

7/15/05

Introducing the Maternal Infant Health Program: Q & A

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EXAMINING RISKS, OUTCOMES & EXPENDITURES FOR MSS/ISS RECIPEINTS IN 2001

Collecting Outcome Data

You say that the data you're reporting shows that MSS/ISS is not meeting purported outcomes, but we have never collected outcome data. Where did you get the data?

We used a variety of data sources from the MDCH data warehouse – Medicaid enrollment, claims, and encounters; vital records; WIC; and lead screening. We also had data from MSS/ISS chart reviews and from previous studies, including the MDCH MSS External Quality Review Study and the MDCH 1999 MSS study conducted by Janet Zimmerman. Generally, we feel the program could have better outcomes.

Providers haven't been asked to submit data on outcomes at case closure, so we don't even know if our own programs are making a difference or not.

With the MIHP, we will begin collecting data on risk factors, interventions and outcomes.

This is what WIC asks its providers – did you reduce the risk factors?

Yes. It's important to look at the numbers and the percentages.

Outcome data are buried in our charts.

Yes, and the new reporting system will "UN-bury" it.

You could have asked providers how many women we'd enrolled with certain characteristics.

We'll be doing that in FY 06. The data we're presenting today from FY 01 provides a global, statewide analysis.

There are several levels of evaluation. You did a macro-level analysis rather than a program-level analysis. A program-level analysis would pick up on the issues that we are raising here. Until we get a good look at how the programs are working in context, we won't have the full picture.

You're correct – this is a population-level study. But we also have the Janet Zimmerman study done in 1998. She reviewed MSS/ISS charts at four representative programs and found that "we have 4 different MSS/ISS programs" due, in part, to the fact that communities have different resources. We don't need to do chart audits of the whole state to get a clear picture, if the sample was representative. We also have data from a representative sample of chart reviews conducted annually as part of the Medicaid External Quality Review. The important walk-away message for today is: we are not just changing MSS/ISS – we're also changing the total system that serves pregnant women. MIHP will have more narrow parameters, but it's just one of many programs. We will definitely be collecting program-level data in the new program.

You presented statewide data showing that MSS/ISS isn't doing what we want it to do, but there are pockets where we are doing very well.

True. We presented aggregate data, but there is great variability across the state, county by county and provider by provider.

It's frustrating to know that our county is doing well, but that we're being lumped in with all the other counties, including large urban areas that aren't doing well, and judged on a statewide basis.

Clearly, the state must assess performance on a statewide basis, and that's the level of analysis we have done here. From a research standpoint, it's always helpful to look at the extremes. We need to look further at the major urban areas where infant mortality rates are very high because the populations are so large, as we need to look further at the communities where the data are better.

What works well in a rural area, may not work well in an urban area. We may need different outreach strategies, for example.

Yes, we are aware of this.

The data show no difference in outcomes for women who were enrolled compared to those who weren't. But maybe the program really is working because we're taking high-risk women and getting them to an even playing field with women who aren't on Medicaid.

Except that we aren't comparing Medicaid beneficiaries with non-Medicaid beneficiaries. When we say there's no difference in outcomes, we're comparing Medicaid beneficiaries who enrolled in MSS/ISS with Medicaid beneficiaries who didn't enroll in MSS/ISS.

Any difference in MSS enrollment rates between counties that have mandated managed care and those that don't?

There's no difference – women in managed care are equally as likely to be enrolled in MSS as women on fee for service (FFS).

In the past, health plans had to approve more than 3 MSS visits, which made it harder to get care. Was this an issue in 2001?

At one time it may have been an issue, but our data from FY 01 indicate that statewide, women in health plans had more MSS/ISS visits than women in FFS.

Does your data report moms who are enrolled in MSS in a county different from their county of residence?

No, data are reported by mom's county of residence. It's too complicated to get provider's county of service through the data warehouse.

If there was a conflict between two data sources, what did you do (e.g., on substance abuse)?

We know that risk factors are under-reported in vital records, so we would go with the WIC data on substance abuse.

Did you track how many times data sources differed?

No.

Women Who Refuse Services

We offer MSS to all WIC women in our community, but many decline. Do you have data on the number who refuse our services?

No, this hasn't been tracked, and you're right – we definitely need to collect this data. The MIHP is a population-management model, which means we will try to engage the entire population of eligible women and systematically track them over time. This should give us a much clearer idea of the number of refusals. Of course, the critical question remains: how do we engage the high-risk women who don't want to be engaged? We have a lot of work to do on this. There are some data and ideas in the literature that we can build on.

You showed a slide indicating that WIC serves women with multiple risk factors. We identify numerous women with multiple risk factors too, but they refuse our services. In our program, WIC identifies women for us, but when we contact them at the prenatal clinic, they refuse. If the MIHP is voluntary, like MSS/ISS is, then we'll have the same problem. We'd have more participation if women had to be in the program.

We know that it's very difficult to engage high-risk women, but Medicaid can't mandate participation. However, women will automatically be enrolled in the MIHP until they opt out. They'll have to say, "I don't want your services." We'll have to turn everything upside down and inside out. For example, we need to consider using community health workers (paraprofessionals) to do outreach in the streets. There are models out there that are working better.

Some states mandate schools to get their immunization rates up for children in certain age groups or they will get a cut in Medicaid reimbursements. Why can't Michigan mandate participation in the MIHP?

Medicaid is an entitlement program. We can offer services, but cannot force services on anyone.

I've worked in WIC and MSS. WIC gives out formula. We don't give out anything. Women have all of these unmet basic needs and we want them to stop smoking. We have to give them something that they want, if we expect them to participate.

Incentives are important. Some people have suggested that diapers and wipes would work. Georgia tied Medicaid eligibility to EPSDT visits and immunizations. Illinois engages a high percentage of women in their case management program through WIC. While a woman is waiting for her WIC coupons to print out, the case manager is starting the process. Women don't even realize that WIC and case management are two different programs.

WIC gives women something they want and doesn't go into their homes. We get WIC referrals and then call the women to tell them we'll come into their homes to give them something they don't want. No wonder WIC serves a much higher percentage of pregnant women than we do.

Yes. We need other methods besides home visits, although home visits do provide useful information that can be integrated into care plans.

Maybe MSS/ISS isn't valuable to the high-risk women.

We need to try new strategies to engage women who perceive our services as threatening rather than valuable. They may not want us in their homes, but they may be willing to connect with us on the phone or somewhere else in the community.

Are pregnant women mandated to be in health plans?

Not unless they are already in a health plan when they become pregnant. Health plans do as well or better than FFS with respect to MSS enrollment and number of visits. Part of our responsibility is to link incentives to our desired outcomes, as we have done with lead testing. Women in health plans are covered for 20 OP mental health visits, although

many are unaware of this. Women on FFS have no OP mental health benefit. We are looking at all of this on many fronts (not just MIHP) as part of our systems approach to addressing infant mortality. We almost mandated all pregnant women into health plans a while back. Should we move in this direction again to give more women access to mental health services, knowing that CMH is only seeing women with severe and persistent mental illness these days?

When women already have multiple providers coming into their homes, they don't want another one.

We will be looking at this.

Questions on Specific Slides

Is the smoking data based on self-report?

Yes, so it is probably not as accurate as if we were able to collect data based on hair analysis or nicotine swabs.

Where did you get the smoking data?

From the MDCH data warehouse – vital records and WIC.

We tried to look at smoking using vital records here (northern Michigan), but Kids Count said that vital records stats may not be accurate because responses depend on how the hospital worker asks the questions.

We'll collect smoking data more precisely through the MIHP screener and match it to the other data sources. We'd likely have issues with training hospitals to collect data more systematically.

Looking at the Medicaid data on depression, do you know when women were diagnosed?

We didn't look at point of diagnosis.

Doesn't the literature show that depressed women are likely to self-medicate with smoking, drinking, and drugs? So why would African American women be less likely to drink and smoke?

The literature shows that African American women don't really smoke less – they just report that they do. This was confirmed by the MSS/ISS providers we met with in Southgate the other day.

It's interesting that the slides show that African American women were less likely to say that they smoked, but more likely to say they used drugs – seems odd that they were more hesitant to admit to smoking than to drug use.

Point well taken. There's not much on this in the literature, other than to say that after women self-disclose drug use, they tend to disappear.

Is it also because women know they will be tested for drugs at the time of delivery?

This is true in the claims data. We get the best data on smoking from WIC, and the best data on substance abuse/detox from Medicaid claims.

