Perinatal Psychiatry Access Program in Pennsylvania

January 2024

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In Partnership with Thriving PA

Thriving PA

Background

There is a shortage of perinatal psychiatrists and an increase in the prevalence of psychiatric conditions in the perinatal period for women. Mental health conditions during this period are the most common obstetrics complications, affecting one in five women during pregnancy and up to one-year postpartum.[i] According to a survey conducted in spring 2023 by the Pennsylvania Health Access Network in partnership with the Maternity Care Coalition, Thriving PA, and the March of Dimes, 3 out of 4 of the 403 women who had given birth within the last six years expressed needing access to mental health services, yet only 1 in 5 received the mental health services they desired.[ii]

This mirrors national data, which finds that 25 to 50% of women who experience perinatal depression are diagnosed and 10 to 20% access treatment.[iii] More than half (53%) of pregnancy-related deaths occur in the first year after giving birth (80% of which are preventable), and mental health conditions are the leading cause of death among white and Hispanic women.[iv] Suicide and overdose, both complications of substance use disorders (SUD) and mental health conditions are a significant contributor to maternal mortality and morbidity.[v] Overall, as many as 23% of maternal deaths are caused by perinatal mental health and substance use disorders, highlighting the need for screening and treatment.[vi]

Treatment rates for perinatal mental health (PMH) conditions, particularly for perinatal depression, are inequitable across racial and ethnic groups.[vii] Black mothers experience postpartum depression at nearly twice the rate (38%) of new white mothers but are significantly less likely to be screened and referred for treatment.[viii] Stress due to systemic and structural factors such as racism and classism disproportionately impact individuals of color, which contribute to higher rates of PMH conditions.[ix] Despite an increase in research and policy focus, mental health conditions and SUD in the perinatal population remain widespread and largely untreated.[x] This has a significant financial impact, costing $32,000 per mother-child pair, totaling $14 billion nationally.[xi] Although there is support for increased screening for pregnant and postpartum individuals, barriers to mental health care and SUD treatment for the perinatal populations are substantial and include issues such as poverty, structural racism, history of trauma, complexity of mental health conditions, lack of providers and/or referral services, and difficulty navigating the mental healthcare system for both patients and providers.[xii]

Clinical Care Challenges

Challenges in clinical care have also impacted progress in effectively addressing PMH conditions. A lack of consistent guidance for primary providers on perinatal mood and anxiety disorders (PMAD) screening processes has resulted in varied practices leading to discrepancies and a lack of consensus for how screenings should be handled.[xiii] Even when positive PMAD screenings are uncovered, many primary care providers lack adequate training on basic management of PMH conditions and treatment options, including on safe medication prescribing in the perinatal period.[xiv] Primary providers often have limited access to resources and referral services, such as psychiatric providers, therapists, and support groups who are skilled in treating PMH needs.[xv] Mental health provider shortages and a discomfort from mental health providers with treating the perinatal population further hinder treatment for the perinatal population experiencing PMH conditions.[xvi]

Treating Perinatal Mental Health Conditions

Addressing these challenges is critical as the perinatal period provides an opportunity for frontline providers to diagnose and treat PMH conditions. Frontline providers may include practitioners in obstetrics, primary care, pediatrics, or psychiatry, advanced care providers including midwives, nurse practitioners, and physician assistants, and non-prescribers such as home visitors, doulas, and lactation specialists.[xvii] During a routine pregnancy

and the first year of a baby's life, perinatal individuals interact with healthcare providers 20 to 25 times.[xviii] Because the frontline provider is in a unique position to educate perinatal individuals and conduct regular screenings, innovative approaches that consider resources, training, and support are needed to increase the capacity of providers to identify and treat PMH conditions and SUD in the perinatal population. Doing so will help to achieve perinatal mental health equity in states with diverse populations and urban/rural demographics like Pennsylvania.

