

**DATE:** June , 28, 2019

**Re:** Final Report for Telehealth Project *Telementalhealth: A Promising Approach to Reducing Perinatal Depression in Utah's Rural and Frontier Communities*

**From:** Gwen Latendresse, PhD CNM FACNM (Principal Investigator)

**To:** Health and Human Services Interim Committee

### **Project Overview**

The project addresses the mental health needs of childbearing women in collaborating rural/frontier public health district clinics. San Juan Public Health (serving frontier San Juan County), Central Utah Public Health Department (serving rural & frontier Wayne, Sevier, Sanpete, Piute, Millard, and Juab counties), and Southeastern Utah Public Health Department (serving rural and frontier Carbon, Emery, and Grand counties) all participated in year one, and continue to participate in year two. We have just expanded to an additional rural health district; Southwest Utah (serving Washington, Iron, Beaver, Garfield, and Kane counties). All pregnant and postpartum women (up to 1 year after birth) receiving services at any of the collaborating public health clinics are included in an electronic universal screening program to detect perinatal depression (PD). Please see Table 1 for demographics. Women who screen "positive" for depression are invited to participate in the telementalhealth program.

### **Summary of Progress**

**Objective 1:** *Establish a system for universal electronic screening for depression among pregnant and postpartum women in rural/frontier Utah.*

The project has screened 842 pregnant and postpartum women using universal electronic screening for maternal depression. We have worked closely with the Health Districts to identify clinic-specific strategies for improving screening approaches and coverage, and have adjusted the screening system, based on input from these collaborating clinics. The project has demonstrated an increase in the number of women participating in screening over time. See Table 2 for PD screening and prevalence.

**Objective 2:** *Offer Utah Telehealth Network (UTN) -supported mental health videoconference support groups for at-risk pregnant and postpartum women in rural/frontier Utah.*

The project has offered videoconference mental health support groups through the Utah Telehealth Network (UTN). A project assistant contacts women within 24-48 hours of a positive screening test to determine the most appropriate referral (group or individual mental health services). The project assistant facilitates connection between the woman and a trained mental health provider.

**Objective 3:** *Offer UTN-supported one-on-one (individual) videoconference mental health services to pregnant and postpartum women in rural/frontier Utah who screen positive for perinatal depression. Services are provided by a mental health professional.*

The project offered individual mental health services by videoconference with psychiatric-mental health nurse practitioners (PMHNP) and/or Licensed Clinical Social Workers (LCSW) specifically trained for maternal mental health conditions. All women who screened positive (n=288 out of 842; 34.2%) during the project period were offered connection with mental health services, or additional information about available resources and contacts. 118 women who screened positive indicated interest in being contacted. Of these, 49 met one-on-one with a project mental health provider via telehealth and an additional 35 attended at least one group session via telehealth (see Table 3).

Notably, 164 women (56.9%) of women currently experiencing PD symptoms declined any contact or mental health resources. When available, women were referred to local resources, such as San Juan Counseling and Four Corners Behavioral Health. Importantly, our mental health professionals with the project have been available for several cases of women with suicidal ideation and in urgent need of mental health services.

***Objective 4:** Establish a telementalhealth referral and resource service (phone, text, web, videoconference) that will connect rural/frontier childbearing women and their providers with the most appropriate mental health resources, referrals, and information available in the state of Utah.*

We have collaborated with the UDOH Maternal-Child Health Bureau's Maternal Mental Health Specialist and the Utah Women and Newborn Quality Collaborative (UWNQC) – Maternal Mental Health Committee to develop a comprehensive listing of all available mental health resources for childbearing women across Utah, including all rural communities. A one-page resource and information flyer is sent to everyone who interacts with our project. Additionally, the project distributes a newsletter to all women who participate in the universal electronic screening program, if they indicate an interest in receiving it. The Newsletter is distributed on a regular basis and includes tips for promoting and maintaining mental health wellness, as well as mental health resources available to all childbearing women, locally and statewide. ***As this pilot project ends on June 30, we have begun planning for long-term sustainability beyond state funding, to continue this important support for rural childbearing women.*** This planning includes training of local public health nurses and women with 'lived experiences' to facilitate ongoing group sessions in local communities and via telehealth for more remote rural and frontier-dwelling women. A major focus for the upcoming 3 years is to work closely with the Utah Department of Health (UDOH) to develop a highly functional, interactive web-based platform for providing a referral and resource service for the state of Utah beyond the end of our project.

***Objective 5:** Provide consultative services to primary care providers in rural/frontier Utah, such as assistance with medication management, and treatment and referral assistance for more serious and acute maternal mental health and psychiatric conditions.*

We meet regularly with the project advisory board members, and collaborate closely with Postpartum Support International-Utah (PSI-UT), the University of Utah Neuropsychiatric Institute (UNI), and the Utah Women and Newborns Quality Collaborative (UWNQC) Maternal Mental Health Committee to formulate sustainable approaches to PD screening, identification, and referral of childbearing women across Utah. These networks and partnerships support increasing access to care, and successful development of sustainable access over time.