Lots has to do with trust level. WIC is a trusting environment – women tend to see it as separate from protective services, etc.

Interestingly, when we ask the women with whom we are piloting the new screener if they are concerned about their privacy or that the data will be used against them (e.g., with protective services), they say no. However, the pilot sites are at WIC offices, so the trusting feeling may still be there.

The data show we need more African American providers.

Yes, including paraprofessionals. Byllye Avery, an African-American researcher with the Harvard School of Public Health, says that it's very different for a poor white woman to look into the eyes of a white professional than it is for a poor African American woman to look into the eyes of a white professional. If they are from different races, their ability to bond is compromised. It's worth going out to hear Avery speak if you ever get the chance.

Do you have any data on level of trust by race?

We haven't looked at that yet.

What is “the Kotelchuck” that you referenced when you were talking about the slide on the adequacy of prenatal care?

It's a measure of the adequacy of prenatal care - an index of the number of prenatal visits by gestational age. 11-14 visits=adequate and 14 + visits=adequate plus.

On the EPSDT slide, are you referring to well child visits?

Yes.

On the expenditures slides, what does PMPM mean?

Per member per month.

On the slide on “Expenditures for All Mothers,” do the numbers reflect all Medicaid care for the women?

Yes, broken down by those in managed care and those in FFS.

When you look at pregnancy costs, there's a flat amount regardless of the number of visits. If most women are in the hospital for two days when they deliver, the only variable is MSS, unless they are hospitalized for longer. There's not a lot of variation.

There's also mental health, substance abuse, pharmacy, delivery, NICU, etc. – but there isn't a lot of variation.

Were women who participated separated out by enrollment rather than by risk factors?

Yes.

On the depression slide, what falls under “depression associated with stress?”

In the literature, it’s a broad category - an amalgamation of “I feel stressed.” People have varying thresholds for stress. Some researchers assert that a pregnant woman living in poverty is likely to have a fetus immersed in stress before birth.

Were the differences on the immunizations slide statistically significant?

Stats don’t come into play because this is a population study.

The 8% figure for women diagnosed with depression seems low.

It’s taken from Medicaid claims for scripts, etc.

So we don’t know if they were enrolled in MSS?

Yes. We do know that it’s hard for Medicaid beneficiaries to access a clinician to get a diagnosis. We have to assume that the 8% were significantly depressed, and we know that 72% of smokers were diagnosed with depression, 18% of alcohol users were diagnosed with depression, 22% of drug users were diagnosed with depression, and that 35% had documentation of use of both substances.

Referring to the ISS lead slide – was lead assessment the reason they got into ISS?

We don’t know.

Explain the slide on “Pregnant Women in WIC by MSS.” How many women were there in WIC who weren’t / were enrolled in MSS/ISS? If I’m in MSS, am I more likely to be in WIC?

There’s a small difference – a woman was a tinge more likely to be in WIC if she was already enrolled in MSS/ISS, but this was just an association. Most of the women in MSS also got WIC. Lots of the women in WIC never got MSS. WIC says they refer to MSS, but just handing a woman the MSS phone number doesn’t work well.

The slides show that one thing MSS/ISS does do is to get our women into WIC?

Yes.

FAMILY PLANNING WAIVER

Will the Medicaid family planning waiver cover the emergency services only (ESO) Medicaid population?

No, it will not cover the ESO population (e.g., migrants). It will cover women with incomes up to 185% of the federal poverty level (FPL), ages 19-44, who are citizens or who meet citizenship requirements. However, we’ll be able to shift women from Title X to the waiver, which will free up Title X funds for women on ESO. The goal is to save money by reducing unintended pregnancies.

Who is eligible for Title X?

Basically anyone – documented or undocumented (by self-report). There is a sliding scale fee for Title X.

Will the waiver cover tubal ligation and vasectomies? For what ages?

The waiver covers women ages 19-44. Women under age 19 are covered under regular Medicaid or MICHild. The waiver doesn't cover men – they can get vasectomies under Title X. We're somewhat constrained by funding requirements, but we want to put the two programs side by side so that it feels seamless to people. We want to make more efficient use of Title X funds. After 5 years, we have to demonstrate budget neutrality - if it turns out that costs with the waiver are more than costs without the waiver, we have to pay the difference back to the federal government. Other states have been very successful with the waiver.

What is the difference in services between Title X and the waiver?

The services are the same under both. Under the waiver, women between the regular income threshold for full Medicaid and up to 185% of FPL will have Medicaid for family planning only. The waiver will cover the following family planning services: annual visits, routine office visits, and associated lab tests.

Reproductive health education programs in Michigan schools are weak. Is there a chief at MDE pushing for improved reproductive health education?

The Michigan Model dollars flow through Brenda's division at DCH – she partners with MDE on this. The Michigan Model has taken a huge cut in funding – it's practically demolished. We're looking at Medicaid match for this and re-doing the curriculum. Michigan is a state where the politics of reproductive education very much affects what we do. Legislation passed this year makes it even harder. Those who want schools to have a very narrow role on reproductive health have constrained the Michigan Model.

MATERNAL INFANT HEALTH PROGRAM GOALS AND DESIGN

MSS/ISS has been serving about 20% of the Medicaid-eligible population. Do you have a goal for what the percentage should be three years down the road?

We haven't set one, but what's wrong with shooting for 90%, like WIC? Because poverty is such a compelling risk factor, we want to reach as many eligible women as possible. The low-risk group will get info packets and periodic follow-up calls. Moderate and high-risk groups will get more intensive interventions.

Will the MIHP still be a voluntary program?

Yes, but women may have to opt out, rather than opt in – we're considering this approach.

The MIHP will be one program, not two. If a woman has a history of depression, is she still eligible for the MIHP after the baby is born?

For most pregnant women, Medicaid eligibility will end 60 days postpartum. However, the infant will be Medicaid eligible, so MIHP services will continue beyond the 60 days. We are still working on how all of this will unfold.

Will the new program be effective and acceptable to women in Wayne/Oakland/Macomb Counties?

There are African-Americans on the MIHP Design Workgroup (DWG), but we need you to keep us honest in terms of how we look at this. We want to be respectful of families and of the African-American, Hispanic, and Arab-Chaldean cultures. The coalitions in the 11 communities with the highest rates of infant mortality among African-Americans will help us, but we need to hear your voices as well.

It sounds like the new program won't be uniform – that it will be different across communities?

No, overall it will be much more consistent, with defined common outcomes, common intervention parameters, common data collection procedures, etc. It's just that how you deliver services will be more flexible – you can use other modalities in addition to home visits (groups, phone calls, clinic-based services, etc.). For example, it will be more efficient to do the 5A's smoking cessation program in groups, rather than one-on-one. In addition to the three disciplines (RN, RD, SW), we may be adding a paraprofessional and other professionals such as infant mental health specialists.

We deal with behaviors. Has the DWG thought about adding mental health specialists for moms and infants?

The state will move away from prescribing staff – providers will have the flexibility to use a broader range of disciplines. For example, providers may decide to contract with a mental health specialist to run depression groups, if mental health treatment is unavailable in the community (although we don't want to give up on the health plans or CMH system). Providers can experiment with ways to deliver services. For example, women may be willing to get together to do crafts, and then share their experiences and bond with each other in the process.

So we'll still have the three disciplines on our teams?

We won't say you can't have them, but you may not need all three. For example, depending on how the WIC program in your community is staffed, you may not need a nutritionist. Also, you may decide to involve other disciplines, including community health workers (parapros) to do outreach, mental health professionals to run support groups, etc.

When will we have web-based data entry?

We don't know. It will take a while – the state moves slowly on IT issues.

When the web-based registry is developed, can we use it to look up the new address for a woman who moves to a different county (like WIC can do)?

Yes. You wouldn't have to start all over again.

I could go into the registry every day and see who the pregnant women are in my county?

Yes. You could get their names, along with their entire risk profile if they were already screened by another agency.

All the data going into a huge data warehouse sounds intrusive. What are we doing to preserve a woman's privacy?

When you enroll in Medicaid, you agree that info regarding your case can be shared. We are obligated to follow HIPAA rules for an electronic database. It's similar to the electronic medical records that many providers are using these days.

Some women refuse services because they don't want to make themselves more vulnerable by losing their privacy. This is part of the access to services question and needs to be looked at very seriously.

We totally agree that as we integrate the systems elements, we need to be respectful of every woman's privacy rights in a way that supports her independence. The huge cost of Medicaid is pressuring the state to contain costs, but we can't crush beneficiary rights and choice in the process.

