
Council of the District of Columbia
John A. Wilson Building
1350 Pennsylvania Avenue, N.W., Suite 504
Washington, D.C. 20004

Dear Chairman Mendelson:

I am pleased to submit to the Council of the District of Columbia the enclosed Perinatal Mental Health Task Force: Recommendations to Improve Mental Health in the District, which was prepared by the Department of Health Care Finance (DHCF) pursuant to section 7-1234.02 of the D.C. Code.

The report includes findings of the Task Force which represented diverse stakeholders, including government representatives from behavioral health, Medicaid, public health, and the Council. As well as by members representing various fields including medicine, mental health, nursing, midwifery, doula services, community-based organizations, health centers, and managed care plans. Notably, the Task Force included birthing individuals, caregivers, or advocates with personal experience in perinatal mood and anxiety disorders. Over 20 recommendations are provided in the report, with a focus on enhancing navigation and care coordination; investment in the continuum of care of perinatal mental health services; system accountability; development of workforce; and considerations for special populations. The recommendations outlined aim to catalyze transformative change, forging a path toward greater equity, accessibility, and improved mental health outcomes for all residents of the District, regardless of their perinatal journey or background.

If you have any questions regarding this report, please contact Tai Meah, Deputy Chief of Staff at (202) 923-9035 or by email at tai.meah@dc.gov.

Sincerely,

Muriel Bowser

Perinatal Mental Health Task Force

Recommendations to Improve Perinatal Mental Health in the District

District of Columbia 2023 Department of Health Care Finance

District of Columbia

Perinatal Mental Health Task Force Report and Recommendations

Presented To:

The Honorable Muriel Bowser, Mayor, District of Columbia

The Council of the District of Columbia

The Residents of the District of Columbia

December 2023

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Glossary

AAP	American Academy of Pediatrics
ACOG	American College of Obstetricians and Gynecologists
BHC	Behavioral Health Consultant
BIPOC	Black, Indigenous, and People of Color
CEU	Continuing Education Unit
CHI	Centering Healthcare Institute
CHW	Community Health Worker
CPT	Current Procedural Terminology
DC MAP	DC Mental Health Access in Pediatrics
DC MMRC	District of Columbia Maternal Mortality Review Committee
DC NEXT	D.C. Network for Expectant and Parenting Teens
ECHO	Extension for Community Healthcare Outcomes
EPDS	Edinburgh Postnatal Depression Scale
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
FQHC	Federally Qualified Health Centers
GPC	Group Prenatal Care
HEDIS	Healthcare Effectiveness Data and Information Set
HPHB	Healthy Parents Healthy Babies
HRSA	Health Resources and Services Administration
LGBTQIA	Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual
MCO	Managed Care Organizations
MMHLA	Maternal Mental Health Leadership Alliance
NIH	National Institutes of Health
OB/GYN	Obstetrician-Gynecologist
PAT	Parent as Teachers
PCIT	Parent-Child Interaction Therapy
PMAD	Perinatal Mood or Anxiety Disorder
PMH	Perinatal Mental Health
PRAMS	Pregnancy Risk Assessment Monitoring System
UDC	University of the District of Columbia
USPSTF	US Preventive Services Task Force
WMHP	Women's Mental Health Program

Greetings from the Perinatal Mental Health Task Force Co-Chairs

Melisa Byrd – Government Co-Chair
Medicaid Director/Senior Deputy Director, Department of Health Care Finance

Nandi Barton – Non-Government Co-Chair
Community Member

Aimee Danielson, PhD - Non-Government Co-Chair
Clinical Psychologist, MedStar Georgetown University Hospital/ MedStar Washington Hospital Center

As the co-chairs of the Perinatal Mental Health Task Force ("Task Force"), we write to you today with a profound sense of gratitude and accomplishment as we introduce the 2023 Perinatal Mental Health Report. This report is an embodiment of the collective efforts made by a devoted task force comprised of experts with clinical, community, and lived experience, and esteemed advocates like yourself.

From January 2023 to September 2023, the Task Force sought to thoroughly understand the distinct mental health needs and challenges faced by individuals across Washington, D.C., ("the District") both during pregnancy and in the year after childbirth. We diligently studied numerous local and national evidence-based programs as well as strategies, policies, and initiatives from other states that address or offer solutions related to improving perinatal mental healthcare. Our collaborative efforts led to the development of this report which, while acknowledging progress, identifies numerous complex challenges encountered by birthing individuals.

Most importantly, this report offers thoughtfully crafted recommendations that provide a roadmap towards a future where perinatal mental health services are not only accessible but are compassionate, comprehensive, and community-driven. These recommendations are than mere suggestions; they represent a pledge to all women, mothers, and birthing individuals in the District that we will continue to advocate, support, and stand alongside them.

The work of the Task Force is a testament to the shared vision that every woman, regardless of her background, can embark on the incredible journey of motherhood with confidence, support, hope, and health.

Executive Summary

Perinatal mental health (PMH) conditions encompass a range of mental health conditions that pregnant individuals may experience during pregnancy and up to one year postpartum. PMH conditions include perinatal loss and individuals who may experience infertility challenges.[1,2] Perinatal mood and anxiety disorders (PMAD) is also a commonly used term in medical literature, but this report primarily refers to PMH disorders. PMH disorders include depression and anxiety disorders, bipolar disorder, obsessive-compulsive disorder, post-traumatic stress disorder, and psychosis.

PMH disorders peak between three to six months postpartum, underscoring the significance of implementing effective screening and timely treatment to support those in need before and within that time frame. Untreated maternal mental illness is demonstrated to contribute to multiple early childhood developmental problems, including impaired cognitive, social, and academic functioning. Children of depressed birthing persons are at least two to three times more likely to develop adjustment problems, including mood disorders.

Efforts to prioritize maternal health at the national level have spurred various initiatives undertaken by federal government agencies, community-based organizations, and advocacy groups. The Council of the District of Columbia took decisive action by establishing a Perinatal Mental Health Task Force as part of the Fiscal Year 2023 Budget Support Act of 2022.

The Task Force brought together diverse stakeholders, including government representatives from behavioral health, Medicaid, public health, and the Council. The Task Force was further enriched by members representing various fields including medicine, mental health, nursing, midwifery, doula services, community-based organizations, health centers, and managed care plans. Notably, the Task Force included birthing individuals, caregivers, and advocates with personal experience in perinatal mood and anxiety disorders.

The Task Force met nine times between January 2023 and September 2023. Meeting notices were posted on the Department of Health Care Finance ("DHCF") website. Public comments were accepted and considered at every meeting. The work of the Task Force was divided into four workgroups: (1) Navigation and Access; (4) Resources and Data; (3) Screening, Referral, and Workforce Development; and (4) Public Awareness and Systems Capacity. Each workgroup met multiple times to gather information, share resources, and develop recommendations to address the District's unmet maternal mental health needs. The following report and recommendations are the result of that work. The recommendations in this report draw inspiration from successful policies implemented at national, state, and local levels to address PMH disorders.

The Task Force recognizes that implementing the recommendations of this report requires a sustained and multifaceted public-private approach that addresses individual, provider, and systemic barriers to care. Leveraging the work of community-based organizations in the District is key to success when paired with the strong, committed partnership of the District government. By scaling up current practices, executing the recommendations of this report, and building community rapport and trust, the District can significantly expand PMH services.

Summary of Recommendations

- ✓ Resume the "fast-tracking" (or creating a new process) of getting pregnant patients insured within 28 days of application.
- ✓ Develop a District Perinatal Psychiatry Access Program.
- ✓ Develop policy guidance and adequate reimbursement for care coordination services.
- ✓ Support public awareness campaigns, similar to immunization and tobacco cessation campaigns, which raise awareness and reduce stigma around PMH disorders.
- ✓ Increase patient accessibility and reduce provider administration burdens via standardization of perinatal mental health services and Medicaid Managed Care Plans.
- ✓ Invest in prevention counseling interventions.
- ✓ Invest in group support models to alleviate the shortage of culturally competent mental health support.
- ✓ Provide direct consultation reimbursement in Medicaid. This will allow more patients to be treated where PMADs are identified and will reduce access challenges where there are limited therapy and program resources.
- ✓ Expand reproductive health coordinators at all school-based behavioral health centers, in order to increase access to vital reproductive health services where they are needed and where they can have optimal impact.
- ✓ Support the establishment of an inpatient perinatal psychiatry unit in the District. Incentives for the development of an inpatient unit can include financial incentives for healthcare institution(s) to invest in this care.
- ✓ Support the establishment of perinatal intensive outpatient programs and partial hospitalization programs in the District.
- ✓ Ensure perinatal mental health representation on all relevant Boards.
- ✓ Develop a standing District perinatal mental health advisory group, board, or task force.
- ✓ Increase collection of relevant perinatal mental health data including HEDIS (Healthcare Effectiveness Data and Information Set) measures from Medicaid and commercial insurers across public and District-wide sources, and ensure data is published publicly for better understanding across the District.
- ✓ Expand the workforce by investing in community health workers, peer support, and other paraprofessionals to help prevent and address PMH disorders.
    - Allow Medicaid payment for mental health support services provided by community health workers and other paraprofessionals serving pregnant and postpartum populations.

- Resource a team of perinatal community health workers trained and equipped to support young or teen parents and assist them in navigating the adult-parent system of health and social services.

- ✓ Support the increased recruitment of perinatal mental health providers that are culturally and linguistically representative of the diverse populations that they serve and offer training to the existing workforce on culturally congruent practices.
- ✓ Support a city-wide perinatal mental health Extension for Community Healthcare Outcomes (ECHO) program, offering a valuable education and training model to PMH providers.
- ✓ Provide enhanced Medicaid reimbursement for mental health providers (holding any type of clinical license) who have specialized training and certifications in perinatal mental health.
- ✓ Offer and encourage perinatal mental health Continuing Education Unit (CEU) hours for the next renewal cycle for clinical licensure for social workers, counselors, psychologists, and psychiatrists (those holding any type of clinical license).
- ✓ Provide career training, financial incentives, scholarships/ loan repayment, and other financial support to those entering the perinatal mental health field.
- ✓ Partner with organizations and universities that can offer substantial professional pre- and postpartum doula training, certification, and technical assistance that specifically targets candidates seeking to support people with a range of disabilities navigating the perinatal health system, particularly the Districts perinatal behavioral healthcare system.

Section I:

The Work of the Perinatal Mental Health Task Force

Establishing the Task Force

In recognition of the increasing awareness and concern surrounding untreated perinatal mental health disorders and their profound impact on birthing individuals, children, families, and the broader community, the Council of the District of Columbia took decisive action by establishing a Perinatal Mental Health Task Force as part of the Fiscal Year 2023 Budget Support Act of 2022.

Scope of the Task Force

The Task Force was tasked with conducting a comprehensive study of and presenting recommendations on the following key areas:

1. **Vulnerable Populations and Risk Factors:** Identifying vulnerable populations and risk factors associated with perinatal mental health disorders.
2. **Evidence-Based Practices:** Investigating evidence-based and promising practices for individuals experiencing or at risk of perinatal mood and anxiety disorders.
3. **Access to Care:** Analyzing barriers to accessing care during the perinatal period for both birthing individuals and their partners. Identifying evidence-based and promising practices for care coordination, systems navigation, and case management services to eliminate these barriers.
4. **Racial and Ethnic Disparities:** Examining evidence-informed practices that are culturally congruent and accessible to address and eliminate racial and ethnic disparities in the prevention, screening, diagnosis, intervention, treatment, and recovery from perinatal mood and anxiety disorders.
5. **Access Models:** Studying national and global models that have successfully promoted access to care, including screening, diagnosis, intervention, treatment, recovery, and prevention services for perinatal mood and anxiety disorders in pregnant or postpartum individuals and non-birthing partners.
6. **Community-Based Support:** Evaluating community-based or multigenerational practices that provide support to individuals and families affected by maternal mental health conditions.
7. **Workforce Development:** Assessing successful initiatives related to workforce development, encompassing the recruitment, training, and retention of a behavioral health care workforce focused on perinatal mental health. This includes maximizing the utilization of non-traditional behavioral health supports such as peer support and community health workers.
8. **Funding Models:** Exploring models for both private and public funding of perinatal mental health initiatives.
9. **Landscape Analysis:** Conducting a thorough landscape analysis of available perinatal mental health programs, treatments, and services. Identifying notable innovations and gaps in care provision and coordination, with a particular focus on meeting the diverse needs of unique populations, including Black birthing individuals, Hispanic birthing individuals, pregnant and postpartum individuals of color, perinatal immigrant populations, adolescents who are pregnant and parenting, and LGBTQIA+ individuals.

Task Force Membership

The Task Force consisted of a diverse group of stakeholders, including government representatives from behavioral health, Medicaid, public health, and the Council. Additionally, the task force included members from various sectors, including medicine, mental health, nursing, midwifery, doula services, community-based organizations, health centers, and managed care plans. Among these members were birthing individuals, caregivers, and advocates with personal experience in perinatal mood and anxiety disorders.

List of Perinatal Mental Health Task Force Members

Andrea Agalloco, MSW, LICSW, PMH-C Mary's Center	**Ona Balkus** Council's Committee on Health	**Maariya Bassa** Unity Health	**Maislyn Christie** Amerigroup
Lauren Demosthenes Babyscripts	**Fari Ghamina Tumpe** SPACEs in Action	**Tiffany Gray, DrPH, MPH** DC Health	**Amena Hamilton**[+] AmeriHealth Caritas DC
Bryan Harrison Office of Deputy Mayor of Health and Human Services	**Crystal Jackson**[+] Birth & Postpartum Doula A Queen Momma Doula Services	**Lenore Jarvis, MD, Med, FAAP** Children's National Hospital	**Anna Koozmin** Children's National Hospital
Annette Lee Registered Nurse Department of Behavioral Health	**NaToya Mitchell**[+] Infinitely Consulting	**Keila Olughu** Mary's Center	**Raymond Tu, MD, MS** MedStar Family Choice – District of Columbia
Victoria Roberts Community of Hope	**Katie Whitehouse** Council's Committee on Housing	**Sydney Wilson**[+] Mamatoto Village	**Wanda Wilson** Department of Behavioral Health

Perinatal Mental Health Task Force Co-Chairs

Nandi Barton Community Member	**Melisa Byrd** Department of Health Care Finance	**Aimee Danielson, PhD** MedStar Georgetown University Hospital/MedStar Washington Hospital Center

+ Denotes subcommittee chairpersons

Task Force Process

Task Force Members, along with the public, convened on the 4th Tuesday of each month starting from January 2023 to discuss specific topics (see appendix A). The Task Force operated in two distinct phases. In the first phase, experts and community members were invited to explore existing programs, initiatives, and guidelines. To facilitate this, four subcommittees were established, open to public input.

Each subcommittee held monthly meetings until July 2023, focusing on addressing questions related to the legislated key areas for the Task Force. Phase II, Development of Recommendations, is covered in the second half of this report.

Phase I: Landscape Exploration - The Subcommittees and Their Focus Areas

The Screening, Referral, and Workforce Development

This subcommittee investigated perinatal mental health screening across the country, searching for models for PMH screening implementation. The subcommittee sought to understand the current situation of screening in the District and actions required to improve screening rates and referrals across the District through all healthcare settings.[3] From the workforce perspective, the committee aimed to understand what training is required for providers to become more culturally aware and to address implicit bias and PMH needs within the District. Additionally, the subcommittee aimed to identify current non-billable services that would support the perinatal population which DHCF could make reimbursable, to increase referral pathways.

Navigation and Access

This subcommittee investigated barriers that populations face in accessing the necessary services for screening and treatment. The committee sought to understand the extent to which telehealth or other methods of treatment or support would help address these disparities.

Resources and Data

The Resources and Data subcommittee sought to understand available resources in the District to support PMH services and determine the extent to which these resources are utilized. Furthermore, the subcommittee examined the needs assessment, research, and program evaluations that were required to better understand the status of and monitor progress on perinatal mental health disorders in the District.

Public Awareness and Systems Capacity

This subcommittee aimed to understand how the District can better raise awareness and reduce the stigma surrounding PMH disorders. Additionally, the subcommittee sought to identify ways in which the District can build upon existing partners to better support perinatal mental health. The subcommittee fielded a survey to the community to solicit feedback. Lastly, the subcommittee strove to identify community-based, peer-based, and multigenerational care models to support the perinatal population and their families.

Phase II: Development of Recommendations

In the second phase, the findings from the first phase were utilized to formulate recommendations. Both the Task Force and the public submitted recommendations for consideration. During the months of June 2023 and July 2023, each Task Force member was asked to submit at least two recommendations to be considered for the report. The call for recommendations was then expanded to the subcommittee members and the public.

During the August 2023 Task Force meeting, members were asked to evaluate these recommendations and indicate their level of agreement. Absent members had the opportunity to submit their votes and comments in writing. The Task Force used a level of agreement facilitation exercise to determine the

level of agreement with the 51 recommendations that were submitted for the consideration of the Task Force. The recommendations have been categorized in terms of:

- Access and Navigation: Issues around addressing social needs and care coordination.
- Public Awareness and Systems Capacity: Issues around public awareness campaigns, continuing the work of the task force, and working with other agencies.
- Screening and Referral: Issues around screening tools and referrals including incentives.
- Services and Data Reporting: Issues around expanding services/programs or creating new ones as well as data collection and public reporting.
- Workforce Development: Issues around recruitment, retention, training, or incentives.

Members were asked to indicate their level of agreement with each of the recommendations. Each number corresponds to a different level of agreement with recommendations:

1. I vehemently disagree and feel I must stand in the way of this statement.
2. I disagree but will not stand in the way.
3. I am undecided and/or abstain from voting.
4. I agree with some reservations.
5. I am in complete agreement and unreservedly support this statement.

Recommendations were considered to reach a consensus threshold when more than 70 percent of the members were in complete agreement and unreservedly supported the statement or when the recommendation received an average score greater than 4.6 on the Likert scale.[4,5] Of the 51 recommendations, 32 reached the consensus threshold and are put forth in this report. All 51 recommendations that were reviewed can be found in Appendix B.

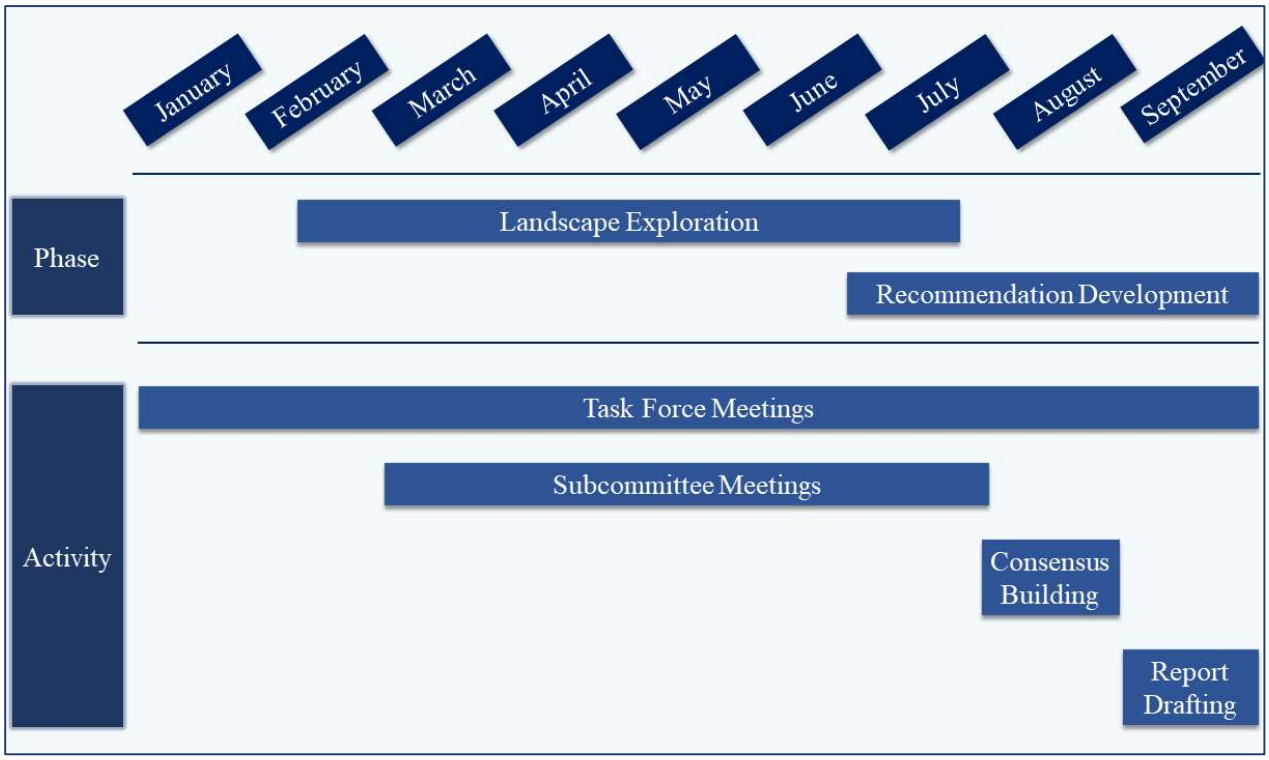


Figure 1: Task Force Recommendation Process

Section II:

The Perinatal Mental Health Landscape

Introduction

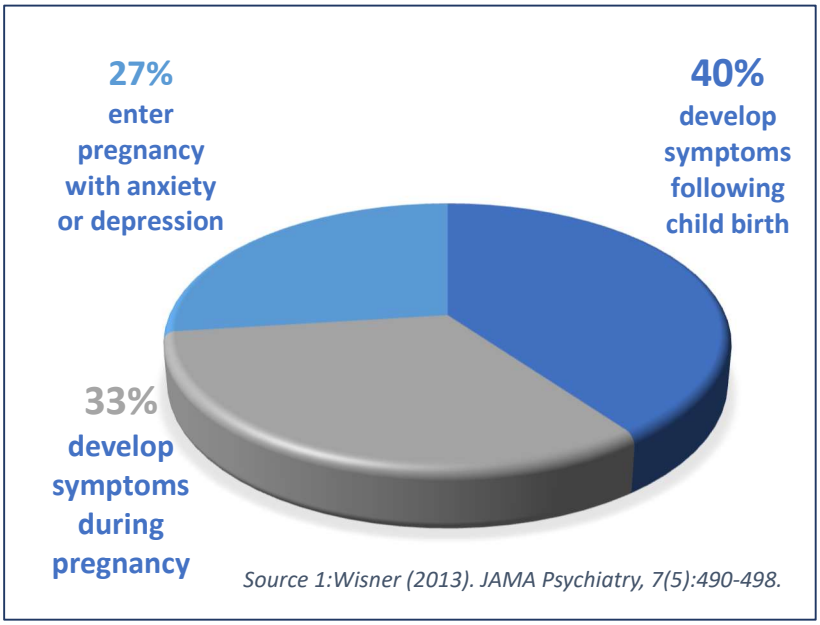
Perinatal mental health conditions (PMH) refer to mental health conditions that pregnant individuals may experience during pregnancy and up to one year postpartum including perinatal loss or individuals who may experience infertility challenges.[6,7] While the term "perinatal mood and anxiety disorders (PMAD)" is also used in literature, this report primarily utilizes PMH disorders. PMH disorders include depression, anxiety disorders, bipolar disorder, obsessive-compulsive disorder, post-traumatic stress disorder, and psychosis. These disorders can range in severity and can present or recur anytime during pregnancy and the first year after childbirth.[8]

Statistics reveal that one in five pregnant individuals experience a PMH disorder. This number is much higher for Black birthing persons, half of whom experience a PMH disorder.[9,10] This disparity, coupled with the demographics of the District, emphasize the need to address this issue. Research demonstrates an association between PMH disorders and increased costs per delivery hospitalization, and 50% higher rates of severe maternal morbidity compared to those without mental health disorders.[11] This is an issue that touches on the healthcare system as a whole and contains numerous fiscal implications.

