AHCCCS
Arizona Health Care Cost Containment System

Maternal Mental Health Advisory Committee
Report of Recommendations

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TABLE OF CONTENTS

Background

The Maternal Mental Health Advisory Committee was created through Senate Bill 1011[1] to recommend improvements for screening and treating maternal mental health disorders in Arizona. The AHCCCS Chief Medical Officer served as the Arizona Health Care Cost Containment System (AHCCCS) Director's designee to chair the Committee and AHCCCS appointed members of the advisory committee as established by the legislation.[2] This report provides a list of recommendations concerning improvements for screening and treating maternal mental health disorders in Arizona.

Introduction

The ultimate goal of screening for and treating perinatal mental health and substance use disorders is to prevent maternal morbidity and mortality. Almost half of all pregnancy-associated deaths between 2016 to 2018 in Arizona were related to mental health conditions or substance use disorders according to the Arizona Department of Health Services (ADHS) Maternal Mortality Review Committee (MMRC), 98% of which were determined to be preventable.[3] Almost two thirds of pregnancy-associated deaths related to mental health conditions or substance use disorder occurred between 42 and 365 days postpartum. American Indian and Alaska Native (AI/AN) Arizonans experience the greatest disparity in pregnancy-associated deaths related to mental health conditions or substance use disorder, representing 5.9% of the live births in Arizona and 11.1% of the pregnancy associated deaths due to mental health or substance use disorders.

To leverage the work already established through ADHS, MMRC, and their Maternal Health Task Force, the Committee not only included ADHS representatives on the Committee and workgroups, but also drew from the ADHS recommendations already established to address maternal mental health and substance use needs as summarized in Table I. This allowed the Committee to reflect on progress made toward these recommendations and to generate further recommendation refinement outlined in this report.

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[1] "Senate Bill 1011." *Arizona State Legislature*, https://www.azleg.gov/legtext/55leg/1R/laws/0054.pdf. Accessed 28 Dec. 2022.

[2] "Maternal Mental Health Advisory Committee Membership Roster." *Arizona Health Care Cost Containment System* (*AHCCCS)*, https://www.azahcccs.gov/AHCCCS/Downloads/MaternalMentalHealthAdvisoryCommitteeMembers.pdf. Accessed 28 Dec. 2022.

[3] Baer CE, Ramirez GM, Rubio V, Indatwa A, Tarango P, Bellucci L, Celaya MF. Maternal Mental Health and Substance Use-Related Deaths in Arizona. Phoenix, AZ: Arizona Department of Health Services; 2022. https://www.azdhs.gov/documents/prevention/womens-childrens-health/reports-fact-sheets/mm-su-az-03-2022.pdf. Accessed 28 Dec. 2022.

Table I. Recommendations to Reduce Maternal Mortality[4]

Recommendations to Reduce Maternal Mortality Related to Mental Health Conditions and/or Substance Use Disorder
1. Arizona should expand AHCCCS coverage to one year postpartum.
2. Arizona should establish a fully funded Perinatal Psychiatric Access Program that would provide consultation services and training to front line providers for assessment and treatment of maternal mental health and substance use disorders.
3. Arizona should expand loan reimbursement and incentives (e.g., free certifications) for the range of behavioral health providers (prescribers and non-prescribers), particularly incentivizing service in rural areas.
4. Payers should ensure collaborative care codes allow behavioral health medical practitioners and perinatal mental health providers to be reimbursed regardless of where and when care is delivered (e.g., eliminate the same-day limitation for psychiatric reimbursement).
5. Payers should recognize perinatal behavioral health specialists as a contracted medical specialty with health plans.
6. Payers should establish quality metrics to improve accountability and utilization of case management, care navigation, social work, peer support, and doula services to ensure continuity of care for high-risk patients.
7. First responders and law enforcement agencies should dispatch behavioral health providers on all calls involving domestic violence, substance use, mental health challenges, or social/economic instabilities and require all first responders and law enforcement staff are trained in a trauma-informed approach.
8. All agencies and organizations impacting maternal and infant health should adopt outreach and education practices to reduce stigma of maternal mental health and substance use disorder to increase help-seeking behaviors, including universal screening and referral practices.

[4] Baer CE, Ramirez GM, Rubio V, Indatwa A, Tarango P, Bellucci L, Celaya MF. Maternal Mental Health and Substance Use-Related Deaths in Arizona. Arizona Department of Health Services, 2022, Phoenix, AZ, https://www.azdhs.gov/documents/prevention/womens-childrens-health/reports-fact-sheets/mm-su-az-03-2022.pdf. Accessed 28 Dec. 2022.

Accomplishments toward these ADHS recommendations and other State successes include:

- On June 23, 2022, the Arizona State Legislature passed House Bill 2863, which included a postpartum coverage extension for Medicaid members and will provide 12-months of continuous eligibility to pregnant individuals who were eligible and enrolled under the state plan while pregnant.
- In 2021, over 457 Arizona practitioners trained in a three-part perinatal mental health training series in perinatal mood and anxiety disorders, advanced perinatal psychotherapy, and advanced perinatal psychopharmacology, increasing the perinatal workforce capacity by providing continuing education credits and a pathway to obtaining a certification in perinatal mental health. ADHS offered 100 scholarships to take the certification exam and 79 professionals accepted the scholarships to become certified in Perinatal Mental Health provided by Postpartum Support International (PSI).
- In 2022, House Bill 2691 created the following health care workforce development programs which are anticipated to have a direct impact on the perinatal workforce in Arizona:
    - Arizona Nurse Education Investment Program
    - Student Nurse Clinical Rotation and Licensed Nurse Training Program
    - Licensed RN Transition to Practice Pilot Program
    - The Preceptor Grant Program
    - Behavioral Health Workforce Demonstration Pilot Program
- ADHS launched the Hope Heals & See Me Differently marketing campaign to raise awareness and reduce the stigma associated with pregnant and postpartum individuals with substance use disorder targeting mothers and providers in 2021.
- ADHS launched the Know the Signs marketing campaign to raise awareness of perinatal mood and anxiety disorders in December 2022.
- AHCCCS launched an Opioid Treatment and Naloxone Locator[5] in October 2021, which provides information about opioid treatment provider availability by zip code, including for pregnant women.
- In November 2022, CommunityCares, a statewide social determinants of health (SDOH) closed-loop-referral- system (CLRS) launched. CommunityCares enables health care and community service providers to connect on a single statewide technology platform to seamlessly improve and track the referral process between health care providers and social services.

[5] "AHCCCS Opioid Service Locator." *Arizona Health Care Cost Containment System* (*AHCCCS)*, https://opioidservicelocator.azahcccs.gov/. Accessed 28 Dec. 2022.

