California Task Force on the Status of Maternal Mental Health Care – Meeting Minutes

DATE/TIME: Thursday, September 10, 2015 9-11:15 am (Webinar)

Meeting materials can be found here: http://www.2020mom.org/sept_10_meeting

Task Force Members PRESENT: Angelica Alvarez, Stephanie Chandler, Athena Chapman, Genevieve Colvin, Emily Dossett, Erik Fernandez y Garcia, Tracy Flanagan, Justin Garrett, Neal Kohatsu, Janice LeRoux, Elliott Main, Gretchen Mallios, Connie Mitchell, Sandra Naylor-Goodwin, Brynn Rubinstein, Laura Sirott, Stephanie Teleki,

Task Force Members ABSENT: Carol Berkowitz, Liz Fuller, Sheree Kruckenber, Beth Stephens-Hennessy, Maggie Merritt (Resigned from Task Force)

Standing Contributors PRESENT: Jo Bloomfield, Jessica Walker, Anna Sutton

<table>
<thead>
<tr>
<th>AGENDA ITEMS</th>
<th>DISCUSSION</th>
<th>ACTION ITEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>WELCOME, AGENDA</td>
<td>Joy Burkhard, Founder and Director of 2020 Mom and a key leader of the Task Force work, welcomes the California Task Force members and reviews the meeting’s agenda.</td>
<td>Please reach out to Joy Burkhard or September Hill if you have questions regarding calendar dates</td>
</tr>
<tr>
<td></td>
<td>Announcements: Mistake with January meeting invitation, meeting will be in-person and invitations will be re-sent. Webinar links should be deleted from calendar (Items sent by Amanda Conley) Work stream sessions are going well</td>
<td>Respond to Doodle Poll for next round of Work streams (before October meeting)</td>
</tr>
<tr>
<td></td>
<td>Agenda</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Welcome &amp; Housekeeping</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review of Barriers: Joy Burkhard, MBA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MMH in California: Heather Forquer, MPH</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Racial Disparities: Alinne Barrera, PhD &amp; Marguerite Morgan, PhD, LMSW</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Takeaways</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plus/Delta</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bruce Spurlock reviews webinar tool bar options, webinar netiquette, welcomes contribution from all attendees “Net Positive Energy/Momentum” Listen and understand other perspectives, without immediate judgment “Net Negative” immediate critique (not as helpful)</td>
<td></td>
</tr>
<tr>
<td>REVIEW OF BARRIERS, THE ACA AND FEDERAL MENTAL HEALTH PARITY</td>
<td>Medical record review at Cigna (Quality Assurance and ACOG measures) Screening for depression, validated tools (PHQ-9, Edinburgh) Maternal Depression Screening by OB/GYNs: 5% during pregnancy, 6% postpartum (screening may/may not have been used with a validated tool) Why providers are not screening?</td>
<td>Powerpoint Presentation can be found here: <a href="https://d3n8a8pro7vhmx.cloudfront.net/camaternalmentalhealth/pages/213/attachments/original/1441895428/TF_9-10-15_Bariers___TreatmentPreferences.pdf">https://d3n8a8pro7vhmx.cloudfront.net/camaternalmentalhealth/pages/213/attachments/original/1441895428/TF_9-10-15_Bariers___TreatmentPreferences.pdf</a></td>
</tr>
</tbody>
</table>
- Do not feel qualified, not interested in MMH
- Not enough time to manage a positive screening
- Do not know where to refer patients, shortage of behavioral health providers (California: <10 reproductive psychiatrists)
- Lack of financial incentives (Aetna: depression screening coverage did not yield increase in overall screening rates)

### Family Barriers
- Confused, not informed about MMH disorders
- Normalization
- Stigma
- Do not want to appear ungrateful for their baby
- Fear of baby being taken away (esp. in underserved populations)
- Lack of understanding of Psychosis
- Do not understand risk to baby’s health

Cannot afford care, even if MMH depression signs/symptoms are recognized

### Comments/Questions

**Q.** Genevieve Colvin: Lack of access to Employed Family leave, employed mothers vs. mothers at home, is there any research?

**C.** Neal Kohatsu: Doctors are evaluated on patient satisfaction, may refrain from depression screening, if they feel the patient wouldn’t appreciate bringing up an issue.

