MATERNAL MENTAL HEALTH & POLICY

2024 LEADERSHIP & INNOVATION SUMMIT

November 14, 2024

Erin Crites

OBJECTIVES

- **Define** perinatal mental health and the 4th trimester
- **Identify** the variations of perinatal mental health and potential risk factors or contributing issues, including signs and symptoms
- **Discuss** current climate for perinatal mental health in North Carolina and what work is being done to address these disparities
- **Introduce** the Maternal Mental Health Roadmap for State Policies to improve outcomes
- **Identify** one action that can be taken in your home state to improve perinatal mental health outcomes

MY STORY

4TH TRIMESTER

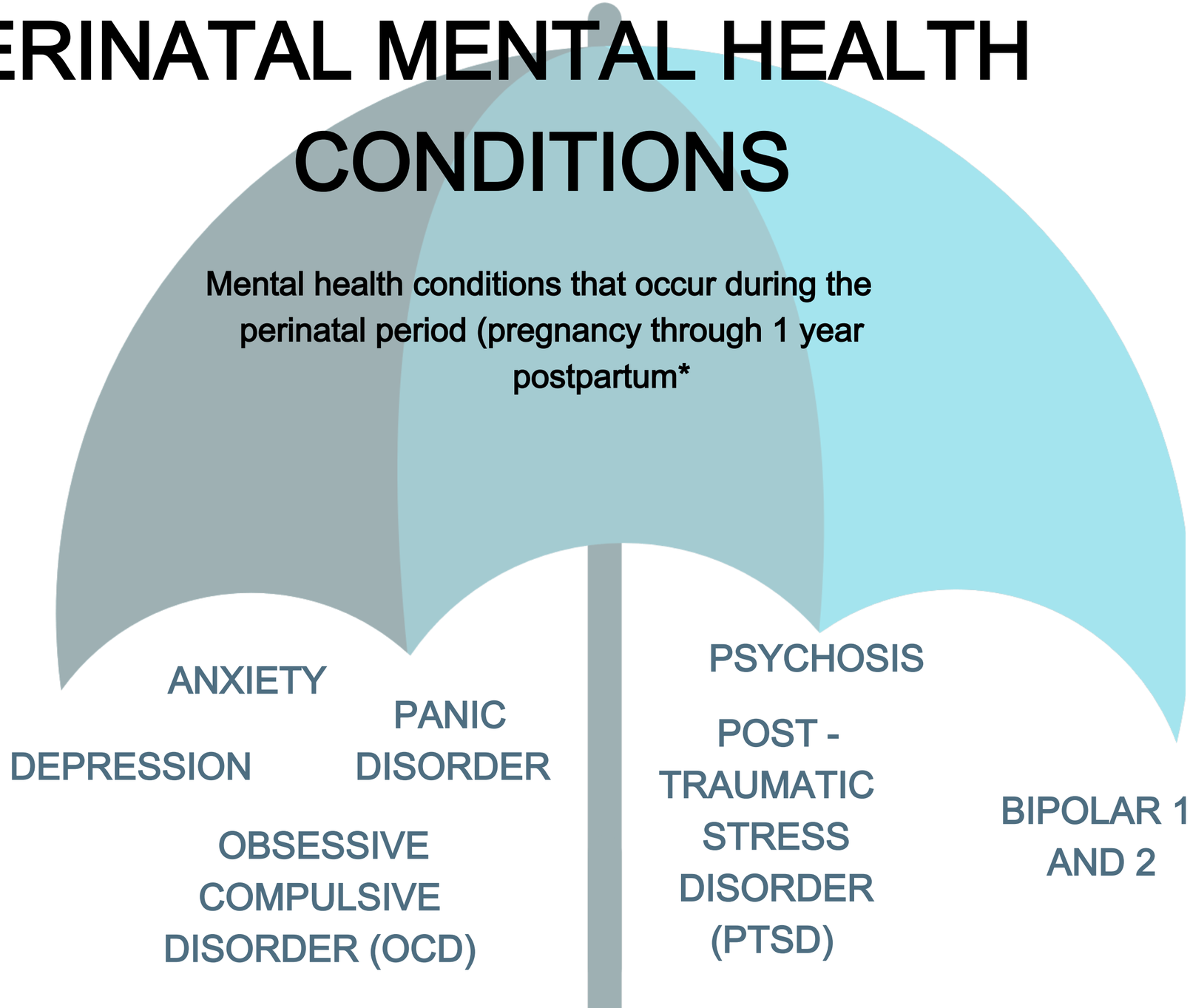
