(MIHP) September 2016 Coordinator Training Webinar

MIHP PROGRAM UPDATES

MIHP Opening Remarks

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Michigan Department of Health and Human Services

AGENDA

- Welcome- MPHI
- Opening Remarks
- MIHP Updates
- Perinatal Oral Health Presentation
- Infant Safe Sleep Presentation
- Medicaid Services Administration Updates
- Infant Mental Health Presentation
- Keynote Presentation: Diabetes and Pregnancy
  - Q and A
- Closing Remarks

Michigan's Maternal Infant Health Program

Jointly Administered by Population Health and Medicaid

- MIHP Operations Guide
- Medicaid Policy Manual- MIHP section
  - Home Visiting Michigan Public Act 291 of 2012
    - MIHP- Michigan Evidence-based Model
  - Michigan's Infant Mortality Reduction Plan
    - Goal 6: expand HV to promote healthy women and children

www.michigan.gov/mihp

MIHP Benefits and Outcomes

- Improve care coordination and service integration between MIHP providers, primary care providers & Medicaid Health Plans
- Improve data collection and information sharing to better integrate and improve quality service delivery and promote health equity
- Increase the percentage of all pregnant and infant beneficiaries engaged in MIHP and screened for risks; demonstrated by a completed risk identifier
- Increase the percentage of high-risk beneficiaries accessing MIHP services
- Earlier access and engagement to MIHP services
- Increase the percentage of infants receiving timely development evaluations – Ages and Stages Questionnaire®: Social - Emotional
- **Increase breastfeeding initiation and duration**

Equity. Quality. Collaboration.

Creating Healthy People, Healthy Communities through HV

- Beneficiaries
- MIHP Team
  - -Staff
  - -Reviewers
- MIHP Providers
- Medicaid Policy
- Medicaid Health Plans
- Medical & other Providers
- MSU Institute for Health Policy

MIHP Operations

Health Plan Transition- Proposed MSA Policy MIHP-1611

- Effective date January 1, 2017
- As described in the health plan contract, services rendered by MIHP providers to Medicaid Health Plan enrollees will be reimbursed by the Medicaid Health Plans.
- There are no changes in the administration of MIHP benefits provided to the FFS population.
- There are no anticipated changes in the MIHP certification process.
- Medicaid policy and the MIHP Operations Guide continue to apply.
- Care coordination agreements continue to be required.
- The updated FAQ document has been posted to the MIHP website along with the updated MHP contact information.

8.5 Service Acceptability, General Information for Providers (Medicaid Provider Manual)

Consultants are monitoring agencies to ensure transfers are made within 10 working days.

- Agencies cannot make additional visits after a transfer request has been received.
- Such practices are not deemed acceptable and are out of compliance with Medicaid policy on Service Acceptability. Failure to comply with certain provisions in this policy may result in disenrollment from Medicaid.

Effective Cycle 6- Agencies receiving a referral from CPS must check to see if a beneficiary is already enrolled in another MIHP program, if so, a "warm referral" is made to that agency. CPS does not dictate which MIHP a beneficiary must enroll in, it is the beneficiary's choice.

MIHP Operations Cont.

- New staff must have a copy of the "Notice of new Professional Staff Training Completion" Form in their file
- **Approved** waiver staff must have a copy of the "Notice of waiver Completion" Form in their personnel file
- As a reminder, waivers may only be obtained for staff who do not meet the experience requirement outlined in the MIHP Operation's Guide and Medicaid Manual.
- Waivers are only granted by MDHHS to SW or RN staff

MIHP Operations Cont.

- As a reminder, Agency protocol for indicator #16 (confidentiality) indicates that protected health information (PHI) cannot be sent via email unless the agency has encrypted software.
- Please send PHI via fax to your consultant or leave a voicemail.

  -When leaving a voicemail, please speak clearly and spell the beneficiaries name that you are inquiring about.

Maternal Infant Health Program (MIHP) Email Addresses

As distributed in Coordinator email #11 on July 21, 2016:

- MIHP has a new email address for sending and receiving MIHP Certification documents and corrective action plans. Please adhere to the guidelines below for use of these MIHP email addresses:
- NewProviderApplication@michigan.gov **Inquiries** for becoming a **New MIHP Provider**
- MIHP@michigan.gov Submission of **Personnel Rosters and Directory changes**
- MDHHS-MIHPCertification@michigan.gov **Certification Review Documents** and **CAPs**

Checklist & POC

- When a mom chooses to enroll her baby in the same MIHP as she is enrolled in, she is listed as the referral source on the checklist and the date of the referral is the same date as the infant risk identifier date.
- As a reminder Birth health-scoring on the infant risk identifier is a One-time snapshot of the baby's status at birth based on gestational age, weight, etc. No POC is needed.

