MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin: MSA 05-51

Distribution: Maternal Infant Health Program (formerly known as the Maternal and Infant Support Services Program)

Issued: November 1, 2005

Subject: Maternal Infant Health Program (MIHP) Form Changes and Revised Billing Instructions

Effective: December 1, 2005

Programs Affected: Medicaid, MOMS

Purpose

In an ongoing effort to improve the health status of pregnant women and infants, the Michigan Department of Community Health (MDCH) is in the process of re-engineering the Maternal Support Services and Infant Support Services (MSS/ISS) programs. MDCH's goal is to create a program that will better identify prenatal women and infants by level of risk and create a case management program designed to address such risks. The desired outcome is to improve the maternal and infant mortality and morbidity rates of the Michigan Medicaid population. Moving from a fee-for-service (FFS) program to a case management program will occur incrementally through a series of policy implementation steps. The purpose of this bulletin is to introduce the first step moving towards this goal.

This bulletin, effective for dates of service on and after 12/1/05, will introduce the following: 1) changing the official program name from MSS/ISS to the "Maternal Infant Health Program" (MIHP); 2) implementation of a new screening form; 3) implementation of a revised assessment form; and 4) implementation of a revised care plan. These four changes and associated reimbursement are discussed in this policy bulletin.

MIHP Program Screening Form

Medicaid is integrating a revised MIHP screening form into the existing MSS/ISS program for MIHP provider use only. The new/revised form is titled "Prenatal Risk Factor Eligibility Screening Form" (MSA-1200; herein referred to as the new screening form). The new screening form will be used to determine if a Medicaid pregnant woman is eligible for the MIHP program. This is a required form, and each beneficiary screened subsequent to December 1, 2005 must have this form in her MIHP record. The MIHP provider must work face-to-face with the beneficiary to complete the form.

Similar to the Maternal Support Services Risk Screening Tool (form DCH-1191), MIHP eligibility determination will be based on the beneficiary's response to the various questions on the new screening form. Throughout the new screening form, an asterisk (*) is placed next to the responses that, if indicated by the beneficiary, would identify a risk. If a beneficiary's answer results in checking, at a minimum, one box where the corresponding response has an asterisk, they are automatically eligible for MIHP services. In the event a beneficiary completes the new screening form and their responses do not identify a risk, they may still be assessed and eligible for the program based on the MIHP provider's judgment. Under these circumstances, MIHP providers must clearly document the need for services in the beneficiary's record. After eligibility is determined, MIHP providers will then complete the revised Prenatal Services Assessment (form DCH-1192; subsequently discussed in this bulletin). In the future,

MDCH will introduce a scoring key, specific to the new screening form, to assist MIHP providers in identifying pregnant women by level of risk. This scoring key will help MIHP providers to begin identifying level of risk and creating a care plan and risk-focused interventions specific to level of risk.

For MIHP charting purposes, this new screening form will replace the current MSS/ISS screening form (DCH-1191). The new screening form must be completed to determine beneficiary MIHP eligibility prior to enrollment in the program. When reviewing the form with a beneficiary, providers must assure that the new screening form is fully completed in order to receive reimbursement for screening services. This policy does not preclude MIHP providers from integrating the screening form with WIC screening forms. Should a MIHP provider wish to integrate their form, they must assure that all of the questions in the new screening form remain intact.

Providers (MDs, DOs, CNMs, other agencies, etc.) may still use DCH-1191 to refer beneficiaries to MIHP providers for further screening. Effective December 1, 2005, MIHP providers are no longer required to have form DCH-1191 in their records.

MIHP program eligibility risk criteria, as identified in Section 2.1 of the Maternal & Infant Support Services Chapter of the Michigan Medicaid Provider Manual, will not change as a result of this policy issuance. The new screening form's program eligibility determination is aligned with the current risk factors and is designed to help MIHP providers identify those risks, as well as collect important beneficiary-specific information. The medical care provider or MIHP provider may authorize the initiation of services, as currently stated in policy.

Credentials

The new screening form must be completed face-to-face with the Medicaid beneficiary by one of the three MIHP disciplines (i.e., social worker, nutritionist, or nurse) as currently stated in policy.

Reimbursement

MIHP providers will receive a separate $20.00 reimbursement for each new screening form completed. If a MIHP provider completes a screening form on a Medicaid beneficiary and it is determined that they are not eligible for MIHP services, the screen is reimbursable. Use the code T1023 when submitting a claim for this service. If a Medicaid beneficiary is found to be eligible for the MIHP, the screening form would also receive a separate reimbursement, and the information is integrated into the assessment process. Under these circumstances, MIHP providers will bill the code T1023 and, after completing an assessment visit, they will also bill the assessment code separately. Accordingly, reimbursement for the assessment visit will be decreased by $10.00 as a result of this policy.

MIHP providers will be reimbursed for one screen per pregnant woman during her pregnancy. Due to factors such as premature termination of a pregnancy or a subsequent pregnancy in the same year, a MIHP provider may screen a beneficiary and receive reimbursement twice in the same year. In such instances, the provider must indicate "second pregnancy" in the Remarks section of the claim.

