



King County

Department of Community and Human Services

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FINAL PROCUREMENT PLAN

Veterans and Human Services Levy: 4.2

Piloting New Services for Maternal Depression in Community Health Centers, Public Health Centers, and Other Safety Net Clinics

1. Goal (Overarching Investment Strategy)

The Veterans & Human Services Levy Service Improvement Plan (SIP) outlines strategies to meet critical needs for families at risk. Many families in King County face circumstances that put them at increased risk of homelessness and involvement in the child welfare, treatment or justice systems. Other children are at risk because their mothers are young, are single and/or have limited social and family support, have low-incomes, and are struggling to secure the necessities of life for themselves and for their children (page iv of SIP).

2. Objective (Specific Investment Strategy)

Depression – one of the most prevalent and disabling mental illnesses in the U.S. – is twice as likely to affect women as men, with rates of major depression peaking during women’s childbearing years. Research has demonstrated that maternal depression can affect parenting behaviors and, ultimately harm children’s health and development.¹

The Veterans & Human Services Levy Service Improvement Plan (SIP) suggests piloting initial investment strategies to address maternal depression in five or more sites, to be integrated and coordinated with the overall Levy investment in integrated behavioral health services in safety net primary care (page 24 of SIP).

3. Population Focus

The Levy Service Improvement Plan focuses strategies to strengthen families at risk, including:

- Young first-time mothers,
- Single parents exiting the criminal justice system, and
- Recent immigrant mothers who are isolated from services and face linguistic and/or cultural barriers to participation in community life.

¹ McLearn, K et al. “The Timing of Maternal Depression Symptoms and Mothers’ Parenting Practices with Young Children: Implications for Pediatric Practice.” *Pediatrics*, 2006; e174-e182. Available online at www.pediatrics.org/cgi/doi/10:1542/peds.2005-1551.

Depression symptoms and other mood disorders are common in pregnant women and women with young infants and children. In most recent studies, depression was most frequently reported by mothers who are less than 20 years of age, low-income, nonwhite, Hispanic, not living with the child’s biological father, and had less than a high school education.² As many as 13 percent of women experience major or minor depression during the perinatal period,³ and estimates of the overall prevalence of depression among mothers of young children range from 12 percent to 50 percent.⁴ The most significant recent study estimated that 17 percent of women with young children have elevated depressive symptoms, with six percent of those women exhibiting severe depression. Of those with elevated symptoms, almost half continued to have persistent symptoms at one-year follow-up.⁵

Depression, anxiety and other mood disorders are most persistent in situations where women face financial difficulties, are experiencing high family conflict including domestic violence, have poor physical health, and live in circumstances in which they have little family and social support. Persistent symptoms are also associated with low-income status and low educational attainment.

4. Service Needs and Populations to Be Served

Demographics of Target Population

In 2005, a total of 8,364 low-income Medicaid-covered women gave birth in King County, representing almost 38 percent of all King County births.⁶ Around 30 percent of this group did not graduate from high school; only 47 percent were married. Racial /ethnic distribution is described in the following table:

Race / Ethnicity of King County Births Covered by Medicaid, 2005			
White	33.9%	Asian	12.4%
Hispanic	28.5%	Hawaiian/PI	2.3%
Black	13.9%	Multiracial	4.5%
Native American	1.4%	Unknown	3.2%

Source: *First Steps* Database, Washington State DSHS Research and Data Analysis Unit

Black, including African American and East African, and Hispanic women are disproportionately represented among low-income King County mothers:

- Hispanic women comprised 14 percent of King County women who gave birth in 2005, but represented 29 percent of women whose births were covered by Medicaid.
- Black women comprised seven percent of King County women who gave birth in 2005, but represented 14 percent of women whose births were covered by Medicaid. No

² Ibid.

³ Perinatal Depression: Prevalence, Screening Accuracy, and Screening Outcomes. Evidence Report / Technical Assessment No. 119. AHRQ: US DHHS. Available online: <http://www.ahrq.gov/downloads/pub/evidence/pdf/peridepr/peridep.pdf>

⁴ Wassel, R. “Maternal Depression: A Review of the Literature.” Prepared for Health Start Bureau, US Depart. Of Health and Human Services (Washington DC: US DHHS 2000.).

⁵ Horwitz, S et al. ‘Prevalence, Correlates, and Persistence of Maternal Depression.’ *Journal of Women’s Health*. 2007. 16(5) 678-691.

⁶ *First Steps* Database, Washington State DSHS Research and Data Analysis Unit

breakout is available for East African-born mothers as compared to African American mothers.

