Maternal Infant Health Program

Model Day Session

July 28, 2020

AGENDA

- Welcome and housekeeping items: Dan Thompson
- Medicaid Update: Janell Troutman
- PATH—Patient-Centered Reproductive Goals and Counseling: Quess Derman and Sue Montei
- Break
- SE Michigan MIHP Survey Results: Robin Jacob
- MIHP Updates: Dan Thompson

Medicaid Updates

Janell Troutman MSN, RN

Health Policy Specialist

Program Policy Division

Medical Services Administration

Michigan Department of Health and Human Services

MICHIGAN DEPARTMENT OF HEALTH & HUMAN SERVICES

Medical Services Administration
Medicaid Program Policy Updates

July 2020

Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.

MIHP Telehealth Visits

- Temporary measure relaxing face-to-face requirements (MSA 20-12)
- MIHP was included in one of the first COVID-19 related changes made in policy
- Allowable codes need to be reported with (MSA 20-09):
  - GT modifier
  - 02 place of service

MIHP Telehealth Visits

- Stay tuned for when services will return to face-to-face through MIHP weekly updates or email alerts
- Your continued flexibility and persistence during this time is greatly appreciated

Quarterly Newborn Recoveries

- Between birth and MHP enrollment- newborns are FFS in CHAMPS
- Newborns are eventually enrolled in an MHP
- If MIHP providers bill FFS, once the newborn is enrolled in an MHP, the FFS payment will be recouped, and the provider must bill the MHP to receive payment
- This occurs on a quarterly basis

Quarterly Newborn Recoveries

- Providers can wait until the newborn is enrolled in the MHP to bill- to avoid recoupment altogether
- This process **only includes newborns** and not maternal participants
- This process is not unique to MIHP providers

Quarterly Newborn Recoveries

- You can subscribe to receive provider notifications:
  - To manage your subscriptions visit: https://public.govdelivery.com/accounts/MIDHHS/subscriber/new

- Where to find more information about this process-
  - The MIHP-MHP FAQ transition document (posted on MIHP's website under MHP Resources)
  - Specifically the answer to EN23

Notification of Quarterly Newborn Recoveries

All Providers,

The latest batch of MDHHS Quarterly Newborn Recoveries is currently being processed. This batch includes fee for service claims for newborns that were retroactively enrolled into a Medicaid Health Plan. Please note, as with previous quarterly newborn take backs, claims must be submitted to the Medicaid Health Plans within 60 days from the Medicaid Remittance Advice date.

Please review the following for information on how to verify the Adjustment Source of your claim.

Providers with further questions please contact provider support at 1-800-292-2550 or by email ProviderSupport@Michigan.gov.

Medicaid Program Policy Updates Resources

Please submit questions about presentation to:

MIHP@michigan.gov

General provider questions

Provider Support at 1-800-292-2550 or
ProviderSupport@michigan.gov

Public comments and questions on proposed policy

Visit MSA's website here
or contact us at msapolicy@michigan.gov

Comments and questions about Healthy Michigan Plan

Visit the website https://www.michigan.gov/healthymiplan
or contact us at healthymichiganplan@michigan.gov

PATH-Patient Centered Reproductive Goals and Counseling

Quess Derman
Sue Montei

Client Centered Reproductive Goals & Counseling

Quess Derman, MSW, Public Health Consultant

Sue Montei BSN, NP, Clinical Consultant

Disclosure Statement

- All speakers for this presentation have nothing to disclose.

Why Family Planning?

Family Planning programs provide women and men access to a wide range of birth control methods and help them make informed choices, so they can plan and space their births.

Family planning empowers women and men to make healthy life decisions.

This leads to positive health, social and economic outcomes for women, men, families and society.

Contraceptive use in the US

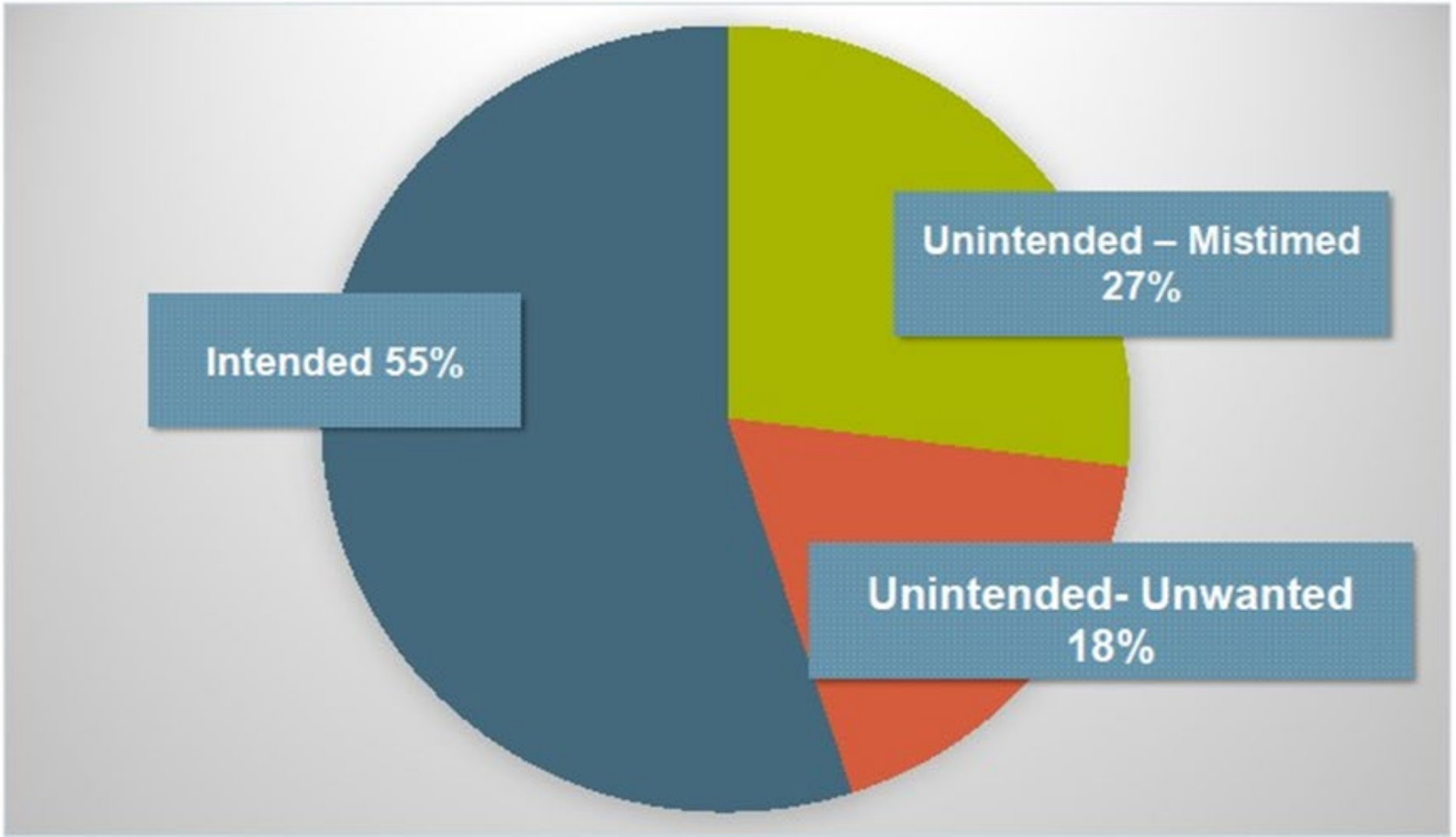
61 million US women in childbearing years

43 million of them (70%) are at risk of unintended pregnancy

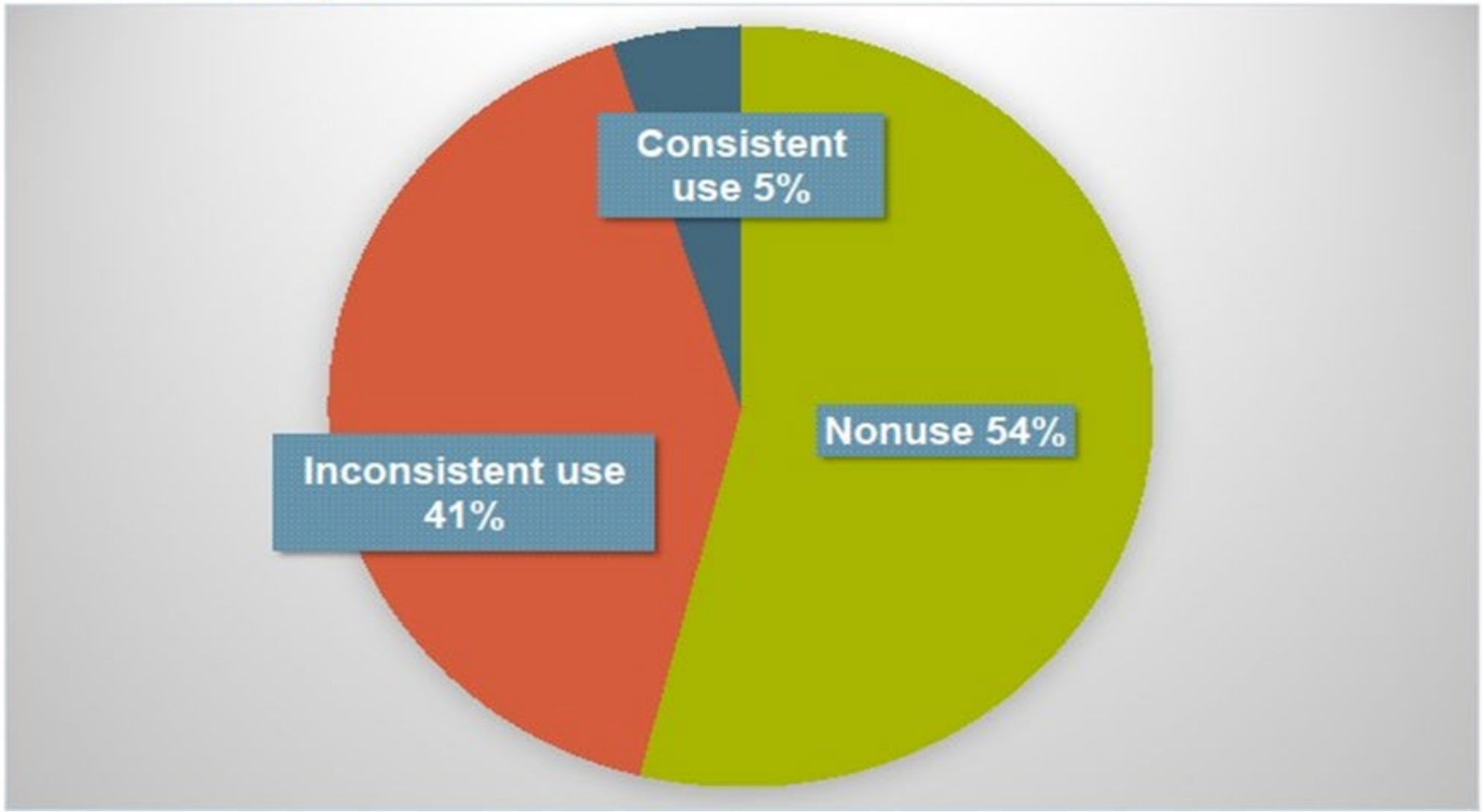
62% of women of reproductive age currently use some form of contraception

Couples who don't use contraception have 85% chance of becoming pregnant of experiencing pregnancy over the course of a year

Nearly half (45%) of pregnancies in the US are unintended



Unintended pregnancy by consistency of contraception use



Publicly Funded Family Planning

- Publicly Funded Family Planning Services expand access to high-quality and affordable family planning services.
- Provide a full range of contraceptive methods, accurate information and effective counseling.
- Publicly Funded Family Planning Programs
  - Medicaid Providers
  - Title X Family Planning Programs
  - Federally Qualified Health Centers

The Title X Overview

Title X helps individuals and couples to plan and space births, prevent unintended pregnancy, and access preventive health screenings.

Prioritizes low-income women, men and teens, uninsured or underinsured individuals.

No one is denied services because of inability to pay

Provides services in a manner which protects the dignity of the individual.

Provides services without regard to religion, race, color national origin, handicapping condition, age, sex number of pregnancies or marital status

Provides follow up and referral to other health, mental health and social services.