**Q.** Joy Burkhard: Any additional barriers important to address?

**A.** Tracy Flanagan: Need standard tool that goes across OB/GYN, medicine and psychiatry. Need to enable our electronic medical record to cross talk. Screening needs to be part of the standard of care. Establish screening times and process standardization, overcome doctors’ fears of not knowing what to do.

**C.** Bruce Spurlock: Add to patient barriers - Diffusion of patient care responsibility and accountability (among doctors)
C. Tracy Flanagan: A large portion of patients don’t go to mental health specialists. They are treated in primary care. Their treatment isn’t evidenced by medication because many of the patients don’t want medication. They offer it but don’t want it. Have seen a fair amount of improvement with time. The big question is: How is that happening when we can’t evidence it with a lot of medication, classes or one on one treatment.

C. Joy Burkhard: Study showed OB/GYN suffer highest level of burnout. Research: pediatrician’s cite the same barriers, plus challenge that mother is not the patient, uncertain how to document in medical record(s). The scope of practice record is a real challenge.

Federal Landscape
ACOG recently revised committee opinion, recommend OB/GYN screen at least once during perinatal period for depression/anxiety using a validated tool. AAP recommends asking the question, “How are you feeling? – not an official screen.
USPSTF revised draft opinion that now recommends at least one maternal depression screen (with validated tool) and find a way to treat patients. Focus on postpartum and pregnant population.

ACA
Essential health benefits (including mental health) must be available in individual and small group plans (<50 members). Large group plans 51+ members) need not cover EHB but if an EHB benefit is included there can be no annual lifetime dollar or visit limits.
Requires screening coverage at no cost to patient
Cost Shares
HMOs already covered maternity services with no additional cost share (before ACA) but for Insurance plans/PPOs would require co-pays, deductibles still required.

Federal Mental Health Parity: Requires health plans/insurers who cover MH to cover at the same cost-shares/limit shares as similar medical coverage. If one of six categories are covered, then all 6 categories must be covered. All plans,
Other Federal Legislation:
Stokes Act: NIMH consider additional research, HHS additional funding, not much net change
Federal Bill (HR 3235): “Bringing PPD out of the shadows” would authorizes funding for states for innovative solutions.

Comments/Questions
C. Elliott Main: In terms of making screening successful you need to make it part of the standard work. ACOG is redesigning the postpartum visit agenda to have PPD screening become part of visit. Standardized E.H.R. screens, make it part of standard work.

C. Athena Chapman: There’s a lot of moving pieces with health care reform and Medi-Cal expansion. The Federal government is trying its best, but it’s important to provide clarity in order to keep MMH on the federal radar. They are working hard to bring all mental health parity up to speed. However, it is difficult in the coordination of the plans between providers, counties, Medi-Cal and the Mental Health Department.

C. Neal Kohatsu: System impact in health plans which are 80% of care, although there is Medi-Cal, fee for service. Have to be cautious about additional work being requested of providers. Confront the need to integrate mental and physical health. There is not enough behavioral health (esp. in rural population). Primary care will have to fill this gap to take care of mental health and behavioral health and drug treatment. How this is going to get done on top of all the other quality expectations that plans and payers have, we have to think systematically about larger transformation of the health care system – concept of a bill of health. In a limited clinical day and it won’t all be farmed out to specialists.

DISPARITIES IN CARE
Joy summarizes health disparities. Latina/Black women less likely to initiate, receive care. Treatment of depression varies by insurance coverage, Medi-Cal
vs. Private. Factors affecting health: treatment access, social environment, treatment preferences (talk therapy vs. medication), cultural preferences.

**Q.** Gretchen Mallios: Why does CIGNA medical records show that 5-6% of OB/GYNs are screening; it’s interesting that a higher percentage of women (up to 25%) are actually getting treatment? **A.** Women will find/seek treatment on their own without diagnosis through behavioral health support groups or therapist. The 5% is for OB/GYN who actually screen.

**C.** Tracy Flanagan: We are looking at this in our own cohort at Kaiser. There’s a lot going on, the data source is what gets coded. Reluctance to use depression diagnosis, even though score may be high. Also, people may have a depression diagnosis, but it might be very controlled and can be considered ‘history of’ rather than active diagnosis in medical record. Difficult to assess in large databases.