Ages & Stages Developmental Tool

- ASQ:SE 2 begins at 2 month and adjusts for age prematurity.
- Learning tools and development guides must be given when a 2 month follow-up is necessary as well as to care givers who decline a referral to Early on.
- Cycle 6 indicator #44 lists ASQ-3 and ASQ-SE 2 training, which is currently under development.

ASQ™
Ages & Stages

Electronic Medical Records

- To request permission to electronically upload your MIHP data you must complete the MIHP Provider Data Transfer File Request Form. Contact Connie Frantz for this form.
- The form to request access to MIHP forms in an unlocked format, may be found on the MIHP website under "Request for Unprotected Forms"- Policy and Operations.
- Contact your consultant with any questions.

MIHP QUALITY IMPROVEMENT

Quality Assurance

Quality Assurance activities ensure minimum quality standards are being followed and demonstrates services meet standard requirements.

MIHP agencies must implement **internal quality assurance activities, including chart reviews and billing audits**
At a minimum you must have a protocol and implement:

- Chart reviews for correct forms and form completion
- Chart review for correct billing
- Professional chart review for content and care coordination referrals and program requirements to ensure model fidelity

Certification

Updates for Cycle 6 MIHP Certification

To ensure continuous quality improvement, the Cycle 6 tool is undergoing minor corrections. The following indicator corrections should be noted:

- **Indicator #1c,** gives examples for correcting forms and states you must initial/date corrections. MDHHS does not require you to "date" your corrections on forms; however you must initial the change.
- **Indicator #2**, when reviewing the Professional Visit Progress Note, consultants and reviewers are looking for the one of the following for the Medicaid Health Plan field:
  - Name of beneficiary's Medicaid Health Plan, or
  - Fee For Service (FFS), or
  - Straight, or
  - No Medicaid Health Plan (MHP) yet

Updates for Cycle 6 MIHP Certification

- **Indicator #6 b and c,1, Home visits and beneficiary referral for OB-Based maternal only clinics –** applies to beneficiaries opened after 7/31/16
- **Indicator #7f, Both RN and SW must visit beneficiary** – applies to beneficiaries opened after 7/31/16
- **Indicators #51 and #52, Family Planning and Immunization (for infant beneficiaries) discussed at every visit** – applies for PVPN dated after 7/31/16

Certification Review Scheduling

- Your certification review will be scheduled by your assigned reviewer 6, 12, or 18 months after your previous review.
  - Example: If your review was conducted on November 26 and 27, 2015, and you received a full certification, your review will be scheduled after May 27, 2017.
- Reviewers are assigned 6-8 weeks before a review and will contact the agency to schedule a review at that time.

Corrective Action Plans (CAP)

Please Remember to:

- Acknowledge receipt of the email
- Include all of the reviewer's comments - **Word for Word**
  - Include the findings
  - Include what is supposed to go in the CAP
  - Have improved since the last training
- Submit CAP as one single document in Word format to the new mailbox….

  MDHHS-MIHPCertification@michigan.gov

Corrective Action Plans (CAP) cont.

- **Be specific and clear in your plan**
  - Specify frequency of chart review for ongoing compliance
  - Include dates
  - How you are going to improve your process
  - How you are going to assure documentation is in personnel or client charts
- Include how you will provide continuous monitoring of the "Not-Met" indicators (ongoing compliance)
- Make the plan specific to each indicator (do NOT cut and paste statements from one page to the next)

MIHP IT Updates

Technical Difficulties Related to the MIHP Application and MILogin System

The state IT Team continues to work diligently to identify and resolve technical difficulties MIHP providers are experiencing with the MIHP application

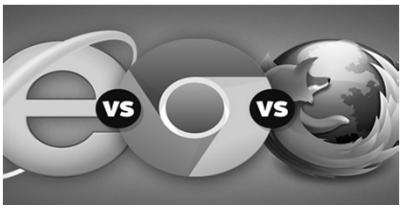
MI Login

- **MILogin has replaced Single Sign-On (SSO). Please access CHAMPS through MILogin at the link shown below:** https://milogintp.michigan.gov
- **If you previously used SSO, you will use your same User ID and Password to access MILogin. DO NOT register as a new user.**
- If users experience login issues with MILogin, contact the Client Service Center **at** 1-877-932-6424 or 1-877-web-mich to reset passwords or address MILogin related issues.
- For more information, you may also access the MILogin webpage at www.michigan.gov/mdhhs-milogin-info

MILogin System

Verifying Your Browser

- Acceptable browsers for MI Login (which is the database) is IE 8 or IE11. You cannot use IE 9, IE10. Occasionally, Internet Explorer (IE) will auto-update to another level (IE 8 increases to 9 or 10), and you may not know if you have not disabled the auto-update function.
- You should always check the printed version of your risk identifier and discharge summary for accuracy.



