

Maternal-Infant Health Program Design Workgroup Notes

October 6, 2004

Present: Diana Baker, Lynette Biery, Sandy Brandt, Alethia Carr, Paulette Dobynes Dunbar, Sheila Embry, Brenda Fink, Pat Fralick, Sue Gough, Deb Marciniak, Debra Marx (for Mary Pat Randall), Bonnie Miller, Sue Moran, Christie Peck (for Peggy Vander Meulen), Jackie Prokop, Diane Revitte,Carolynn Rowland, Paul Shaheen, Tom Summerfelt (presenter), Betty Tableman, Sharon Wallace, Betty Yancey.

Present via phone: Anne Bianchi, Rosemary Blashill (for Nancy Heyns), Leslie Boulette (for Rick Haverkate), A. Cole, Diane Douglas, Judy Fitzgerald, Nina Siagkris, Geri Toney.

Not present: Bonnie Ayers, Mark Bertler, Ingrid Davis, Stacey Duncan-Jackson, Sheri Falvay, Adanad Hammad, Rick Haverkate, Nancy Heyns, Ed Kemp, Mary Ludtke, Rick Murdock, Doug Paterson, Mary Pat Randall, Peggy Vander Meulen.

Future MIHP Design Workgroup Meeting Dates

Thursday, Nov. 18, 2004	1:00 – 3:30 pm BOW, Large EPI Resource Room
Thursday, Dec. 16, 2004	1:00 – 3:30 pm BOW, Room 1C

Tasks / Assignments

1. Assignment for Design Workgroup (DWG) members for Nov. 18 meeting - please come prepared to discuss:
 - a. *Maternal-Infant Health Program Design (Handout 6)*. What did the data that was presented today say to you for informing our process in terms of design criteria listed here? Did we capture the right things to move forward?
 - b. *Maternal-Infant Health Program Goal, Objectives and Potential Outcome Measures (Draft - 09/28/04) (Handout 7)*. How would you improve upon the objectives and potential outcome measures listed here? What ideas do you have for measuring outcomes?
2. Paulette will try to move up the 2:00 pm start time for the December meeting, so people who must travel long distances can leave Lansing earlier than 4:30 pm. (Time has been changed to 1:00 pm.)
3. Paulette will clarify any remaining confusion regarding DWG membership.
4. DWG members will inform Raquel Montalvo who their alternate is (517 335-8294 or montalvor@michigan.gov).
5. Deb Marciniak will provide conference phone etiquette information to DWG.

Welcome and Introductions

Brenda Fink, Director, MDCH Division of Family and Community Health, welcomed the group and facilitated introductions. She indicated that Doug Paterson, Director, Bureau of Family, Maternal and Child Health, sent his regrets, as he is attending an out-of-state meeting. Brenda stated that the MIHP Steering Committee worked hard to formulate a design process that balances a focused effort with a broad-based inclusive process. The goal of today's meeting is to ensure that participants understand:

- Their role and responsibilities regarding the MIHP design process.
- How the MSU Institute for Health Care Studies (IHCS) data on MSS/ISS informs the MIHP design process.
- How the MIHP design project is structured.

MIHP Background

Susan Moran, Director, MDCH Bureau of Medicaid Program Operations and Quality Assurance, provided the background on the MIHP design effort. She said that an initial exploration of MSS/ISS data indicated that it was time to step back and take a critical look at both programs. If our goal is to decrease infant mortality, we are not meeting it – the rate is not decreasing and significant disparities persist. External Quality Review data on MSS/ISS over several years show that 20-28% of pregnant Medicaid beneficiaries have received MSS/ISS in any given year, but are we reaching the women at highest risk? If not, and we could find better ways to do so, could we decrease the infant mortality rate and improve the disparity stats? MDCH contracted with IHCS to conduct a study using fee-for-service claims, managed care encounter data, vital stats and cost data to formulate a clearer picture of MSS/ISS. This was an exciting undertaking because IHCS was able to access the MDCH data warehouse, allowing them to link across data sets including PRAMS, newborn hearing, metabolic screening, lead, etc. When MDCH saw the initial results of the study, they decided it was time to bring the stakeholders together to re-think how we might achieve better prenatal outcomes for low-income women in Michigan.