Committee Recommendations

I. Create and Sustain a Perinatal Psychiatric Consultation Line

Individuals see a health care provider (e.g., obstetrics, pediatrics, or other primary care provider) 20 to 25 times during a routine pregnancy and the first year of their baby's life,[6] providing opportunity for these providers to screen for maternal mental health and substance use conditions. However, these frontline health care providers do not always have the training, knowledge, and/or resources to address these conditions. This challenge is magnified by the limited number of perinatal specialists available to provide care.

In Arizona there are several barriers to accessing high-quality and immediately responsive perinatal psychiatric care. These barriers include:

- Provider pipeline (e.g., despite workforce attrition from the field of psychiatry, there has not been an increase in national psychiatry residency training spots),
- Provider training (e.g., few psychiatrists are trained to competence in perinatal mental health care), and
- Geography (e.g., Arizona is a large and mostly rural state, with most health care providers living in the three metropolitan areas – Phoenix, Tucson, and Flagstaff).

To address this challenge with increased clinical demand and limited access to perinatal psychiatrists, state and federally funded perinatal telephonic access programs have emerged across the country as successful and scalable models of care.[7] The first perinatal access line in the country was developed in Massachusetts[8] and continues to be sustainable through a state legislative appropriation and a commercial health plan assessment. In November 2022, AHCCCS entered into an intergovernmental agreement with the University of Arizona Perinatal Psychiatry Program to launch the Arizona-Perinatal Access Line (A-PAL), utilizing time limited American Rescue Plan Act (ARPA) funding. The A-PAL will provide the following services:

- Perinatal Psychiatric Clinical Consultation for Health Care Providers; A-PAL will provide real-time psychiatric consultations and Arizona-specific mental health resources to any health care provider caring for patients during the perinatal period.
- Perinatal Mental Health and Substance Use Disorder Workforce Development for Health Care Providers; A-PAL will provide education in the form of both in-person and internet-delivered trainings and clinical toolkits (e.g., clinical screeners, algorithmic guidance of care, community resources specific for different counties, and communities) for providers

[6] McInerny, Thomas K. MD, FAAP; Henry M. Adam, MD, FAAP; Deborah E. Campbell, MD, FAAP; Jane Meschan Foy, MD, FAAP; Deepak M. Kamat, MD, PhD, FAAP. American Academy of Pediatrics Textbook of Pediatric Care (2nd Edition), June 2016. https://doi.org/10.1542/9781610020473.

[7] "State Perinatal Access Lines." *Postpartum Support International*, https://www.postpartum.net/professionals/state-perinatal-psychiatry-access-lines/. Accessed 28 Dec. 2022.

[8] "About MCPAP for Moms." *Massachusetts Child Psychiatry Access Program for Moms*, https://www.mcpapformoms.org/. Accessed 28 Dec. 2022.

and staff on evidence-based guidelines for screening, triage, referral, and treatment options.

AHCCCS will monitor A-PAL utilization trends, including both qualitative and quantitative information, to revise the program to meet the needs of Arizona as well as inform health care quality improvement efforts to address the perinatal mental health and substance use disorder needs in Arizona. Given the initial funding through ARPA is time limited, financial sustainability of this program will need to be addressed and other states' models can be of assistance in guiding this sustainability.

Recommendations:

Similar to other state perinatal consultation line models, including Massachusetts[9] and Michigan,[10] the Legislature should appropriate annual funding and/or require an assessment on commercial health plans in Arizona to sustain the A-PAL model in Arizona beyond ARPA funding, which ends on September 30, 2024.

[9] "Child and Adolescent Mental Health Services." *Massachusetts FY 2021 Budget Summary*, https://budget.digital.mass.gov/summary/fy21/enacted/health-and-human-services/mental-health/50425000. Accessed 28 Dec. 2022.

[10] "FY 2021 Executive Budget Recommendation General Briefing Papers." *Michigan State Budget Office,* 6 Feb. 2020, https://www.msbo.org/sites/default/files/FY21_General_Briefing_Papers_680401_7.pdf#page=6. Accessed 28 Dec. 2022.

II. Increase the Diversity of the Perinatal Behavioral Health Workforce

Nationally, maternal and infant mortality is higher among Black, Indigenous, and People of Color (BIPOC). Severe adverse maternal health outcomes improve as much as 50 percent in states with higher provider diversity.[11] This also translates to the mental health care arena, where those who are cared for by mental health providers who are racially and ethnically congruent, feel more satisfied with their treatment.[12] This may in part be due to the incongruency of western behavioral health curriculum with cultural practices and teachings familiar to BIPOC populations. The recency of forced sterilization and child removal among Native people in the United States necessitates reproductive and mental health providers who can support Native people in traditional birthing and parenting.

The American Psychological Association (APA) estimates that only 15.5% of psychologists in the U.S. are racial and ethnic minorities, with only 4.5% being Black and 0.15% being American Indian/Alaska Native (AI/AN).[13] Furthermore, only 10.4% of practicing psychiatrists are non-White. Among subspecialties, addiction medicine contains the smallest percentage of racial and ethnic minority providers.[14] This presents a problem to improving maternal mental health outcomes among BIPOC populations in Arizona, particularly those living in rural and remote areas of the state.

There are several efforts underway to increase the diversity of the perinatal behavioral health workforce in Arizona, including:

- Maricopa County Community Colleges Road to Relief program provides individuals with free tuition, monthly stipends, and employment assistance when enrolled in eligible programs across the 10 Maricopa Community Colleges. This project is designed to assist individuals whose employment or household income was impacted by the COVID-19 pandemic. Students will be eligible to receive funding beginning July 2022 and the project will continue through December 2024. Behavioral health programs are eligible.[15]

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[11] Guglielminotti, Jean et al. "Nurse workforce diversity and reduced risk of severe adverse maternal outcomes." *American Journal of Obstetrics & Gynecology MFM* vol. 4,5 (2022): 100689.

[12] Chao, Puihan J et al. "The effects of working alliance and client-clinician ethnic match on recovery status." *Community Mental Health Journal* vol. 48,1 (2012): 91-7.

[13] "Demographics of U.S. Psychology Workforce." *American Psychological Association*, 2022, https://www.apa.org/workforce/data-tools/demographics. Accessed 28 Dec. 2022.

[14] Wyse, Rhea et al. "Diversity by Race, Ethnicity, and Sex within the US Psychiatry Physician Workforce." *Academic psychiatry: The Journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry* vol. 44,5 (2020): 523-530.

[15] "Route to Relief." *Maricopa Community Colleges*, http://info.maricopacorporate.com/en-us/r2r-student. Accessed 28 Dec. 2022.