Key Title X Services

- Client- Centered counseling and education
- A broad range of FDA-approved contraceptive methods
- Preventive health exams to screen for cancer or other health issues
- Pregnancy diagnosis and counseling
- Screening for sexually transmitted diseases and HIV/AIDS
- Preconception health and basic infertility services
- Follow-up and referrals for Medical, behavioral, and897 social services
- Services are charged based on the client's ability to pay
- Insurances are billed, including Medicaid

Michigan's Title X Program

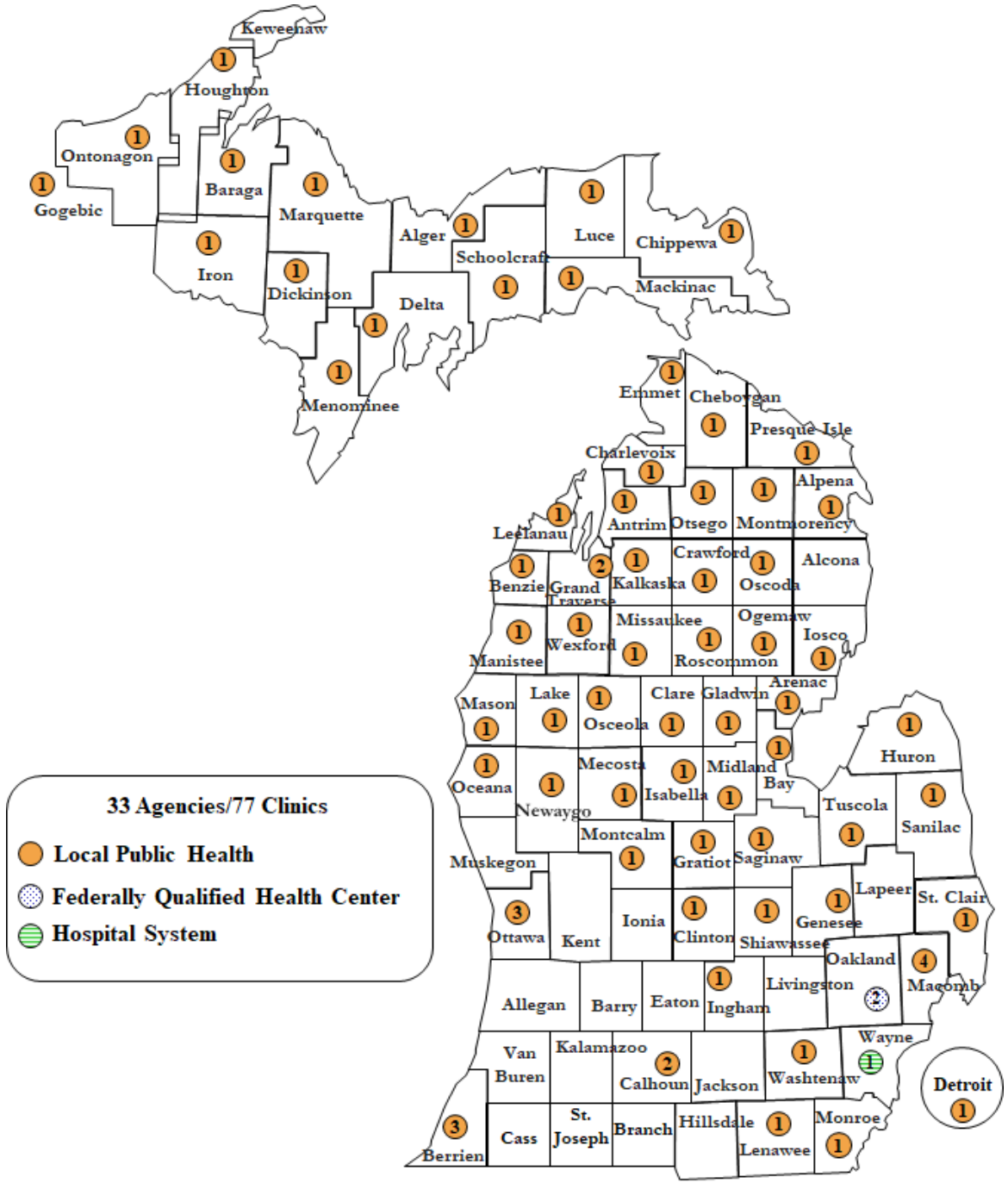
- Michigan's Family Planning Program has provided services across the state since 1973
- On-site clinical services are delivered through a statewide network of 33 local agencies and 77 clinical sites.
- Serves as a safety net with a network of experienced providers long seen as a reliable and trusted source of care.
- For many clients, Family Planning clinics are the only health care providers they see annually.
- The program's educational and counseling component helps reduce health risks and promote healthy behaviors.

Michigan's Title X Program Serves a vulnerable Population

- Served 54,012 clients in 2019:
  - 47,485 (88%) were women
  - 6,527 (12%) were men
- 28,355 (52%) had family income at or below the poverty level
- 47,576 (88%) received services at a reduced or no charge
  - 63% identified as white
  - 20% Black or African American
  - 8% identified as Latinx
  - 4% multi-racial
  - 2% Asian
- 1.545 (2%) had limited English proficiency

Michigan's Title X Network - 2020

- 33 Local Agencies
- 77 Clinic Locations
- 28 Local Health Departments
- 1 FQHC
- 1 Hospital Based Clinic



Last Updated: 05/2020

Client Centered

Reproductive Life Plan and Counseling

Reproductive Life Plan

Helping clients develop a Reproductive Life Plan is the starting point

Preconception Health and Health Care
My Reproductive Life Plan

Thinking about your goals for having or not having children and how to achieve those goals is called a ***reproductive life plan***. There are many kinds of reproductive life plans. Your plan will depend on your personal goals and dreams.

How to Make a Plan

First, think about your goals for school, for your job or career, and for other important things in your life. Then, think about how having children fits in with those goals.

If you do want to have children one day, think about when and under what conditions you want to become pregnant. This can help ensure that you and your partner are healthy and ready when you choose to have a baby. If you do not want to have children (now or ever), think about how you will prevent pregnancy and what steps you can take to be as healthy as possible.

Try to include as many details as possible in your plan. Some people find it helpful to write their plan down on a piece of paper or in a journal. Be sure to talk with your health care professionals. Doctors and counselors can help you make your plan and achieve your goals.

Questions to Get Started

When making a reproductive life plan, the following questions might be helpful. These are probably not all of the questions that you will want to ask yourself, but they will help you to get started.

If you **DO NOT** want to have children, you might ask yourself:

- How do I plan to prevent pregnancy? Am I sure that I or my partner will be able to use the method chosen without any problems?
- What will I do if I or my partner becomes pregnant by accident?

Reproductive Life Plan

Men and women setting life goals in regard to childbearing.

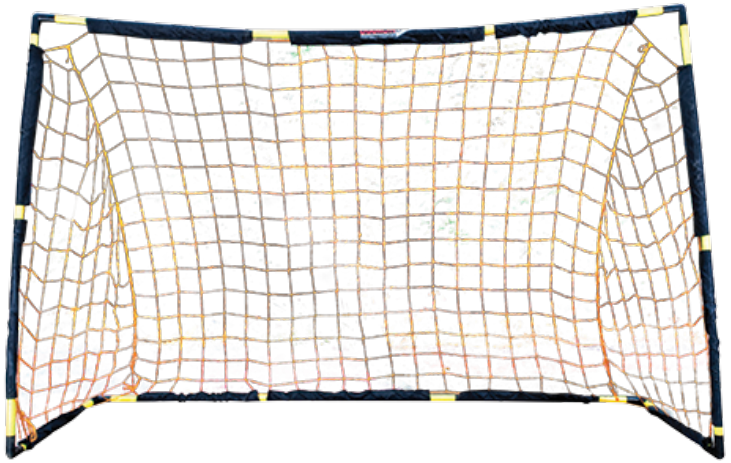
Planning the timing and spacing of healthy pregnancies.

Identifying and modifying medical, behavioral, and social factors negatively affecting pregnancy outcomes.

Managing pre-existing conditions and behaviors before, between, and beyond pregnancies.

Reproductive Intention/Goals

- Clarifies motivation and degree of acceptability regarding pregnancy
- …so we can offer **appropriate** interventions
  - +/-Preconception Care
  - +/-Contraception
  - Infertility Services
  - Adoption



Client-Centered Counseling

Improving the quality of contraceptive counseling is one strategy to prevent unintended pregnancy.

Approaches to optimizing women's experiences of contraceptive counseling include working to develop a close, trusting relationship with patients and using a shared decision-making approach that focuses on eliciting and responding to patient preferences.

Optimizing this counseling is one approach to helping women of all race/ethnicities and socioeconomic strata to improve their ability to plan pregnancies.

Clinicians should consider a tiered approach to contraceptive counseling, whereby the most effective and appropriate options are presented before less effective options.

Client-Centered Counseling: Shared Decision Making

- Preferred by clients
- Associated with method continuation and satisfaction with method
- Associated with patient satisfaction with provider
- Shared Decision Making
  - "…clinicians provide clients with information about all the options and help them to identify their preferences in the context of their values."

Fried, T. R. (2016).N Engl J MedChewning et al., (2012). Patient Educ CounsDehlendorf, C., Krajewski, C., & Borrero, S. 2014Fox, E., et al., 2018)

General Principles for Client-Centered Counseling

ASK AND LISTEN MORE, TALK LESS

APPROACH EACH CLIENT AS AN INDIVIDUAL

FOCUS ON ISSUES AND REALITIES THAT THE CLIENT IDENTIFIES

MAINTAIN A NEUTRAL, NON-JUDGMENTAL ATTITUDE

OFFER OPTIONS, NOT DIRECTIVES

REMEMBER THE ACTION AND RESPONSIBILITY REMAIN WITH THE CLIENT

GOAL IS CLIENT CENTERED CARE

Asking questions is a client centered approach

"Plant a seed"

Efficient use of limited time

More satisfying for the clinician

Client satisfaction is only realized when the client is engaged and participatory in those decisions that impact their lives.

Client-Centered Counseling Recommendations

- Build a rapport with client.
- Be respectful of client.
- Listen carefully to understand client's point of view.
- Listen for what has worked and what hasn't worked for the client.
- Recognize ambivalence.
- Support client's self-confidence—communicate that change is possible and client is cable of implementing that change. Be optimistic!
- Work collaboratively with client.

Shared Decision Making

Client Contribution:

- Their values
- Their preferences
- Their goals
- Their past experiences

Clinician Contribution:

- Assist in clarifying client's goals and preferences
- Provide scientific/medical information that is:
  - relevant
  - assimilated/integrated by the client!

Formulate a Realistic, Simple Plan

Risk reduction plans must be:

- Client driven
- Based on client's medical and sexual health history
- Incorporate clients' reediness to adopt safe behaviors

As the health care provider we can:

- Support client's efforts –big or small
- Offer options, not directives
- Remain non-judgmental

Explore Attitudes About:

- Need to conceal contraception;
  - no supplies?
  - normal bleeding pattern?
- Non-contraceptive benefits
- Side effects
- Menstrual cycle and bleeding profile
- Effect on sexual life

- Effectiveness
- Hormones
- Length of use
- Control over removal
- Object in body
- Return to fertility

Sample Action Plan Questions

How will you go about that?

What one thing could you do to begin?

What do you need to do first? Next?

When will be a good time to try/begin?

Who can you go to for support or talk to?

Pregnancy Prevention

BEST QUESTION

"Do you have a sense of what is important to you in your birth control?"

"FIND THE YES"

WAYS TO SAY "YES"

START with either:

1. Agreement
2. Display of empathy
3. Validation

- TRY NOT TO CORRECT OR DISAGREE
- First step is to find something in what the patient is saying to agree with or support
- Instead of "No" or "But"
- "Yes! …. And_____ "
- Not "Yes, but…"

EMPATHY WITHOUT **"LABELING"** FEELINGS

- Rather than using a negative label:
  - "You sound angry" (or anxious)
- •Use neutral words:
  - "It sounds like this is really concerning to you"
  - "Wow, anyone would find that really hard to deal with!"
- Not: "I know how you feel."

- **"I hear you saying is _____ that what you mean?**
- **"It sounds like _____Do I have that right?"**
- **"Wow, so you feel pretty strong about _____"**
- **"Many of my clients say that ____ is that what concerns you"**

HOW IMPORTANT is PREVENTION

- Individualize the question with information the client has shared
  - **How important is it to you to prevent/achieve pregnancy__ _____:**
    - until you are out of school?
    - until your partner gets back?
    - for the next 5 years?
    - until then (for teens and if you have no other information)?

WHY ON EARTH?

- ***Instead:***
- “What is concerning to you about_____”
- “Tell me more about that”
- “People have various reasons that concern them, I’d like to understand your particular concerns.”

