



The Family Four-Month Visit: A Multi-Generational and Multi-Caregiver Approach to Whole Family Health

Background

In 2016, the U.S. Preventive Service Task Force (USPSTF) released its [final recommendation statement](#) for adult depression screening that included a call for all women who are pregnant or within one year of giving birth to be [screened for depression](#).¹ The Affordable Care Act (ACA) requires that private insurance plans cover USPSTF recommended preventive services without any patient cost sharing. It is well established that [untreated maternal depression](#) not only impacts the health of mothers, but also the health and well-being of their partners, infants and young children. Taken together, the 2016 USPSTF recommendation and the ACA preventive service requirement altered the landscape for maternal depression screening, providing new opportunity for states to cover screening and treatment for depression.

Five months following the USPSTF announcement, Centers for Medicare and Medicaid Services (CMS) released an [informational bulletin](#) on maternal depression and the role of Medicaid. The bulletin clarifies the role that Medicaid can play in identifying mothers experiencing depression as an [important extension](#) of Early, Periodic Screening, Diagnosis and Treatment (EPSDT)² because it benefits the child, creating a protective factor for the child's healthy development by supporting parental resilience or the ability to manage or recover from life's challenges.³ As a result, family therapy can be a supported outcome of a positive screen, creating a pathway to better health and securing a bond for the parent-child dyad. The combination of the USPSTF recommendation for depression screening, which applies to how preventive services are reimbursed in private insurance products, and the CMS bulletin regarding maternal depression screens during a child's well visit covered by Medicaid, work together to institutionalize the practice of depression screening during the postpartum period. [Thirteen states](#) enacted policies for postpartum depression screening as part of the pediatric well visit—New Jersey, Massachusetts, West Virginia and Illinois also [mandate some aspects](#) of postpartum screening. The increased awareness of maternal depression and subsequent increase in screening represents a positive step toward ensuring a child's developmental health and mother's well-being. Despite these important steps to reinforce screening practices of caregivers, **there remains a gap in care**: explicit recognition of fathers or other primary caregivers that may need access to depression screening during the postpartum period.

Currently, there is widespread and much needed focus on mothers and postpartum depression, supported by robust [research and evidence](#) that screening and treatment are vital to both mother and infant long-term health. According to the [Centers for Disease Control \(CDC\)](#), upwards of 13 percent of women living in the United States experience postpartum depression symptoms (about 1 in 9 women). **Women are not alone in experiencing depression symptoms during the postpartum period—a significant proportion of fathers also confront depression.**

The baseline prevalence of depression among men is [4.8 percent](#) while the prevalence of postpartum depression for fathers is estimated at [10 percent](#). The prevalence of paternal depression is highest when the infant is between [3 and 6 months](#) of age, and is associated with having a partner who is experiencing postpartum depression. Similar to mothers, fathers experiencing depression symptoms may negatively affect a child's health and development. Specifically, these parenting behaviors can range from [poor interactions with their infant](#) to limited or no verbal stimulation with their infant and in extreme cases, physical abuse, substance use or neglect. Long-term impacts can be similar to those of maternal depression including increased lack of school readiness, [increased adolescent depression](#) and poor health. Unlike mothers, however, fathers are [not frequent users](#) of health care services and do not regularly engage with the health care system. Fathers are increasingly participating in the day-to-day care of their young children, from childcare to pediatric visits. However, they still remain less likely to seek health care for themselves and navigate these systems without partner support. Broadly, depression is an often unseen risk for all parents and caregivers. While there is a limited but growing body of research regarding the prevalence of postpartum depression among fathers, there is even less research on [other types of caregivers](#) including same-sex partners, adoptive parents and multi-generational partners (such as grandparents and guardians).

Regardless, the message of the research is clear: depression is a challenge for all parents and caregivers, and their infants. The prevalence of depression among adults during the perinatal and postpartum period are high ([up to 25 percent](#)). Furthermore, children who grow up in households with a depressed parent are more likely to face [their own mental health](#) issues including challenges in school, emotional problems and substance use. Integrating depression screens for all caregivers into pediatric well visits is one pathway into combating the stigma of depression, and would open up a dialogue about family health and the role all caregivers play in supporting their children in meeting developmental milestones.

