

Q & A
MIHP Regional Coordinator Meetings – September 2012

Comments on MA Transportation Policy

1. Only one of our four counties has a birthing hospital. It seems more costly for Health Plan to transport a client to medical appointments vs reimbursing the client to drive themselves. When we are looking at health birth outcomes we need to ask what is the best way to get the mother to the doctor!! Roseanne Schultz, DHD4.
2. We currently write gas vouchers for clients for all pregnancy-related appointments. They get the voucher and can use it at local/designated gas stations. Most of our clients travel 60 miles plus round trip for OB care. Our clients are low-income and do not have resources to purchase gas for all of the added appointments during a pregnancy. They also need the reimbursement now to get to their scheduled appointments – they can't wait weeks to be reimbursed. By their MHP! Sometimes the only way that they can get someone to take them to their appointment is to put gas in the vehicle that will be taking them. There is no public transportation in the Thumb that crosses county lines – you need to travel through two counties to get to the hospital/OB. There are no taxi services in the Thumb. A mother was denied transportation services through our local DHS because she was going to a meth clinic in Saginaw.
3. MHPs cannot use local transportation – it doesn't cross county lines. Five out of six of our counties do not have OB/or delivering hospitals. It is 25-60 miles one-way to get to PB/hospital.
4. MHPs cancel at the last minute and appointments are missed. We have no buses and no cabs – the only way to get to appointments is someone driving the clients.
5. People haven't been able to get ahold of MHPs for transportation.
6. We provide MIHP services in a rural county. There is no public transportation, taxi service, etc. We have no OB's or hospitals that are located in our county so clients have to travel quite a distance for these services.
7. We have had a lot of problems with the MHPs providing services.
8. How long will clients have to wait for reimbursement from MHPs for mileage? I think this may be very detrimental to clients' getting their needed care.
9. MIHP providers need to be able to provide transportation reimbursement in northern MI for medical care. Our geographic area for the top 23 counties is as large as the UP. This is a huge area to provide transportation service. We presently have a system in place that is working well. Our goal should be to get pregnant women to their medical care. The greatest majority of pregnant women are in a FFS MA program before they are assigned to a MHP, so two systems have to be straddled and it becomes confusing for both clients and providers.
10. Clients are not getting transportation through MHP.

11. Historically MHPs have not provided transportation to WIC, mental health and SA.
12. Transporters have been sent from several counties away to take someone to an appointment.
13. Could carve-out for transportation be done?
14. Families must give several days to a week's notice which is difficult for families to do (without phone minutes, without cars, etc.).
15. Northern Michigan pregnant women are better served by getting mileage reimbursement to get to their appointments. They are working with us for MIHP regularly and we can assess their need and provide reimbursement.
16. Public transportation is not always available in our counties.
17. We have a county bus system but it doesn't cover the whole county. If you call the bus, you may only be able to be picked up and dropped off at one time during the day if the bus even goes there that day. No travel outside of the county with the buses. No taxi in the county. Transportation through DHS is not available – they no longer have drivers.
18. Public comment on transportation policy: MHP sends a van up to Northern MI from Grand Rapids (2½ hours away) to take client to medical appointments a couple miles away. That is their definition of "coverage" for transportation.
19. In Grand Traverse County, very unreliable transportation is provided by every HP. For example, rides (drivers) come from Grand Rapids or Detroit to take clients to local MD appointments.
20. MHP will not transport without car seats, but can go on the bus, but needs the money to buy token.
21. MHPs do not provide drivers who are bilingual or culturally sensitive.
22. How can we reduce the waiting/time ahead planning? MHPs require calls 4-5 days in advance, but many clients don't have that much warning.
23. What about clients who have a car in the home, but it is in use all day – no available transportation. Can get denied transportation by MHP.
24. Transportation is a huge issue for our families to get to their medical appointments. It is very difficult for our at-risk families to access transportation through their MHP. Most MHPs require planning in advance – most at least 5 days to receive assistance and/or reimbursement weeks/months later. It is much easier for families to receive transportation assistance for medical appointments from MIHP providers.
25. Clients can't or don't want to use MHP for appointments. We end up giving bus tickets. Clients then never use MHP.