PMH disorders contribute to maternal mortality. A notable report released by the CDC on maternal mortality identified suicide and overdose/poisoning related to substance use as the leading causes of pregnancy-associated mortality, accounting for 23% of deaths.[12] This underscored the importance of addressing mental health concerns, particularly during the perinatal period. The District of Columbia Maternal Mortality Review Committee (DC MMRC) was established in 2018 to address systemic factors impacting maternal mortality by evaluating services, care delivery, and referrals provided to birthing persons who died during pregnancy, childbirth, or within 365 days of the end of a pregnancy. In the 2019-2020 and 2021 Annual Reports, the DC MMRC encouraged the focus on PMH disorders in future reports to benefit public discourse and direct needed attention and resources to the District's perinatal population based on both maternal mortality and morbidity.[13] [14]

PMH disorders peak between three to six months postpartum, underscoring the significance of implementing effective screening and timely treatment prior to or within that particular time frame to provide support to those in need.[15] Untreated maternal mental illness is demonstrated to contribute to multiple early child developmental problems, including impaired cognitive, social and academic functioning.[16] [17] [18] [19] Children of depressed birthing persons are at least two to three times more likely to develop adjustment problems, including mood disorders.[20]

Figure 2: Of Birthing Persons Who Experience Anxiety or Depression During Pregnancy or First Year of Baby's Life



Source 1:Wisner (2013). JAMA Psychiatry, 7(5):490-498.

Even in infancy, children of depressed birthing persons are more fussy, less responsive to facial and vocal expressions, more inactive, and have elevated stress hormone levels compared to infants of non-depressed birthing persons.[21] [22] Accordingly, the study of child development in the context of maternal depression has been a major childhood developmental research focus for the past several decades.

Risk Factors

The recent Clinical Practice Guidelines,[23] published by the American College of Obstetricians and Gynecologists (ACOG), identified several risk factors associated with perinatal mental health conditions, offering a comprehensive understanding of the biological, environmental, and psychological determinants of PMH disorders.[24] These factors include traumatic birth experiences, adverse child experiences, encounters with racism, substance use disorder, socioeconomic conditions (transportation, housing, employment status), and coping skills.[25]

Moreover, specific barriers within the District are transportation, housing, and childcare, which further hinder the ability of an individual suffering from a PMH disorder to seek the appropriate care.[26] PMH disorders disproportionately affect historically underserved populations, including low-income individuals, and people of color.[27] For instance, Black individuals face depression at more than double the rate of their non-black counterparts with structural racism and "weathering" contributing to this disparity.[28,29] However, despite higher prevalence, Black individuals are half as likely to receive treatment.[30] In terms of maternal health overall, the maternal mortality ratio for Black pregnant individuals is three to four times that of their White counterparts, with high rates regardless of educational attainment or income level.[31] Additionally, parents of color or those facing economic disparities encounter greater barriers to access to screening and subsequent care in comparison to their white counterparts.[32] Insufficient support during PMH illness has been associated with an increased risk of suicide, psychotic illness, and even infanticide.[33] Therefore, expanding screening for these groups is crucial as early identification and treatment leads to better outcomes.[34]

Apart from the physical and emotional toll associated with untreated PMH disorders, there is also a heavy financial cost. A joint 2022 report by the Maternal Mental Health Leadership Alliance (MMHLA) and March of Dimes estimates the cost of untreated PMH disorders at "$32,000 per mother/infant dyad (or $14 billion nationally for a single year birth cohort)". [35] This includes health outcomes of the mother and baby as well as loss of wages and productivity of the parent. The largest costs are attributed to the reduced economic activity among affected mothers, an increase in preterm births, and higher maternal health spending.[36] Mothers bear 65% of these costs, while their children account for the remaining 35%. This economic burden further underscores the need to address PMH disorders in the District.

The State of Perinatal Mental Health in the District

In December 2021, the DC MMRC released data on cause-specific maternal mortality. Between 2014 and 2018, the maternal mortality ratio stood at 23.1 per 100,000 live births.[37] Notably, pregnancy-associated deaths disproportionately impact Wards 7 and 8, where 70% of the entire District's pregnancy-associated deaths occur. [38] Despite accounting for roughly half of recent births, Black birthing individuals in the District constituted 93% of pregnancy-associated non-related deaths.

It is important to highlight that much of the data presented in the MMRC report is not directly linked to PMH disorders. Consequently, the specific role that PMH disorders play in the MMRC report remains unclear. There is a notable lack of data on PMH disorders in the District. This gap in data makes it challenging to assess the prevalence and impact of PMH disorders on maternal and infant health accurately. It underscores the need for comprehensive research and data collection efforts to better understand and address PMH disorders within the District.

There is a notable lack of data on PMH disorders in the District. This gap in data makes it challenging to assess the prevalence and impact of PMH disorders on maternal and infant health accurately.

In the District, the richest data currently available is DC's Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS is an ongoing surveillance project that collects data by surveying residents who have recently delivered a live-born infant. This comprehensive data collection initiative encompasses a wide range of topics related to the experiences and behaviors of childbearing-age individuals, including breast- or chest feeding, childhood stressors, experiences of discrimination, prenatal and postpartum care, substance use, and mental health. Additionally, PRAMS includes supplemental topics such as opioid use and experiences related to COVID-19.

The most recent PRAMS report, which was published in 2020, offers vital insight into the state of perinatal mental health in the District:

- Approximately twelve percent of participants reported receiving counseling during pregnancy.
- Postpartum counseling rates showed an increase compared to 2018 but experienced a slight decline from 2019 to 2020.
- Participants indicated higher levels of discussions with their healthcare providers about depression during the postpartum period compared to discussions during the prenatal or pre-conception phases.
- The postpartum counseling rate reached 17% as of 2020, but there still appear to be gaps in care during pregnancy, with fewer individuals reporting receiving counseling compared to those who reported experiencing depression during pregnancy. [39]

Evaluations of the District's Perinatal Mental Health Services

The Mary's Center DC Perinatal Mental Health Impact Evaluation and the Policy Center for Maternal Mental Health's 2023 Inaugural Maternal Health State Report Card provide a collective emphasis on the urgent need for addressing training, coordination, access barriers, and the shortage of mental health providers to effectively enhance PMH services in the District.

Mary's Center DC Perinatal Mental Health Impact Evaluation 2015-2018

Mary's Center is a federally qualified health center serving over 65,000 people of all ages, incomes, and backgrounds in the District and offers a Maternal Mental Health Program. In 2015, Mary's Center, in partnership with the DC Collaborative for Mental Health in Pediatric Primary Care, conducted a perinatal mental health needs assessment to determine the gaps in programming, training, organizational capacity, and advocacy. In 2018, Mary's Center conducted and published the DC Perinatal Mental Health

Impact Evaluation Brief, aimed at gaining insight into the changes in various PMH activities in the District by examining the perspectives of primary care, mental health, and healthcare service providers, as well as patients.[40] Data collection methods included provider surveys, participant surveys, and participant focus groups. Key findings from the impact brief include:

Provider Understanding: Approximately 72% of allied and medical providers demonstrated a good understanding of PMH disorders. This marked an increase in the level of comfort in assessing mental health needs within the medical provider group, rising from 38% in 2015 to 72% in 2018. Additionally, 67% of respondents reported feeling comfortable discussing their emotional health with their medical providers.

Referrals and Training: Many mental health providers were not receiving referrals from pediatricians or adult primary care providers, with a significant proportion of referrals originating from participants themselves. The report highlighted the need for PMH training, as approximately 72% of medical providers believed that such training would increase the likelihood of screening and provider referrals.

Gaps in Care Coordination: The report identified gaps in care coordination and follow-through on appointment scheduling and referrals. For example, 80% of respondents were never scheduled for their appointment, and even among those who were scheduled, 60% did not attend the appointment. These findings underscore the need for a person-centered approach to screening and improved care coordination.

Language Services and Access Barriers: Language services were identified as a barrier to care for perinatal individuals with limited English proficiency. Patients and providers both cited barriers to access, including a lack of awareness about available services and difficulty scheduling initial appointments.

Persistent Barriers: Barriers to care, as understood by providers, remained largely consistent since the 2015 evaluation. These included insufficient time and other demands, stigma and cultural issues, financial challenges, and inadequate insurance coverage. A more prominent theme in the 2018 assessment was the identification of the location and physical accessibility of treatment options.

Lack of Mental Health Providers: One of the main concerns raised by allied and medical providers was the shortage of mental health providers in the District.

Until the establishment of the Task Force, there has not been a consistent measurement of overall perinatal mental health access, provider network, or services in the District. While the Mary's Center evaluation is important, and helped guide the work of the taskforce, its age, and the lack of any follow-up reports in the intermediate time period, highlight the need for this report.

The Policy Center for Maternal Mental Health: Inaugural Maternal Mental Health State Report Card

More recently, The Policy Center for Maternal Mental Health released their 2023 Inaugural Maternal Health State Report Card providing a comprehensive view of the state of maternal mental health in America. The three domains evaluated in the report were:

Providers and Programs assessed the availability of perinatal mental health certified or trained providers and services (i.e., outpatient intensive or partial hospitalization programs, inpatient perinatal mental health treatment programs, etc.)

Screening Requirements and Reimbursement focused on the requirements pertaining to screening in Medicaid or private insurance, the collection of HEDIS measures, and whether screening was reimbursable.

Insurance Coverage and Payment focused on policies regarding Medicaid expansion, 12-month postpartum Medicaid coverage, a state requirement to develop a maternal mental health quality program, private insurance billing for prenatal treatment, and private insurance billing for postpartum treatment.

The District received an overall grade of "D+" for maternal mental health services, while the national average was a "D". California was the only state to receive a passing grade of "B-". Forty states and the District received either "D's" or "F's". In particular, the District received an "F" for screening requirements and reimbursement and a "D" for providers and programs. However, the District performed relatively better in the Insurance Coverage and Payment domain, meeting all but one of the five measures, which pertained to the requirement for health plans to develop a maternal mental health quality program.

These findings underscore the alignment between Task Force discussions and the evaluations, emphasizing the importance of addressing training, care coordination, access barriers, and the shortage of mental health providers to enhance PMH services within the District. There is a lack of publicly available data, however, to effectively assess perinatal mental health in the District. The absence of data provides challenges to confirming the most effective strategies to meet the needs of birthing people.

National, State, Local, and District Efforts to Address PMH Disorders

Efforts to prioritize maternal health at the national level have spurred various initiatives undertaken by federal government agencies, community-based organizations, and advocacy groups. For example, in June 2022, the Biden-Harris administration unveiled the "Blueprint for Addressing the Maternal Health Crisis" which included fifty actions to enhance maternal health.[41] Key among these actions is Goal 1, which focuses on improving access to and coverage of behavioral health services, including PMH services. The U.S. Department of Health and Human Services and the Biden-Harris Administration have awarded more than $103 million to support and expand access to maternal health. This included forming a new task force to address maternal mental health conditions and co-occurring substance use disorders, and launching a national public education campaign, Talking Postpartum Depression, to provide information about and combat stigmatization associated with this significant public health issue as part of the latest steps to continue the implementation of Blueprint.[42]

Additionally, the blueprint acknowledges the role of health-related social needs in maternal health outcomes. It calls for increased screening for individuals with specific social risk factors, such as homelessness and food insecurity, and aims to reduce administrative barriers to enrollment in federal programs offering childcare, food, and housing assistance.[43] By doing so, it aims to address the broader social determinants impacting maternal health.

Numerous government entities, universities, and nonprofit organizations have taken steps to enhance perinatal mental health at national, state, and local levels. This landscape scan aims to provide an overview of national, state, and District-specific efforts to address perinatal mental health within their jurisdictions.

Notably, state actions encompass a range of services related to perinatal mental health disorders, which were initially explored within the list compiled by the MMHLA. Research was divided into the following topics, which align closely with the Task Force subcommittees – screening and referral, workforce; navigation and access; services and data; and public awareness and systems capacity to identify potential solutions to the challenges faced within the District.

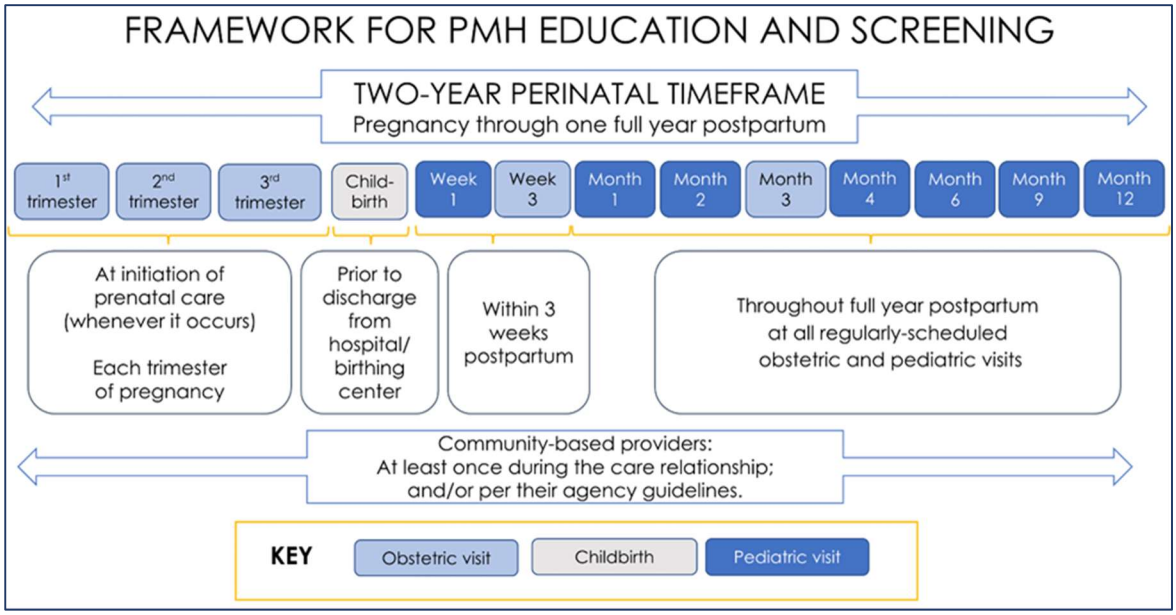
Figure 3: State Activities Addressing PMH Disorders

Screening Requirements	Education for Providers and/or Parents	Public Awareness Campaigns	PMH Awareness Proclamations	Task Forces/ Commissions
California	California	California	Arizona	Arizona
Delaware	Delaware	Colorado	California	California
Florida	Illinois	Florida	Georgia	Colorado
Illinois	Minnesota	Maryland	Illinois	DC
New Jersey	Oklahoma	Michigan	Indiana	Florida
Oklahoma	Oregon	New York	Michigan	Maine
Texas	Pennsylvania	Oregon	Minnesota	Massachusetts
Utah	Tennessee	Utah	Montana	Maryland
West Virginia	Utah	Washington	New Jersey	Oregon
	Virgina		North Carolina	Utah
			North Dakota	
			Pennsylvania	
			Texas	
			Tennessee	
			Utah	
			Virginia	

National Organizations Screening Recommendations

The initial phase in the identification and management of PMH disorders begins with the process of screening and subsequent referrals. Effective screening involves the use of validated instruments to identify individuals within a population who may require intervention. Such screening methods have the capacity to detect a range of anxiety and mood disorders among perinatal individuals, including postpartum depression, obsessive-compulsive disorder, and generalized anxiety disorder.

MMHLA and March of Dimes partnered to release a report in 2022 which provided a suggested framework for PMH education and screening in the two-year perinatal period as shown below:



Source: MMHLA, 2002.

The MMHLA report also underscores the importance of integrating PMH screenings with existing screenings for physical conditions. For example, screenings could be conducted during the anatomy sonogram in the second trimester and/or at the third-trimester glucose screening. Additionally, the report emphasizes the need for frequent check-ins, especially during the first few weeks postpartum, to identify conditions like postpartum psychosis, which, though rare, require immediate treatment according to ACOG's recommendations.

According to ACOG and other national organizations, to ensure early detection and intervention for PMH disorders, regular screening at specific intervals needs to be normalized. ACOG emphasizes the significance of using validated screening tools for every individual receiving well-woman, pre-pregnancy, prenatal, and postpartum care.

During this early postpartum period, it is also crucial to recognize the common experience of "baby blues," which affects approximately 85% of postpartum individuals and can potentially escalate into a clinical PMH disorder. ACOG highlights the importance of establishing proper referral channels once an individual is identified as having a PMH disorder, ensuring they receive the necessary care and support.

The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression in the adult population. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. USPSTF highlighted group-based interventions as a potential avenue for preventing the development of PMH disorders.[44] USPSTF recognizes there is little evidence regarding the optimal timing for screening for depression as more evidence is needed in both the perinatal and general adult populations. Ongoing assessment of risks that may develop during pregnancy and the postpartum period is also a reasonable approach.

The American Academy of Pediatrics (AAP) in their task force on mental health and in their publication titled the *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents,* highlights that the primary care pediatrician has a longitudinal relationship with families.[45] Screening can

be integrated into the well-childcare schedule and included in the prenatal visit. AAP recommends that pediatricians screen mothers for postpartum depression at the infant's 1, 2, 4, and 6-month well-child visits.[46]

When untreated, postpartum depression can interfere with the birthing persons' ability to bond with and care for their baby and lead to poor mother-infant bonding, family dysfunction, and an increased risk of child abuse and neglect.[47] [48] Untreated depression also can affect a baby's brain development by increasing the risk of toxic stress, which can delay language, cognitive, and social-emotional development in infants of depressed mothers.[49]

Federally Funded Programs Advancing Navigation to Perinatal Mental Health Services

National Maternal Mental Health Hotline: Launched in May 2022, this 24-hour hotline, available in both English and Spanish text and voice, has become a crucial resource for mothers, birthing individuals, and their families across the US. The hotline is set to receive increased investments to enhance its staffing and capacity, making it an essential lifeline for pregnant and postpartum individuals seeking support and information.

Healthy Start: A Health Resources and Services Administration (HRSA)-funded program that, as of 2023, is in 35 states, the District of Columbia, and Puerto Rico.[50] The District program operates in Wards 5, 7, and 8, offering free services to parents and infants up to 18 months of age. Its mission is to improve health outcomes before, during, and after pregnancy while reducing racial and ethnic disparities in rates of infant mortality and adverse perinatal outcomes.

National Models Promoting Navigation and Coordination

Perinatal Psychiatry Access Programs: Population-based programs that aim to increase access to perinatal mental health care. Modeled after the Massachusetts Child Psychiatry Access Program (MCPAP) for Moms, these programs build the capacity of medical professionals to address perinatal mental health and substance use disorders. These programs train frontline providers to screen for PMH conditions and assess and treat mild to moderate conditions. Providers can contact the access program for expert consultation that includes clinical guidance, PMH resources, and community-based referrals. The model has emerged as a successful and scalable model with at least 25 states or organizations implementing or developing similar perinatal psychiatry access programs.

Mahmee: A digital platform that offers comprehensive pregnancy and postpartum coordination services, including care coordination, mental health support, support groups, evidence-based resources, skill development, and referrals.[51] They create a dyadic record for both birthing parents and babies to ensure coordinated care. Mahmee's services include registered nurses for remote patient monitoring, doula care, nutrition guidance, and support for infant feeding. Operating in 44 states with 750 providers, Mahmee has a significant national presence. Notably, in partnership with DC Health, Mahmee offers District residents access to its services at a subsidized rate of $49 annually, aiming to enhance support for pregnant and postpartum individuals in the District and contribute to improved maternal and infant well-being.

District-led Initiatives Enhancing Access to Care

The following local programs collectively contribute to creating a supportive environment for recognizing, addressing, and referring individuals with PMH needs, enhancing access to care and resources within the District. While many of these resources encompass more than just perinatal

populations or services, they can provide important pathways to perinatal mental health services if supported appropriately. When complemented with strong perinatal mental health supports, these general, pediatric, or family resources can sustain a critical safety net for the District.

DC Mental Health Access in Pediatrics (DC MAP)[52]: A District-wide initiative that helps pediatric healthcare providers take better care of children and adolescents with behavioral health needs. Modeled after the MCPAP, this program builds the capacity of pediatricians and family medicine physicians to address child and adolescent mental health in their practice setting. The DC MAP team supports healthcare providers in addressing behavioral health challenges through consultation with a team of psychiatry providers, clinical social workers, and care coordinators, providing access to referrals and resources, and facilitating provider education and training that enhances integration.

Help Me Grow: An initiative by DC Health, Help Me Grow aims to connect District residents to direct child developmental services and supports through a centralized telephone access point. This program facilitates access to care coordinators who can answer questions and concerns about pregnancy or a child's development, connect individuals with community services, and follow up to ensure successful connections are made. The program offers multilingual access and utilizes language access lines to effectively communicate with diverse language speakers, further breaking down barriers to access.

DC Health Check: A platform from DHCF with resources that contains a range of toolkits and local resources addressing Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services also includes various mental health issues for children, adolescents, pregnant, and postpartum individuals. Specific perinatal mental health resources include the perinatal mental health toolkit and primer for pediatric primary care providers, a tip sheet, and maternal well-being plan available in both English and Spanish, and the DC-MD-VA Perinatal Mental Health Resource Guide, which serves as a valuable link between providers, patients, and their family members seeking specialized evaluation and treatment. The perinatal mental health toolkit and resource guide was developed and is continuously updated by the DC Collaborative for Mental Health in Pediatric Primary Care.

DC-Wide Community Network for Mother-Baby Wellness Program: Developed in 2020 as part of a five-year initiative funded by the A. James & Alice B. Clark Foundation by a community network of birthing hospitals, community-based organizations, and providers focused on perinatal mental health and well-being.[53] This program has significantly increased perinatal mental health clinical capacity across the District through providing comprehensive care coordination, and individual and group therapy for under-resourced perinatal individuals living in the District. This program also provides city-wide training opportunities focused on PMH.

Perinatal Mental Health Continuum of Care

A comprehensive continuum of care includes screening, prevention services, and therapeutic interventions such as counseling and therapy, in addition to the many tools and services listed below. Currently, screening is recommended but not required, though some states have begun to require PMH screening (see Figure 3).

Therapeutical interventions (including counseling, individual therapy, and group options) are important links in the continuum of care. They offer pathways to wellness before conditions escalate and require more acute interventions. These services are already available in health care systems through insurance coverage.

In the evolving landscape of healthcare, telehealth has emerged as a tool to increase access to these interventions. Telehealth offers a lifeline to individuals experiencing PMH challenges, providing convenient and accessible mental health support from the comfort of one's home. For many birthing individuals, telehealth bridges the gap, ensuring they have access to specialized PMH professionals who might be otherwise geographically distant. This remote platform eliminates barriers related to transportation and childcare and promotes a sense of safety and security, crucial for individuals dealing with the emotional complexities of pregnancy and postpartum. Furthermore, telehealth facilitates timely interventions and regular check-ins, promoting early detection of PMH disorders and reducing the stigma associated with seeking mental health support. Its flexibility and convenience empower individuals to prioritize their mental well-being, fostering a healthier perinatal experience for both the parent and the child. In the District, DHCF covers a wide range of telehealth services for Medicaid beneficiaries, including those related to PMH conditions. Some examples of telehealth services that can be used to address PMH conditions include:

- Individual therapy: A mental health professional can provide individual therapy to help people with PMADs manage their symptoms, develop coping skills, and build resilience.
- Group therapy: Group therapy can provide people with PMH conditions with support and connection from other people who are going through similar experiences.
- Medication management: A psychiatrist can prescribe and manage medication to help people with PMH conditions manage their symptoms.
- Parent-child interaction therapy (PCIT): PCIT is a type of therapy that can help parents with PMH conditions improve their communication and interaction skills with their children.