Does the DWG have a profile of the typical provider in mind in terms of computer-assigned referrals? Wouldn't it depend on the population of the county?

We haven't gotten to the details on computer-assignment of women yet. Generally speaking, once MDCH became aware of a pregnant Medicaid beneficiary through a particular data source, she would have to be offered her choice of MIHP providers. If she didn't make a choice, DCH could auto-assign her to a provider. We do recognize that different parts of the state bring unique sets of issues. It's true that communities and providers are very different but how we get women to stop smoking isn't different across the state – how we measure progress on the smoking continuum wouldn't vary.

What will the paper trail be like?

Nothing will be automated in the coming year (FY 06). We haven't gotten to the detail on who will submit what to whom yet.

Will we still need releases, HIPAA forms, etc? What records will we be required to keep?

You will still need to maintain files in keeping with Medicaid guidelines. All of this will come out in policy.

What are the 11 counties receiving funds to support coalitions to work on decreasing high African American infant mortality rates?

City of Detroit and the following counties: Berrien, Genesee, Ingham, Kalamazoo, Kent, Macomb, Oakland, Saginaw, Washtenaw, and Wayne.

Our program is working well, so we don't feel the need to be fixed.

You're already down the road to where we all want to go. It wouldn't make sense for DCH to drive you out of business, so we will proceed slowly and carefully.

When you look at rural areas, look at the culture. In northern Michigan, we have high rates of smoking, substance abuse and obesity, but we have no African American babies. It doesn't look like our families will get much from the MIHP. We feel we're being left out.

The data we saw indicated that the risks African Americans experience are not there when you get to a certain degree of latitude, but smoking and drinking rates are very high in northern Michigan. It's true that African American babies are dying at 4 times the rate of other babies in Michigan, but the MIHP is still for all pregnant Medicaid beneficiaries.

MIHP DESIGN WORKGROUP (DWG)

Does the DWG include both public health and private providers?

Yes.

Are there dieticians on the DWG?

Yes, some from WIC and some not affiliated with WIC, on both the DWG and the Steering Committee, but we still need input from you.

Are African-Americans represented on the DWG?

Yes.

What is the role of the MSU IHCS in the design of the MIHP?

IHCS has a contract with MDCH to do research and technical assistance for them. MDCH asked IHCS to put together a number of MIHP program options, and MDCH chose to go with the one we are discussing today. IHCS works on behalf of MDCH. The MIHP is MDCH's program.

MIHP MATERNAL SCREENER DEVELOPMENT & TESTING

Piloting the Screener

How many women are participating in the pilot testing?

We expect to have 120 in Genesee, 200 in Kent, and 200 in District 10.

You need to pilot the screener with women in Wayne/Oakland/Macomb, since there are MSS populations within populations here.

We're going to implement statewide policy based on what we learn from our 3 pilot sites, but Medicaid policy staff will work with Wayne, Oakland and Macomb to tailor the screener to their needs, if necessary.

Are you piloting the screener in other languages?

We're piloting a Spanish version. We hope to test it with at least 25 Spanish-speaking women, but we may get more.

Our women think MSS is linked to their eligibility to get public assistance benefits, so they won't tell us the true story about their work activities, their baby's father, etc. We don't start interviewing a woman until we have made it very clear we aren't part of DHS, the Friend of the Court, etc. It takes time to build trust. Will women answer the screening questions honestly if the interviewer doesn't have time to build rapport? My sense is that women will share more at follow-up contacts.

It appears to be working in our pilot sites so far.

What does SNAG mean on the screener?

It's just for the pilot testing of the screener. It's a box for interviewers to note if there was a problem with a particular question (e.g., the woman didn't understand it). If SNAG is noted for a significant number of women, the question has to be redone.

So an interviewer can check more than one option – the woman's response to the question and SNAG?

Yes.

Why aren't there SNAG boxes for the questions on abuse and violence?

No good reason – they got left off. But we would have had to go back and get the change approved by the IRB, which would have delayed the pilot phase by a month, so we just went with it. Several people have suggested we don't have enough questions on emotional abuse (e.g., stalking).

What do interviewers do with info that doesn't fit into a response box (e.g., we ask the woman if she has had any problems with her lungs {question 2.7E} and she answers, "I had pneumonia two years ago.")?

We talked about having a big "other" box at the end with guidelines on what can be included there. We don't want to extend the length of the screener.

Questions on Specific Screener Questions

On question 2 - Prenatal Health History/Risks – have you had any feedback on use of the word "risk"? We have found that some moms are alarmed by this word, so we've gotten away from this.

We could certainly just call it Health History.

In the health history section, did you consider asking about a history of multiple births?

Multiple births with the current pregnancy may lead to complications with respect to birth weight, but this falls under the care of the OB. We could make that case for chronic illnesses too, except that one role of the MIHP provider is to help women get treatment for existing conditions. We'll look at this.

The health history section asks questions about chronic diseases. We've never asked questions about diseases that lead to poor birth outcomes.

The point is to better integrate our efforts with those of the OBs.

Aren't some of the questions the same as the WIC questions?

Yes, we borrowed from the WIC health history.

Why ask about dental needs (question 2.9) when we have no place to send women for dental care?

It's for research purposes. Researchers at WSU are studying the relationship between dental problems and pre-term labor and need to collect data on a large population. We also need the data for continuing discussions and decisions about restoration of the Medicaid adult dental benefit. Medicaid has been pushing to restore the benefit for pregnant women, but no luck yet. If we had data and tied it to cost-savings, we'd have something to hang our hat on. It would be great to be able to show this data to the feds in the hope that they would use it to require states to cover dental services for pregnant women.

When we ask this question, women will think we can help them access dental care. Medicaid does cover dental services for urgent and emergent dental care. We just need to be clear that regardless of the issues and questions discussed, what Medicaid provides is defined and doesn't cover everything.

Question 3.1 (where do you go for prenatal care?) may be confusing for migrants who don't distinguish between a doctor's office and a public health clinic.
This is a training issue for interviewers.

In question 3.1, does "doctor's office" = private provider?
Yes, Federally Qualified Health Centers fall under "other" now.

It's common for a woman who just found out that she's pregnant to say she isn't smoking, but on subsequent visits we see signs that lead us to believe she is.
Yes, you need to continually monitor this. The intervention matrix gives strategies based on the literature.

Is there any evidence of negative effects on the fetus when a pregnant woman is continually exposed to second-hand smoke?
On the woman's health, yes, but not on the fetus, as far as I know. We'll check. We will have questions on second-hand smoke on the infant screener, since it's a major issue post-natally.

Would a pregnant woman at least be low risk if everyone in the house smokes except her?
It still wouldn't be a risk factor, but we should give out info on second hand smoke. As we develop the infant piece, this could be part of the matrix.

Why is depression question 8.3 only for black women?
Because the literature says that African American women respond better to this question. We wanted to test this during the pilot phase. We've struggled with whether or not to ask it of all women.

I don't think we should have race-specific questions.
We hear that.

What if you put questions 8.2 and 8.3 together?

We can't change 8.2 because it's copyrighted.

How many SNAGS are you getting on question 8.2?

Not many in Genesee County, where there is a large number of African American women.

Anxiety isn't a risk factor we want to screen for?

No. The literature on this is underdeveloped, but at the moment it's looking as if depression and anxiety may be the same animal with different manifestations.

The current assessment asks questions on child protective services history. Some women don't answer "yes" when asked if they have a history with CPS, but the follow-up questions prompt them to provide more information.

The infant screener will address this.

The CPS questions belong on the maternal screener – the hospital needs to know about CPS involvement before delivery, and there may be other children in the home.

You can ask these questions during the assessment – we didn't think they're appropriate for the screener.

The intervention matrix refers only to depression, but what looks like depression may really be post-traumatic stress disorder. The screener needs questions to get at past child abuse, domestic violence, etc., which often result in dissociative states.

We have changed the domestic violence questions and will probably add more questions on emotional abuse.

Will you ask about previous sexual abuse? This is very prevalent in our population.

The literature says women in poverty are likely to be depressed and be in an abusive relationship. There's no literature that says that a history of sexual abuse impacts birth outcomes. It was a hard decision, but we chose to screen only for those risks that we can impact, based on the literature. We can't change a history of sexual abuse, but we can do something about depression.

But she keeps choosing the wrong partners as a result of sexual abuse.