The following brief proposes an approach to addressing caregiver depression through integrating depression screenings for partners into a four-month infant visit. The sections below outline the contours of a Family Four-Month Visit and offer advocates guidance on engaging pediatric partners in piloting and championing this approach to caregiving when appropriate. Leveraging this key moment in the pediatric visit schedule is the first step toward a broader approach to supporting healthy families and addressing social determinants of health.

Paternal Depression

Depression in fathers is a growing concern.

- On average [10 percent](#) of men experience postpartum depression (PPD), peaking at the 4th month.
- The incidence rate of paternal depression among men whose partners experience PPD ranges from [24 to 50 percent](#).
- [Men of color](#) also experience higher rates of depression compared to their white peers.

Fathers undergo hormonal changes during the postpartum period, most notably a decrease in testosterone. A [decrease in testosterone](#) can be associated with an increased risk of depression. Fathers, like mothers, get less sleep and manage new demands; as concepts of fatherhood evolve, many fathers are navigating new roles without the benefit of role models. Access to mental health screening is an important step in supporting fathers and their families, providing an opportunity to build family resilience.

Why the Family Four-Month Visit?

The four-month visit is a key moment in both the infant's development and in the caregivers' own mental health. At the four-month mark, infants are beginning to interact with smiles, laughs and sounds, sleep more soundly and physically manage their physical movements such as reaching out for objects in front of them. At four months, caregivers who were able to take parental leave are returning to the workplace and are adjusting to a new schedule that includes childcare and managing sibling needs, either with or without a secondary caregiver. According to the [Bright Futures guide](#), pediatricians use the four-month visit and wellness exam to discuss sleep and safety, review immunizations and outline what to expect in the months ahead. The four-month infant visit is an ideal moment to screen caregivers, particularly because there are no new immunizations, leaving space for engagement about parent resilience and education. Coupled with the research on peak incidence of depression presented above, the four-month window is important as multiple demands on parents intersect with the growing needs of a developing infant.

The four-month visit is about *family health* not just infant health. As such, using the time to explicitly screen both parents or a single parent and another family member for depression and refer those screening positively to needed services is a key opportunity in supporting two-generational needs. A *Family Four-Month Visit* is an opening—a juncture for parents to discuss mental and behavioral health challenges and an opportunity for deeper exploration of the root causes of depression that may be related to other social factors. These factors may include [parents' or caregivers' own Adverse Childhood Experiences \(ACEs\)](#) or trauma that affect how they care for an infant or child. This approach communicates to the caregivers being screened that their mental health is important to infant development and specifically, it creates space for men to discuss their feelings with an understanding that it is important not only for their child but for themselves.

What are Adverse Childhood Experiences (ACEs)?

A national study on adversity experienced by adults defines ACEs: **household level** events including abuse, neglect, mental illness or substance use disorder in the household, and **neighborhood and community level** events such as experiencing racism or living in unsafe neighborhoods.

Source: [CDC-Kaiser Permanent ACEs Study](#)

Universally, pediatricians need support in operationalizing depression screens in office settings. Pediatricians may feel unprepared to screen an adult population and unsure of how to build a referral network when screens return positive. Thanks to increasing focus on maternal postpartum depression, there are models for strengthening the screening and referral capacity among pediatric practices. These effective practices include [psychiatric access networks](#), [learning collaboratives](#) for physicians that include training and physician practice pilots to test screening integration approaches, and support workflow [adjustments](#).

Whole Family Support

The *Family Four-Month Visit* is an opportunity to re-frame Early Periodic Screening, Diagnosis and Treatment (EPSDT) as a whole family strategy for health. EPSDT is the federal mandate to ensure that children enrolled in Medicaid gain access to a spectrum of comprehensive and preventive services. The American Academy of Pediatrics (AAP) provides clinical guidelines for EPDST services, entitled Bright Futures.⁴ States can use Bright Futures to develop state programs and policies to ensure that children and youth are accessing evidenced-based services throughout their development. Part of their healthy development is reliant on healthy, engaged parents and caregivers. While the *Family Four-Month Visit* can be effective for all families regardless of insurance status, Medicaid's [EPSDT offers a vehicle](#) for building family resilience for caregivers' disproportionately at risk of poor health outcomes and health inequities.