MIHP Assessment Form

Medicaid is implementing a revised Maternal Support Services assessment form, herein known as the MIHP assessment form (Prenatal Services Assessment; form DCH-1192). Changes were made to avoid duplication of information based on the question content found in the new screening form. If a beneficiary is determined eligible for MIHP services, the MIHP provider will proceed to complete the revised assessment form. The purpose of the assessment is to: 1) integrate information from the new screening form; 2) further validate the beneficiary's appropriateness for the program; and 3) determine what services are needed. Providers must start using the revised assessment form beginning December 1, 2005.

The assessment must precede any professional visits. Only one assessment per beneficiary under MIHP is covered. Due to factors such as premature termination of a pregnancy or a subsequent pregnancy in the same year, a beneficiary may be assessed and/or receive MIHP services twice in the same year. In such instances, the provider must indicate "second pregnancy" in the Remarks section of the claim. Assessments must be completed

by a MIHP interdisciplinary team/member. All three professionals (i.e., the nurse, nutritionist, social worker) must be involved in the assessment process – either directly or through a review/approval process.

The initial assessment and up to nine professional visits per pregnancy are billable under MIHP. The reimbursement structure will remain as currently stated in policy. All professional assessments and visits will be reimbursed under the FFS system. Professional visits cannot be billed for services provided to a group of beneficiaries. Policy regarding individual visits will remain as stated in Section 2.8 of the Maternal & Infant Support Services Chapter of the Michigan Medicaid Provider Manual.

Care Plan Form

Medicaid is implementing a revised care plan document which is consistent with the new screening form and revised assessment form. Providers are to begin using this revised care plan form effective December 1, 2005. Since development of the care plan is part of the assessment visit process, there will not be a separate reimbursement for this activity.

Based on the assessment, and in collaboration with the beneficiary, the interdisciplinary team develops a comprehensive care plan to provide needed services to the beneficiary and/or referrals to community agencies. The care plan must indicate the specific risk(s), specific outcome/objective(s), specific intervention(s) to be implemented, and the number of visits required for actualizing the plan. The care plan must be updated whenever a significant change occurs and must justify the interventions that are occurring. Follow-up services must be provided by the nurse, social worker and/or nutritionist based on the care plan. While the provider must determine how best to involve staff in implementing the care plan, it is expected that all professional staff will be involved to some extent. It is not expected that one professional discipline will implement all interventions on a solo basis. The beneficiary's exit from the program is expected to occur when the objectives/outcomes of the care plan are completed, or when the team concludes that continued intervention is unnecessary.

Smoking Cessation

In order to assure consistency with smoking cessation intervention among prenatal clients, MIHP providers must begin integrating the MDCH "Prenatal Smoking Cessation: Smoke-Free for Baby and Me" intervention model into their program. The "Smoke-Free for Baby and Me" curriculum includes the 5A's intervention model in addition to other intervention strategies for smoking cessation. For more information about this program, contact the MDCH Prenatal Smoking Cessation program at (517) 335-9750.

Manual Maintenance

The provider should retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Paul Reinhart, Director
Medical Services Administration

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

MATERNAL INFANT HEALTH PROGRAM
PRENATAL SERVICES ASSESSMENT

Medicaid ID #: _____ Date of Assessment: _____
Provider Name: _____
Type (Check one): ☐ Fee For Service ☐ Medicaid Health Plan (MHP), MHP Name: _____
Non-Medicaid: Visit Location: ☐ Home Visit ☐ Other Visit
☐ Application in process. Explain _____ ☐ Office Visit
☐ Not yet applied. Explain _____

Has the consent form been signed? ☐YES ☐NO

GENERAL INFORMATION

Beneficiary's First Name _____ Last Name _____ Date of Birth ____/_____/____
Phone Number _____ (hm) _____(wk) Best time to reach Beneficiary _____
Is there another phone number where you can be reached?_____
Current Address _____
Street Address City Zip County
Travel Directions_____
_____
What language do you prefer to speak? _____ What language do you prefer to use for reading? _____

Name of Father of Baby (FOB)_____Date of Birth ____/_____/____ Race/Ethnicity _____
Employment Status: ☐ Full Time (FT) ☐ Part Time (PT) ☐ Not Working ☐ Student
Relationship with Mother: ☐ Involved ☐ Not Involved

Household members other than mother or FOB	Relationship to Beneficiary	Sex	Race/Ethnicity	DOB or Age*

*List DOB for preschool children - may list age for others living in the household.

IMMUNIZATIONS

1. Have you been immunized against any of the following infections?
   ☐ Chicken Pox ☐ Hepatitis B ☐ MMR ☐ Meningitis ☐ Polio ☐ Flu ☐ Don't Know
2. Have you been around anyone with these infections in the last month?..... ☐ NO ☐ YES
3. Are the immunization records on all preschool children in the household available?..... ☐ YES ☐ NO

COGNITION

1. Do you have trouble reading materials given to you by WIC or your doctor? ☐ Always ☐ Sometimes ☐ Never
2. Did you or do you attend special education classes in school? ..... ☐ YES ☐ NO
3. How do you like to receive educational materials? ☐ Written ☐ Verbally ☐ Audio ☐ Video

NUTRITION

1. How much weight would you like to gain with this pregnancy? _____
2. Have you had any of the following problems?

   ☐ change in appetite ☐ constipation ☐ diarrhea ☐ food allergies ☐ heartburn ☐ nausea ☐ vomiting
3. What changes have you made in eating since you found out you are pregnant? _____

   a. Are you on a special diet? ..... ☐ NO ☐ YES

      If yes, please describe _____

   b. Are you able to drink milk and/or eat milk products? ..... ☐ YES ☐ NO

   c. Do you feel the need to eat any non-food, such as ice, clay, starch, etc.? ..... ☐ YES ☐ NO