"Teach Back" and "Alternates"

- "**It sounds like** you are not interested in kids any time soon. **Do I have that right?"**
- **"I am hearing you say** it's super important to you to have a birth control method that you can rely on. **Is that correct**?"

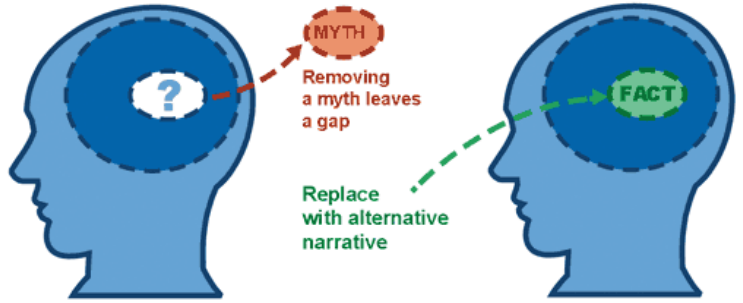
More Examples: Paraphrasing and Alternates

" **I hear you saying** that you really like the idea of continuing to use a method with hormones that you can forget about. **Is that what you mean?**

"Wow, so **you feel pretty strong** about avoiding the side effects you had from the pill and the shot!"

ADDRESS MISINFORMATION-MISCONCEPTIONS

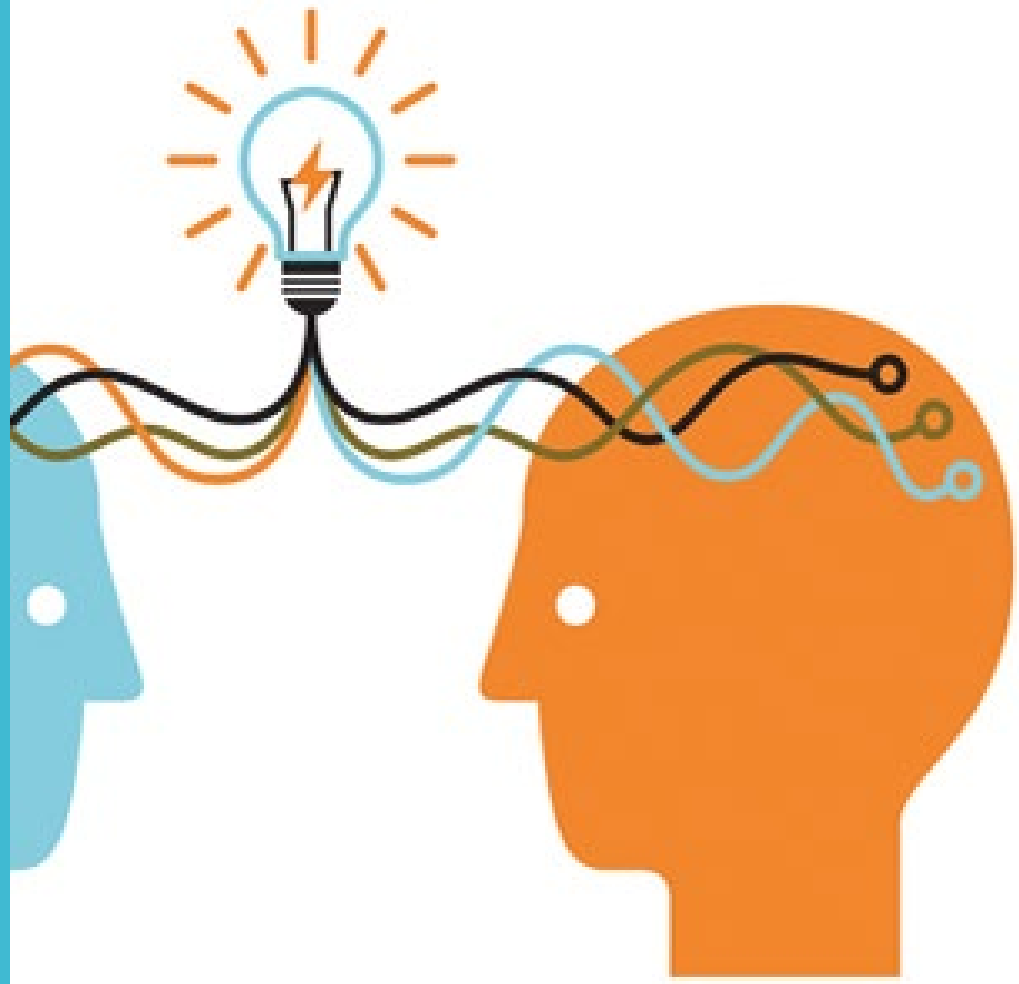
1. About relative effectiveness of methods
2. Underestimates their own or their partner's fertility
3. Pregnancy is safer than contraception



A FOLLOW UP QUESTION REQUIRES THE PATIENT TO **INTEGRATE** INFORMATION

- How would that be for you?
- Has that ever happened before?
- How did you manage it?
- Do you have a sense of how you would manage it?

- (Hatcher. 2018)



- "It sounds like one of the things that is important to you is that your birth control is very good at preventing pregnancy. Do you have a sense of what else is important to you?"

POSITIVE FEEDBACK

"It's great that you were so strong in standing up for yourself --asking your partner to use condoms."

"Great question!"

"I wish all my patients knew that…"

"Not many people (your age) act so responsibly about using a condom every time."

"It's great you know that!"

POINT OUT POSITIVES

Condom use, adherence to a method, exercise, diet improvement, knowledgeable.

Shows the patient that you are both on the same side (their side)

Builds rapport and the patient will trust you

OFFER PRECONCEPTION CARE

"Since_____ would you like to discuss ways **to be prepared** for a healthy pregnancy?"

For example

…you have said "if it happens, it happens…

…many people using this method of contraception get pregnant…

WHAT QUESTIONS DO YOU HAVE?

What other questions do you have for me ?

Being "*Mindful*" of a Time

Giving the client information that is not directly relevant to them can use up precious time

Paraphrasing saves time --the clinician is in control

clients who feel like their care is client centered feel less resistance and more trust = less time

Consider the whole day's schedule and average out the visits

Some visits are straightforward

Some clients need more time to clarify their preferences

VISUAL AIDS AND TACTILE AIDS

- Effectiveness chart
- Anatomy image and model
- Your hands, arms and drawn pictures

- "Demo units" to hold and manipulate
  - IUDs
  - Implants
  - Vaginal Ring
  - Patch
  - Diaphragm
  - Internal condom, male condom

EFFECTIVENESS OF FAMILY PLANNING METHODS*

*The percentages indicate the number out of every 100 women who experienced an unintended pregnancy within the first year of typical use of each contraceptive method.

MOST EFFECTIVE

Less than 1 pregnancy per 100 women in a year

6-12 pregnancies per 100 women in a year

18 or more pregnancies per 100 women in a year

LEAST EFFECTIVE

REVERSIBLE

Once in place, little or nothing to do or remember.

Implant

0.05%

Intrauterine Device (IUD)

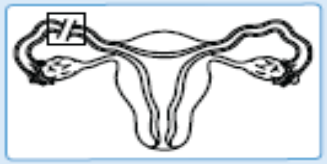
0.2% LNG

0.8% Copper T

PERMANENT STERILIZATION

After procedure, little or nothing to do or remember.
Use another method for first 3 months (Hysteroscopic, Vasectomy).

Female (Abdominal, Laparoscopic, and Hysteroscopic)



0.5%

Male (Vasectomy)

0.15%

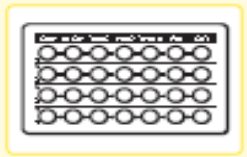
REVERSIBLE

Get repeat injections on time. | *Take a pill each day.* | *Keep in place, change on time.* | *Use correctly every time you have sex.*

Injectable

6%

Pill

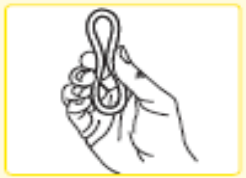


9%

Patch

9%

Ring



9%

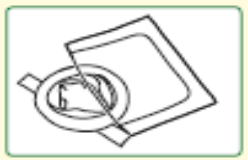
Diaphragm

12%

REVERSIBLE

Use correctly every time you have sex.

Male Condom



18%

Female Condom

21%

Condoms should always be used to reduce the risk of sexually transmitted infections.

Withdrawal

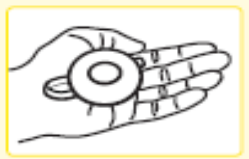
22%

Fertility Awareness-Based Methods

Abstain or use condoms on fertile days.

24%

Sponge



12% Nulliparous Women

24% Parous Women

Spermicide

28%

Other Methods of Contraception: (1) Lactational Amenorrhea Method (LAM): is a highly effective, temporary method of contraception; and (2) Emergency Contraception: emergency contraceptive pills or a copper IUD after unprotected intercourse substantially reduces risk of pregnancy.

Adapted from World Health Organization (WHO) Department of Reproductive Health and Research, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP). Knowledge for health project. Family planning: a global handbook for providers (2011 update). Baltimore, MD; Geneva, Switzerland: CCP and WHO; 2011; and Trussell J. Contraceptive failure in the United States. Contraception 2011;83:397–404.

CDC Centers for Disease Control and Prevention National Center for Chronic Disease Prevention and Health Promotion

Contraceptive Methods [www.bedsider.org]

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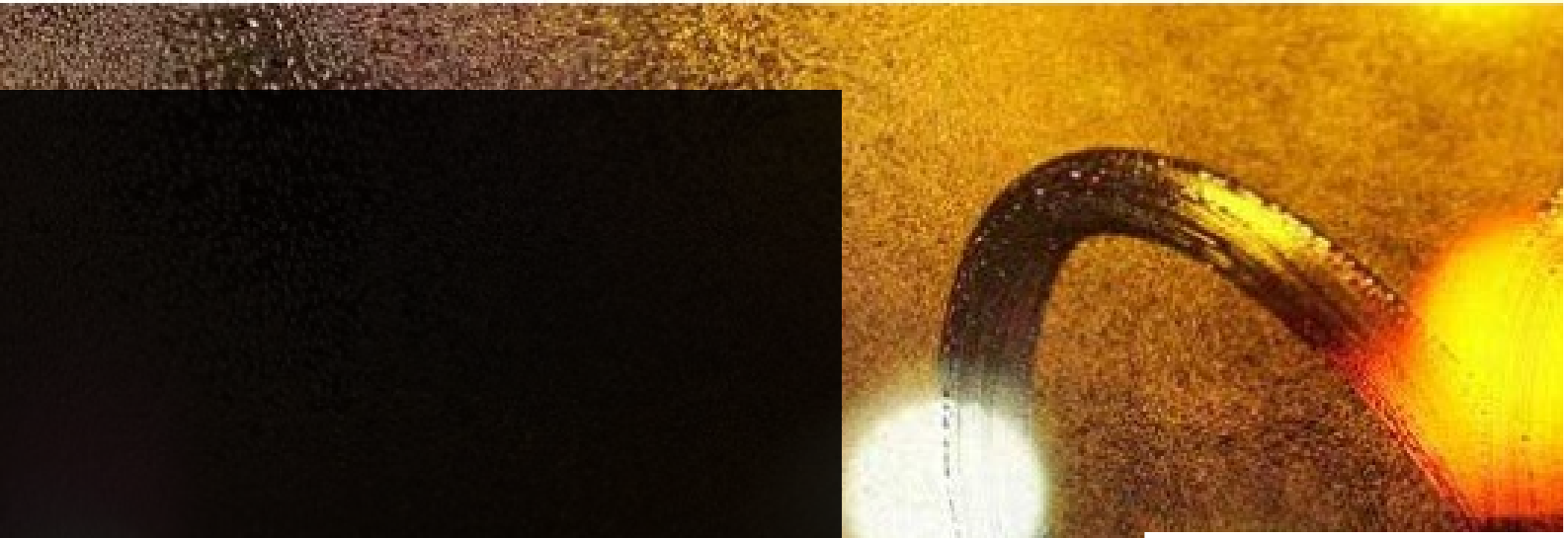

