

California Home Visiting Program Monthly Conference Call

Meeting Minutes

Thursday, May 8, 2014

1:30-3:00 p.m.

Next Meeting: July 10, 1:30-3; calls will now be alternate months instead of monthly

Participants: MCAH Directors and Coordinators of MIECHV Funded Programs

Meeting Facilitator: Kristen Rogers

I. General Updates

a. *Reauthorization*

Home Visiting was reauthorized under the Doc Fix Bill that continues funding for 6 months from October 1, 2014, to March 30, 2015. The expectation and hope is that when the new Congress begins in January, 2015, the home visiting funding may again get reauthorized for several more years. This Doc Fix was simply a quick remedy to the current expiration date of September 30, 2014. The good news is that this Doc Fix Bill was a bipartisan effort and written by a Republican and a Democrat. It is projected to continue having this strong bipartisan support.

b. *ECCS Progress Report and Formula Grant Submission*

We are working on our Formula Grant that is due on May 23rd. This grant is for the period of August 1, 2014 – September 30, 2016. The ECCS Progress Report is also due May 23rd. Update: both the Formula Grant and ECCS Progress Report have been submitted.

II. Updates from the Program and Evaluation Sections

a. *TA Meetings*

- i. Los Angeles had the first TA meeting and it went very well. In particular, the session with Patrick Sutton on blended and Medi-Cal funding spoke to sustainability issues. The next 2 meetings are in Fresno (June 11 & 12) and Sacramento (June 25 & 26).

b. *Site Visits*

- i. Most of our site visits are now complete. We have a few more to do in the months of June and July. The visits have been very informative to state staff and we thank you all for hosting us and for doing such an excellent job in your work.

c. *AFA Packets/SOW*

- i. We are working hard to complete the new packets and SOW. We anticipate these will be released within the next month.

d. *MCAH Director Calls*

- i. We will have our monthly Director Calls moved to every other month. Each call will include discussion from selected sites on important topic areas.

III. **San Mateo, LA, Alameda: Mental Health Services for Home Visiting Clients**

a. *San Mateo: Dr. Anand Chabra and Lizelle Lirio de Luna*

- i. *Funding Mechanism: grant funding evolving into reimbursement from insurance.*

Background (*Anand Chabra*): Most of the NFP clients are teens. We have two mental health clinicians who work exclusively with pregnant/parenting teens in San Mateo County. This arose out of federal grants, a series of three 5-year competitive federal grants [starting] 1995-2010. In 1995-2000, through Federal AFLP competitive funding, we identified a lot of mental health needs and thought it would be an important area to focus on. For 2000-2005, in discussion with the mental health division (who are part of same agency), they were supportive of the idea. We put funding into the federal grant application which was matched by the mental health division. [It was] for 1 clinician to work exclusively with pregnant/parenting teens. [There is a] caseload of 18 clients. [Clinicians] go on home visits, not just [work in] clinics, and work with home visiting staff- community health workers and nurses. We expanded that in 2005-2010, to two home visiting clinicians who had specific expertise in working with teens. That was a big part of the attractiveness of the grant, and we had experience working with fathers.

That funding ended. We were wondering what would happen next. So [we had some] discussion with the (newly named) Behavioral Health program, they looked at the financial billing for services/Medi-Cal. And since most of the clients were Medi-Cal or Healthy Kids or had some form of insurance, they could recoup most [from] the usual sources. So Behavioral Health agreed to continue working with us in the same way, but they absorbed the cost and bill client's insurance/public insurance. Throughout this, the staff was supervised by Behavioral Health staff. They weren't our division, but worked with our staff. That's the history. Lizelle can talk about operations.

Operations (*Lizelle Lirio de Luna*): We have a staff meeting every other week. The MFT is part of our staff meeting, a regular presence. A standing item on our agenda is case coordination for shared clients. The MFT is part of the team for AFLP and NFP. In between meetings, nurses regularly refer to the MFT. We're constantly screening with the Edinburg Depression Scale, and any time nurses identify a need they can write a referral right away. We can just walk it over; those folks can assign the case. Nurses get consent [from clients] so we can share. We're open with the clients that we

aren't going to share everything, so there is a limitation. And we ask, "You're expressing these feeling with me, can I check in with your therapist?" or vice versa for the therapist. So we share that way; we're very transparent with the client. MFTs also do home visits, so they coordinate [with nurses] so that they aren't inundating the clients, depending on the clients' needs. And we do a warm handoff. If we feel the client will potentially benefit from a MFT, we offer a joint visit to introduce the client to the MFT; often that makes for a good connection. MFTs also carry a caseload of 25 clients. Generally, they are constantly receiving referrals, but are not usually at caseload. Clients have various mental health issues such as PTSD, history of sexual abuse, depression and anxiety. Both of our MFTs are bilingual and very experienced working with teens, specifically. We have a local AFLP program through county general funds, not a state AFLP program.