- Black Therapists in Arizona was established in 2020 as a coalition of Black therapists working toward ridding their community of the stigma of mental health by providing education, training, and affordable access to services to increase the visibility of Black therapists in Arizona.[16]
- AHCCCS's ARPA Spending Plan for the Substance Abuse Prevention and Treatment Block Grant (SABG) identified several needs and gaps for primary prevention related to improving diversity in the mental health workforce. Specifically, it recommends prioritizing prevention programs that are culturally competent, engaging, and up to date to ensure effectiveness. One of their alternative strategies includes "connection and engagement in cultural activities, tribal practices, and learning cultural and/or tribal ways." This plan also includes partnering with Arizona State University (ASU) Social Transformation Lab to facilitate sessions with Black, Hispanic, and Tribal providers who treat substance use disorders to identify barriers and opportunities to address behavioral health disparities.

Recommendations:

1. ADHS, AHCCCS, and professional boards continue to engage BIPOC communities in Arizona to evaluate barriers and create solutions for more BIPOC members to enter the behavioral health workforce, including the completion of education, licensure requirements, insurance credentialing, and contracting.

2. ADHS, AHCCCS, and institutes of higher education to evaluate and enhance current tuition assistance programs available in Arizona for BIPOC individuals.

3. Improve the understanding of the current Arizona behavioral health workforce composition, recommending the Arizona Board of Behavioral Health Examiners, Arizona Board of Psychology, Arizona Board of Nursing, and the Arizona Board of Medicine work together and evaluate current practice and demographic information received upon licensure activation and renewal and track and trend data to evaluate how specific interventions are achieving desired outcomes.

[16] "About Us - Black Therapists in Arizona." *Black Therapists in AZ, https://www.blacktherapistsinaz.org/about*. Accessed 28 Dec. 2022.

III. Increase Cultural Competency Trainings for Health Care Professions

Recognizing bias in maternal health is a crucial step in beginning to improve maternal health and maternal mental health outcomes. Research demonstrates that medical mistrust and bias play central roles in the underutilization of services and poorer health outcomes, including maternal deaths, by racially and ethnically diverse women during pregnancy and postpartum. To effectively address these disparities, it is imperative to understand the drivers of medical mistrust in perinatal health care systems.[17]

Several organizations offer trainings and tools around cultural competency for health care professionals:

- American College of Obstetricians and Gynecologists - Importance of Social Determinants of Health and Cultural Awareness in the Delivery of Reproductive Health Care
- March of Dimes - Awareness to Action: Dismantling Bias in Maternal and Infant Healthcare
- Maternal Health Learning and Innovation Center Trainings:
    - Cultural Humility and Black Maternal Health in Historical Context (clinical audience webinar)
    - Culturally and Linguistically Appropriate Services (CLAS) in Maternal Health Care (clinical & partner audience, modules, and credits/certification offered)
    - Equity Resources
    - American Indian Webinar Series
    - Episode 5: Examining maternal health in Indigenous Communities, with Amy Stiffarm and Dr. Donald Warne
    - Listening to Understand and Not to Respond Across Different Cultural Contexts with Camie Goldhammer (webinar)
- Montana Obstetrics & Maternal Support - Indigenous Health Policy and The Impact of Poverty on Indigenous Health. This presentation is offered in tribute to Indigenous People's Day 2022 and is part of a cultural safety education series sponsored by MOMS. October 14, 2022
- Inter Tribal Council of Arizona - Keynote Presentation: Cultural Resilience in Public Health: An Indigenous Framework Approach, Eric Hardy
- First Nations Health Authority (Canada) 11-webinar series - Cultural Safety and Humility
- Diversity Science - Dignity in Pregnancy and Childbirth Project

[17] Conteh, Nkechi et al. "Medical Mistrust in Perinatal Mental Health." *Harvard review of psychiatry* vol. 30,4 (2022): 238-247. doi:10.1097/HRP.0000000000000345

Currently, the Arizona Board of Behavioral Health Examiners requires all behavioral health licensees to report at least three hours of continuing education in cultural competency and diversity for each license period. [18]

Recommendations:

ADHS and AHCCCS should partner with the Arizona Hospital Associations, the Arizona Perinatal Trust, and the major licensing boards of professionals who serve the perinatal population to evaluate and enhance the current cultural competency training for hospital and clinic staff. This evaluation should include: 1) Determining the process for annual refreshers for existing staff and training for new staff; 2) Consideration of the utilization of one or more of the training courses listed above; and 3) Understanding that each community has its own culture, language, strengths, and assets, and that the adaptations to the referenced training may be needed depending on the tribal nation where services are provided.

[18] "Article 8 License Renewal and Continuing Education." *Arizona Board of Behavioral Health Examiners*, 3 Jan. 2021, https://www.azbbhe.us/pdfs/ARTICLE%208.pdf#:~:text=A%20minimum%20of%20three%20clock%20hours%20of%20continuing,of%20the%20three%20clock%20hour%20Arizona%20Statutes%2FRegulations%20Tutorial. Accessed 28 Dec. 2022.

IV. Expand Maternal Peer Support Coverage

Peer support provided by trained peer support specialists is a proven model for addressing perinatal behavioral health conditions.[19,20] Peer support specialists have their own story of behavioral health recovery and utilize their lived experience to help the people they serve and promote recovery-oriented environments. Peer support specialists collaborate with individuals and families during their recovery journey by sharing skills, coaching, and providing support.

In 2007, the Centers for Medicare and Medicaid Service (CMS) identified peer support services for mental health to be an evidence-based practice, which has been shown to:[21]

- Reduce symptoms and hospitalizations,
- Increase social support and participation in the community,
- Decrease lengths of hospital stays and costs of services,
- Improve well-being, self-esteem, and social functioning, and
- Encourage more thorough and longer lasting recovery.

Perinatal peer support differs from traditional peer support in that the perinatal peer support has received advanced training in perinatal mood and anxiety disorders, birthing support, and postpartum care and needs. Some perinatal peer support specialists are also credentialed doulas. Peer support services include, but are not limited to assistance with:

- Identifying needs and recovery goals,
- Lessening feelings of isolation,
- Increasing practical knowledge to access supports and resources in the community,
- Exploring continued education and/or employment opportunities,
- Partnering with other health care practitioners,
- Overcoming service barriers,
- Understanding and positively adapting to behavioral health challenges, and
- Support groups, coaching, role modeling, and mentoring.

Arizona has successfully implemented perinatal peer support programs, primarily supported through Medicaid funding. Some specific programs include the Center for Health and Recovery

[19] "Comparative Analysis of State Requirements for Peer Support Specialist Training and Certification in the United States." *Peer Recovery Now*, 2021, https://peerrecoverynow.org/documents/Final.Comparative.Analysis.pdf. Accessed 28 Dec. 2022.

[20] Singla, Daisy R et al. "Implementation and Effectiveness of Nonspecialist-Delivered Interventions for Perinatal Mental Health in High-Income Countries: A Systematic Review and Meta-analysis." *JAMA psychiatry* vol. 78,5 (2021): 498-509.

[21] "Evidence for Peer Support", Mental Health America, May 2019, https://mhanational.org/sites/default/files/Evidence%20for%20Peer%20Support%20May%202019.pdf. Accessed 28 Dec. 2022.