OVERVIEW

- The 3 months or 12 weeks following birth*
- Not as well known, but equally if not more so important
- Focus may shift to baby but we can’t forget about the mom
- A time of transition and change
  - Hormones
  - Sleep
  - Appetite
  - Autonomy and/or identity
  - Mental health

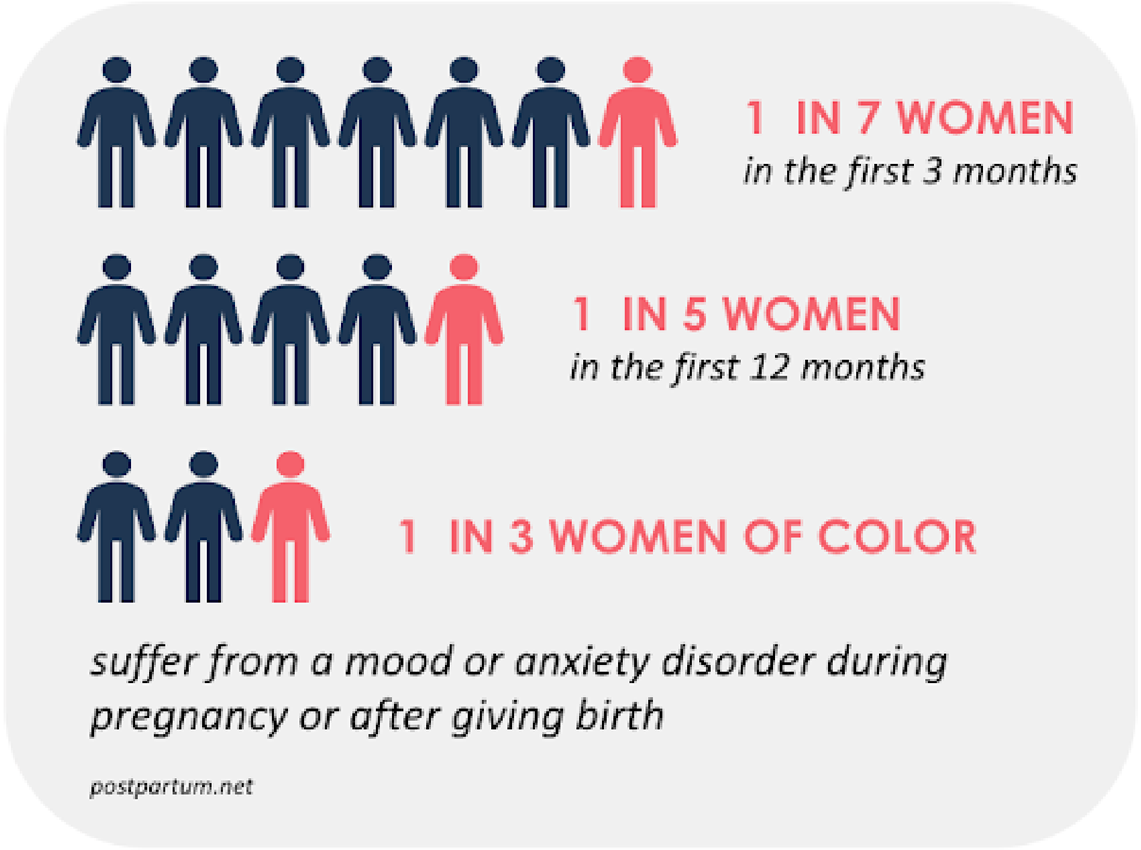
PERINATAL MENTAL HEALTH (PMH)

- Perinatal: throughout pregnancy through 1 year postpartum*

PERINATAL MENTAL HEALTH CONDITIONS



STATISTICS




POLICY CENTER for Maternal Mental Health
FACT SHEET
Maternal Mental Health
Prevalence & Range of Disorders
A Leading Cause of Preventable Maternal Death
Detection and Treatment
Why It Matters