Births to immigrant and refugee women comprised 30 percent of all Medicaid-covered births in 2006. Hispanic women accounted for an overwhelming majority (70 percent) of these births, and women from countries of Asia accounted for around 16 percent of these births. The highest proportions of births to non-citizens were reported in neighborhoods surrounding the White Center Community Service Office or CSO (16 percent), Rainier Valley CSO (15 percent), and South King County CSO (14 percent).⁷

Mothers at risk of depression live in every community in King County. The largest numbers of women at risk reside in south King County and south Seattle neighborhoods, but families at risk also live on the eastside and in the north end, notably in the Crossroads area and Shoreline communities.

Table 1 summarizes countywide distribution of Medicaid-covered births to the low-income maternal population that is at particularly high risk of depression. Of 5,956 births in 2004, a significant majority (65 percent) of Medicaid mothers resided in south King County communities. Another 12 percent resided in east and north King County and 23 percent resided in Seattle neighborhoods.

Table 1: 2004 Births to King County Women Covered by Medicaid

Health Planning Areas	Number of Births Medicaid-Covered Mothers
South King County	
Burien, Des Moines/Normandy Park, Tukwila/SeaTac, White Center/Blvd. Park	1,154
Kent, Covington, Maple Valley	967
Auburn, Southeast King County	713
Renton, Cascade/Fairwood	570
Federal Way	446
<i>South King County - Total 2004 Births</i>	<i>3,850 (64.6%)</i>
Seattle	
Ballard, Fremont/Green lake, Shoreline, North Seattle, NE Seattle, NW Seattle	546
Beacon Hill, Georgetown, South Park, Southeast Seattle	338
Downtown, First Hill, West Seattle, Delridge	508
<i>Seattle - Total 2004 Births</i>	<i>1,392 (23.4%)</i>
East & North King County	
Bellevue, Issaquah, Sammamish	415
Bothell, Northshore, Kirkland	299
<i>East & North King County - Total 2004 Births</i>	<i>714 (12 %)</i>
Total King County Medicaid-Covered Births, 2004	5,956 (100%)

Data Source: Washington State Department of Health Birth Certificate Data

⁷ CSO Profiles: Maternal Characteristics and Birth Outcomes for Community Service Offices, 1991-2004. Available at <http://www1.dshs.wa.gov/pdf/ms/rda/research/9/86.pdf>

In similar fashion, King County children living in poverty are also concentrated in south King County and south Seattle neighborhoods. Table 2 below describes the distribution and proportion of children living below 100 percent of the 2005 federal poverty guidelines (FPL). Over 46,000 King County children resided in households experiencing severe poverty in 2005, with household incomes equal to or less than the equivalent of \$12,830 for a family of two. A much larger number reside in households with incomes up to 250 percent of FPL – still well below the estimated living wage level for King County.

Table 2: Estimated Number of Children Living Below 100% FPL by County Region

King County Region	Number of Children (% KC Population)	Estimated Number (Percent) Children Living Below 100% FPL
South	161,555 (41%)	18,418 (11.4%)
East	101,635 (26%)	4,777 (4.7%)
Seattle	93,520 (24%)	13,560(14.5%)
North	33,936 (9%)	10,016 (6.2%)
Total	390,646 (100%)	46,771 (12%)

Data Source: Communities Count 2005, Public Health Seattle & King County

Need for Maternal Depression Screening and Intervention:

Pregnant women and mothers suffering from depression want the best for their children but anxiety, sadness, fatigue, and poor concentration affect their ability to care for themselves, their parenting ability and their relationships with family members. Research has shown that depression has many adverse and potentially adverse impacts on children and on parenting behaviors:⁸

- Mothers who reported depressive symptoms when their children were two to four months of age were less likely to engage in practices that are typically established early in a child’s life, such as the use of a car seat. Infants with depressed mothers may have difficulties forming emotional bonds and may become less responsive to caregivers and external stimuli.⁹
- Among mothers of toddlers, those with depressive symptoms were also less likely to initiate age-appropriate safety recommendations and development practices, such as using electric outlet covers and limiting television exposure.
- These mothers were also more likely to use harsh discipline and physical punishments with their toddler-age child. Their toddlers tend to exhibit attention problems and poor self-control.
- Effects of maternal depression do not necessarily dissipate or disappear as children reach school age. For school-age children and adolescents, maternal depression is associated with low self-esteem and problems in school; they are at higher risk of developing mental disorders themselves.