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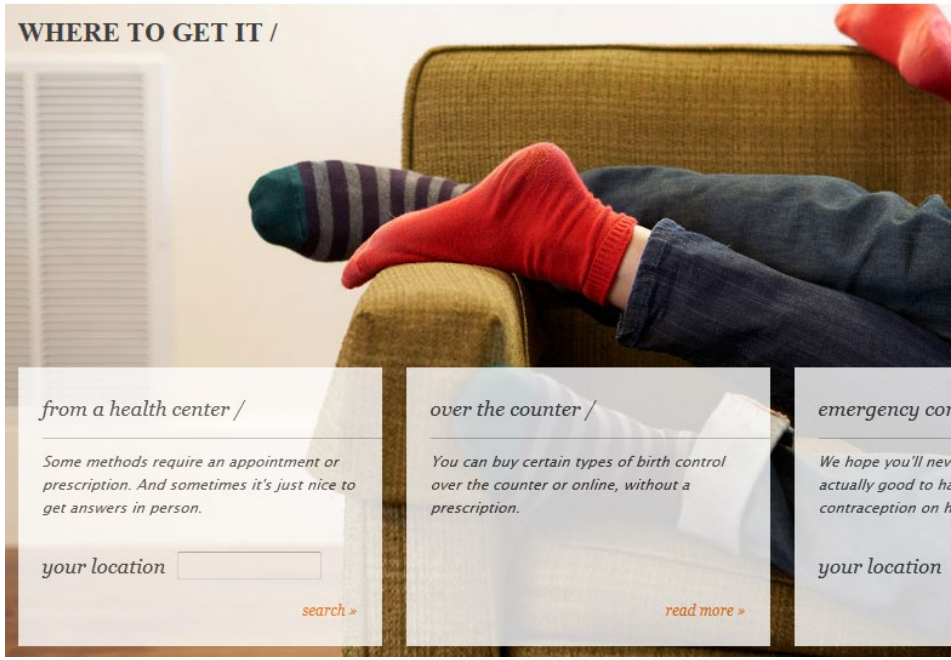
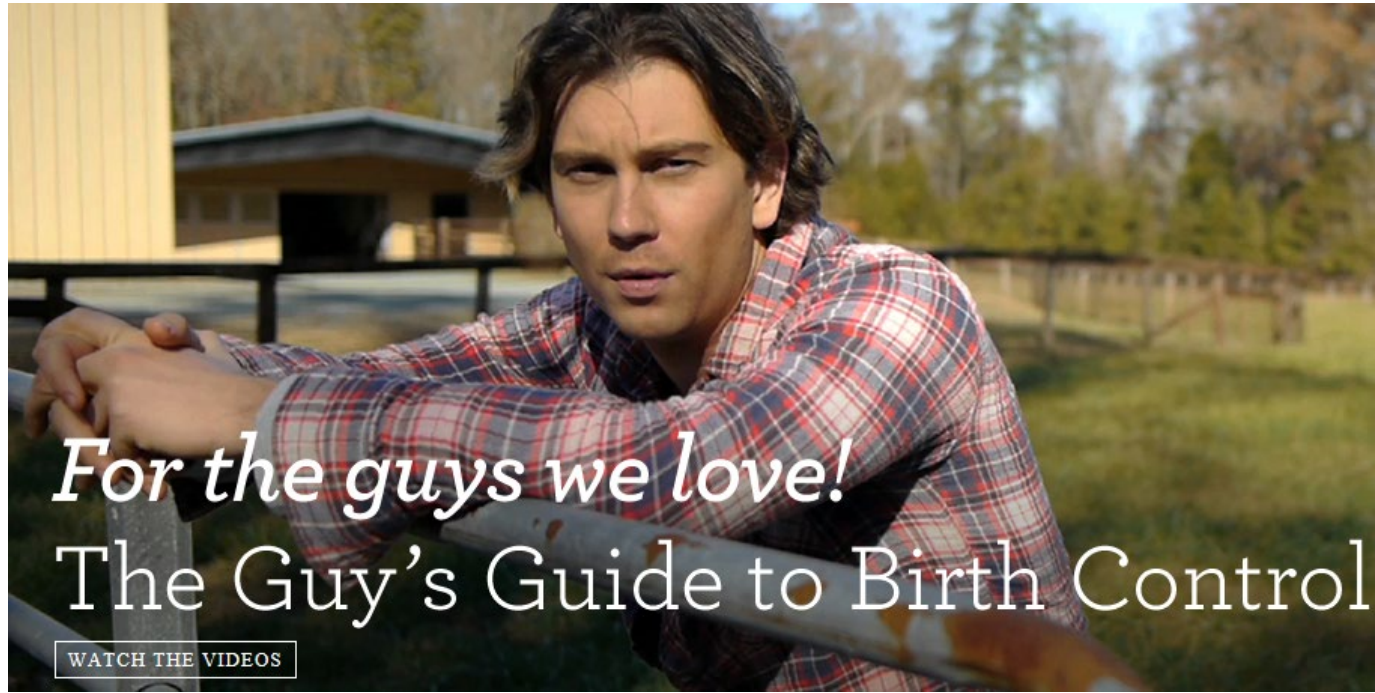


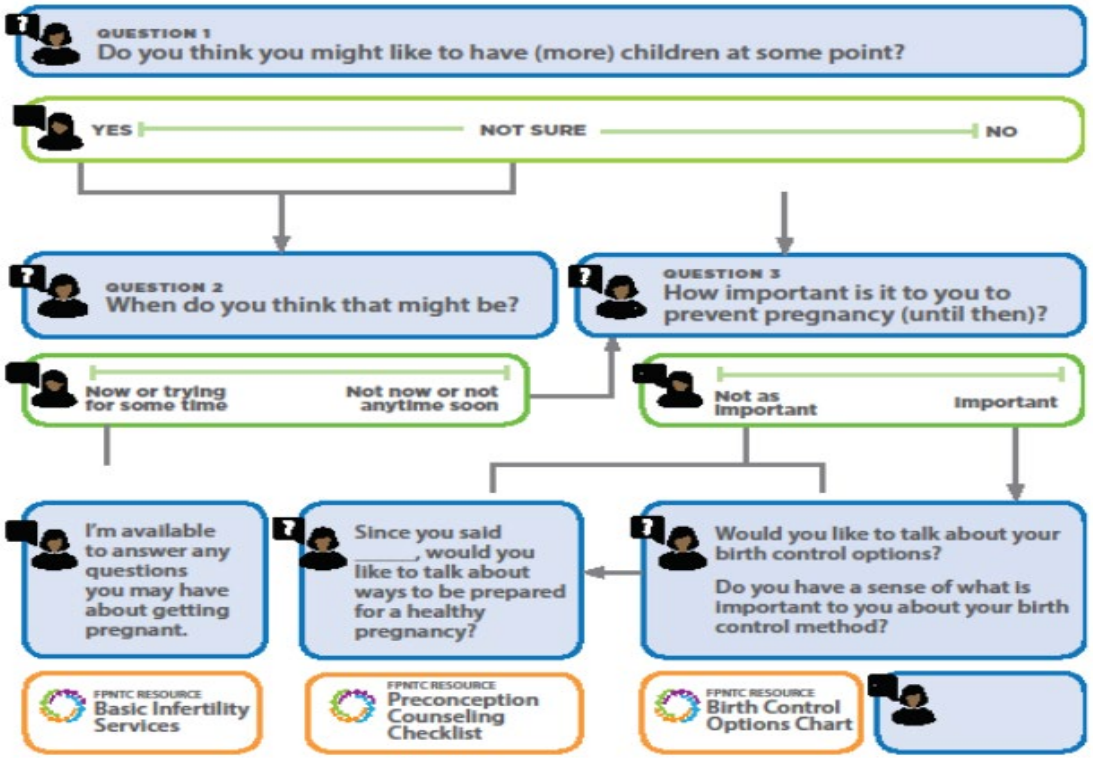


Resources:

Client-Centered Reproductive Goals & Counseling Flow Chart

FPNTC
FAMILY PLANNING NATIONAL TRAINING CENTER

The PATH questions are one client-centered approach to assess **P**arenthood/**P**regnancy **A**ttitude, **T**iming, and **H**ow important is pregnancy prevention. PATH can be used with clients of any gender, sexual orientation, or age. PATH is designed to facilitate listening and efficient client-centered conversations about preconception care, contraception, and fertility as appropriate.



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Efficient Questions for Client-Centered Contraceptive Counseling

Asking about **P**arenthood/**P**regnancy **A**ttitude, **T**iming, and **H**ow important is pregnancy prevention (PATH) is an efficient approach for engaging clients in a conversation to help clarify their reproductive goals and needs.

CLARIFY YOUR CLIENT'S REPRODUCTIVE GOALS AND NEEDS, ASK THEM:

"Do you think you might like to have (more) children at some point?"

"When do you think that might be?"

"How important is it to you to prevent pregnancy (until then)?"

IF YOUR CLIENT IS INTERESTED IN PREGNANCY PREVENTION, ASK THEM:

"Do you have a sense of what is important to you about your birth control method?"

"Some methods of birth control _____. How important is that to you?"

"In addition to preventing pregnancy, there are birth control methods that _____. Would you like to know more about that?"

"I hear you saying that you are interested in a method that is _____. Do you have a sense of what else is important to you?"

Learn more about PATH at **envisionsrh.com**
Find more resources at **FPNTC.org**

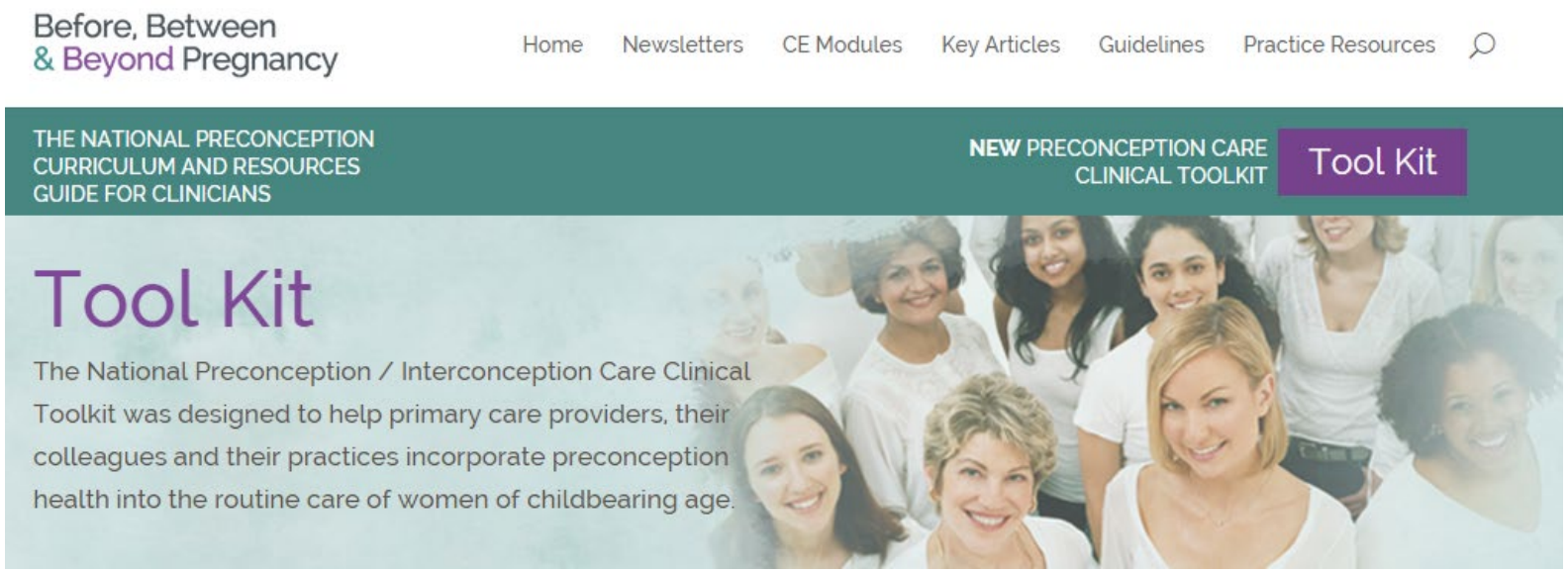
FPNTC
FAMILY PLANNING NATIONAL TRAINING CENTER

- **FPNTC or National Clinical Training Center (CTC)** are good resources for trainings
  - Family Planning National Training Center
  - National Clinical Training Center

Before, Between and Beyond Pregnancy

Pre/ Interconception Care Information

www.beforeandbeyond.org



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Maternal Infant Health Program

- **Break Time!**
- **We will reconvene shortly…**

UM Youth Policy Lab—Robin Jacob

SE Michigan MIHP Survey results

MIHP: Participation Patterns and Beneficiary Experiences

Findings from a Survey of
Eligible Women in Southeast Michigan

July 28, 2020

YOUTH POLICY LAB
UNIVERSITY OF MICHIGAN

Overview

- MDHHS and the UM Youth Policy Lab have partnered to increase MIHP participation
- Data analysis: understand who is eligible for MIHP, who enrolls in MIHP, and factors that predict enrollment
- Survey analysis: understand perceptions of MIHP and experiences with the program among beneficiaries

MIHP Data Analysis

- Combined dataset: Vital Records, Medicaid claims, MIHP program data (e.g., MRI, IRI)

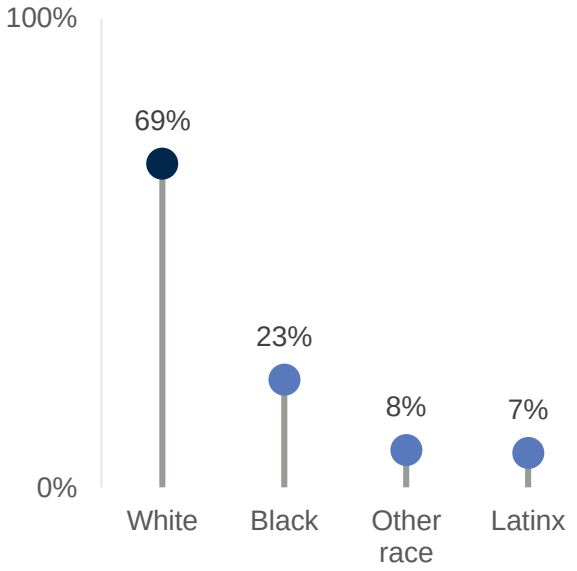
- All Medicaid-covered births in MI, 2009-2016
  - 530,593 infant beneficiaries
  - 246,594 maternal beneficiaries

- Linked to county and census tract of residence

Who is eligible for MIHP?

