

Child and Adolescent Health Centers Frequently Asked Questions Non-Clinical Programs

Minimum Program Requirements (MPR's)

Q: What types of services are provided by the CAHC Non-Clinical programs? Can non-clinical dollars support clinical services?

A: The non-clinical adolescent health center should provide a range of services based on the needs of the target population. The non-clinical model provides some flexibility for programs to address the needs in their population. Many non-clinical programs are funded to provide limited clinical services, while others focus primarily on health education and peer education programming. Services offered by non-clinical health centers can include limited clinical care that meets the unique needs of the adolescent population, case finding, health education, health screenings, referral for primary and/or other needed health or psychosocial services and Medicaid outreach and enrollment. If limited clinical services are offered, referral as appropriate is expected as follow-up is critical to assuring quality care of adolescents.

Q: MPR #10 (adolescent centers) states that “the health center shall be open during hours accessible to its target population, and provisions must be in place for the same services to be delivered during times when school is not in session. Not in session refers to times of the year when schools are closed for extended periods, such as holiday, spring breaks, and summer vacation.” How can a non-clinical center provide services over the summer?

A: The expectation is that your non-clinical center will be delivering services to youth throughout the year. While the number of students accessing school-based sites may diminish during times when school is not in session, programming can still continue via other avenues outside the school building to target youth. Many non-clinical programs offer health education presentations, peer education programs, health programming that meets one of the required MDCH “focus” areas and Medicaid outreach trainings during the summer months to other agencies outside of the school building (e.g., summer camps, youth-serving organizations, health fairs, community events) and within the school community (e.g., sports camps, cheerleading camps, summer school, etc.). While the client flow may be lessened during school breaks, staff can take advantage of this relaxed pace to conduct administrative and evaluation activities (e.g., review and tabulate needs assessments and client satisfaction surveys, conduct chart reviews, research programming that can be used in the upcoming school year, write work plans, etc.).

Q: What is the typical staff pattern of a non-clinical program?

A: Due to the wide variety of activities that are being performed in the non-clinical program there is no standard staffing pattern. It is important that the staffing reflect the scope of services being provided at the non-clinical center. The majority of non-clinical centers are staffed with a Program Coordinator, Health Educator, Registered Nurse, and/or Social Worker.

Q: Can I write a non-clinical grant to provide the support services/health education required through the clinical grant?

A: No. Non-clinical grant funds can not be used to supplant current funding for support or health education services required by a clinical CAHC grant. However, there are non-clinical programs that have been funded to provide services that complement a clinical program's health education component.

Q: MPR #2 indicates that our health center must conduct or have access to a comprehensive needs assessment every two to three years to determine the health and psychosocial needs of the population. Can we use the Michigan-YRBS as our needs assessment?

A: The Youth Risk Behavior Survey (YRBS), organized by the Center for Disease Control and Prevention and Michigan Department of Education, is generally not approved as the sole source of health/needs assessment data for any center. It can be used as part of the overall needs assessment process, but should not be considered as the only source of health risk behavior data for your student population.

The Michigan-YRBS is conducted with a sample of schools and the school with which you work most likely does not participate. While the results of the YRBS can usually be generalized to the larger adolescent population, there may be some distinct differences or unique needs among the population with which you work. One of the best ways to draw out such nuances is to conduct a health/needs assessment survey with that population specifically. Each center is required to conduct a health/needs assessment survey every two to three years, so permission to use the YRBS as the health needs assessment survey is granted in very rare circumstances e.g., to a non-clinical center that serves many different schools or to a school that can verify participation in the YRBS (Michigan or Detroit-specific). Even then, those centers are strongly encouraged to gather other sources of data specific to the school population(s) they serve.

Q: MPR #1 requires the local community advisory council (CAC) approve three specific policies. Why does this policy exist when an outside body can't approve or change policies governed by our sponsoring agency?