MIHP Planning Process and Structure & Role of the Design Workgroup

Brenda Fink stated that it was no easy task to put the MIHP planning process and structure together, given the magnitude of the initiative and the large number of stakeholders who want to participate. MDCH began by forming an internal group (the MIHP Steering Committee) that met for several months to clarify their own parameters in approaching the process, so they could speak in one voice about it. At first, the Steering Committee considered establishing a large planning group with subcommittees, but with a list of 300 people who were potentially interested, that did not appear to be a practical, functional structure. The Steering Committee decided to invite Mark Bertler (MALPH), Rick Murdock (MAHP), and Paul Shaheen (MCMCH), who represented large key stakeholder groups, to help formulate a more workable structure. The structure has 3 parts, ensuring that no interested party is excluded from participation:

1. MIHP Steering Committee

This group of 15 persons consists of state agency personnel and project consultants. It is responsible for the nuts-and-bolts work of designing and implementing the new program. It will meet as often as necessary between monthly meetings of the MIHP Design Workgroup.

2. MIHP Design Workgroup (DWG)

This group consists of the MIHP Steering Committee members plus representatives of 18 key stakeholder groups. It is charged with providing input on the design and implementation of the new program. It will meet monthly in Lansing for 2½ hours. DWG members will have the option of participating by phone. DWG members and the stakeholder groups they represent are listed in the document titled, “Maternal-Infant Health Program Design Workgroup Roster.”

3. Large Stakeholder Group

This group consists of an unlimited number of persons who wish to receive periodic updates about the work of the MIHP DWG and Steering Committee. Updates may be provided via email, web site, special meetings, etc. Members will be encouraged to provide input on drafts of various products. The web site, which will be similar to those established for Medicaid and Great Start, will be up in a few weeks.

Originally, the Steering Committee referred to this initiative as MSS/ISS re-engineering, but eventually decided to use the temporary working title, Maternal-Infant Health Program, so as not to box ourselves in. The Steering Committee struggled mightily to identify representative stakeholder categories for the DWG, but if any gaping holes are identified, we will work to fill them. Brenda apologized for the confusion and distress that occurred when a general invitation was inadvertently issued to all of the health plans. If you have questions about whether or not you were an invited member, contact Paulette Dunbar at 517 335-8903 (phone), 517 335-8294 (fax), or dunbarp@michigan.gov.

Paul Shaheen said that obstetricians from ACOG want to ensure that the medical home is incorporated within the new design, but can't attend DWG meetings - they need a way to provide input, other than as members of the Large Stakeholder Group. Brenda replied that as we identify tasks that require content expertise in particular areas, we would appoint subcommittees, pulling in the appropriate people.

Brenda explained that we'll take the first 6-8 months of this fiscal year to develop protocols, forms, etc., so we can contract for pilots in FY 06. It's a huge undertaking and we want to be planful, but not take forever. We need DWG members who are able to commit the necessary time and energy. Brenda asked everyone to read and sign the “MIHP Design Workgroup Memorandum of Agreement”, which we adapted from another MDCH initiative. MDCH will collect the signed agreements. DWG members are encouraged to keep a copy of the agreement as well - it was one of the handouts for this meeting that was attached to the email message from Raquel Montalvo dated 10/04/04. It's critical that workgroup members are diligent about sharing what happens here with their constituents, and bringing input from their constituents back to this group.

Paul stated that this is a momentous occasion and that the vision of MDCH is to be congratulated. It's appreciated that we're looking objectively at MSS/ISS after 12 years of experience with it.

Medicaid Families Project: Examining Risk, Outcomes, and Expenditure Data

Tom Summerfelt, Director of Research, Grand Rapids Medical Education & Research Center for Health Professions, and Lynette Biery, Project Manager, MSU Institute for Health Care Studies, did a presentation on their MSS/ISS study titled, "Medicaid Families Project: Examining Risk, Outcomes, Expenditures for MSS Recipients in 2001." They provided a handout of their PowerPoint slides (available at the IHCS web site - http://www.healthteam.msu.edu/imc/MFMP/MIHP10_6_04_files/frame.htm).

Tom described the IHCS study team as follows: Lynette Biery brings a strong background in maternal-child health; Lee Ann Roman, MSU Dept. of OB/GYN, brings a national perspective on scientific trends in maternal-child health; Tom Summerfelt brings experience working with state departments, health systems and foundations to improve effectiveness and efficiency; Tom McRae (formerly with MDCH) brings unsurpassed technical expertise in using the data warehouse; and Shelley Berkowitz is an excellent grad student.

Key observations based on the data analysis are as follows:

- MSS/ISS is not reaching the highest risk women.
- MSS/ISS activities are not linked to purported outcomes.
- Birth outcomes of enrolled women are not different than those of non-enrolled women.