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26. It is not only difficult to get health plan to assist with transportation, but is NOT in best interest of our clients. Clients that have own vehicle but cannot afford gas cannot wait weeks to get a check from the health plan. They need the money the day that they go to the doctor. Same with bus – they need it to get on the bus. Our office is able to reimburse client the date of service – when the client needs it. Take that away and compliance with OB appointments will decrease drastically!! Please confirm this not effective yet.
27. Many times we set up transportation with managed care. The providers they use sometimes don't show up or come really late. This has been the problem with several managed cares. There is no other way for our clients to get transportation. Connie Braxton, Silverspoon MIHP.
28. I think it would be a good idea if LogistiCare would have to contract with MIHP providers, so that MIHP can provide transportation for their participants. LogistiCare pays their contractors \$21.20 for one-way trips. If they had to contract it would make a difference. Tammy
29. Our clients are not getting into HMOs quickly. In fact, it has been taking longer for HMO assignment for the last 6 months. This has a huge impact on the # of MIHP cabs. If it takes 6 months to get assigned to an HMO, then we must provide transportation via MIHP for 6 months. We have had little insight from DHS on why this assignment of HMO is so slow. (One problem is if the client is overwhelmed, they may not be complying with MA paperwork quickly, but this hasn't changed in the last 6 months.)
30. Some clients are stating that in order to receive transportation, HMOs are asking for doctor letters that document any disabilities and explain why the client couldn't catch buses or walk if center is near them.
31. A lot of moms aren't getting a card to even know the phone number to call for MHP transportation.

Transportation Questions

1. Where do we go for public comment on the proposed transportation policy?
2. In our area we have no taxi service – no way to transport women when they need it. This new policy will cause many women not to keep their doctor appointments. I thought the goal in MI was healthy pregnancy, delivery and baby. Many women can't afford gas and need the money back quickly to afford their next visit. How long will it take for reimbursement?
3. What is your turn-around time for transportation reimbursement to clients from Medicaid Health Plans?
4. Grid for transportation, if it is not supposed to be out for public view – will a grid be available when changes come?
5. Are dental services included under medical care as far as MHP covering transportation to and from appointments? I had a client who was refused transportation to a dental appointment.
6. Can you confirm mileage reimbursement effective 10/01/12: 21 cents to client, bill 23 cents?

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7. Can MIHP offer mileage reimbursement for moms going to NICU to visit infant?
8. Question: For MIHP women enrolled in a MHP who choose not to use their MHP for transportation, they have a car but lack ability to pay for gas, can the MIHP reimburse the woman for all appointments related to her pregnancy (i.e., medical, WIC, education classes)?
9. Are we allowed to pay mileage, bus tickets and taxi to MIHP clients who have a MHP?

IT

1. Is there any way possible to update the Infant Risk Identifier so there is an umbrella to only enter the infant demographic info once and to combine it into one database, rather than two?
2. Would it be possible to make a change in SSO for the Infant Risk Identifier for data that is answered on both forms – i.e., mom’s age @ delivery can prefill on the other identifier?
3. Error Message 500 – can the time be changed from 5 minutes to 10 minutes? Five minutes can easily go by when you’re doing a Risk Identifier and having a conversation with a client. You aren’t leaving your desk to so you don’t think to “close out” so it then becomes a problem.
4. Please take the social security number of the printed version of Discharge Summaries.
5. The SSN error in the infant component of the Infant Risk Identifier: When you click “ok” to acknowledge the error message, it takes you back to the maternal component screen of the Infant Risk Identifier.
6. Regarding Discharge Summaries to providers when printed from online SSO – can we send only the last sheet, which is a summary? Complete Summary is way too much paper.
7. For Maternal Discharge Summary, may need to have unknown put in some electronic screeners let contact person know.
8. Suggest extending completion of Maternal Discharge Summary to 90 days due to putting in gestational age and birthweight at DOB. Otherwise, you have to keep the info somewhere else – i.e., duplicate paperwork.
9. UPHP wants to pilot access to MIHP quarterly data in addition to plan of allowing Health Plans view-only access to Risk Identifiers. Paula Kivela - UPHP
10. Is there a way to determine if a patient is enrolled in another MIHP other than entering their info on the first page as if they’re a new intake?
11. Is it possible to update the SSO system to reflect MIHP transferred patients? I’ve had requests for transfers because I’m listed as the patient’s MIHP. However, the patient has already been transferred to another MIHP.