⁸ McLearn, K et al. “The Timing of Maternal Depression Symptoms and Mothers’ Parenting Practices with Young Children: Implications for Pediatric Practice.” *Pediatrics* 2006; e174-e182. Available at www.pediatrics.org/cgi/doi/10:1542/peds.2005-1551.

⁹ Center for Disabilities and Development, “Fact Sheet on Maternal Depression,” *EPSDT Care for Kids Newsletter* Spring 2000.

These studies underscore the importance of screening for maternal depression and intervening not only during the prenatal period but also during a woman’s first three years in the parenting role. Comprehensive analyses with diagnostic interviews showed that the prevalence of major depression is the same for postpartum women as for many other women with children.¹⁰ Nearly as many mothers of children who are 2.5 to 3 years of age reported depressive symptoms as those reporting depressive symptoms when their children were two to four months old.¹¹ To prevent negative consequences of depression for mothers and their children, screening and treatment for maternal depression must continue well beyond the immediate postpartum period.

Few surveys or evaluations have been conducted, but there is widespread agreement that pregnant women and mothers of young children are seldom screened for depression or other mental health concerns. However, Washington State’s *First Steps* Maternity Support Program in collaboration with the University of Washington School of Nursing will soon offer new resources and training in screening and supportive strategies for providers in maternity support programs.¹²

The Levy Strategic Improvement Plan (SIP) recognized that a significant challenge for King County is the lack of access to behavioral health services, especially for individuals who are not eligible in the public mental health system (page 22 of SIP). Washington State’s Medicaid plan covers prenatal care and family planning for up to twelve months following delivery, but mental health evaluation and intervention are rarely available to pregnant women and new mothers covered by Medicaid. Under the current state formula for funding Regional Support Network (RSN) services, RSN-supported community mental health agencies can offer limited to no access to outpatient mental health services for those who do not qualify for the Medicaid mental health benefit. Mothers who do not have severe mental illness will not qualify. Consequently, primary care and maternity support programs which already serve a significant number of at-risk, low-income mothers are ideally suited to pilot evidence-based and promising practices to meet these needs.

5. Funds Available

The Service Improvement Plan (SIP) establishes funding levels as follows:

Levy Funds Available by Year		
	2007 Funds	Annualized, 2008-2011
Human Services Levy	\$500,000	\$500,000

The SIP proposed \$500,000 annually to support services targeting low-income women at risk of maternal depression. In addition, this procurement plan proposes that \$500,000 in 2007 funds will be carried forward and divided over the remaining four years of the Levy, adding

¹⁰ Jellinek M; Patel, BP, Froehle, MC, Eds. “Bright Futures in Practice: Mental Health.” Vol. 1, Practice Guide. Arlington, VA: National Center for Education in Maternal and Child Health, 2002.

¹¹ Ibid.

¹² Barnard, Kathryn. “Perinatal Depression: Developing Professional Awareness of the Need to Help Women Speak Up.” *Northwest Bulletin: Family and Child Health*. 2007. 21(2) p. 14.

\$125,000 annually. This procurement plan proposes that total Levy funding for each year, 2008 through 2011, total \$625,000, to be budgeted as in the following table:

Total Levy Funds Proposed, 2008-2011	
	Annualized Funds + 2007 Carry-Forward
Annualized - Human Services Levy	\$500,000
2007 Carry Forward - Annualized	\$125,000
Annual Funding Available, 2008-2011	\$625,000

6. Program Description:

The proposed program design for this Levy investment calls for program pilots that would include the following three components:

- Promote maternal mental health through preventive interventions, especially during the perinatal period (i.e., throughout pregnancy and for twelve months postpartum).
- Implement universal, standardized screening for depression that is coordinated across maternity support programs and primary care, aimed at pregnant women and mothers of children, 0 to 3 years.
- Treat maternal depression and other mood disorders using the evidence-based, integrated behavioral health model.

Specific strategies for these program components are described in more depth below:

Solchany’s practice and intervention model to promote maternal mental health during pregnancy outlines appropriate competencies and tools for clinicians and other professionals in maternal-child health to assist mothers in preparation for mothering.¹³ This framework, developed by the University of Washington School of Nursing, provides guidelines and a series of interventions that support the eventual development of a nurturing mother-child relationship:

- Interventions address the physical, relational, psychological, and emotional health of mother and fetus/child.
- The framework provides a series of interventions that support the psychological course of pregnancy. Solchany’s interventions are adaptable to both prenatal primary care and prenatal education programs.
- Maternal support programs might partner with culturally and linguistically competent community partners to effectively pilot individual and peer group interventions among immigrant mothers-to-be, a target population among families at risk.