A: The community advisory councils are a major source of support for the non-clinical health center. In fact, they are viewed as so integral to the health centers that the Michigan Legislature requires each center to have an operational community advisory council and stipulates some membership and operational requirements, including one-third parent member composition.

The three policies (parental consent, request for medical records and release of information, and reporting of child abuse and neglect) which are required to be approved by the community advisory council are those that are often the most controversial and/or misunderstood. It is imperative that the community advisory councils are familiar with the policies, their purpose and their relationship to Michigan law and that the council's endorsement of these policies is documented. In the event of any violation or challenge to one of these policies, the community advisory council would no doubt be one of the first entities that would be looked to in terms of response or action. An uninformed council which did not approve the policies will not be able to support the center or the client.

Performance-Based Contracts

Q: Child & Adolescent Health Centers recently moved to “performance-based contracts.” What does this mean and how does it affect my health center?

A: Performance-based contracts involve measuring contractor (health center) performance for the purpose of determining the proportion of the total contract amount paid to a health center in terms of the attainment of a performance output measure. For the non-clinical program, there are two output measures. The performance output measure for the number of clients served is applicable if direct services are provided to youth. This measure will be monitored by data submitted on the Adolescent Health Services & Referrals form. The other non-clinical program output measure is a projected number of youth to be reached through health education presentations. This measure will be monitored by data submitted on the Adolescent Health Education Presentation form. Non-clinical programs will work with their MDCH consultant to determine if their center is responsible

for meeting both required measures. If satisfactory achievement of the determined performance output measures is not realized, a reduction will be made in the total contract amount for the subsequent year.

Fiscal Year 2006 was the first year for performance-based contracting for the health centers, meaning this was the first year that non-clinical health centers had to project these specific performance output measures. Because this was a new concept to the health centers, no financial reductions in contracts were issued in Fiscal Year 2007 based on the previous year's performance. In future years, centers who fail to reach at least 90% of the projected performance output measure will see a proportionate reduction in funding of subsequent year contracts. In year five of the five-year funding cycle, centers will either have the last payment withheld and reductions taken out of the last payment; or will be required to repay the amount of the contract reduction.

Q: Who determines the performance output measure?

A: The health center, together with its sponsoring agency, projects an annual performance output measure and proposes this to MDCH by submitting it along with the contract each fiscal year. The performance output measure should be based on factors including a review of previous unduplicated user numbers and population size in the school/community where the center is located. MDCH reviews the proposed, projected performance output measure and will re-negotiate a new measure if the number proposed by the health center/sponsoring agency is viewed as unreasonably high or low based on the aforementioned factors.

Mandatory Focus Areas and Research-Based Interventions

Q: How were the six mandatory focus areas determined?

A: The six mandatory focus areas were determined mutually by the Michigan Departments of Education and Community Health in response to the number of requests from other state agencies, legislators and the public as to what the departments/health centers were doing to impact these issues. These focus areas are: teen pregnancy prevention, HIV/STI prevention, tobacco prevention/cessation, obesity prevention/management (includes nutrition and physical activity), asthma and mental health. These are health issues of concern in the adolescent population and the non-clinical health centers can reasonably be expected to make an impact in these areas through limited clinical services, support services and/or health education.

Q: What is my non-clinical health center expected to do to address these focus areas?

A: Every year, each health center is required to develop programming/ interventions in a minimum of two of the six mandatory focus areas; and many centers opt to concentrate on more than just two focus areas. In the health center's annual work plan, the focus areas selected must be identified and include an overall goal, measurable outcome objectives with evaluation methods and research-based and/or promising programming/interventions. For centers providing limited clinical services, the programming/interventions can include a mix of evidence-based clinical approaches and support services and/or health education interventions. Health education can be individual or group-based programs. Each focus area should have at least two to three distinct programs/interventions identified to be considered an area of focus. Additionally, your center can include other types of activities in the work plan (e.g., assemblies, one-time presentations) to supplement the research-based and promising interventions, but these types of activities are not expected to have a significant or lasting impact on knowledge, attitudes or behaviors so they alone would not meet the criteria for addressing the mandatory focus areas.