(CHR) and Women's Health Innovations of Arizona (WHI). The CHR program utilizes certified peers with specialized maternal mental health training, birth and postpartum doula credentials, and personal experience living, coping, and managing a mental health and/or substance use disorder. Perinatal peer support is offered to individuals with mental health and/or substance use disorders during all phases of their reproductive health, including perinatal periods.

WHI has also leveraged certified peers as part of their therapeutic team. WHI is a licensed outpatient treatment center that specializes in the support and treatment of perinatal mood and anxiety disorders. Certified peers at WHI receive weekly supervision, ongoing training, and support. Before the COVID-19 pandemic, peers were used at the bedside in the antepartum, postpartum, and NICU at various hospital systems to provide education, support, and resources to those parents at high risk for a perinatal mood and/or anxiety disorder. Peers continue to facilitate support groups within community partners and offer support, case management services, and a warm hand off to additional therapeutic interventions. This is significant as many cases of perinatal mood and anxiety disorders go untreated, resulting in long term consequences for the mother, children, and family system. Thus, this perinatal peer support model supported through WHI has improved access to care.

There are several other efforts underway to increase the availability of peer support in Arizona, including peer support programs at the University of Arizona to support training and stipends for those in rural and underrepresented areas. Additionally, AHCCCS received federal approval for the use of Mental Health Block Grant (MHBG) ARPA funding to expand the number of peer support services available, including additional perinatal mental health peer support positions at provider agencies and peer support training workforce development support.

Recommendations:

In addition to the workforce development efforts of certified perinatal peer support by AHCCCS, it is recommended that perinatal peer support coverage be expanded to commercial insurers in Arizona.

V. Expand Home Visitor Coverage

Maternal, infant, and early childhood home visiting is an evidence-based early intervention that can reduce or prevent the effects of adverse experiences during pregnancy and postpartum period, and for very young children and their families.[22] It is an intervention that recognizes parents or designated guardians as children's first educators, who may need additional support to improve their education, health, safety, and economic well-being. All home visiting models that are classified as evidence-based have been evaluated for replicability, with research standards including randomized controlled trials and longitudinal evaluations to evaluate multi-generational impact. They have demonstrated effectiveness at reducing child maltreatment, juvenile delinquency, family violence, and crime; and improving maternal and child health, child development and school readiness, positive parenting practices, families' economic self-sufficiency, referrals, and linkages to community providers.[23]

Evidence-based home visiting has demonstrated to be an optimal entry point along the continuum of care for home visitors to assess for anxiety, depression, substance misuse, and other contributors to perinatal mood and anxiety disorders both prenatally and through the 12 months after birth (the period of greatest risk for preventable maternal mortalities and severe maternal morbidities).[24,25,26] ADHS reported that from October 2019 to September 2020, 80% of the primary caregivers who were enrolled in early childhood home visiting services funded by federal Maternal, Infant and Early Childhood Home Visiting (MIECHV) dollars in Arizona were screened for depression. Evidence-based home visiting programs reduce socio-economic barriers to care and have been shown to yield cost savings to both state and federal government programs, including Medicaid. For instance, a 2005 Rand Corporation analysis found benefit-cost

[22] "Early Childhood Home Visiting Models: Reviewing Evidence of Effectiveness." *Administration for Children & Families, U.S. Department of Health & Human Services*, 2020. https://www.acf.hhs.gov/opre/report/home-visiting-evidence-effectiveness-review-brief-december-2020. Accessed 28 Dec. 2022.

[23] "Home Visiting Evidence of Effectiveness." *U.S. Department of Health & Human Services.* *https://homvee.acf.hhs.gov/outcomes*. Accessed 28 Dec. 2022.

[24] "Improving Maternal and Child Health Outcomes and Reducing State Costs." National Service Office for Nurse-Family Partnership & Child First, 2020, https://www.nursefamilypartnership.org/wp-content/uploads/2022/12/NFP-MCH-Improvements-within-Medicaid.pdf. Accessed 28 Dec. 2022.

[25] "The Arizona MIECHV Benchmark Report: Fiscal Year Summary Federal Fiscal Year (FFY) 2019-20". Arizona Department of Health Services, 2020, https://www.azdhs.gov/documents/prevention/womens-childrens-health/childrens-health/homevisiting/2020-az-miechv-benchmark-report.pdf. Accessed 28 Dec. 2022.

[26] Tandon, S Darius et al. "Formative evaluation of home visitors' role in addressing poor mental health, domestic violence, and substance abuse among low-income pregnant and parenting women." *Maternal and child health journal* vol. 9,3 (2005): 273-83.

ratios can range from $2.24 for every dollar invested to $5.70 when the Nurse-Family Partnership program is delivered to the highest-risk families.[27]

Enrollment in home visitation is voluntary; in communities where multiple home-visiting models are available, families can enroll in the program that best meets their needs. Each home visiting model has distinct characteristics, differs in the age of enrollment for families (ranging from pregnancy through early childhood), number and frequency of visits, and meets different families' or a particular population's needs in different ways. Similarly, the training and background of home visitors vary across different models, with home visiting professionals including nurses, social workers, and community health workers.

Historically home visitation programs have succeeded due to the threading of federal and state level policy and financing, and supplemental partnerships between public and private donors and stakeholders. In Arizona and across the nation, pregnant women or children enrolled in Medicaid are the primary recipients of home visitation programs. There are more than 20 states that have established structures utilizing Medicaid to finance, strengthen, and scale up home visiting with Idaho, Illinois, and North Dakota are three prime examples.[28]

Arizona has developed a statewide home visiting system, the Strong Families Arizona Home Visiting Alliance, which includes research-informed or promising practices, as well as evidence-based programs, to offer voluntary, high-quality early childhood home visiting services to families. This multi-model system responds to the diverse needs of Arizona's families, including the state's large rural areas and tribal communities.[29] Arizona's home-visiting models are operationalized by a diverse range of local implementing agencies, including the Arizona Department of Health Services (ADHS), the Arizona Department of Child Safety (DCS), community providers, county health departments, tribal and non-profit organizations. Similar to other states, supplemental funding sources are utilized to support home visiting, including public and private funds, state revenue through regional First Thing First (FTF) grants, and federal funding, such as Federal MIECHV funds.[30] The National Home Visiting Resource Center 2022 Yearbook reports 7,919 Arizona families were served and 96,568 home visits were conducted; it also indicated the need to expand home visiting to ensure 389,600 pregnant women and their families' who are eligible for home visiting services can access services.

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[27] Lynn A. Karoly, M. Rebecca Kilburn, Jill S. Cannon. "Benefit-Cost Results for Selected Early Childhood Intervention Programs in Early Childhood Interventions: Proven Results, Future Promise." RAND Corp, 2005, https://www.rand.org/content/dam/rand/pubs/monographs/2005/RAND_MG341.pdf. Accessed 28 Dec. 2022.

