Date of Hearing: April 2, 2019

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 798 (Cervantes) – As Amended March 27, 2019

SUBJECT: Maternal mental health.

SUMMARY: Establishes a pilot program, in counties that elect to participate, including the County of Riverside, to increase providers to address postpartum depression and other mental health conditions. Specifically, **this bill**:

1) Creates a pilot program, in counties that elect to participate, including the County of Riverside, to increase the capacity of health care providers that serve pregnant and postpartum women up to one year after delivery to effectively prevent, identify, and manage postpartum depression and other mental health conditions.

2) Permits the pilot program to be coordinated by the Department of Public Health (DPH).

3) Requires the pilot program to be privately funded.

4) Permits the pilot program to include a provider-to-provider or patient-to-provider consultation program and utilize telehealth or e-consult technologies.

5) Permits the pilot program to include the following elements:
   a) Training and toolkits on screening, assessment, and the range of treatment options;
   b) Coordination of care to link women with individual services in their communities; and,
   c) Access to perinatal psychiatric consultations.

6) Requires, within six months after the results of the pilot program are reported, the California Health and Human Services Agency, in consultation with state entities, as necessary, to submit a report to the Legislature.

7) Requires the report specified in 6) above to do all of the following:
   a) Document the impact of the pilot program on increasing the number of women who were screened, assessed, and treated for maternal mental health disorders;
   b) Identify methods to expand the pilot program to additional counties or statewide; and,
   c) Identify funding opportunities to support the expansion of the pilot program, including federal funding, state funding, and surcharges.

8) States the intent of the Legislature to address the shortage of treatment options for women suffering from maternal mental health disorders, including postpartum depression and anxiety orders.

EXISTING LAW:

1) Establishes within DPH, the Maternal, Child and Adolescent Health Division to work with statewide and local partners to develop systems that protect and improve the health of California's reproductive-aged and pregnant women, infants, children, adolescents, and their families.

2) Defines telehealth as the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

3) Requires prior to the delivery of telehealth, the health care provider initiating the use of telehealth to inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health. Requires the consent to be documented in the patient's medical record, and states that all laws regarding the confidentiality of health care information and a patient's rights to his or her medical information apply to telehealth interactions.

FISCAL EFFECT: This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, it is important to address the key issues of improving access to treatment for maternal mental health (MMH). Ensuring the creation of a pilot program that will accommodate a provider-to-provider psychiatry teleconsult and/or virtual mentoring service and a provider training capacity program in Riverside County, among other counties, would help build the capacity of health providers serving pregnant and postpartum women. This bill would ensure comprehensive monitoring and access to specialists, especially where specialized staff is unavailable. This bill would also serve as an important step towards addressing the lack of access to psychiatrists and any perinatal services to improve access to treatment, taking into consideration birth trauma, and the need to increase access for women and their families in need of mental health services during and after pregnancy.

2) **BACKGROUND.**

   a) **California MMH Collaborative.** The California MMH Collaborative was established in 2011 as a result of the passage of ACR 105 (Nava), Resolution Chapter 9, Statutes of 2010, which declared May as Perinatal Depression Awareness month in California. ACR 105 also urged private and public stakeholders to form a volunteer task force to address opportunities for increasing awareness of, and screening for MMH disorders. The stated mission of the California MMH Collaborative is to bring stakeholders together to exchange ideas, identify barriers and opportunities and form collaborative relationships to increase and improve MMH awareness, diagnosis and treatment in California and beyond. In 2013, the organization launched with its partner, Postpartum Support International, a web-based training in MMH to address the shortage of trained providers, and its national campaign, called the 2020 Mom Project, which sets forth tactical steps that hospitals, insurers and providers can take to improve awareness and outcomes.

   ACR 148 (Leventhal), Resolution Chapter 96, Statutes of 2014, sponsored by the California Legislative Women's Caucus, requested the formation of a MMH task force to study, review, and identify: i) current barriers to screening and diagnosis; ii) current

treatment options for both those who are privately insured and those who receive care through the public health system; and, iii) evidence-based data on emerging treatment options that are scalable in public and private health settings. The MMH task force Implementation Steering Committee was asked to identify the needs of both providers and patients in order to improve diagnosis and treatment. On March 1, 2017, the MMH task force released a white paper that identified gaps in the current effort to identify and treat MMH disorders and provides recommendations that address physician capacity, treatment shortages, screening and referral, an awareness campaign, and action steps for stakeholder groups. This bill addresses the treatment shortage recommendation, specifically the recommendation that California adopt a statewide provider-to-provider expert psychiatric access program by 2021.