Numerous health services studies have recently evaluated the timing, feasibility and implications of depression screening in maternity services and primary care. For primary care clinicians, data are limited about when or how often to screen for maternal depressive symptoms or how to target anticipatory guidance that can address parental needs.¹⁴

¹³ Solchany, JE. “Promoting Maternal Mental Health During Pregnancy: Theory, Practice & Intervention. NCAST Publications.” Seattle, 2001.

¹⁴ McLearn, K et al. “The Timing of Maternal Depression Symptoms and Mothers’ Parentin Practices with Young Children: Implications for Pediatric Practice.” *Pediatrics*, 2006; e174-e182. Available at: www.pediatrics.org/cgi/doi/10:1542/peds.2005-1551.

- Researchers have concluded that screening is feasible during well child visits and did not require large amounts of time.
- The majority mothers with depressive symptoms have been found to be willing to discuss these concerns with their provider and are generally willing to consider treatment options if warranted.

The IMPACT behavioral health model, supported by the University of Washington Department of Psychiatry and Behavioral Sciences, is an evidence-based integrated, practice model that helps nursing and primary care providers and mental health providers collaborate successfully to treat depression in primary care clinics.¹⁵ This model is applicable to women with depression symptoms and other mood disorders, and will also be used in addressing the behavioral health needs of other Levy target populations.¹⁶ Key elements of the IMPACT model reflect the best practices in integrated behavioral health models, including:

- Behavioral health coordinators or clinicians (BHCs) provide consultation, support and assistance to primary care providers and their patients in order to address mental health and chemical dependency concerns, but without engaging clients in extended or specialized mental health treatment.
- Psychiatrists provide consultation to BHCs and primary care providers, but are not involved in direct patient care.
- Systematic diagnosis is based on the use of standardized screening and clinical assessment tools.
- All members of the primary care team use evidence-based treatment algorithms.
- Patient treatment and outcomes are tracked using registries and other information systems to allow for close follow-up.
- “Stepped care” protocols and guidelines are used to change the plan of treatment depending on patient outcomes.

7. Framework for Evidence-Based and Promising Practices

Integrated behavioral health models in primary care are based on evidence-based strategies and proven practices that have been shown in numerous studies and evaluations to improve clinical outcomes in depression. Gilbody’s 2006 cumulative meta-analysis of integrated care found that this treatment model is more effective than standard care in improving depression, in both the short and longer term.¹⁷ The Buncombe County, North Carolina, public health clinic demonstrated improved access to mental health services and reduced overall costs for clients with clinical depression, although these findings are not specific to maternal depression. An external evaluation found increases in mental functioning, reductions in the number of days of work or school missed; and increases in the number of depression-free

¹⁵ Information about this practice model is available at <http://impact-uw.org/>

¹⁶ For more detailed information about integrated practice models, see the draft procurement plan, “Increasing Access to Behavioral Health Services Available through Community Health Centers, Public Health Centers, and Other Safety Net Clinics.” Available online: <http://www.metrokc.gov/dchs/Levy/>

¹⁷ Gilbody, S, et al. “Collaborative Care for Depression: A Cumulative Meta-analysis and Review of Longer Term Outcomes.” *Archives of Internal Medicine*. 2006; 166:2314-2321.

days for clients. In addition, overall health care cost reductions of \$66 per patient per month were achieved.¹⁸

However, many practices and alternative strategies to identify and address maternal depression are relatively unstudied, and so constitute promising but as yet unproven intervention models. Recently two major health foundations, the Robert Wood Johnson Foundation and Grantmakers in Health (GIH), have targeted maternal depression for further exploration and investment.¹⁹ This procurement plan proposes to fund programs that utilize the four strategies framed and recommended by GIH. GIH strategies are organized into four types of intervention, as follows:

- Educate women about maternal depression. Although depression is relatively common, many women are not adequately prepared for this potential risk, do not recognize symptoms and/or know where help might be available. Education and health promotion strategies might be better incorporated into maternity support programs and through anticipatory guidance provided in prenatal care.
- Promote depression screening. Providers may fail to screen for or recognize signs of maternal depression or other mood disorders in a busy primary care or obstetric practice. As previously noted, data are limited about when or how often to screen or how to target anticipatory guidance. But numerous researchers have concluded that screening is feasible during nursing visits and well child visits, and does not require large amounts of time. Applicable clinical tools for depression screening already in use in King County include the Edinburgh Postpartum Depression Scale, the Patient Health Questionnaire (PHQ) - 2, and the PHQ - 9.
- Integrate behavioral health services into programs already serving women and children. The Service Improvement Plan (SIP) has recommended that criteria for sites selected for pilot interventions include the number of childbearing women in the target population that are served at the site and progress in implementing universal screening for mood disorders and domestic violence (SIP, page 24). Capacity to gather data is also important in order to evaluate the impact of interventions and apply course corrections as indicated. Pilots should also build upon behavioral health models that are already in place in King County health centers.
- Increase the availability of peer support for women who are experiencing depression. Peer support groups and other mechanisms that promote interpersonal support may be an effective and efficient mechanism to help depressed mothers share their experiences, expand social support networks, and receive emotional support as well as practical advice. Peer connections reduce isolation and help women deal with the stresses of parenting.