      If yes, what _____

   d. Have you ever had an eating disorder, such as bulimia or anorexia nervosa? ..... ☐ NO ☐ YES

      If yes, please explain _____

   e. How often do you eat fast foods in a week? _____

   f. How many pops/Kool-aid do you drink in a day? _____

   g. How many caffeinated drinks (i.e., coffee, tea, pop, etc.) do you drink in a day? _____

   h. How many glasses of water do you drink in a day? _____

   l. Describe a typical day's meals: _____

      _____
4. Are you taking a prenatal vitamin daily? ..... ☐ YES ☐ NO

   a. Are you taking herbal supplements? ..... ☐ NO ☐ YES
5. Breast-Feeding:

   a. Are you planning to breast-feed this baby? ..... ☐ YES ☐ NO

   b. What concerns do you have about breast-feeding? _____

      _____
6. Family Planning:

   What do you want to use for birth control after your baby is born? _____

SEXUALLY TRANSMITTED INFECTIONS

1. Have you had a test for HIV during this pregnancy? ..... ☐ YES ☐ NO
2. Would you like more information on HIV? ..... ☐ YES ☐ NO

ENVIRONMENTAL INFORMATION

1. What is your current housing situation? (Check all that apply.)
   ☐ House-own ☐ Apartment Live With: ☐ FOB ☐ Friend
   ☐ House-rent ☐ Shelter ☐ Parents ☐ Relative
   ☐ Migrant Housing ☐ Homeless/other ☐ SO (not FOB)
2. Is your current housing: (Check all that apply.)
   ☐ built before 1978 ☐ remodeled/renovated in the last year ☐ near an industrial plant, dump site
3. Does your house (or frequently visited home) have peeling or chipping paint? ..... ☐ NO ☐ YES
4. Does your house (or frequently visited home) have a lot of dust and mold? ..... ☐ NO ☐ YES
5. Was asbestos insulation used on pipes or hot water tank or for insulation in attic/walls? ..... ☐ NO ☐ YES
6. Does anyone in your household work around lead (pottery, automobile repair, plumbing)? ..... ☐ NO ☐ YES
7. Do you regularly (at least weekly) use cleaners for glass, oven, floors, or use glues, solvents, paint strippers? .. ☐ NO ☐ YES
8. Do you currently use pesticides (bug or weed killer, flea or tick spray) in the home? ..... ☐ NO ☐ YES
9. What is the source of your drinking water? ☐ well ☐ city ☐ store bought
10. Are the following in good working order? ☐ furnace ☐ plumbing ☐ refrigerator ☐ stove
11. Do you have a working smoke detector(s)? ..... ☐ YES ☐ NO
    Last time checked: _____
12. Do you use a wood stove?..... ☐ NO ☐ YES
13. Do you have guns and/or weapons in your home? ..... ☐ NO ☐ YES
14. Are you having problems paying bills at this time? ..... ☐ NO ☐ YES
    If yes, check all that apply. ☐ rent/mortgage ☐ gas ☐ electric ☐ phone
    Please describe: _____
15. Does your child/children have a car seat? ..... ☐ YES ☐ NO
    If yes, is the car seat: ☐ new ☐ used
    a. Have you been shown how to install the seat in your vehicle? ..... ☐ YES ☐ NO
16. Do you have a crib for your new baby? ..... ☐ YES ☐ NO
17. Do you need help getting baby items? ..... ☐ NO ☐ YES

CHILDBIRTH EDUCATION CLASSES (CBE)

1. Are you nervous about going through the labor and delivery process? ..... ☐ NO ☐ YES
   Please describe: _____
2. Who will be taking you to the hospital when you are in labor? _____
3. Who will be your coach/with you during delivery? _____
4. Have you ever taken a CBE class? ..... ☐ YES ☐ NO
5. Do you plan to take a CBE class? ..... ☐ YES ☐ NO
6. Will there be a problem getting to the class? ..... ☐ NO ☐ YES

SUMMARY

BENEFICIARY SUMMARY

1. Do you have any questions about the MIHP program? ..... ☐ YES ☐ NO
2. What do you want the MIHP team to work with you on? _____
   _____
3. Do you foresee any problems keeping appointments with the MIHP team? ..... ☐ NO ☐ YES
   What kind? _____
   _____

CLINICIAN ASSESSMENT SUMMARY

Strengths:

Problems:

Referrals Made:

I have provided a copy of the following Maternal Infant Health Program (MIHP) information:

- ☐ Beneficiary grievance policy/procedure
- ☐ Medical and non-medical emergency options

MIHP Prenatal Services Assessment form completed by:

Signature | Discipline | Date

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

MATERNAL INFANT HEALTH PROGRAM

PRENATAL PLAN OF CARE

Beneficiary Name	Care Coordinator	Discipline

PROBLEMS / NEEDS	OBJECTIVES/OUTCOMES	INTERVENTIONS
Demographics and Health History Risk ___ Client needs information on resources available and how to access health care providers for _____ .		
Prenatal Care/Nutrition ___ Client needs information on resources available and how to access prenatal care providers to assist her to get to her appointments. ___ Client needs information on prenatal nutrition due to: _____		
Smoking ___ Client needs information on effects of tobacco on her baby. ___ Client needs information on how to decrease tobacco use.	Client will have information to recognize risk of substances to self and fetus and wil: ☐ Have a smoke free environment ☐ Quit smoking by (date): _____ ☐ Decrease cigarette use to (number): ____ per day by (date) _____ ☐ Identify a support for smoking cessation	
Alcohol/Drug Use ___ Client needs information on effects of substances on her baby. ___ Client needs information on resources available to assist her to decrease or discontinue her substance use.		