[28] "Medicaid Financing for Home Visiting: The State of States' Approaches." *Georgetown*, 2019, https://ccf.georgetown.edu/wp-content/uploads/2019/01/Medicaid-and-Home-Visiting.pdf. Accessed 28 Dec. 2022.

[29] "State Profile: Arizona, Home Visiting Yearbook, Early Head Start Home-Based Option." *National Home Visiting Resource Center*, 2021, https://nhvrc.org/state_profile/arizona-2021/. Accessed 28 Dec. 2022.

[30] "FY 2021 Maternal, Infant, and Early Childhood Home Visiting Awards." Health Resources and Services Administration, 2021, https://mchb.hrsa.gov/fy-2021-maternal-infant-early-childhood-home-visiting-awards#:~:text=In%20FY21%2C%20HRSA%20awarded%20%24342%2C246%2C049,Visiting%20Program%20(MIECHV%20Program). Accessed 28 Dec. 2022.

Recommendations:

1. Home visiting stakeholders collaborate with developers of home visiting models to incorporate universal screening and referral for mental and behavioral health needs and substance misuse as a standard practice in home-visiting models to improve the health, well-being, and life outcomes of pregnant people, parents, and children.

2. Reimburse early childhood home visitation services through AHCCCS, including securing a specific appropriation to meet the federally required state match. AHCCCS should collaborate with stakeholders to develop the AHCCCS Medical Policy Manual (AMPM) operational guidelines including provider qualifications, universal behavioral health screening, and referral for further assessment when indicated. In recognition of Arizona's diverse home visiting system, it is recommended that AHCCCS explore a SPA or other federal authority that may be necessary to authorize reimbursement for home visits delivered through both HomVEE-recognized evidence-based home visiting programs and research-informed home visiting programs like Arizona Health Start as has been approved in other states.

3. Allocate funding to expand home visiting services to more Arizona families. The appropriation should allow for expansion of both evidence-based and research-informed home-visitation services. This would increase the capacity for communities and organizations to extend home visiting services to more families that are not covered by AHCCCS.

VI. Expand Doula Coverage

Continuous labor support by a trained doula has proven benefits and is recognized as an effective strategy to improve maternal and infant health, enhance engagement, and satisfaction with maternity care, and reduce costs.[31] A birth doula is a trained professional who provides continuous support to their birthing client before, during and shortly after childbirth to help them achieve the healthiest, most satisfying experience possible. There are four different ways doulas can help support the birthing person: physical support, emotional support, childbirth preparation/information, and advocacy.

Rigorous studies show that doula care reduces the likelihood of such consequential and costly interventions as cesarean birth and epidural pain relief while increasing the likelihood of a shorter labor, a spontaneous vaginal birth, higher Apgar scores for babies, and a positive childbirth experience. Other studies suggest that doula support is associated with increased breastfeeding and decreased postpartum depression.[32] Providing doula labor support to birthing people is both low risk and highly effective at improving outcomes.

Because doula support increases the likelihood of vaginal birth, it lowers the cost of maternity care while improving women and infant health. Other factors associated with doula support that would contribute to cost savings include the reduced use of epidural pain relief and instrument-assisted births, increased breastfeeding, a reduction in repeat cesarean births, and associated complications and chronic conditions.[33]

Continuous labor support from a doula is especially vital for birthing BIPOC population. Black women are at the most risk for poor birth outcomes including higher rates of cesarean birth, preterm birth, low birth weight, and infant death. Doula support has the potential to reduce health disparities and improve health equity.[34] Doula programs in underserved communities have positive outcomes, but the persistent problem of unstable funding limits their reach and impact.[35]

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[31] Bohren, Meghan A et al. "Continuous support for women during childbirth." *The Cochrane Database of Dystematic Reviews* vol. 7,7 CD003766. 6 Jul. 2017.

[32] Wolman, W L et al. "Postpartum depression and companionship in the clinical birth environment: a randomized, controlled study." *American Journal of Obstetrics and Gynecology* vol. 168,5 (1993): 1388-93.

[33] Strauss, Nan et al. "Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health." *The Journal of Perinatal Education* vol. 25,3 (2016): 145-149.

[34] Giscombé, Cheryl L, and Marci Lobel. "Explaining disproportionately high rates of adverse birth outcomes among African Americans: the impact of stress, racism, and related factors in pregnancy." *Psychological Bulletin* vol. 131,5 (2005): 662-83. 2

[35] Thomas, Mary-Powel et al. "Doula Services Within a Healthy Start Program: Increasing Access for an Underserved Population." *Maternal and Child Health Journal* vol. 21, Suppl 1 (2017): 59-64.

In Arizona, the main barrier to accessing high-quality doula care is reimbursement for services. Currently, coverage for this service is not covered by AHCCCS or commercial plans. Senate Bill 1181 created a voluntary certification program for doulas within the Arizona Department of Health Services.[36] A.R.S. § 36-766(3) states a doula is "... a trained nonmedical professional who may provide continuous physical, emotional and informational support to families before, during and after childbirth for a period of one year after birth or in the case of loss and who may serve as a liaison between the birth parents and medical and social services staff to improve the quality of medical, social, and behavioral outcomes."

Recommendations:

Following ADHS rule promulgation, doula services should be reimbursed for state-certified doula services through commercial insurers and AHCCCS, including securing a specific appropriation to meet the federally required state match for AHCCCS. It is recommended that AHCCCS explore a SPA or other federal authority that authorizes reimbursement for state-certified doula services and work with stakeholders to develop an AMPM service delivery model.

[36] "Senate Bill 1181." *Arizona Legislature*, https://www.azleg.gov/legtext/55leg/1R/laws/0282.pdf. Accessed 28 Dec. 2022.

VII. Expand Community Health Worker (CHW)/Community Health Representative (CHR) Coverage

Community Health Workers (CHWs) are frontline public health workers who have a deep understanding of the communities they serve and are trusted members of the community. The CHW movement has roots in Arizona from both the long history of Community Health Representatives (CHRs) in tribal communities dating back to the early 1960s, as well as the Promotora movement dating back to the Health Start/Un Comienzo Sano program in Yuma in the 1980s. CHWs use their understanding of the people and cultures in their community to address social determinants of health and make the local health system more responsive to the needs of each community, resulting in better health outcomes and reduced cost of care.

CHWs encompass many different job titles including CHRs, Patient Navigators, Promotores de Salud, Community Health Advisors, Midwifes, and Cultural Health Navigators. CHWs provide a variety of services, which are mostly aimed at helping individuals:

- Navigate a complex health care system,
- Receive preventive care (mammograms, cervical cancer screenings, and immunizations),
- Manage chronic illnesses (maintain healthy blood sugar levels, follow treatment plans, and lower blood pressure),
- Maintain healthy lifestyles, and
- Receive the health care they need in culturally and linguistically relevant ways.