#### **Number of Patients Served and Demographics**

Table 1 (attached) displays the number of women who completed electronic screening, along with demographics. Screening over the entire project period included 824 women in four Health Districts in Utah, Central, San Juan, Southeast, and more recently, Southwest Utah.

#### **Cost per Patient to Provide Service**

We were not able to conduct a cost analysis, given the third-party payer issues, particularly Medicaid's subcontract system.

#### **Insurance Reimbursed**

None of the women participating in the 8-week videoconference support group were billed for services. However, for women who were referred to individual one-on-one psychotherapy/counseling outside of the telementalhealth program, the referral MH provider billed third party payers on their own, with the exception of Medicaid.

### **Barriers Encountered:**

A major barrier to providing mental health services in rural/frontier Utah is related to the high percentage of childbearing women living in rural communities, visiting the public health clinics, and receiving Medicaid (62.5% overall). Women who screen positive and are Medicaid recipients are obligated to receive mental health services with the Local Mental Health Authority - LMHA (such as San Juan Counseling or Four Corners Behavioral Health). Mental health providers are only reimbursed for provision of mental health services to Medicaid recipients if they are contracted with the LMHA. The only exception is with a special arrangement (called a single case agreement – SCA) between a mental health provider and the LMHA. These are cumbersome to arrange, and the LMHAs are overall reluctant to authorize a SCA because it results in reimbursement to a provider outside their facility. In other words, the LMHA has to go through the trouble of arranging the SCA, and then loses the revenue they otherwise would have received by keeping the patient “in house.”

Our telehealth program is designed to increase access to mental health services for childbearing women. However, the current arrangement for behavioral health services for Medicaid recipients is a definite impediment to increasing access in rural and frontier communities. The LMHAs, as well as the rural communities they serve, rarely have mental health professionals who are specifically trained in perinatal mental health. Our project had mental health professionals educated and certified in perinatal mental health conditions, and were willing, ready, and available to provide services via our telehealth platform. However, they were not reimbursed for services to Medicaid recipients, unless an SCA was authorized (rare). Through perseverance and much effort, some of our telehealth MH providers were able to receive authorization for SCAs, and thus were able to provide the mental health services needed for only three women. We commend the LMHA (San Juan Counseling) that facilitated this arrangement, as these women would not otherwise have received the specialized mental health services required, nor in an expedient fashion to avoid harm.

***Our recommendation would be to carve out these mental health services for perinatal depression from the LMHAs, and pay for them as a fee for service, although we recognize that Medicaid would need additional resources to pay for these services.***

### **Patient Outcomes**

Tables 2 and 3 (attached) provide specific outcomes for the 824 women who completed electronic screening with the project.

### **Achieving Best Practices in Addressing Maternal Mental Health**

One objective of the project was to develop Best Practices for delivery of telementalhealth services to childbearing women in rural communities. To achieve this objective, we sought input from our collaborating rural sites, the UWNQC – MMH committee, PSI-UT, and our Advisory Board and community partners, to develop best practices.

- 1) In collaboration with UWNQC – MMH committee, we developed recommendations for screening, triage, response, and referral for childbearing women with mental health needs across the state of Utah, to include access by telehealth platforms. The UWNQC is now in the process of developing a dissemination and pilot plan for the upcoming year.
- 2) We have worked collaboratively with the public health clinics and the LMHAs to identify training needs for rural mental health providers, and to make this accessible via remote platforms. We supported approximately 20 health care providers from rural Utah to attend the PSI-UT training conference on May 31 and June 1, 2019. Most attended via remote videoconference connection from their rural communities.

- 3) A high percentage (56.9%) of women who screened positive in this project declined to receive any mental health services, referrals, or even information about resources. The implication of this finding is very concerning, and has led us to initiate a study to help us identify barriers to accessing mental health services. We suspect that the high level of stigma surrounding mental health may be a significant contributor. We expect to complete this study in fall 2019.
- 4) Many women with interest/need in mental health resources did not have reliable contact (phone service disconnected, inconsistent phone access, no answer, no response to email). On many occasions, cell phones had been disconnected, preventing further contact. Based on input from our rural collaborators, loss of phone service and inability to contact women is a very common issue, particularly for San Juan County. Working with the clinic sites, we were able to arrange for more immediate access to mental health care services while patients were still on site, rather than relying on follow up or another appointment scheduled later. We had two MH professionals maintain a few open appointments for women being screened at a public health clinic, were determined to need the services of a mental health professional, and for whom scheduling an appointment for a later time was not feasible. This only partially addressed the barrier.