Beneficiary's Name: _____

PRENATAL PLAN OF CARE

PROBLEMS / NEEDS	OBJECTIVES/OUTCOMES	INTERVENTIONS
Stress ___ Client needs information on how to deal with stress.	Client will verbalize her stress has decreased.	
Depression and Mental Health ___ Client needs information on perinatal depression.		
Social Support ___ Client needs assistance with finding a good support system.	Client will identify a support system and will describe who will support her during her pregnancy and after delivery of the baby.	
Abuse/Violence		
Basic Needs ___ Client needs information on (circle appropriate responses): housing; financial resources; food supply; transportation; Other _____ _____		

Beneficiary's Name: _____

PRENATAL PLAN OF CARE

PROBLEMS / NEEDS	OBJECTIVES/OUTCOMES	INTERVENTIONS
Breastfeeding ___ Client needs information on the benefits of breastfeeding. ___ Client needs information on breastfeeding techniques and supportive community resources.	.	
Family Planning ___ Client needs information on contraceptive options available. ___ Client needs information on how to access reproductive health care after Medicaid coverage ends.	Client will verbalize future reproductive plans, including: ☐ Contraceptive Choice: _____ ☐ Reproductive Health Care Provider: _____ ☐ Method of Payment for Care: _____ ☐ Spacing of Children	
Other		

We, the undersigned, have reviewed the initial assessment and have participated in the above described plan. We concur with the number of visits to implement the interventions. Estimated Number of Visits By: _____RN _____SW _____RD

RN Signature	Date	SW Signature	Date	RD Signature	Date

Care Plan Update

We, the undersigned, have reviewed the care plan update and agreed to the changes in the above described plan. We concur with the number of visits to achieve the specific objectives. Estimated Number of Visits By: _____RN _____SW _____RD

RN Signature	Date	SW Signature	Date	RD Signature	Date

Michigan Department of Community Health

Maternal Infant Health Program

Prenatal Risk Factor Eligibility Screening Form

1 BASICS/DEMOGRAPHICS

0 SCREENING DATE

MM DD YY

1.0 IDENTIFICATION

1.0A NAME

FIRST

MI

LAST

1.0B MEDICAID ID #

1.0C SOCIAL SECURITY #

- -

1.1 What is your date of birth?

MM DD YY

☐ REFUSED

1.2 What do you identify as your race/ethnic background? (Check all that apply, question is optional)

☐ Asian
☐ American Indian or Alaska Native
☐ Black or African American
☐ Hispanic/Latino
☐ Native Hawaiian or other Pacific Islander
☐ White/Caucasian
☐ REFUSED

➡ 1.3

1.3 How many grades of school have you completed?

☐☐ grades completed

Junior high/middle school = 8
High school diploma/GED = 12
Associate's degree = 14
Bachelor's degree = 16

☐ REFUSED

1.4A Do you currently work outside the home?

☐ Yes
☐ No ⇩ 1.5

1.4B How many hours do you work in a typical week?

☐☐ Hours

1.5 Are you currently attending school?

☐ Yes
☐ No

1.6 Are you currently married or unmarried?

☐ Married
☐ Unmarried ➡ 2.1A
☐ REFUSED

2 HEALTH HISTORY/RISKS

2.1A When was your last menstrual period?

MM DD YY ⇩2.2A

☐ DON'T KNOW

☐ REFUSED

2.1B When is your baby due?

MM DD YY

☐ DON'T KNOW

☐ REFUSED

2.2A How do you feel about becoming pregnant? Did you:

☐ Want to be pregnant sooner ⇩2.3

☐ *Want to be pregnant later

☐ Want to be pregnant now ⇩2.3

☐ *Not want to be pregnant now or at any time in the future

☐ DON'T KNOW ⇩2.3

☐ REFUSED

2.2B At the time you became pregnant, were you using any birth control method?

☐ Yes

☐ No

☐ DON'T KNOW

☐ REFUSED

2.3 What was your weight just before you became pregnant this time?

☐☐☐ Pounds

☐ DON'T KNOW

☐ REFUSED

2.4 What is your height without shoes?

☐ Feet ☐ Inches ➡2.5A

☐ REFUSED

2.5A Including this pregnancy, how many times have you been pregnant? (Count any abortions, miscarriages or stillbirths)

☐ 1 TIME (FIRST PREGNANCY) ⇨2.7

☐ TIMES

☐ REFUSED ⇨2.7

2.5B When did your last pregnancy end? (date of last delivery, abortion, miscarriage or stillbirth)

☐☐ ☐☐ (Approximate if necessary)