Whole family support is vital to a child's healthy development and long-term success.⁵ Whole family support requires deliberate attention to not just the child but also the child's home environment and community in order to build out the protective factors needed for resilience and healthy brain development. Research shows that a child's earliest experiences affects their brain architecture, laying the groundwork for a robust or a fragile start to their health, behavior and learning. Positive parent/caregiver-infant interactions drive healthy brain connections; the first years of life are incredibly important to a child's development and require a loving and present caregiver. Exposure to toxic stress as a result of ACEs or other hardships—such as parent or caregiver depression—interferes with [healthy brain development](#). Pediatricians

and caregivers alike must be active participants in ensuring infants are developing in a loving and supportive environment. Addressing the challenges and effects of adult depression is central to this shared goal. **Just as pediatricians regularly question parents about smoking in the home and fluoride levels in the water and lead exposure, depression should also be considered an important environmental factor that influences an infant's well-being.**

Broadening our understanding of these factors should spur pediatricians and advocates into reassessing their approach to infant health, and take steps to account for elements such as depression in their assessments. The EPSDT standard invites such as reassessment and serves as a model for private insurance standards.

What are protective factors?

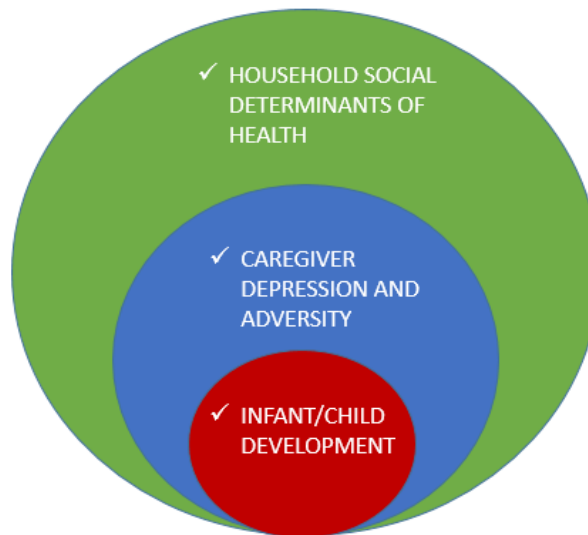
Protective factors are a set of attributes, skills or resources present in individuals, families or communities that help mitigate stress and adversity and increase the health of children and families.

What is resilience? Resilience is ability to maintain healthy functioning or adapt to a situation in the face of significant adversity.

Source: [Futures Without Violence](#) and [Center for Study of Social Policies](#)

The image below illustrates how being inclusive of parents and caregivers in the interpretation and implementation of EPSDT also builds family resilience and ensures that children and their caregivers are [forming the protective factors](#) needed to succeed.

BUILDING RESILIENCE THROUGH EPSDT: Screen, Consult, Refer and Treat



The Opportunity

Integrating caregiver depression screens is the first step in a broader effort to address the familial need to secure stable infant and parent health. This [multi-generational framework](#) leverages the EPSDT standard to encompass caregiver health, as well as addressing factors outside of the physician's office that influence family health status. These factors, or social determinants of health (SDOH), include caregivers' access to stable employment, healthy food, reliable transportation, affordable housing and safe neighborhoods. Research shows that [SDOH play an important role in family health](#), as well as children's future health and family stability.

By expanding our framework of EPSDT to include SDOH, the health system is better able to improve population and community health—particularly for [children of color](#), who are disproportionately affected by poverty, discrimination and poor health. There are a [multitude of projects](#) currently testing interventions to strengthen children and families through parent coaching and support across health, early childhood and child welfare sectors. These include medical-legal partnerships, such as *Project DULCE*, that work to ensure that providers and early childhood professionals are promoting quality driven strategies to support parents and caregivers, expansion of home visiting to new parents and targeted programs like *Reach Out and Read* that support parent-infant interaction and literacy. The *Family Four-Month Visit* is an added framework that focuses on depression screening and offers a vehicle to improve both child and caregiver health and wellness outcomes. The *Family Four-Month Visit* is the first step in

incorporating screening practices and establishing community partnerships that support families outside the medical home. While social determinant screening is gathering support nationwide, adding depression screens for adult caregivers would provide pediatricians an opportunity to move their practices in the direction of a whole family health model.

The Challenges

With any cultural shift in practice, particularly among a workforce that faces multiple demands on their time, there are barriers to implementation. These challenges include provider education and training around the screening tools available for depression, time constraints that allow for parent interactions during a well visit, resources for referral and follow-up with parents, parent and caregiver attendance and finally, billing practices for caregiver screenings.

