

# **MIHP Implementation WG**

Jan 30 2007

**Present:** Dianna Baker, Lynette Biery, Ingrid Davis, Paulette Dobyne Dunbar, Jean Egan, Sheila Embry, Brenda Fink, Sue Gough, Eileen Guilford, Bonnie Havlicek, Gary Kirk, Deb Marciniak, Diane Revitte,Carolynn Rowland, Betty Tableman, Peggy Vandermeulen, Darlene VanOveren.

**Phone:** Ann Bianchi, Mark Bertler, Stacey Duncan-Jackson, Sheri Falvay, Judy Fitzgerald, Nancy Hynes, Gail Maurer, Betty Yancey.

## **Tasks**

- 1) Mary, Lynette & Deb will draft a 3-year depression domain action plan, as described on page 6 below.
- 2) Implementation WG members have until Feb 14 to send email comments on the Prenatal and Postnatal Screener Recommendations from the MFMP Year 3 Final Report Deb.
- 3) Paulette and Brenda will address request to draft a letter on status of certification process so that MIHP providers have something to show Health Plans when they ask how they can know which providers are certified.

## **Welcome & Introductions**

Brenda said that in order to save time, we're sending documents out to the MIHP Implementation Workgroup before meetings and expecting people to read and come prepared to discuss them, rather than have presentations on them at our meetings. She also said we know that some stakeholders are concerned that the MIHP re-design is moving too slowly, but that we really are moving along with a lot of components. She encouraged Implementation WG members to complete the blue feedback form in the packet – just 3 questions: What are you encouraged about, discouraged about, other comments.

## **Michigan Families Medicaid Project Year 3 Final Report Overview**

Peggy and Diana said the report was excellent, truly captured the experience of the pilot sites, and is very timely in light of the increasing impetus on evidence-based practice within our local agencies. Peggy already has used it to write a grant application. Lynette noted some highlights of the report:

- The WIC-MIHP integrated screener was very successful. After the pilot was over, the pilot sites asked for permission to continue to use it, even though it's not yet in policy.
- Piloting of the postnatal screener, concluded in August, was also successful. However, the screener is long (includes both maternal and infant components), so

MFMP is recommending that providers be allowed to do it in two visits, rather than one.

- There are recommendations for tweaking the wording of some of the questions.
- The Risk Stratification Algorithm (Section 5 of report) that is being recommended takes individual risk domains and rolls out low/mod/high risk scores. It has not been piloted, but MFMP did use it with a number of completed screens and it seems logical. However, it's hard to identify women who have cognitive impairments, and providers may just need to go by their gut and count some of these women as high risk. Otherwise, the algorithm is easy to use, especially if it's done electronically. It will need to be tweaked based on what is learned from using it with larger numbers of women.
- Another big part of the report is the white papers which have been drafted for most of the domains except for chronic disease, transportation and basic needs. The white papers include lit reviews and recommendations. Lynette noted that depression white paper is part of a larger report soon to be submitted by the MIHP Perinatal Depression Workgroup (PDWG) and that we're happy with how this report came out.
- It was suggested that we replace the term "white papers" with the term "position papers."

Call or email Lynette if you have questions about the report.

### **Actions Taken by Admin Team in Response to MFMP YR 3 Final Report**

- Brenda said Admin Team approved the risk stratification algorithm and will discuss next steps for moving it along at an upcoming Admin Team meeting, as it is a very critical piece of MIHP. We may need to tweak it and determine if we need to do a pilot before we go statewide with it.
- The Admin Team and Steering Committee reviewed the Perinatal Depression (PD) position paper and decided to forward it to the Implementation WG for initial input today, with the understanding that we are looking at the best-practice recommendations now and will address the cost considerations later. (None of the workgroups were asked to do cost analyses, just to identify best practices in their targeted domain.) Brenda noted that the PDWG was an impressive group of people and that they had formulated their recommendations very thoughtfully.