CHWs may work under the Maternal Child Health (MCH) home visitor model under the Arizona Health Start Program, providing education, support, and linkages to care to pregnant and postpartum women with children up to the age of two.

In sustaining CHWs model nationally, the challenge is multifold, including developing a certification construct and the lack of funding mechanisms beyond short-term categorical grants from foundations and government agencies. To help address these concerns, in 2018 passed House Bill 2324[37] required ADHS to establish qualifications, a scope of practice, and core competencies to certify CHWs in Arizona. The ADHS Special Licensing Department began accepting CHW certification applications in November 2022. As of December 23, 2022, ADHS has awarded 29 CHW certifications of the 51 applications received.

[37] "House Bill 2324." *Arizona Legislature*, https://www.azleg.gov/legtext/53leg/2R/laws/0300.pdf. Accessed 28 Dec. 2022.

Additionally, for AHCCCS to be able to reimburse using Medicaid funding for CHW services, a State Plan Amendment (SPA) was submitted to CMS in December 2022[38] which includes the provision for coverage of certified CHWs acting within their scope of practice as defined in state law to provide AHCCCS-covered patient education and preventative services. AHCCCS is actively working on how coverage of certified CHW services will be operationalized while awaiting CMS approval.

Recommendations:

It is recommended that AHCCCS continue to pursue coverage of CHW/CHR services, including monitoring the CMS SPA approval and operationalization of this benefit.

[38] "Arizona SPA # 22-0029." *Arizona Health Care Cost Containment System (AHCCCS)*, December 8, 2022, https://www.azahcccs.gov/Resources/Downloads/MedicaidStatePlan/Amendments/2022/SPA22-0029Submitted12922.pdf. Accessed 28 Dec. 2022.

VIII. Expand Traditional Healing Services Coverage

Each community has its own culture and language, and each has its strengths and assets. Overall, assets of tribal communities are rooted in healthy traditional values, practices, teachings, and stories that can create cultural protection and resiliency as well as community connections and support systems. Extended family and Tribal Elders, traditional teachings, and cultural restoration (mentors, crafts, stories, and language) are important strengths to build on.

Prior to the 1940s, more than 90% of births to women from the western Navajo reservation occurred outside of the hospital setting; however, due to assimilation efforts from the U.S. government, the responsibility of medical care for those residing on the Navajo reservation was assumed by the U.S. Indian Health Service (IHS) in the late 1950s. This resulted in a shift towards almost exclusively hospital births over the next 30 years and a loss of Indigenous knowledge regarding traditional Navajo in-home childbirth practices.[39] Now, over 60 years later, large disparities in maternal mortality rates are seen within Indigenous populations. A review of maternal deaths in Arizona from 2012 to 2015 found the maternal mortality rate for the Indigenous population of Arizona was 70.8 per 100,000 live births; this is over four times higher than the rate for White, non-Hispanic women at 17.4 per 100,000 live births.[40]

The disparities seen in Indigenous health have resulted from a combination of inequities within the commonly known social determinants of health coupled with factors specific to tribal communities. These factors relate to the historical traumas experienced by tribal communities, such as colonization and forced assimilation, which have resulted in a loss of language and culture and a disconnect from the land.[41] Additionally, and specific to maternal populations, a history of forced sterilization and infant separation has led to severe mistrust of the healthcare system by Indigenous women.[42] These findings have resulted in national efforts to address the unique challenges faced by tribal communities.

One effort underway is allowing and supporting tribal communities to connect back to their cultural roots through traditional healing practices, as the tribes have long recognized the contribution of healers and practitioners who are valued for their role in aiding the healing of the spirit, mind, and body. Traditional Indigenous notions of health encompass a much broader definition than that utilized by the biomedical model for health as they are rooted in beliefs of

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[39] Begay, R. Cruz. "Changes in Childbirth Knowledge." *The American Indian Quarterly*, vol. 28 no. 3, 2004, p. 550-565. *Project MUSE*,

[40] "Arizona Maternal Mortality Review: Program Report 2012-2015." Arizona Department of Health Services (ADHS), Office of Injury Prevention, 2019, https://www.azdhs.gov/documents/prevention/womens-childrens-health/reports-fact-sheets/maternal-mortality-review-2012-2015.pdf. Accessed 28 Dec. 2022.

[41] King, Malcolm et al. "Indigenous health part 2: the underlying causes of the health gap." *Lancet (London, England)* vol. 374,9683 (2009): 76-85.

[42] "Safe Motherhood: Maternal Mortality in Indian Country." National Indian Health Board (NIHB), 2020, https://www.nihb.org/public_health/maternal_mortality.php. Accessed 28 Dec. 2022.

balance and harmony between the four elements of life (physical, emotional, mental, and spiritual) which extend past the individual and are interlaced amongst others, their community, and the spirit worlds in order to achieve good health and healing.

In 1978, with the passage of the American Indian Religious Freedom Act, IHS policy required their Service Units to comply with patients' requests for the services of native practitioners, to provide a private space to accommodate the services, and required the staff to be respectful of individual religious and native beliefs. In 1994, IHS updated the policy, indicating that IHS would facilitate access to traditional medicine practices recognizing that traditional health care practices for many patients contribute to the healing process and help patients maintain their health and wellness.

Traditional healing services have not historically been approved as covered Medicaid services, even though they are promoted in the Indian Health Care Improvement Act and by IHS. Over the years, the provision of traditional healing services has been supported primarily through tribal funds, various pilot programs, grants, and individual personal resources. In order to address the sustainability for coverage of traditional healing services, AHCCCS has included traditional healing services in the latest waiver Demonstration Renewal Proposal.[43]

Recommendations:

It is recommended that AHCCCS continue to pursue coverage of traditional healing services, including monitoring the CMS Waiver approval and AHCCCS operationalization of this benefit consistent with the proposed waiver.

[43] "Arizona's Demonstration Project Renewal Application, 2021-2026." *Arizona Health Care Cost Containment System (AHCCCS)*, December 21, 2020, https://www.azahcccs.gov/Resources/Downloads/1115Waiver/AZ_Final_1115WaiverRenewalPacket.pdf. Accessed 28 Dec. 2022.