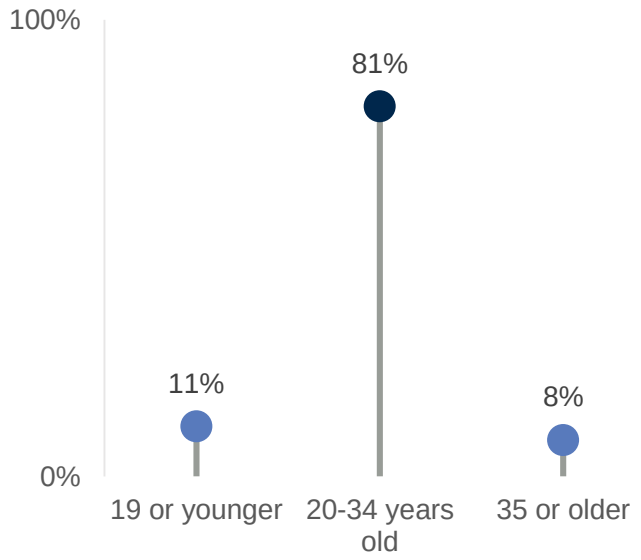
A **majority (69%) of Medicaid-eligible women** who gave birth between 2009-2016 were **white**.

Race/Ethnicity of Medicaid-eligible Women (2009-2016)
n=528,789



Women typically fell between the **ages of 20 and 34 years old**, but 11% were 19 or younger and 8% were 35 or older.

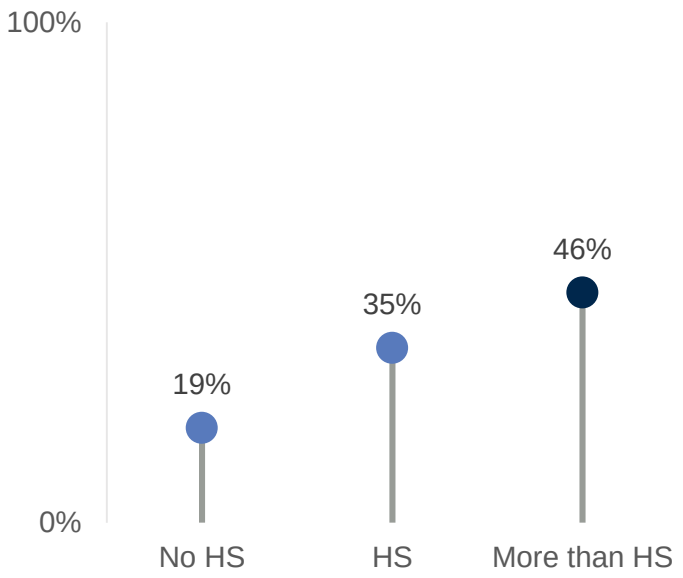
Age of Medicaid-eligible Women (2009-2016)
n=459,929



Who is eligible for MIHP?

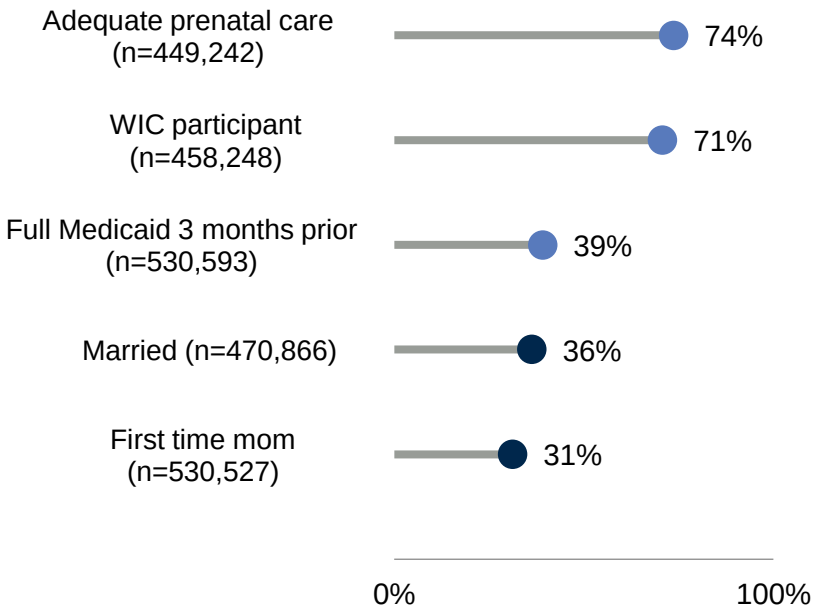
Most had a least a high school degree and 46% had some **education beyond high school**.

Education of Medicaid-eligible Women (2009-2016)
n=467,567



36% were **married at conception** or birth and 31% were **first time moms**.

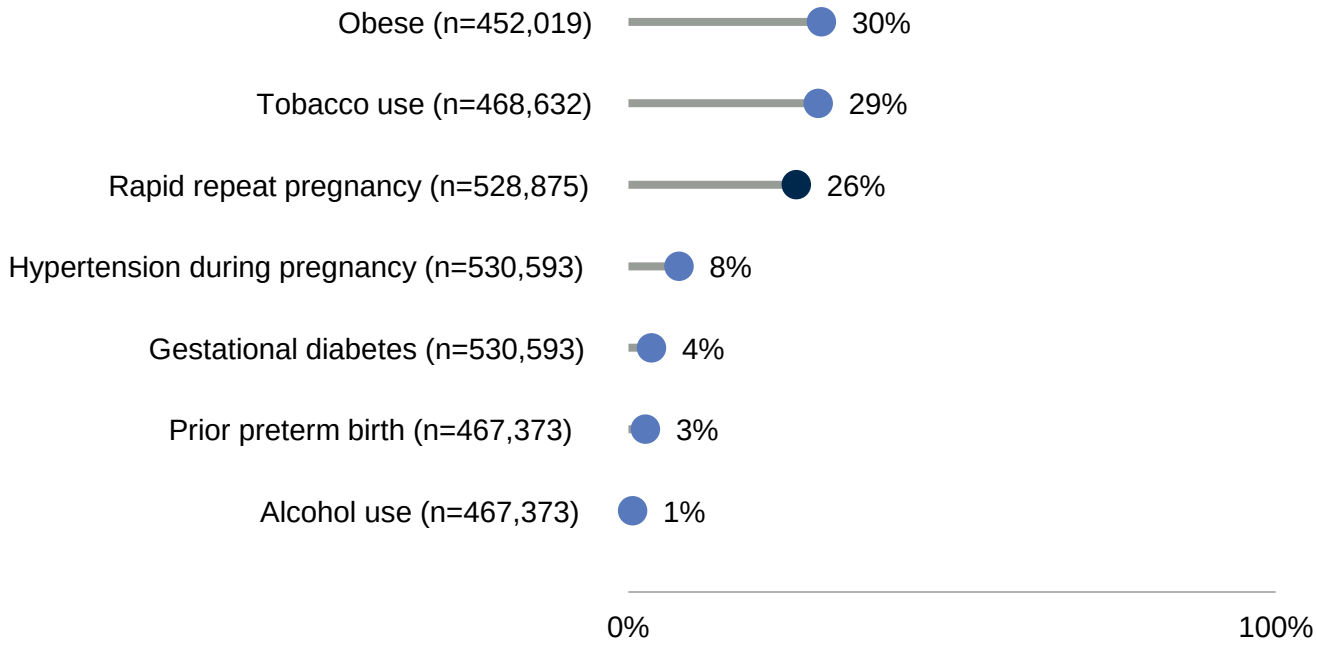
Social Supports of Medicaid-eligible Women (2009-2016)



Who is eligible for MIHP?

Over a quarter had **a previous birth within 18 months of their most recent birth**.
Other **pregnancy-related risk factors include**:

Risk Factors of Medicaid-eligible Women (2009-2016)



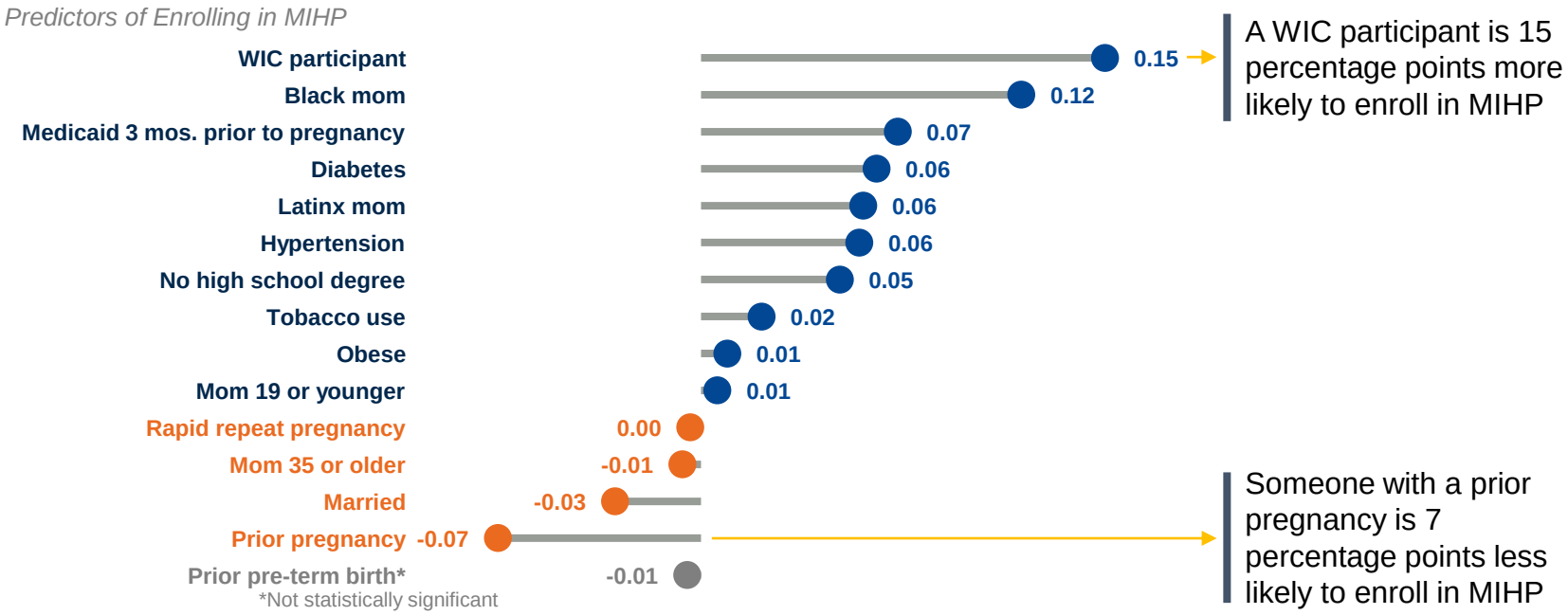
Who enrolls in MIHP?