MM YY

☐ REFUSED

2.6 Did any of your previous pregnancies result in:	YES	PG #	NO
2.6A *Miscarriage in the 4th month of pregnancy or later?	☐	☐	☐
2.6B *Stillbirth?	☐	☐	☐
2.6C *Baby weighing less than 5.5 pounds at birth?	☐	☐	☐
2.6D *Baby born more than 3 weeks early (or did anyone tell you that your baby was premature/preterm?)	☐	☐	☐
2.6E *Baby that stayed in the hospital after you went home?	☐	☐	☐

☐ REFUSED ➡

2.7	**Have you ever been treated for or told that you have:**

2.7A	**High blood pressure (hypertension)?**	
	No	⇩2.7B
	Yes	➡

2.7A.1	**When did you last see a health care provider about this problem?**			
MONTH:		YEAR:		⬇
2.7A.2	**Do you have another visit scheduled?**			
	Yes			⬇
	No			
2.7A.3	**Have you been in the hospital or ER for this problem in the last six months?**			
	Yes			⬅2.7B
	No			

2.7B	**Anemia or sickle cell disease?**	
	No	⇩2.7C
	Yes	➡

2.7B.1	**Have you ever had a blood transfusion for this problem?**			
	Yes	LAST DATE:	/	⬇
	No			
2.7B.2	**When did you last see a health care provider about this problem?**			
MONTH:		YEAR:		⬇
2.7B.3	**Do you have another visit scheduled?**			
	Yes			⬇
	*No			
2.7B.4	**Have you been in the hospital or ER for this problem in the last six months?**			
	Yes			⬅2.7C
	No			

2.7C	**Diabetes or high blood sugar?**	
	No	⇨2.7D
	*Yes	➡

2.7C.1	**Is it Insulin dependent?**			
	Yes			⬇
	No			
2.7C.2	**When did you last see a health care provider about this problem?**			
MONTH:		YEAR:		⬇
2.7C.3	**Do you have another visit scheduled?**			
	Yes			⬇
	No			
2.7C.4	**Have you been in the hospital or ER for this problem in the last six months?**			
	Yes			➡2.7D
	No			

2.7D	**Asthma?**	
	No	⇩2.7E
	Yes	➡

2.7D.1	**When did you last see a health care provider about this problem?**			
MONTH:		YEAR:		⬇
2.7D.2	**Do you have another visit scheduled?**			
	Yes			⬇
	No			
2.7D.3	**Have you been in the hospital or ER for this problem in the last six months?**			
	Yes			⬅2.7E
	No			

2.7E	**Problems with your heart, kidneys, or lungs?**	
	No	⇩2.7F
	Yes	➡

2.7E.1	**When did you last see a health care provider about this problem?**			
MONTH:		YEAR:		⬇
2.7E.2	**Do you have another visit scheduled?**			
	Yes			⬇
	No			
2.7E.3	**Have you been in the hospital or ER for this problem in the last six months?**			
	Yes			⬅2.7F
	No			

2.7F	**Problems with bleeding?**	
	No	⇩2.7G
	Yes	➡

2.7F.1	**When did you last see a health care provider about this problem?**			
MONTH:		YEAR:		⬇
2.7F.2	**Do you have another visit scheduled?**			
	Yes			⬇
	No			
2.7F.3	**Have you been in the hospital or ER for this problem in the last six months?**			
	Yes			⬅2.7G
	No			

2.7G	**Recurring vaginal infections?**	
	No	⇨2.7H
	Yes	➡

2.7G.1	**When did you last see a health care provider about this problem?**			
MONTH:		YEAR:		⬇
2.7G.2	**Do you have another visit scheduled?**			
	Yes			⬇
	No			
2.7G.3	**Have you been in the hospital or ER for this problem in the last six months?**			
	Yes			➡2.7H
	No			

2.7H	A sexually transmitted infection?	
	No	⇩2.7I
	Yes	➡

2.7H.1	When did you last see a health care provider about this problem?			
MONTH:		YEAR:		⬇
2.7H.2	Do you have another visit scheduled?			
	Yes			⬇
	No			
2.7H.3	Have you been in the hospital or ER for this problem in the last six months?			
	Yes			⬅2.7I
	No			

2.7I	Other problem(s) that you see a doctor for?	
	No	⇩2.8
	Yes	➡

2.7I.1	When did you last see a health care provider about this problem?			
MONTH:		YEAR:		⬇
2.7I.2	Do you have another visit scheduled?			
	Yes			⬇
	No			
2.7I.3	Have you been in the hospital or ER for this problem in the last six months?			
	Yes			
	No			⬅2.8A
	REFUSED			

2.8A	Are you now taking any prescription drugs?	
	Yes	➡
	No	⇩2.9A
	REFUSED	

2.8B	Which prescription drugs are you taking?	
		⬅2.9A

2.9A	How long has it been since you had a dental exam and cleaning?	
	Within the past year	⇨3.1
	Within the past 2 years	
	Within the past 5 years	
	More than 5 years ago	➡2.9B
	Don't know/not sure	
	Never	
	REFUSED	

2.9B	In the past year, have you noticed any problems with your teeth or gums such as bad breath that won't go away, loose or sensitive teeth, or gums that are red, swollen, tender, or bleeding?	
	Yes	➡3.1
	No	

3 PRENATAL CARE

3.1 When you have a health issue or problem, where do you usually go for care?

- ☐ Doctor's office
- ☐ Public health clinic
- ☐ Readicare facility
- ☐ Hospital
- ☐ Emergency room
- ☐ Other _____
- ☐ Nowhere
- ☐ REFUSED

3.2 How many months' pregnant were you when you had your first visit for prenatal care? Do not count a visit that was only for a pregnancy test or only for WIC.