Other noteworthy observations include the following:

- 31% of women smoked at sometime during pregnancy, which is consistent with national studies using Medicaid databases.
- Not quite 10% of women get 6 or more MSS visits.
- 8% of women are treated for depression according to MDCH expenditure data. National studies show that 20-25% are diagnosed with depression and 50% have depressive symptoms.
- White women receive more MSS services than African American women do, although we would expect that they would receive more services, given the disparity data. Native American women do better, but they have their own services.
- The women we're serving appear to be those who are the easiest to reach – white women at 100-185% of the poverty level. Some system other than level of risk is operating to get women into services.
- We have aggregated data for several years that shows 22-28% of women receive MSS services. It's slightly higher for women in managed care health plans, according to the most recent data. However, pregnant women are not required to join health plans, and 2/3 of births are fee-for-service. There is variability across health

plans, as there is across counties. A few health plans have well-developed prenatal programs, assuming that a higher MSS rate indicates a well-integrated prenatal program, although this is just an assumption.

- Women in MSS/ISS are more likely to breastfeed than those who are not.

Some comments on the data:

- Lynette said that smoking is a good place to focus efforts – it's linked to many other risks including depression and domestic violence. Although it's difficult to get women to quit, women who manage to quit even a few days before birth, have better outcomes. Currently, providers use different smoking cessation approaches – we don't know who does what. We know more about cessation strategies than we did before – a combination of strategies works better than a single strategy, and health care providers and others must reinforce the message over and over. Pat Fralick noted that many new providers aren't adequately prepared, as smoking cessation training is not provided regularly, and is not offered north of Lansing; this needs to be a local-state effort. Another provider noted that the problem is multi-faceted and it's difficult to select what to work on. A third provider said that our interventions are driven by clients' needs and desires – they turn off with canned programs. Lynette suggested that as clinicians, we pick the issues that will get us the biggest bang for the buck. If smoking is a key issue to change outcomes, and a particular woman does not wish to work on it, then perhaps you go on to the next woman who is ready to work with you. Tom said that maybe there's a teaching moment in there. In a prevention program, you want to target the highest risk women to change the trajectory. If women are low risk, you decrease the impact. Diane Revitte said we must look at behavioral change and stages of change – we can't just bop in and out. Pat said a lot of this is about trust and relationships, and that takes time.
- Tom said that we're in a unique position because we don't see other people using the data as we have here. How do we capitalize on this?
- Pat said Northwest Michigan Community Health Agency has high MSS/ISS enrollment rates because they have a single point of entry, do aggressive outreach, and provide a social home.
- Kent County has a 40% enrollment rate, although they still aren't reaching the women at highest risk.
- We need to start distally by determining what outcomes we want to accomplish – (e.g., reduce low birth-weight births), use evidence-based interventions, and collect data to support quality improvement measures. We need to identify the interventions that lead to the outcomes we want. The problem now is that the overall goal is to decrease infant mortality, but each provider is left to decide how to do it - that's why we get what we get.
- Betty Tableman said that the data indicates we've got a recruitment/retention issue. We need to know what we're dealing with, but most women will have multiple issues.
- The Adequacy of Prenatal Care Utilization Index (Kotelchuck) was the tool used to determine adequacy of prenatal care.

- Diane said that although WIC has an 82-85% participation rate, WIC isn't getting enough women in their first trimester either.
- Paul said that the more you're tied to procedure codes, the more restricted you are. Capitation frees up the decision-making – FFS doesn't get at outcomes.
- How broad should our outcomes be? Paul said that it's not all about clinical outcomes – if ISS strengthened a family's capacity to care for a child and get him or her to read, the governor would love it. Tom noted that in their final report, IHCS will summarize interviews with providers and families who said that one of most helpful things we could possibly do is to help families get good jobs with benefits. Brenda asks how will we balance clinical/concrete outcomes within the softer context? How will we nest the MIHP within other programs in the system? Where does it fit?

Brenda said that our dialogue suggests that the data does indeed stimulate a great deal of thought. The data will be refined, and we'll keep referring to it as we go along. The questions we raise here will go back to IHCS team.

Agenda for Nov 18 Design Workgroup Meeting

1. Stacey Duncan-Jackson or Lynette Biery will present on the Population Management Model.
2. We will discuss *Maternal-Infant Health Program Design (Handout 6)*. These are the intended design parameters from MDCH's perspective.
3. We will discuss *Maternal-Infant Health Program Goal, Objectives and Potential Outcome Measures (Draft - 09/28/04) (Handout 7)*.

Brenda requested that when DWG members must send alternates to our meetings, please be sure to prepare them, as we don't have time to catch everyone up at every meeting. Brenda and Sue thanked DWG members for their invaluable input today, and asked them to complete the meeting evaluation form.