The most important barrier is that pediatric providers may feel uncomfortable screening adults for mental health issues; most pediatricians do not receive this training during their medical education and/or are unfamiliar with the literature, tools and resources available to support adults. Widespread prevalence of depression among mothers, fathers and caregivers during the postpartum period, and the effect on infant and child development, demand a prioritization of continuing education for providers on screening, referral and treatment of mental health challenges for families. One important component of professional training is motivational interviewing and similar strategies used to engage adults in conversations about their mental health and wellness. It is important to couple professional training with provider education on the connection between parent and child health. Screening parents or caregivers is an integral part of a securing a child's long term health and wellness. While pediatricians may not feel that the caregiver is their patient, the growing evidence on infant health tells a different story, prompting a re-evaluation of care delivery.

A second obstacle is the perception that there is not enough time in the four-month visit to include an additional depression screen for caregivers. As outlined in the section above, the four-month visit is an ideal window for parent engagement because the visit is a broad check-in. Some pediatricians [are taking steps to integrate screenings](#) into their practice approach and find it is both useful and important to children's health. Pediatricians already performing parent/caregiver screening report the added screenings amount to [3-5 minutes](#), on average.

Having access to a robust referral network is an added challenge for integration of adult depression screens into pediatric settings. If caregivers screen positive for depression, pediatricians need a reliable, high quality referral network, ensuring that caregivers can access mental health services. Lessons from maternal postpartum screening efforts show that psychiatric access networks similar to the Massachusetts Child Psychiatry Access Program (MCPAP) are vital resources for providers screening adults (and children) for mental health issues. These networks offer immediate access to psychiatric consults to ensure a smooth transition to further assessment and treatment. Alternatives to psychiatric access networks include [co-location, integration or partnerships with mental health providers](#) that serve as referral extensions for patients.

A fourth issue involves parents and caregivers themselves. Having both parents and/or caregivers attend a four-month visit is challenging. Many parents and caregivers confront work restraints, transportation challenges or other issues in their lives that prevent them from attending a child's well visits. Establishing the *Family Four-Month Visit* requires reinforcement and messaging from providers and other support systems throughout the prenatal and pregnancy periods that emphasize the importance of infant-caregiver connection. This framework must include all caregivers. It is important to develop and nurture expectations that the long-term success of a child is tied to all caregivers and that they all play a pivotal role in an infant's healthy development.

Finally, thanks to federal CMS guidance, the maternal depression screen can be billed under the child's record; this is particularly important for children enrolled in Medicaid programs when their parent's insurance status may be less secure. For a second caregiver, the billing practices are less clear and may require state level advocacy to ensure similar billing potential for fathers, partners and other caregivers.

Beginning Steps

Moving the needle toward a more holistic approach to improving a child's health opportunity includes the *Family Four-Month Visit*. Advocates can support adoption of a multi-generational approach to children's health and wellness by taking some beginning steps towards generating awareness around parent/caregiver screening and child health, and by pursuing policy changes at the system and practice levels. Potential steps include a range of activities listed below:

Build Demand: Awareness Campaign for Providers and Families

- [Work with your health care coalition](#) to jumpstart a public health campaign that elevates the value of a *Family Four-Month Visit* at the infant's four-month child checkup to support any effort to screen caregivers (mother and father, partners or caregivers, inclusive of adoptive and foster parents). This public awareness work would include engaging health and human service agencies, social service organizations and local non-profits that support families.
 - Meet with the local and/or state Department of Public Health staff to ensure that any public awareness efforts are connected to ongoing public awareness work to strengthen families and communities.
 - Any public health awareness effort should include influencing and educating issuers both in private and public markets about screening benefits. [Increasing evidence](#) shows that caregiver screening improves family health.
- Work with your local American Academy of Pediatrics (AAP) chapter to publish a position paper on dual caregiver screening for depression during the postpartum period. Other professional organizations could follow suit to influence provider and practice behavior such as the American College of Obstetricians and Gynecologists (ACOG) or the National Perinatal Association. For example, in April of 2018 ACOG published a revised [committee position](#) on postpartum care that outlined the details of an extended postpartum period including, among other things, screening for depression as a key element of postpartum health.

- Use trauma-informed language and concepts in your messaging and educational materials to promote trauma-informed practices and services. An example is the [Changing Trauma, Changing Minds](#) campaign launched by [Futures without Violence](#) and Department of Justice. The campaign provides messages, actions and tools to support children and families confronting trauma. [Trauma](#) may be a precursor to depression and other mental health disorders.