- ☐☐ Months
- ☐ I haven't gone for prenatal care
- ☐ REFUSED

3.3 Have you had any trouble getting the prenatal care you want or need?

- ☐ * Yes
- ☐ No → 3.4
- ☐ REFUSED

3.4 Here is a list of problems some women can have getting prenatal care. For each item, please let us know if it has been true for you at any time during this pregnancy [READ LIST]

- ☐ I couldn't get an appointment when I wanted one
- ☐ I couldn't find a doctor or clinic that accepted Medicaid
- ☐ It is hard to communicate with the doctor or clinic staff
- ☐ It is hard to understand the information the doctor or clinic give to me
- ☐ I haven't had enough money or insurance to pay for my visits
- ☐ I haven't had my Medicaid card or Guarantee of Payment letter
- ☐ *I've had no way to get to the clinic or doctor's office
- ☐ I couldn't take time off from work
- ☐ I've had no one to take care of my children
- ☐ I have had too many other things going on in my life
- ☐ *I didn't want anyone to know I was pregnant
- ☐ Other. Please tell us: _____
- ☐ REFUSED

→ 4.1

4 SMOKING

4.1 Which of the following statements would you say best describes your cigarette smoking? Would you say:

	*I smoke regularly now – about the same amount as before finding out I was pregnant	
	*I smoke regularly now, but I've cut down since I found out I was pregnant	⬇
	*I smoke every once in a while	
	I have quit smoking since finding out I was pregnant	
	I wasn't smoking around the time I found out I was pregnant, and I don't currently smoke cigarettes.	⇨ 5.1
	REFUSED	⬇

4.2 How many cigarettes do you smoke on an average day now/or did before quitting?

	1-1/2 or more packs	
	1 to 1-1/2 packs	➡
	1/2 to 1 pack	
	6 to 10 cigarettes	
	1 to 5 cigarettes	⇨ 4.4A If smoking
	Less than 1 cigarette	
	REFUSED	➡

4.3A How soon after you wake up do you smoke your first cigarette?

	Within 5 minutes	⬇
	6-30 minutes	
	31 or more minutes	

4.3B Do you find it difficult to stop smoking in non-smoking areas?

	No	⬇
	Yes	

4.3C Which cigarette would you MOST hate to give up?

	The first cigarette in the morning	⬇
	All others	

4.3D Do you smoke MORE FREQUENTLY in the first hours after waking than the rest of the day?

	No	⬇
	Yes	

4.3E Do you smoke if you are so ill that you are in bed most of the day?

	No	⬇
	Yes	

If still smoking:

4.4A Have you seriously thought about quitting smoking during this pregnancy?

	Yes	⬇
	No	⇨ 5.1

4.4B Have you tried to quit smoking in the last 30 days?

	Yes	⬇
	No	⇨ 5.1

4.4C Have you made any changes or gotten any supports to make it easier for you to not smoke?

	Yes	➡ 5.1
	No	

5 ALCOHOL

5.1 Which of the following statements would you say best describes your alcohol consumption, INCLUDING beer and wine coolers? Would you say:

- ☐ *I drink alcohol regularly now – about the same amount as before finding out I was pregnant
- ☐ *I drink alcohol regularly now, but I've cut down since I found out I was pregnant
- ☐ *I drink alcohol every once in a while
- ☐ I have quit drinking alcohol since finding out I was pregnant → 5.3A
- ☐ I wasn't drinking alcohol around the time I found out I was pregnant, and I don't currently drink. → 6.1
- ☐ REFUSED

5.2 Approximately how many alcoholic drinks do you have in an average week/or did when drinking?

- ☐ 14 drinks or more a week
- ☐ 7 to 13 drinks a week
- ☐ 4 to 6 drinks a week
- ☐ 1 to 3 drinks a week
- ☐ Less than 1 drink a week
- ☐ REFUSED

5.3A How many drinks does it/did it take to make you feel high?

- ☐ 1
- ☐ 2
- ☐ 3 or more

5.3B Have people annoyed you by criticizing your drinking?

- ☐ Yes
- ☐ No

5.3C Have you ever felt you ought to cut down on your drinking?

- ☐ Yes
- ☐ No

5.3D Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

- ☐ Yes
- ☐ No

If still drinking alcohol:

5.4A Have you seriously thought about quitting all alcohol during this pregnancy?

- ☐ Yes
- ☐ No → 6.1

5.4B Have you tried to quit drinking alcohol in the last 30 days?

- ☐ Yes
- ☐ No → 6.1

5.4C Have you made any changes or gotten any supports to make it easier for you to not drink alcohol?