- *What is the frequency of contact with the families for MFT?*

Generally, every other week, sometimes weekly if a higher need.

- *What is the duration? Or ongoing as needed?*

Generally, ongoing. With AFLP they can keep the clients a lot longer.

But even if we closed them out of NFP they could continue with the MFT as needed.

b. Los Angeles: Jeanne Smart

i. Funding Mechanism: Mental Health Services Act.

Background: Los Angeles County (LA), has their own mental health provider (mental health specialist, MHS), a licensed clinical social worker who is solely assigned to Nurse-Family Partnership Program home visiting. The position is funded through the Department of Mental Health (DMH), Mental Health Services Act (MHSA) grant of \$5 million, renewable each year. MHSA called for early intervention, elimination of stigma, and had many other foci, but to get support for serving the prenatal population required intense outreach and education. LA consistently sent people who knew the importance of prenatal intervention to community planning meetings. The grant also funds 20 PHNS and support staff.

The grant called for focusing on clients with high risk situations: mental health issues, physical disabilities, or who were in foster care or on probation. This results in a high acuity caseload with many issues, so a caseload of 25 is problematic.

Other challenges with mental health that were observed by nurses prior to having a MHS:

- Clients who were in or had been placed in foster care had received prior counseling, but not sufficient to address core issues like past sexual trauma.
- Perinatal mood disorder screening with the PHQ 9 and other tools dropped because nurses felt like they were opening a “Pandora's Box” when clients revealed past trauma, and nurses didn’t have sufficient professional mental health system support.
- Clients wouldn’t go to traditional mental health providers because of anxiety and depression keeping them in the home; and the inability to get appointments with Medi-Cal providers and thus having to stay in the waiting rooms with severely mentally ill clients which scared them or made them feel like their problems were not as severe as what was in that room.

How it Works: After the first year of DMH funding, LA NFP asked for funding of a MHS. The MHS needed experience with adolescents and evidence-based practices. The MHS was entirely in NFP; she supplements and provides professional consultation, but does not duplicate what the NFP nurses do. The MHS sits with nurses in the main nursing unit.

Responding to Barriers: Sometimes NFP nurses do the PHQ-9 depression screen and the Edinburg and get “insignificant” results, but the nurse’s gut feeling says something different is going on indicating “something is not right here.” The nurse can then refer to MHS for consultation, even though the numbers said all was well. Some of those “gut-referred” cases have proven to be very challenging for the nurse, and required complex intervention for the mother and her child involving a more interdisciplinary approach with several other professionals. They were scary, intense, and hard to handle for the nurses.

As people get stressed out at age 15-28 with their pregnancy and life situation, the early onset of mental disease is quite prevalent. Compounding perinatal mood disorder is onset of bipolar, schizophrenia or other mental health conditions that are often associated with drug additions, past traumas and other issues. The MHS provides professional consultation and client evaluation for referral to trauma focused care.

A MHS helps clients access mental health services. A warm hand-off occurs by a joint visit with the NFP nurse and the NFP MHS, and this opens the doors to mental health therapy that the girls don’t close. The MHS further evaluates the client then helps the client using crisis-focused care initially, and the frequency of MHS visits vary according to the needs of the client. As soon as they get through the client’s crises, the MHS closes their case, or if needed, she refers her to the DMH system of care in her community and facilitates linkages and warm hand-offs to them as well.

Next Steps: It's been an incredibly interesting 2 ½ years now, and we've just begun to write referral protocols. Any client who needs greater mental health evaluation or support as determined by their NFP nurse will be sent to the MHS via an electronic referral form. As the MHS caseload grows (currently about 32) it will become necessary to triage those mental health cases that need greater support. LA NFP is looking to hire two more MHSs. DMH is now coming to the realization that they need to "beef-up" their own system of care for pregnant and parenting families, and are looking toward NFP Los Angeles to help them prepare their contracted entities to be better prepared. DMH has been a unique partnership that has paid off well.