IX. Expand Lactation Support Coverage

The American Academy of Pediatrics recommends that new mothers breastfeed exclusively for six months, and continue breastfeeding with the addition of complementary foods for two years and beyond.[44] While 85% of Arizona's new parents start out breastfeeding, by six months, only 58% are still breastfeeding, and these numbers drop to just forty percent at one year.[45] The total medical costs of suboptimal breastfeeding rates in the United States has been estimated at three billion dollars.[46] Studies indicate that breastfeeding is a protective factor against the onset of depressive symptoms in the mother, and that breastfeeding interruption is a stressor involved in the development of the disorder.[47,48] A large population-based study conducted in 2021 demonstrated that breastfeeding is associated with lower rates of depressive symptoms, and the longer a woman breastfed her infant, the lower her risk of postpartum depression.[49]

Breastfeeding is not always easy to initiate or maintain. Most new mothers are discharged from the hospital 24 hours after birth, yet they experience breastfeeding challenges such as difficulty latching, pain, mastitis, low milk supply, and inadequate weight gain in their infants in the first six weeks to twelve months postpartum, when they are no longer under the care of the hospital. Breastfeeding failure due to lack of support places additional mental and physical health burdens on low income mothers, increasing their risk of depression, type 2 diabetes, and obesity.[50] A recent Cochrane systematic review found that when multiple postpartum breastfeeding support visits are offered to women, the duration and exclusivity of breastfeeding increases; support is particularly effective in reducing the number of women who stop breastfeeding at the three to four month and six month timepoints.[51] Clinical breastfeeding support and management is the purview of the International Board Certified Lactation Consultant (IBCLC), who must complete college courses in counseling, anatomy, and medical terminology, 90 hours of lactation specific

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[44] Meek, Joan Younger et al. "Policy Statement: Breastfeeding and the Use of Human Milk." *Pediatrics* vol. 150,1 (2022): e2022057988. 8

[45] "Breastfeeding Report Card." *Centers for Disease Control (CDC)*, 2022, https://www.cdc.gov/breastfeeding/data/reportcard.htm. Accessed 28 Dec. 2022.

[46] Porter, Elisa et al. "Perinatal maternal mental health and infant socio-emotional development: A growth curve analysis using the MPEWS cohort." *Infant behavior & development* vol. 57 (2019): 101336.

[47] Borra, Cristina et al. "New evidence on breastfeeding and postpartum depression: the importance of understanding women's intentions." *Maternal and child health journal* vol. 19,4 (2015): 897-907.

[48] Pope, Carley J, and Dwight Mazmanian. "Breastfeeding and Postpartum Depression: An Overview and Methodological Recommendations for Future Research." *Depression research and treatment* vol. 2016 (2016): 4765310.

[49] Toledo, Christine et al. "The significance of breastfeeding practices on postpartum depression risk." *Public health nursing (Boston, Mass.)* vol. 39,1 (2022): 15-23.

[50] Bartick, Melissa C et al. "Suboptimal breastfeeding in the United States: Maternal and pediatric health outcomes and costs." *Maternal & child nutrition* vol. 13,1 (2017): e12366.

[51] Gavine, Anna et al. "Support for healthy breastfeeding mothers with healthy term babies." *The Cochrane database of systematic reviews* vol. 10,10 CD001141. 25 Oct. 2022.

education, a year or more of hands on clinical training, and pass an international exam to receive this credential.[52] As of March 2022, Arizona has 396 IBCLCs.[53] An estimated 200 Arizona IBCLCs are currently practicing clinically outside of hospital settings.[54]

Federal Law mandates that all private insurers provide breastfeeding support and counseling as well as breastfeeding equipment without cost sharing to all new mothers for as long as they breastfeed.[55] Insurance coverage of breastfeeding support reduces overall dependence on and costs of infant formula, as well as reduces parental stress and anxiety when shortages occur.[56]

Currently, AHCCCS does not cover breastfeeding support and counseling as a separate billable service outside of the hospital stay.[57] While many AHCCCS participants qualify for the Women Infants and Children's Program (WIC), this program was primarily created to provide nutrition assistance for pregnant women and children 5 years of age and under. In Arizona, WIC agencies lack the funding, capacity, or clinical expertise to provide clinical breastfeeding support to all WIC participants. In several Arizona counties, a single contracted IBCLC is responsible for all WIC participants. As a result, only 30.4% of Arizona WIC participants report any breastfeeding, and 69.9% report fully formula feeding.[58]

Recommendations:

Separately reimburse the IBCLCs for breastfeeding support and counseling services in the outpatient setting through the Current Procedural Terminology (CPT©) office visit and home visits codes. This requires securing a specific appropriation to meet the federally required state match for AHCCCS. It is recommended that AHCCCS explore a SPA or other federal authority that may be necessary to authorize reimbursement for lactation support services and work with stakeholders to develop an AMPM service delivery model.

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[52] Office of the Surgeon General (US), et al. *The Surgeon General's Call to Action to Support Breastfeeding*. Office of the Surgeon General (US), 2011.

[53] "Current Statistics on Worldwide IBCLCs." *International Board of Lactation Consultant Examiners*, 2022, https://iblce.org/about-iblce/current-statistics-on-worldwide-ibclcs/. Accessed 28 Dec. 2022.

[54] "2019 Lactation care provider demographics." *United States Lactation Consultant Association*, 2020, https://iblce.org/about-iblce/current-statistics-on-worldwide-ibclcs/. Accessed 28 Dec. 2022.

[55] Toledo, Christine et al. "The significance of breastfeeding practices on postpartum depression risk." *Public health nursing (Boston, Mass.)* vol. 39,1 (2022): 15-23. 9

[56] Asiodu, Ifeyinwa V.. "Infant Formula Shortage: This Should Not Be Our Reality." *The Journal of perinatal & neonatal nursing* vol. 36,4 (2022): 340-343.

[57] "Medicaid Coverage of Pregnancy and Perinatal Benefits: Results from a State Survey." *Kaiser Family Foundation*, Gifford, K. , Walls, J. , Ranji, U , Salganicoff, A and Gomez, I, 2017, https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-and-perinatal-benefits-survey-results/. Accessed 28 Dec. 2022.

[58] "Fiscal Year 2021 WIC Breastfeeding Data Local Agency Report." *U.S. Department of Agriculture, Food and Nutrition Service*, 2021, https://fns-prod.azureedge.us/sites/default/files/resource-files/FY2021-BFDLA-Report.pdf. Accessed 28 Dec. 2022.

X. Increase Postpartum Support International (PSI) Certified Perinatal Mental Health Providers

It is essential for providers who serve perinatal conditions to understand the unique therapeutic needs of this population, as the application of inappropriate and/or ineffective therapy types can contribute to adverse maternal outcomes. Likewise, it is essential for prescribers working with the perinatal population to have specialty training or access to specialty trained perinatal psychiatrists due to the additional risks of psychotropic prescribing during pregnancy and breastfeeding. Unfortunately, behavioral health providers typically receive limited perinatal mental health training.