Q: State-funded health centers are required to use “research-based” or “promising” programming and/or interventions in the work plans to address the six mandatory focus areas. How are “research-based” and “promising” defined? Why does this requirement exist?

A: Research-based programs (also known as evidence-based programs) are those which have been shown through rigorous evaluation design to be effective in significantly impacting specific health outcomes and/or risk behaviors among the population to which the program was delivered. These programs generally have been replicated in multiple populations or locations with similar effects. The results of an empirical evaluation design, demonstrating significant effectiveness, are typically published in the literature (e.g., peer-reviewed journals), reviewed by independent scientific review panels, and are recognized by nationally respected organizations and/or government agencies.

Similarly, promising programs (sometimes also called “best practice”) are those that, through a smaller body of research, are proving to be reliable or showing promise in achieving a desired outcome. These are emerging programs or interventions that show promise in consistently producing evidence that they work, but the outcomes may not be as widely tested or documented as those considered to be “research-based.”

Numerous entities publish compendia of research-based and promising programs and interventions (including clinical interventions) depending on the health issue or risk behaviors addressed. Some compendia may use research or evidence-based and promising or best practice terminology interchangeably, so be sure to look at the criteria for inclusion in whatever resource you are using to identify programs/interventions.

This requirement exists to ensure the greatest impact of programming and maximum impact of the dollars used to support the CAHC Program. Policy makers increasingly request to see outcome evaluation results and the best way to ensure good outcome evaluation is to use research-based programming.

Q: Does MDE or MDCH have a list of approved “research-based” or “promising” programs/interventions?

A: Neither agency maintains a single, exhaustive list of programs or interventions that a health center must use. MDCH does maintain a list of programs that have been approved for use in the health centers, but this list is not exhaustive. You can request a copy of this list by contacting your assigned MDCH State Consultant. There are myriad resources available for identifying programs and interventions appropriate for your youth population through government, university, private and non-profit entities. Your health center staff should carefully review needs assessment and services data to determine the needs of your target population, and then research the options best-suited to address those needs.

Q: Can the Michigan Model be used as a research-based curriculum?

A: Yes. In 2001, the U.S. Department of Education’s Expert Panel on Safe, Disciplined, and Drug Free Schools designated the Michigan Model® as one of 44 promising programs that met the federal criteria for program effectiveness. However, if the curriculum is being provided by the school staff this cannot be considered an activity in a chosen focus area. Health center staff must be presenting the curriculum in the classroom for it to meet this grant requirement.

Reporting

Q: Why are some reports collected on the state fiscal year (October 1 to September 30) and other reports collected on the calendar year?

A: The narrative progress report on the work plan, financial status report (FSR) and Medicaid outreach coincide directly to the state fiscal year of October 1 – September 30. The Request for Proposal and renewal applications must be issued on the fiscal year cycle. Therefore, contracts, progress reports, Medicaid outreach reports and budgetary information tied to the applications must also run on this fiscal year which is why these reports must correspond to this time frame.

The Michigan Legislature requires the Health Education Presentation Form and Services and Referrals Form be collected and reported to the Legislature on the calendar year.

(Remember that because you submit the Medicaid outreach data by quarter, MDCH reconciles the year-to-date data on the fiscal year – this is not something your health center is required to do any longer.)

Q: Should a non-clinical center be providing services and referrals? Are limited clinical services reported on the services and referral form?

A: Yes. The Services and Referrals Form consists of eleven categories of services that may be provided by clinic staff. Any service that a non-clinical program provides in any of these categories should be counted on this form. A service is a unit of health care provided during a visit to the center. It is not required that services be provided in all eleven categories, however every attempt should be made to assure the youth receive the care they need. If a referral is made to another provider this should be indicated on this form also. A referral is a recommendation for health services not provided by the health center and should be made for the purpose of further facilitating comprehensive health services. It is imperative that all referrals are followed up on to assure the youth obtained the services needed. If you have questions regarding reporting a specific service, contact your MDCH consultant.