¹⁸ Mims, SJ. "A Sustainable Behavioral Health program Integrated with Public Health Primary Care." J Public Health Management Practice. 2006, 12(5), 456-461.

¹⁹ GIH Bulletin. "Issue Focus: Addressing Maternal Depression." October 18, 2004. Available online: http://www.gih.org/usr_doc/Addressing_Maternal_Depression.pdf

8. Coordination, Partnerships, and Alignment Across Systems

The health department has consulted with numerous parties, including health centers and other safety net clinics, suburban planners, DCHS program staff, and others, in framing this procurement plan. The proposed service strategy requires close coordination and partnership with numerous programs, including other Levy funded programs, which serve families at risk:

- Programs addressing maternal depression will be made available to and coordinated among community agencies that support low-income women during pregnancy and twelve months after birth through the Medicaid *First Steps* Maternity Support Program. *First Steps* services include nursing, nutrition, and social work services, and are provided by numerous community health centers, public health centers, and other safety net providers.
- The King County Children’s Health Initiative (CHI), launched in January 2007, provides private funding to develop innovative strategies to integrate behavioral health care for children into primary care. One of CHI’s goals is to pilot mechanisms to promote healthy social and emotional development among underserved King County children, 0 to 12 years. As CHI is targeting its interventions to the same family populations targeted by the Levy, CHI and Levy funds will be combined into one RFP process to simplify implementation of both programs and allow for more effective use of resources. This approach also has potential to leverage the program investments so that CHI and the Levy can achieve stronger, more family-focused outcomes.
- The Levy allocation plan provides \$493,000 per year investment in early childhood prevention and intervention services, to be administered by the King County Children and Family Commission, which resides at Public Health – Seattle & King County. Health promotion strategies, depression screening, and referrals for treatment will need to be coordinated with home visiting programs, in trainings for caregivers and staff that work with high-risk children and their families, and in expanded programs for immigrant and refugee families.
- The Levy allocation plan provides \$400,000 per year investment in expanding the health department’s Nurse Family Partnership Program. This proven program provides for home visits to low-income, first time young mothers who are at increased risk for poor birth outcomes and who face increased educational and economic challenges as parents. Program guidelines incorporate depression screening. With Levy support, this program will be available countywide for the first time; these home-based services will be aligned and coordinated with pilots in addressing maternal depression.
- Information about pilots should be widely disseminated and coordinated with programs that serve pregnant and parenting adolescents, including Renton Area Youth Services, Kent Youth and Family Services, Children’s Home Society, Southwest Youth and Family Services, El Centro De La Raza, Amara Parenting and Adoption Services, Highline School District, and school-based teen health centers in twelve Kent, Seattle and SeaTac high schools.
- DCHS Mental Health, Chemical Abuse and Dependency Services Division (MHCADS) administers state funding for the Regional Support Network (RSN), funds which are

contracted to numerous community mental health agencies. Health centers will need to strengthen working relationships with RSN agencies and may elect to contract with RSN agencies to provide behavioral health staffing, psychiatric back-up and other consultation to primary care teams managing maternal depression. The goal is to increase the availability of integrated / linked mental health services across a wider continuum of care – not to build a “parallel” system in health centers.

- Information about pilot programs will also be disseminated widely among programs that increase awareness and address issues around domestic violence. Linkages to evidence-based programs funded by the Children’s Trust / Washington Council for the Prevention of Child Abuse and Neglect can increase availability of support for women and leverage resources that are culturally targeted. Children’s Trust programs include agencies such as the Refugee Women’s Alliance, Friends of Youth, Children’s Home Society, and Martin Luther King Jr. Family Outreach Center that serve diverse populations.

9. RFP Process and Allocation of Funds

The allocation of funds will occur through a competitive Request For Proposals (RFP) process managed by Public Health – Seattle & King County. The PHSKC Community and School-Based Partnerships Program, which oversees other local investments in community health centers, public health centers, and other safety net clinics, will provide oversight, develop the RFP, provide staff support to RFP reviewers, and be responsible for all contracting and technical support functions related to these funds.