Perinatal Psychiatry Access Programs

Overview

One such tool is the Perinatal Psychiatry Access Program ("Access Program") model. Initially designed and launched in Massachusetts in 2014 to address gaps in mental health support and improve access to care, the evidence-based Access Program model has proven to be an effective mechanism in the U.S. for reducing perinatal mental health inequities and building primary provider care capacity.[xix] Access Programs achieve these goals through three pillars: training and education, perinatal psychiatric consultation, and resources and referrals to community-based mental health resources. These tools help providers gain increased knowledge, understanding, and ability to address perinatal patients' mental PMH needs through screening, assessment, triage and referral, and treatment.[xx]

Modeled after the Massachusetts Child Psychiatry Access Programs for Moms (MCPAP for Moms), there are now 21 state-based Access Programs in the U.S. (see **Appendix A**) that provide perinatal mental health support services and have the potential to cover approximately 1.94 (or 53.69%) of the 3.61 million yearly births in the U.S.[xxi]. Nationally, Access Program models are recommended by the 2022 White House Blueprint for Addressing the Maternal Health Crisis and the U.S. Department of Health and Human Services 2020 Action Plan to Improve Mental Health for pregnant women and mothers.[xxii] In total, MCPAP for Moms has emerged as a successful and scalable model with at least 25 states or organizations implementing or developing similar Access Programs. [xxiii]

Access Program Design

Access Program designs consider state and local policies, partnerships, availability of funding, and workforce capacity to address local and state mental health needs for perinatal populations. As a result, Access Program structures, strategies, and components vary by state and locality. The program component that is most implemented is the telephonic consultation, which connects a provider who is caring for a perinatal individual with a perinatal psychiatrist.[xxiv] In interviews with Access Program managers the opportunity for providers to connect directly with other providers through the consultation line was seen as an invaluable asset in program design (see **Appendix B**).

Core components of the telephonic consultation line structure include operating during regular business hours from Monday through Friday, a guaranteed response timeframe to connect the provider to the perinatal psychiatrist, and a trained professional who triages calls to determine if the provider requires resources, community referrals, or referral to the perinatal psychiatrist. Another standard process is that the consultation service is a free service; providers treating the perinatal population may access the consultation line regardless of patients' insurance status.

Levels of Access Programs

The elements included in Access Programs range depending upon state need and support, availability and sustainability of funding, access to perinatal psychiatrists, and capacity of program team. **Table 1** provides examples of differing levels of Program Access services. At the basic level, a telephonic consultation line is funded for operation Monday through Friday during regular business hours to connect providers with perinatal psychiatrists or offer referral and resources and includes training education opportunities to build provider capacity in

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Table 1: Examples of elements included in different levels of Perinatal Psychiatry Access Programs

Level	Structure	Availability	Staffing*	Annual Cost**
Basic Program	• M – F (9am to 5pm) triaged clinician-to-clinician telephonic consultation service. • Referral to community-based mental health resources. • Provider capacity building through regular trainings and educational materials and resources. • Proactive implementation support to integrate mental health care into obstetric practices' workflows.	Initially focusing on specific regions of their states and expanding statewide based on funding and staffing capacity.	Equivalent of: • 0.5 to 1 FTE perinatal psychiatrist • 1 FTE resource and referral specialist • 1 FTE program manager	Range of $400k to $500k (e.g., WI, NC)
Mid-level Program	• Expanded consultation services include emails and texts with guaranteed 24-hour response. • Outreach incorporates non-prescribers, including doulas, lactation consultants, and home visitors. • Scope may include substance use disorder (SUD) perinatal population provider outreach. • Education resources and related trainings offered quarterly using ECHO model.	Statewide availability although may focus on targeted regional areas based on funding and staffing capacity.	Equivalent of: • 1 FTE psychiatrist • 1.5 FTE resource and referral specialists (split between 2) • 1 FTE program manager • 0.5 FTE data manager • 0.5 FTE support specialist	Range of $500k to 800k (e.g., from FL, GA)
Premier Program	• Perinatal psychiatrists speak directly with provider, bypassing the triage process. • 30-minute guaranteed call-back to provider from psychiatrist. • In-person and/or telepsychiatry evaluation component for direct patient care. • Group case consultation for providers and their colleagues to review cases with consulting psychiatrist. • Virtual space for providers to meet and discuss strategies or manage the stress of providers and/or their patients. • Trainings may offer CE credits.	Statewide availability and support with outreach occurring at the local level to ensure rural communities are engaged.	Equivalent of: • 1 FTE Psychiatrist • 1 FTE program manager • 1 FTE program coordinator • 3 FTE resource and referral specialists • 1 FTE SUD/DEI manager • 0.3 FTE medical directors	Range of $875k to $1 million + (e.g., MA, MI)