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12. When entering the Infant Risk Identifier (maternal portion), I cannot/didn't receive a scoring. When I tried to enter the Infant's portion, I received a message stating that there is another infant with the same ID#. There are major problems with the Infant Identifier.
13. How do we get feedback after initiating a remedy ticked problem (as an MIHP agency)?
14. Inquiry to see if a beneficiary is with another provider – when trying to “inquire” via name and DOB, it always says “not found” and if we use MCD RID – unless it is someone we previously had – it doesn't come up. If you go under new screener, that's the only time it will alert you to a beneficiary being enrolled in a different MIHP. What can we do?
15. Some suggestions for the Infant Risk Identifier:
 - Instead of a delete function, have the client deleted out when you use the cancel button (just like the maternal screener).
 - Make both infant and maternal components one screener to avoid entering the info twice.
 - Make it easier to switch from the IRI to the MRI without having to exit the application and start all over.
 - We have gotten a couple of errors, once one component has been entered. Both errors cite Medicaid ID#s either “match another beneficiary” or “does not match the infant entered.” This prevents us from completing both components. Please explain this.
 - Thank you for creating the direct links to the pages with errors on the IRI.
16. Multiple births: Could there be a button on the Infant Risk Identifier that would indicate multiple births, so that the maternal component would be prepopulated and only entered into the system once?
17. If a client drops out of MIHP, we are told to complete a D/C Summary. If we are not sure of the birth outcome, there is not an “unknown” option and we cannot move on to next section. Do we click “other?”
18. Will scoring of the depression screening part of the Risk Identifier ever be included in the database, so that at the end of the Risk Screen, we would know the total score for the Edinburgh?
19. When you print the Maternal or Infant Discharge Summary it is very small print, hard to read, and prints many pages.
20. I completed infant component of the IRI and saved + exit before I printed the score result sheet. I tried to re-enter to print it, and couldn't. I tried going through inquiry + deleted+ non-complete – stated “no record found.” Tried to go through new screen – message came up w/already been entered.
21. Domestic Violence scored “high” for no reason. It only happens once in a while, not on a consistent basis.
22. Repeat questions that don't automatically fill in (married, age, etc.).

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23. Question that asks "How many children?" Does this include the infant? If so, how to report his/her age?
24. "Age first received formula" ___ months? If birth?
25. "How often does baby eat?" Should answer be how many times?
26. WIC question is out of order.
27. Infant screener allows you to submit more than once, and once you to delete it, it says, "Are you sure you want to delete tot record?"

Risk Identifier

1. New Maternal Risk Identifier: Would like a more accurate way of measuring transportation problems.
2. On revised Maternal Risk Identifier, please include space for MD name, question on if client is enrolled in WIC and who client is living with (alone, with FOB, with family).
3. The current domestic violence questions address relationships with serious physical abuse. It would be good to have questions that address power and central issues because current questions send the message that you're not in a DV relationships unless you're being physically abused.
4. Is there a reason that on the maternal section of the Infant Screener, under mental health/depression, it asks about hx of depression, bipolar, but does not ask about history of anxiety, like the Prenatal Screener does?
5. Does the entire Risk Identifier need to be saved in the EMR, or just the scoring results page? Previously we were told to save and import just the RI scoring results page, so that's what we have been doing. Bay Co HD.
6. For infants in foster care, do we have to complete the maternal component of the Risk Identifier?
7. Please clarify how to enter an Infant Risk Identifier maternal component when father has custody or if child is in foster care.
8. When doing the Maternal Risk Identifier, is it better to have the FOB in the room? We want to include him if he comes, but staff feel uncomfortable with the questions which put the client at more risk. Ask the FOB to leave the room or ask sensitive questions in front of him?
9. Please investigate the algorithm for Abuse/Violence in the new Infant Risk Identifier. We have an example of one that the abuse was in the past and she answered "no" to question "are you afraid of your partner or anyone you listed above?" Yet, she scored "high" in abuse/violence.