Reviewers will include representatives from the Levy Oversight Boards, Children and Family Commission, those with expertise in the implementation and delivery of evidence-based maternal and child health programs or behavioral health services, and those with expertise in the structuring of local safety net primary care services. The review team will be selected so as to also represent diverse backgrounds in culture, language, and specific program expertise.

The competitive RFP process for each investment area will include a written application, site visit and/or interviews with key management responsible for program implementation. One or more informational session/bidders’ conferences will be held for prospective applicants to ask questions and receive technical assistance.

As previously noted, \$625,000 is available each year to support strategies addressing maternal depression. This procurement plan proposed the following annual allocations of this Levy investment (also summarized in Table 3 below):

- A total of \$481,950 will be allocated for multi-year contracts to pilot strategies to prevent, identify and treat maternal depression.
 - In year 1 (2008), the RFP process will award five or more four-year grants to pilot strategies as described to address maternal depression among low-income pregnant women and mothers of children 0 to 12 years.
 - Contractors will be required to use all four strategies described at length in the framework for evidence-based and promising practices (see page 7). These include education, screening, peer support and interpersonal support, and integrated behavioral health services. This will assure that the full range of services is available in all pilots.

- Proposals to pilot culturally specific strategies to address the needs of low-income Hispanic mothers, low-income black mothers, or immigrant and refugee mothers are strongly encouraged. Many factors place these populations at disproportionately high risk in King County (see page 2).
 - Proposals that strengthen linkages, partnerships or service consortiums among maternity support programs and health centers or other safety net clinics are strongly encouraged.
 - Contractors must have the capacity to collect relevant data so as to participate fully in evaluation activities.
- A total of \$94,987 will support training and technical assistance to contractors and other maternal-child health providers by expanding capacity in the health department:
 - The health department will train and provide technical support to contractors' program staff, offer training to other health center staff, coordinate contractors' data collection for performance measurement, and assist in tracking of process and clinical outcomes.
 - Technical assistance and support will be available to contractors in start-up and implementation, and will be offered through a learning collaborative after programs are fully staffed.
 - The department will also disseminate pilot interventions to other programs and clinics serving high-risk mothers.
 - Funds will be set aside for training and technical assistance for two years, after which time contractors' continuing training and assistance needs will be evaluated. The health department will make a recommendation to DCHS and the oversight boards in July 2009 about whether these funds should continue to be used for contractors' training and support or can be used to expand pilot services.
- Public health indirect costs of \$48,069 will be covered at an indirect rate of 7.69 percent. The health department's role in piloting programs to address maternal depression will also include significant in-kind commitments of staff time and resources to guide implementation of this Levy investment in numerous clinics and communities, support mid-course corrections, and provide systems for data collection and reporting to be used for summary evaluative reports.

Table 3: Proposed Investment Areas and Funding, 2008-2011

Proposed Investment Areas	Annual Funding, 2008-2011
Pilot programs to address maternal depression: Contractors will include five or more agencies, partnerships or consortia among community health centers, public health centers and maternal/child programs	\$481,950 (77.11%)
Training, technical assistance, and support for implementation, performance measurement and quality improvement provided by the health department <ul style="list-style-type: none"> • Funds set aside for this purpose for two years 	\$94,987 (15.20%)
Health department indirect costs	\$48,069 (7.69%)
Proposed Total Annual Funding	\$625,000 (100%)

10. Geographic Coverage

As previously described, mothers at risk live in every community in King County. The largest numbers of women at risk reside in south King County, but families at risk also live in Seattle neighborhoods and on the eastside and the north end, notably in the Crossroads area and Shoreline communities.

Residency of high-risk mothers who delivered in 2004 whose deliveries were covered by Medicaid is described on Table 1, page 3. The table describes countywide distribution of low-income mothers who are at particularly high risk of depression.

11. Timeline

Table 4 below describes the anticipated timeline for program start-up and implementation.

Table 4: Addressing Maternal Depression, Timeline for First Year Activities

First Year Activity	2007 Q4	2008 Q1	2008 Q2	2008 Q3
Final review and approval of procurement plan by Levy Oversight Boards	X			
Release of RFP for Integrated Behavioral Health Services		X		
Complete review of proposals and final selection of programs		X		
Negotiation and complete contracts			X	
Program hiring and start-up by successful applicants			X	
Programs at full capacity				X

12. Leveraging Resources

Medicaid Administrative matching funds: Though difficult to estimate, a significant portion of the costs of Public Health staff time to support the planning and implementation of this program are eligible to receive matching federal funds. Medicaid match revenues will be

retained in the administrative budget and used to cover expenditures for program management, technical assistance, and program evaluation.