Several programs and services in the District provide specialized perinatal mental health treatment to pregnant and postpartum individuals:

- *The Women's Mental Health Program (WMHP)* at MedStar Georgetown is a large and comprehensive perinatal mental health program offering specialty outpatient mental health services for pregnant and postpartum individuals since 2008. They provide an array of services including short-term psychotherapy, group psychotherapy, psychiatric evaluation and treatment, and one-time psychiatric consultations for perinatal individuals.

  This program coordinates with MedStar Georgetown and Washington Hospital Center obstetric and pediatric providers to provide all PMH programming, including training on screening, crisis management, and referrals. Additionally, the program has supported the implementation of universal perinatal mental health screenings across all obstetric, pediatric, and NICU settings at both MedStar Hospitals.

- *Mary's Center Perinatal Mental Health Program* offers clinical services and care coordination to District and Maryland residents with symptoms of PMH disorders and pregnancy and postpartum support groups in both English and Spanish. This PMH program was the host of an annual perinatal mental health-focused conference from 2020 to 2022 which convened over 130 local providers and paraprofessionals of various types to learn about perinatal mental health. Since spring 2021, the Mary's Center PMH program has hosted a monthly virtual perinatal

mental health project ECHO which brings together regional perinatal providers for learning, case consultation, and resource sharing in an effort to support best-practice care for people with PMH disorders in our region. Attendance averages 40 people monthly. The PMH program also works internally at Mary's Center to promote training and collaboration among the various programs supporting perinatal participants, including home visiting, WIC, obstetric care coordination, centering, and family support services.

- The George Washington University Department of Psychiatry's Five Trimesters Clinic offers a range of services to support women's wellness during pregnancy. The faculty includes three female psychiatrists with special expertise in advising women about the use of medication during pregnancy or while breastfeeding, mood and anxiety disorders while pregnant or after birth, and support for fathers and partners. The weekly clinic offers evaluations, brief treatment, and referrals by psychiatrists in training at reduced rates. Although they do not accept direct insurance payments for psychiatric care, they provide all necessary documentation for accessing out-of-network benefits.

Preventive Intervention and Early Intervention

The District has initiated innovative programs and interventions in perinatal mental health that have focused on ensuring the well-being of birthing individuals. From financial assistance initiatives to secure stable housing and income, to evidence-based counseling programs to prevent perinatal depression, the District's approach is holistic and inclusive. Tailored support for young parents and those with language barriers amplifies the commitment to accessibility. This section explores these impactful strides, showcasing the District's dedication to creating a supportive environment for every individual during their parenting journey.

In July of 2023, Healthy Parents Healthy Babies (HPHB), which was established to document and disseminate strategies to reduce racial disparities, increase housing stability, and improve maternal health, birth outcomes, and child health associated with homelessness and extreme housing instability among women and families of color, put forth a recommendation to provide housing and income during the entire perinatal period. This recommendation has been adopted by the Task Force's Subcommittee on Public Awareness and Systems Capacity (see Appendix C). The District has begun to address cash assistance through the following two programs.

Strong Families, Strong Futures DC: A direct cash assistance program supporting new and expecting mothers residing in Wards 5, 7, and 8 during the pivotal first year of their child's life. This program was established through a partnership between the Executive Office of the Mayor and Martha's Table.

Mother Up Pilot: A guaranteed income pilot run by Mother's Outreach Network. Recruitment for the pilot's first cohort started in December 2022 and concluded with the launch of the first group of participants in April 2023.[54] Cash assistance, with no strings attached, will be provided to these mothers for three years.

The USPSTF found convincing evidence that counseling interventions, such as cognitive behavioral therapy and interpersonal therapy, are effective in preventing perinatal depression in those at increased risk.[55] These programs include the following examples.

ROSE Program (Reach Out, Stay Strong, Essentials for mothers of newborns): An evidence-based program that has been demonstrated to reduce cases of postpartum depression by half among low-income women in a series of randomized control trials.[56] The USPSTF recommends the implementation of this program. The program provides interpersonal therapy and is intended for prenatal administration in groups of two to five pregnant individuals. Components of the program include psychoeducation and interpersonal therapy-based skills for relationship building and social support, including improved communication skills. Such education takes place over the span of four or eight 90-minute group sessions over four weeks along with a postpartum "booster" session.

Mothers and Babies Program:[57] An evidence-based program aimed at preventing the onset of perinatal depression by providing tools for stress management and improving the mental health of families. The program included modules on the cognitive behavioral theory of mood and health, the physiological effects of stress, the importance of pleasant and rewarding activities, how to reduce cognitive distortions and automatic thoughts, and the importance of social networks. It also includes material on positive mother-child attachment and parenting strategies to promote child development.

Virtual Group Therapy: Mommy & Me program is funded by the Patient-Centered Outcomes Research Institute (PCORI). This program provides perinatal mental health services to low-income Black pregnant and postpartum individuals. It offers patient navigation, virtual peer support, group therapy, and individual therapy. The program fosters peer connections, particularly among Black pregnant and postpartum individuals, as they navigate parenthood.

Group Perinatal Care: Group prenatal care (GPC) is an increasingly popular system of delivering prenatal care. GPC allows women to come together as a support system while both receiving prenatal care and participating in education. There are currently many models of GPC, including CenteringPregnancy®, CenteringPregnancy Plus, and Expect with Me.[58] CenteringPregnancy®'s model of GPC is comprised of three major components: health assessment, education, and support. Groups are composed of 8–12 women. Sessions generally last 90–120 minutes and the women meet, along with their health provider and group facilitator, about 10 times during their pregnancy. This interactive approach empowers women to take control of their health during their pregnancy. Mary's Center offers Centering Pregnancy.

Multi-generational Care Model: For example, Safe Babies, Safe Moms a collaboration between Community of Hope, Mamatoto Village, MedStar Health, and Health Justice Alliance. Safe Babies, Safe Moms provides comprehensive prenatal postpartum and pediatric care, which includes nutrition counseling, breastfeeding support, behavioral health screenings, and integrated behavioral health. It also includes assistance with community support navigation and legal services. This program is aimed at eliminating maternal and infant healthcare disparities in the District, offering services to residents of Wards 5, 7, and 8.

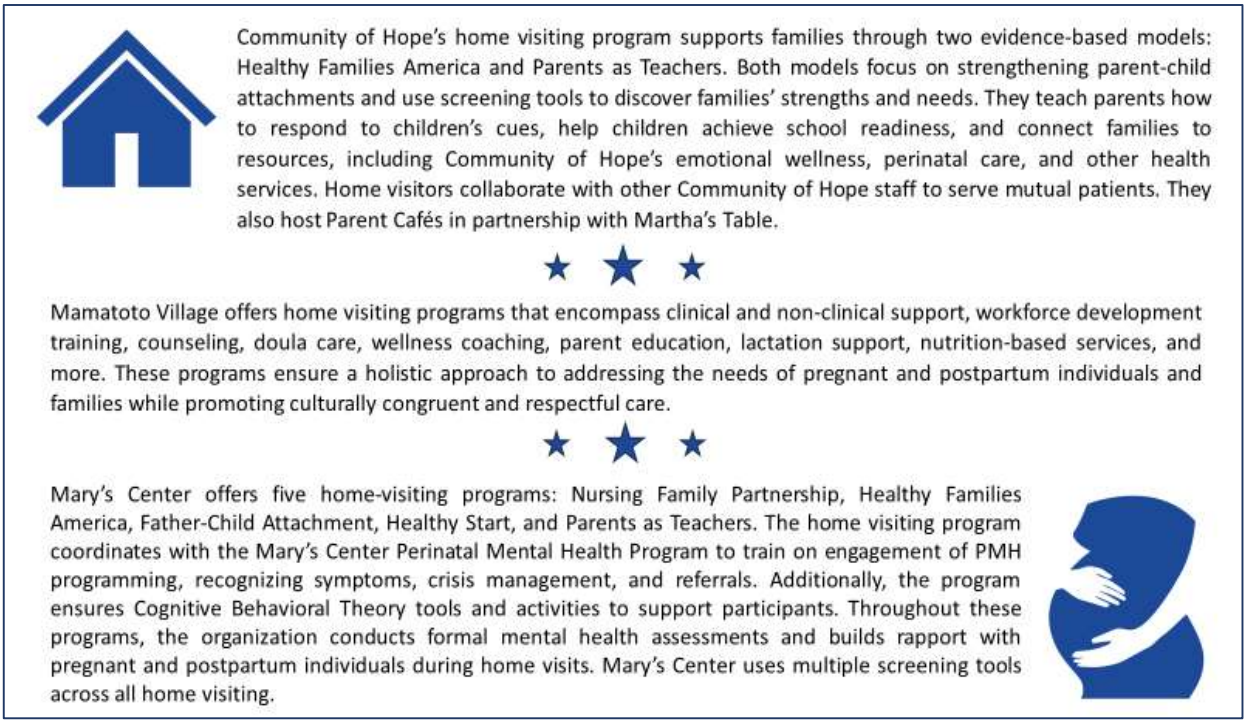
Teen Programs: The D.C. Network for Expectant and Parenting Teens (DC NEXT!) is a collective impact innovation network of young parents, community providers, educational institutions, healthcare agencies, government partners, and other stakeholders grounded in the principle that young people who are valued and respected by responsive adults are key to reducing teen pregnancy, reducing sexually transmitted infections, and achieving optimal health. DCPCA coordinates a virtual meet up for moms.

Children's National's Healthy Generations Program is an evidence-based program to prevent repeat teen pregnancy. This program provides comprehensive, family-centered healthcare for teen parents and their

children. It enrolls young parents up to 19 years old and offers health and other related services through the age of 21. It has provided services to more than 2,000 parenting teens since its inception in 1995.[59]

Home Visiting Programs: Home visiting programs can be a cost-effective and impactful approach to supporting new and expectant parents in promoting healthy child development and family well-being. These programs involve trained professionals, such as nurses or educators, who visit the homes of parents to provide guidance on caregiving skills, positive parenting practices, and creating safe home environments. They also serve as a connection to essential services and resources for families. Home visiting programs play a crucial role in empowering parents, preventing child maltreatment, and enhancing family functioning, particularly during the early stages of parenting. Parents as Teachers (PAT) is the most prevalent evidence-based model in the District. The PAT model is a home-visiting parent education program that teaches new and expectant parents skills to promote positive child development and prevent child maltreatment. PAT offers services to parents with children up to age 5 with the goal of increasing parental knowledge of early childhood development, improving parenting practices, promoting early detection of developmental delays and health issues, preventing child abuse and neglect, and increasing school readiness and success.

Figure 4: Examples of Home Visiting Programs in the District



These initiatives underscore the District's commitment to providing comprehensive perinatal mental health services and support to pregnant and postpartum individuals, aiming to improve overall maternal and infant well-being.

Integration of Services

Integration of services means a smoother journey, where mental health support is readily available alongside prenatal and postnatal care, ultimately promoting healthier pregnancies, robust perinatal mental health, and enhanced child well-being.

Collaborative Care: The collaborative care model seeks to blend mental health care with general or specialty medical services. In this model, the patient-centered team is composed of a behavioral health care manager, a psychiatric consultant, and the primary care provider. The behavioral health care manager is housed within the primary health care setting who coordinates with the primary care provider and the psychiatrist consultant to offer support on cases.[60] This model monitors population-level care and uses a registry to track cases. Shared treatment plans are established with measurable outcomes to ensure progress or course correction if necessary. ACOG asserts that the collaborative care model "hold[s] promise as an equity promotion intervention for maternal mental health."[61] Research supports the use of a collaborative care model for reducing health inequities.[62] Arizona and New York both identified collaborative care as an appropriate framework for the issue of maternal mental health.

Primary Care Behavioral Health (PCBH) Model: The Primary Care Behavioral Health model of integration is a team-based primary care approach to managing behavioral health problems and biopsychosocial-influenced health conditions. The PCBH model utilizes a behavioral health consultant (BHC) who functions as a fully integrated member of the primary care team. The BHC supports the primary care team to ensure the behavioral needs of a specific population are met. BHCs are embedded in the medical setting to provide support to medical staff and assist with the behavioral management of health concerns. BHCs assist patients when their stressful experiences, chronic conditions, and behavioral concerns which are interfering with daily life or wellness.

HealthySteps: An evidence-based integrated care model that embeds a behavioral health specialist in the pediatric primary care setting and addresses potential maternal mental health and dyadic/ multigenerational healthy development in the primary care setting. It is a critical access point for perinatal mental health offering six or more interactions in the first year following delivery. The infant's well-child visits are likely to be kept even as fewer maternity patients complete their postpartum visit and have few other interactions with their own provider postpartum The District government currently invests in six HealthySteps sites, and the model has been successfully implemented in a variety of settings across the country.

Intensive Treatment Programs

The United States has started to witness a growing number of specialized perinatal mental health programs that emphasize the importance of keeping mothers and infants together during intensive outpatient or inpatient treatment. This recognition stems from the understanding that perinatal anxiety and depression can significantly impact parenting, attachment, child well-being, and overall development. However, our region currently lacks intensive outpatient programs that can effectively address the unique needs of perinatal women dealing with acute and severe mental health disorders. This gap in the continuum of care presents a significant challenge for perinatal patients requiring more intensive mental health support but who do not necessitate inpatient psychiatric care or prefer to avoid the potential disruption, trauma, and separation from their newborns associated with a hospital stay. These programs are especially crucial for pregnant and postpartum women facing a moderate to high risk of conditions such as depression, anxiety, bipolar disorder, schizophrenia, or other psychotic

disorders. The comprehensive care provided by these programs is centered on nurturing the mother-baby relationship, encompassing individual and group therapies, medication management, health education, and engagement in activities that promote attachment and facilitate healthy child development.

Perinatal Inpatient Psychiatric Programs: Also known as perinatal psychiatric units or mother-baby units, they are specialized healthcare facilities or inpatient units within larger hospitals that are designed to provide comprehensive psychiatric care for pregnant and postpartum individuals who are experiencing severe mental health disorders. These programs are critically important for the continuum of care. Only four states (California, Louisiana, New York, and North Carolina) have inpatient perinatal programs.

Intensive Outpatient and Partial Hospitalization Perinatal Psychiatry Programs: These specialized perinatal mental health programs are tailored to offer intensive and comprehensive care to pregnant and postpartum individuals facing significant mental health challenges. These programs go beyond standard outpatient services, delivering more frequent and intensified therapy and support. They are especially beneficial for individuals dealing with moderate to severe perinatal mental health disorders. Pregnant and postpartum women falling within the moderate to high-risk range for conditions such as depression, anxiety, bipolar disorder, schizophrenia, or other psychotic disorders receive holistic care with a focus on recovery while nurturing the mother-baby relationship. This approach encompasses individual and group therapy, medication management, perinatal health education, and participation in mother-baby dyadic activities that promote attachment and healthy child development.

Substance Use Disorder Services for Perinatal Individuals: Noticeably lacking in the District are any dedicated services for perinatal patients with substance use disorders. With growing concern for substance use among all populations, particularly when a perinatal patient is involved, the District must seriously consider the services required to meet those needs. Ignoring these needs can have severe consequences for both the birthing person and the infant, with lasting damage to the infant.[63] It is not uncommon for birth individuals with substance use disorders to have co-occurring mental health needs, and specialized services can best meet all those needs and provide opportunities to improve the well-being of the birthing person, the infant, and the whole family.

Perinatal Mental Health Workforce

As identified in the Mary's Center DC Perinatal Mental Health Impact Evaluation 2015-2018 Impact Evaluation Brief, there is a national shortage of mental health providers. Already, more than 150 million people live in federally designated mental health professional shortage areas.[64] Within a few years, the United States will be between 14,280 and 31,109 psychiatrists short of what is required based on need. Psychologists, social workers, and other mental health professionals will be overextended as well, experts say.[65] There have been several efforts to address the gap in mental health care availability by expanding the mental health workforce. For example, task shifting is a model that focuses on training lay people to facilitate psychological interventions.[66] One study indicated that, with sufficient training and practice, peer facilitators can assess the fidelity of peer-delivered group cognitive behavior therapy just as well as an expert or a trained student.[67]

In New York, Governor Kathy Hochul has announced a significant $4 million dollar investment aimed at fostering diversity within the mental health workforce in 2022. This initiative encompasses various forms

of support, including tuition assistance, paid internships, and direct stipends, with a particular focus on minority and multilingual students.[68] This collaborative program involves partnerships with key institutions such as the New York State Office of Mental Health, State University of New York, and City University of New York, all of whom are working to strengthen the mental health workforce. The program extends its support to individuals pursuing higher education in relevant fields, spanning certificate, associate, bachelor's, master's, and doctorate programs.

Currently, the University of North Carolina at Chapel Hill Behavioral Health Workforce Research Center (UNC-BHWRC) is performing data-driven research on the workforce responsible for providing mental health and substance use services. UNC-BHWRC plans to use IBM MarketScan® Commercial Claims and Encounters data to investigate which types of professionals commonly treat patients with perinatal mental health needs, in what settings, and for what diagnoses and treatments.[69]

Since 2019, doula care has been introduced in several states as a Medicaid-covered benefit, providing nonclinical emotional, physical, and informational support to pregnant individuals and new parents. Professionally trained doulas can make a significant impact on maternal morbidity and mortality rates, especially in certain geographic regions and among Black mothers. States are beginning to recognize this fact and several of them have introduced doula care as a Medicaid-covered benefit in the last two years, with more expected to follow. Recent studies in Minnesota, Oregon, and Wisconsin have showed that Medicaid reimbursement for doula care provided cost savings**.**[70] DHCF has made doula services available to support birthing parents up to six months after pregnancy.

Community health workers (CHWs) play a crucial role in addressing PMH disorders by providing culturally sensitive and personalized support to individuals during their perinatal journey. As trusted members of the community, CHWs bridge the gap between healthcare providers and patients, offering valuable assistance and guidance.[71] They can educate expectant and new parents about the signs and symptoms of PMADs, ensuring early recognition and intervention. CHWs also provide emotional support, helping individuals navigate the challenges of pregnancy and new parenthood. By connecting families with appropriate resources, such as mental health services, support groups, and counseling, CHWs empower individuals to seek help when needed. Their empathetic approach fosters a sense of trust and security, encouraging open conversations about mental health concerns. Through their advocacy, education, and ongoing support, community health workers also play a pivotal role in promoting mental wellness and resilience among perinatal individuals and their families.

States may authorize Medicaid payment for certain CHW services through the use of either the State Plan or Section 1115 demonstration authority allowing more flexibility to cover services. States may allow or require managed care organizations (MCOs) to provide CHW services or include CHWs in care teams. Many states use CHW services to address the health needs of targeted populations including enrollees with chronic conditions or complex behavioral or physical health needs, enrollees receiving targeted case management services, or enrollees who are frequent users of health care services.[72] As of July 1, 2022, 29 states reported allowing Medicaid payment for services provided by CHWs.[73] The District does not reimburse separately for CHW services through its Medicaid program, however, some services are incorporated into the Federally- Qualified Health Centers Prospective Payment System (FQHC PPS) reimbursement rates. The District also uses Title V Maternal and Child Block Grant funding for some Community Health Worker perinatal and maternal work.

Public Awareness to Educate and Reduce Stigma

National public awareness efforts play a pivotal role in shedding light on PMH disorders during and after pregnancy, ensuring that individuals receive the support and care they need. One prominent contributor to these efforts is Postpartum Support International, an organization dedicated to raising awareness about PMH disorders during and after pregnancy. Their national strategic plan, "Mind the Gap," developed in collaboration with various organizations, outlines actionable steps to improve perinatal mental health. The organization offers valuable tools to the public, including patient tracking tools, awareness posters, factsheets for providers and parents, and medication resources.[74] They also have additional resources available for purchase, such as educational DVDs and guidebooks for creating sustainable perinatal support networks at the community level.[75] Additionally, the National Institutes of Health (NIH) offers a pamphlet on Perinatal Depression that could be disseminated through community-based organizations and existing partners to expand public awareness in the District.[76] Such efforts, at both the national and local levels, aim to shed light on PMH disorders and improve the well-being of pregnant and postpartum individuals across the United States. The National Governor's Association *Tackling the Maternal and Infant Health Crisis: A Governor's Playbook*, is a toolkit for immediate action to improve maternal and infant health. Many of the highlighted policies work to address the significant discriminatory policies and practices embedded in organizational structures that lead to disparities in maternal health.[77]

Public Awareness in the District

While knowledge gaps persist regarding the recognition of PMH disorder signs and symptoms as well resources to address PMH disorders in the District, several key organizations and initiatives play crucial roles in disseminating information. Among them are this Task Force, DC Metro Perinatal Mental Health Collaborative, DC Collaborative for Mental Health in Pediatric Primary Care, and DC Health serve as valuable channels for increasing awareness.

The DC Metro Perinatal Mental Health Collaborative is a network of clinicians, researchers, and advocates in the Washington DC area dedicated to improving the emotional well-being of parents during the perinatal period. It operates with a three-fold mission: to identify perinatal mental health conditions early, combat stigma and misconceptions surrounding them, and provide support to the community of professionals dedicated to this cause.

Moreover, the DC Collaborative for Mental Health in Pediatric Primary Care, in collaboration with other organizations, has developed a range of resources, including tip sheets, wellbeing plans, and a comprehensive PMH Toolkit, all available in both Spanish and English. Additionally, they have compiled a Perinatal Mental Health Community Resource that offers essential information about organizations, their services, locations, and languages available. These local resources and collaborative efforts in the District are essential components of expanding awareness and facilitating access to PMH resources for individuals and families in need.

Section III:

Recommendations

These recommendations are rooted in successful policies implemented at the national, state, and local levels to address PMH disorders and focus on providing increased access to resources, improved screening, and expanded PMH treatment with the use of peer support models and virtual mental health groups. Such actions require a multi-level approach that addresses individual, provider, and systemic barriers to care, and leverages the work of community-based organizations within the District. By scaling up current practices within the District and executing the recommendations of this report, the District can leverage community trust to increase the likelihood of PMH service implementation success. The following recommendations address the removal of barriers to access to care, investment in the continuum of care services, data collection and public reporting, and development of workforce capacity.

Enhancing Navigation and Care Coordination to Improve Access to Perinatal Mental Health Care

1. Resume the "fast-tracking" (or creating a new process) whereby pregnant patients can become insured within 28 days of application.

   Since pregnancy is a very time-sensitive condition, the faster patients can get insured, the earlier we can intervene. Earlier access to resources to improve outcomes.

2. Develop a District perinatal psychiatry access program.

   Because of the shortage of perinatal or reproductive psychiatrists who participate in public and private insurance, there is increased demand for referrals due to the number of screenings in District healthcare settings. In partnership with a District government agency, a leading psychiatry program in the District or the DC Perinatal Quality Collaborative could develop such a program. These programs are funded through HRSA, but some states have funded them directly as well. Access to consultation and training for clinical providers who touch perinatal individuals is needed so that more patients can be served in primary care practices instead of being referred to behavioral health providers who are already in short supply, have long wait lists, or do not accept any/all insurance options.

3. Develop policy guidance and adequate reimbursement for care coordination services.

   Care coordination provides needed support within the setting of health care offices where prenatal and pediatric providers identify patients at risk for perinatal mood and anxiety disorders who require connection to support and treatment services. Without sustainable funding for care coordination services, clinicians are required to spend nonbillable clinical time connecting patients to services. Often, the absence of care coordination results in patients “falling through the cracks” and not connecting with necessary support or treatment.

   There is a general concern that the patchwork philanthropic donations and grants will end. This is especially troubling since these funding sources support numerous District programs offering PMH care coordination, navigation, and psychotherapy for no or little cost to patients. The District must look to diversify funding to sustain these initiatives. Medicaid and commercial insurance should reimburse for care coordination. In additions to reimbursement, there should be care coordination policy guidance developed that identifies the use of active CPT codes at the point of health care service. Guidance should include the range of behavioral health specialists able to provide care coordination. Care coordination at the point of service (within OB/GYN,

pediatric primary care, etc.) greatly increases access to needed therapies and services for individuals at risk for or diagnosed with perinatal mood and anxiety disorders.