MILogin cont.

To check your browser on Internet Explorer:

- 1. Open Internet Explorer
- 2. Click on the "tools" button in the top far right corner of your screen
- 3. Go to "About Internet Explorer" to verify which version you are operating
- 4. Uncheck/Disable the box, (if need be) that asks "Install new versions automatically"
- 5. If your operating system is Windows 10, and you are utilizing Microsoft Edge, it's browser is the current version of explorer which is currently Internet explorer 11.

MIHP DATA UPDATES

Quarterly Report Data

Information in the quarterly reports that can assist with Quality and Utilization Management in ***YOUR*** agency:

Referrals

Screens completed

Discharges completed

Demographics

Education provided

Breastfeeding information

Risk screening domain scores

MIHP Data Reports

- MIHP Quarterly Data Reports – First quarter data from 10/01/2014– 12/31/2014 is now available in your CHAMPS inbox.
- These reports have taken the place of the MIHP File Transfer data reports.
- Archived data reports from FY 2013 and FY 2014 will remain available on the MIHP File Transfer area. Going forward, your agency MIHP quarterly data reports will be available via CHAMPS.
- The second quarter fiscal year 2015 reports should be available in mid October.

  Coordinator email #9

Building a Better Bridge: Transitioning Adolescents Young Adults w/Sickle Cell Disease
(update state sickle cell strategic plan)

- The state public health strategic plan is the result of many months of collaborative efforts by nearly 100 individuals.
- The plan provides a set of public health interventions to reduce the burden of SCD in the state through improved awareness, comprehensive transitional care programs, and increased utilization of community mental health and behavioral health services.
- Seven key gaps were identified as public health priorities by planning participants.
- Efforts are focused on improving patients experiences transitioning from pediatric to adult care, highlight barriers experienced by patients gleaned from focus group discussions, and identify several practices that can help patients successfully transition.

A Public Health Plan to Address Sickle Cell Disease
http://www.michigan.gov/documents/mdhhs/MDHHS_Final_SCD_Strategic_Plan_504325_7.pdf

Sickle Cell Disease cont. What Can Providers Do?

- Emphasize **L**ife skills
- **E**ducate patient about disease, financial implications, community supports
- **A**dvocate for the patient with providers, support agencies
- Pay attention to **V**ocational concerns
- Stress importance of **E**mpowerment of patient/family.
- Transition is a process, not an event; takes team approach
- Coordination is key – includes health/vocational/education/social service systems
- Use questionnaires to assess needs and measure progress (Ex. www.gottransition.org)
- Self-determination skills should be encouraged and taught throughout the process
- Adopt a transition model for your practice – We can help!!!

Contact: Dominic Smith at 517-373-5818 or smithd82@michigan.gov

Postpartum Support International (PSI)

Perinatal Mood & Anxiety Disorders 2-day Certificate Training

October 20 & 21, 2016
Crossroads Conference Center
6569 Clay Avenue SW Grand Rapids, MI

Sponsored by Healthy Kent Perinatal Mood Disorders Coalition www.mipmdcoalition.org

Sponsorship options are available. Vendor tables are also an option. Contact Nancy for more information.

Nancy Roberts RN, CCE, CBC
Spectrum Health Healthier Communities
616-391-5000 616-391-2561 Voicemail

Call for Workshop Proposals & Student Posters for the 2017 MI-AIMH Biennial Conference are now OPEN!

- The 2017 Conference, "Integrating Mindfulness and Diversity in Practice: Nurturing Authentic Relationships with Infants, Young Children, and Families," will be May 7 - 9, 2017 and will have keynote presentations by Michael Trout, Marva Lewis & Kandace Thomas.
- Please go here for more information, instructions & the applications: http://mi-aimh.org/event/2017-conference/
- Contact the MI-AIMH Conference Co-Chairs: Ashley and Sarah at miaimh.conference@gmail.com for additional questions.

Fatherhood Resources

ENGAGING MEN IN HOME VISITING PROGRAMS

Mr. Cole Williams

Website: www.colespeaks.com

Breastfeeding Resources

http://www.coffective.com/
Coffective prenatal education and links to area resources

http://www.womenshealth.gov/breastfeeding/learning-to-breastfeed.html
Learning to breastfeed

http://www.womenshealth.gov/breastfeeding/breastfeeding-and-everyday-life/
Breastfeeding and everyday life

Breastfeeding Resources cont.

http://www.womenshealth.gov/breastfeeding/pumping-and-breastmilk-storage.html
Pumping and breastmilk storage

https://events.mphi.org/wic/wic-breastfeeding-basics/

Breastfeeding Basics training ($45 for 2 days)
Provides info on the normal course of breastfeeding, skill development, breastfeeding promotion & support.