- ☐ Yes
- ☐ No → 6.1

6 DRUG USE

6.1	Does your partner or anyone in your household use street drugs?	
	*Yes	⬇
	No	
	REFUSED	

6.2A	In the month before you knew you were pregnant, did you use any street drugs, diet pills, or drugs not prescribed by a physician?	
	*Yes	⬇ 6.2B
	No	⇨ 7.1
	REFUSED	

6.2B	What did you use? (check all that apply) [OPEN ENDED, PROMPT FOR OTHERS]	
	Marijuana	
	PCP	
	Crack	
	Cocaine	
	Heroin	
	Uppers/Crank/Meth/Speed	⬇
	Downers	
	LSD	
	Diet Pills	
	Prescription drugs not prescribed for you	
	Other:	

6.2C	What drugs have you used since becoming pregnant? (check all that apply) [OPEN ENDED, PROMPT FOR OTHERS]	
	Marijuana	
	PCP	
	Crack	
	Cocaine	
	Heroin	
	Uppers/Crank/Meth/Speed	⬇
	Downers	
	LSD	
	Diet Pills	
	Prescription drugs not prescribed for you	
	Other:	
	None	

If still using drugs:		
6.3A	Have you seriously thought about quitting all drugs during this pregnancy?	
	Yes	
	No	
6.3B	Have you tried to quit using drugs in the last 30 days?	
	Yes	
	No	
6.3C	Have you made any changes or gotten any supports to make it easier for you to not use drugs?	
	Yes	
	No	

7 STRESS

7.1 In the last month, how often have you felt nervous and stressed?

- ☐ Never → 8.1
- ☐ Almost Never
- ☐ *Sometimes
- ☐ *Fairly Often
- ☐ *Very Often
- ☐ REFUSED
- ☐ SNAG

7.2 During pregnancy, pressures and hassles of everyday life can become even harder to cope with. In the last month, have you felt like you were struggling to cope with:

	YES	NO
Problems with money?	*	
Problems with a personal relationship?	*	
Demands of family or children?	*	
Demands of work or school?	*	

→

7.3A In the last month, how often have you felt that you were unable to control the important things in your life?

- ☐ Never
- ☐ Almost never
- ☐ *Sometimes
- ☐ *Fairly often
- ☐ *Very often

↓

7.3B In the last month, how often have you felt confident about your ability to handle your personal problems?

- ☐ *Never
- ☐ *Almost never
- ☐ *Sometimes
- ☐ Fairly often
- ☐ Very often

↓

7.3C In the last month, how often have you felt that things were going your way?

- ☐ *Never
- ☐ *Almost never
- ☐ *Sometimes
- ☐ Fairly often
- ☐ Very often

↓

7.3D In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

- ☐ Never
- ☐ Almost never
- ☐ *Sometimes
- ☐ *Fairly often
- ☐ *Very often

→ 8.1

8 DEPRESSION AND MENTAL HEALTH

8.1 Over the past 2 weeks, how often have you felt down, depressed, or hopeless?

- ☐ Not at all
- ☐ *Several days
- ☐ *More than half the days
- ☐ *Nearly every day
- ☐ REFUSED

8.2 Over the past 2 weeks, how often have you felt little interest or pleasure in doing things?

- ☐ Not at all
- ☐ *Several days
- ☐ *More than half the days
- ☐ *Nearly every day
- ☐ REFUSED

8.3 Over the past 2 weeks, how often have you had 'nerves' or felt angry, blue, or out of sorts?

- ☐ Not at all
- ☐ *Several days
- ☐ *More than half the days → 8.4
- ☐ *Nearly every day
- ☐ REFUSED

8.4A Have you ever had the "baby blues"?

- ☐ *Yes
- ☐ No
- ☐ REFUSED

8.4B Have you ever been treated for or told that you have depression, bipolar disorder, or schizophrenia?

- ☐ No ⇩ BELOW
- ☐ *Yes → 8.4B.1

8.4B.1 When did you last see a health care provider about this problem?

MONTH: ☐☐ YEAR: ☐☐☐☐

8.4B.2 Do you have another visit scheduled?

- ☐ Yes
- ☐ No

8.4B.3 Have you been in the hospital or ER for this condition in the last six months?

- ☐ Yes → BELOW
- ☐ No

IF ONE OR MORE ANSWERS TO 8.1 – 8.3 ARE MARKED ★, CONTINUE TO 8.5.

OTHERWISE, SKIP TO 9.1

QUESTIONS 8.5 – 8.14: DEPRESSION FOLLOW UP SCREENING

I'd like to ask you some follow up questions about how you're feeling.
I'm going to read you some statements and responses. For each statement, please let me know which response is closest to how you've been in the past 7 days.

8.5	**I have been able to laugh and see the funny side of things**
	As much as I always could
	Not quite so much now
	Definitely not so much now
	Not at all

8.6	**I have looked forward with enjoyment to things**
	As much as I ever did
	Rather less than I used to
	Definitely less than I used to
	Hardly at all

8.7	**I have blamed myself unnecessarily when things went wrong**
	Yes, most of the time
	Yes, some of the time
	Not very often
	No, never

8.8	**I have been anxious or worried for no good reason**
	No, not at all
	Hardly ever
	Yes, sometimes
	Yes, very often

8.9	**I have felt scared or panicky for no very good reason**
	Yes, quite a lot
	Yes, sometimes
	No, not much
	No, not at all

8.10	**Things have been getting the best of me**
	Yes, most of the time I haven't been able to cope at all
	Yes, sometimes I haven't been coping as well as usual
	No, most of the time I have coped quite well
	No, I have been coping as well as ever

8.11	**I have been so unhappy that I have had difficulty sleeping**
	Yes, most of the time
	Yes, sometimes
	Not very often
	No, not at all

8.12	**I have felt sad or miserable**
	Yes, most of the time
	Yes, quite often
	Not very often
	No, not at all