10. In the abuse/violence domain, all interventions are tailored to DV/IPV, but women are flagged as moderate/high risks if there is abuse from a family member, fights at school, attack by a stranger, etc. Suggestion to address in new Maternal Risk ID.
11. There are occasions when the entire Risk Identifier cannot be completed during one visit (others present in same room as visit, mom needs to leave unexpectedly). How do we complete the Risk Identifier (on SSO) if not all info is collected (i.e., abuse/violence, depression, family planning) especially if no further visits are able to be completed?
12. The format of the newest Infant Risk Identifier is difficult to follow. Many of the questions could be overlooked. There are no lines for the responses.
13. When filling out the Risk Identifier, it's confusing to answer the SA questions when client has a medical marijuana card. "Is client taking street drugs or drugs not prescribed by doc?" I think the answer is no. Then later, you are asked about drug use – yes for marijuana. Medical marijuana is very confusing with breastfeeding, etc.
14. Take SSN off Maternal Risk Identifiers. We don't need it.
15. Who can enter identifiers?
 - a. Only RN
 - b. Only MSW
 - c. Maybe coordinator/advocate
16. If the SW/RN do the assessment on paper in the home, can our secretary enter the info into the SSO?
17. How do you enter screener for twins, guardian, etc?
18. What to do about a drug-exposed infant whose mother answers no about drug questions?
19. Are you doing anything to prevent pregnancy? "Yes" and "No" are options. Have option: "I am not having sex."
20. How soon after D/C from hospital (not NICU)?

Discharge Summary

1. In regards to completing the initial risk identifier – after a summary is generated and a domain isn't identified as a risk but we still pull a plan of care – do we identify it as initial on the Discharge Summary even if it didn't score out?
2. The purpose of the Highest Interim Risk is uncertain. What difference does it make to identify this? Providers will not understand or care about this. The note could be made in comments section.

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3. Do we have to enter previous infant Risk Identifier in order to generate an online Infant D/C Summary? If we chose not to (it is time consuming because all the bugs are not worked out), is the paper form acceptable?
4. M200 Discharge Form on web site is different format than the SSO form. Can the form please be consistent so staff do not have to enter the data twice?
5. What to send to doctor as the current D/C form is not a clean copy?
6. Idea for Discharge Summaries: Make form with a list of numbers for each POC. Then make it possible to check off interventions as completed (per PVN) as you go. Mercedes Williams, RN, BSN, Infant Mortality Program.
7. On the D/C Summary, is the chronic disease CP supposed to automatically come up low, even if there is no risk?
8. On the D/C Summary, the asthma CP does not have a low domain (just moderate, high and emergency) and there is not a high domain on the actual care plan.
9. Do you plan to capture local agency ID risk factors (from state domains) that are not captured on Maternal/Infant Risk Identifiers, especially in relation to D/C Summaries being populated?
10. It would be helpful if the date ID could be populated on the D/C Summary when ID on. Rosanne Schultz – DHD
11. Can we change the risk level (on the progress note) after the first visit to match the highest interim risk on the Discharge Summary?

Communication Form

1. Does the form need to be sent to Provider every time a new Care Plan is added?
2. It would be nice if the MIHP notification letter to the beneficiary's provider had a space to note updates or changes instead of completing a whole new letter and summary. Would save time!!
3. Where should Maternal Considerations be documented on the letter to the provider for Infant (housing, depression, etc.)? There is no specific area identified.

POC2

1. The outcomes for POC2 for Fdg and Nutrition could be elaborated. The only two are: Discuss breastfeeding and refer to WIC. These two things alone will not necessarily reduce the initial risk. Most moms by the time Risk ID is completed are already breastfeeding or not and too late to ___ at two weeks postpartum.

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2. Need POC2's for Breastfeeding, Language Barrier, and Cognitive Impairment. It would be nice to add some additional qualifiers under the Infant Fdg/Nutrition POC2: slow weight gain, reflux, lack of knowledge related to infant fdg, early (< 6 months) intro of solids (not in bottle!)
3. When working on the Infant POC2 Nutrition, or Maternal POC2 Food, it says "Referred to WIC" but what do I do if she is already on WIC? Technically, I didn't refer her, but it seems incomplete to leave it blank. Bay Co HD.
4. Do we pull an environment substance exposure CP for medical marijuana (father, not mother)?
5. Drug exposed interventions do not apply for suboxone/methadone positive babies because it is considered a treatment.
6. Why can't we start drug exposed POC @ first 9 visits? Most of the time we lose mom/baby before the 9 are complete. We are waiting too long.
7. We need a POC for foster parents. Grand Traverse Co. HD.
8. If the Infant Risk Identifier is done and the scoring results come out as "no risk" for Health, but "moderate or high risk" for Birth Health, do we pull POC2 Infant health or not? Bay Co HD.
9. Not all interventions are applicable to every client (i.e., referral for mental health or applied for Plan First).
10. POC2 - Family Planning, "check off" items in right column, first one is "method identified." Often women do not decide on a method until after post-partum. Consider other items such as "received information on methods available."
11. What does the date under the domain on the new POC's represent?
12. How do you add an additional domain (update) at time of closure?