Other leveraging and in-kind support: The RFP will examine how applicants for funding might propose to leverage additional federal, state, local government and private foundation support. In addition, some health centers have been able to enhance behavioral health resources by incorporating professional internships and psychiatric rotations, in collaboration with the University of Washington.

13. Disproportionality in Access to Behavioral Health

Unmet behavioral health needs are especially high among racial and ethnic minorities. The 2001 report of the Surgeon General found that, compared to other groups nationwide, and despite having similar rates of mental illness over all common mental health diagnoses, minorities are less likely to receive needed care or are more likely to receive poorer quality care.²⁰ Some examples of disparities cited include:

- The percentage of African Americans receiving care is only half that of non-Hispanic whites.
- Among Hispanic/Latino Americans with a mental health concern, fewer than 1 in 11 contact a mental health specialist for care.
- A large study of Asian Americans/Pacific Islanders found that only 17 percent of those experiencing mental health problems sought care.

Researchers have only recently started to examine racial, ethnic, and birthplace-specific prevalence estimates of maternal depression. A 2006 study reports that minority mothers with depressive symptoms and foreign-born mothers with depressive symptoms were about twice as likely not to think they need help and 2.5 times more likely to lack access to any mental health care, compared to non-Hispanic white mothers and US-born mothers.²¹

14. Disproportionality Reduction Strategy

Barriers to behavioral health care are complex and include a lack of available providers and services, as well as issues of language, culture, and stigma. Stigma surrounding mental health services may prevent individuals from seeking care, and has been well documented in studies among minorities. Mental health is not an issue that is easy to discuss for immigrant and refugee families; in many cultures, therapy may be a foreign concept. In some cultures, manifestation of mental illness often occurs through psychosomatic symptoms and diagnosis is more likely to be delayed if not missed entirely.

Applicants in the RFP process will be asked to demonstrate partnerships with culturally relevant community-based agencies where appropriate. A significant body of literature has documented that services provided by persons speaking the clients' native language and knowledgeable of the customs and belief systems of that culture are far more effective than

²⁰ USPHS Office of the Surgeon General (2001). "Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General." Rockville, MD.

²¹ Huang ZJ et al. "Depressive Symptomatology and Mental Health Help-seeking Patterns of U.S.- and Foreign-born Mothers." *Maternal and Child Health Journal Online First*, published online December 15, 2006. <http://springer.metapress.com/content/a715m0580l24123g/fulltext.pdf>.

mainstream services. For example, a recent pilot study evaluated culturally relevant interpersonal psychotherapy in a primary care setting for African American and white low-income women with perinatal depression; findings suggested that depression was ameliorated and women were also more likely to access and engage in mental health services when treatment was provided in this context.²²

15. Cultural Competency

Successful applicants in the RFP process will need to demonstrate strong mechanisms to ensure cultural and linguistic competency, an area that is already of foremost concern to King County's core safety net clinics and maternity support programs. Applications from partnerships that include culturally relevant community-based agencies where appropriate will be strongly encouraged.

Proposals to pilot culturally specific strategies to address the needs of low-income Hispanic mothers, low-income black mothers, or immigrant and refugee mothers are also strongly encouraged. Many factors place these populations at disproportionately high risk in King County (see page 2).

Every contractor will be required to propose one or more specific contract deliverables that are responsive to the cultural context of the diverse family populations they intend to serve. For example, a health care agency or consortium focusing on services to Hispanic/Latino mothers might propose and implement a new partnership with a licensed mental health provider that has a track record of cultural and linguistic competency among Hispanic populations. Another example that might be more appropriate for some agencies might be implementation of selected standards and best practices of the National Standards on Culturally and Linguistically Appropriate Services (CLAS).²³ The CLAS standards are primarily directed at health care organizations, but implementation is in partnership with the communities being served.

Safety net programs hire many bilingual/bicultural staff and their comprehensive services are well designed to deal with the complexities and challenges of serving diverse populations. Consequently they are uniquely suited to provide and expand their behavioral health services for the high-risk populations identified by the Service Improvement Plan.

16. Dismantling Systemic and Structural Racism

The health department works internally and with its safety net contractors to increase awareness of racism as a core determinant of health through training opportunities. Racial discrimination in health care delivery, financing, and research continues to exist and racial barriers to quality health care manifests in a number of ways including: access to primary

²² Grote, NK et al. "Feasibility of Providing Culturally Relevant, Brief Interpersonal Psychotherapy for Antenatal Depression in an Obstetrics Clinic: A Pilot Study." *Research on Social Work Practice*. 2004. Vol. 14, no. 6, p. 397-407.