- MIHP had relatively low enrollment rates from 2009-2016
  - ~30% of eligible individuals enrolled in MIHP

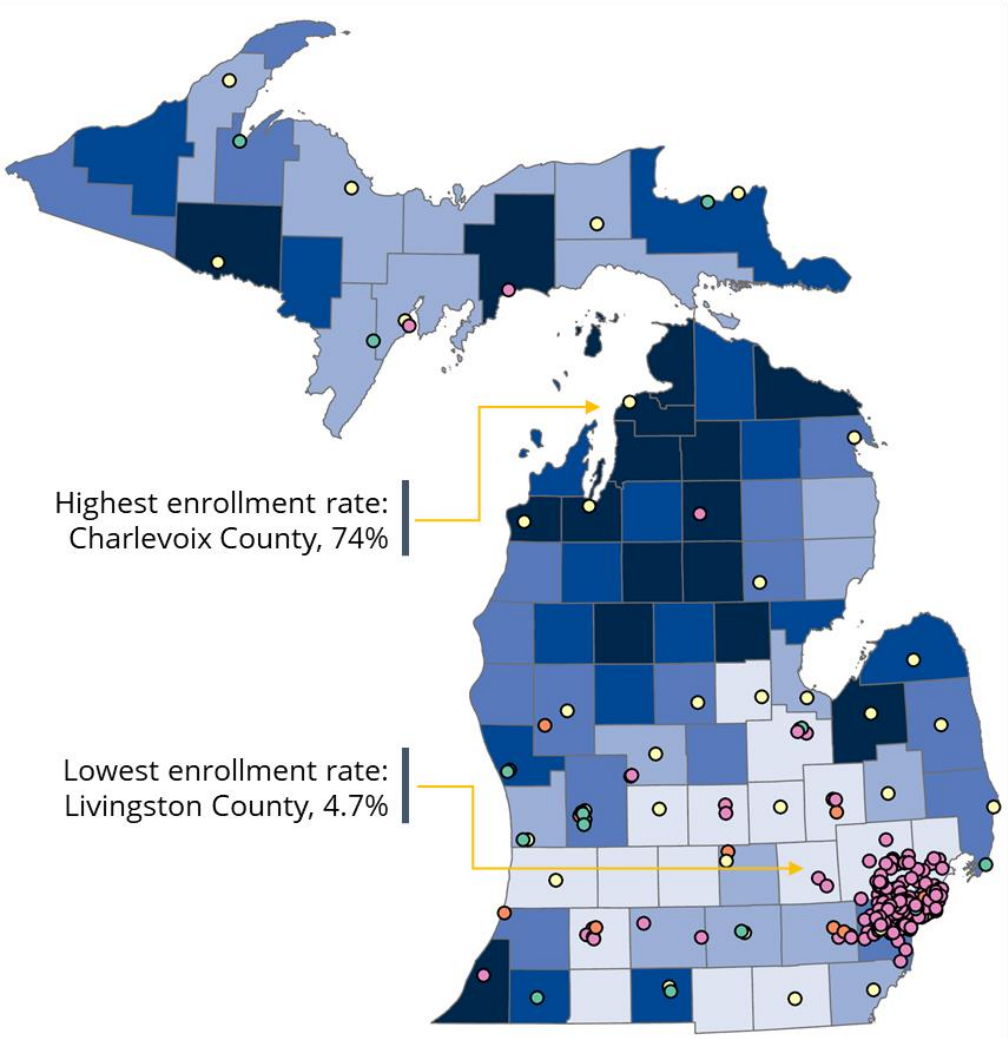
- Among those who *did* enroll, not all fully participated
  - 58% of MIHP enrollees were "full" participants
    - = Enrolled during pregnancy, at least 3 home visits
  - 42% of MIHP enrollees were "partial" participants
    - = Fewer than 3 home visits

What predicts MIHP enrollment and participation?

- A variety of demographic and health factors predict an individual's likelihood to enroll in MIHP
  - Compared to: first-time parent who is white, not married, has at least a high school degree, was not on Medicaid prior to current pregnancy, and has no health risk factors



Geographic Variation



- County enrollment rates ranged from 5% to 74%
- Northern MI: highest rates of enrollment and full participation

MIHP Survey

- MDHHS and the UM Youth Policy Lab partnered to survey MIHP-eligible women in Region 10
  - Macomb, Oakland, Wayne counties

- Fielded August 2019-February 2020
  - $10 incentives for completed survey

Survey Overview

- 3 targeted groups:
  - MIHP participants
    - Full participants = Enrolled during pregnancy, 3+ home visits
    - Partial participants = Fewer than 3 home visits
  - Non-participants
    - Eligible for MIHP but unenrolled

Survey Groups

- Separate survey instruments developed for each group

- MIHP participants were asked questions about:
  - Where they first heard of the program and when they enrolled
  - Experiences with their home visitor
  - Satisfaction with the program and opportunities for improvement

- Non-participants were asked about:
  - Their awareness of MIHP
  - Reasons for not enrolling in the program

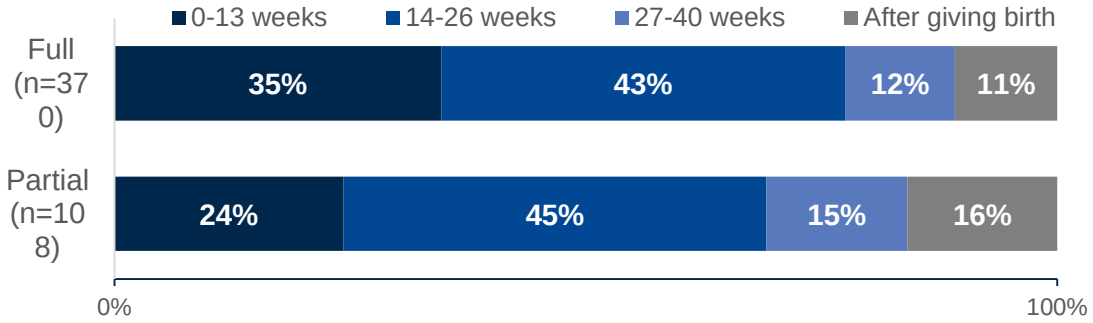
Response Rates

Responses by Participant Category			
Category	Sample	Respondents	Response Rate
Full Participant	2,299	370	16%
Partial Participant	579	108	19%
Non-Participant	1,926	323	17%
Total	4,804	801	17%

Initial Program Experiences

- Most participants enrolled after their first trimester
- Partial participants enrolled later than full participants

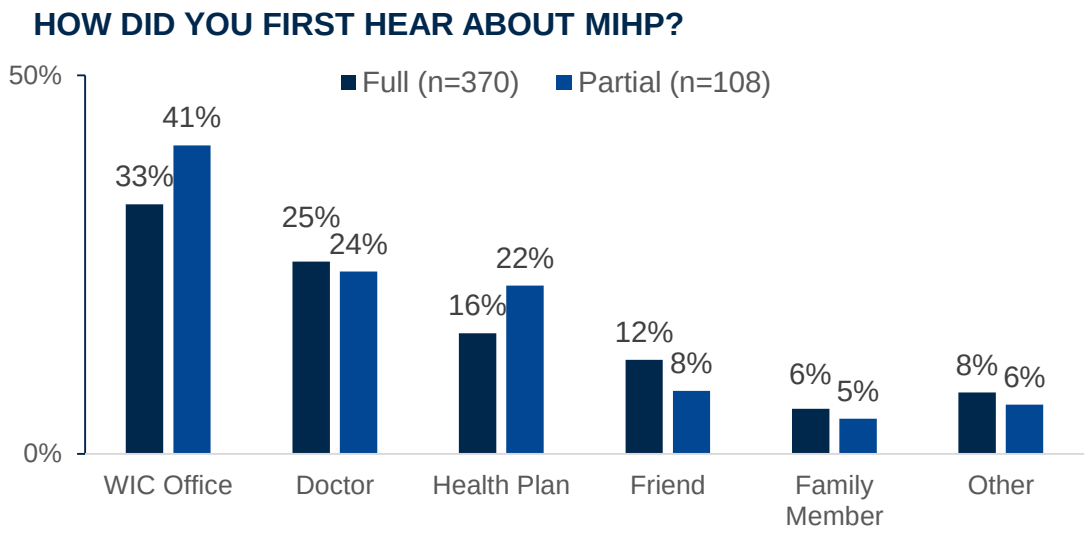
TIMING OF INITIAL ENROLLMENT



"I think we met later in my pregnancy. I believe if I had been enrolled in the program earlier we would've benefited earlier."
– Partial participant

Initial Program Experiences

- Most participants first heard of MIHP from their WIC office, doctor, or health plan



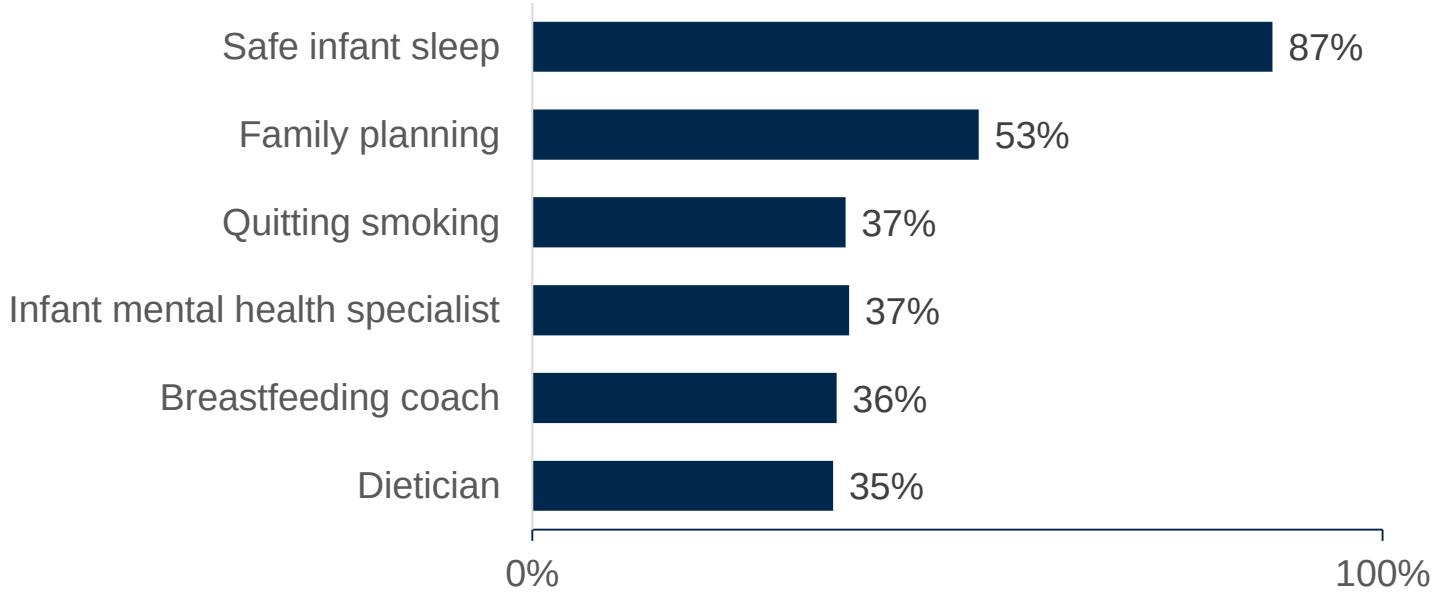
Home Visitor Experiences

- 99% of all participants (n=471) said that their home visitor spoke to them clearly in a language they understood
- Outside of a home visit, phone was the most common communication method
- Most visits were 30 min-1 hour