* Staffing models vary and include support from psychiatrist residents, fellows, and shared program staff
**Costs do not directly correlate to staffing model listed; varies state by state

addressing PHM conditions. In interviews with state Access Program managers of a basic level funded plan, shortcomings included lack of backup coverage for resource and referral specialists, challenges with data management and evaluation, and less resources for outreach planning to reach more providers (e.g., less travel, conference attendance, etc.).

At the mid-level range, challenges noted by Access Program managers in larger states, like Florida and Georgia, included difficulties engaging providers in counties that are further from program operation locations when travel may be limited due to funding availability. However, adding additional staffing support provided more focused on time on outreach initiatives, which the program managers from both states noted was an important investment. Some states noted the value of including staff time for data and evaluation, which may allow for time for program managers to focus on outreach. The premier level programs include aspects mentioned in the basic and mid-level program as well as including CE credits for training and education, comprehensive outreach plans, and additional services for providers, like virtual group sessions to discuss strategies for treating the perinatal population at practices.

Administering and Funding Access Programs

How Access Programs are administered also differ; departments within state governments may receive funding and contract with healthcare systems or university medical partners to implement the program regionally. In some states, the Access Program is administered directly by a healthcare or university medical system that works with state partners to obtain funding and support.

Funding Opportunities

In interviews with Access Program managers and subject matter experts (SMEs), the main sources of funding identified for Access Programs included Health Resources and Services Administration (HRSA) grants, funding through Title V Maternal and Child Health Block Grant, other funding from state departments of health, and philanthropic funding. In several examples, multiple funding sources were needed to support Access Programs, highlighting the necessity to blend (wrap funds from two or more funding sources), and braid (coordinate two or more funding sources funds) to sustain programs and continue to build the capacity of providers to treat perinatal PMH conditions.

Federal Funding

The initial successes of the MCPAP for Moms Access Program prompted legislative action through federal HR. 3235 Section 10005, which was consolidated into the *21st Century Cures Act* and resulted in legislated funding that was appropriated to HRSA, which is part of the U.S. Department of Health and Human Services, to support Access Programs in other states.[xxv] In 2018, HRSA awarded $4.5 million to seven states (Florida, Kansas, Louisiana, Montana, North Carolina, Rhode Island, and Vermont), becoming a main source of funding for the creation of Access Programs through real-time psychiatric consultation, care coordination, and training to support front line providers.[xxvi]

There continues to be a federal focus on supporting perinatal mental health and SUDs, as is highlighted by the passing of *Into the Light for Maternal Mental Health and Substance Use Disorder Act of 2022 (Into the Light)*.[xxvii] This legislation authorizes $170 million in funding for maternal health programs over the next five years, of which $24 million per year will be used for state grants and $10 million per year for the National Maternal Mental Health Hotline, which provides perinatal patients with 24/7 mental health support in English and Spanish.[xxviii]

In April 2023, HRSA announced a new round of funding authorized through *Into the Light legislation*. Entitled the FY2023 Screening and Treatment for Maternal Mental Health and Substance Use Disorders (MMHSUD) Program, 14 states will receive $750,000 for five years to support Access Programs that provide real-time-psychiatric consultation, care coordination services, and culturally appropriate training to maternity care providers and clinical practices.[xxix]

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Funding Opportunities ... continued from page 5

Additional federal funding opportunities include the Substance Abuse and Mental Health Administration (SAMHSA) block grants, funded through the *American Rescue Plan Act of 2021*. Public Law 117-2 directed SAMHSA to provide additional funds in the amount of $3 billion to support states and territories in addressing SUDs and the mental health crisis.[xxx] States have until September 30, 2025, to expend these funds.[xxxi]