²³ Information on CLAS and best practices is available at the following websites:

<http://xculture.org/research/downloads/CLAS.pdf>

<http://www.omhrc.gov/templates/browse.aspx?lvl=1&lvlID=3>

care, access to insurance coverage, diagnosis and treatment, and provider decision-making.²⁴ Some researchers have noted that, in many instances, disparities in diagnosis and treatment do not reflect conscious racial bias, but are a stereotyping response that can occur as a result of time pressures in office visits and providers' need for cognitive multi-tasking.²⁵

Applicants to the RFP will be asked to describe their agency's strategies in addressing systemic racism through policies and in staff training and support. Aspects of the integrated, behavioral health model also help to address some concerns:

- Providing a significant level of evidence-based consultative support to maternal/child providers and primary care providers helps to offset some of the typical pressures of managing diverse clients challenged by complex health needs and stressful parenting circumstances.
- The IMPACT practice model requires use of evidence-based decision-making and standardized treatment plan algorithms, well coordinated through the primary care team. This improves clinicians' ability to apply the results of applicable research for minority patients, whenever relevant research exists.
- Public health /community health nurses and behavioral health clinicians have experience working with a range of community agencies and resources, and can link clients to culturally relevant services where useful and appropriate.

17. Improvement in Access to Services

The proposal to pilot a number of service delivery strategies will help to make services available to high-risk mothers countywide and build a better understanding of needs and service gaps, particularly in suburban cities. Factors such as population demographics and services already available in a community will be taken into consideration in awarding Levy funds. Data on recent Medicaid births summarized in Table 1, page 3, suggest geographic areas of particular concern:

- Around two-thirds of mothers at high risk reside in south King County.
- Around 24 percent of mothers at risk are widely distributed in Seattle neighborhoods.
- A smaller number of families at risk are concentrated in the Crossroads area and in Shoreline.

18. Outcomes

This Levy investment will support high-risk families by piloting and evaluating strategies to prevent, identify and treat maternal depression among King County mothers. This will be accomplished by providing support for staffing models that increase access to medical, mental health and chemical dependency services for low-income mothers who lack Medicaid mental health benefits or other coverage options. Five or more community health centers, public health centers and maternal/child programs will receive funding to develop programs, in coordination with behavioral health services already offered in many safety net clinics.

²⁴ Nelson, A. "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," JAMA Vol. 94, No. 8. August 2002.

²⁵ Geiger, HJ. "Racial Stereotyping: The Need for Cultural Competence." Canadian Medical Assoc. J. Vol. 164, No. 12. June 2001.

Selected contractors will participate in developing measurable outcomes and a data collection plan. Proposed outcomes and performance measures are summarized in Table 5 at the end of this procurement plan.

19. Evaluation

As previously noted, the health department will work with its contractors to collect and report sufficient data so as to report on outcomes, evaluate progress in implementation, make course corrections where necessary, and describe other impacts and aspects of the new Levy investment.

The investment strategies to support high-risk families will be evaluated on both process and outcome measures by staff hired in DCHS Community Services Division. In addition, the health department will seek grant funding for an independent external evaluation of pilot interventions addressing maternal depression. A coordinated evaluation effort with the King County Health Action Plan will also be explored.

**Table 5:
Piloting New Services to Address Maternal Depression
Strategies and Outcomes / Performance Measures**

Strategies	Outcomes / Performance Measures
Improve access to standardized depression screening	# (%) Maternity support clients screened periodically through <i>First Steps</i> and other maternity support programs # (%) Primary care clients screened for depression during prenatal and well child care visits
Improve mental health status and functioning	Results of clients' periodic screening over time: <ul style="list-style-type: none"> • Edinburgh Prenatal Depression Scale • PHQ-2 • PHQ-9 • GAD-7 (anxiety) Major mental health and medical diagnoses of clients
Improve capacity to reduce risk and address early symptoms of depression	# (%) Clients attending peer support groups or receiving other early intervention strategies during pregnancy or early in parenting years (0-3 years)
Improve primary care capacity to treat mental health issues	# (%) Clients receiving treatment and follow-up through integrated behavioral health programs Average length of stay in behavioral health treatment and care coordination
Assure access to interventions available to diverse King County pregnant women and mothers	Demographic profile of clients served in pilot programs: <ul style="list-style-type: none"> • Race / Ethnicity • Residence • Age • Insurance status • Housing status