8.13	**I have been so unhappy that I have been crying**
	Yes, most of the time
	Yes, quite often
	Only occasionally
	No, never

8.14	**The thought of harming myself has occurred to me**
	Yes, quite often
	Sometimes
	Hardly ever
	Never

9 SOCIAL SUPPORT

9.1	Would you describe the father of this baby as:	
	Involved in my pregnancy and supportive of me	
	Involved but not supportive of me	
	*Aware that I'm pregnant but not involved	⬇
	Not aware that I'm pregnant	
	REFUSED	

9.2A	Is there someone in your life who you can count on to help you during this pregnancy and with your new baby?	
	Yes	➡
	*No	⇨ 10.1

9.2B	Who do you count on for support? (check all that apply)	
	Partner and/or the baby's father	
	Parent(s)	
	Other child or children	
	Other relative(s)	➡ 10.1
	Friend(s)/Neighbor(s)	
	Clergy and/or people at my place of worship	
	Other:_____	

10 ABUSE/VIOLENCE

10.1 Do you feel safe in your present relationship?

- ☐ I am not in a relationship right now
- ☐ Yes
- ☐ *No

10.2A Within the last year, have you been hit, kicked, slapped, or otherwise physically hurt by someone?

- ☐ *Yes
- ☐ No ⇨ 10.4

10.2B By whom? (Check all that apply)

- ☐ Current partner
- ☐ Ex-partner
- ☐ Stranger
- ☐ Others
- ☐ Specify_____

10.2C How many times has this happened?

- ☐ times

10.3A Since you have been pregnant, have you been hit, slapped, kicked or otherwise physically hurt by someone?

- ☐ *Yes
- ☐ No ⇨ 10.4

10.3B By whom? (Check all that apply)

- ☐ Current partner
- ☐ Ex-partner
- ☐ Stranger
- ☐ Others
- ☐ Specify:

10.3C How many times has this happened?

- ☐ times

10.3D What part or parts of your body were hurt?

- ☐ Limbs
- ☐ Torso
- ☐ Head

➡ 10.3E

10.3E How did this person hurt you? (Score the most severe incident to the following scale)**:**

- ☐ Threats of abuse, including use of a weapon
- ☐ Slapping, pushing; no injuries and/or lasting pain
- ☐ Punching, kicking, bruises, cuts and/or continuing pain
- ☐ Beaten up, severe contusions, burns, broken bones
- ☐ Head, internal, and/or permanent injury
- ☐ Use of weapon, wound from weapon

10.4 Has your partner or someone else now in your life:

- ☐ *Called you names, humiliated you, or made you feel that you don't count?
- ☐ *Kept you from seeing or talking to your family, friends, or other people?
- ☐ *Thrown away or destroyed your belongings, threatened pets, or done other things to bully or scare you?
- ☐ *Controlled your use of money, your access to money or your ability to work?

10.5A Within the past year, has anyone forced you to have sexual activities?

- ☐ *Yes
- ☐ No ⇩ 10.6

10.5B Who was it?

- ☐ Current partner
- ☐ Ex-partner
- ☐ Stranger
- ☐ Others
- ☐ Specify:

10.5C How many times has this happened?

- ☐ times

10.6 Have you *ever* been emotionally or physically abused by your partner or someone important to you?

- ☐ *Yes
- ☐ No

10.7 Are you afraid of your partner or anyone you listed above?

- ☐ *Yes
- ☐ No

➡ 11.1A

11 BASIC NEEDS

11.1A	**In the last 12 months, did you (or other adults in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food?**	
	Yes	⇩
	No	⇩ 11.2
11.1B	**How often did this happen?**	
	Almost every month	⇩
	Some months but not every month	
	In only 1 or 2 months	
11.2	**How many times have you moved in the past 12 months?**	
	0	⇩
	1	
	2	
	3	
	4 or more	
11.3A	**Do you currently have any concerns or worries about your housing situation?**	
	*Yes	⇩
	No	⇨ 11.4

11.3B	**What are your concerns or worries about housing? (check all that apply)** [OPEN ENDED]	
	Instability	⇨ 11.4
	No place to live, no regular nighttime residence, or live in a shelter.	
	Eviction or being forced to move out.	
	Affordability of current house or apartment	
	Strained relations with others in household	
	Adequacy	
	House or apartment is too crowded.	
	Lack of continuous functioning basic utility service (e.g., heat, electricity)	
	Safety	
	Safety of house/apartment	
	Safety of neighborhood	

11.4	**How often do you have access to a telephone to make and receive calls where you live?**	
	Always	⇩ 12.1
	Sometimes	
	Never	

12 BREASTFEEDING

12.1	**Which of the following best describes your thoughts on breastfeeding your new baby?**	
	I know I will breastfeed	
	I think I might breastfeed	
	I know I will not breastfeed	
	I don't know what to do about breastfeeding	
	REFUSED	

END

Throughout this risk-screening form an asterisk (*) was placed next to the responses that if checked by the beneficiary would indicate they have a risk. If a beneficiary checks, at a minimum, one box where the corresponding response has an asterisk, they are automatically eligible for Maternal Infant Health Program (MIHP). In the event none of the beneficiary's answers on this form are marked by an asterisk, they may still be assessed based on the MIHP provider's judgment.

MIHP Prenatal Risk Factor Eligibility Screening Form completed by:

Signature Discipline Date