#### **How Service was Beneficial to the Patient**

- Universal screening – increasing numbers of childbearing women were screened; detection of PD was improved
- Women had screening scores interpreted on the spot, which increased knowledge and response time
- All childbearing women received information on the spot about available resources, which improved access to care
- There was an increased awareness of perinatal mood disorders and access to appropriate mental health services, when needed
- Screening opened the door for women to ask questions and feel supported when mental health services were needed
- There was a ‘normalization’ of maternal mental health conditions, which may reduce stigma
- There is an increased number of healthcare professionals (e.g. nurses) in rural communities who are better prepared to directly assist women with their mental health care needs (appropriate referrals, accurate information, support)
- We assisted a perinatal mental health professional outside of the contracted LMHA to negotiate single case agreements. This facilitated expeditious and appropriate referral to mental health services via telehealth.
- We consistently received positive responses from the collaborating public health clinics, and the women who participated in the telementalhealth project. Indeed, public health nurses have expressed a high level of concern about the end of the project, as they fear going back to the situation they had prior to the project.
- We are currently working with PSI-UT Policy group, and the UWNQC-MMH committee to explore sustainable funding through local communities and third-party payers. The recent Utah appropriations success during this year’s legislative session will allow a much scaled-down telehealth program to continue for the next 3 years while these reimbursement issues are addressed.

Please let me know if I can provide any additional information that you may need.

Sincerely submitted on behalf of the project team,



Gwen Latendresse, PhD CNM FACNM

Tables Attached: three (3)

Data Period: November 7, 2017 through June 12, 2019

<b>TABLE 1</b>	<b>NUMBER</b>
<b>DEMOGRAPHICS</b>	<b>SCREENED (%)</b>
<b>Marital Status</b>	
Single/Divorced/Widowed	307 (37.0)
Married	378 (44.9)
Living with Partner	142 (16.9)
Missing	15 (1.8)
<b>Total</b>	<b>842</b>
<b>Insurance Coverage</b>	
None	108 (12.8)
Medicaid	526 (62.5)
Private	148 (17.6)
Other	48 (5.7)
Missing	12 (1.4)
<b>Racial Background</b>	
American Indian or Alaskan Native	186 (22.1)
Asian, Black or African American, Hawaiian or Pacific Islander	16 (1.9)
White	565 (67.1)
Multiple	19 (2.3)
Missing	56 (6.7)
<b>Ethnicity</b>	
Not Hispanic or Latino	661 (78.5)
Hispanic or Latino	120 (14.3)
Missing	61(7.2)
<b>Health District</b>	
Central	257 (30.5)
San Juan	215 (25.5)
Southeast UT	296 (35.2)
Southwest	17 (2.0)
Missing	57(6.8)

<b>Table 2</b> <b>Screening and PD Prevalence (11/17/2017 – 6/12/2019)</b>	<b>Number (percent)</b>
All women completed electronic screening and received immediate information on their screening score and risk, interpretation of the risk score, and a list of mental health resources available to them	<b>842 Total</b>
Women who screen negative for current perinatal depression received services, as described above	554 (65.8)
Women who screened positive (EPDS $\geq$ 10) for current perinatal depression; onsite public health nurse addressed results and provided support for referral	288 (34.2)
Women who are High Risk for PD based on Significant Life Events (regardless of EPDS score)	169 (20.1)
Women who are High Risk for PD based on History of past depression and/or anxiety (regardless of EPDS score)	382 (45.5)
Women without current PD symptoms (EPDS < 10) but are at high risk (based on significant life events)	59(10.7)
Women without current PD symptoms (EPDS < 10) but are at high risk (based on history of past depression and/or anxiety)	159 (28.7)
Women at high risk for PD (based on history of past depression and/or anxiety) AND currently experiencing PD symptoms (EPDS $\geq$ 10)	223 (58.4)
Women at high risk for PD (based on significant life events) AND currently experiencing PD symptoms (EPDS $\geq$ 10)	110 (65.1)
Women with PD symptoms (EPDS $\geq$ 10) and indicated NO interest in mental health services	164 (56.9)

EPDS = Edinburgh Postnatal Depression Scale

<b>Table 3: Utilization Numbers (Post Screening) for women who screened positive for PD (EPDS <math>\geq</math> 10)</b>	<b>Public Health Clinic Interface</b>	<b>Referred from Community Provider</b>	<b>Total</b>
Screen Positive; interested in being contacted	118	32	150
Attempted contact	118	32	150
Actually contacted	72	20	92
Unable to reach	46	12	58
Lost to contact after initial contact	32	4	36
Declined contact	9	4	13
Met one-on-one with project mental health provider via telehealth at least once	36	13	49
Established ongoing individual therapy with mental health provider via telehealth	10	6	16
Participated in at least one group session via telehealth			35