MDHHS Breastfeeding Coordinator:
Marji Cyrul, MPH, RD, CLS cyrulm@Michigan.gov
(517) 373-6486 desk or (423) 322-7898 cell

New FDA Birth Control Chart

The FDA Office of Women's Health has released an updated version of their Birth Control Chart. The easy-to-read chart provides information on the safety and effectiveness of FDA-approved medicines and devices for birth control.

You can download the FDA Birth Control Chart in English or Spanish @ www.fda.gov/womens

FDA Office of Women's Health
10903 New Hampshire Avenue
WO32 - Room 2333
Silver Spring, MD 20993-0002
301-796-9440

RESOURCES…

- *Early On* has developmental wheels in English, Spanish and Arabic and are **FREE!**
- HEALTHY MICHIGAN PLAN http://www.michigan.gov/documents/mdch/DCH-1317_Healthy_Michigan_Plan_Brochure_452129_7.pdf
- *Text for Baby* cards are still available through your consultant.

MPHI

- Continuing Education Credits
- 2017-One MIHP training webinar
- 2017-Returning to the format of two on-site trainings in May and October
- Other pertinent information

Perinatal Oral Health

Emily Norrix, MPH

Perinatal Oral Health Consultant

Michigan Department of Health and Human Services

The Michigan Oral Health Program
Increasing Access to Prevention
Now that's something to SMILE about!

Today's goals!

- Learn about the Perinatal Oral Health Initiative
- Examine our current priorities, activities, and updates
- Leave with an understanding of what you can do to help!

What is so important about Perinatal Oral Health?

- Mothers (and other caregivers) can transmit caries causing bacteria (Strep. mutans) to their infants via saliva.
- Poor maternal oral health has been associated with preterm birth!
  - The #1 cause of infant mortality in Michigan is low birthweight/ premature birth.
- This is a time when some mothers may not only have increased health insurance coverage, but also the motivation to change habits to improve her health and the health of her child!

Oral Health, Mom, and Infant

- Early transmission of microbes is a significant risk factor for future caries experience.
- Mothers with higher salivary levels of Streptococci mutans are more likely to infect their infants early in life.
- Controlling these levels through preventive care for the mother has shown a reduction in the transmission.

Fujiwara T, et al. Caries prevalence and salivary mutans streptococci in 0.2-year-old children of Japan. Community Dent Oral Epidemiol 1991;19:151-154.

Grinderfjord M, et al. Stepwise prediction of dental caries in children up to 3.5 years of age. Caries Res 1995;30:356-366.

Berkowitz RJ, Turner J, Green P. Maternal salivary levels of Streptococcus mutans: The primary oral infection in infants. Arch Oral Biol 1981;26:147-149.

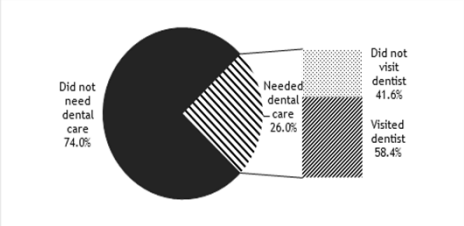
Background Information

- Nationally, >50% of women do not visit the dentist while pregnant
- Nationally, only ½ of pregnant women with oral health problems receive appropriate and timely dental care
- Significant oral health disparities due to socioeconomic status and race

A look at Michigan Data: PRAMS

Prevalence of dental care needed and dental care sought

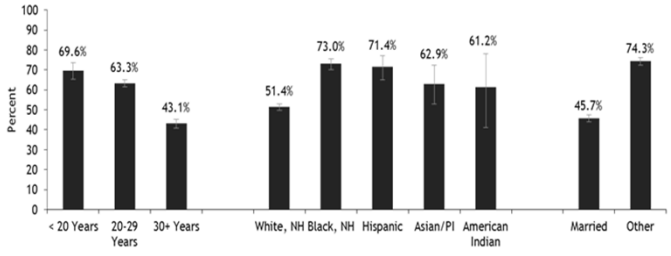
- **Over a quarter of women reported that they needed dental care during their pregnancy.**
- **Of the women who needed care, 58.4% sought dental care during their pregnancy, while 41.6% did not seek dental care**



Michigan Department of Community Health (MDCH). Michigan Pregnancy Risk Assessment Monitoring System Data. Lansing, MI: MDCH, Lifecourse Epidemiology and Genomics Division, Maternal Child Health Epidemiology Section; [2015].