BY THE NUMBERS

- The most common complication of childbirth - more common than gestational diabetes, perinatal hypertension, and pre-eclampsia **combined**
- **Less than 20%** are screened for PMH disorders
- Approximately **50%** of women who are diagnosed with PPD experienced symptoms during pregnancy
- Less than **15%** of women diagnosed will receive treatment
- **20%** of PMH issues occur during pregnancy through 2 years postpartum
- **13%** of parents are still experiencing PMH issues at 4 years postpartum
- **Roughly 20%** of maternal deaths are due to suicide

CONTRIBUTING FACTORS

- Biological
- Psychological
- Environmental

- Personal history of mental health
- Fertility challenges
- Sensitive to hormonal changes (estrogen, progesterone, and cortisol)
- Pregnancy complications
- Miscarriage, stillbirth, or infant loss
- Feeding complications
- Pain
- Lack of sleep

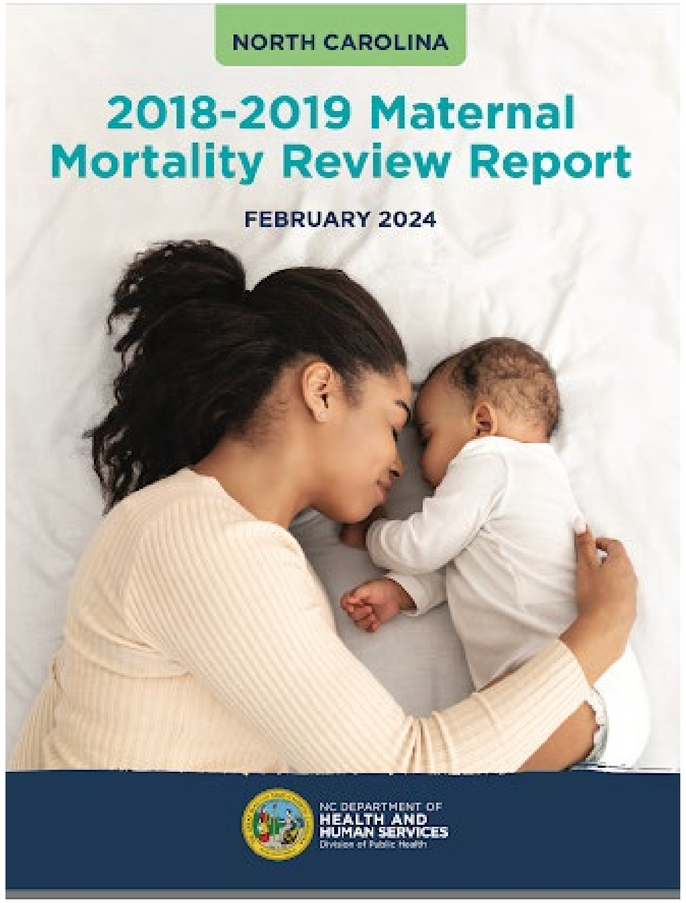
- Personal history of mental health
- Mental health repercussions as a result of: fertility challenges, pregnancy complications, and/or loss
- Identity shift
- Perfectionism, unrealistic expectations
- History of trauma and/or abuse
- Worry, fears, negative memories
- Returning to work

- Social determinants - finances, access to health care, housing, childcare
- Primary circle substance use history
- Trauma and/or abuse
- Recent move or job change/loss
- Lack of support from family
- Relationship stress
- NICU stay