State Funding

Several Access Program managers and SMEs also acknowledged the need for the appropriation of state financial resources to support the sustainability of Access Programs so they may continue to build the capacity of frontline providers to address PMH conditions and SUDs. States such as Michigan and Massachusetts receive funding as a line item in the state's annual appropriated budget. North Carolina's Access Program's main source of funding is HRSA, however two years ago the state braided together additional funds from the NC Department of Health and Human Services, including NC Medicaid. Other states like Wisconsin and Kansas have accessed state funding through the Title V Maternal and Child Block Grant to coordinate with their states' home visiting program to train home visitors in screening and identification of PMH conditions to address perinatal mental health equity. Coordination with pediatric psychiatry access lines was also noted as a way to secure state funding. Pediatric mental health needs continue to be a prominent issue and many lines were established prior to the implementation of perinatal lines and have proven to be effective in treating child mental health conditions.

Philanthropic Funding

States including South Carolina and Washington acknowledged how critical philanthropic funding is for program sustainability. Wisconsin used philanthropic funding to support their Access Program through the United Health Foundation, initially implementing the program in the Milwaukee area to achieve the aims of the foundation funding requirements.

Exploring philanthropic support through organizations such as the Pritzker Family Foundation or through endowments at medical universities may offer critical implementation support for developing a new Access Program in Pennsylvania.

Recommendations and Challenges for Access Program Implementation

In interviews conducted with 12 state Access Program managers and SMEs, several themes emerged for recommendations and challenges for implementing a new Access Program, which are listed in **Table 2**. Four specific recommendations are outlined below.

Services Free to Providers of Perinatal Populations

All states recommend that the Access Program be offered as a free service to providers regardless of patient insurance. By offering the service as "payor blind", providers may be more apt to use the line as they do not have to worry about whether a patient qualifies or what paperwork is required. Further, reimbursement may be challenging for the psychiatrist to recoup as they are consulting with the provider and not seeing the patient directly (except for states that have in-person consultation options). However, a few states expressed an interest in exploring an assessment of commercial insurance companies and/or a reimbursement model from Medicaid. Further advocacy efforts may focus on engaging the national Center for Medicaid Services to highlight the value of Access Programs to Medicaid state plans as the pillars of the Access Program address perinatal mental health inequities.

Increasing the range of providers served through the Access Program to include non-prescribers was also recommended, especially to address mental health inequities in the perinatal population. In Philadelphia, for example, non-Hispanic Black women account for 43% of births, but represent 73% of pregnancy-related deaths.[xxxii] To find support, more Black women are turning to doulas, who often provide services ranging from prenatal information and care to delivery room coaching and postpartum support.[xxxiii] Promoting the access line to doulas as a free-of-charge service may

Table 2: Examples of challenges and recommendations offered during interviews with Access Programs

Access Program Challenges and Recommendations

- Access Program is free to providers caring for perinatal population to encourage utilization.
- Join the Lifeline for Moms network, which supports Access Programs nationally.
- Identify and capture community-based resources throughout the state to offer to providers.
- Training and education for providers is critical; identify effective methods that work for your state (e.g., Echo Model, online modules, etc.) and hold at regularly scheduled intervals and tailor to provider needs.
- Engage state-wide collaborative groups that include stakeholders focused on mental health and include individuals with lived experience.
- Develop a strong outreach plan and engage psychiatrists in efforts to build trusting relationships with frontline providers.
- Highlight the importance of the workforce development and training aspects of the Access Program; this is especially critical considering the shortages of mental health providers and frontline providers in rural areas.
- Build champions from a range of providers including pediatricians and non-prescribers such as home visitors, lactation specialists, and doulas.
- Coordinate with the pediatric psychiatry access line to use existing infrastructure and expand into the perinatal domain to serve mom and baby.
- Engage with commercial insurers and Medicaid MCOs.
- Tracking data can be complex and challenging; understand the metrics you want to collect ahead of implementation and build into the process of engagement efforts with providers.

lead to increased screenings and treatment options for PMH conditions and SUDs. Other non-prescribers such as lactation specialists and home visitors are also in a unique position to screen and refer perinatal patients for treatment.