- *Who else funds mental health workers?*
NFP hired our own mental health worker/specialist on our DMH grant money. We did not want DMH to "loan" or "assign" us a caseworker because we would not have full ownership of the position. I needed someone to go to the client's home on an as-needed basis when the NFP nurses felt their clients needed help.
- *Was the NSO OK with the mental health worker getting trained in NFP?*
I discussed the plan with Dr. David Olds. So I started at the top, but then made sure everyone in NFP National Service Office knew what I was trying to do.
- *Have there been other people trained by NSO that weren't NFP nurses, have you established a precedent?*
I don't think so. I think that was many years ago when Dr. Olds hired non-nursing professionals to test the model with other disciplines.

c. *Alameda: Anna Gruver*

i. *Funding Mechanism: Mental Health Services Act, leveraged with Medi-Cal Administrative Activities (MAA)*

We're at the beginning stages of developing a Mental Health Unit in our MCH/Early Childhood Home Visiting Programs with 4 staff; one supervisor and three mental health specialists. Two of the positions will be funded by our Behavioral Health Care Services Department (BHCS) using MHSA dollars, the third funded through SAMHSA/Project LAUNCH and the last supported by Health Care Services Agency. The two BHCS mental health specialists will be leveraging Mental Health MAA (Medi-Cal Administrative Activities) and the other two positions will be leveraging FFP. Once the unit is hired, we will assign staff to specific home visiting programs including NFP so they can be more deeply connected to teams. Amy Marrero requested that the mental health specialist assigned to NFP should attend Unit 2 training. To back up, we're working on home visiting integration of system of care with common standards, outcomes, and a training

framework. When we started, mental health was one of the biggest issues identified by both home visitors and program managers; the need for support, consultation, and treatment services- very similar to Los Angeles and San Mateo. However, we're not focusing just on young mothers, but all at-high-risk families. There is such an issue around history of trauma, community and family violence, and sexual violence. Five years ago a SAMHSA grant for Project Launch placed a mental health provider in our home visiting programs. Similar to what others have said, the position was co-located with the home visiting programs- sitting with us, training with us, supporting us. She [Project Launch mental health provider] has been active in BIH, Healthy Start, group and individual interventions and always with a full caseload. Through her experience we've been able to profile and promote the incredible work she has done with the support of our First 5 and local leadership. We consulted with San Francisco and San Mateo. We've had a lot of champions. We are doing a lot of shifting of culture about what mental health is, and what interventions can be provided. Also, we are exploring and refining what it means to be a trauma-informed organization/system including the implementation of reflective supervision across all MCAH programs, not just the ones that require it.

- *Are the mental health workers stationed at public health?*
Yes, our two current mental health specialist are. And the two funded through BHCS will be. It was important that their staff be housed here. It was a stipulation. And our in-kind match for the positions was the provision of space, computers, training, and mileage reimbursement.
- *They are by Behavioral Health?*
Behavioral Health will do oversight of mental health MAA to leverage, and the current Project Launch provider will do the clinical supervision. She has the experience and expertise for supporting the work. Behavioral Health was very open to that. We were lucky – all the right people were at the table. We had a lot of education about how our clients don't fit into traditional, long-term mental health treatment system. We have families with trauma and depression. Because our services are home-based it is easier to connect with them. If they do quality for services, we'd link them, but it's a big gap in our services.
- *Is there a required caseload?*
Between 15 and 20 for a full-time person. We'll have some ramping up to do.

d. *Riverside: Judy Atchison*

i. *Funding Mechanism: in-kind*

We have an extension of Amy Larsen's Master's Thesis. She started a support group for women with post-partum depression. We got funding

from Mental Health Prevention and Early Intervention and we did support groups in Spanish and English that included training topics and support for clients that participated. Topics included anything from “How to Handle Anger” to “Breastfeeding.” We’d have a support group, [talk about] why they are feeling sad. We did a video and showed it at the American Public Health Nurses Association. It was a testimonial about how much it meant that they were not alone and that they weren't the only one who thought they were a bad mom. We do about 12 per week across the county. We track diligently to see improvement. We’re looking at other ways to fund the program. We’ve started listening visits, like a therapeutic home visit conducted by Public Health Nurses and Medical Social Workers. And we do evening family gatherings once per quarter with families (fathers) and fathers are saying they want their own support group.