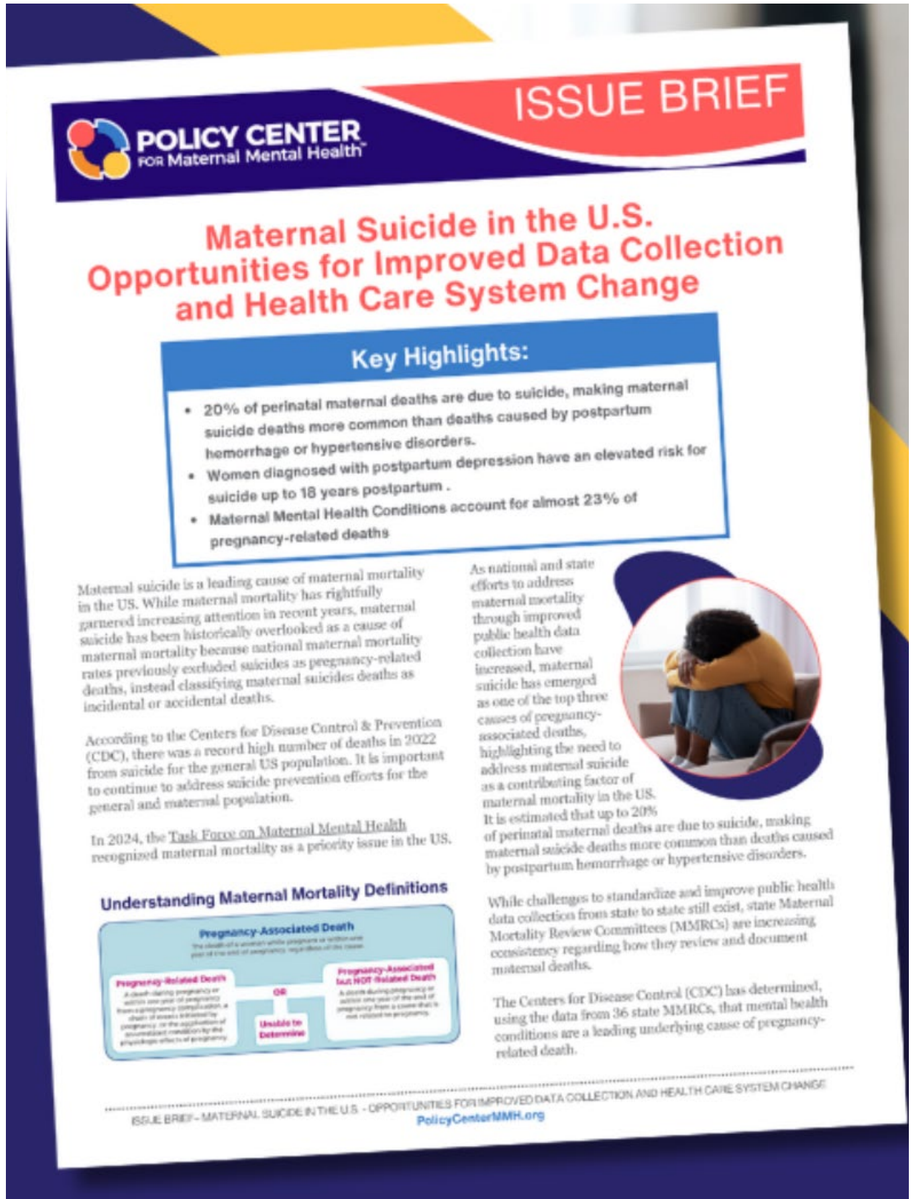
HIGH STRESS PARENTING GROUPS

- Queer & Trans families
- Loss - stillbirth, miscarriage, infant loss
- NICU families
- Near miss survivor
- Adoptive parents
- Military families
- Teen parents
- Parents of Color
- Families with multiples
- Single parents

CURRENT CLIMATE: NORTH CAROLINA



- Key contributory factors: 1) bias and discrimination (69.7%), 2) mental health conditions (46.1%), 3) substance use disorder (38.2%)
- Discrimination was a probable contributing factor in 69.7% of pregnancy-related deaths. It was the most common contributory factor recorded.
- Mental health conditions were the overall leading cause of death in pregnancy-related deaths - ⅓ of all cases (approx. 24 of 76 total deaths)
- Substance use is a leading cause with 20 cases attributed to overdoses. 18 out of 20 involved opioids; 14 of the 20 involved fentanyl



POLICY CENTER FOR Maternal Mental Health

ISSUE BRIEF

Maternal Suicide in the U.S. Opportunities for Improved Data Collection and Health Care System Change

Key Highlights:

- 20% of perinatal maternal deaths are due to suicide, making maternal suicide deaths more common than deaths caused by postpartum hemorrhage or hypertensive disorders.
- Women diagnosed with postpartum depression have an elevated risk for suicide up to 18 years postpartum .
- Maternal Mental Health Conditions account for almost 23% of pregnancy-related deaths

Maternal suicide is a leading cause of maternal mortality in the US. While maternal mortality has rightfully garnered increasing attention in recent years, maternal suicide has been historically overlooked as a cause of maternal mortality because national maternal mortality rates previously excluded suicides as pregnancy-related deaths, instead classifying maternal suicides deaths as incidental or accidental deaths.