The District can prioritize funding for existing care coordination and integrated health care services through enhanced Medicaid reimbursements and innovative care models, which embed mental health professionals in primary care (pediatric and adult) and OB/GYN settings where patients access care the most such as Healthy Steps.

4. Support public awareness campaigns similar to immunization and tobacco cessation campaigns, which raise awareness and reduce stigma around PMH disorders.

   There are currently no public awareness campaigns to inform District residents, especially BIPOC birthing persons and their families, of the challenges of pregnancy and childbirth or where to get information. Public awareness campaigns for PMH disorders will decrease the stigma around mental wellness by increasing mental health literacy. Positive messages should be visible in a variety of mental health care settings, as perinatal individuals may access multiple environments. The District will need to engage a variety of community partners, from health services organizations and providers to social services agencies and faith-based communities, to expand the reach of the messages around mental wellness and family support.

5. Increase patient accessibility and reduce provider administration burdens through the standardization of managed care plan perinatal mental health services across Medicaid managed care plans.

   Various managed care organizations cover perinatal mental health services at different levels or with varied procedures, causing confusion among providers and patients that reduces or delays access to care.

Investment in the Continuum of Care of Perinatal Mental Health Services

1. Invest in prevention counseling interventions.

   DHCF should provide billing and reimbursement guidance for prevention counseling interventions, including ROSE program and Mothers and Babies program, as identified by the USPSTF as evidence-based perinatal mental health prevention interventions. The USPSTF underscores the importance of this service, and the relevant guidance necessary for billing and reimbursement for individuals to access this preventive services benefit. This should address reimbursement options for both clinical and non-clinical providers who are qualified to deliver prevention interventions and can be implemented immediately. Reimbursement should also be provided for telehealth options.

   With clear guidance on how to bill for prevention counseling interventions, evidence-based services can be provided to perinatal individuals in need. This will reduce the acceleration of PMH disorders, improve maternal and infant mental health, and reduce strain on mental health services. Providers need adequate reimbursement to sustain these prevention counseling interventions.

2. Invest in group support models to alleviate the shortage of culturally competent mental health support.

Programs that provide group support give parents who seek an alternative to one on one therapy a different treatment option. CenteringPregnancy is one example of a group model of healthcare that includes educational topics related to mental health and wellbeing in pregnancy as well as fostering peer support.

There is a need to increase access to mental and behavioral health providers, including pediatric and adult primary care provider settings, OB/GYN, and other healthcare settings where perinatal individuals interact with the healthcare system. Integrated behavioral healthcare models such as HealthySteps bring mental health services to the places where patients already access care.

For example, Maryland Medicaid provides additional reimbursement to CenteringPregnancy. Maryland requires that the practice administering GPC must be licensed by Centering Healthcare Institute (CHI). As long as it follows the correct steps the group will be able to add the code 99078 to up to ten Centering perinatal visits. This code will pay an additional $50 per participant per visit. Unfortunately, the enhanced Medicaid reimbursement is not applicable to Federally Qualified Health Care (FQHC) providers. Maryland also announced that they would provide $430,000 in grant funding to expand CenteringPregnancy.

3. Provide direct consultation reimbursement in Medicaid, including telehealth modifiers.

   This will allow more patients to be treated where PMADs are identified and reduce access challenges where there are limited therapy and program resources. In January 2023, the Centers for Medicare and Medicaid Services released a State Health Official Letter clarifying Medicaid and CHIP policies for coverage and payment of interprofessional consultations.[78]

   Access to consultation and training for clinical providers who touch perinatal individuals is needed so that more patients can be served in primary care practices instead of being referred to behavioral health providers who are already in short supply, have long wait lists, or do not accept any/all insurance options.

   With access to experts in PMH disorders, more providers will be able to serve patients in their medical homes, increasing access to more specialized care and treatment. Shortages of mental health professionals with PMH specialization make it difficult for providers to refer patients. With consultation reimbursement, more providers will comfortably meet the needs of their patients without long waits and insurance barriers.

4. Expand reproductive health coordinators at all School Based Behavioral Health Centers to increase access to vital reproductive health services where they are needed most and where they can have optimal impact.

   Access to reproductive healthcare and education in the school-based setting will improve health outcomes, school retention, career success, decrease poor birth outcomes such as low birth weight and preterm delivery that carry long-term costs to the health system and society. It will also improve connection to a wide range of health services that lead to physical and mental well-being.

5. Support the establishment of an inpatient perinatal psychiatry unit in the District. Incentives for the development of an inpatient unit can include financial incentives for healthcare institution(s) to invest in this care.

   Those requiring inpatient psychiatric units currently have no options in proximity to the District that address perinatal needs. Instead, they need to seek care far away or in units that do not have training in perinatal mental health. A dedicated perinatal inpatient unit will provide quality therapy and care to patients in need. Best practice also ensures access to the baby, which is important for bonding and strengthening healthy dyadic attachments/reducing the occurrence of unhealthy attachments. This reduces the incidence of a variety of short and long-term issues for the child which could negatively impact the child's long-term well-being. Attention should be made to creating pathways for anyone who is uninsured or on the Alliance program to be able to access these programs during the perinatal period.

6. Support the establishment of perinatal intensive outpatient programs and partial hospitalization programs.

   Incentives for the development of an inpatient unit can include financial incentives for healthcare institution(s) to invest in this care. Investment in billing and reimbursement models that can sustain these programs is also essential to eliminate barriers to new program development and should ensure pathways to care for perinatal individuals with Alliance coverage in addition to Medicaid and commercial insurance.

   Perinatal intensive outpatient programs and partial hospitalization programs are absent in the District, with no programs identified by Postpartum Support International within 4 hours of the District. Successful programs (both independent and housed within healthcare institutions) allow for intensive services without the inpatient requirement, which may be better suited to various conditions and personal circumstances. Access to quality care reduces long-term consequences, including reduced bonding, impaired attachment, child development delays, increased family stress, and risk of long-term trauma for mother and child. Special consideration should be given to ensuring access to these programs for the uninsured, underinsured, or those covered by the Alliance program.

System Accountability through Data Collection, Public Reporting and Boards

1. Ensure perinatal mental health representation on all relevant boards.

   All relevant boards should have at least one designated seat for someone representing perinatal mental health needs. This may include the Maternal Mortality Review Board, Maternal Health Advisory Committee, Perinatal and Infant Health Advisory Committee, Interagency Council on Housing, DC Commission for Women, and others, where birthing people intersect with public supports. These Boards, Committees, and Councils will also make efforts to distribute information and train professionals across all relevant services in the health and social needs of pregnant and parenting people.

   District Committees, Boards, Commissions, and Task Forces that have dedicated representation will better identify needs and opportunities that benefit perinatal individuals and the professionals who serve them. For instance, Professional Boards shall ensure that training on

perinatal mood and anxiety disorders is made available to all licensed and certified professionals in the District.

2. Develop a standing District perinatal mental health advisory group/board/task force.

   Understanding how to increase programs, policies and funding aimed at PMH prevention and better leveraging existing supports in the District with a goal of protecting and preserving mental health and preventing negative mental health outcomes for perinatal people, requires a long-term commitment to this work beyond a one-year taskforce period. An ongoing commitment could include further work and recommendations to better serve the special populations identified in this report, including people using substances during pregnancy and postpartum, teen parents, refugee and immigrant populations, LGBTQIA and anyone experiencing homelessness or housing insecurity.

3. Increase collection of relevant perinatal mental health data (including HEDIS from Medicaid and Commercial insurers) across public and District-wide sources, and ensure data is published publicly for better understanding across the District.

   Quality data collection on perinatal mental health screening, prevalence, and availability of services are lacking for District populations. Data should be delineated by race, ethnicity, income, geography, and other factors. Better data collection will allow for valuable analysis of prevalence and access. This will lead to more precise planning and resource allocation where need is high. Data that delineates by race, ethnicity, income level, geography, and other measures of social-related health needs will further identify areas for investment. Public reporting will also ensure all are held accountable for addressing gaps in care and services.

Development of Workforce to Address Shortages and Wait Times

1. Expand the workforce by investing in community health workers, peer support, and other paraprofessionals to help prevent and address PMH disorders.

   A. Allow Medicaid payment for mental health support services provided by Community Health Workers and other paraprofessionals serving pregnant and postpartum populations. The District can employ a state plan amendment, integration as members of interdisciplinary teams under a Section 1115 demonstration waiver, or as services provided and reimbursed by MCOs.

   B. Source a team of perinatal community health workers trained and equipped to support young or teen parents and assist them in navigating the adult-parent system of health and social services.

      A teen-parent system of care can be tailored to meet the needs of adolescent parents and their children. While young parents are eligible for the range of supports available for all parents who meet eligibility, these services are not designed to meet the unique needs of adolescent parents. They need a system of care responsive to their developmental needs as adolescents and as parents.

2. Support the increased recruitment of perinatal mental health providers that are culturally and linguistically representative of the diverse populations that they serve and offer training to the

existing workforce on culturally congruent practices. For example, offer incentives for bilingual professionals.

Perinatal populations who identify as Black/African American, or Latinx, or are more comfortable speaking a different language are more likely to access services when they are provided in a culturally congruent way. Reducing these barriers further improves access to care when needed.

3. Provide District funding to support a city-wide Perinatal Mental Health ECHO (Extension for Community Healthcare Outcomes) program, offering a valuable education and training model to PMH providers paraprofessionals, and related professions. Attendees receive valuable training, education, and professional support, which leads to more informed, quality care for more patients. For example, Mary's Center PMH ECHO has been operating its program and has built rapport with the PMH clinical community.

4. Provide enhanced Medicaid reimbursement for mental health providers (holding any type of clinical license) who have specialized training and certifications in perinatal mental health. Studies have shown that perinatal mental health providers with specialized training significantly improve outcomes for individuals experiencing PMH disorders. Specialized training ensures that mental health providers are equipped with the knowledge and skills necessary to address the unique challenges faced by perinatal individuals. This includes understanding cultural sensitivities, language barriers, and the specific psychological needs associated with pregnancy and early parenthood. Enhanced reimbursement serves as an incentive for providers to undergo this specialized training, thereby increasing the overall competency of the workforce.

   For example, the Board of Social Work could require individuals seeking licensure renewal to attest that they work in a setting that serves patients who have Medicaid, or they must have at least one client that uses Medicaid per renewal period to keep their license active. This would be similar to the CEU requirements for license renewals, but an intervention that actually benefits a population that is underserved.

5. Offer and encourage perinatal mental health CEU hours for the next renewal cycle for clinical licensure for all physical and mental health service providers with a clinical license. This could support capacity within the provider network for working with the perinatal population. Perhaps expert clinical perinatal mental health providers who are local to the DC region can develop a curriculum and record asynchronous training that can be provided, free of charge, through the DBH Training Institute.

   While psychiatrists are a specialized group who can treat the entire range of perinatal mood and anxiety disorders, very few behavioral health specialists will be first-line clinicians to screen or interact with perinatal individuals. Therefore, all clinicians should be trained on symptoms and conditions to watch for. For instance, only 1 in 5 women received a diagnosis, meaning most patients will be seen in other settings and the providers in those settings should be educated on what to watch for.[79] Screening and brief interventions can occur in many settings, while therapeutic treatment also needs an increased workforce ready to serve. Therefore, all providers should be educated on PMADs and treatments.

6. Provide career training, financial incentives, scholarships/loan repayment, and other financial support to those already in, are preparing to enter, or have touchpoints with the perinatal mental health field. Many loan repayment models exist and can be adapted and scaled to account for the increased need. Perhaps there could also be additional incentives for students who speak multiple languages or identify as BIPOC. Training should also be culturally competent and appropriate.

   The District could partner with a local university, such as UDC, to build out a specific training program or PMH certificate program, similar to current legislation moving through the Council. Scholarship program(s) can require recipients to work in DC or even perhaps at an agency that serves a significant number of Medicaid beneficiaries. The certificate program at Georgetown for the Infant and Early Childhood Mental clinical specialization is an example, which can be applied to PMH.

7. Partner with organizations and universities that can offer substantial professional pre- and postpartum doula training, certification, and technical assistance that specifically targets candidates seeking to support people with a range of disabilities navigating the perinatal health system, particularly the perinatal behavioral healthcare system in the District.

Consideration for Special Populations

When implementing the recommendations to enhance perinatal mental health (PMH) outcomes in the District, special attention must be devoted to populations that are especially vulnerable. This includes Black, Indigenous, and People of Color (BIPOC), the LGBTQIA+ community, refugees and immigrants, people living with disabilities, and individuals experiencing housing insecurity or homelessness.

Additionally, the mental health needs of non-birthing partners or fathers also need attention as they may also struggle with symptoms and disorders during the perinatal period. These populations may face unique challenges and barriers to accessing PMH services, such as language barriers, discrimination, or lack of stable housing. To ensure equity in PMH care, efforts should be made to tailor services to the specific needs of these communities, provide culturally sensitive care, and address social determinants of health that disproportionately affect them. By prioritizing inclusivity and considering the diverse needs of all residents, the District can work towards achieving more equitable PMH outcomes for everyone.

Considerations of the BIPOC Community

Addressing perinatal mental health disparities within BIPOC communities necessitates a multifaceted approach that prioritizes cultural competence, representation, community engagement, language accessibility, trauma-informed care, preventative measures, public awareness, affordable and accessible care, supportive networks, and robust data collection and research. Culturally competent mental health training and increased representation of BIPOC professionals are essential to provide care that respects cultural nuances and understands the impacts of systemic racism. Engaging directly with BIPOC communities, offering services in multiple languages, and addressing racial trauma through trauma-informed care are crucial steps. Preventative measures tailored to BIPOC needs, awareness campaigns, and policies for affordable care further contribute to equitable perinatal mental health outcomes. Additionally, supportive networks and comprehensive data collection aim to reduce disparities and improve overall well-being among BIPOC individuals and families.

Considerations of the LGBTQIA+ Community

A systematic review of issues that LGBTQIA+ individuals face regarding perinatal mental health includes heteronormativity, cisnormativity, isolation, exclusion from traditional pregnancy care, stigma, and distressing situations from the gendered nature of pregnancy.[80] With respect to gender identity, trans parents struggle with gender dysphoria, concerns with bodily autonomy, and struggle with gender identity for birthing bodies. The study cited a series of practices that can aid in improving perinatal outcomes for the LGBTQIA+ by providing identity-affirming, person-centered care including "community provider education, avoidance of gendered language, documentation of correct pronouns, trauma-informed practices, cultural humility training, and tailored care."[81] Trans parents face additional barriers and stressors related to legal acknowledgment of parenthood once a child is born, which further increases the risk of PMH disorders.[82]

Considerations of Refugee/Immigrant Populations

Immigrant birthing individuals face an even higher likelihood of PMH disorder compared to the general population with one in three immigrant women experiencing a PMH disorder.[83] Several barriers to care within this specific population include uncertain migrant status, lack of social support, and low socioeconomic status. Additionally, there is a lack of linguistically and culturally congruent screening tools, treatment, and workforce to effectively address their needs.[84] Several studies have stressed the importance of cultural sensitivity when interpreting screening results (even when translated) suggesting that a lower Edinburgh Postnatal Depression Scale (EPDS) cut-off score greater than 9 is recommended to balance psychometric performance with differences in cultural practices, beliefs, and degree of stigma.[85] Another study taking a systems perspective engages stakeholders to understand the issue more holistically.[86] The study underscored the importance of recognizing the cultural influences on the perception of perinatal mental health among immigrant populations and the need for culturally and linguistically appropriate programs. To address these differences, the study emphasized the need to build capacity and empower individuals which included sharing stories, feelings, and experiences, with a trauma-informed approach.[87]

Considerations for People Living with Disabilities

People with disabilities often experience a wide and varying range of health conditions that lead to poorer health. In addition, discrimination, inequality, and exclusionary structural practices, programs, and policies create barriers to timely and comprehensive health care, which further results in poorer health outcomes.[88] People with disabilities who also belong to one or more other populations with health disparities fare even worse. Navigating perinatal mental health challenges can be uniquely challenging for individuals with disabilities. It is crucial to ensure accessibility in healthcare facilities and services, offering materials in accessible formats such as braille or audio. Effective communication and utilizing interpreters or assistive devices are vital. Tailored emotional support acknowledging the intersection of disability and perinatal mental health is essential, along with caregiver support and inclusive education efforts. Healthcare providers must receive training in disability awareness to provide empathetic and informed care. Addressing these considerations ensures an inclusive perinatal mental health support system, offering individuals with disabilities the specific care and support they require during their perinatal journey.

Considerations for Those Experiencing Housing Insecurity or Homelessness

Addressing PMH disorders among pregnant individuals experiencing homelessness or those who may face housing insecurity requires targeted efforts to overcome their unique challenges. These individuals often lack consistent access to healthcare services, making outreach and early screening crucial. Providing safe and stable housing options with integrated mental health support is essential. Trauma-informed care, cultural competency, and peer support programs can help create a safe and empathetic environment. Providing these individuals an 'express lane' for public assistance programs, including housing, can improve access to needed care and a stable housing environment. Additionally, initiatives should address transportation and childcare barriers, raise awareness, and advocate for policies that prioritize the mental health of homeless pregnant individuals. By addressing these considerations, the mental health outcomes of this vulnerable population can be improved during and after pregnancy.

Other Barriers in the District

Additional health-related social needs include education, employment status, insurance status, and general socioeconomic status. In fact, 20% of individuals living in Wards 7 and 8 live below the federal poverty level, representing higher percentages than other wards in the city. Beyond considerations previously discussed for immigrant and refugee populations and individuals who identify as LGBTQIA+, other groups such as justice-involved individuals, individuals with substance use disorder, and teen parents face further barriers to proper screening and treatment. Limited healthcare services within certain neighborhoods of the District further impede access to certain populations, particularly those living within Wards 7 and 8, who also constitute an over-representation of maternal deaths.

Conclusion

The comprehensive analysis and recommendations presented in this report underscore the urgency of addressing PMH within the District. Perinatal mental health is a complex and multifaceted issue that requires a holistic, community-driven response. By identifying key challenges, such as the shortage of providers, disparities in access to care, and the unique needs of vulnerable populations, and by proposing solutions ranging from streamlined insurance processes to expanded care coordination and public awareness campaigns, this report provides a roadmap for transformative change. The District has made commendable strides in recognizing the importance of PMH, but there is still much work to be done to ensure that every individual who experiences pregnancy and the postpartum period has access to the mental health support they need. The recommendations outlined herein aim to catalyze this transformative change, forging a path toward greater equity, accessibility, and improved mental health outcomes for all residents of the District, regardless of their perinatal journey or background. It is our hope that the District will embrace these recommendations and work collaboratively across sectors to build a brighter, healthier future for its perinatal population.

Index of Appendices

Appendix A: Task Force Calendar of Topics

Tuesday, January 31, 2023 – 4:00-5:00 PM

- Roundtable Discussion on Task Force Outcomes
- Current State of Perinatal Mental Health Programs

  Speakers:

  - Jasmine Bihm, DC Health, Perinatal and Infant Health Division Chief
  - Wanda Wilson, Department of Behavioral Health, Parent Infant Early Childhood Enhancement Program

Tuesday, February 28th, 2023 – 4:00-5:00 PM

- Perinatal Mental Health Primer, Part I

  Speaker:

  - Aimee Danielson, MedStar Georgetown University Hospital/ MedStar Washington Hospital Center
- Overview and Discussion of Proposed Subcommittees

Tuesday, March 28th, 2023 – 4:00-6:00 PM

- Perinatal Mental Health Primer, Part II: Screenings and Programs
  Speaker:
  - Aimee Danielson, MedStar Georgetown University Hospital/ MedStar Washington Hospital Center
- Findings from Other States
  Speaker:
  - DaShawn Groves, Department of Health Care Finance
- Discussion of Proposed Subcommittees
- Medicaid Renewals
  Speaker:
  - Melisa Byrd, Department of Health Care Finance

Tuesday, April 25, 2023 – 4:00-6:00 PM

- District of Columbia Perinatal Quality Collaborative Overview
  Speaker:
  - Yolette Gray, DC Hospital Association
- DC Primary Care Association DC NEXT Program Overview
  Speaker:
  - Tricia Quinn, DC Primary Care Association
- Subcommittee Updates and Discussion

Tuesday, May 29, 2023 – 4:00-6:00 PM

- DC Mother Baby Wellness Initiative Overview
  Speaker:
    - Tracy Vozar, Children's National
- Task Force Recommendation and Report Drafting Process
- Subcommittee Updates and Discussion

Tuesday, June 27, 2023 – 3:30-5:30 PM

- Public Awareness and Systems Capacity Survey
- Mommy and Me Overview
  Speaker:
    - Children's National
- Well-being Survey Briefing
  Speaker:
    - Tricia Quinn, DC Primary Care Association
- ACOG Recommendations
  Speakers:
    - Maariya Bassa, Unity Health
    - Lauren Demosthenes, Babyscripts
- Task Force Meetings and Report
- Subcommittee Deep Dive: Screening, Referral and Workforce Development

Tuesday, July 25 – 3:30-5:30 PM

- Peer and Community-based Programs
  Speakers:
    - Safe Baby Safe Moms
    - Mary's Center Home Visiting
    - Mamatoto Village
    - DC Health Family Bureau – Help Me Grow Program
- Task Force Discussion

Tuesday, August 29, 2023 – 3:30-5:30 PM

- Level of Agreement Tabletop Exercise

Tuesday, September 28, 2023 – 3:30-5:30 PM

- Report and Recommendations Overview and Discussion

Appendix B: Compiled Task Force Recommendations

Consensus Threshold	Rec. No	Issue	Solution	Impact	Budget Implications	Domain
	1	There are currently not enough licensed providers to support the growing number of patients needing to connect with perinatal mental health support services. Additionally, those who are currently do specialize in in perinatal mental health either have extensive wait times and/or offer services that may be cost prohibitive for a large portion of the population seeking care. Additionally, navigating an already complex and challenging system may be burdensome and overwhelming to a patient seeking to connect with care.	Expand DC Mental Health Access in Pediatrics (DC MAP) to offer support to OB-GYN providers and include PMH services/care coordination support for patients seeking PMH support.			Access and Navigation
	2	Barriers to access to care during the perinatal period for birthing people and their partners. There is currently no access to intensive outpatient care or partial hospitalization program for noncitizens of the United States who have some form of DC Alliance insurance. We have participants on an ongoing basis who would benefit from more intensive care after inpatient treatment but there is no option for them to receive this treatment. We are then trying to treat people who need more intensive care in outpatient treatment which strains the already limited resources we have to offer our participants. With Medstar working to start a Mother/Baby IOP to specifically serve the perinatal population, let's not forget some of our most vulnerable residents who may have recently arrived to the city.	There should be a safety net for Alliance insurance consumers to be able to access IOP and PHP care. I understand there will be some changes this year with what Alliance insurance will offer but we need to be sure that this is included and that access to the Mother/Baby IOP at Medstar will have access to all who would benefit from this type of care, regardless of insurance or ability to pay.	Perinatal participants with severe mental illness will have access to treatment levels in-between inpatient and outpatient. Recently we had a participant with Alliance who went to United Medical Center for psychosis and depression symptoms and was discharged without any discharge planning and sent home without even a psychiatry appointment scheduled.	A budget will be needed to cover the cost of the care.	Access and Navigation