We landed with the principle that our program can't do all things for all women. The literature shows that the most effective programs target specific risks that we can actually do something about. We could identify a long list of risks to add to the screener that we don't know how to do anything about and have no impact whatsoever on birth outcomes.

There's nothing on housing under social support.

Housing is addressed under basic needs, question 11.3b.

Don't we need a place to note that a woman is cognitively impaired and may need someone to follow her throughout her entire pregnancy?

Cognitive impairment, like race and age, is one of the risk factors we can't change. However, it's an important consideration in developing the care plan and delivering services. There isn't a place now to note that a woman is cognitively impaired, but we are looking at adding a question on cognitive impairment or an "other" box with guidelines on what to include there. We would have to present information differently for women with cognitive impairments – READY Kits wouldn't do it.

Some counties are experiencing a huge influx of refugees from Somalia and the Sudan.

The literature shows that these groups are not as high risk for infant mortality as African Americans are.

Why are there so few nutrition questions on the screener (question 11)?

You will work with WIC and they'll identify the risks related to nutrition. There are a number of questions that are related to nutrition on the screener, which is similar to the old MSS screening tool. The follow-up assessment also contains many nutrition-related questions. The tool will go through the Medicaid policy promulgation process before it is finalized, so you will have an opportunity to comment further on it then.

Why is there a breastfeeding question (12.1) on the screener?

So the MIHP can support WIC's breastfeeding efforts. DCH is working on clarifying the core set of outcomes for each of its MCH programs. The big three are MIHP, WIC and family planning. The MIHP may not concentrate on breastfeeding, but we want to reinforce it. We also want to ensure that the women served by the MIHP are linked to family planning services and that this is reflected in their care plans.

So WIC will tell us the nutrition concerns and we'll go out and follow up on them?

Info will be shared between the two programs. Who will do the follow up hasn't been determined yet. Each will likely reinforce the other, but programmatically, WIC is the lead nutrition program. Working with WIC should be considered a partnership. You certainly may further assess nutritional needs and issues.

There's no question on transportation?

It's there - question 3.4 under access to prenatal care.

Was the age of the mom discussed as a risk factor? A 13 year-old could end up with a negative screen.

There is no intervention to change a woman's age. However, like race, age will go into the algorithm for the risk score.

Why don't we have a question on mom's immunization status?

This is the clinician's role, although some doctors do and some don't address it. This program can't do everything. If we direct resources to immunizations, we redirect them away from smoking, depression, and domestic violence interventions.

What about rubella?

Women need this before they become pregnant, not during pregnancy. It could be addressed for the next pregnancy, but again, we can't solve all problems for all women with this program.

So we should stop buying handouts on mom's immunizations from MSU?

You can buy them if you have the resources. If our docs aren't addressing mom's immunizations, we can address it from the policy/reimbursement side. We need to know the problems so we can systemically intervene, rather than lay the burden of solving everything on you.

I like the screening tool because it's so research based. I'm really sold on it. I say you should get the nutrition questions from the literature, as you did for the other risk factors.

Mark Chaffin, Center on Child Abuse and Neglect, University of Oklahoma, wrote an editorial saying that we continue to implement programs that are based on bad data, and that we should only implement programs that were evaluated using randomized trials. If there were 20 evaluations on a program and there were only two with randomized trials, we should go with the two with randomized trials and forget the others. The literature shows that home visits work for some issues, but not for others. The reference to this editorial will be posted on the MIHP web site.

I'm concerned that the screener is very deficit-based – as we move toward risk-stratification, we need to determine the woman's strengths as well as her risks. This tool seems to be based on the medical-model, but we're public health practitioners.

IHCS is part of the MSU Medical School – the screener is based on the medical model. Women give birth in the medical model. To capture the synergy of working with OBs, we have to work with their legacy/reality. They need help getting diabetic and depressed women to do what they need to do. At this point, the literature is not clear that family-centered, strengths-based practice results in better birth outcomes. However, we intend to incorporate this into the total process. MSS/ISS – MIHP is not solely viewed as a public health model. It really crosses several models of care, (i.e., public health, medical field, etc.).

The public health literature says that prenatal medical care isn't as significant as addressing some of the psychosocial elements around that care.

We could have a very long discussion about this. However, the very existence of this program, which is largely a support model, speaks to our recognition of the importance of these psychosocial elements. We just need to be more realistic about where and to what extent this program can actually impact them.

There are 2 pages of questions on risks that are screened in the doctor's office and only 3 questions on social support, which is our strength in being community-based rather than office-based. We assist with life issues that aren't impacted by the medical model. Our current assessment tool looks at strengths.

We don't have this all solved. We haven't determined yet if the screener will be entirely based upon need. The current assessment tool has questions on life issues we've traditionally wanted to understand. But now that we want to go deeper in fewer domains, to what extent do we downsize the info we collect up front? We need your feedback on this.

Implementing the Screener

Who does the risk stratification?

The screening tool will do this. You'll be trained on it before Oct. 1. Eventually, we'll train WIC and other programs or agencies that wish to do screenings, since they will be able to be reimbursed for screens. In some communities, the WIC and MIHP screeners will be totally integrated, which will increase the volume of completed screens and save funds.

A woman will be stratified into an overall category of low, moderate or high risk, even though she could be high risk in some domains and low risk in others?

Yes, it's very complex. The more domains in which she is rated high risk, the higher her overall risk level. Ideally, pregnant women will be re-screened at 28 weeks and after the baby's birth. It will be important for MIHP workers to have relationships with physicians.

When we get a referral from a physician, they assume we're following along throughout the entire pregnancy. What are they going to think about service intensity being dependent on stratification level?

DCH and the health plans will educate providers about the changes. They'll all hear about it, but you'll still have work with them and help them understand the new model.

Who inputs the data?

If the woman is screened by WIC, the WIC worker would do it. If you screen the woman at a WIC office or elsewhere, you would do it. Eventually, data entry will be web-based. We are testing the wireless download of data onto the web, which means no one has to input the data!

Like real-time data entry?

Yes.

So we can't do the screener electronically in someone's home at this point?

You could use a PDA and then plug it into a PC (not wireless).

Do you get an electronic printout of the results when you use the electronic version of the screener?

Yes. In Kent County, where they are integrating the WIC and MIHP screeners, the printout will include the WIC risk codes and the MIHP risk codes (not quite there yet).

Does it give you the risk-level?

Not yet, but it will once we program the algorithm. Then you will get back a statement about the woman's risk level and case rate.

You're saying tablets and PDAs will automatically pop-up the woman's risk level?
Yes.

Please let us know what technology we will need as soon as you know – we update our equipment year to year, not all at once.

We're testing a mixture of technologies. The screener was built for PDAs, the lowest form of technology, then the tablet, then the PC. You could use any of the three. We're testing wireless capability.

Will the state pay for the PDAs?

We're looking at the Medicaid match mechanism as a potential way to do this.

Will there be a way to know how many eligible women there are in our county vs. how many we have enrolled?

Yes.

We are looking at the population of all pregnant women in our county?

The population of all Medicaid-eligible pregnant women in your county.

What if the woman is diabetic, but the person conducting the screen doesn't have medical background (e.g., CHW)?

Community Health Workers (CHWs) aren't going to be case managers - their role is screening only. Every woman, including those at low risk, will get at least one phone call from a professional case manager. Providers will not be required to hire CHWs, but some providers have been begging for this as a way to be able to touch more women.

How long does it take to complete a screen with the new screening tool?

We are about 1/3 of the way through the pilot study, but at this point it looks as though it takes about 20-25 minutes. If it was totally integrated with the WIC screener, it would take longer.

We'll get paid per screen?

Yes. Our intent is to pay for screens on a stand-alone basis. This means that WIC and other community agencies, churches, etc., could also be paid for completing screens.

How does the MIHP get the screening results if someone else does the screening?

It depends on the community. In Kent County, WIC is doing the screening and then handing it off to MSS - so far, it's working. Each provider will need to develop handoff procedures with WIC and eventually, with other agencies that conduct screenings.

If WIC screens, how do they get the MIHP screening results to us – there isn't a name, phone, etc. on the screener?

Our assumption is that you could get this from WIC, but you could add identifying info to the screener. Down the line, you'll get a woman's most recent address and phone number automatically from the database.

Can you revise the screener if you need to make changes?

We wanted to design the database to be sensitive to edits. If you change an element in the database, it changes it in the screener. We'll be testing this.

Does the new screener replace the MSS assessment? How is the assessment done?