Michigan Data: PRAMS

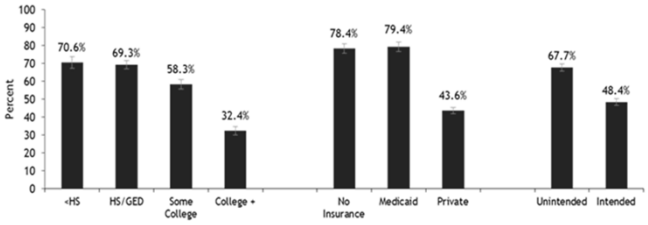
Figure 2. Prevalence of not receiving dental care by maternal age and race



Michigan Department of Community Health (MDCH). Michigan Pregnancy Risk Assessment Monitoring System Data. Lansing, MI: MDCH, Lifecourse Epidemiology and Genomics Division, Maternal Child Health Epidemiology Section; [2015].

Michigan Data: PRAMS

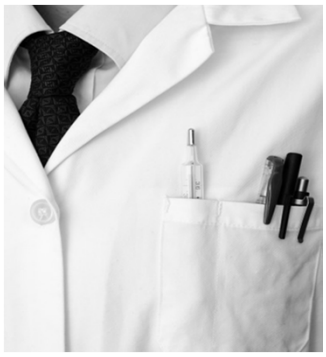
Figure 3. Prevalence of not receiving dental care by maternal education and pre-pregnancy insurance status



Michigan Department of Community Health (MDCH). Michigan Pregnancy Risk Assessment Monitoring System Data. Lansing, MI: MDCH, Lifecourse Epidemiology and Genomics Division, Maternal Child Health Epidemiology Section; [2015].

Michigan Data: Obstetric Providers

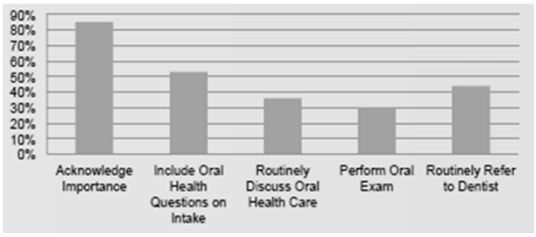
- **Methods: An online survey of knowledge, attitudes and practices was sent using provider databases in the state of Michigan. Questions included:**
  - **Do you consider oral health care to be important?**
  - **Does your health questionnaire form include an oral health history?**
  - **Do you frequently discuss with your patients the importance of oral health?**
  - **Do you perform an oral exam?**
  - **Do you frequently refer your prenatal patients to a dental provider if they are not receiving dental care?**



Wilson, EH, Farrell, C, Zielinski, R, Gonik, B. Wayne State University School of Medicine. "Obstetric Provider Approach to Perinatal Oral health

Michigan Data: Obstetric Providers

- **85%** of providers considered perinatal oral health as an important consideration for optimal prenatal care
- **53%** reported having oral health questions on their intake documents
- **36%** regularly discuss the importance of oral health
- **30%** routinely perform an oral cavity exam
- **44%** consistently recommend oral health assessment by a dentist if the patient is not already receiving care.

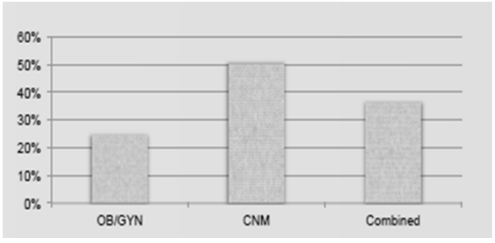


Wilson, EH, Farrell, C, Zielinski, R, Gonik, B. Wayne State University School of Medicine. "Obstetric Provider Approach to Perinatal Oral health"

Michigan Data: Obstetric Providers

- **OB/GYN's are less likely to discuss the importance of oral health with their patients compared to CNM's.**

(24 % vs 50 % respectively)



Wilson, EH, Farrell, C, Zielinski, R, Gonik, B. Wayne State University School of Medicine. "Obstetric Provider Approach to Perinatal Oral health

Dental Providers: Data and Practices

- **96% of the dentists surveyed provide dental care for their pregnant patients. However this favorable response changes drastically when the referred pregnant patient has Medicaid insurance.**
- **In such cases only 17% of the respondents indicated they are willing to accept pregnant patients with Medicaid.**

Mayberry, M. University of Detroit Mercy School of Dentistry. Data Analysis, January 22 2015

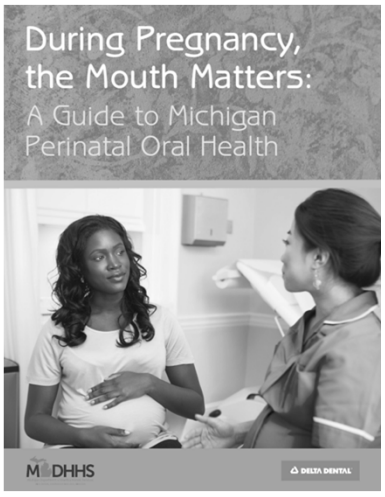
What are we and our partner's doing?