According to the Centers for Disease Control & Prevention (CDC), there was a record high number of deaths in 2022 from suicide for the general US population. It is important to continue to address suicide prevention efforts for the general and maternal population.

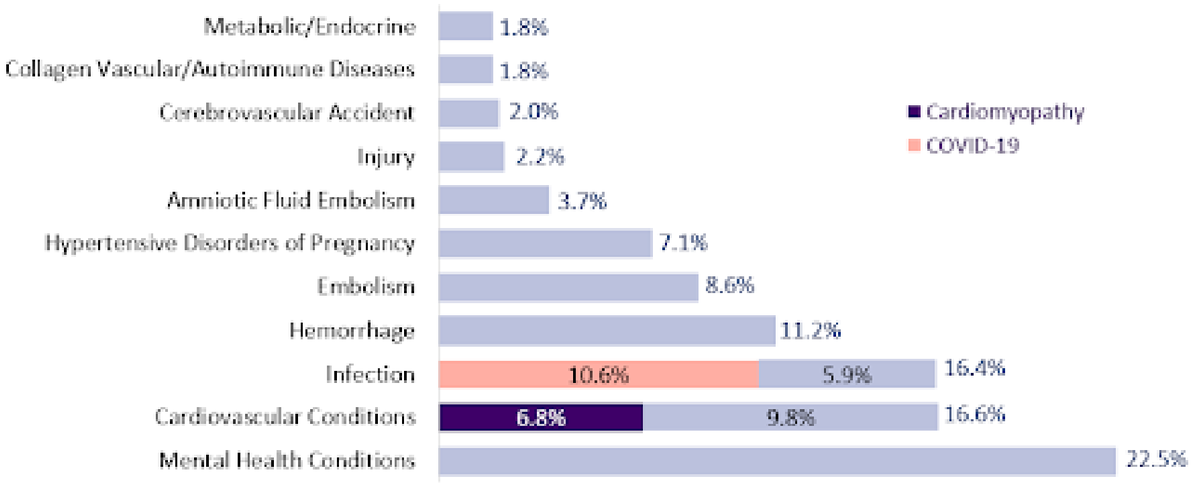
In 2024, the Task Force on Maternal Mental Health recognized maternal mortality as a priority issue in the US.

As national and state efforts to address maternal mortality through improved public health data collection have increased, maternal suicide has emerged as one of the top three causes of pregnancy-associated deaths, highlighting the need to address maternal suicide as a contributing factor of maternal mortality in the US. It is estimated that up to 20% of perinatal maternal deaths are due to suicide, making maternal suicide deaths more common than deaths caused by postpartum hemorrhage or hypertensive disorders.

While challenges to standardize and improve public health data collection from state to state still exist, state Maternal Mortality Review Committees (MMRCs) are increasing consistency regarding how they review and document maternal deaths.

The Centers for Disease Control (CDC) has determined, using the data from 36 state MMRCs, that mental health conditions are a leading underlying cause of pregnancy-related death.