	3	Our current system of support and resources that exist in WDC for mothers is a complex patchwork of grant and foundation funded programs many of which are providing care coordination, navigation, and psychotherapy for no or little cost. These resources have been very helpful but they are not sustainable and have created a false sense that these services are more readily available and accessible in DC (through Clark funded projects at MedStar and Children's). Given that care coordination and navigation is critical to help perinatal individuals get connected with PMH treatment and support AND it is not something that is currently billable and reimbursable, once these foundation funds run dry, mothers will be left to scramble and try to navigate the complex patchwork of options on their own.	A single city-wide telephone line with access to care coordination and referrals, akin to 'Help me Grow' but focused on mental health of Mothers and Caregivers.			Access and Navigation
x	4	From working with the District's most vulnerable patients at an FQHC, I can say that the two biggest barriers to patients getting access to perinatal mental health services are lack of providers and being uninsured. While the district has excellent insurance coverage available, the process to become insured has become more difficult since the pandemic ended and is taking much longer than in the past. Previously, there were channels to help patients who are pregnant "fast track" their insurance applications, but this is gone. I have patients who applied 4 months ago who are still not covered. What this means is the patients have extremely limited access to mental health services since there are so few provider already in the district. The need is especially acute for patients seeking therapy in Spanish, psychiatry medical management and crisis services.	Resume the "fast tracking" (or creating a new process) whereby pregnant patients can become insured within 28 days of application. Since pregnancy is a very time sensitive condition, the faster patients can get insured, the earlier we can intervene.	Earlier access to resources to improve outcomes		Access and Navigation

x	5	According to DC NEXT!'s pilot well-being survey Most young parents (63%) reported that they are not thriving, highlighting that barriers related to housing instability as well as inadequate access to employment, childcare, and transportation stand between young parents and the futures they yearn to create. A subset of young parents in DC are facing severe challenges including frequent hunger, frequent housing insecurity, poor mental health, and social isolation. Respondants with the lowest personal status ratings (0-4) are almost 3x as likely to have worries about housing and 3.5x as likely to have worries about having enough to eat as compared to those who rate their current personal status as THRIVING (7+).	DC needs a teen parent system of care tailored to meet the needs of adolescent parents and their children. While young parents are eligible for the range of supports available for all parents who meet eligibility, these services are not designed to meet the unique needs of adolescent parents. They need a system of care responsive to their developmental needs as adolescents and as parents. Recommendation: Resource a team of community health workers trained and equipped to support young parents and assist them in navigating the adult-parent system of health and social services	Our research consistently surfaced teen parents' need for navigation assistance to get access to needed programs and supports in the adult system of services. While this intervention does not create the teen parent services system we need, it provides CHWs trained in adolescent development to help teen parents access and engage in services that can help them thrive.		Access and Navigation
x	6	Various managed care organizations cover perinatal mental health services at different levels or with varied procedures, thus causing confusion among providers and patients that reduces or delays access to care. Lack of standardization leads to confusion of what services are covered under different MCO contracts.	Create uniformity in the accessibility of perinatal mental health services across managed care organization contracts, to the extent possible, to reduce administrative burden on providers and increase accessibility for patients.	With uniformity across managed care organizations, clinicians and patients can better understand what services and therapies are available, in addition to what costs may be incurred. This leads to improved access, and consequently better outcomes.	none	Access and Navigation

x	7	There is a need to increase access to mental and behavioral health providers where PMADs are identfied, including pediatric, OB/GYN, and other primary care settings.	Provide sustainable Medicaid funding for HealthySteps, which provides valuable perinatal mental health screening, education, brief interventions, and referrals to additional community services.	Mental health services provided through HealthySteps model in pediatric primary care settings can lead to increased access to needed services, thus treating conditions before they escalate to more costly severe diagnoses. Mental and behavioral health services are severely lacking across the District, most critically in high-need and lower resourced areas such as Wards 7 & 8. HealthySteps brings mental health services to the patient where they access care, increasing access in areas often experiences shortages.	Medicaid MCOs will provide reimbursement for mental and behavioral health services offered in primary care settings where HealthySteps is implemented. Budget implications are expected to be very low, due to lower acuity care offsetting higher acuity care needed later, and federal match rate.	Access and Navigation

x	8	Care coordination services are not reimbursed when they are provided through a clinical setting, even though this trusted setting can have a strong success outcome for at-risk patients and families.	Include care coordination policy guidance, active CPT codes and adequate reimbursement rates at point of health care service. Guidance should include the range of behavioral health specialists able to provide care coordination. Care coordination at the point of service (within ob/gyn, pediatric PC, etc) greatly increases access to needed therapies and services for individuals at risk for or diagnosed with perinatal mood and anxiety disorders.	Care coordination provides needed supports within the setting of health care offices where providers identify perinatal mood and anxiety disorders through increased screenings, and now require connection to services. Without sutainable funding for care coordination services, clinicians may spend clinical time connecting patients to services. Philanthropic funding can support limited pilots, though sustainable funding is required to scale this service. Delivering care coordination is more successful in a trusted setting and with trusted providers who have built rapport with the patient and family. This reduces a major barrier to successfully accessing needed services.	Care coordination is budgeted into Medicaid reimbursement, with federal matching funds where appropriate.	Access and Navigation
x	9	High demand for psychiatric care for pregnant and lactating individuals. A shortage of perinatal or reproductive psychiatrists who participate with public and private insurance. Increased demand for these kinds of referrals due to increased perinatal mental health screening in settings across DC.	DC needs a Perinatal Psychiatry Access Program, which would best be served by a partnership between a DC Agency (like DC Health) or the DC PQC and a healthcare partner who could develop, staff and implement the program. Many states			Access and Navigation

			have solved problems with accessing PMH care, coordination of PMH referrals, and building the capacity of OB providers to address their patient's mental health needs as part of their OB care, through a state-based perinatal psychiatry access project. HRSA funds many of these projects but some other states have funded them to start directly out of the state budgets.			

x	10	Many PMADS are preventable if pregnant women have the support they need. It is much better for the health and wellbeing of a mother and her child for a depressive disorder to be prevented, if possible, rather than her becoming ill and requiring treatment. There are three USPSTF recommended evidence-based perinatal depression prevention programs and there are myriad barriers to implementing these programs, including no way to bill for them. Home visiting is another model that has been universally recognized as a way to provide in-home support to reduce or eliminate negative postpartum health outcomes including postpartum mental health disorders. Home visiting is available in DC, but it is a complicated system that is tough for folks to navigate and it is not universally available to all birthing individuals. The availability of a postpartum Doula is another form of support that is thought of as a preventative intervention when it comes to the development of postpartum mental health conditions. Progress has been made IN DC to increase access to affordable doula care , but there is still a long way to go. There are too many barriers to each of these forms of support which interferes with a population-based preventative health approach to addressing perinatal mental health.	Understanding how to increase programs/supports aimed at depression prevention and better leveraging existing supports in DC with a goal of protecting and preserving mental health and preventing negative mental health outcomes for perinatal people, requires a long-term commitment to this work beyond a one-year DC PMH taskforce period. This requires that there is a standing DC Perinatal Mental Health to ensure accountability and follow-through of the recommendations provided by this process.			Public Awarenes s and Systems Capacity
	11	Information and resources should be DC centric, refreshed and updated. As new peer reviewed updates and community partners and resources become available a central repository of information should be maintained and out dated and retired resources be removed.	New programs come on line and legacy programs disappear. Having a central easy to reach repository of resources will be helpful.	Affected groups will have the ability to access the best resources available to them. Resources that are not DC Centric may be excellent for other regions but not reflective of the community we serve.	There would be a vendor who would be tasked to update the database and to promote the resource.	Public Awarenes s and Systems Capacity

x	12	Current District Committees, Boards, Commissions, and Task Forces around maternal and child health do not included dedicated representation of perinatal mental health issues, providers, and impacted individuals. This leads to gaps in planning, identification of issues, and policy solutions.	All relevant Boards should have at least one designated seat for someone representing perinatal mental health needs. This may include the Maternal Mortality Review Board, Maternal Health Advisory Committee, Perinatal and Infant Health Advisory Committee, Interagency Council on Housing, Office of Women's Policies and Initiatives, DC Commission for Women, and others where birthing people intersect with public supports. These Boards, Committees, and Councils will also make efforts to distribute information and train professionals across all relevant services in the health and social needs of pregnant and parenting people.	District Committees, Boards, Commissions, and Task Forces that have dedicated representation will better identify needs and opportunities that benefit perinatal individuals and the professionals who serve them. For instance, Professional Boards shall ensure that training on perinatal mood and anxiety disorders are made available to all licensed and certified professionals in the District	no known budget implications.	Public Awarenes s and Systems Capacity
x	13	Increase general population and targeted population awareness of perinatal mood and anxiety disorders as the most common complication of the pregnancy.	Support public awareness campaigns similar to immunization and tobacco cessarion campaigns, which raise areness and reduce stigma around PMADs. Engage a variety of community partners, from health services organizations and providers to social services agencies and faith-based communities, to expand reach of the	Public awareness campaigns for PMADs will increase awareness, in turn decreasing stigma around mental wellnesss. Positive messages for receiving mental health care should be visible in a variety of settings, as perinatal individuals may access multiple environments.	Dedicated District funding has large potential benefit, including increased wellness which reduces acuity of care , improved maternal well-being and reduced maternal mortality and morbidity. Specific attention	Public Awarenes s and Systems Capacity

			messages around mental wellness and family support.		must be paid to Black/ African American women and other populations with health equity disparities, in order to improve outcomes.	
	14	Mental and behavioral health workforce, including psychiatrists and psychologists, is severely limited in the District. Health care providers specializing in perinatal mental health are also in short supply in the District, and many providers do not take insurance. This becomes a severe barrier to those with public insurance especially.	Implement the Health Care Workforce Task Force Report Recommendations, submitted in 2022, which should be published and distributed publicly. This Task Force extensively researched and outlined a wide range of workforce solutions to increase capacity through recruitment, retention, and training across the health care spectrum. Many of these recommendations would inform the perinatal mental health workforce challenges currently. Similar extensive recommendations in A Path Forward report detail workforce solutions that will strengthen perinatal services, and should be acted upon.	The District lacks the quantity of perinatal mental health providers, including psychiatrists and psychologists with perinatal mental health training, needed to fully serve the at-risk and in-need population. More perinatal individuals will access needed care with increased workforce capacity.	n/a	Public Awareness and Systems Capacity

x	15	Pediatricians are one piece in the solution to provide wrap-around services.	Concern that the Clark Family Foundation is funding a SIGNIFICANT portion of PMADs care in the District. What are we to do after the funding is complete? DC needs to continue to fund mental health initiatives, in particular, programs that already exist and have shown success.	Can continue to provide screening and linkages to care in the perinatal period.	DC Government and/or DC Medicaid or other insurers should anticipate that the Clark funding will conclude in 2025. How can we increase government funding support and/or insurance reimbursement/coverage in anticipation of this date so that services to not go away for our families?	Public Awareness and Systems Capacity
	16	The District lacks a single agency or department where perinatal mental health can be centered and organized across the various programs, policies, and service delivery vehicles. This leaves open the risk of missing important policy levers around perinatal mental health.	Strong agency leadership and commitment is essential to ensure perinatal mental health issues are represented and advocated within the Administration and across the many departments that touch pregnant and parenting individuals.	With strong leadership from the Administration, resources and policies can be best allocated, channeling them to where they are needed most. District residents will see a coordinated approach to meeting the need of pregnant and parenting individuals, and providers will find solutions to maximize the resources available to the District.	n/a	Public Awareness and Systems Capacity

x	17	BIPOC mothers and fathers who have experienced miscarriages or stillbirths. As well as BIPOC engaged in personal family planning. This population is unaware of the health challenges associated that may stem from pregnancy and childbirth. There is no public awareness campaign to inform them of the challenges or where to get information. They do not know the critical questions to ask and the protective or risk factors.	I recommend a comprehensive public health awareness campaign that would provide practical information and guide them on how to engage with their PCP health care provider.	Reduce infant mortality, reduce mothers fatalities during the delivery process, and support the mental health of BIPOC parents.	Not sure.	Public Awarenes s and Systems Capacity
	18	The need for increasing the number and type of healthcare providers who screen pregnant and postpartum patients for anxiety and depression is well understood. It is also understood that prioritizing healthcare appointments can be a challenge for patients during the perinatal period, especially when those patients are also receiving other essential social services that require competing appointments. The need to juggle competing demands for the physical, economic, and other needs can be a source of additional stress. One way to ensure that birthing people who are unable to attend medical appointments are still screened for potential mental health concerns is by training non-medical services providers to administer screenings.	Universal screening of birthing persons for signs of perinatal mood disorders should be inclusive of non-medical service providers. All DC agencies that provide one-on-one case management or supportive services to individuals during the perinatal period should be required to administer perinatal mental health screenings and provide referrals when appropriate. This should include case workers providing support for TANF, SNAP, housing, unemployment or other similar programs. District employees should receive comprehensive training on how to administer screening assessments, like the EPDS, and be able to provide birthing people with up to date resources that can provide mental health support if needed. The training should	By increasing the number and type of individuals who are beginning conversations with birthing people regarding their mental health we can increase the likelihood that a birthing person will seek professional help if needed. Starting these conversations will also signal to birthing people that all of the individuals and agencies who are supporting them care about their mental well-being as well as the material needs specific to the social service they're receiving.	Not known	Screening and Referral

			recognize that many of the stresses that come with housing, economic, or food insecurity can contribute to feelings of anxiety and depression. Service providers should be able to discuss the meaning of the screening score and contextualize that with an individual's specific circumstances.			
	19	CPT codes which identify prevention-level and early intervention pathways are lacking in DC Medicaid.	Add Z-codes to DC Medicaid, which provide diagnostic pathways when a specific diagnosis is still under consideration or a more severe diagnosis that can be prevented with appropriate therapy and services.	Z-codes allow clinicians to treat for conditions before they escalate or require more expensive acute care. They also reduce stigma around mental health diagnoses, by eliminating the need to diagnose more severe conditions when they are not warranted yet. Z-codes are a potential solution to constraints in billing for prevention services, and allow providers to take a greater prevention approach to address challenges before they rise to the level of a diagnosable disorder.	Normal Medicaid reimbursement mechanisms expected.	Screening and Referral

	20	There is a general lack of psychiatric services and often this gap is covered with psychiatric nurse practitioners. In our experience, they often recommend discontinuation of medications and are very hesitant to start them perinatally as well. It might make sense to fund a resource that could provide guidance to providers/clinicians as well as to patients. It will be impossible to have enough psychiatric time to fill all the need. It may take a couple of hires. Children's may have some thoughts about this through their current grant funded program.	Probably this involves centralization of this resource within an existing service somewhere.			Screening and Referral
	21	Pregnant and parenting teens have higher rates of depression, anxiety, and PTSD compared to adult parents. Adolescents require intensive services and teen-friendly staff to support their health and well-being during the perinatal period. Doula services, an evidence based strategy to support healthy births, can help pregnant teens identify mental health concerns and connect to resources. Additionally they can advocate for teens during the perinatal period, leading to improved birth outcomes and decreased birth-related traumatic events. From 2022-2023, Children's National and DC Primary Care Association piloted a doula program for teen parents, called "Beyond the Bump." 10 teens living in DC have received comprehensive doula services during pregnancy, childbirth, and the postpartum period. 100% of participants have had full-term, vaginal deliveries; 100% initiated breastfeeding; and 100% accessed other community programs, including mental health resources. Beyond the Bump was supported by grant funding that will end after December 2023.	Comprehensive doula services for teen parents is a promising intervention that should be available to all pregnant teens in DC. This existing program can be scaled and studied with additional funds, and will continue to benefit individuals and the broader community. In our pilot program, we found that doulas needed to spend more hours face to face with teen parents compared to adult parents. Doulas spent an average of 50 hours with teen clients, and to appropriately compensate their time required $2500-$3500 per client.	Among participants in Beyond the Bump, 100% of participants have had full-term, vaginal deliveries and 100% initiated breastfeeding. These are huge improvements over the population wide c-section rate (20%) and breastfeeding rate (40%) for teen parents. Having a healthy birth is also associated with improved post-partum mental health, which this program supports. Additionally, 100% of participants accessed other community programs, including mental health resources. Building a relationship with a doula throughout the perinatal period supported our participants' mood,	In our pilot program "Beyond the Bump", we found that doulas needed to spend more hours face to face with teen parents compared to adult parents. Doulas spent an average of 50 hours with teen clients, and to appropriately compensate their time required $2500-$3500 per client. Participating doulas are currently registering as Medicaid providers, however the expected reimbursement through Medicaid would require	Services and Data

				recovery from childbirth, and return to school/work.	changes to the current effective program.	

	22	There are currently not enough licensed providers to support the growing number of patients needing to connect with perinatal mental health support services. Additionally, those who are currently do specialize in in perinatal mental health either have extensive wait times and/or offer services that may be cost prohibitive for a large portion of the population seeking care. Additionally, navigating an already complex and challenging system may be burdensome and overwhelming to a patient seeking to connect with care.	Use DC Mental Health Access in Pediatrics (DC MAP) expansion opportunity to include and expand post-partum doula roles and abilities to support individuals who have recently given birth by hiring post-partum doulas as care coordinators. Not sure if this role would then be able to be reimbursable through insurance?	3. Care coordination has shown to be an effective intervention and offering educational support to existing providers may improve care outcomes for patients seeking information around PMH support.		Services and Data
	23	I suggest that perinatal care coordination to be a Medicaid funded activity like doula and lactation services. We know that there is a lack of licensed mental health providers and that they cannot always be integrated into perinatal care services. As a result, we need additional staff who are able to back up clinicians, complete and follow up on screenings, and bridge to mental health and social service support. We need people who can have some higher caseloads than doulas are capable of supporting or for people who may not trust having staff in their homes. They can also provide support in crisis and help overcome barriers to receiving care. I think that we need the care team to be diverse and this role would help fill in some of the gaps in our care.	We should have a per visit rate and allow nonlicensed staff to be able to meet some standards and create notes which reflect work and are able to be submitted for reimbursement to Medicaid.	These roles are working very well in many agencies but are currently funded by grants - the large one from the Clark Foundation that has supported much of this will be ending soon.	Would need to be included in the 1130 Waiver and would require both federal and local funding.	Services and Data

x	24	Our current system of support and resources that exist in WDC for mothers is a complex patchwork of grant and foundation funded programs many of which are providing care coordination, navigation, and psychotherapy for no or little cost. These resources have been very helpful but they are not sustainable and have created a false sense that these services are more readily available and accessible in DC (through Clark funded projects at MedStar and Children's). Given that care coordination and navigation is critical to help perinatal individuals get connected with PMH treatment and support AND it is not something that is currently billable and reimbursable, once these foundation funds run dry, mothers will be left to scramble and try to navigate the complex patchwork of options on their own.	An ability to be reimbursed by Medicaid and commercial insurance for care coordination.			Services and Data
	25	From working with the District's most vulnerable patients at an FQHC, I can say that the two biggest barriers to patients getting access to perinatal mental health services are lack of providers and being uninsured. While the district has excellent insurance coverage available, the process to become insured has become more difficult since the pandemic ended and is taking much longer than in the past. Previously, there were channels to help patients who are pregnant "fast track" their insurance applications, but this is gone. I have patients who applied 4 months ago who are still not covered. What this means is the patients have extremely limited access to mental health services since there are so few provider already in the district. The need is especially acute for patients seeking therapy in Spanish, psychiatry medical management and crisis services.	Support DC Mother Baby Wellness to hire additional Spanish speaking therapists (their services are available for all pregnant and postpartum patients in the district, independent of where they get their care)	Earlier access to resources to improve outcomes		Services and Data

	26	From working with the District's most vulnerable patients at an FQHC, I can say that the two biggest barriers to patients getting access to perinatal mental health services are lack of providers and being uninsured. While the district has excellent insurance coverage available, the process to become insured has become more difficult since the pandemic ended and is taking much longer than in the past. Previously, there were channels to help patients who are pregnant "fast track" their insurance applications, but this is gone. I have patients who applied 4 months ago who are still not covered. What this means is the patients have extremely limited access to mental health services since there are so few provider already in the district. The need is especially acute for patients seeking therapy in Spanish, psychiatry medical management and crisis services.	Work with the hospitals and/or DC Mother Baby Wellness to create a crisis intervention team for pregnant and postpartum patients. Ideally would work with CPS as they are often involved in these cases.	Earlier access to resources to improve outcomes	For the insurance change, none	Services and Data
x	27	Women of color during their pregnancy and postpartum journey need preventive mental health spaces. There are many moms who need mental health support that might not warrant 1:1 therapy. They just need a safe space to talk with a specialist. Perhaps a group mental health support during pregnancy and postpartum to prevent crisis. This might help with the shortage in culturally competent mental health support.	Programs that provide group support, it can be peer matching or a group support that covers different topics related to mental health (transitions in motherhood, navigating struggles of pregnancy). Wolomi currently offer virtual group support moderated by mental health specialists and peers. It will be great for this to be a billable service for the different groups like this across the city.	Preventing mental health crisis and wellness.	It will be great if it is billable. $4k-$6k per group. Depending on the level of complication and outreach efforts.	Services and Data