Perinatal Oral Health Action Plan

5 Objectives and Taskforces

I. **Develop Evidence-based Perinatal Oral Health Guidelines**
II. **Integrate Oral Health into the Health Home for Women and Infants**
III. **Develop Interdisciplinary Professional Education to Improve Perinatal Oral Health**
IV. **Increase Public Awareness of the Importance of Oral Health to the Overall Health of Pregnant Women and Infants**
V. **Ensure a Financing System to Support Perinatal Oral Health**

Michigan Perinatal Oral Health Guidelines



WIC Module

- **A module on perinatal and infant oral health is currently in development with a team from WIChealth.org.**
- **Release in the November of 2016**
- **Available to all Michigan WIC clients and 25 other states…for free!**

IPE Collaboration project

Connecting the OBGYN and Oral Health Care Provider, A Team Based Approach to Perinatal Care

The Double O 3T Project: Training, Teaching, and Treating

OB-Oral Health Project between UDM School of Dentistry dental student providers and OB resident providers.

- **Oral health patient education**
- **Co location**
- **Coordinated care**
- **Referrals for care**

What Can I Do?

- Make oral health a priority
- Talk about this with your colleagues
- Talk about this with your clients
- Refer…..and FOLLOW UP
- Help clients find oral health services

Help Finding Care

- Detroit Area: Pregnancy Dental Days
  - UDM School of Dentistry, at the University Health Center and Corktown Campuses
  - Contact Danielle the coordinator at (313) 288-2314 or the clinic directly at (313) 494-6700.
- Federally Qualified Health Centers (FQHC's)
  - http://findahealthcenter.hrsa.gov/
- MY Community Dental Centers
  - http://www.midental.org/
- Health Departments
- Michigan Dental Association
  - https://www.smilemichigan.com/Find-a-Dentist
- Michigan Department of Health Human Services
  - www.Michigan.gov/oralhealth

Resources

Smiles for Life Curriculum

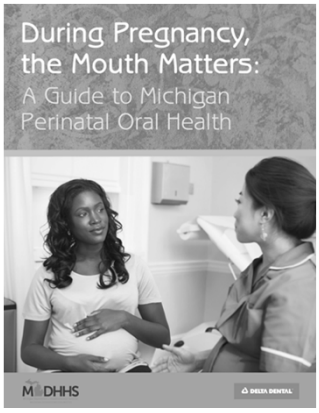
smilesforlifeoralhealth.org

Michigan Perinatal Oral Health Guidelines

Michigan.gov/oralhealth

National Maternal and Child Oral Health Resource Center

http://mchoralhealth.org/



Contact information

Emily Norrix, MPH

517-241-0593

norrixe@Michigan.gov

Infant Safe Sleep

PATTI KELLY, LMSW, MPH
MDHHS INFANT SAFE SLEEP PROGRAM
SEPTEMBER 15, 2016

How many babies are dying due to unsafe sleep?

Every **2-3** days in Michigan a baby dies due to unsafe sleep.

From 2010-2014, **712** Michigan infants died in unsafe sleep environments.

What do we know about these deaths?

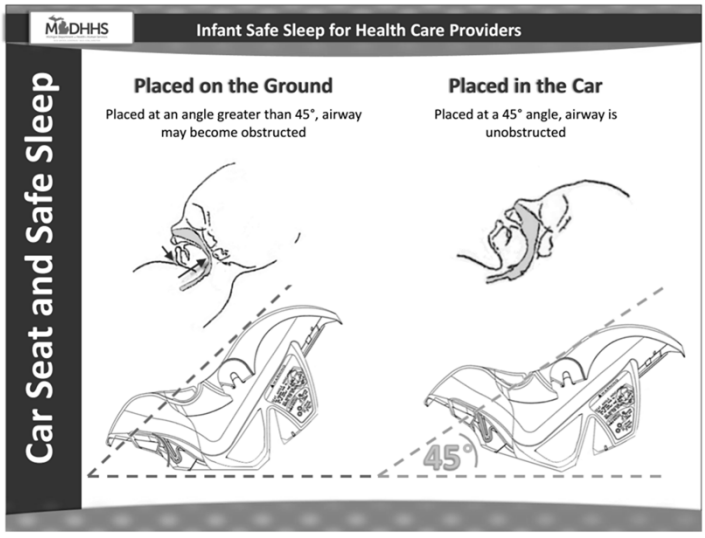
- There is a significant racial disparity in the rate
  - 3x higher for African American infants than White infants
  - 2x higher for American Indian infants than White infants
  - Elevated for Hispanic infants
- 2 in 3 of the infants found unresponsive are not on their backs
- 3 in 5 sleep-related deaths involve an infant sharing a sleep surface
- 3 in 4 sleep-related deaths occur in an unsafe sleep location
  - Majority in an adult bed