Consent

1. How do we have consent to share maternal considerations information with the pediatrician on the Infant Discharge Summary?
2. If the beneficiary declines to release her protected health info, how can the info from the MIHP Risk Identifier be entered into SSO?
3. When a client is transferring to another provider, is it sufficient to have the agency that is to release the information (the record) be listed on the Release of Information or does the transfer of Record need to be signed/sent as well?
4. Do we need to copy consent forms for transfers? New agency gets new consent, but date will not be consistent with opening if not sent with transfer.

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5. If you're giving the Health Plans access to MIHP PHI, do you have to change the consent form? Does it say we share info with Health Plans? Do we have to write it in?
6. Regarding Maternal Risk Identifier, if woman initially declines and signs consents to decline, she then changes her mind, can she sign same consent with new date to enroll in program?

Infant Eligibility for MIHP

1. Our agency had a transfer from another county on a 22-month old. Are we normally able to provide services this old?
2. Is it ok to enroll an 18-month old for Infant Services if there are moderate or high risks? On the screen there is not a Bright Futures for this age. Bay Co HD.
3. Does a baby on MICHild qualify for MIHP?

Requests for Training and Support

1. It would be very helpful and appreciated if a notice could be sent out to coordinators when updates or changes are posted on the MIHP web site (webinars, new forms, MIHP brochure, etc.). It is frustrating to have to "come upon it." Notice by email is likely the easiest for all. Notifications need to be made when changes are made to pamphlets, forms, etc.!!
2. Please consider setting up some type of list-serve for MIHP coordinators. It would be great to have a mechanism for coordinators to share tools that help our program/staff to meet fidelity expectations.
3. Offer opportunities for "field" workers to review/critique/give input into updated forms and audit tools prior to release of utilization.
4. Before moving forward with next steps, get feedback from providers.
5. Can changes in forms, processes, IT, etc. be cycled in groups rather than changed throughout the year? For example, changes 1-5 are all implemented Oct. 1 of Year One. Then the next group of changes (6-10) are implemented Oct. 1 of Year Two.
6. Please consider - as an end user - that as we move toward evidence-based practice, that we don't just add and add but rather look at what we have, delete when appropriate, and add when needed.
7. Please offer instructions and/or guidance on completing the MIHP Consent and Consent to Release Protected PHI that were released many months ago!
8. Please provide detailed instructions on how to complete the Release of Information form.
9. More examples of staff-to-client ratio would be helpful (visits weekly, 2x/month, and monthly).
10. There should be some training on scope of practice so it is better understood which domains/interventions are to be provided by which discipline. Ex: Can RD and SW document on Family Planning?

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11. I consistently have to ask for my program's quarterly reports. Can a mass email be sent out to coordinators when quarterly reports are sent? The only way I know they are available is from other coordinators. Susan Henning.
12. WHO growth charts – can we get these for use in MIHP?
13. Is there any possible way the list of MIHP providers can be broken down by county? This would be extremely helpful when looking for a provider if a client needs to transfer.
14. MDCH/MSU staff should do data collection, not frontline staff or providers.
15. Please make sure MIHP is up to date on Medicaid changes. I have heard several times today that "they" forgot to send info to MIHP.
16. Did not like location of conference. Hard to find. Bathrooms not nice, toilets not flushing, cold water. No Wi-Fi.

MOMS

1. Will Medicaid pay for MOMS clients to participate in MIHP?
2. Postpartum visit for women on MOMS?
3. When did MOMS start allowing MIHP to bill postpartum? This wasn't always the case and I would like to know when it changed.