Build Skills: Provide Continuing Education and Professional Development to Pediatricians

- Collaborate with your state's [psychiatric access network](#) to ensure that providers have information and access to needed referrals and supports. If your state does not have a psychiatric access project, work with your AAP affiliate and other advocates in the mental health space to assess the need for a referral network.
 - Massachusetts is a leader in the development and implementation of these networks. You can learn more [here](#). In recent years, these projects have expanded to include referral supports for mothers, and have the potential to also serve fathers and other types of caregivers. Providers should know the referral landscape for mental health support. In an effort to ease the referral process, practices can develop workflow practices so that follow-up is accomplished and the caregiver does get their needed evaluation and support.⁶
 - Often these networks provide resources and training in addition to needed referral support. Other training modules that can increase the comfort level of providers include [motivational interviewing](#)—a learned skill that is patient centered with the goal of directing conversations with patients to co-create plans to make life changes.

Build Networks: Support Community Connections to Pediatric Networks

- Connect with local groups that support men's health. These may include [men's health groups](#) connected to community health centers or health networks or other advocacy groups that focus on men such as [My Brother's Keeper](#), a nonprofit that supports healthy development and leadership support for boys and men of color. Enlisting leaders of fatherhood projects to educate providers about the importance of fathers can help develop pediatric champions.
- Map out your local public health programs and other [local assets](#) that support families with young children in the community and facilitate connections to local pediatricians and mental health providers. These programs can [support education](#) on the importance of screening and serve as a feedback loop for local providers on the health and well-being of families.
- In addition to local public health programs and initiatives, connect with and educate early childhood councils that serve as an informational and professional development hub for childcare providers and early childhood teachers and caregivers. These providers are important barometers of caregiver and infant health.

Build Pathways: Expand Billing to Include Multiple Parents/Caregivers

- Currently, Medicaid guidance highlights the importance of screening women during the postpartum period – this includes the four-month well visit for an infant, creating a billing pathway to screen the mother and bill to the child's record. While not explicit in the CMS guidance, there is room to create a second pathway to screen a father, partner or

other caregiver. Advocates can play an important role in [influencing the policy](#) at the state level for Medicaid to include a secondary screen. Additionally, advocates can support parity practices in billing to the child's record across both public and private coverage.

Build Evidence: Promote Data Collection and Evaluation

- Encourage the collection of screening data by practices and payers. Understanding the prevalence of partner postpartum depression is an important contribution to strengthening the movement for whole family health and supporting best practices.

A range of social and economic determinants of health—including [trauma and ACEs](#)—affect adult mental health and the health of a developing infant or child. Medical providers have an opportunity to influence the health of the whole family through a more comprehensive approach to depression screening and referral to treatment. Advocates can play an important role in influencing the policies and systems that help providers serve families facing adversity. While there are obstacles to moving this agenda, there is also the energy and skill in the community to implement key changes in practice settings, resulting in a positive effect on our future generations.

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CITATIONS

¹ USPTF services with an “A” or “B” rating do not require a patient co-pay. For adults, depression screen annually and holds a “B” rating.

² Early Periodic Screening, Diagnosis and Treatment or EPSDT is the gold standard for pediatric preventive service provision, outlining a comprehensive set of screenings and services to ensure healthy development. These are included in the [Bright Futures schedule](#) of screenings and vaccinations recommended by the American Academy of Pediatrics. Well-child visits may be an opportunity to screen fathers for depression and refer them for treatment.

³ [The Protective Factors Framework](#), issue brief, Center for the Study of Social Policy.

⁴ In the Centers for Medicare and Medicaid Services' State Medicaid Manual (Section 5123.2), Bright Futures is cited as an example of recognized and accepted clinical practice guidelines for EPSDT screening.

⁵ The Family Four Month visit draws on the *Strengthening Families Approach* from the Center on Social Services Policy and other whole family approaches such as the [CDC's](#) Whole School, Whole Community, Whole Child model and the [Maternal and Child Health's](#) whole-person, whole-family, whole-community model.

⁶ In 2016, Congress enacted the [21st Century Cures Act](#), which authorized grants to develop new or strengthen existing statewide or regional pediatric mental health care telehealth access programs. For federal fiscal year 2018, Congress [appropriated](#) \$10 million dollars for these grants. The Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau has been tasked with administering the program.