American Academy of Pediatrics

- Baby should be placed on the back to sleep – nap times and night time
- Baby should be placed to sleep on a firm surface – such as in a safety approved crib, bassinet or pack and play with a mattress that fits snugly and a tight-fitting sheet
- Keep soft objects and loose bedding out of the crib – no bumper pads, blankets, pillows, stuffed animals, etc.
- Baby should sleep in the same room as the parents, but not the same bed
- Wedges and positioners should not be used
- Avoid covering the infant's head or overheating
- Baby's environment should be smoke-free
- Breastfeeding is recommended
- Can offer a pacifier after breastfeeding is well-established

Car seats, swings and other sitting devices are *not* safe for routine sleep

- Baby's airways are very small – can become obstructed
- Baby can unexpectedly turn or roll over in the device and suffocate
- Baby is safe sleeping in car seat when in car, once the car seat comes out of the car and is set down, the resting angle changes and baby's airway may become obstructed – at that point if baby is asleep, she should be moved to a safe sleep space
- If baby falls asleep in any sitting device, she should be moved to a safe sleep space



In addition to the guidelines, what to talk with parents/caregivers about?

- **Crying:** how to handle, especially at night, as this often leads to baby being brought to bed; teach soothing techniques
- **Prepare sleep environment prior to birth:** plan where baby will sleep and set it up
- **Danger of falling asleep with baby:** while cuddling, feeding, etc.
- **Involve all family members:** especially dads and grandparents
- **Promote breastfeeding:** protective; can breastfeed *and* practice safe sleep
- **Promote smoke-free environment for baby:** prenatally and after birth
- **Inform all caregivers:** babysitters, child care staff, grandparents, friends, siblings, etc.
- **Use motivational interviewing techniques:** start where the client is
- **Use a wide variety of educational resources:** written, visual, video, etc.

Be consistent with messaging

- Printed material, promotional items, etc. should be consistent with the AAP message
- Always use visuals that depict safe sleep environments
- Resources

  "Safe sleep image guidelines":

  http://www.firstcandle.org/media_stars/first-candles-safe-sleep-image-guidelines/

  Images of safe sleep environments: https://www.flickr.com/photos/131057828@N07/sets/72157654071312421

State infant safe sleep resources

- **MDHHS Safe Sleep website** - www.michigan.gov/safesleep
  - variety of information for parents and professionals
  - links to additional resources (including free educational materials) and to trainings
- **MDHHS Clearinghouse** – www.healthymichigan.com
  - Order free brochures, posters, decals and dvds
- **MDHHS Infant Health Unit**
  - Request trainings/presentations; assistance with program development; questions
  - Contact: Patti Kelly, Infant Safe Sleep Program Coordinator, kellyp2@michigan.gov or 517-335-5911
- **Michigan Public Health Institute (MPHI)**
  - Fact sheets for Michigan and many counties
  - Contact Lindsay Gross: lgross@mphi.org or 517-324-7340
- **MPHI learning network** - https://courses.mihealth.org/PUBLIC
  - Two online courses – "Infant Safe Sleep for Health Care Providers" offers free social work, nursing & CHES continuing ed; "Infant Safe Sleep for Child Care Providers"

State bereavement resources

- **Available for families who experience miscarriage, stillbirth and infant death**
- **MDHHS Infant Health Unit**
  - Contact Susanna Joy, Infant Health Consultant, FIMR Coordinator, joys@michigan.gov or 517-335-9017
- **Written materials, phone support and connection with community resources and support groups**
  - Complete "Grief Support Referral Form"
  - Submit to Dr. John Canine at Maximum Living Services
- **MPHI learning network** - https://courses.mihealth.org/PUBLIC
  - Online course "Grief: Supporting Families after Miscarriage, Stillbirth, and Infant Death"; offers free social work and nursing continuing ed.