### **MIHP Depression Intervention Recommendations**

The MIHP Perinatal Depression Workgroup (PDWG) was charged with assisting Lynette to review the literature, look at model projects in other states, identify PD screening and treatment initiatives in Michigan, and survey MIHP providers, in order to generate recommendations for MIHP interventions. There are 22 PDWG members, including: MIHP providers; representatives of ACOG and AAP; researchers from the U of M, WSU, and the Borgess Research Institute; health systems; Medicaid health plans; public and private mental health treatment providers; DCH mental health and maternal and child

02-20-07

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health consultants; DCH Medicaid specialists; MSU Institute for Health Care Studies; and MPHI. Mary Ludtke is the PDWG chair.

The PDWG pulled together a great deal of information and made recommendations for assisting MIHP clients who screen positive for mild, moderate and severe depression. The recommendations we're discussing today are fairly general; at this stage they aren't specific enough to be used as procedures.

### Cognitive Behavioral Counseling

The literature indicates that medication and psychotherapy (especially Cognitive Behavioral Therapy (CBT) and interpersonal therapy (IPT) are the most effective treatments for PD at this time. Meds are critical at the moderate and severe levels. (In MIHP, 10-15% of the women screened with the EPDS scored above 13 {moderate to severe}). Most women can be evaluated for medication by their OB or PCP, however, the reality is that many women are not able to access psychotherapy. When psychotherapy is not accessible, the PDWG is recommending that MIHP providers offer a brief, manualized version of CBT, referred to as Cognitive Behavioral Counseling (CBC), with women with moderate or severe depression.

There are several manualized versions of CBC – different authors use different steps. Carolyn said that Detroit Healthy Start uses the Sheela Seeley model, developed specifically for perinatal depression (PD) and designed to be delivered by home health visitors. It has been tested on 4,000 people and those who complete it have lower depression scores. The model consists of 8 home visits, with a protocol for each visit and specific policies and procedures.

Detroit Healthy Start uses the CBC with women with mild depression only – women with moderate and severe depression are referred to infant mental health services which are funded through a Healthy Start grant. Their protocol is as follows: all women are screened for depression using the EPDS; those who score positive are clinically assessed; those with a score under 15 (equates to mild and moderate using MIHP score cut-offs) get the short-term intervention (8-week CBC); those with a score between 16-20 get long-term intervention (6 month infant mental health services); those with a score greater than 20 get psychiatric evaluation. Home visitors who implement the intervention participate in a 4-day training, and then a mental health consultant works with them on the job. Detroit Healthy Start trained nurses, but they didn't like using the intervention.

True CBT is provided by individuals with a masters or PhD. CBC is provided in a prescribed way by individuals with less than a master's degree. CBC helps people deal with the here and now – doesn't explore childhood traumas. The Seeley model covers: cognitive strategies; problem solving; coping skills; and active listening and relationship building skills, which are critically important.

If an MIHP provider is expected to do CBC while she's making sure that the woman is getting mental health treatment - what's the indication to do it all together? Carlynn

02-20-07

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said that in Detroit Healthy Start, only women with mild depression get the CBC and that it doesn't replace therapy; it's for a small group who don't fit anywhere else. Women with moderate or severe depression get infant mental health from a CMH provider.

However, most MIHP providers don't have the mental health treatment resources that Detroit Healthy Start has, and although every woman above a 9 on the EPDS needs a diagnostic assessment, the literature is not clear on treatment for those who score 9-12 (mild), because of regression to the mean. The thinking is that support is enough to help these women through an episode of mild depression. Therefore, the PDWG is recommending CBC for women with moderate to severe depression when psychotherapy is not accessible.

Sheri said she sees CBC as a way to get some help for women who can't or won't access mental health treatment - if MIHP providers are appropriately trained and supervised.

### Referring Women to Mental Health Services

Gail said that as we review these recommendations, we need to be careful about using terms like mild and moderate depression until a doctor looks at the scores, as this is beyond the scope of practice for a nutritionist. Lynette said that the EPDS is just a screening tool and that MIHP providers are not using it to make a diagnosis, but as a way to identify women who need to be referred for a clinical assessment.