This is not completely decided. IHCS is recommending that the screener replace the current screening and assessment tools - it includes most of the questions on the current assessment and a few more (e.g., nutrition) could be added if need be. MDCH is not sure about this yet. We hope that the Medicaid policy on the new screener will go out for public comment in June. We also need to work on billing codes.

Right now, we're thinking we may use the current assessment tool for a while. The IHCS rationale for replacing the current assessment with the new screener is that clinicians would do the actual assessment. For example, a woman who screens positive for moderate-severe depression would be referred to a mental health clinician for assessment, diagnosis and treatment, assuming there's a mental health clinician available to refer her to. The MIHP is not a treatment program - it's a support/care management program. If we are addressing the right domains, we don't need as much info at the front end, as clinicians will be doing the assessments.

If the new screener does end up replacing the old screening and assessment tools and WIC does the screening, then we're supposed to sit down and develop the plan of care from that, without having talked with the woman ourselves?

You would talk with her in depth as you develop the plan of care.

Will the screener come with a consent form so the woman can enroll immediately?

The current consent form process will remain unchanged. As of Oct. 1, we are simply introducing the new screener and assessment form.

How reliable would a phone screen be vs. the current face-to-face requirement, and will the MIHP require one or the other?

Face-to-face contact will be required for the screening.

So if I'm making a Healthy Futures call, and it sounds like the woman has risks that might make her eligible for MIHP, I couldn't do a screen right there on the phone.

It's our thinking that you would use that call to arrange a face-to-face MIHP screening.

How do we score the Edinburgh Post-Partum Depression Scale?

We'll show you how to score it by hand. When we go electronic, it will be scored for you.

Will the screener be used in the 11 African American communities with the high infant mortality rates?

The MIHP providers in those communities will use the screener.

MIHP INFANT SCREENER

Will there be a separate screening tool for infants?

Yes. We want to do everything possible to support the healthy growth and development of the infant. It's likely that we'll be using the Ages & Stages Questionnaire: Social/Emotional (ASQ: SE) screener, with some wraparound questions of our own. The ASQ: SE is valid and reliable, and Early On, AAP, and lots of others are using it.

When will the infant screener be implemented?

IHCS can hand the infant screener off to MDCH around 12/01/05, if MDCH agrees to go with the ASQ: SE. Then it will have to go through the policy promulgation process. We're not sure exactly when providers will begin to use it.

MIHP - WIC PARTNERSHIP TO SCREEN MIHP-ELIGIBLE WOMEN

Women who use substances don't want to be engaged in MSS/ISS.

Yes - they certainly won't walk through our agency doors and ask for MSS. We may be able to engage more of them through WIC, since WIC serves such a high percentage of our target population, including women at high risk.

You prefer us to refer nutrition concerns out to WIC?

Yes, generally, although it will depend on the particular community. WIC is federally funded to do nutrition. To the extent that MIHP does not have to do nutrition, we can save state dollars to use for other critical purposes.

The eligibility criteria for MSS and WIC aren't the same.

90% of WIC consumers have risk factors that make them eligible for MSS.

Wayne, Oakland and Macomb (W/O/M) WIC offices have huge waiting lists. They aren't serving pregnant women – can't get appointments until 1½ months after delivery.

We will look into this.

Our WIC only does 15-minute contacts.

W/O/M has some WIC issues that are not issues elsewhere in the state. WIC does do more in-depth follow-up in other communities. As we work to improve infant mortality rates, we are looking at the whole continuum of domains that we need to address to determine which state program can address which domain. WIC is the program to address nutrition, but how do we get there? Nutrition will never be a totally separate domain. Alethia Carr, WIC State Director, is part of the MIHP Steering Committee. There is a great deal of work to be done on the details, but the intent is to clarify and more narrowly define the cope of MIHP – to go farther on fewer domains. This only works if the other programs really can pick up the other domains.

It's not true that WIC provides extensive nutrition education – it provides limited nutrition education. WIC does do assessment for high-risk women, but most of our clients are the in-betweens.

Nutrition cannot be lost. We have to re-look at this across programs and figure it out. We won't drop it without being sure there's a net.

WIC can't impact nutrition and breastfeeding all by itself. WIC sees women once every three months and does a 5-minute nutrition evaluation before dispensing her WIC coupons. This isn't enough contact to impact behavior related to nutrition and breastfeeding. WIC doesn't really have the opportunity to sit down with a woman and explain what her diet is doing to her baby.

DCH is working to assure that WIC is doing what it needs to do. We need to move toward WIC taking the primary role in nutrition, while MIHP takes a supporting role. We won't drop any component unless we're sure it's being provided by another program.

In my community, it's the MSS dieticians who do the high-risk follow-up for gestational diabetes.

WIC says this is true in a number of communities. MDCH needs to follow up on this further. Certainly we must assure access to nutrition info and services for all who need it.

We need your help to fix the WIC problems in W/O/M if the nutrition component will be WIC's responsibility. We need dieticians because WIC doesn't have services in place.

We wouldn't expect MIHP to ignore nutritional concerns if WIC can't address them. We must and will work it out. We will make sure nutrition is part of the mix.

In Wayne County, what do you see as the role of the MIHP dietician, if there are no nutrition questions on the screener?

This is why we're saying that maybe we should continue with the current assessment tool for a while, as it does include nutrition questions. Nutrition is an area we will go slowly with. Nutritionists are hard to come by – we don't want to eliminate them unless we're sure they are available in another community program. In some cases, the MIHP will have to provide nutrition education.

We have dieticians at our hospital – will Medicaid pay them to work with MIHP clients?

We don't know how nutrition follow-up will be done yet. Medicaid OP pays for gestational diabetes classes.

WIC does get federal funding but we put a ton of local dollars into WIC, so please don't think it's all federally funded.

We're a LPHD – our WIC program screens for our MSS/ISS program. We get 50% of our MSS/ISS referrals this way, but how long can we support this?

Your health officers know that DCH is promulgating policy to match the local dollars you contribute to WIC with Medicaid funds. Local dollars count the same as state dollars do for drawing down federal match. We're doing all sorts of things to maximize the

dollars for the state. Then we're realigning priorities across programs to better resource all of them. WIC will get paid to screen for the MIHP.

We heard this was happening, but haven't seen the policy.

The policy is out.

If WIC is in a different building or agency, could MIHP staff go to the WIC office to do screenings?

Yes! Or you could arrange for WIC to do all the screenings (they will be paid for them) and you do all the follow-up. We don't want WIC auditors to find that WIC funds are being used to screen for MIHP. You'll have more flexibility to do what you need to do to make screening work in your community.

We invite you to come up north and see how we do WIC and MSS together. 90% of our WIC women are getting MSS. We do it onsite with one appointment. We have "Pregnancy WIC Day". It's like a class and we have breastfeeding conversations, Medicaid enrollment, etc. Women come out for the food and they love the day and we engage them in MSS. We'd hate to lose this – it's the only way we can survive up here, and you have the power to make it happen elsewhere. We also send newsletters at different stages of pregnancy (e.g., 18-22 weeks) as part of Healthy Futures. Brenda, Ingrid, WIC consultants, and anyone else – come on up.

Ingrid will schedule the visit. Tom said that IHCS is preparing its proposal for its 3rd year of doing research to support the MIHP design effort. IHCS will propose to look at the top 10 and bottom 10 performers in the state. Some general findings will translate across all MIHP projects.

I'm not in Genesee County anymore, but I can see how "Pregnancy WIC Day" could work. Maybe health departments could be matched to mentor each other.

We're setting up a mentoring system with school-based health centers. We will actually pay existing centers to mentor emerging centers.

Does WIC know they'll be doing MIHP screenings?

State-level WIC staff, Alethia Carr and Diane Revitte, are on the MIHP Steering Committee. We don't think WIC will be mandated to do screenings. The Kent model is voluntary. The Genesee / District 10 model (MIHP worker screens woman at WIC clinics) may be the predominant model, at least initially. WIC providers may be unaware that screening will be an option for them. Until we have a separate reimbursement rate for screening, WIC may not be in a position to do screenings.

Will WIC get training on how to do screenings?

Yes – we'll train MIHP and WIC staff before Oct. 1, and then we'll offer the training intermittently and online. Since WIC sees 90% of the population we want to serve, it makes sense to align with them as closely as possible. The Illinois case management program for pregnant women is so integrated with WIC, that the women don't even realize that they're two different programs. Eventually, we'll train other agencies that want to do MIHP screens, but MIHP staff will continue to screen.