Understanding Maternal Mortality Definitions



MATERNAL SUICIDE

MMRCs in 38 U.S. States, 2020: Most frequent underlying causes of pregnancy-related deaths

MATERNAL MENTAL HEALTH ROADMAP

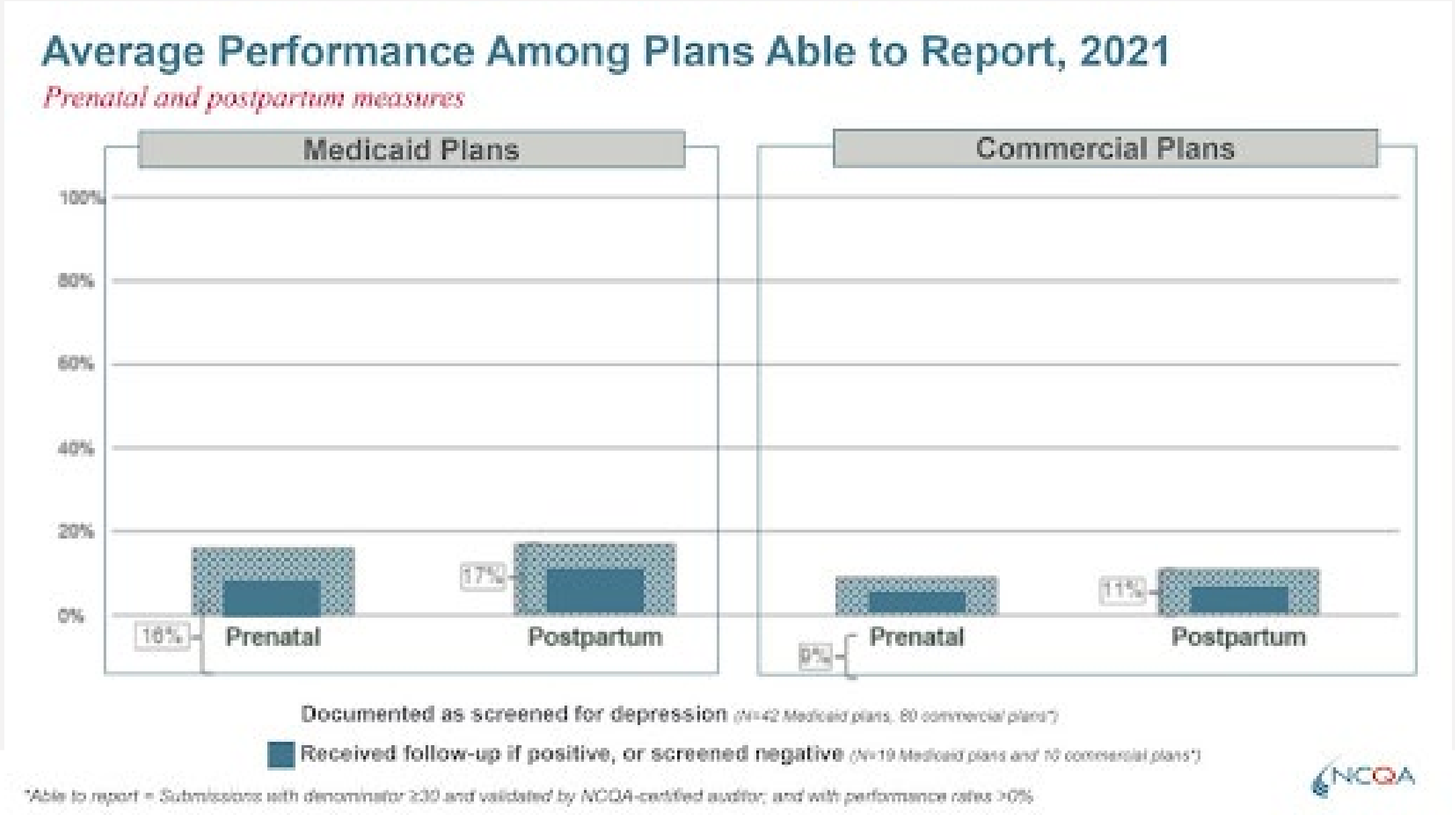
- May as Maternal Mental Health Awareness Month
- Form a Cross-Sector Commission to Study and Develop a State Strategic Plan
- Require Plans to Report Maternal Depression HEDIS Measures
- Medicaid Agencies Can Promote Reimbursement Strategies for Maternal Mental Health for Obstetricians and Midwives
- Require Health Plans/Insurers to Develop Quality Management Programs
- Propel Peer Support Specialists for Maternal Mental Health
- Support Community-Based Organizations
- Require Health Plan/Insurer Coverage of Group Maternity Care, Birth Doulas, Postpartum Doulas, and Home Health Nursing Care

WHAT IS HEDIS?