The PD interventions at all levels require the MIHP provider to communicate with the PCP if a woman scores positive for depression, but Lynette said she could provide more detail on referring a woman with a positive screen for a clinical assessment. Sheri said it would be helpful if we were more explicit about this, as it's also relevant for the work of another committee she's on that's promoting screening for developmental delays by pediatricians.

It's very common for health care workers at all levels to be extremely uncomfortable when dealing with suicidal persons. This is a huge training issue. Gary said we need to make sure that MIHP providers understand that it's not sufficient to simply refer a person with suicide ideation to CMH or the ED – the provider must stay with the woman until she is in the care of someone else. We hope it's a very rare occurrence, but some MIHP providers will be honored with the privilege of caring for a very vulnerable person and we need to have very clear policies and procedures to guide them. Gary said these policies and procedures should be tested before an event occurs. Brenda said that policies and procedures will be specified very clearly in the MIHP program manual, and that care coordination is the piece that overlays the entire program.

Sheila said policies and procedures are important, but can only take us so far - we also have to educate MIHP providers and other health care professionals about referral resources. Peggy said that providers didn't know what to do with women who screened positive. Deb said she's heard providers say that CMH will serve women who are suicidal, but they don't know where to refer women with severe depression who are not

02-20-07

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suicidal, and that this is a fair number of women. Carolynn said that providers need to do something to help these women, not just refer them to other agencies.

Peggy said her program has developed a decision tree which she would be glad to share with interested persons. Deb said that Beaumont has developed a PD referral guide for community professionals to use, which also is worth looking at. Mary Ludtke has been working with the 2-1-1 state coordinator about listing PD resources in their data base.

Do we need to establish a protocol to get women to CMH? Sheri said that she and Mary Ludtke have been talking with CMH policy people about working it out so that women who score at the severe level on the EPDS would have to be served by CMHs across the state – CMHs would be required to take the referral. Sheri said that IMH services would be appropriate for with women with moderate or severe depression.

Brenda said that depression is a complex domain and that state-level people have much to do. However, their work must be followed by work at the local level by program administrators who need to develop referral agreements among MIHP, CMH, HPs, community crisis services, etc. In May, DCH is doing an in-service for HPs to update them on MIHP. Women in HPs get a 20-visit OP mental health benefit.

The majority of women lose Medicaid coverage at two months postpartum, so they can't get mental health treatment. Brenda noted that the governor's new health plan would cover women beyond two months. Gail said that women who lose Medicaid coverage at 2 months postpartum can get health care services at FQHCs. Peggy said the FQHC in her area has a 4-month waiting list and there's a waiting list for the waiting list.

### Questions and Concerns

The following questions and concerns about the PD recommendations (primarily the recommendation on CBC) were raised:

- **Detail on the interventions.** We need detailed protocols on providing the safety net for women with suicide or homicide ideation, and for helping woman with severe depression who aren't suicidal. We touch the lives of these women for a very brief time – we must give them resources and supports they can use when we're gone.
- **Liability.** Are there liability issues if CBC is provided by staff who don't have mental health background/credentials? Lynette said that in the literature, CBC has been done by bachelors- level and paraprofessional staff. Actually, there's less risk involved in having a protocol to follow that's endorsed by the state than not to have clear guidelines. Betty Yancey noted that we're seeing these women anyway, and we need tools to help serve them better – we want to take advantage of what we know from the literature. In a world of unlimited resources, the PDWG would prefer that MSWs do CBC, but resources are limited, and the literature documents bachelors-level home health workers can get results with

- CBC. Always, if a provider's gut says a woman is too depressed for the protocol, the provider's job is to get the woman specialized help.
- **Social work licensing/credentialing requirements.** The new social work act requires certain credentials to do counseling – BA level social workers can't do it. Does the act distinguish between therapy and counseling? What if we referred to CBC as Cognitive Behavioral Education (CBE)? The PDWG didn't look at licensing issues at all.
  - **Staffing.** Lynette said that the literature shows that CBC is used more often by social workers than by nurses. The PDWG is recommending that an MSW supervises social workers and nurses who do CBC. Some MIHP providers don't have masters-level staff at all sites and hiring MSWs may be too costly. Who picks up cost of asking providers to pay for another MIHP employee?
  - **Reflective supervision.** There also are costs associated with reflective supervision. Is it possible for state consultants to provide it over the phone, if we used a speaker phone at our end?
  - **Groups.** Can CBC be done in groups?
  - **Training.** This is a huge need and it doesn't come cheap. Lynette estimates it would cost \$50,000 to \$100,000 to train the whole system on CBC. But, the ROI is high and we may be able to get a grant. We train people and then they leave, but this is an issue in all programs.
  - **Cost.** Lynette said depression clearly is not a cost-neutral domain, but quality comes with a certain price. We may need to shift costs, perhaps by doing fewer domains, but it would be short-sighted to throw CBC out because of cost.