Postpartum Support International (PSI) is the world's largest non-profit organization dedicated to helping women and families suffering from perinatal mood and anxiety disorders, including postpartum depression, the most common complication of childbirth. The challenge most frequently encountered by PSI is women and families' access to quality treatment by trained professionals for perinatal mental health conditions. To address this need, PSI offers a comprehensive perinatal mental health training and certification program for providers.[59]

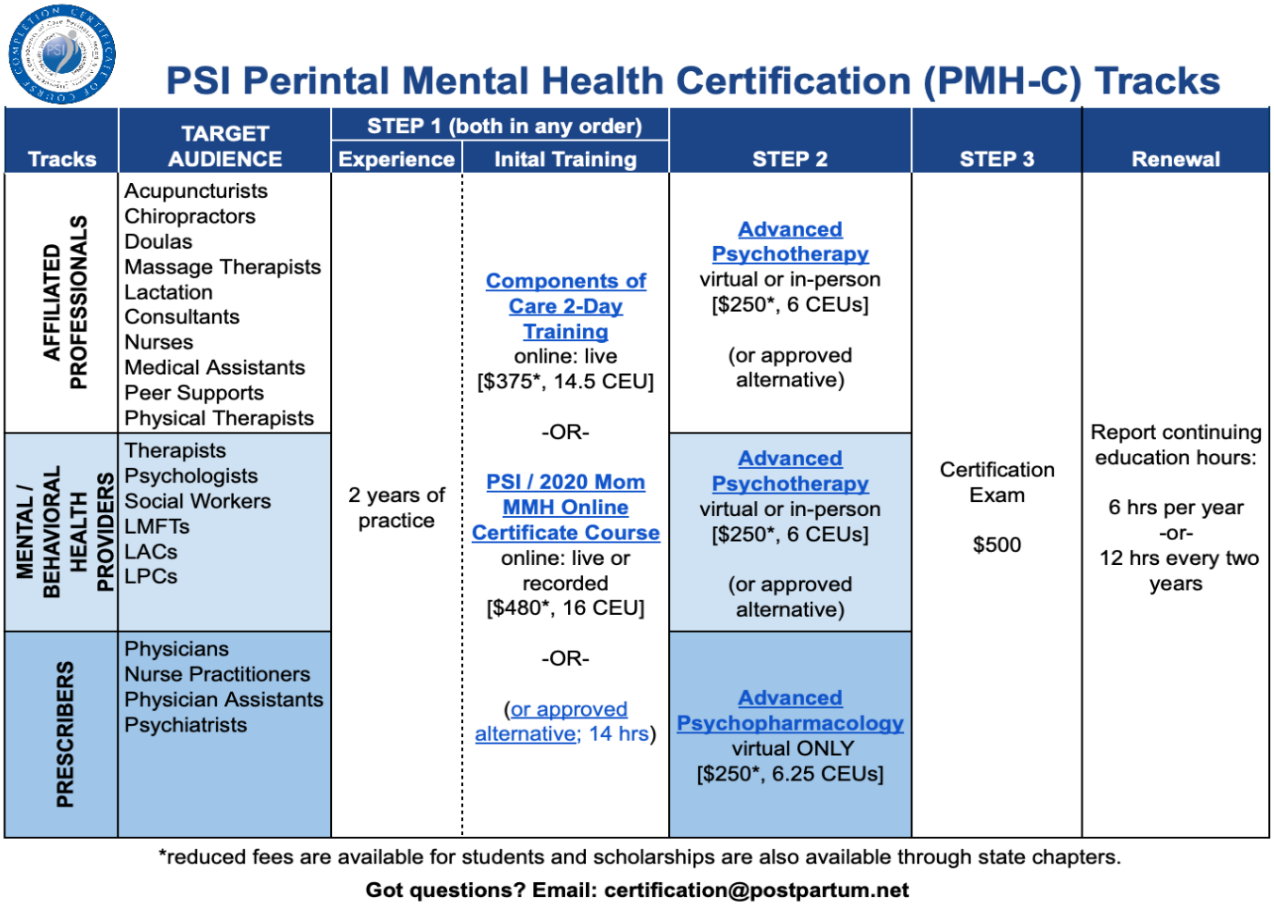
The PSI certification in perinatal mental health creates a structure for professional education, evaluation, standardized training, and experience to inform the community and payers of perinatal mental health specialists. The certification curriculum requirements are built on existing evidence-based perinatal mental health certificate training, adding an advanced training component. Before approval to take the certification exam, candidates must meet all minimal requirements outlined in Table II.

Only six of Arizona's 15 counties have providers with the Perinatal Mental Health Certification (PMH-C); specifically, Coconino, Navajo, Pinal, and Yavapai counties each have one provider whereas Maricopa County has 48 providers and Pima County has five providers. Even in Maricopa County, where the majority of PMH-Cs are located, there are less than one-third of the needed PMH-Cs available to care for pregnant and postpartum mothers based on the 2019 number of births (50,998).[60] It is estimated that there is a 20% prevalence of perinatal mood and anxiety disorders, and the suggested caseload of 55 patients per PMH-C.

[59] "Certificate Trainings." *Postpartum support international*, https://www.postpartum.net/professionals/certificate-trainings/. Accessed 28 Dec. 2022.

[60] "Number of Births by Year and County of Residence." *Arizona Department of Health Services (ADHS), https://pub.azdhs.gov/health-stats/report/ahs/ahs2019/pdf/5b3.pdf.* Accessed 28 Dec. 2022.

Table II. PSI Perinatal Mental Health Certification (PMH-C) Tracks



PSI Perintal Mental Health Certification (PMH-C) Tracks

Tracks	TARGET AUDIENCE	STEP 1 (both in any order)		STEP 2	STEP 3	Renewal
		Experience	Inital Training			
AFFILIATED PROFESSIONALS	Acupuncturists Chiropractors Doulas Massage Therapists Lactation Consultants Nurses Medical Assistants Peer Supports Physical Therapists	2 years of practice	Components of Care 2-Day Training online: live [$375*, 14.5 CEU] -OR- PSI / 2020 Mom MMH Online Certificate Course online: live or recorded [$480*, 16 CEU] -OR- (or approved alternative; 14 hrs)	Advanced Psychotherapy virtual or in-person [$250*, 6 CEUs] (or approved alternative)	Certification Exam $500	Report continuing education hours: 6 hrs per year -or- 12 hrs every two years
MENTAL / BEHAVIORAL HEALTH PROVIDERS	Therapists Psychologists Social Workers LMFTs LACs LPCs			Advanced Psychotherapy virtual or in-person [$250*, 6 CEUs] (or approved alternative)		
PRESCRIBERS	Physicians Nurse Practitioners Physician Assistants Psychiatrists			Advanced Psychopharmacology virtual ONLY [$250*, 6.25 CEUs]		

*reduced fees are available for students and scholarships are also available through state chapters.

Got questions? Email: certification@postpartum.net

Recommendations:

1. It is recommended that ADHS continue to provide scholarships and incentives for perinatal mental health certification to perinatal and pediatric health care providers, including nurse practitioners and other prescribing clinicians.

2. It is recommended that AHCCCS and commercial insurers recognize perinatal mental health as a specialty for purposes of behavioral health provider capacity development and network requirements.