Information and Supports

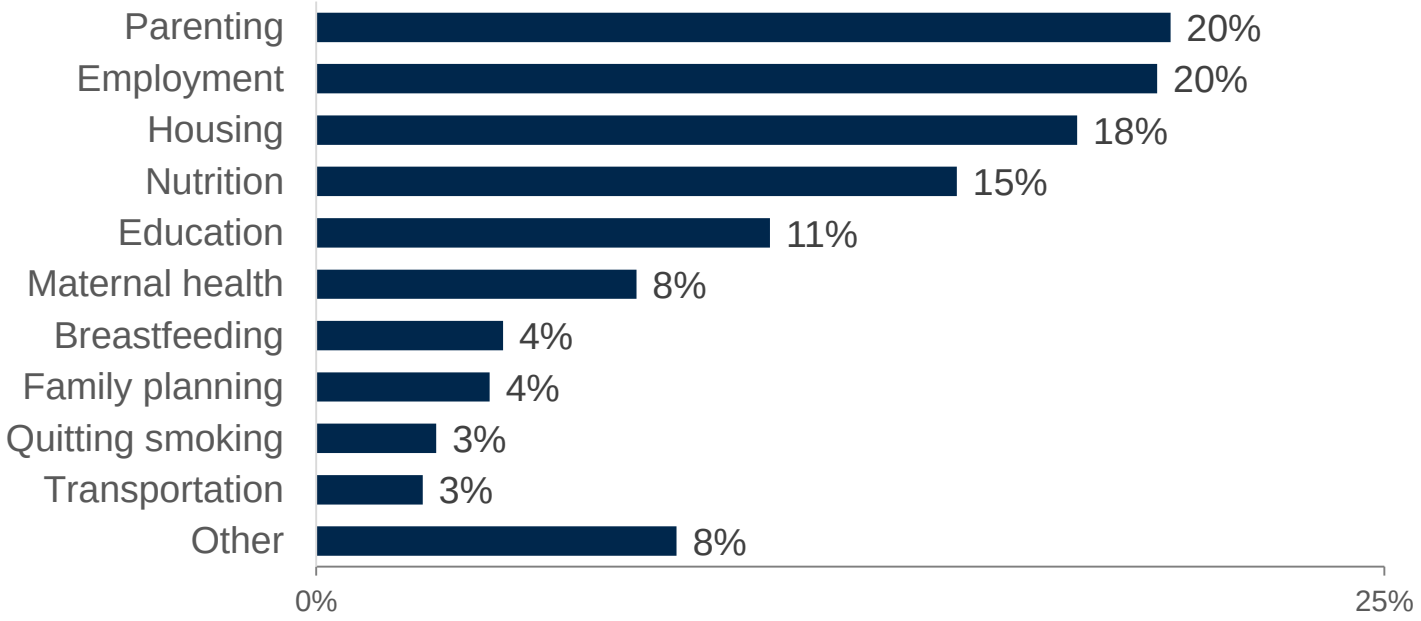
- Almost all participants received info on safe infant sleep
  - Smaller shares received info on family planning, quitting smoking
  - About one-third were connected to additional supports

CHECK ALL THAT APPLY: DID YOUR HOME VISITOR PROVIDE THE FOLLOWING INFORMATION OR CONNECT YOU TO THE FOLLOWING SUPPORTS? (N=478)

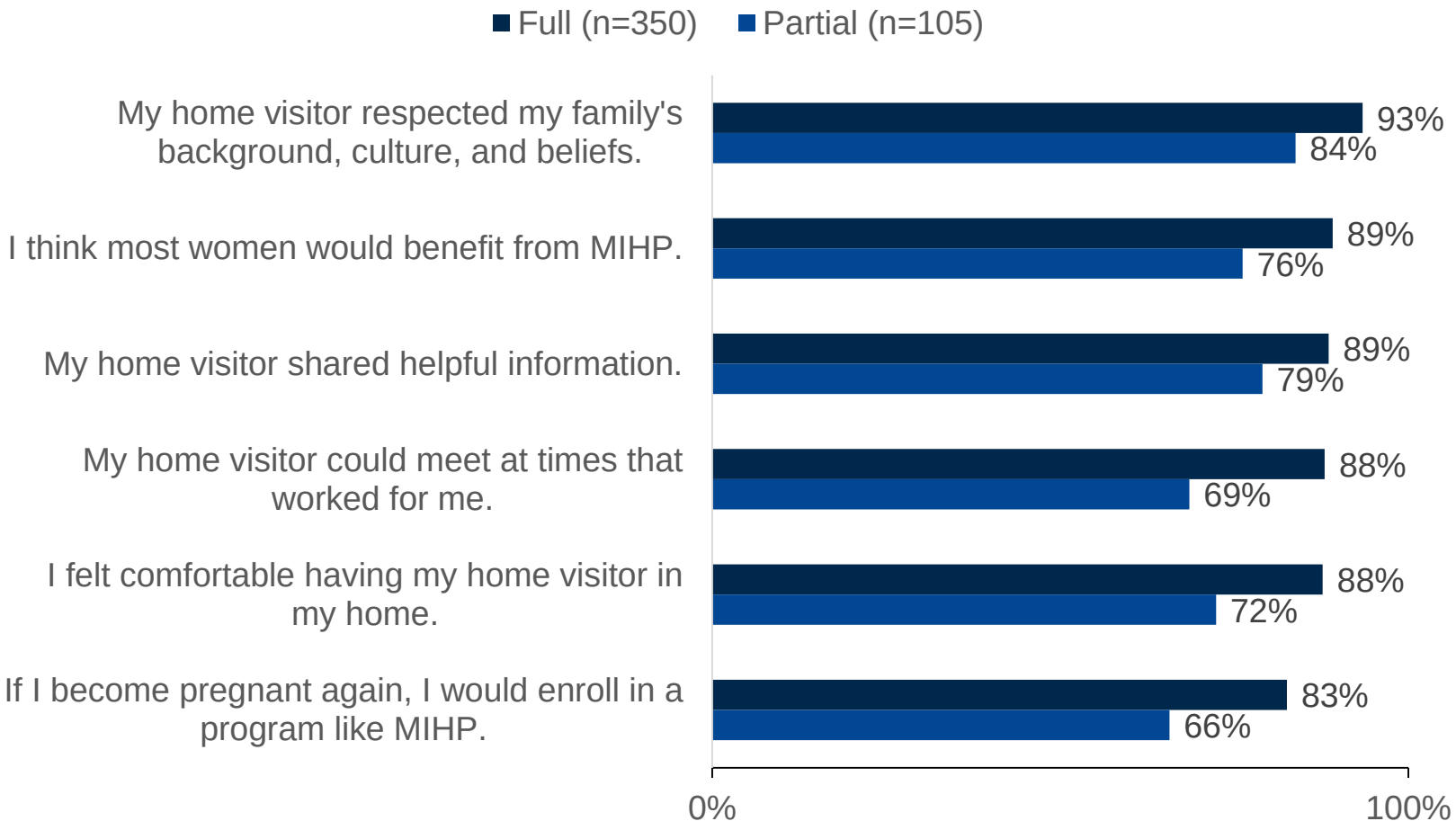


Goals

- Two-thirds of participants discussed goals with home visitors
- Respondents described these goals in an open field; we sorted responses into categories below
- Many goals were related to social determinants of health

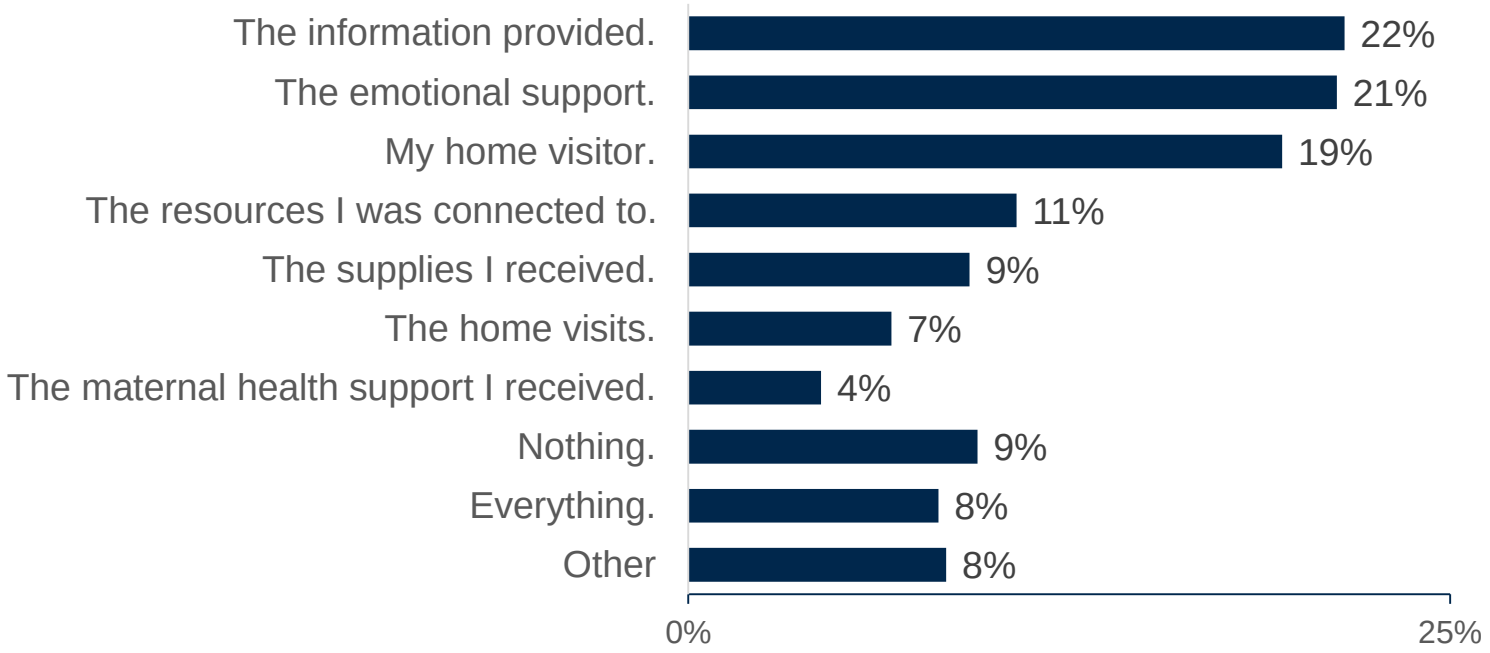


Program Satisfaction



Program Highlights

- All participants (n=390) were asked to share in an open field what they thought was the best part of MIHP. We sorted responses into the categories below:



The best part of MIHP was…

"I very much enjoyed our visits, and knew I had a great support system. I liked how my nurse did extra research about topics she wasn't super familiar with."
– *Full participant*

"Just talking to someone who was excited about my new baby."
– *Partial participant*

"Having someone I can trust and talk to about everything and help me provide a better environment for my family."
– *Full participant*

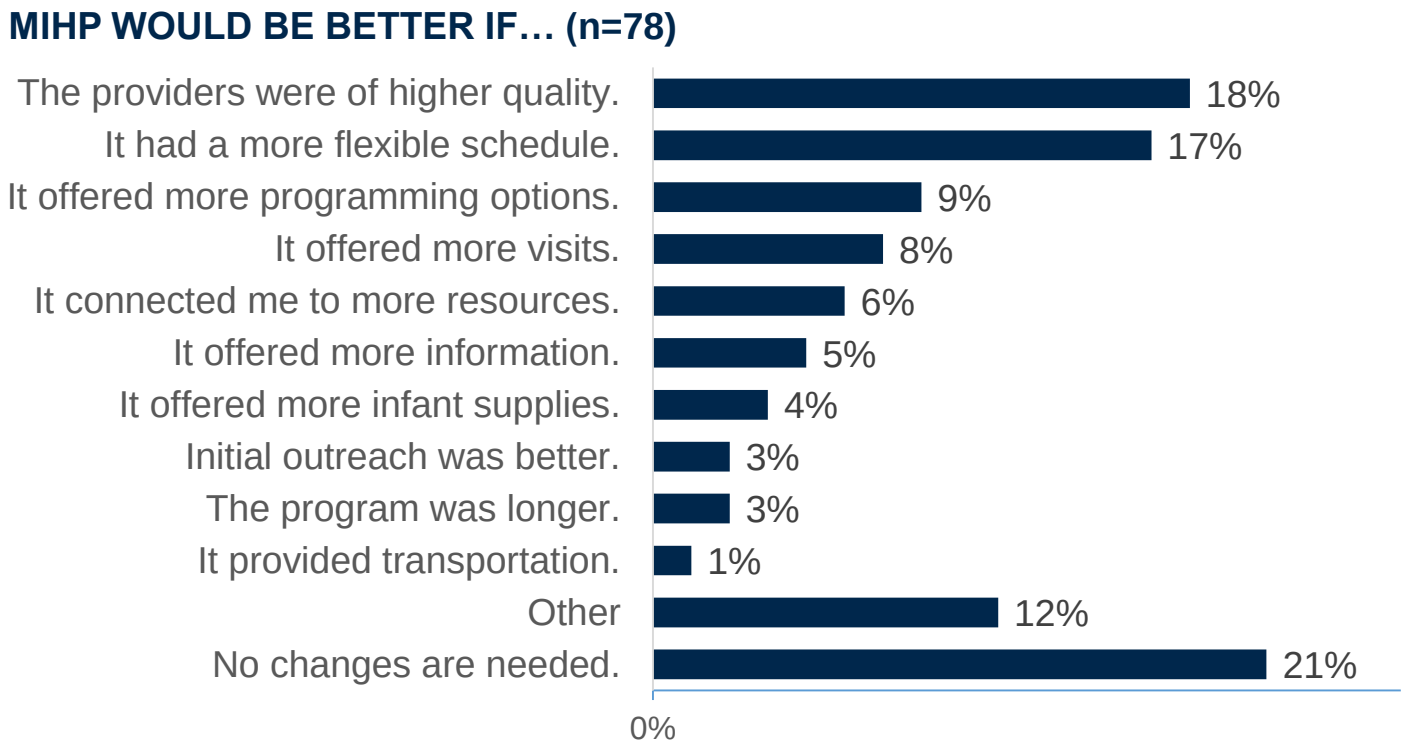
"They gave me certain resources that helped with my kids."
– *Partial participant*