- The Healthcare Effectiveness Data and Information Set (HEDIS) monitors how often services are delivered in the U.S. as reported by Health Insurers/Plans
- Depression Screening Pregnancy PND-E & Postpartum PDS-E
  - The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period.
- Follow-Up on Positive Screen: The percentage of positive screens which received follow-up care within 30 days of a positive depression screen finding.

HEDIS SCREENING RESULTS

2021 Data Collection Year (2022 Report Year)



Less than 20% of patients were screened.

The Medicaid Screening and follow rates were 16% during pregnancy and 17% in the postpartum period.

For private insurers, screening rates were lower, at **9**% during pregnancy and **11** % in the postpartum.

HEDIS PRENATAL & POSTPARTUM DEPRESSION SCREENING RATES

Highest Performing States

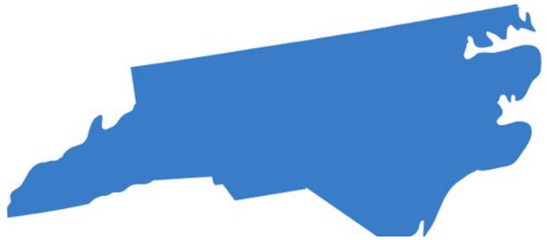
2022 Data Collection Year (2023 Report Year)

State	MedicaidPrenatal Depression Screening Rate	Commercial Prenatal DepressionScreening Rate	Medicaid Postpartum Depression Screening Rate	Commercial Postpartum Depression Screening Rate
Pennsylvania	28.7	8.4	26.9	12.6
New Mexico	NR	15.6	NR	12.8
California	19.1	11.5	14.7	11.4
Wisconsin	13.4	14.3	11.1	13.8
Washington	2.2	13.2	0.3	14.0
Georgia	NR	9.6	NR	10.3
Utah	NR	11.3	NR	11.0
Minnesota	NR	8.5	NR	9.6

2024 REPORT CARD

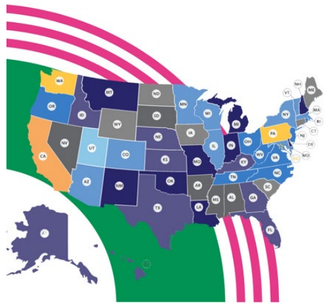
C- | D+ | D | D- | F

NC



Providers and Programs — D

- Meets Ratio of Non-Prescriber MMH Providers to Perinatal Population ✗
- Meets Ratio of MMH Prescribers to Perinatal Population ✓
- Has at Least One Inpatient MMH Treatment Program ✓
- Has at Least One Outpatient Intensive or Partial Hospitalization MMH Program ✓
- Has or Has Had a State-Sanctioned MMH Task Force or Commission ✗
- Meets Ratio for CBOs Providing MMH Direct Services to Perinatal Population ✗
- Has a Perinatal Quality Collaborative (PQC) that Has Prioritized MMH ✗