Develop an Intentional Outreach Plan and Use Psychiatrists in Engagement Efforts

Each state emphasized the need to have an intentional outreach plan to engage providers and encourage use of the psychiatry access line and program features. All states acknowledged that engagement with providers is one of the biggest challenges they face and noted the value in the provider-to-provider contact ("doctors want to hear from doctors"), although engagement efforts differed on state funding and capacity. At a minimum, recommendations include allowing time for the program manager to focus on outreach efforts and securing psychiatrists to speak with practices and/or attend conferences where providers are present to build relationships and develop trust. If a provider knows who will be answering the call and providing expert advice, they may be more willing to use the service.

Many states develop lists of primary obstetric provider practices in targeted regions and schedul visits to present information about the Access Program in-person, including the psychiatrist as a presenter when possible. During the "road shows" it was noted how important it is to highlight why the consult line should be integrated as part of the practice workflow, focusing on the benefits and opportunity for all providers to access critical support, grow their

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knowledge base and share this knowledge with colleagues, and support the perinatal population. If practices have a practice manager, incorporate that person in outreach efforts. States with similar maternity care provider challenges in rural areas noted the importance of identifying related resources for practices and/or providers and highlighting how critical the consult line is for treating the perinatal population in rural communities.

If there are already champions in the state who value Access Programs, engage them in outreach efforts; a range of providers is most effective in spreading the word (consider obstetrics and pediatric providers as well as doulas, lactation specialists, NPs, and PAs). As several states noted, engagement from both the bottom up and top down helps to secure buy-in. These efforts may range from meeting with home visitors to highlighting how the consult line can support their efforts in increasing screenings. Other ideas include attending grand rounds for an obstetrics and gynecology department or speaking to medical students who are training to work with the perinatal population and about to enter the workforce to encourage utilization of the Access Program.

Build Strong Partnerships throughout the State

Although a formal partnership often exists between the state and the medical system(s) to administer the Access Program state-wide, other valuable partnerships were mentioned by Access Program managers and SMEs. Several states noted the benefit of working with collaborative groups comprised of stakeholders focused on maternal mental health. When possible, it is beneficial to include individuals with lived experience. A challenge of Access Programs is that because most are not patient facing, there is a gap in the feedback loop and the benefits (or continued barriers) for perinatal patients are not always captured or recognized. Including individuals with lived experience provides a voice to the perinatal population and may lead to improved training for providers to continue to meet patient needs. Other partnerships included the state chapters of the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and Postpartum Support International (which currently does not have a Pennsylvania Chapter). Working with advocacy groups is also critical to obtain funding and continued support Access programs.

Coordinate with Pediatric Psychiatry Access Lines

Although the synergy between pediatric and perinatal psychiatry access lines differs by state, most Access Program managers and SMEs highlighted that when possible, it is cost-effective to use existing infrastructure in implementing a perinatal dedicated line. In several cases, the pediatric psychiatry access line was established first and the perinatal line followed, citing effectiveness in building pediatric provider capacity in treating mental health conditions in children to secure funding. In several states, including Kansas, North Carolina, and Wisconsin the perinatal and pediatric operate separately, but share a centralized phone number ("press 1 for pediatric and press 2 for perinatal"). In Kansas, although triage for the pediatric and perinatal lines are handled separately, they have implemented cross-training for triage specialists to provide back up to one another as another means of building workforce capacity.

Strategies for Implementing an Access Program in Pennsylvania

In examining models in states with similar demographics, geographies, and/or political makeup like North Carolina, Wisconsin, and Florida, trends have emerged for consideration in implementing an Access Program in Pennsylvania.

It is recommended that the Pennsylvania Access Program include three focus areas in its design: consultation, referrals, and education and training. Implementing the program in a stepwise manner, as similar states like NC, WI, and FL have all done, allows for a targeted approach to engage specific regions. In Pennsylvania, working with healthcare systems such as Penn Medicine (east), Penn State Health (central), and Allegheny Health Network (west) will reach providers in both rural and urban areas and support strategic outreach and engagement in

the targeted regions. This may also help to identify champions, or providers who see value in the Access Program and can speak to other providers to encourage use.