**C.** Joy notes many women fear a depression diagnosis will result in lack of insurance/disability coverage. ACA prevents this, still affects disability, life insurance coverage.

**C.** Tracy Flanagan – To add to that, I had our analyst run our data a couple of different ways to find % of prevalence – PHQ9’s with scores over 10; PHQ9+depression diagnosis; PHQ9+ depression diagnosis + medication. They are all very different numbers. Then, I had them run an either/or. The depression burden is best described by: either a high score or a depression diagnosis or medication and that number is somewhere around 18% in our population. It is very interesting to run it all three ways.

**C.** Elliott Main: Remember these are screening tools not diagnostic tools. So, you will get a spectrum of disorders, but it might not get you the diagnosis of depression. The patient needs to go to the next step and get evaluated.

**C.** Tracy Flanagan: Where the field is going in primary care is less focused on diagnosis, more focused on treating symptoms to attain high Quality of Life.
C. Elliott Main: I was referring to the ability to use the administrative data sets and the quality of the actual terminology.

C. Joy Burkhard believes the conversation merits addressing on upcoming work force call – Do we need diagnosis to seek treatment? What are the challenges.

C. Bruce Spurlock: What Tracy seems to be talking about from a measuring standpoint is towards an outcome. So a diagnosis is not necessarily an outcome and a symptom screen or a symptom level measurement is more of an outcome.

C. Tracy Flanagan – Yes. We are getting away from diagnosis and just trying to make people better – a drop in score. We are looking for improvement and remission and less so on the diagnosis.

**Online Chat:**

**REVIEW OF BARRIERS, THE ACA AND FEDERAL MENTAL HEALTH PARITY**

**Elliott Main (to Everyone):** This is Elliott, I co-chaired the NCQA/AMA/ACOG committee that developed the screening quality measure. We identified the need to have a structured part of the prenatal/postnatal form and to have a formal metric (measures drive performance).

**Genevieve Colvin (to Everyone):** Barriers - I think that many mothers lack financial resources - so lack of paid family leave, lack of extra income to cover deductible costs.

**Erik Fernandez (to Everyone):** [http://pediatrics.aappublications.org/content/early/2010/10/25/peds.2010-2348.full.pdf+html](http://pediatrics.aappublications.org/content/early/2010/10/25/peds.2010-2348.full.pdf+html)

**Erik Fernandez (to Everyone):** American Academy of Pediatrics Clinical Report recommending screening for PPD using screening tools, not just asking how mothers are doing. Bright Futures (defacto guidance for most pediatric well child care) recommends PHQ2
DISPARITIES IN CARE
Angelica Alvarez (to Everyone): 9:49 AM: Stigma
Language
Transportation
Lack of health insurance/access to affordable care
Lack of culturally competent care
Challenges faced by Latinos: Vulnerable to the stresses of immigration and acculturation. Women that have to adjust to a new culture are more likely to have major depression

Maternal and Infant Health Assessment (MIHA) Survey
- Annual population-based survey of women with recent live births.
- Addresses maternal and infant social and economic conditions, health status and access to care.
- Modeled after Pregnancy Risk Assessment Monitoring System (PRAMS) Questionnaire emailed to participants in English/Spanish languages, ~70% response rate and 6,800 women have participated since 2010. Women complete survey 2-7 months postpartum.

PREVALENCE OF PPD SYMPTOMS
MIHA questions based on DSM-IV, and validated screening tools. Not diagnostic, just about symptoms.
- 2 Q’s - Prenatal depressive symptoms (Y/N), must answer yes to both to be categorized as prenatal depressive symptoms
- 2 Q’s - PPD symptoms (Y/N), must answer yes to both to be categorized
- 2006-13 prevalence rates declined for both Prenatal, PPD symptoms
- Women more likely to experience one (Prenatal or PPD symptoms) rather than combined symptoms for 2013
- MediCal vs. Private Insurance: more women reported depressive symptoms who had MediCal

Powerpoint Presentation can be found here: https://d3n8a8pro7vhmx.cloudfront.net/camaternalmentalhealth/pages/213/attachments/original/1441858364/Maternal_mental_health_task_force_presentation_FINAL.pdf?1441858364
- Depressive symptoms more common in Black/Hispanic women
- Geographic variation (Top 20 birthing counties in Ca) 2011-13 grouped data.
  - Kern Co (worst), San Mateo (best –among 20 counties)
  - Overall prevalence for California between (2011-2013) is 21.5.