	28	Digital resources hold great potential, but will require dedicated resources to expand development of evidence-based models at scale and commitment to sustaining them with connection to providers and community resources that can support the mental well-being of perinatal individuals.	Expand digital resources for perinatal individuals focused on prevention and treatment of PMADs, including the continuation of the relationship with Canopie, as announced at the 4th Annual Mayor's Maternal and Infant Health Summit.	Digital health resources, also known as mHealth, meet perinatal individuals where they are in the community. Many health messages can be relayed through digital format, and reimforce information and services received in care, further increasing the likelihood of successful treatment. Yet others are innovative treatment type models being employed in clinical settings. A comprehensive study of Wyoming Medicaid's Due Date Plus app used by enrolled pregnant women estimated a 3:1 return on investment (ROI) based on cost avoidance. Benefits of participation included earlier initiation of prenatal visits and fewer preterm births. Preterm births are correlated to a host of physical, behavioral, and intellectual complications throughout childhood and into adulthood, so reducing preterm births has widespread health and economic consequences.	Financial commitment equivalent to existing digital campaigns and resources.	Services and Data

x	29	Quality data collection on perinatal mental health screening, prevalence, and availability of services are lacking for District populations. Data that delineates by race, ethnicity, income, geography, and other factors	Increase collection of relevant perinatal mental health data across public and District-wide sources, and ensure data is published publicly for better understanding across the District.	Better data collection will allow for valuable analysis of prevalence and access. This in turn will lead to more precise planning and resources allocation where need is high, impact and outcomes can be measured. Data that delineates by race, ethnicity, income level, geography, and other measures of social-related health needs will further identify areas for investment.	Current data collection mechanisms will reduce or eliminate any budget implications.	Services and Data
x	30	Access to consultation and training for clinical providers who touch perinatal individuals is needed, so that more patients can be served in primary care practices and not have to be referred to behavioral health providers who are already in short supply, have long wait lists, or do not accept any/all insurance options.	Support establishment of Perinatal Psychiatry Access Program, similar to MCPAP for Moms in Massachusetts, which provides education and training, consultations services to providers, and connection to services. This will increase capacity of OB/GYNs, Pediatricians, and other providers serving perinatal individuals to address PMAD concerns of their patients, so more patients can be treated in their medical home and access needed services and therapies.	With access to experts in PMADs, more providers will be able to serve patients in their medical home, increasing access to more care and treatment for affected patients. Shortages of mental health professionals with PMH specialization makes it difficult for providers to refer patients; with consultation more providers will comfortably meet the needs of their patients without long waits and insurance barriers.	Significant funding from HRSA is available by RFP, if granted. Next RFP cycle unknown.	Services and Data

x	31	Guidance is lacking for the billing and reimbursement of prevention counseling interventions, including ROSE program and Mothers and Babies Course.	DHCF provide billing and reimbursement guidance for prevention counseling interventions, including ROSE program and Mothers and Babies Course, as identified by the US Prevention Services Task Force as evidence-based perinatal mental health prevention interventions. This should address reimbursement options for both clinical and non-clinical providers who are qualified to deliver prevention interventions, and can be implemented immediately.	With clear guidance on how to bill for prevention counseling interventions, evidence-based services can be provided to perinatal individuals in need. This will reduce acceleration of PMADs, improvide maternal and infant mental health, and reduce strain on mental health services. Providers need adequate reimbursement to sustain these prevention counseling interventions.	no budget implications.	Services and Data
x	32	Community Health Workers are currently not reimbursed by Medicaid. The inability to extend the delivery of care by community health workers constricts capacity to meet the growing need of patients and families presenting with PMADs.	Allow Medicaid payment for services provided by Community Health Workers serving pregnant and postpartum populations. The District can employ a state plan amendment, integration as members of interdisciplinary teams under a Section 1115 demonstration waiver, or as services provided and reimbursed by MCOs.	Community Health Workers are important health care extenders. They are trusted members of the health care team, and can serve to bridge information between clinicians and patients/ families. They are able to connect with patients and families, even when other providers may not be able to or have capacity to.	Community Health Worker reimbursement is budgeted into Medicaid provider contract rates, with federal matching funds.	Services and Data

x	33	There is a need to increase access to mental and behavioral health providers where PMADs are identfied, including pediatric and adult primary care provider settings, OB/GYN, and other health care settings where perinatal individuals are interacting with the health care system.	Fund integrated health care services through enhanced Medicaid reimbursements and innovative care models, which embed mental health professionals in primary care (pediatric and adult) and OB/GYN settings where patients access care the most.	Mental health services provided in pediatric and adult, OB/GYN, and other primary care settings can lead to increased access to needed services, thus treating conditions before they escalate to more costly severe diagnoses. Mental and behavioral health services are severely lacking across the District, most critically in high-need and lower resourced areas such as Wards 7 & 8. Integrated health care models bring mental health services to the patient where they access care, increasing access in areas often experiences shortages.	Medicaid managed care providers will provide reimbursement for mental and behavioral health services offered in primary care settings (pediatric and adult)a where integrated health models are implemented. Budget implications are expected to be very low, due to lower acuity care offsetting higher acuity care needed later, and federal match rate.	Services and Data
x	34	Improvement on health outcomes is measured by using the HEDIS measures.	Direct District agencies overseeing public and commercial insurance products to measure and report HEDIS metrics. Consider options to hold managed care organizations accountable for improvements in PMAD-specific measures.	HEDIS measures	n/a	Services and Data

x	35	MCOs may not be meeting all the standards and responsibilities of the Medicaid contracts regarding perinatal mental health. This leaves gaps in services, conflicting messages for providers and patients alike who are accessing services, and reduces the outcomes at crticial periods of higher risk for perinatal patients.	MCOs need to be held accountable for services in their Medicaid contracts. MCO contract requirements regarding data collection, coverage of prevention, brief intervention, and therapy services, network adequacy, care coordination, and other components of care are all critical pieces to a successful support system for perinatal inviduals. MCOs should be required to report these metrics and outcomes on a regular basis, in order to ensure gaps are not extensive or continued.	Medicaid patients are entitled to access all covered services, without fear of gaps or challenging in accessing care. Providers should be assured that services they provide will be covered if they comport to the Medicaid contract, without concern for retribution or unsustainably low reimbursements.	This oversight should already be accounted for in DHCF funding, and therefore not require additional funds.	Services and Data
x	36	Intensive Outpatient Programs and Partial Hospitalization Programs are severely lacking in the District region, with no programs identified by Postpartum Support International within 4 hours of DC.	Support establishment of Intensive Outpatient Programs and Partial Hospitalization Programs in the District.	Successful programs (both independent and housed within health care institutions) allow for intensive services without the inpatient requirement, which may be better suited to various conditions and personal circumstances. Access to quality care reduces long-term consequences, including reduced bonding, attachment, and child development delays, increased family stress, and risk of long-term trauma.	Possible fiscal incentives to health care institution(s) establishing outpatient programs.	Services and Data

x	37	There is currently no Inpatient Program with Child Interaction in reasonable proximity of the District, thus severely limiting care options for those in need.	Support establishment of Inpatient Perinatal Psychiatry Unit in the District. Incentives for the development of an Inpatient Unit can include financial incentives for health care institution(s) to invest in this care.	Those requiring Inpatient Psychiatric Units currently have no options in proximity to the District that address Perinatal needs, instead needing to seek care far away or in units that do not have training in perinatal mental health. A dedicated Perinatal Inpatient Unit will provide quality therapy and care to patients in need. Best practice also ensures access to baby, which is important for bonding and strengthening healthy dyadic attachments/ reducing occurence of unhealthy attachments. This reduces the incidence of a variety of short and long term issues for the child, impacting the child's long term wellbeing.	Possible fiscal incentives to health care institution(s) housing inpatient units.	Services and Data

	38	There are currently not enough licensed providers to support the growing number of patients needing to connect with perinatal mental health support services. Additionally, those who are currently do specialize in in perinatal mental health either have extensive wait times and/or offer services that may be cost prohibitive for a large portion of the population seeking care. Additionally, navigating an already complex and challenging system may be burdensome and overwhelming to a patient seeking to connect with care.	Incentive currently licensed therapists to complete certification in PMH to expand the network of licensed providers.	Incentivizing existing providers could more readily expand the network of available resources, possibly making care more accessible and available to patients.	All of the recommendations are likely expensive and require significant funding to be able to be sustainable.	Workforce Development
	39	BIPOC mothers and fathers who have experienced miscarriages or stillbirths. As well as BIPOC engaged in personal family planning. This population is unaware of the health challenges associated that may stem from pregnancy and childbirth. There is no public awareness campaign to inform them of the challenges or where to get information. They do not know the critical questions to ask and the protective or risk factors.	I would also like to recommend training mental health providers to support this population and create policy directing PCPs to inform all BIPOC patients of the protective and risk factors and to make the appropriate referrals to a mental health provider,	Reduce infant mortality, reduce mothers fatalities during the delivery process, and support the mental health of BIPOC parents.	Not sure.	Workforce Development
	40	There are currently not enough licensed providers to support the growing number of patients needing to connect with perinatal mental health support services. Additionally, those who are currently do specialize in in perinatal mental health either have extensive wait times and/or offer services that may be cost prohibitive for a large portion of the population seeking care. Additionally, navigating an already complex and challenging system may be burdensome and overwhelming to a patient seeking to connect with care.	Incentivize OB-GYN offices to recruit and hire embedded therapists within the practice to offer short term therapy for patients screening positive for PMH diagnosis tools.	Being able to access care in house may more convenient, accessible, and could increase patients successfully being referred to and connecting with appropriate services and improve PMH outcomes for patients.	All of the recommendations are likely expensive and require significant funding to be able to be sustainable.	Workforce Development

x	41	Currently, my programs (in Home Visiting) work with participants, many of who are English as a Second Language speaker or who do not speak English. Among these participants, Spanish and Amharic are the prevalent languages we see. However, when accessing PMH services, our participants have limited access to bilingual PMH professionals and have mentioned that they find 1:1 services through an interpreter uncomfortable.	In addition to this challenge, when the limited number of PMH professionals see participants, they have additional workload compared to English only speaking professionals or sessions with English-speaking participants. Which is discouraging to engage this bilingual professionals. This additional workload is a result of the fact that documentations have to be made in English, as such this professionals have to serve as translators of their own sessions (conducted in another language) into English. A beneficial solution is having incentives for bilingual professionals and taking into consideration the additional workload they have to take on.	With this policy, more PMH professionals will be incentivized to work and Populations with limited English language abilities will feel more comfortable accessing PMH services and as a result could potentially increase PMH service utilization.		Workforce Development

x	42	There are very few mental health providers that specialize in perinatal mental health who also accept Medicaid in the District. For patients that may require this specialized assistance and support, they have limited options and inequitable care if they have to choose from providers that are in-network with their MCO but do not have the skill set to support PMADs.	There needs to be funding provided to providers who accept Medicaid so that they can be trained to support this unique population. Reversely, there should also be an incentive for providers that are trained to support this unique population to reserve pro bono spots for clients that have Medicaid or are uninsured. In the same way that some careers receive higher wages when they have increased specialized training and certifications to show for those trainings, providers that undergo training for the perinatal population should receive some sort of financial compensation for doing so.	I believe the group within the Dept of Health that supports licensing efforts could be one place to focus to create an incentivization structure. Perhaps the DC Board of Social Work could require each person seeking licensure renewal to attest that they work in a setting that serves patients that have Medicaid or they have to have at least one client that uses Medicaid per renewal period to keep their license active. This would be similar to the CEU requirements for license renewals, but an intervention that actually benefits a population that is being underserved.	There would need to be funding set aside to train providers who do not have specialized training about PMADs.	Workforce Development

x	43	We do not have enough behavioral health providers who are trained in perinatal mental health.	If we can make several perinatal mental health CEU hours required for the next renewal cycle for clinical licensure for social workers, counselors, psychologists and psychiatrists this could support capacity within the provider network for working with the perinatal population. Perhaps a few providers local to the DC region can develop curriculum and record an asychronous training that can be provided through DBH training institute for free. The work required here seems to be bringing this to the boards of each of the clinical health professions and making a request for this to be included as an addition to the requirements for ongoing continuing education.	Perinatal people seeking care in a variety of settings may receive improved sensitivity to the concerns they are presenting with.	A budget would likely be required to set up an online course, potentially pay instructors and to support the infrastructure of disseminating CEU certificates.	Workforce Development

x	44	I am most concerned with developing better early childhood transition processes that support disabled pregnant people and/or disabled families with young children in the home. The heavy emphasis on postpartum depression is very important yet for mothers and non-binary pregnant people, there are many that experience pre-existing mental health conditions and/or co-occuring developmental disabilities whose pregnancy needs go unmet - causing and contributing to lots of medical, social, and economic avoidable issues, impacting the political determinants of health. It is important to expand doula training opportunities and the service delivery system to meet the needs of pre-term and postpartum support for disabled people experiencing pregnancy, birthing, navigating the systems in the early years for child rearing, and meeting unmet transition support needs that keep children in the home and families safe and healthy.	Our solution is to partner with organizations and universities that can offer substantial professional pre- and postpartum doula training, certification, and technical assistance that specifically targets candidates seeking to support people with a range of disabilities navigating the perinatal l system, particularly the perinatal behavioral healthcare system in DC. Right now, DC is hyper focused on supporting parents with intellectual disabilities through the home visiting program, which is extremely important. Yet, there are other disability categories that get neglected in terms of perinatal mental health considerations - particularly those with known and emerging mental health disabilities that exacerbate during pregnancy. The need to support existing doula providing agencies and organizations to collaborate with disability focused organizations to enhance service offerings as early as possible in the pregnancy journey and before crisis.	Harm reduction by investing in a tiered system of response and an invested doula workforce trained in peer support strategies and knowledge of how to support at risk families impacted by a range of low-to-high needs existing and emerging mental health disabilities during pregnancy, in postpartum period, and in transition to other services as the child(ren) in the home matriculate through the systems of care. We hope that a fortified workforce and well thought out tiered intervention plan specific to perinatal mental healthcare has great potential for less family separation, more opportunities for prevention and early intervention strategies, and better social outcomes for the whole family throughout the entire life span.	There will definitely be need for investments and encourage exploring braided funding strategies that attract private foundation money to pilot and perfect models of the emerging perinatal mental health service delivery system. Considering that doula training does not require strict formal education pre-requisites, the cost of training a mental health disability focused workforce will be less expensive than clinical and medical staff trainings with the benefit of more sustainable social outcomes.	Workforce Development

	45	Perinatal Mental Health services and therapies are new to many clinicians, provider networks, and other health systems. Emerging research is also expanding the understanding and capacity of this field on a regular basis. A mechanism is needed to diseminate this information and organize best practices in the District.	Implement a Perinatal Mental Health Quality Improvement Learning Collaborative that could bolster skills among primary care providers, ob/gyns and other primary care providers touching perinatal mental health, in terms of screening, integrated care, referral and usage of the consultation codes. This is awell established model.	Enhancing the skills among primary care providers (Pediatricians, OB/GYNs, and other PCPs) allows more patients to be cared for in the medical home, accessing care faster in a trusted setting, reducing strain on the behavioral health providers, and improving access and outcomes for patients.	n/a	Workforce Development

x	46	Mental and behavioral health workforce, including psychiatrists and psychologists, is severely limited in the District. Health care providers specializing in perinatal mental health are also in short supply in the District, and many providers do not take insurance. This becomes a severe barrier to those with public insurance especially.	Increase mental health workforce at every educational training and skill level, including those with perinatal specialization, by providing career training, financial incentives, scholarships/ loan repayment, and other financial supports to those entering the field. Many loan repayment models exist, and can be adapted and scaled to account for the increased need. For example, DC can partner with a local university or UDC to build out a specific training program or PMH certificate program, similar to current legislation moving through Council. Scholarship program(s) can require receiptients to work in DC or even perhaps at an agecy that serves a significant number of Medicaid beneficiaries. The IECMH certificate program at Georgetown for the IECMH clinical specialization is an example, which can be applied to PMH.	Increasing the quantity of mental health providers with perinatal mental health specialization in the District will increase access to needed services and therapies for perinatal individuals.	Budget obligation similar to existing loan repayment programs, with liminations and regulations.	Workforce Developm ent

x	47	Mental and behavioral health workforce, including psychiatrists and psychologists, is severely limited in the District. Health care providers specializing in perinatal mental health are also in short supply in the District, and many providers do not take insurance. This becomes a severe barrier to those with public insurance especially.	Expand paraprofessional pathways in mental health and perinatal mental health with Medicaid funding mechanisms as well as reimbursement policy changes to support and sustain these services within health care and social services agencies where they can be most beneficial to perinatal individuals.	Reimbursement mechanisms are needed which will support health care providers and social services agencies, allowing them to expand their capacity so that highly skilled mental health professionals can work at the top of their training.	Minimal investment in paraprofessional training pathways can result in large increases in workforce capacity.	Workforce Development
x	48	Access to consultation and training for clinical providers who touch perinatal individuals is needed, so that more patients can be served in primary care practices and not have to be referred to behavioral health providers who are already in short supply, have long wait lists, or do not accept any/all insurance options.	Provide direct consultation reimbursement in Medicaid. This will allow more patients to be treated where PMADs are identified and reduce access challenges where there are limited therapy and program resources.	With access to experts in PMADs, more providers will be able to serve patients in their medical home, increasing access to more care and treatment for affected patients. Shortages of mental health professionals with PMH specialization makes it difficult for providers to refer patients; with consultation more providers will comfortably meet the needs of their patients without long waits and insurance barriers.	No budget implications, as providers can receive insurance reimbursement for providing services in-house, instead of separate mental health providers.	Workforce Development

	49	Access to consultation and training for clinical providers who touch perinatal individuals is needed, so that more patients can be served in primary care practices and not have to be referred to behavioral health providers who are already in short supply, have long wait lists, or do not accept any/all insurance options.	Support Mary's Center Perinatal Mental Health ECHO (Extension for Community Healthcare Outcomes) program, offering a valuable education and training model to PMH providers.	Providers receive valuable training, education, and professional support, which leads to more informed, quality care for more patients.	Dedicated funds in annual budget will ensure this essential professional ongoing training can be maintained for perinatal mental health specialists in the District.	Workforce Development
x	50	The District lacks adequate numbers of perinatal specialists, particularly those of BIPOC, Latinx, and other under-represented populations. This leaves patients seeking providers with whole they can relate.	Support the increase recruitment of perinatal behavioral health providers that are culturally and linguistically representative of the diverse populations they will serve, and offer training to existing workforce on culturally congruent practices.	Perinatal populations who identify as Black/ African American, Latinx, or are more comfortable speaking a different language are more likely to access services when they are provided in a culturally congruent way. Reducing these barriers further improves access to care when needed.	Limited budget impact.	Workforce Development
x	51	Access to reproductive health services through the schools is limited and does not meet the need of the District, thus reducing the ability to prevent unwanted pregnancies, reduce pregnancy complications, and provide reproductive health education that all impact perinatal mental health.	Expand reproductive health coordinators at all School Based Behavioral Health Centers, in order to increase access to vital reproductive health services where they are needed and where they can have optimal impact.	Having access to reproductive healthcare and education in the school-based setting will improve health outcomes, school retention and inevitable career success, decrease poor birth outcomes such as low birth weight and preterm delivery that carry long-term costs to the health system and society, and improve connection to a wide range of health	Grant amounts necessary to reach all high schools with space and capacity to deliver these services.	Workforce Development

				services that lead to physical and mental well-being.		

Other Recommendations Proposed After Deliberations:

- Screening for Substance Use Disorders Substance use warrants high priority for screening as well. Many healthcare professional organizations, including ACOG (ACOG 2017), APA (APA 2019), American Academy of Family Physicians (AAFP 2021), the Alliance for Innovation on Maternal Health (AMCHP 2020), and the USPSTF (USPSTF 2020), recommend universal screening of perinatal women for substance use with validated instruments (ACOG 2008, AIM 2021). Ideally, this should occur at the initial obstetric visit. If positive, screening should be continued at subsequent visits in pregnancy and postpartum, and biological testing should be considered only with the patient's consent and in compliance with state mandates (Committee on Substance et al. 2011, Jones et al. 2014, 2017, Ecker et al. 2019). However, using urine or blood specimens as the primary method for screening is not recommended because of the risk of false positives, the potential legal ramifications (i.e., state laws) of a patient producing a positive test, and the inability of biological tests to provide other important information, such as frequency and severity of use (Price et al. 2018).
- Increase Medicaid fee schedule reimbursement rate for CPT code 96161 for PMH screening" to encourage more utilization of this tool, increasing screening rates and better reflecting real cost to implement in clinical settings and full opportunity to identify and support perinatal individuals at risk for or with elevated PMH screening levels.
- Possible use of EPDS US. Researchers through VCU are updating the EPDS screening and including different languages for resposnes
- A DC-specific one pager on EPDS or PMH Connect that provides psychoeducation and resources for persons being screened.
- Continued access for home-based care and navigation
- Use Centering Pregnancy model and add mental health a separate in-depth component

Appendix C: Public Awareness and Systems Capacity Survey Results

How does the District raise awareness among the public and reduce stigma to encourage help-seeking behavior?

- Have active participants working together to support and provide access to services in whatever space they are in
    - Employer provides insurance, feel/felt comfortable selecting care provider, attending appointments, and seeking additional care to support me.
- Have a variety of options and informational methods to reduce the stigma of mental health.
    - Also, variety of care options (group therapy, support groups, community events, care providers, handouts, flyers, additional training, campaigns, cultural competence, and awareness)
- Less barriers to system navigation
    - User-friendly websites, provider materials (language, someone to help them, Q/A)
- More advocacy by providers, employees, and in public areas
    - District leaders need to be more vocal about what efforts are taken towards PMH and help build public trust and promote mental health; teach about it in schools (health class, electives, after school)
- Set expectations (standards) for interacting, caring, and supporting birthing families.
    - More fathers need to be addressed too; they are dealing with mental health issues.
- More exposure for individuals who do not have experience in this space.
    - Prepares them for when they must deal with it and allows for education of issues they don't directly relate to (you don't know what you don't know so how you can advocate for it)
- Require insurance/businesses to do more for families.
    - Increase FMLA, access and information for doula care, how to navigate to other resources, and expansion of systems already in place.
- Less criminalization for mothers needing/ actively seeking help.

What systems need to be created to assist both mothers and providers?

- Familial support
    - Housing and childcare, utilities, culturally and trauma-focused support, paid maternity leave for mothers and fathers (or other caregivers), transportation other than public transit, food, and food assistance.
- Wrap around services.
    - Scheduling and completing appointments; keeping in touch up to date and helping individuals figure out to keep up with their health.
- Livable wages for workers and reimbursements
    - Ex. Not enough incentive to work with the Medicaid population.
- Referrals and additional funds to help cover the cost of services.
- Revisions of current systems and how to expand/ change them with the resources we already have.
- Alternative methods of follow-up/ monitoring

    - Similar to wrap-around services; how do we keep people engaged with their services?
- Better coordination with Medicaid MCOs
- Follow evidence-based practices.

What program funding, reimbursement strategies, and policy development need to be implemented for perinatal mental health initiatives?

- Maternity leave (universal policy; more pay)
- Cultural competence training
- Medicaid funding/billing for doulas, counseling, home visiting, etc.
- Clinical and social supports
- Training for how to identify, care for, support, and provide PMH.
- Reimbursement for services
- Subsidized tuition for medical schools, midwife programs, and doula certifications
- Coverage for comprehensive prenatal care
- Incentives for completing programs or training.

What systems, program funding, reimbursement strategies, and policy development have occurred in other states that we could use to model our recommendations?

- HRSA funding to support the development of state-wide perinatal psychiatry access projects that build the capacity of perinatal healthcare providers (OBs, etc.) to address PMH in the healthcare setting. DC does not have one. The states that have started these projects have radically increased access to perinatal mental health care trained OB providers and drastically improved PMH care. Also, reimbursement for higher levels of psychiatric care (IOP, PHP) for treatment models that include the baby and center the mother-baby relationship in her treatment is needed. One of the barriers to starting these programs is that current billing models cannot sustain the elements these programs need to be effective and sustainable. Policies that require screening and the presence of a referral workflow that can create supported referrals have been impactful.
- GW Hospital
- I love the work of the New York Coalition for Doula Access, Mama Glow Foundation and Carol's Daughter Have Love Delivered. The MOMNIBUS has great plans for equity and access to maternal health care. Also, the 2023 Black Reproductive Justice Policy Agenda.
- Perinatal Psychiatry Access Programs – Massachusetts's well-developed MCPAP for Moms is a national model for provider consultation services and information dissemination. HRSA has since supported 7 state Perinatal Psychiatry Access Programs, and just completed a RFP for up to 14 additional state programs. With commitment from the District, DC is well-suited to develop its own Perinatal Psychiatry Access Program.
- There are successful examples of Inpatient Programs with Child Interaction, Intensive Outpatient Programs, and Partial Hospitalization Programs, all of which are lacking in the immediate DC area. Properly supporting these programs is essential to ensuring they are available when needed.
    - Inpatient Program with Child Interaction – The University of North Carolina School of Medicine's Perinatal Psychiatry Inpatient Unit was established in 2011 and houses 5 beds, with a comprehensive team of providers who create individualized treatment

plans. There is no equivalent care in reasonable proximity to the District, thus severely limiting care options for those in need.
    - Intensive Outpatient Programs and Partial Hospitalization Programs – severely lacking in the District region, successful programs (both independent and housed within healthcare institutions) allow for intensive services without the inpatient requirement, which may be better suited to various conditions and personal circumstances. No programs are identified by Postpartum Support International within 4 hours of DC. Access to quality care reduces long-term consequences, including reduced bonding, attachment, and child development delays, increased family stress, and risk of long-term trauma.
- Community Health Workers reimbursed by Medicaid –According to the Kaiser Family Foundation, as of July 1, 2022, 29 states allowed Medicaid payment for services provided by Community Health Workers, with a few states planning to target CHW interventions to pregnant and postpartum populations in this fiscal year. States have employed state plan amendments, inclusion in Health Home program care teams, members of interdisciplinary teams under a Section 1115 demonstration waiver, or services provided and reimbursed by MCOs.
- Z-codes allow pediatricians, OB/GYNs, and other PCPs to identify perinatal mood and anxiety disorders before they escalate to acuate or crisis level and require intensive (and costly) interventions. Z-codes are a potential solution to constraints in billing for prevention services and allow providers to take a greater prevention approach to address challenges before they rise to the level of a diagnosable disorder. Many states have implemented z-codes and allow for the appropriate therapies and services to address concerns; Oregon, North Carolina, California, and Colorado are some states where these policies have been in place for 4 or more years.
- Policy guidance and reimbursement mechanisms for care coordination at point of health care service – care coordination at the point of service (within OB/GYN, pediatric PC, etc.) greatly increases access to needed therapies and services for individuals at risk for or diagnosed with perinatal mood and anxiety disorders. Delivering care coordination is more successful in a trusted setting and with trusted providers who have built rapport with the patient and family. This reduces a major barrier to successfully accessing needed services.
- Policy and research organizations with extensive information on innovative perinatal mental health services and policies include:
    - Postpartum Support International and their Mind The Gap Initiative
    - Maternal Mental Health Policy Center (formerly 2020 Mom)
    - Maternal Mental Health Leadership Alliance
- Seattle, Washington
- Live listening sessions with offered honorariums are a great way to hear from people with lived experiences.