Telephonic Consultation and Staffing

The most common component, the telephonic consult line should be included in the program structure with set operations occurring Monday through Friday, from 9am to 5pm. Because the intent is to partner with medical systems from across the state, perinatal psychiatrists may be sourced for portions of their time, ensuring that one psychiatrist is available during telephonic consultation hours. A 24-hour guaranteed response (M-F) from psychiatrist to provider should be considered when implementing the phone line. One program manager is recommended to oversee the functionality of the Access Program. As the triage position (often filled by social workers) was distinguished by many states as a critical role, ensuring a portion of at least two individuals' times (1.5 FTE) is secured will allow one person to answer calls during business hours and one person to be available to provide backup coverage.

Coordination with the Pennsylvania Telephonic Psychiatric Consultation Service Program (TiPS) may be considered for use of the existing infrastructure to implement the consultation access line. As noted, several states operate the perinatal and pediatric lines separately, and with different funding streams, but use one shared phone line for initial calls ("press 1 for pediatrics or press 2 for perinatal"). This may provide cost savings and still allow for a separate Perinatal Psychiatry Access Program to be developed with a connection to the TiPS program, potentially leading to funding opportunities for the perinatal line by promoting the program as a didactic benefit for the health of both mom and baby.

Resources and Referrals

It is important that the triage role (often referred to as the resource and referral specialist, or care coordination specialist) is familiar with community-based resources and referrals in the providers' area. Some states, such as Florida, have dedicated staff time to developing a resources directory of mental health and SUD providers. However, this requires staff time to regularly update the directory. It is recommended that triage individuals in Pennsylvania are at least familiar with search mechanisms to locate appropriate resources for providers when referrals are necessary.

Training and Education

Offering tailored training to providers to build knowledge on treating PMH conditions is critical and can occur in a variety of ways. Some states use the ECHO model for knowledge sharing whereas other states have found this option to be too costly and have chosen to follow the ECHO model, offering a didactic presentation through a case consultation model at regular intervals throughout the year, which may be an appropriate approach for the initial pilot period. Other considerations for Pennsylvania include in-person trainings led by the perinatal psychiatrists at obstetrics ground rounds in the three regional-area medical institutions.

Evaluation and Metrics

As noted, data collection and evaluation are costly and time-consuming. However, prior to launching the Access Program, the program team should determine what data will be collected and build this into outreach to providers. As several states expressed, streamlining the process for providers will encourage more participation. Understanding how the state will evaluate success without feedback from patients is also an important consideration. In one state example, a survey is issued immediately following the completion of the call to ask, "If you had not called us, what would you have done instead?". Other states have issued surveys to providers but felt the response rates were not representative of the user population. Several states use the RedCAT System to track data and if financially possible, have promoted having a dedicated staff person (or a portion of an employee's time) to manage data and evaluation using the RedCAT system.

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Advocacy Efforts and Funding

Highlighting the workforce development impact of the Access Program is central to sustainability. This is not just a referral line; consultations with primary care providers help them grow and become more comfortable with treating mental health conditions, which they share with their colleagues. It is also important for the Pennsylvania team to consider the providers they want to reach. For example, is there an opportunity in one region to pilot with home visitors? If so, how does this impact funding, such as obtaining resources through a Title V Maternal and Child Block Grant as other states have secured.

Ensuring that an Access Program focus in Pennsylvania includes supports for the perinatal population experiencing both PMH conditions and SUDs is also critical to meet the state's growing issue with opioid use in the perinatal population. In Pennsylvania, perinatal population rates of diagnosed SUDs and newborns born with neonatal abstinence syndrome are both two times higher than that of national averages.[xxxiv] Further, accidental poisonings, including drug overdoses, were the leading cause of pregnancy-associated death in the state between 2013 and 2018.[xxxv] Considering that more than one in four adults living with serious mental health problems also have SUDs (SAMHSA, 2023), building capacity for providers to identify and treat co-occurring disorders and offering resources and referrals through an Access Program will benefit perinatal individuals.

Including outreach to physician assistants, nurse practitioners, and non-prescribers such as doulas and lactation specialists also helps to address disparities in screening and treatment of PMH conditions by building the capacity of frontline providers who are actively engaged with the perinatal population. Storytelling is also an effective tool and engaging providers who have personally found value in the Access Program will help to encourage provider participation. As noted, identify champions of the Access Programs, including patients if possible, and share their experiences.