PROVIDER SCREENINGS
Starting in 2013 asked questions re: Prenatal care visits, 4 (Y/N) questions
- Focus today, "Ask you if you were feeling sad, empty, or depressed?"
- 4:5 women screened for depressive symptoms.
- MediCal recipients screened more often compared to private insurance holders,
  - Black/Hispanic women have higher screening rates
  - Top 20 counties (2013 only): Fresno County has highest, Ventura County has lowest screening rates. Overall prevalence 81.1 in California.

CONCLUSIONS
Prevalence of depressive symptoms high. Highest among Black/Hispanic women, MediCal recipients. 1 in 5 women experience perinatal depressive symptoms.

Do not know: how many women were diagnosed with depression, prevalence of other mental health disorders, if referrals for treatments were given

Q. Eric Fernandez y Garcia: Where did the survey obtain its wording? Have not seen this language before.  
A. Y/N format used for simplicity, not found on any existing tool. Available in English and Spanish language.

Q. Elliott Main: Any MIHA data on pregnancy intention?  
A. We do have pregnancy intention data, data inquiries welcomed from Task Force members please email Heather directly.

Q. Genevieve Colvin,: Are women asked which industry sector they are employed, can this information be correlated to depressive symptoms?  
A. We do ask if women are employed, would be interesting to examine that.
C. Tracy Flanagan: Adverse childhood events, any correlation to resiliency. A. Heather – survey does asks about childhood experiences, something to look at.

Q. Bruce Spurlock: Do you have any thoughts about the differences between MIHA survey and Cigna’s results? A. MIHA did not ask if screenings were conducted with validated tools, questions are not limited to OB/GYNs, higher representation of MediCal patients, other questions (smoking, mood, violence), possible MIHA is capturing something different. Joy Burkhard: Cigna records only include OB/GYNs, did not include MediCal, recall may differ based upon research question.

**Online Chat:**

**MIHA SURVEY PRESENTATION**

**Erik Fernandez (to Everyone):** In my review of maternal depression literature, there are very different outcomes measured. It makes it difficult to compare one study’s outcome to another. I would use caution doing that or specifying exactly what each rate is reflecting.

**Bruce Spurlock (to Everyone):** Great point Erik. The agreement on the specifications of outcome measures is critical. Perhaps someone may be able to comment on the NQF activities of outcome measurement.

**Erik Fernandez (to Everyone):** These MIHA 2-question screening questions are slightly different from the published PHQ2. From where they were derived? ALSO, sorry if I missed it, are you only asking the questions in English?

**Genevieve Colvin (to Everyone):** High agriculture counties.

**Janice LeRoux (to Everyone):** I would be interested in seeing how the other 38 counties ran with respect to these data…. can we get data on the smaller counties? Rural would be interesting to me.

**Heather Forquer (to Everyone):** Due to the MIHA sampling plan, we are not able to report county level data for all counties in California. However, we group the remaining counties in to 9 regions. For example, you can see postpartum depressive symptoms by region in this document published on our website:
<table>
<thead>
<tr>
<th>BARRIERS TO CARE, MMH IN CALIFORNIA, AND RACIAL DISPARITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALINNE BARRERA, PhD</td>
</tr>
<tr>
<td>PALO ALTO UNIVERSITY</td>
</tr>
<tr>
<td><a href="mailto:abarrera@paloaltou.edu">abarrera@paloaltou.edu</a></td>
</tr>
</tbody>
</table>

U.S. Latinos: 54 million (17%) of population, largest ethnic group in California. Lack of availability for language and cultural services.

Cultural factors: building and maintaining relationships within care settings, consider cultural outlook, nuclear and extended family/community. Culture specific barriers to care (marianismo/machismo) can also be protective factors. Consider Latino Paradox.

How accessible is care? 28.6% lack health coverage, Latinos underutilize mental health services. Bringing care by technology to share information, bringing care to women who need it, lack of services available or hesitancy to seek care.