Reimbursement

1. Professional visits need to be reimbursed at a higher amount, especially infant visits. They are very time consuming and cost for gas to travel to home.
2. Please consider the pay for an RN in MIHP. It is insulting that my clerk makes just about the same as I do. Does your education not count for anything? We too have a huge turnover rate because you can't keep RNs for the amount you are paying them.
3. The RN rate should be increased or allow LPNs to do visits.
4. Please make discharges billable, for example (administrative fee) \$20 - \$25.
5. Transportation rate is unacceptable.
6. This program services a population of low-income people who have limited resources of transportation. Can we please consider reinstating \$21.31 per transportation?
7. If we (Spectrum Health) provide MIHP services to a client of another MIHP program, can we bill for that service? We have an MIHP SW stationed in a high-risk OB office in Grand Rapids. She recently saw a client of a rural county MIHP at this office. She collaborated with that MIHP and helped to

improve communication between the physician and the MIHP and helped the client better understand caring for her gestational diabetes. In this case, we reviewed the POC with the MIHP provider before seeing the patient.

8. Community vs office visit: visit at a satellite office (adolescent health clinic) 5 miles and 8 miles from the main office. Should this be billed as an office or community visit?

Fidelity Reports

1. Fidelity Report – where do you document:
 - Reasons for infrequency of visits, such as unable to contact?
 - Reasons for judgment on who visits (i.e., does not respond to RN calls, etc.) that are currently on our communication log?
2. Based on feedback, most of documentation is limited to check boxes; difficult to gauge what is truly going on.
3. How does a provider document a success? For example: When Risk Identifier is completed, beneficiary is couch-hopping and has a moderate or high housing risk. Two months later, she finds safe, affordable house and has a plan in place to stay in housing (employed, can afford rent/utilities). It is important to document this under Domain on visit note but what is the level now and what is the intervention?
4. What if the client has moderate risk for depression and is already seeing a therapist. Should we still address this on the second visit?
5. % of depression addressed at first visit – if client has a more pressing issue (i.e., eviction), even if sent SW out to address need, must we always address depression if scores out as moderate or high at first visit with client no matter what?

MHPs

1. Is MIHP going back into the MHP's capitated rate structure? When this occurred in the past, the MHPs tried to further "micro-manage" an already capitated program and it was an administrative nightmare. It is also a concern for local health departments who received MA cost-based reimbursement, as we cannot get this when clients are enrolled in a health plan.
2. Some health plans are issuing cards with a different number than their mcaid ID# (has added digits at the beginning). I found this with McLaren MHP.

NICU Follow-Up Home Visiting

1. I think the CSHCS/MIHP interventions are great! I am so glad that you are thinking outside the box. My question to you is with having a nurse be required to do these visits – are we not allowing the richness of the multi-disciplinary interventions/teamwork that could aid these families greatly? Please don't limit these effects.

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2. We have some babies born in South Bend Memorial (Indiana). Who is tracking out-of-state sites?
3. Will NICU follow-up be provided to non-Medicaid clients?

Other

1. I have a concern with agency's NPI being published.
2. Two quarterly reports due to two NPI #'s. How do we correct this at local level?
3. On POC1, what does it mean to check off "text4baby?" Does it mean the client or MOB signed up for it during the visit, or does it mean we gave her info about how to receive "text4baby?" Bay Co CHD.
4. Do we need to get re-approval for using incentives yearly? Do we need to get new approval if the incentive method changed?
5. CPS told us if we are aware that someone in the home has a CSC charge, it is mandated to be reported. Do you recommend viewing the state registry for FOBs? We may not know all in the home or an FOB may have a charge not related to a child.
6. Home visit barriers: Client absolutely declines home visits – she lives with parent who told her no one can come to her house. We document this, but ___ client mentioned about chose to stop the program. She didn't want to hear any more about a home visit. Barrier?
7. Does Medicaid foster care policy outline the mental health assessment required by the state as part of the physical?
8. Ingham Co HD has EHR. Interested. Please contact Barb Mastin at (517) 281-2292.
9. Benzie-Leelanau HD
Deborah Aldridge RN
Sheila Pritchard RN
Kristine Gawne RN
Amanda Meyer-Stowe MSW
?Jenifer Murray RN
10. The world changes life – evidence-base – nothing stays the same. The companies need to realize life is changes. Always be prepared for changes. So thanks you guys - Joni, Rose Mary, Ingrid - for your hard work.
11. We've elected a stupid president in the past! They keep putting food out and that's mean.