How does the District build on the existing network of partners to strengthen mental health in pregnancy and postpartum?

- Sole agency or an agency dedicated to PMH work and coordinating partners.
- Collecting information from mothers (birthers) when they fill out their other paperwork for delivery or care.
- Improve workforce and cultural competency.

- Educated and provided surveys to distribute to PCPs.
- Postpartum doula care and education for after-delivery care
- Engage mental health professionals as resources for postpartum care.
- Revising and improving current systems (figure out what works and what doesn't)
    - Mahmee, Mae Health, Irth App, Doulas, Midwives, OB/GYN, Nurses, Lactation, Perinatal Mental Health, Perinatal Massage, Nutritionist, etc.
    - Ensuring that work currently done at WHC, Sibley, Children's Hospital, and Howard funded by the Clark investment endowment is able to continue.
- Access to information and programs
- The District Administration supports a number of Committees, Boards, Commissions, and Task Forces around maternal and child health. All relevant Boards should have at least one designated seat for someone representing perinatal mental health needs. This may include the Maternal Mortality Review Board, Maternal Health Advisory Committee, Perinatal and Infant Health Advisory Committee, Interagency Council on Housing, and others where birthing people intersect with public support. These Boards, Committees, and Councils will also make efforts to distribute information and train professionals across all relevant services in the health and social needs of pregnant and parenting people. Professional Boards shall ensure that training on perinatal mood and anxiety disorders is made available to all licensed and certified professionals in the District.

What organization or agency in the District could oversee future Perinatal Mental Health Initiatives that include program funding, reimbursement strategies, and policy development?

- Department of Health
- DHCF
- Mary's Center
- Community of Hope
- Department of Health and Human Services
- MedStar Georgetown
- Department of Behavioral Health
    - Some specifically do not want this agency
- National Birth Equity Collaborative
- Black Mamas Matter Alliance
- Alliance for Innovation on Maternal Health
- Association of Maternal and Child Health Programs
- Combinations of representatives for an oversight committee

Additional Thoughts

- Here to learn more
- Big issues with patients not feeling comfortable talking to providers. More work to be done with providers, so they know how to effectively communicate with patients.
- Love this survey – it would be great to get this distributed broadly to task force members and the community.
- In general, after a positive mental health screen, each healthcare team should refer the patient to the appropriate resources. That may be virtual, or in person. This needs to be reimbursed.

- PAID maternity leave! PAID post-partum doula if a new mom does not have community support.
- Can Title V block grants be made available to address PMH needs in the city?
- PAID maternity leave for all! FREE post-partum visits from a home visitor, post-partum doula, or telehealth appointments, at least once a month for six months!
- https://blackrj.org/wp-content/uploads/2023/06/RJPolicyAgenda2023.pdf

Appendix D: DC Perinatal Mental Health Workgroup Summary of Task Force Issues

Introduction

The DC Perinatal Mental Health Workgroup is a collective voice of those in Washington, DC committed to improving the perinatal mental health of birthing people. Members of the Workgroup represent a wide range of provider types, agencies serving the varied needs in the District, and those with lived experience and supporting those with lived experience.

At least 1 in 5 birthing persons will suffer from a perinatal mood and anxiety disorder, with double that rate reported by Black birthing people. Most of these disorders can be prevented or treated with proper support and resources. Currently, however, these resources and supports are not accessible at the level necessary to properly serve perinatal individuals in the District.

To address this challenge, the DC Perinatal Mental Health Workgroup (DC PMH Workgroup) highlights policies and priorities which would ensure birthing persons and their families --especially those in Black, Brown, and immigrant communities -- have the behavioral health supports they need. Using the framework language in the 2023 Budget Support Act that established the DC Perinatal Mental Health Task Force, DC PMH Workgroup members were surveyed regarding the priority areas of the Task Force work. Members of the DCPMH Workgroup identified key populations, issues, and programs that should be at the forefront of deliberations as the DC Perinatal Mental Health Task Force conducts a landscape analysis and develops recommendations for improving the perinatal mental health of DC residents.

The DCPMH Workgroup is pleased to share these survey results here. They represent a broad assessment of the needs of our community, and the innovative and evidence-based successes that can help bring appropriate perinatal mental health services to all who need in the District. The DCPMH Workgroup welcomes any questions you may have. Members of the Workgroup are available to meet, and a number are pleased to have been appointed to the DC Perinatal Mental Health Task Force conducting this important work to support every pregnant and birthing person when they have a need.

Outline of Key Issues

DCPMH Workgroup has outlined the key issues in the document below. This outline attempts to organize the results of the survey into broad categories that the District can impact with strengthened policies and dedicated resources. The complete survey results are attached as Addendum 1. First, four overarching key issues are discussed below: Racial Equity in Perinatal Mental Health Crosses the Entire Spectrum of Care, Continuum of Care in Perinatal Mental Health, General Barriers to Care, and Workforce.

Below those, each key issues section is divided into Challenges, Strengths, and Resources. Challenges describe the difficulties in accessing perinatal mental health services or the fractured experiences in the District. Strengths highlights many of the programs and features that the District is doing well for its pregnant and parenting individuals. Resources identifies additional programs, services and policies that

the District can implement to further meet the needs of pregnant and parenting individuals in the District.

The DC PMH Workgroup encourages the connection of this document to additional resources from the District, in addition to research and reports made available nationally. There are numerous resources with a broad array of recommendations that have been developed which can supplement this memo. The Children's Law Center has compiled a comprehensive review of the DC PMH landscape with data and recommendations to advance perinatal mental health which provide a foundation for understanding and decision-making. Additionally, the White House has published a Maternal Health Blueprint , Postpartum Support International has developed Mind The Gap national strategic plan, and SAMHSA Strategic Plan published in April 2023. Locally, Georgetown University's Center for Child and Human Development prepared a Perinatal Needs Assessment. And A Path Forward report identifies recommendations that create a comprehensive system of behavioral health care for children, as well as perinatal individuals and families.

Racial Inequity in Perinatal Mental Health Crosses the Entire Spectrum of Care

Perinatal mental health is an overarching issue that disproportionately affects Black women, with devastating impact. Rates of depression are more than double in the Black population, due to structural racism and "weathering".[lxxxix] In addition, the Black maternal mortality rate is significantly higher than the general population, with unacceptable high rates regardless of educational attainment or income level. Stigma and other challenges add additional barriers to care. To properly address and reduce disparities, thoughtful and accountable solutions must be implemented that reach the entire spectrum of care including but not limited to: implicit bias training, community of practice accountability programs, enhanced resources where neglect or under-resourced populations experience challenges or suffer greater impact.

Continuum of Care in Perinatal Mental Health

The DC Perinatal Mental Health Workgroup recognizes that access to a full spectrum of perinatal mental health services is essential to ensure every pregnant and parenting person is served when and where care is needed. That continuum includes promotion and prevention/early intervention strategies, screening, and a robust array of treatment services from individual and group therapy to inpatient services which account for dyadic care where appropriate. A strong continuum of care protects perinatal patients and their families from falling through gaps, builds safe communities that can meet needs of those who screen positive for PMADs or are at risk for screening positive, and reduces reliance on more expensive acute psychiatric care for those whose needs go unmet initially.

General Barriers to Care

The following systemic barriers collectively contribute to the underdiagnosis, undertreatment, and inadequate support for individuals experiencing perinatal mental health challenges.

Addressing these barriers is essential to ensure that all individuals in the District have equitable access to comprehensive perinatal mental health support:

- Socioeconomic barriers to treatment - Parents with significant socioeconomic barriers are less likely to seek healthcare. Lack of awareness and stigma, lack of time, lack of childcare, and not knowing where to go for help can prevent birthing people from seeking help for perinatal mental health disorders. In 2016, approximately 20% of women living in DC had incomes below the federal poverty level, with the highest concentration living in neighborhoods in Wards 7 and 8; thoughtful solutions to reduce the stress of poverty for people struggling with PMADs must be implemented to provide comprehensive care to all District residents.
- Social determinants of health - Factors such as socioeconomic status, housing, food insecurity, access to healthcare, education, employment, social support, and cultural norms greatly impact an individual's risk for PMADs and their ability to seek timely support. Limited resources, financial stressors, and lack of health insurance can hinder access to prenatal care and mental health services, which makes it challenging for individuals to receive proper screening, interventions, and treatment.
- Discrimination against vulnerable groups - Immigrants, homeless individuals, disabled people, and LGBTQIA+ birthing people also struggle to access appropriate health care due to various systemic barriers. Moreover, individuals involved in the child welfare system, justice system, or those who are incarcerated during pregnancy and postpartum periods encounter unique challenges and stigma that hinder access to appropriate mental health care. Additionally, there is a lack of specific hospital units, partial hospitalization programs, and intensive outpatient programs tailored for pregnant and postpartum individuals with high levels of psychiatric symptoms, leaving them with limited options for specialized care.
- Documentation status in the U.S. - Many individuals who are undocumented may hesitate to seek healthcare services due to fears of potential repercussions, such as detainment or deportation; this fear can create barriers to accessing screenings, interventions, and treatment for PMADs.
- Language - Language can serve as a significant barrier to perinatal mental health care for District residents for whom English is not their primary language. These language barriers can result in limited access to relevant information about perinatal mental health resources, available treatments or support networks, further exacerbating the difficulties faced by individuals seeking care. Healthcare providers need to ensure the availability of language interpretation services, multilingual staff, and culturally sensitive materials to provide equitable access to perinatal mental health care for all residents.
- Transportation - Transportation barriers prevent DC residents from accessing health care providers, especially in Wards 7 and 8. The current NEMT program is underutilized, and persisting barriers include (i) reimbursement requirement for recipients to pay upfront for approved transportation and then to submit for reimbursement, (ii) reports that Lyft, Uber, and taxis will not pick up or drop off to Wards 7 and 8 in DC, (iii) appointments

must be made three business days in advance, and (iv) recipients must share personal identifying information, protected health information, and sensitive data to secure rides. Caregivers need consistent health and wellness care appointments, and since there are no healthcare facilities in certain neighborhoods, caregivers need help accessing reliable transportation to address healthcare concerns.

- Childcare - Many individuals experiencing PMADs may require regular therapy sessions, support groups, or other forms of mental health treatment. However, without reliable and affordable childcare options, parents may struggle to attend these sessions or be forced to interrupt treatment due to childcare responsibilities, preventing timely and consistent access to screening, intervention, and treatment.

Workforce

In order to provide adequate perinatal mental health support to birthing people in the District, we must ensure that local healthcare providers have the necessary knowledge and resources to effectively treat individuals experiencing PMADs. To develop the workforce, efforts should be focused on strengthening adult behavioral healthcare providers' capabilities rather than attempting to teach new capabilities to child-focused behavioral health service providers. The following programs represent initiatives to strengthen behavioral healthcare capabilities that have shown promise in other jurisdictions:

- MCPAP for Moms, a Massachusetts-based program, provides a promising example for workforce development as the organization provides trainings and toolkits for healthcare providers and their staff on evidence-based guidelines for mental health screening, treatment options, risks and benefits of medications, and triage and referral; implementing a similar program in the District could help increase the obstetric workforce that is able to address PMADs in DC.
- Shades of Blue provides the I.N.S.P.I.R.E Method Training, a live, virtual two-day training on maternal mental health. This training is specific to care for women of color and minorities and can be implemented by doulas, midwives, clinicians and those facilitating perinatal mental health support groups.
- The Maternal Child Health Community Health Worker training is an 8-week comprehensive program that provides community health workers with skills and competencies focused on perinatal health. The goal of the program is to understand the racism in existing healthcare delivery systems and alleviate inequities in health outcomes.

As we look at the current workforce pipeline and build incentives to encourage and retain diverse behavioral healthcare providers, these programs can provide guidance to District officials in their efforts to increase the number of behavioral health providers, especially those who come from or can relate to the communities they serve.

General Access to Care

Building capacity for the foundational services, including better access to prenatal care,

preconceptual care, transition points for women before and after perinatal period are important in developing a full continuum of care. To ensure perinatal mental health services are available for pregnant and parenting people, the District must invest in building its capacity of foundational services and transition points before and after pregnancy.

Access to perinatal mental health services also requires attention to those foundational services that bridge either side of the perinatal experience. When patients have better access to preconceptual care and early prenatal care, their perinatal health and mental health needs will be better served. A person already accessing health care appropriately will continue to prioritize appropriate use of health care services when needed. Early initiation of prenatal care has proven positive outcomes, including reduced low birth weight and preterm deliveries; access to perinatal mental health can be expected to have equivalent positive health outcomes if adequate access is available. Transition points for pregnant people before and after the perinatal period must also be considered. A lack of available providers with perinatal mental health training may leave patients vulnerable at a critical time and lead to negative mental health outcomes. Likewise, losing health insurance or lacking accessible providers when still experiencing perinatal mood and anxiety disorders will impact access to needed services.

Challenges

- Need to build capacity - Some prenatal patients report delays in accessing early prenatal care due to wait times at prenatal providers. Increasing the availability of prenatal care services will reduce wait times to begin prenatal care, which in turn allows for earlier screening for PMADs and entry into perinatal mental health services when appropriate.
- Increase therapy and psychiatric services - When perinatal patients screen positive for PMADs, there are often challenges in accessing therapy or psychiatric care in a timely manner. Many providers do not accept insurance, and some that do have long wait lists that patients must endure. Washington, DC is considered a mental health shortage area, with too few behavioral health providers for the population in need. This is especially the case for those providers with specialized perinatal mental health training.

Strengths

- Adequate health insurance coverage - Washington, DC residents are almost universally insured. Medicaid eligibility levels allow for coverage even while earning a modest income, and the DC Health Benefit Exchange offers many reasonably priced options for those who may not qualify for Medicaid or have access to reasonably priced employer coverage.
- Institutions in the District that have expertise in perinatal mental health - Numerous health care and academic institutions across the District, and the dedicated providers of that clinical care, are developing services and programs addressing PMADs. With proper investments by the District, some of these resources can be scaled to serve more residents in need.
- Integrated Care Models - Health care delivery models that integrate behavioral health into the primary care and obstetric setting are valuable tools, and can meet the needs of many patients with less severe behavioral health needs. The District has examples of practices that have successfully done this, including HealthySteps and Whole Bear Care in the pediatric setting.

Resources

- District Agencies - Department of Health, Department of Health Care Finance, and Department of Behavioral Health each have the structure to support direct programs to prevent and/or treat PMADs, and indirect support for private providers to build or expand services to treat this population.
- Budget - Various funding mechanisms exist within agencies which can support local PMH promotion, prevention, early intervention, and treatment services. With adequate funding, more pregnant and parenting people can be served.

Screening - Tools, Frequency, and Settings

The vast majority of PMADs remain undiagnosed due to various factors, such as limited public knowledge about PMADs and the persistent stigmatization of mental health. However, a crucial aspect contributing to this underdiagnosis is the lack of screening in opportune healthcare settings. Screening involves the systematic assessment and identification of individuals at risk for or experiencing mood and anxiety disorders during the perinatal period to provide timely intervention and treatment. Screening serves as the entry point into the PMAD treatment pipeline, and thus, to ensure perinatal mental health services are effective for pregnant and parenting people, the District must invest in building its capacity for PMAD screening.

Challenges:

- Need to build capacity for screening - PMADs are under-diagnosed due to lack of screening for PMADs. A shortage of healthcare services, including mental health services, in D.C. communities can stifle screening for PMADs, and currently, about 50% to 70% of PMADs are undiagnosed. In particular, vulnerable groups face significant challenges in accessing perinatal mental health care; hospitals are concentrated in the Northwest and Northeast quadrants of DC; therefore, those who live in the east end of the city, who are predominantly Black and low-income, have difficulty accessing screening services. The District should incorporate regular PMADs screenings into preand post-natal healthcare visits, as well as into annual physicals and well visits for pregnant people and new parents and follow guidance for PMADs screenings in the pediatric setting to increase the number of touchpoints where PMADs can be identified and referred where appropriate.
- Long wait times - Long wait lists for perinatal mental health services lead to delays in PMAD screening and support for individuals in need. By expanding the availability of prenatal care services, wait times can be reduced, enabling individuals to initiate prenatal care at an earlier stage and facilitating timely screening for PMADs.
- Resistance from providers to conduct screening for PMADs in different settings - This resistance is due to myriad reasons including lack of dedicated staff and time for such screening and lack of confidence about resources to offer for positive screenings.
- Stigma - A persistent stigma surrounding mental health hinders screening for PMADs. Black women are only half as likely as White women to seek (and ultimately accept) mental health care due to systemic biases and cultural stigmatization. Women of color often prioritize

healthcare providers who offer mental health services with a focus on cultural sensitivity, and therefore, efforts to introduce implicit bias, cultural humility, and anti-racism training into therapy and psychiatric services may increase rates of PMAD screening and treatment for women of color.

● Lack of MH SBIRT training - a lack of training among pediatricians and OB/GYNs in perinatal mental health Screening, Brief Intervention, and Referral to Treatment (SBIRT) limits comprehensive care for pregnant and postpartum individuals.

● EPDS is not culturally accessible - The Edinburgh Postnatal Depression Scale (EPDS), considered the "gold standard" perinatal depression and anxiety screening tool, is the most widely used screening tool for PMADs. However, as the scale was originally developed and validated in a specific cultural context, primarily in Western societies, EPDS may not fully capture the cultural determinants of mood and anxiety disorders, leading to under or misdiagnosis of postnatal depression. The use of culturally insensitive screening tool can perpetuate racial biases in screening, as people of color are less likely to be diagnosed for PMADs when compared to white individuals; this disparity can also be attributed to the implicit biases held by healthcare providers, which may lead to the misinterpretation or dismissal of symptoms reported by people of color. Creating and implementing culturally accessible screening alternatives to EPDS can ensure the screening process is inclusive and effective in identifying PMADs in diverse populations.

<u>Strengths:</u>

● Adequate health insurance coverage - Washington, DC residents are almost universally insured. Medicaid eligibility levels allow for coverage even while earning a modest income, and the DC Health Benefit Exchange offers many reasonably priced options for those who may not qualify for Medicaid or have access to reasonably priced employer coverage.

● Availability of screening - screening is established in multiple settings already, including most prenatal care providers, which has increased the screening rates in D.C.

● New recommendations from MMHLA - a new set of recommendations from the Maternal Mental Health Leadership Alliance are aimed at promoting normalized screening patterns for perinatal mental health by suggesting that individuals should be routinely screened for mental health disorders at least three times during the perinatal period. By normalizing the practice of screening at specific intervals, healthcare providers can ensure early detection and intervention for PMADs.

● DC Mother-Baby Wellness Program - this city-wide program brings together prenatal care providers, pediatricians, community-based organizations and birthing hospitals to provide essential services to birthing people, including universal maternal mental health screening during and after pregnancy and interventions for those identified at-risk. This program has served over 15,000 prenatal patients in D.C.

● HealthySteps - this evidence-based national pediatric primary care program model integrates a child development specialist, called a HealthySteps Specialist (HSS), into primary care visits to ensure universal medical, developmental, and social-emotional screenings. HealthySteps in DC has already served over 2200 children and families.

● HealthyStart - this free program for residents of Wards 5, 7 and 8 provides services, referrals, and support for all women, parents, and infants up to 18 months of age. In particular, the program provides comprehensive screenings and referrals for maternal depression, domestic violence, substance use, and developmental delays.

Resources:

• National CLAS standards and NCQA Health Equity Plus standards - health care providers can adopt these new standards to implement culturally and linguistically appropriate services to address health care disparities and help combat the racial and socioeconomic disparities in PMAD screening.

• Clark Philanthropy - funding from Clark Philanthropy and other relevant foundations can support research to determine the cost-effectiveness of implementing universal PMADs screening. Currently, insufficient data regarding the resources necessary for program implementation and a lack of reimbursement mechanisms are significant barriers for widespread adoption. Cost-effectiveness and payer data are useful to motivate buy-in from administrative leaders.

• Home Visiting - in other jurisdictions, Family Home Visits are used increasingly as an effective tool to screen birthing people for PMADs.

Prevention and Early Intervention

Prevention and early intervention strategies are crucial components of the continuum of care for addressing perinatal mental health challenges and promoting the well-being of birthing people in the District. Prevention efforts aim to minimize the occurrence of perinatal mental health disorders, and early intervention focuses on identifying and treating PMADs as early as possible to prevent their escalation and minimize their impact on families. By investing in prevention and early intervention initiatives, the District can foster resilience, promote positive parental and infant outcomes, and contribute to comprehensive mental healthcare.

Challenges:

● Availability of healthcare services - lack of healthcare services, including mental health services, in communities that do not have access to healthcare facilities can cause or exacerbate PMADs by preventing early intervention.

● Long wait lists for perinatal mental health services - long wait times to receive mental health services significantly limit early intervention for PMADs. Increasing the capacity for mental health services in the District is necessary to facilitate better early intervention strategies.

● Gaps in care regarding transition from pregnancy to postpartum - gaps in care during the transition from pregnancy to postpartum can hinder early intervention for PMADs.

● Lack of access to reliable and available PMADs interventions for caregivers - regardless of whether an individual has been screened for or diagnosed with a PMAD, birthing people should have access to Z-codes, family or group interventions, and similar prevention programs that have been shown to reduce diagnosis and/or mitigate higher acuity cases.

Strengths:

- Mothers and Babies Course - this program is an evidence-based perinatal depression prevention intervention for pregnant people and new parents to help manage stress and prevent postpartum depression.
- Parent Café - this program is designed to address stigmas around mental health and behavioral health challenges within families by facilitating peer-to-peer learning; this program increases parents' resiliency, the quality of their interactions with their children, their ability to handle stressful situations, and their motivation to become involved in their community, showing that Parent Cafes are a valuable resource for prevention and early intervention of PMADs.
- ROSES Prevention Program - this program is an evidence-based prevention intervention for postpartum depression that has been shown to reduce cases of postpartum depression by half among low-income women. D.C. has its own ROSE Program; however, there is limited available information available about this program's reach in D.C.
- CenteringPregnancy - CenteringPregnancy is a model of group prenatal care (GPNC) that has been shown to improve the likelihood that birthing people receive adequate prenatal care and improve the physical and emotional health of birthing people. There are three providers – Community of Hope, Mary's Center, and Unity Health Care – offering CenteringPregnancy across six locations in D.C.
- HealthyStart - this program provides preventative interventions to D.C. families targeting the physical and mental health of birthing people and children by connecting participants with case management, care coordination, and perinatal health support services such as group prenatal care and doula support. This program is estimated to save families and the healthcare system thousands of dollars per year through preventative interventions.
- HealthySteps - this program serves as a useful resource for prevention and early intervention of PMADs as HealthySteps Specialists work directly with D.C. families to facilitate the development of self-regulation skills and family resiliency and provide guidance and referrals to families who need additional services.
- Community-based Doula Support - Doula services play an important role in PMAD prevention and early intervention; their services are provided throughout the perinatal and postpartum period as preventive services designed to prevent perinatal complications and promote the physical and mental health of the birthing person. As of September 2022, doulas can enroll as DHCF providers and receive reimbursement from DHCF.