<table>
<thead>
<tr>
<th>MARGUERITE MORGAN, PhD, LMSW</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARBOR CIRCLE EARLY CHILDHOOD SERVICES PROGRAM, GRAND RAPIDS, MICHIGAN</td>
</tr>
</tbody>
</table>

STRONG BEGINNINGS program

Recorded statistics do not capture African American women who suffer in silence, “Strong Beginnings” founded for this population. Program has expanded to Latino, all Medicaid families, fatherhood program started. Services offered: Stress management group, Seasonal Affective Disorder (SAD) group for depression associated with weather events (lack of sunshine), anger management group will begin, Holiday season group offers support for seasonal related depressions, childhood and family issues.

Model geared towards working with Community Health Worker (CHW), Family Service Worker (FSW), Mental Health Therapist (MHT). CHW, FSW provide resources to family so Therapist can provide intensive treatment. In Grand Rapids, a masters level therapist, but if the family requires basic needs (diapers, formula) the therapist must address these needs first. Strong
Beginnings has filled this service niche to allow therapists opportunity to address higher-level needs of families.

FUBU – For Us, By Us. Strong Beginnings was developed by the African-American community for African Americans (now branching out to service Latinos)

Q. Bruce Spurlock: Impressed with the expansion of Strong Beginnings, what does it take to go big (e.g. to serve Bay Area, Central Valley, CA), how to scale-up Strong Beginnings success? A. Need to have a collaboration a consortium, Collaboration present in every agency that serves families. Need the whole community involved. Q. What gets it going? Is there a backbone organization? A. Started with African-American nurses, connected with local initiatives to improve health status of community, anyone who has investment in improving outcomes of mothers/children is part of the Strong Beginnings network.

Q. Bruce Spurlock: Community Health Workers/ Promotoras, do you have thoughts about the major roles and how to expand this model/approach? A. Marguerite: CHWs were a lifesaver, started Strong Beginnings as a single therapist and focused on finding community resources, did not provide therapy. Group of CHW's had a lot of experience, they are their peers. They understand what these families are going through. Group of CHWs therapists can better serve families, mothers, and children. The Community equates MSW as a social worker with CPS who will remove child from home, CHWs have enabled success. She let the CHW do the resource work and she did the treatment work. Language from Edinburg survey is common language, easier for mothers to respond. A. Alinne Barrera: CHWs breakdown the fear/formality to bridge care gap of needing help and getting help.

C. Angelica Alvarez: CHW/Promotores is a powerful model of self discovery, identity and empowerment. It nurtures empowerment among mothers and the women serving as CHW. Strengthens the community. They identify their own leaders in their own communities.

C. Alinne Barrera: In the process of healing, being a Promotore is an important
part of the process. The value the peers can provide each other can be very helpful to women who are experiencing acute symptoms and in recovery.

C. Bruce Spurlock: Adding in the peers broadens the care process and the care team.

C. Bruce Spurlock: Anna commented on what she has seen in the Asian American community. It’s important to consider in addition to culture, a generational issue or segmentation within the population and how they approach mental health issues.

Q. Bruce Spurlock: Important to address generational issue compounded by cultural barriers, any important nuance to think about when attempting to address treatment, access to care? A. Marguerite: workers must love what they do, population served picks up on non-verbal communication and cues. Relationship is difficult to develop if community feels unsupported. A. Alinne: Immigration status is a factor that needs to be weighed as it relates to health care seeking behavior, how do you interact / integrate with persons in the community you are serving.

Online Chat:

Angelica Alvarez (to Everyone): Promotor/Community Health Worker model is allowed to function according to the theory of change, Promotores will: 1) build profound relationships over time based on mutual respect, empathy and understanding; 2) share information and local resources; and 3) create opportunities for community members to participate in individual and collective actions.

Jessica Walker (to Everyone): Peers often feel devalued. However peers hold valuable insight and experiences not accessible to others.