b) MMH. According to the March 2017 report from the MMH taskforce, MMH disorders, including depression, anxiety, and the much more rare but serious, postpartum psychosis, affect one in five women (20%), during pregnancy or the first year following childbirth. Among those living in poverty, up to 50% may be affected. Maternal depression is the most common complication of pregnancy in the United States, surpassing gestational diabetes and preeclampsia combined. Maternal depression presents a significant early risk to proper child development, the mother-infant bond, and the family. Maternal depression screening and treatment is an important tool to protect the child from the potential adverse physical and developmental effects of maternal depression. According to the American Academy of Pediatrics (AAP), screening mothers for maternal depression is a best practice for primary care pediatricians and can be integrated into the well-child care schedule, as well as included in the prenatal visit.

c) Clinical recommendations for screening. In May of 2015, the American Congress of Obstetricians and Gynecologists published "Committee Opinion Number 630," recommending that clinicians screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool. In January 2016, the U.S. Preventive Services Task Force (USPSTF) released a revised recommendation for depression screening of all adults, including pregnant and postpartum women. The USPSTF noted that screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow up. In February 2016, the National Council on Patient Safety in Women's Health Care issued the *Maternal Mental Health Bundle*, providing high-level direction to health care providers in office and hospital settings on how to implement maternal mental health screening and treatment, and the most recent AAP *Bright Futures Guidelines* recommends postpartum depression screening from the one-month through the six-month well-child visit.

d) Telehealth. Access to providers and health care services is an ongoing concern among stakeholders and policymakers throughout the state. In an effort to ensure quality services are accessible to patients, health reform policies have focused on innovative methods, such as telehealth, to deliver care. Telehealth uses telecommunication tools and technologies to connect providers to patients who may otherwise have limited access to care. In doing so, it provides a means of delivering care and services, including diagnosis, treatment, and patient education. The California HealthCare Foundation reports that health plans, providers, and information technology vendors are currently using telehealth applications to increase quality of care, reduce costs, and increase access for the underserved, and that studies have demonstrated telehealth services have

improved outcomes and continuity of care for patients, particularly in rural settings. AB 415 (Logue), Chapter 547, Statutes of 2011, established the Telehealth Advancement Act to revise and update existing law to facilitate the advancement of telehealth as a service delivery mode in managed care and the Medi-Cal program.

e) **Other states.** In 2015, Minnesota's Department of Human Services received an Adult Medicaid Quality grant from the Centers for Medicare and Medicaid Services which facilitated a quality improvement program (QIP) on postpartum depression screening. Minnesota focused on addressing screening implementation issues during well-child checks because more mothers attend a two-month well-child visit (92% in Minnesota's Medicaid population in 2012) compared to postpartum visits. As of December 2015, providers participating in the project had completed 2,885 screens, with 203 out of the 341 positive screens referred. Even though the grant has concluded, Minnesota continues to run the postpartum depression QIP.

   Massachusetts Child Psychiatry Access Program (MCPAP) for Moms incorporates care coordination to link women to services in their community and telephonic access to perinatal psychiatric consultation. MCPAP for Moms successfully increased provider capacity to address MMH disorders and served more than 1,100 women in its first 18 months. The pilot program proposed by this bill would incorporate elements from MCPAP for Moms.

3) **RELATED LEGISLATION.** AB 577 (Eggman) extends the duration of Medi-Cal eligibility for postpartum care for an individual who is diagnosed with a maternal mental health condition for a period of one year following the last day of the individual's pregnancy if the individual complies with certain requirements. AB 577 is pending a hearing in Assembly Appropriations Committee.

4) **PREVIOUS LEGISLATION.** AB 244 (Cervantes) of 2017 was substantially similar to the provisions of this bill and would have created a pilot program in counties that elect to participate, including Riverside County, to increase the capacity of health providers that serve pregnant and postpartum women to prevent, identify, and manage postpartum depression and other mental health conditions. AB 244 was set for a hearing in Assembly Health Committee but was not heard at the request of the author.

5) **SUGGESTED AMENDMENT.** As currently drafted, this bill requires a report to the Legislature within six months after the results of the pilot program are reported, however there is no specified end date for the pilot program. The Committee may wish to sunset the pilot program in four years to evaluate its effectiveness.

REGISTERED SUPPORT / OPPOSITION:

Support
None on file.

Opposition
None on file.

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