Resources:

- District Agencies - Department of Health, Department of Health Care Finance, and Department of Behavioral Health each have the structure to support direct programs to prevent PMADs, and indirect support for private providers to build or expand prevention and early intervention services.
- Mothers and Babies - the Mothers and Babies Mood and Health Research Program from George Washington University is designed to develop research aimed at preventing the onset of perinatal depression and improving the mental health of families.

● Leverage existing programs to address parental mental health - The Attachment and Biobehavioral Catch-up (ABC) is a national home-visiting parenting program designed to increase caregiver nurturance. By integrating perinatal mental health support into existing programs like ABC, the district can provide more comprehensive prevention and intervention initiatives for families.
● Clark Philanthropy and other Foundation support - funding from Clark Philanthropy and other funding sources can be leveraged to extend funding for doulas, who provide invaluable preventive services to birthing people in D.C. but are currently limited to a total of twelve visits across the perinatal and the postpartum period.
● Access to telehealth - Access to telehealth services can serve as a valuable prevention and early intervention resource for PMADs. Telehealth provides a convenient and flexible means for individuals to access mental health support, reducing barriers such as transportation and childcare. It enables timely interventions, counseling, and education, allowing individuals to receive the necessary care and support during the perinatal period, which can help prevent the onset or escalation of PMADs.
● Health Literacy Campaigns - Health literacy serves as a critical resource for preventing PMADs. When individuals have knowledge of the warning signs of PMADs and the available resources, they are better equipped to recognize and address their own mental well-being. Improved health literacy empowers individuals to seek help, engage in self-care practices, and make informed decisions, contributing to the prevention and early intervention of PMADs.

Treatment

Effective treatment of PMADs represents a critical component of the continuum of care for perinatal mental health. To adequately support birthing people in the District, it is essential to supply a robust array of treatment services from individual and group therapy to inpatient services which account for dyadic care where appropriate. By ensuring accessible and comprehensive treatment options, the District can support individuals on the path to recovery during this critical phase of life.

<u>Challenges:</u>

● Lack of reliable interventions - of those who are screened for and receive a PMADs diagnosis, only 50% are able to access adequate treatment. When a caregiver screens for PMADs, the referral system in DC does not result in that person being able to access behavioral health professionals in a timely manner. Providers need to be able to make referrals to health care providers that are available and can timely provide necessary support to patients.
● Lack of healthcare services - a lack of healthcare services, including mental health services, in communities that do not have access to healthcare facilities can result in or exacerbate PMADs. Hospitals are concentrated in the Northwest and Northeast quadrants of DC; therefore, those who live in the east end of the city, who are predominantly Black and low-income, have difficulty accessing birthing services. Of the seven hospitals in DC, there is no hospital east of South Capitol Street or east of the Anacostia River. The obstetrics ward at United Medical Center was closed in August 2020 and never reopened. Providence Hospital in Ward 5 closed as part of a revised strategic plan. After years of work, the new Cedar Hill Regional Medical Center at the St.

Elizabeths East Campus is not expected to open until at least 2024. To increase birthing people's access to facilities to treat PMADs, the District can plan to build healthcare facilities in areas that lack these facilities, offer pop-up wellness clinics in community centers and churches, organize a medical van that goes into neighborhoods to offer ad hoc care to ensure that pregnant and postpartum individuals, especially those who are Medicaid-eligible, can access the proper health services.

● Racial disparities in treatment - PMADs disproportionately affect Black women in D.C.; Black women are twice as likely as white women to experience PMADs but are only half as likely to receive treatment.

● Stigma - A persistent stigma surrounding mental health hinders treatment for PMADs; Offering mental health services within women's health clinics (rather than limiting mental health services to mental health clinics), to reduce stigma, a potential barrier to care, can facilitate greater access to perinatal mental health treatment.

Strengths:

● Adequate health insurance coverage - Washington, DC residents are almost universally insured. Medicaid eligibility levels allow for coverage even while earning a modest income, and the DC Health Benefit Exchange offers many reasonably priced options for those who may not qualify for Medicaid or have access to reasonably priced employer coverage.

● CenteringPregnancy - CenteringPregnancy is a model of group prenatal care (GPNC) that has been shown to improve the likelihood that birthing people receive adequate prenatal care and improve the physical and emotional health of birthing people. There are three providers – Community of Hope, Mary's Center, and Unity Health Care – offering CenteringPregnancy across six locations in D.C.

● HealthyStart - Through the HealthyStart Program, D.C. families can receive Care Coordination and Case Management Services to assist participants in navigating the health care system and linkages to community resources to assist with the treatment of PMADs.

● Community-based Doula support - Doulas help address and treat PMADs by providing one-on-one personalized support to help pregnant people advocate for their personal care preferences and combat interpersonal and institutional bias in the maternal health care context.

Resources

● CBT - Cognitive behavioral therapy is a common therapeutic intervention that can effectively treat symptoms of PMADs. By focusing on identifying and changing negative thought patterns and behaviors, CBT helps individuals develop coping strategies and skills to manage distress and improve their overall well-being during the perinatal period. With its evidence-based approach, CBT offers a valuable treatment option that can significantly alleviate symptoms and enhance the recovery process for individuals experiencing PMADs.

● IPT - Interpersonal therapy (IPT) is another effective tool for PMAD treatment. By focusing on improving interpersonal relationships and addressing specific interpersonal problems, IPT helps individuals experiencing PMADs enhance their social support, resolve conflicts, and manage transitions related to the perinatal period, ultimately

alleviating symptoms.

● Mindfulness training - mindfulness training can be effective in reducing the symptoms of postpartum depression in new parents. By cultivating present-moment awareness and non-judgmental acceptance, mindfulness practices can help individuals manage stress, regulate emotions, and enhance overall well-being, offering a valuable tool for addressing postpartum depression symptoms.

● EMDR/Brainspotting - These eye movement therapies serve as effective mental health treatments that have been useful addressing postpartum depression, anxiety, and other PMADs. EMDR (Eye Movement Desensitization and Reprocessing) therapy uses bilateral brain stimulation to desensitize one to the traumatic memory, and brainspotting is a somatic mind-body therapy used to process deep challenges.

● Perinatal IOP or PHP - Perinatal intensive outpatient programs or partial hospitalization programs offer comprehensive mental health care to birthing people who are pregnant or postpartum and suffer from severe PMADs, requiring a high level of care. The programs offer comprehensive and specialized care in an outpatient setting, allowing mothers to receive therapy, education, and support while remaining connected to their families and communities.

● Family therapy - Family therapy has shown to be an effective treatment for PMADs as it recognizes the significant role of the family unit in the well-being of the individual experiencing PMADs. To better leverage this treatment, the District can improve payment rates for family therapy versus individual therapy.

● MCAP for Moms - this Massachusetts-based program, dedicated to supporting maternal mental health during and after pregnancy, provides perinatal psychiatric consultations and referrals for obstetric, pediatric, primary care, psychiatric and substance use disorder providers to effectively prevent, identify, and manage PMADs.

● Hushabye Nursery Program - this program, based in Arizona, serves as a valuable resource for treating PMADs as it embraces substance-exposed babies and their caregivers with compassionate, evidence-based care by providing support, education, and counseling to families with children suffering from Neonatal Abstinence Syndrome.

● Mothering from the Inside Out - developed at Yale, this program is an individual psychotherapeutic intervention designed to support parents who are in treatment for drug addiction or mental illness that serves as a promising treatment for PMADs. .

● Home visiting - home visiting programs can successfully provide treatment for perinatal depression and reduce the effects of depression for birthing people by providing personalized, in-home support to pregnant and postpartum people.

● Telehealth - telehealth serves as a valuable resource for PMAD treatment that provides accessible and convenient mental health services to pregnant and postpartum people in their own homes, overcoming barriers to treatment such as transportation and childcare.

● National CLAS standards and NCQA Health Equity Plus standards - healthcare providers can adopt these new standards to implement culturally and linguistically appropriate services to address healthcare disparities and help combat the racial and socioeconomic disparities in PMAD treatment. Introducing these standards can help

healthcare providers ensure that all birthing people have equal access to PMAD treatment.

- Clark Philanthropy - foundation support can be leveraged to increase accessibility to perinatal behavioral health services and practitioners in DC.

Conclusion

Systemic barriers to healthcare, such as racism, socioeconomic status, and immigration status, remain some of the largest challenges in delivering comprehensive perinatal mental health support in the District, along with an inadequate investment in prevention services, a complete continuum of therapies to treat PMADs, and the workforce. Breaking down these systemic barriers remains a top priority to effectively tackle PMADs. Furthermore, the District faces a significant challenge in terms of limited access to healthcare providers, particularly in the east end of the city. As such, it is essential for the District to expand its capacity for healthcare services to serve the needs of birthing individuals.

Currently, the presence of community-based organizations and nonprofits, such as CenteringPregnancy, HealthyStart, and doula services, has been instrumental in bridging the gap in traditional healthcare services. The diverse range of these programs stands as a true strength of the District, and leveraging these existing programs can enhance access to the appropriate services for birthing people.

The District must learn from promising programs and policies in other states. There should be dedicated resources to increasing the workforce dedicated to perinatal mental health, as workforce development remains a crucial component in providing adequate mental healthcare to birthing individuals in DC. In addition, innovative programs can and must be brought to the District to create the full spectrum of services pregnant and parenting individuals need to ensure their mental well-being.

The members of the DC Perinatal Mental Health Workgroup stand ready to partner with the District leadership to strengthen perinatal mental health policies and resources for all residents.

Addendum 1

DC PMH Workgroup Members Survey Responses

What vulnerable populations and what risk factors should be noted for study and making recommendations?

Vulnerable Populations:

· Black women/Black birthing people/pregnant and postpartum people of color/
· Hispanic birthing people
· Under-resourced Black and Brown communities/Racial-ethnic minoritized groups/ individuals living with low SES/Living in poverty
· People who have first language other than English/Groups whose primary language is not English
· Young Immigrants (16-24)/perinatal immigrant populations/Recent immigrants
· Adolescents who are pregnant or parenting
· People who are homeless, especially homeless youth or adolescents/Homeless birthing people/Individuals living with homelessness
· LGBTQIA+ birthing people
· Disabled birthing people
· Child welfare involved birthing people/Justice involved birthing people/Incarcerated birthing people/Individuals in the criminal justice system
· Fathers and other non-birthing partners
· Single parents
· Families with children in NICU
· Individuals with high level of psychiatric symptoms that require hospitalization (currently no specific hospital that has specific units for pregnant and postpartum individuals, also no partial hospital or intensive outpatient programs for pregnant and postpartum individuals)

Risk Factors:

· Low SES
· Living situation/Ward someone resides in (as it relates to access to care)
· Interaction with criminal legal or child welfare system(s)
· Child(ren) in home with a developmental or intellectual disability or delay/Autism spectrum disorder (parent or child)
· Medical complication during pregnancy and postpartum/birth trauma
· Consideration at multiple levels, from individual (psychiatric hx) to systemic (obstetric racism, discrimination)
· Immigration status
· Transportation
· Insurance status
· Documentation status in the US

· Cost
· Health and health care literacy, telehealth literacy (along with general literacy)
· Access to telehealth

What evidence-based and promising practices should be noted for study and making recommendations?

· Parent Café
    - Parent Cafés are structured discussions that incorporate the principles of adult learning and family support. The Cafés provide "judgment free" safe spaces where caregivers talk about the challenges and joys of raising a family.
· Mothers and Babies Course
· ROSES prevention program
    - Women/Maternal Health Programs
    - Generally provide education and support to women and infants
· CBT
· IPT
· Mindfulness as treatment/Mindfulness Parenting
· CenteringPregnancy
· HealthyStart
    - A program for residents of Wards 5, 7 and 8 of the District of Columbia that provides services, referrals, and support for all women, parents, and infants up to 18 months of age by addressing their health and social service needs.
· Home Visiting Programs
· Peer support/community health workers/doulas
· Integration of mental health services in obstetric, pediatrics, and family services
· Perinatal Access Programs such as MCPAP for Moms
· The Inspire Method – Shades of Blue project
· Perinatal IPT
· EMDR/Brainspotting
· Community-based Doula support
· Care Coordination
· Perinatal rides/transportation
· Perinatal specific IOP or PHP programs
· https://www.hushabyenursery.org/ - program that embraces substance exposed babies and their caregivers with compassionate, evidence-based care that changes the course of their entire lives.

What barriers to access and evidence-based and promising practices for care coordination, systems navigation, and case management should be noted for study and making recommendations?

· Train both pediatricians and OB/GYNs on perinatal MH SBIRT
· Social Determinants of Health, especially housing, food insecurity
· Language
· Long wait lists for perinatal mental health services

· Long waits for general prenatal appointments, which delays assessment for all care
· Psychiatric consultation models for PCP, OB providers
· Lack of delivering hospital in Southeast DC
· Stigma around mental health that continues to exist in communities
· Lack of accessible and affordable childcare
· Care coordination and peer support as billable services
· Transportation

What evidence-informed practices that are culturally congruent and accessible should be noted for study and making recommendations?

· Transform practices: Use US HHS CLAS standards and NCQA Health Equity Plus standards
· Trauma informed care
· Training and practices in implicit biases
· Cultural humility and anti-racism training
· INSPIRE method
· Community based doulas
· Peer support
· Screening alternatives to EPDS that are more culturally accessible

What national and global (or local) models should be noted for study and recommendations?

· More "outside the box" models for treating maternal mental health (such as paid family leave, childcare, housing, cash assistance)
· MCPAP for Moms
· UNC Horizons program, community-based doula program
· Center for Women's Health at Massachusetts General Hospital

What community-based or multigenerational practices should be noted for study and recommendations?

· Improve payment rates for family therapy versus individual
· Home visitation as good example of multigenerational approach - works with both child and mother/caregiver. Example is Minding the Baby Home Visiting Program
· Leverage other programs to also work with parental mental health, such as Attachment and Behavioral Catch up
· Mothering from the Inside Out (for substance use disorders)

What workforce initiatives for perinatal mental health should be noted for study and recommendations?

· Strengthen adult behavioral health provider capabilities since this work is 2 generational, rather than attempting to teach new capabilities to child-focused behavioral health service providers
· MCPAP for Moms to increase obstetric workforce that is able to address PMH
· Shades of Blue certified PMH provider path Maternal Mental Health Specialist - https://www.cci.training/courses/maternal-mental-health-support-specialist Maternal Health Community Health Worker certification - https://www.cci.training/pages/certification

What funding models should be noted for study and recommendations?

· Improve payment rates for family therapy versus individual

· Explore an episode or bundle payment for time-limited intervention tied to performance outcomes

· Clark philanthropy

· Sustainable funding for perinatal and postpartum mental health programs

· Medicaid reimbursement

· Foundation support

· Value-based payments for services

What programs, treatments, services, and notable innovations should be highlighted for unique populations? What gaps in care should be highlighted for unique populations?

- Safe housing and strong social connections to sustain recovery
- HealthySteps DC as innovation.
- Gaps in care regarding transition from pregnancy to postpartum
- Gender affirming reproductive healthcare

Please share any other thoughts or suggestions which the Task Force should include in its study and recommendations.

- Look more into the Maternal Mortality Review Committee as a space to collect MH data and explain to review MH aspects of maternal mortality
- Creating a central landing page for residents to access resources. CA and MN have these webpages where you can explore programs, apply for programs, etc

Appendix E: Summary of Other State Perinatal Mental Health Task Force Recommendations

States with Taskforce/Coalition	Screening and referral	Provider education	Policy and legislation	Financing	Community support/partnerships	Navigation and access	Workforce/Partnership and Infrastructure Development
Arizona	•Improvements for screening and treating maternal mental health disorders	•Perinatal Psychiatric Consultation Line •Increase the Diversity of the Perinatal Behavioral Health Workforce •Increase Cultural Competency Trainings for Health Care Professions		•Peer Support Coverage Home Visitor Coverage •Doula Coverage •Community Health Worker Coverage •Traditional Healing Services Coverage •Lactation Support Coverage •Postpartum Support International Certified Perinatal Providers	•Maternal Peer Support Coverage •Home Visitor •Doula Services •Community Health Worker •Traditional Healing Services •Lactation Support •Postpartum Support International Certified Perinatal Providers	•Increase the Diversity of the Perinatal Behavioral Health Workforce and Increase Cultural Competency Trainings for Health Care Professions •Maternal Peer Support Coverage-could also be doulas. •Home Visitor coverage •Doula Services reimbursement •Community Health Worker coverage •Traditional Healing Services - language and culture, traditional healers, in-home childbirth practices •Lactation Support •Postpartum Support International Certified Perinatal Providers- provide scholarships and incentives for perinatal mental health certification to providers. •Commercial insurers recognize perinatal mental health as a specialty for the purposes of behavioral health provider capacity development and network requirements.	

California	•Adopt the screening and treatment guidelines of ACOG and the Council on Patient Safety in Women's Health Care, adopt HEDIS measure(s) for screening and treatment of MMH disorders, develop certification boards for mental illness	•Ob/Gyns and other obstetric providers serve as the 'home base' for MMH. Provider-to-provider reproductive psychiatric consult program	•Expand access to paid family and medical leave to provide flexibility in the balancing of work and family demands. Family-friendly policies and resources	•Insurers develop MMH case management programs, expand medical provider contracts to reimburse for MMH services, mental health benefits in all medical care benefit contracts	•Statewide culturally and linguistically appropriate awareness campaign, new or employ existing coalitions to address MMH, including correcting local treatment shortages/referral pathways, disseminating educational materials and awareness campaigns, improving support resources for mothers. •Local communities 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. •Family-friendly policies and resources which aim to reduce maternal stress should be considered by employers, communities, and the state legislature. •Churches, Community Centers, Businesses, and others serving women who are pregnant or in the postpartum period should be aware of MMH disorders- prevalence and symptoms, and be prepared to assess for trouble and refer to an Ob/Gyn or another community resource.	• Statewide culturally and linguistically appropriate awareness campaign, new or employ existing coalitions to address MMH, including correcting local treatment shortages/referral pathways, disseminating educational materials and awareness campaigns, improving support resources for mothers. •Local communities 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. •Family-friendly policies and resources which aim to reduce maternal stress should be considered by employers, communities, and the state legislature. •Churches, Community Centers, Businesses, and others serving women who are pregnant or in the postpartum period should be aware of MMH disorders- prevalence and symptoms, and be prepared to assess for trouble and refer to an Ob/Gyn or another community resource.	

Maryland	•Early identification of postpartum depression and other perinatal mood and anxiety disorders through increased screening and patient education. Address co-morbid maternal mental health conditions including those related to substance use disorders, high risk pregnancies, perinatal loss and intimate partner violence.	•Maternal mental health education for providers who interact with women of a reproductive age. Expand psychiatric consultation programs to assist obstetric, primary care, psychiatric and pediatric providers in addressing the emotional and mental health needs of pregnant and postpartum patients.	•Maternal Mental Health Commission to help guide state policy and decision making. Maryland Maternal Mental Health Initiative to coordinate ongoing advocacy, education, awareness, and treatment efforts. Expand access to paid family and medical leave to provide flexibility in the balancing of work and family demands.		Expand peer support networks and navigation	•Develop, maintain, and promote centralized, multicultural educational materials and resources for patients and families. •Create a centralized, multicultural online provider toolkit to assist in the identification and treatment of perinatal mood and anxiety disorders. •Expand maternal mental health and substance use disorder peer support training and infrastructure. •Explore the use of maternal mental health navigators, including issues related to insurance reimbursement and incentives for providing the service.	

Colorado	Universal screening and appropriate referral	Communicate opportunities for collaboration, alignment, and education	Systems-level direction and funding included in law, regulation, and administrative policy, includes operational decision-making, training, adoption of best practice, modifying health plan benefits and reimbursement requirements, and human resource management to support maternal mental health for all.		Communicate importance and opportunity to promote maternal mental health in the community.	Perinatal Mental Health Alliance for Professionals of Color	Build the confidence, capability, and skills to address maternal mental health needs across a variety of sectors. Workforce members affected by maternal mental health, directly and indirectly, receive the support they need.
Oregon	Disseminate community level information/referrals for perinatal depression services. Tool kit drafted -communities needs assessment and resources, strengthen referral systems, and initiate screening for perinatal depression	•Training provided for Oregon public health nurses on identification and treatment of perinatal mood and anxiety disorders. •Symposium on Maternal Mental Health During and After Pregnancy	A bill and a resolution addressing maternal mental health disorders (HB 2666 and HJR 15)		Disseminate community level information/referrals for perinatal depression services,	•Perform outreach and education to expectant and new mothers. •Develop classes and/or support groups for pregnant women, new mothers, and families. •Increase the availability of peer support groups and networks for women with perinatal depression. •Disseminate community level information/referrals for perinatal depression services. •Tool kit drafted - communities needs assessment and resources, strengthen referral	Public Health Action Plan for Perinatal Depression • Partnership initiated to coordinate state agency perinatal depression work. • Partnerships developed with higher education, health, mental health, and early childhood entities. • Technical assistance consultation meetings for community and DHS partners

						systems, and initiate screening for perinatal depression	
Louisiana	Incorporating universal PMH disorder screening into key care systems for pregnant and postpartum persons	Expanding direct access to mental health services for birthing people in need of perinatal mental health services by integrating primary care and mental health			Optimizing and expanding the care coordination system for birthing people in need of perinatal mental health services-care coordination, health promotion, individual and family support, and linkages to community/support services, behavioral, and physical health services	Ensuring that the Louisiana Department of Health supports Louisiana's mental health and substance use provider network in meeting and addressing in a timely manner the mental health needs of pregnant and postpartum persons, particularly persons who are most impacted by structural and social barriers to health	

Massachusetts	Community Health Workers who manage referrals	Provide implicit bias training and capacity building to perinatal mental health providers across the care continuum		Advocating for funding in the FY20 budget for DPH to conduct participatory market research and carry out a two-pronged perinatal mental health awareness campaign	Collaborating with PNQIN to advocate for funding to stabilize grant-funded implementation of maternal safety bundles on high-risk maternal conditions in birthing facilities, clinics, and hospitals across the state to address the rise in maternal mortality and severe maternal morbidity rates. (PNQIN is a joint venture of the Massachusetts Perinatal Quality Collaborative (MPQC) and the Neonatal Quality Improvement Collaborative of Massachusetts (NeoQIC) collaborative, volunteer approach avoids legislative mandates, enables organizations to access valuable data and improve their care systems.)	State money funds Community Health Workers who manage referrals and navigate resources for new moms accessing treatment. Conceived and currently advocating for funding in the FY20 budget for DPH to conduct participatory market research and carry out a two-pronged perinatal mental health awareness campaign to a) provide empowerment and resources to marginalized new mothers and fathers and b) to provide implicit bias training and capacity building to perinatal mental health providers across the care continuum	

Appendix F: Resources on Public Awareness/Informational Campaigns

Awareness Campaigns

- ACOG (Perinatal Mood and Anxiety Disorders | ACOG)
- Perinatal Mental Health (Perinatal Mental Health | NPA (nationalperinatal.org)) – this site provides information and resources to support PMH.
    - Learn More | Postpartum Support International (PSI)
- Policy Center for Maternal Health Awareness Materials — Policy Center for Maternal Mental Health - Formerly 2020 Mom – this site contains posters and flyers.

Informational Campaigns/Readings

- CDC Depression During and After Pregnancy (cdc.gov)
- Cleveland Clinic Mindful Moments: How To Strengthen Your Mental Health – Cleveland Clinic
- NIH Perinatal Depression (nih.gov)
- Mental Health Myths and Facts | MentalHealth.gov
- Mom's Mental Health Matters: Moms-to-be and Moms - NCMHEP | NICHD - Eunice Kennedy Shriver National Institute of Child Health and Human Development (nih.gov)
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