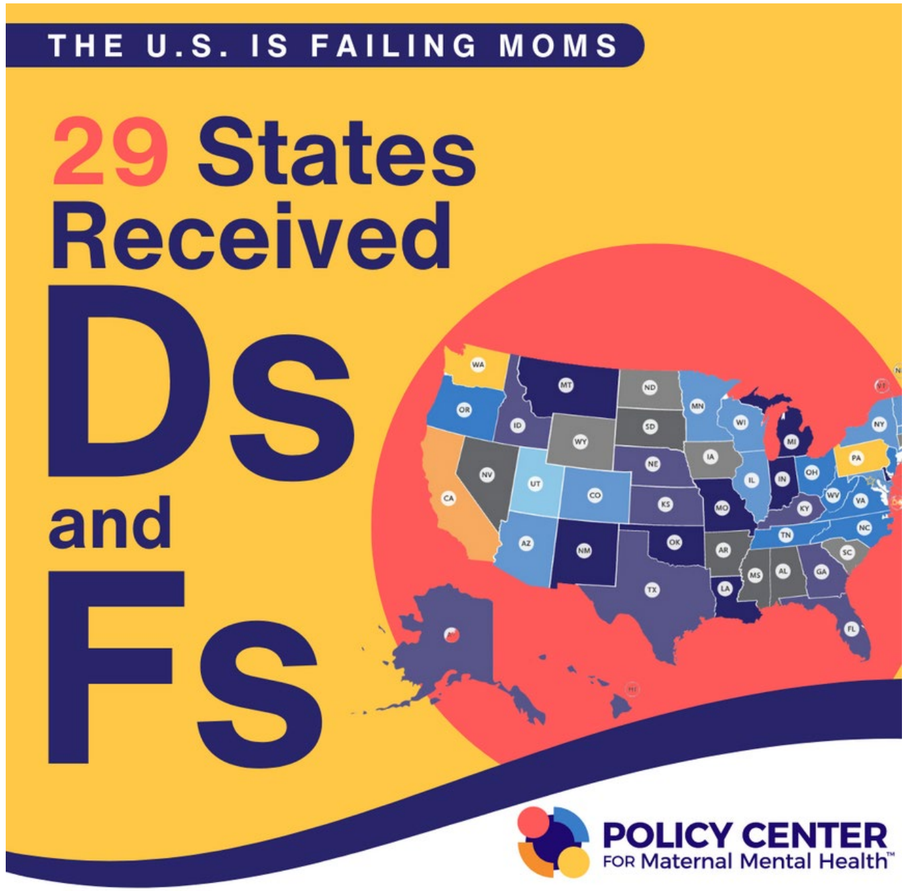
Screening & Screening Reimbursement — F

- Top Performer on the “Prenatal Depression Screening” HEDIS Measure (Among Commercial Insurance or Medicaid) ✗
- Top Performer with Commercial Insurance and/or Medicaid on the “Postpartum Depression Screening” HEDIS Measure (Among Commercial Insurance or Medicaid) ✗
- Medicaid Requires MCOs to Collect the “Prenatal Depression Screening” HEDIS Measure ✓
- Medicaid Requires MCOs to Collect the “Postpartum Depression Screening” HEDIS Measure ✗
- Obstetric Providers Submit Claims to Private Insurers for Prenatal MMH Screening (Among at Least 1% of Prenatal Patients) ✗
- Obstetric Providers Submit Claims to Private Insurers for Postpartum MMH Screening (Among at Least 1% of Postpartum Patients) ✓

Insurance Coverage & Treatment Payment — C

- Expanded Medicaid ✓
- Extended Medicaid Coverage to One Year Postpartum ✓
- Requires Health Plans to Develop a MMH Quality Management Program ✗
- Providers Submit Claims to Private Insurers for Prenatal MMH Treatment (Among at Least 10% of Prenatal Patients) ✓
- Providers Submit Claims to Private Insurers for Postpartum MMH Treatment (Among at Least 10% of Postpartum Patients) ✓

HOW IS YOUR STATE DOING?



Scan here to find yours

State of North Carolina

ROY COOPER
GOVERNOR

MATERNAL MENTAL HEALTH MONTH

2024

BY THE GOVERNOR OF THE STATE OF NORTH CAROLINA

A PROCLAMATION

WHEREAS, the health of mothers and their families is of high priority to the State of North Carolina; the period spanning pregnancy through the first two years postpartum is a universal time of vulnerability with serious concerns, including rising maternal mortality and racial inequities in outcomes for mothers across the nation; and

WHEREAS, approximately 117,000 babies are born in North Carolina each year and the maternal health, specifically the mental health of perinatal people before, during, and after pregnancy, is an issue of great concern to themselves and their families; and

MIND THE GAP
NORTH CAROLINA

WHAT WE'RE DOING ABOUT IT

North Carolina is committed to closing gaps for our perinatal families through a um

MATTERS

ANCHOR
PERINATAL WELLNESS

CERTIFIED
NCQA
HEDIS® MEASURES

PSI
North Carolina

THE GREAT SEAL OF THE STATE OF NORTH CAROLINA
MAY 20, 1775
APRIL 12, 1776
ESSE QUAM VIDERI

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

THANK YOU

ERIN CRITES

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