The Implementation WG endorsed moving in the direction of the PD recommendations, knowing that there are concerns to be addressed, so that we can begin to move forward with this domain and draft a 3-year implementation plan. Sue said she agrees with phased-in approach, noting that providers are trying to figure out what to do with all of the women who screen positive on the EPDS, now that they are identifying them. Any kind of structure, even a loose set protocols or pieces of protocols, would help.

Mary, Lynette & Deb will draft a 3-year action plan, including the following:

- Clarification of interventions.
- Things we could roll out this year for relatively little cost (e.g., training on meds). CBC will require the most work, but there are many other steps we can be taking.
- Identification of any limitations posed by SW Licensing Act.
- Determining if CBC can be used with groups.
- Training needs and process, including CBC training. How much could go online? What are the costs?
- Way to get ongoing feedback so we can track how depression interventions are working out and identify trouble spots, knowing that we're still trying to figure out an overall evaluation plan for MIHP.

## Postnatal Screener

02-20-07

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The Postnatal Screener incorporates the ASQ and ASQ: SE. The Michigan Chapter of AAP has the first leg of an Assuring Better Child Development (ABCD) TA grant designed to encourage pediatricians to use standardized tools for developmental screening (e.g., ASQ and ASQ: SE) and DCH will apply to the Commonwealth for another TA grant to complete this work.

Brenda reviewed the Postnatal Recommendations from the MFMP Year 3 Report. There was a great deal of discussion about the recommendation stating that the tool should be used as a screening and assessment data collection tool. Carolynn said that the info from the screener is not sufficient to generate a care plan, and that we also need a common assessment tool. There was agreement that postnatal screener could be completed in two visits instead of one, since it is so lengthy. There was also agreement that training on the EPDS, ASQ and ASQ: SE should be provided, and that all women should complete the EPDS, rather than continue with the 2-tier approach.

Implementation WG members have until Feb 14 to send email comments on the Prenatal and Postnatal Screener Recommendations from the MFMP Year 3 Final Report Deb.

### **MIHP Progress Updates at a Glance**

Brenda said the *MIHP Progress Updates at a Glance* handout shows that we are moving along on multiple fronts, so much so that the challenge is to get our arms around it. The Admin Team has scheduled extra meetings because there are so many things to process right now. We want the interventions for all of the domains drafted by the end of the year, and to begin discussion on changing the reimbursement structure; it's clear providers can't do all that we're asking in 9 visits.

Paulette discussed the 5<sup>th</sup> item under "Administration" in the Updates Chart - Provider Program Consultation & Monitoring. DCH will start visiting agencies again this spring, but will be using a new review process that won't be called state certification. The new process will include:

- 1) A conversation about how things are going with the program transition, given the changes providers have been asked to implement over the last year.
- 2) A review of how MA policies and standards are being implemented, including chart reviews. The revised state visit tool will be out by March 15; you'll have time to review and comment on it. Both state and local folks will know beforehand what DCH will be looking for when reviewers go out.

Reviews will probably take only one day. The review schedule will be out in March and reviews will begin in April. Gail said she probably needs to search the State Plan on certification and make sure it's all right not to use the original certification process.

Sue said a HP has asked her how they can know which providers are certified. Could a letter go out so providers have something to show HPs that documents where we're at

02-20-07

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with certification? It's getting difficult. Paulette and Brenda said they will look into this and that if providers have individual needs related to this, to let DCH know.