"I never went without. If it was information or clothing, or anything, they always provided."
– *Full participant*

"Seeing my worker, she was so helpful, caring, and understanding. I really enjoyed her." – *Partial participant*

Opportunities for Improvement

- Partial participants shared ideas to improve MIHP in an open-field question:



MIHP would be better if…

"If the time that they come is a little more flexible."
– Partial participant

"If there was an option to meet at an office…I didn't feel comfortable with someone I didn't know coming to my home with just me and my 2 children..."
– Partial participant

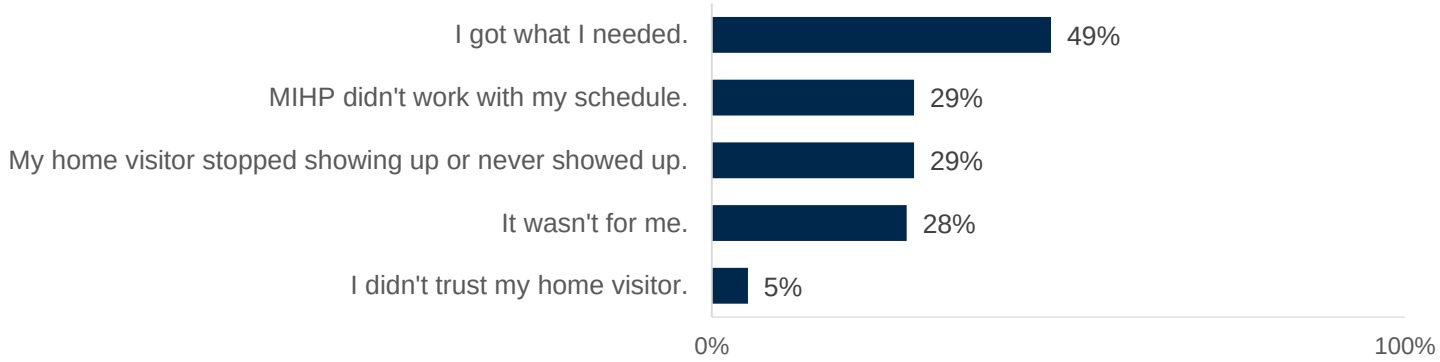
"The program is as good as the workers that come out to your home. If they're good workers, the program is great; if they're not so much, then the program doesn't really do anything for you."
– Partial participant

"If they had an app to keep up with your appointments and know who's coming to your home."
– Partial participant

Partial Participants

- 49% of partial participants (n=96) said they ended MIHP early because they got what they needed
- 29% ended because MIHP didn't work with their schedule, or because their home visitor stopped showing up/never showed up
  - Consistent with suggestions for program improvement

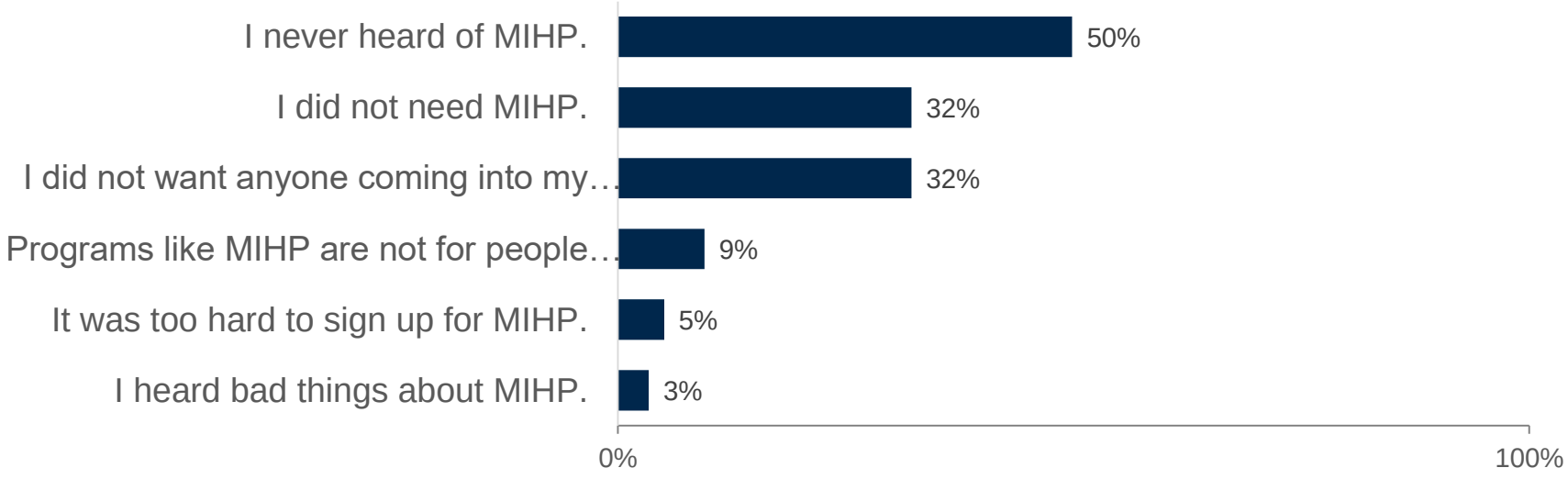
I STOPPED GETTING HOME VISITS BECAUSE… (n=96)



Non-Participants

- 70% of non-participants (n=323) said no one told them about MIHP during their pregnancy
- 50% didn't enroll because they didn't know of MIHP
- 32% didn't want someone coming in to their home

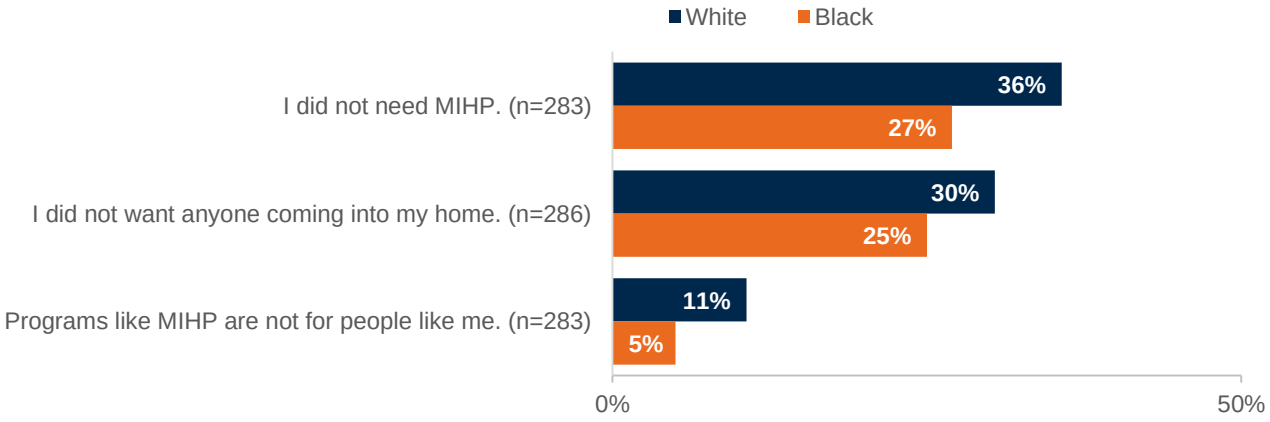
REASONS FOR NOT ENROLLING (n=295):



Non-Participants

- White non-participants were more likely than Black non-participants to agree with the following statements:
  - "I did not need MIHP"
  - "I did not want anyone coming into my home"
  - "Programs like MIHP are not for people like me"

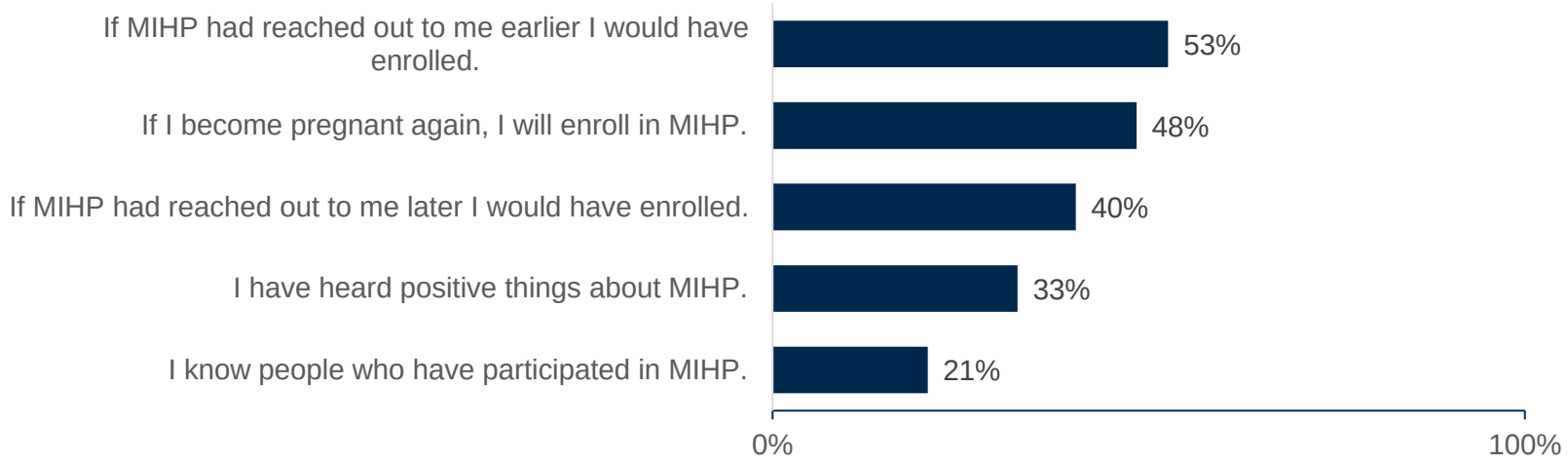
REASONS FOR NOT ENROLLING:



Non-Participants

- Half of non-participants said they would enroll in the program if they became pregnant again
- Many said they would have enrolled if they had been contacted at a different time in their pregnancy

NON-PARTICIPANT VIEWS OF MIHP (n=310)



Key Findings

- In general, participants are satisfied with their experience and think MIHP is a helpful program
    - Partial participants are less satisfied; the quality of their home visitor and scheduling seem to be the biggest sources of dissatisfaction
- Biggest barriers
    - Awareness
    - Having someone in their home
    - Scheduling

Possible Conclusions & Recommendations

- More needs to be done to increase awareness of MIHP
    - Leveraging WIC connections
    - Increasing provider awareness/referrals
    - Other?
- More flexibility in scheduling and meeting location may help improve uptake
    - Potential to expand televisits post-COVID-19 pandemic

THANK YOU

At the University of Michigan Youth Policy Lab, we are surrounded by some of the nation's leading experts on nearly every social challenge and, as a public institution, we are committed to applying that knowledge to the public good.

We are always looking for new opportunities to increase measurable impact. For more information, or to discuss a new project idea, contact us: www.youthpolicylab.umich.edu

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YOUTH POLICY LAB
UNIVERSITY OF MICHIGAN

Maternal Infant Health Program Updates

COVID-19 CHALLENGES

- Guidelines for How to Restart In-Person Visits
- PPE assistance for agencies
- Temporary suspension of services
- MDHHS resources

Maternal Infant Health Program

Model Day Session

July 28, 2020

Cycle 8 Enhancements

- Cycle 7-8 Crosswalk
- Virtual Reviews
- Agenda for Virtual Reviews
  - EMR systems vs. paper charts
  - Practice sessions
- Chart Review Tool

Other MIHP Developments

- MIHP Evaluation
- Full schedules for MIHP staff
- Welcome to new providers
- Training modules review
- Home Visiting Advisory Committee

MIHP Staff

- Suzette Burkitt-Wesolek, QI Specialist
- Joni Detwiler, Consultant
- Connie Frantz, Departmental Analyst
- Maria Garcia, Departmental Technician
- Chelsea Low, Consultant
- Jenn Music, Section Secretary
- Sarah Ostyn, U-M Policy Fellow
- Cherie Ross, Consultant
- Dan Thompson, Manager

Thank you for attending.
Enjoy the conference!
Maternal Infant Health Program