By the time we see the proposed policy on the maternal screener in June, will there be a nutrition component tied to the new form?

Lynette said she is sold on adding nutrition questions to the screener. This will be discussed further by the Steering Committee. Lynette asked if the group thought we should use the WIC questions, the current MSS questions on nutrition, or look to the literature. Additional comments on the web site are welcome.

We made some inroads with WIC through the Building Bridges Initiative over the last several years. Before that, WIC didn't even know we were here.

We are more convinced than ever of the importance of continuing to build bridges with WIC if we want to engage more women in the MIHP.

Will we need a Business Associates Agreement to share info with WIC?

No.

MIHP MATERNAL RISKS, INTERVENTION & OUTCOMES MATRIX

General Questions

The matrix gives us the outcomes, you'll give us the case rates later, but you won't tell us how many visits to do?

Exactly. We determine the outcomes but you determine how many contacts, who provides the services, and how you provide the services. A nurse, dietician and social worker don't have to touch every woman. If you want to contract with a behavioral psychologist to do a group for a subset of women, it becomes an option. Based on the availability of services in your community, you can contract services out or provide them directly.

How automated will it be? Will you tell us what intervention to use with a particular client to achieve a given outcome by a specific date?

Eventually, you will be provided with the risk level and recommended care plan.

You're saying that we'll be case managers, not interventionists, but the matrix is all about interventions.

A tension that we have to come to terms with in a population management model is that communities are very diverse in terms of resources. In a community where mental health services are unavailable, you will have to work with the OB or primary care physician to help a depressed woman, and you may need to provide a great deal of social support for her. Over time, however, as the community system of care is better developed, you'll be doing more and more case management, and less and less direct intervention.

We'll have an even bigger challenge with the community system of care when the infant is born and we have to ensure that he or she is being held, stimulated, put in a safe position to sleep, etc.

Much of what we do is assess, teach and refer, but referral sources have been gutted and we have nowhere to refer women.

There are no mental health resources – we sometimes have to send women with depression to the ER.

Most communities don't have social workers available outside of MSS.

Yes. We understand that mental health resources are very limited in many communities.

I agree that MSS/ISS have always been case management rather than intervention programs, but MIHP sounds like screening and referral only. Unless the state is prepared to fund WIC to provide breastfeeding education, fund mental health services, etc., you should go very slowly with this case management model.

The Institute for Health Care Studies (IHCS) is looking at system of care referral pathways in Kent County and will give MIHP providers a template to map referral pathways in your community. This will help identify service deficits community by community, which will be helpful at the state and local levels.

I looked at the Illinois case management model you have been referring to, but there are numerous MCH programs in that state. In northern Michigan, all we have is the MIHP. We can screen all over the place, but we have no programs to refer to – we're it.

Yes.

We talk about evidence-based intervention – have you thought about how universal resources will be made available (e.g., smoking cessation programs)?

Yes, equalizing the availability of resources across the state is a huge challenge.

Our MSS/ISS team spends a fair amount of time negotiating with DHS – there are huge problems with access to their services.

An enormous amount of work is being done on statewide issues by DHS (formerly FIA) and DCH at high levels. DHS has IT issues and was hit very hard by early retirement - they have huge barriers to contend with. This is why the guarantee of payment letter for pregnant women is so important - it assures that a woman can receive services the same day the letter is issued.

Have you considered coordinating the MIHP with Work First (DHS) at the state level? Most of our moms work now, often on the 3-11 pm shift with no child care. Sometimes this hinders our efforts.

This is absolutely a big systems issue. It's on the table. It would be helpful if women could get Work First "credit" for participating in the MIHP.

Our team has tried to run groups, but lack of child care and transportation is a huge obstacle. Also, DHS requires women to work – doing home visits is getting harder and harder. This needs to be discussed.

Certainly the new program will offer more service provision flexibility.

Many women come to our program with Medicaid pending.

They should have been given guarantee of payment letters so they could access care while their application is being processed. Local DHS offices and Federally Qualified Health Centers can issue the guarantee of payment letters. If you have difficulty getting your DHS office to issue the letters, contact Jackie Prokop, MDCH Medical Services Administration, and she'll assist you. Her phone number is 517 335-5117 and her email address is prokopj@michigan.gov. The directors of DHS and DCH meet monthly – Brenda will get this issue on their agenda again. Michigan hands out 30,000 – 35,000 guarantee of payment letters annually, and pays for 45,000 Medicaid births. Some women just show up in the ER and deliver.

Some women come in for pregnancy tests and haven't applied for Medicaid yet. Medicaid can be retroactive. This is another example of how the guarantee of payment letter can be used. The letter is good for 45 days.

We're moving away from providing home visits?

Yes, we're encouraging you to experiment with other ways to deliver services. However, you can still provide home visits as part of the mix. The Centering Pregnancy Program gets good results with prenatal group visits that promote camaraderie and bonding. You can Google it for more info. Lynette would love to see somebody experiment with groups. In a clinical setting you can't bill for educational groups, but she's heard of providers who do groups and bring the group members in for individual visits before and after the group meeting. If you do decide to do this, let her know.

We'll do groups in Jackson. Diabetic group visits are done with this model.

Please get with Lynette to talk about this.

Questions on Specific Matrix Items

The intervention matrix says a woman screens negative on inadequate prenatal care if care was established by 20 weeks, but she screens high-risk if no care established by 14 weeks. Doesn't make sense.

This is our mistake. The negative screen should say, "established by 14 weeks." IHCS originally recommended 20 weeks for the negative screen, but there's no clear demarcation in the literature between 14 and 20 weeks, so we went with the feedback from the DWG and changed it to 14, but didn't change it correctly on the matrix. The literature discusses entry into care in terms of trimesters.

On the intervention matrix, a woman who smokes a pack a day is "low risk". How can that be?

There's always a debate on defining high-risk smoking. Any smoking at all is detrimental and the more a woman smokes the more detrimental it is, but the literature shows that a pack a day is the point at which the risk for poor pregnancy outcomes skyrockets. We're always trying to figure out whom to target, given limited resources. We stand the greatest chance to impact very high-risk women by intervening at this point. The matrix is based on the literature and best practices, but the exact number of cigarettes is arbitrary – we landed on a pack a day but is it really 15, 20 or 23 cigarettes? A pack a

day is just a point of demarcation. You can still do whatever you want to do within the case rate for low risk smokers, but it does get complicated very quickly. A woman might smoke more than a pack a day but not be ready to change.

To me, smoking ½ pack a day or more should put a woman in the high-risk category.

It's a risk, but a pack a day is the threshold that shoots the risk sky-high. It's another hard choice on how to target our resources to make a real impact. Over time, as we collect data on it, we may decide we have to move the threshold it up or down.

I also think it should be changed to ½ pack. Many women will under-report smoking, especially at the first encounter.

We will look at this again. We may decide it's important enough to reword it. As we go forward, we want to get women to reduce the number of cigarettes per day, no matter how much they're smoking.

A woman is classified low risk for substance abuse if she was previously or is currently in substance abuse treatment. Being in treatment doesn't sound like low risk to me.

But it matters for reimbursement purposes.

At some point, we have to take women at their word, but keep asking them about it.

Did you compare the risk factors to see which is the most prevalent?

It's like a horse race. In FY 01, smoking was the winner, affecting 31% of the population, the greatest percentage except for race.

You're recommending 5As for smoking cessation. What is it?

It's the model for Smoke Free Babies.

We can't even get Smoke Free Babies written materials from DCH any more – just the Quit Kits (one-time shot).

We'll follow up on this. You can also contact Aurea Booncharoen at DCH directly at 517 335-9750 or booncharoenA@michigan.gov.

DCH doesn't recommend nicotine replacement (patch and gum) for pregnant women who smoke, because they would still be getting nicotine. Why does the intervention matrix promote pharmacological therapy?

The literature says you can at least control the dose with nicotine replacement – a harm reduction strategy. Also, there are huge databases of depressed pregnant women on SSRIs (e.g., welbutrin) without ill effects. The risk/benefit ratio is clear – we know that smoking is much riskier than pharmacological therapy. The CDC endorses pharmacological therapy for pregnant women who smoke.

I believe that not being ready to reduce smoking may reflect where a woman is in her pregnancy, so it's inappropriate not to offer her any services.

We aren't saying that she wouldn't get any services at all, but that we'd target more resources to high-risk women who say they're ready to change.

I disagree. I think we should throw the kitchen sink at her at the beginning and intervene based on where she's at developmentally.