Erik Fernandez (to Everyone): I agree with Jessica. Sometimes though, we need to be careful to figure out how close is "too close." Some people will be inhibited by disclosing symptoms. It can be a double-edged sword, especially with families.
<table>
<thead>
<tr>
<th>QUESTIONS/COMMENTS</th>
<th>Joy Burkhard: Of those who watched, “When the Bough Breaks”, what were your thoughts?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>C. Elliott Main: It is a complex topic, many factors (racism, family structure, social structure). Not just an American issue, international. Multiple-drivers in prevent straightforward solutions.</td>
</tr>
<tr>
<td></td>
<td>C. Janice LeRoux: Importance of CHWs, critically important, hope to further this discussion in the upcoming meetings/work force streams.</td>
</tr>
<tr>
<td></td>
<td>C. Gretchen Mallios: 1. When might we see changes and improvements in this community, will we begin to see changes over generations following work of Strong Beginnings. 2. Promotoras –frustration that they are feeling overwhelmed by complexity of symptoms that is beyond CHW skill, how do we make this model important and helpful and address when needs go beyond CHW capabilities? A. Marguerite Morgan: CHW and FSW/Therapists work together, CHW has resources to refer women in need. Generational: worked a lot with grandmothers in church to involve multiple generations.</td>
</tr>
<tr>
<td></td>
<td>C. Connie Mitchell: Appreciated MIHA survey, presentation</td>
</tr>
<tr>
<td></td>
<td>C. Marguerite Morgan: has seen an increase in suicide among program participants, currently working on suicide policy for Strong Beginnings</td>
</tr>
</tbody>
</table>

*Online Chat:*

**Erik Fernandez (to Everyone):** I agree with Dr. Barrera that we must be careful not painting these groups with a wide brush. There are differences within all groups that providers/outreach should look to target. For example, although a small study, we found that differences in antidepressant hesitancy were due to underlying illness belief models rather than ethnicity (and language within Hispanic ethnicity). We recommend figuring out for each depressed person what is/is not relevant to them in terms of their ethnically-ascribe
depression treatment/care-seeking behaviors. 

Angelica Alvarez (to Everyone):: Promotores Create Egalitarian Relationship: Building community trust requires Promotores to participate in community activities, visit people in their homes, spend time sitting with people, listen to their experiences, and share information. Over time, Promotores and the people they meet deepen their commitment to each other.

Emily C Dossett (to Everyone):: In a study we did at LAC+USC of primarily Latina women of child-bearing age and their views on perinatal mental health, up to 98% said that texting was their preferred way of getting information.

Genevieve Colvin (to Everyone):: Insurance should also look at referral networks within their systems and possible telemedicine approach. Can women make contact with someone in the insurance network via skype, etc...

**KEY TAKEAWAYS**

1. Underserved communities and technology
2. Dr. Morgan’s program model, funding
3. Insurance coverage for underserved communities
4. Standard work, reliable process of care for screening. Diagnosis vs. Symptom management
5. Personalization of CHWs
6. MIHA: childhood hardships, racism experiences, suicide

**Online Chat**

Gretchen Mallios (to Everyone):: Another take away: once we surpass screening barriers and get systems to get screening required, we still have the challenge of adoption. Providers think and self-report they are screening yet patients report differently. Once we identify and promote system improvements, getting them adopted and online is the next challenge.

Angelica Alvarez (to Everyone):: Agree Promotores/CHW reflect the community we are serving

**PLUS + DELTA △ MEETING & GENERAL**

**Plus**

Great readings, Yes on the PPTs, Video/media content is powerful, PPTs are

**Joy**

Share your thoughts how to improve discussion breaks during meetings. How do
<table>
<thead>
<tr>
<th>FEEDBACK</th>
<th>helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Delta</strong></td>
<td>More breaks for discussion, agenda for the preparation for the White Paper, Sound check for speakers, make sure links are correct</td>
</tr>
<tr>
<td></td>
<td>you suggest we balance that? More time on work stream calls? Fewer speakers?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NEXT STEPS</th>
<th>October 22 Webinar Agenda:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9-11:15 am</td>
</tr>
<tr>
<td></td>
<td>• Accessing Services: Challenges and Solutions</td>
</tr>
<tr>
<td></td>
<td>• Raul Martinez, Postpartum Psychosis</td>
</tr>
<tr>
<td></td>
<td>• Nancy Byatt, MD, MBA, MCPAP for Moms (MA)</td>
</tr>
<tr>
<td></td>
<td>• One therapist's reasons for leaving an insurance panel: Pec Indman</td>
</tr>
<tr>
<td></td>
<td>Work Stream calls before Oct. 22 Webinar</td>
</tr>
</tbody>
</table>

| ADJOURNMENT | Joy Burkhard thanking everyone for their participation. The meeting ended at 11:16 a.m. |