A main source for funding is through HRSA or other federal programs, or grants from philanthropic organizations. Addressing inequities in the treatment of mental health conditions and SUDs for the perinatal population will lead to less pregnancy-related deaths and this is an issue that continues to grow more pressing.[xxxvi] This focus may offer additional federal funding opportunities through SAMHSA as Access Programs are proven to effectively address these inequities.[xxxvii] Several states have needed to blend and braid funding and securing funding through the Pennsylvania Department of Health or other state departments will lead to sustainability of the program and create opportunities for state-wide expansion.

Appendix A: Access Programs by State

Lifeline for Moms Resource

Arkansas

- Women's Mental Health Program Consultation Services

Connecticut

- ACCESS Mental Health for Moms

Florida

- Florida BH IMPACT

Georgia

- PEACE for Moms

Illinois

- Illinois DocAssist

Indiana

- Indiana Consultations for Healthcare providers in Addiction, Mental Health, and Perinatal Psychiatry Program

Kansas

- Kansas Connecting Communities

Louisiana

- Louisiana Mental Health Perinatal Partnership (LAMHPP)

Maryland (for substance use disorders)

- Maryland Addiction Consultation Service (MACS) for MOMs

Massachusetts

- MCPAP for Moms

Michigan

- MC3 Perinatal

Montana

- Psychiatric Referrals, Interventions, and Support in Montana (PRISM) for Moms

New York

- Project TEACH (Training and Education for the Advancement of Children's Health)

  A project funded by the New York State Office of Mental Health

North Carolina

- NC Maternal Mental Health MATTERS

Rhode Island

- Rhode Island Maternal Psychiatry Resource Network (RI MomsPRN)

South Carolina

- Mom's IMPACTT

Texas

- Perinatal Psychiatry Access Network (PeriPAN)

  Available in 4 pilot regions

Vermont

- Vermont Screening, Treatment, & Access for Mothers and Perinatal Partners (STAMPP)

  Perinatal Mood and Anxiety Consultation Service at the University of Vermont Medical Center

Washington

- Perinatal PCL

Wisconsin

- The Periscope Project

Appendix B: Interviews with Perinatal Psychiatry Access Programs

State	Program Name	Organization	Name	Title	Interview
Connecticut	ACCESS Mental Health for Moms	Carelon Behavioral Health	Elizabeth Garrigan	Program Director	8/3/23
Florida	Florida BH Impact	Florida State University COM	Megan Deichen Hansen	Program Manager	8/3/23
Georgia	PEACE for Moms	Emory School of Medicine	Arica Washington	Program Manager	8/4/23
Kansas	Kansas Connecting Communities	Kansas Department of Health and Environment	Kelsee Torrez	Consultant Unit Director & Behavioral Health Consultant	8/17/23
Maryland	Maryland Addiction Counseling Service for MOMs	University of Maryland School of Med	Kelly Coble	Program Director	8/10/23
Massachusetts	MCPAP for Moms	U Mass Med / LifeLine for Moms	Melissa Maslin	Project Director	7/25/23
Michigan	MC3 Perinatal	Michigan Council for Maternal and Child Health	Amy Zaagman	Executive Director	7/25/23
Michigan	MC3 Perinatal	University of Michigan Med	Anne Kramer	Program Director	8/3/23
Michigan	MC3 Perinatal	Center for Health and Transformation Research	Sandra Bitoni Stewart	Business Development Director	8/3/23
North Carolina	NC Maternal Mental Health MATTERS	UNC School of Med, Duke's Dept. of Psychiatry & Behavioral Sciences, NC HHS	Karen Burns	Program Director	7/25/23
Rhode Island	Rhode Island Maternal Psychiatry Resources Network	Rhode Island Dept. of Health, Women and Infants Hospital	Jim Beasley	Program Manager	8/10/23
South Carolina	Moms IMPACTT	Medical University of SC	Constance Guille	Director, Women's Reproductive Behavioral Health Division	8/3/23
Washington	Perinatal PCL	UW Psychiatry & Behavioral Services	Jamie Adachi	PERC Center Manager	8/10/23
Wisconsin	The Periscope Project	Medical College of Wisconsin	Shelby Kuehn	Program Manager	8/15/23

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