If money was no object, we would agree, but resources are scarce and we must target them toward the women who are ready to change.

Some women want to make very small changes, such as not smoking in the car.

These are important. The trick is not to make the woman feel like she's less of a mother – to help her do some positive things without generating a ton of guilt.

In the past, MDCH told us that if a client didn't want to quit smoking, we should get out after 2 visits. This was drilled into us.

You're the first one who has said this. This will not be the case in the MIHP.

What will happen with women who smoke 1 pack a day when you change to from having two intervention levels (low and moderate/high) to three intervention levels (low, moderate and high)?

One pack a day would be moderate, although we have no plan to change to three levels anytime soon.

Will small changes on smoking be tracked – such as not smoking in the house or reducing from one pack per day to 15 cigarettes per day?

Yes, we do want to capture this. The screener will link to outcomes monitoring but the details aren't worked out yet.

There are two different situations with respect to substance abuse: 1) the woman has a significant substance abuse problem, and 2) the woman doesn't have a significant substance abuse problem, but she is still drinking enough to affect the fetus. How will we deal with the second situation?

Women in both of these situations are likely to be high-risk with intensive interventions, but we simply haven't gotten there yet.

Some of the interventions on the matrix involve making phone calls. We have many women without phones.

We know, but we think it's important for you to have the option of using phone calls with women who do have phones. The literature indicates that some women (e.g., those using substances) who don't want you coming into their homes may be willing to connect with you over the phone.

Will there be educational materials, like WIC has, that will be distributed to all women in the MIHP?

Yes, and we will want you to tell us what you think would be most helpful. Perhaps we can build on the READY Kits, adding information on breastfeeding, nutrition, etc., and then customize them with info about local programs. Maybe we'll want to use videos. If

we can get core information pulled together, MIHP workers could go over it with groups of women to save staff time.

Outcomes and Indicators

As we implement the interventions, you'll collect data on our outcomes? The interventions on the matrix are common interventions, but we haven't been collecting data to see what difference they make.

Yes, there will be a standardized way to capture the outcome data. Eventually, it will be web-based.

We like the WIC data system, because the state supports it.

WIC is re-designing their data system and we're building off of it for MIHP. We'll use the same infrastructure to help build the MIHP data system.

Are we responsible for coming up with the outcome indicators for the intervention matrix?

No, we'll map this out for you. All of you will be able to meet the outcome expectations. The bar will be raised gradually, over time.

Will the new indicators be folded into the certification/accreditation process for LPHDs?

MSS/ISS certification will be suspended for most of FY 05. There are 5 LPHD accreditation site reviews scheduled for summer – these will be completed. Otherwise, the certification (Non Health Departments) schedule is discontinued as of May 2005. We'll pick up on certification sometime next year (2006), when we have made the program changes and are ready to do site reviews again.

MIHP CHANGES EFFECTIVE OCT. 1, 2005

What changes will be made as of October 1, 2005?

1. Since the April trainings, it was determined that there won't be contracts between providers and DCH. Instead, program requirements will be developed and applied via the Medicaid policy promulgation process.
2. Providers will implement the new maternal screener, probably with new intakes only. We're not sure yet about the current assessment form.
3. Providers will start to use some of the evidence-based interventions and outcomes from the matrix in their care plans.
4. Providers will start collecting data on some indicators, based on the matrix (yet to be determined by DCH). Data collection will not be automated in FY 06.

We need to get our budgets in. Will there be any changes in reimbursement as of Oct. 1?

There will be no changes in the reimbursement system as of Oct. 1, except that you will be billing for screenings. It will remain a FFS system, based on home visits throughout FY 06.

Will we be trained on implementing the maternal screener by Oct. 1?

Yes.

Will we use the current infant assessment tool as of Oct. 1?

Yes. The infant screener and intervention matrix are yet to be developed. We'll provide training on these pieces down the line.

Will we still have interdisciplinary teams as of Oct. 1?

The current disciplines will still provide services as of Oct. 1. There won't be any layoffs. Proposed changes will need to go through the policy promulgation process. Paradoxically, as DCH becomes more prescriptive about outcomes and interventions, we will become less prescriptive about who provides the services, giving providers maximum flexibility in this area. If it will be more advantageous for a provider to keep the same disciplines, you certainly can. For example, we know that in some communities, MSS/ISS kept the WIC dietician afloat.

As of Oct. 1, we'll use the maternal screener, but provide a different number of home visits as shown on the intervention matrix?

No, nothing on the matrix is mandatory as of Oct. 1. The matrix is just a guide in FY 06. We just want you to "try it on" before you have to live with it the following year.

As of Oct. 1, do we start incorporating the matrix into our care plans?

Yes. MDCH will develop a new care plan format to go with the screener or at least revise the guidance to describe how to incorporate the matrix using the current format.

As of Oct. 1, what will the program be called?

Right now we have two programs (MSS/ISS) and we need CMS authorization to merge them into one program, plus we have to go through the public policy promulgation process. We're not sure when we'll change the name - it's more than likely that we'll still be calling it MSS as of Oct. 1.

As of October 1, can we still give out transportation tokens if that's the only risk factor a woman has?

Yes, the same as now. You'll see any proposed changes come out for public comment before they go into effect.

Will auto-assignment of cases to providers begin Oct. 1?

No. We don't want to overwhelm you with the additional volume right away. When we're ready, we'll decide together how this will be done, probably based on conversations with health officers, CEOs, and finance officers. We'll have to deal with all of the logistics. With the family planning waiver, family planning claims data will go into the warehouse, so we'll know when a pregnancy has been confirmed. Then DCH will contact the pregnant women, ask her to sign an informed consent, and give her the opportunity to select the provider of her choice. If she declines to choose, we will

automatically assign her to a provider. We will implement an equalized assignment procedure at the outset, so that all providers get their fair share of referrals.

What are your timeframes for getting the Oct. 1 contracts in place?

Since the April trainings, it has been determined that there won't be contracts after all. Program requirements will be developed and applied via the Medicaid policy promulgation process.

PROVIDER REQUESTS FOR SUPPORT TO MAKE CHANGES

Our communities are unique and state funds are limited. To ensure that we're all doing the same things, it would be useful if there were regional managers who could come in and help with our collaborative efforts.

We want you to have access to TA people who can help you get it right – not catch you at getting it wrong. We want to provide a great deal of hands-on TA. Right now, Ingrid Davis is our only MIHP state-level staff. We're working to replace Brenda Henry who left last year. We'll continue to get assistance from MSU and Medicaid staff.

One reason for our success locally is that were structured so that one leader is in charge of everything - WIC, MSS/ISS, immunizations, and family planning. If we had DCH regional managers who had expertise in all of these areas, it would work best to promote interdependent services.

We work together in our division across these program areas, but it would be hard for staff to have expertise in all of them. However, we could work to have more consistent regions and teams across programs. We could improve on this.

In our small county, MSS/ISS services are parceled out – the hospital has ISS, several other agencies have MSS. Will DCH help us develop a local system that will work?

This is not an easy issue - the mix of available services is so different in every community. IHCS is developing a process and template to map out referral paths using an algorithm. Much of the work on this will have to happen at the community level. DCH doesn't have a magic bullet.

Will there be more trainings?

Yes, many more. We'll have trainings on implementing the screener this summer / early fall, and trainings on all of the other components as we go along.

When will providers who only do MSS or ISS have to decide whether they want to serve both pregnant woman and infants, or drop out?

We don't know. Sometime during FY 06, providers need to decide one way or the other.

We providers who are doing only MSS or ISS right now will have a lot of work to do to gear up for the MIHP. Give us as much time as possible to evaluate what we would have to do and figure out what we need to be able to do it.

Everyone is able to follow all proposed changes at the same time on the web site as we go along. We need to look at how many providers are in this boat and work with you. You will need to tell us what you need from us to help you make your decision.

A few years ago, when MSS/ISS programs were folding, you gave us guidelines to maintain viability. We'll need info up front to know how much revenue will be generated by case rate reimbursement. Will we get it far enough in advance?

When the case rates come out some time in FY 06, we'll know about revenue projections. We have to decide if we'll pay at birth or monthly or on some other basis. We also have to decide if the new reimbursement mechanism will apply to new clients only as we begin to implement it. We will work out potential cash flow issues. We are not changing the reimbursement mechanism Oct. 1.

CASE RATE REIMBURSEMENT

When will the work on the case rates be completed so we know how to do our budgets?