Medicaid Outreach

Q: What is the minimum expectation for providing Medicaid Outreach?

A: Each non-clinical center must provide some level of Medicaid outreach in areas 1, 2 and 5 each fiscal year. MDCH is currently finalizing a proposal to impose financial penalties to any center that consistently reports little or no outreach activities. In this proposal, thresholds of acceptable activity will be outlined so a center can gauge whether their level of outreach activity is meeting acceptable standards. Non-clinical Medicaid outreach program data should always be counted separate from any activities that may be provided by a clinical program if both are funded at the same agency.

Q: What happens if our center doesn't provide "enough" Medicaid outreach?

A: MDCH reviews the quarterly Medicaid outreach reports to determine if a good-faith effort is in place to provide Medicaid outreach activities. A formal review of outreach activities is also incorporated into the site review process.

If it is determined at any time during the fiscal year or during a site review that the level or documentation of Medicaid outreach activities is insufficient, MDCH will first try to work with the center to verify what type of outreach is occurring and to verify the tracking/documentation methods being used. Sometimes a center is providing acceptable Medicaid outreach activities but

is not aware that the activities are eligible for inclusion in the Medicaid outreach report. Other times, problems in tracking mechanisms or poor documentation result in inaccurate reports that reflect falsely low levels of activity. MDCH will work with the center to correct these issues and then ask for periodic updates of activity.

Q: What is the difference between Medicaid Outreach area 1 and area 5?

A: Outreach area one includes general public awareness activities used to spread the word about Medicaid services and eligibility. Distribution of health center brochures and flyers, newsletters, direct mailings to families, and health fair participation where health center assistance with application and provision of Medicaid-covered services is presented, are all examples of activities that qualify under this area. Additionally, if you are providing health education to students on any health topic and you incorporate a brief overview of Medicaid eligibility, application and an explanation of Medicaid-covered services offered by the center into a presentation, you would count and report the number of participants in this area. Count and report the number of individuals reached, pieces of literature provided, circulation of the newsletter, number of letters mailed and the like in this outreach area.

Outreach area five is targeted training specific to Medicaid topics such as eligibility, the application process and service provision. These include trainings on “Medicaid only topics” that your health center provides. It also includes trainings that your health center staff participates in to learn more about Medicaid eligibility requirements, to assist clients with the application process, and to improve assistance in the application process. In this outreach area, you report two numbers - the number of trainings attended or provided as well as the number of participants.

For these two outreach areas only, activity that you provide adults is also included in the count of persons reached.

Q: How is the Medicaid Outreach reporting data used?

A: Medicaid outreach reporting data is compiled into a database on a quarterly basis. The data that your individual center reports is provided quarterly to the Medicaid Health Plans and to the Center for Medicaid Services. This data is presented by health center, so a health plan, CMS staff and other interested parties are aware of the level of outreach activity provided by each individual center in each of the five outreach areas for each of the ten Medicaid regions across the state.

Site Reviews

Q: What happens if my center doesn't do well on a site review? Are financial penalties attached to the reviews?

A: If your center does not perform well in a site review, a follow-up site review will be scheduled within three to six months of the original review. At that time, progress will be re-assessed and further action taken based on the number and severity of outstanding citations. Financial penalties could be imposed if improvement has not occurred by this second follow-up site review.

MDCH is considering a proposal to grant centers various levels of accreditation status based on the review findings (similar to the local health department accreditation process). These results would be available to the public. Additionally, MDCH is also considering imposing financial penalties to any center that performs very poorly on a site review, or that performs poorly and does not made sufficient progress in correcting deficient findings within a three-to-six month period.