It will not be ready by Oct. 1 this year. The reimbursement system will remain the same as it is now for FY 06. We don't know how long it will take to complete the work on the case rates, but we hope to unfold it and begin the dialog with you about it sometime in FY 06. It will probably be implemented in FY 07.

Do you have more detail on the shift from fee for service (FFS) to the multi-tiered rate?

The case rate is one of the most complicated pieces to construct. The case rate will be an entirely different way to pay providers. It will be an advantage for providers, as it allows for ultimate flexibility in the way you deliver services. CMS requires rates to be actuarially sound. Providers (and others) will be able to bill for screens on a stand-alone basis. Cash flow may be an issue at the outset, but can be managed once the new system is up and running. Before the shift is made, there will be a series of meetings with agency directors and finance officers to ensure that they clearly understand case rates. In FY 06, providers will still get paid per home visit, but will start focusing on the domains in the screener and matrix and begin to report data on some indicators.

What will the cost per case be?

We don't know yet. It's a huge and complicated actuarial undertaking to determine the algorithms. Utilization and cost data must be integrated so we can figure out what we spend on women at different risk levels on average. Length of time in the program will also be figured in. Providers will need to know how many women you'll serve in each cell in the rate structure. We expect to have a draft for beginning discussions later this year.

If a woman is high risk for one factor and low risk for others, do we get the high-risk case rate?

You will have multiple case rates, depending on risk levels, length of time in program, etc. The case rates are data driven.

Will DCH have standardized criteria for serving women at low, moderate and high-risk that would this figure into the case rates?

The intervention matrix describes interventions for low-risk and for moderate/high risk levels. It's not detailed enough to truly inform the case rate structure, but does give finance people and administrators some idea of what factors are being taken into consideration for determining different case rates.

As a WIC staff, I taught a smoking cessation class for pregnant women. Can we refer women to classes in the community under the case rate system?

Yes. Once we move to the case rate system, the program and fiscal people will really have to communicate with each other. You will become best friends. You and your fiscal officers must understand all the pieces of your program and the costs associated with each piece. You'll need to see how many women you serve in each case rate cell, so you can decide together the best ways to serve them (e.g., in a WIC smoking cessation class). For example, in the care plan you would document that the outcome is smoking reduction, the intervention is 5As, and the service delivery method is the WIC class (or a group you facilitate or one-on-one, etc). Ultimately, you report the outcome: the woman did or didn't reduce smoking during her pregnancy. Your agency will have a vested interest in ensuring the woman gets the best possible intervention in the most economically efficient way.

We find that a woman's risk level changes over the time she is in our program.

Yes, we will do several screenings over time for this very reason, and build changing risk levels into the rate structure too. We'll have a whole set of dialogues about this with your finance officers.

Will some domains be weighted more heavily than others? Are all high-need areas weighted equally?

It's hard to describe – the case rates aren't figured out yet. A woman with major mental health needs would be served by the mental health system, which would provide case management support for her. These women often have huge unmet basic needs.

With the new case rates, will we still submit a bill and get reimbursed or will the billing component be eliminated?

The long-term goal is to eliminate the billing component. We're not sure how the billing will be done when we first shift to case rates. There will be a period of transition.

When will we get paid? After the woman delivers? After the case is closed?

We haven't gotten to this level of detail yet, but we will work out any potential cash flow problems.

Let's say we get \$1,000 for a woman in a particular rate cell, but we figure out how to serve her for less. Isn't there potential for abuse in this system? Will you be monitoring this?

Yes. We'll do hands-on record reviews. However, if the new reimbursement system works the way it should, a provider who isn't spending the money appropriately won't get the desired outcomes. We'll provide a great deal of TA on this.

Some indicators on the matrix specify phone calls. Many of our clients don't have phones, so we won't be able to be reimbursed for calls.

In the case rate system, providers will get a certain amount per case – you won't bill for discrete services, except for screens. We'll work with your finance officers to make sure they know how to identify your service delivery patterns and track costs, or you won't be able to survive in the case rate system. The case rate will be higher than it actually costs to serve some women, but it will be lower than it actually costs to serve others.

You said smoking cessation classes would be good, but we can be reimbursed for them?

Under the case rate reimbursement system, you won't be reimbursed for separately for the classes, but the cost will be figured into the case rates.

Will transportation be included in the MIHP? What about transportation costs in rural areas?

Yes. Travel costs will be built into the case rates. They may be different for different geographic areas.

If a provider can provide group services right now, can we bill for them?

No, in FY 06 you'll still bill per home visit. The costs of doing groups will be built into the case rates – you won't ever bill separately for groups. The only thing that you will bill separately for is screening.

So we are still tied to home visits in FY 06 and can't do the other interventions in the matrix?

Yes. It's the balancing act we have to do. All the elements have to be in place, and we can't do it all at once. We'll move as fast as we can.

We're still using the old reimbursement system in FY 06, based on home visits. How can we start doing groups, etc., if we can't get paid for doing them? Our staff must do a certain number of home visits per day under the current system.

We will stick with the current payment system, which we know will put a crimp in starting some of the new interventions. If your agency requires you to do a certain number of home visits per day, it would be helpful if the DWG knew how many. Please go to the MIHP web site and email us this info if you can.

Until case rates are implemented, will we bill for screening instead of assessment?

The new maternal screening tool will be implemented Oct. 1 with reimbursement tied to it. We're still discussing if there will be a separate assessment tool. If so, you would bill for the assessment too. The pilots have special permission to bill the assessment rate for doing screens, but we haven't finalized any system changes on this yet.

It could have a major financial impact on us if the screen is reimbursed at less than the current assessment rate during the interim period.

We have to match the new activities we want to see on Oct. 1 to the billing system. The new screen takes about 25 minutes, so the rate might be lower than that for the current assessment, which takes one hour. However, you'd have time to complete more screens, in keeping with our goal of getting more women into the program.

Our community contributes extra dollars to MSS/ISS. Will some communities have a problem because they'll be getting fewer dollars under the case rate system?

This is a false assumption. Providers shouldn't get fewer dollars. We know how much you put into family planning, MSS, and each block grant program. Actuarially sound case rates are based on reasonable costs. You'll screen a lot more women and carry higher caseloads – but many of the women you enroll will not receive intensive services. We want to go from serving 25% to 90% of the population over time, so there will be cost efficiencies based on volume. Medicaid will always push the resource envelope.

Do you know that we also contribute CSHCS funds?

We're just trying to figure out how much money is going in, so we can match risk factors to costs, and know what it really takes. The matrix helps us figure out the nuances of the service packages at each risk level for each risk factor in order to achieve the desired outcome, so we can say it costs x amount of dollars to intervene at this level to get this benefit.

Since urban areas have the greatest number of high-risk women, will all the MIHP dollars end up going there?

We won't pull resources away from those of you who are engaging a good percentage of the population. Case rates will incentivize providers to do more outreach and engage high-risk women.

Is it possible to pilot the case rate at a few sites to see how it goes?

We have discussed this, but there is some urgency to move the whole system along as fast as we can because our babies are dying.

Our agency is a certified home health agency. Home health went to case rates a long time ago.

So this isn't new to you – good!

Has Medicaid looked at increasing funds to cover women on MOMS after delivery?

No. Medicaid for MOMS clients ends at birth and Medicaid for non-MOMS clients ends at 60 days postpartum, but the infant remains Medicaid eligible so the family will still qualify for the MIHP.

Will the 4% reduction in the Medicaid reimbursement rate that's going into effect next month carry over into FY 06?

We think it will continue into the next fiscal year. There's no end-date when the rate would go back up.

Won't it cost the state more money to serve more women?

Yes, which is one reason why we're moving so slowly. We can't go from serving 20% to 90% of the population with current funds. Now we're paying for lots of home visits for low-risk women and it's not really working. In the MIHP, low-risk women will not be getting 6 home visits, so we can redirect some of these dollars. We're not saying that low-risk women have no risks, but they are not the group we are targeting. We're trying to get our dollars to go further by targeting high-risk women who have the poorest birth outcomes. We're hoping that as we build it, more dollars will come. Data collection is very important. The Nurse-Family Partnership has data that show cost-savings. We need data to show that the MIHP is cost effective too if we hope to secure additional funds in the future. Part of the resistance to the family planning waiver was overcome because the state has such big budget problems and we were able to project significant savings by implementing the waiver.

Other

Are you videotaping this videoconference? We (Copper Country) are getting disconnected.

Yes. We'll send you the tape.