Michigan Medicaid Update

September, 2016

MDHHS Michigan Department of Health and Human Services

Approved Medicaid Policy 2016

New Form for Prior Authorization of Practitioner Services (MSA 16-15)

- Special practitioner services that require prior authorization such as surgeries, clinical procedures, office-administered pharmaceuticals or biologicals, and out-of-state care require submission of the completed Practitioner Special Services Prior Approval – Request/Authorization Form (MSA-6544-B) and supportive medical documentation.
- The form may be retrieved from the MDHHS website at www.michigan.gov/medicaidproviders>>Policy and Forms>>Forms.

Approved Medicaid Policy 2016

Enrollment of Marriage and Family Therapists as Medicaid Providers (MSA 16-14)

- Effective July 1, 2016, fully-licensed marriage and family therapists are eligible to enroll as Medicaid providers.

Approved Medicaid Policy 2016

Diabetes Self Management Education Policy Changes (MSA 16-29)

- MDHHS covers Diabetes Self-Management Education services in the outpatient hospital or local health department setting for a beneficiary who has been diagnosed with diabetes.

- Effective October 1, 2016, there are changes to the coverage of DSME services.
  - Please refer to the policy for details related to program requirements, billing and reimbursement, and copays and deductibles.

Approved Medicaid Policy 2016

Fee-for-Service Medicaid Transportation Rate and Policy Updates (MSA 16-25)

- Why would this apply?
  - Any and all adjustments to MDHHS Non-emergency medical transportation (NEMT) personal mileage rates are applicable to MIHP providers providing services to Fee-for-Service beneficiaries. Medicaid Health Plans may develop their own requirements which may differ from Fee-for-Service Medicaid.
- Why the change?
  - Aligns with the decrease in the 2016 IRS standard mileage rates
  - FFS NEMT mileage rates align with IRS standard rates to avoid tax implications for providers

Database

www.michigan.gov/medicalproviders>>Billing and Reimbursement>>Provider Specific Information

Proposed Medicaid Policy 2016

Changes in the Administration of MIHP services for Individuals Enrolled in a Medicaid Health Plan (1611-MIHP)

- Effective January 1, 2017. MIHP benefits for beneficiaries enrolled in a Medicaid health plan will be coordinated and reimbursed by that health plan. MIHPs will need to contract with individual health plans to receive payment for services.
- There are no changes in the administration of MIHP benefits to the FFS population.
- *Public comment period ends September 20, 2016.*

Welcome to the new MIHP Medicaid Policy Specialist, Elizabeth Campbell!

Thank you!

Lisa DiLernia
dilernial@michigan.gov

OVERVIEW OF MEDICAID BEHAVIORAL HEALTH SERVICES

INCLUDING infant mental health model/practice

MIHP Coordinators
September 15, 2016

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES ADMINISTRATION AND CHILDREN'S SERVICES AGENCY

Today's Presentation

- Our system today: Priority Populations, Medicaid
- Specialty Services and Supports
- Home-based Services and Prevention-Direct Service Models (Infant Mental Health)
- The IMH Model/Practice
- Referring a MIHP beneficiary to CMHSP

Values of the Behavioral Health System for Children, Youth and their Families

- System of Care Values
- Collaboration with other Child Serving Systems
- Family Driven and Youth Guided Policy and Practice
- Outcomes Driven

The Behavioral Health System Today

- MDHHS contracts with PIHPs for Medicaid Services to children with serious emotional disturbance (SED), adults with serious mental illness (SMI), children and adults with intellectual/developmental disabilities and children and adults with substance use disorders.
- Each region is required to have a comprehensive array of services that maximizes choice.

Priority Populations for PIHP/CMHSP

- Persons with serious mental illness, serious emotional disturbance, intellectual/ developmental disability or addictive disorders
- Persons with Medicaid
- Persons who meet the qualifications above that are underinsured
- Must meet Medical Necessity Criteria outlined in the Michigan Medicaid Provider Manual

Medical Necessity Criteria

To obtain Medicaid covered specialty services and supports, the beneficiary must meet the medical necessity criteria:

Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of services.

Specialty Services and Supports

Mental Health Specialty Services and Supports for Children and Youth

The following array of CMHSP/PIHP specialty services and supports include, but not limited to:

- Community Psychiatric Hospitalization
- Child and Family Therapy
- Home-based Services
- Respite Services
- Wraparound Services
- Prevention Direct Services Models--Infant Mental Health

Specialty Services and Supports--continued

- Community Living Supports
- Family Skill Development
- Family Support and Training
- Parent Support Partners and Youth Peer Support
- Medication Management/Psychiatric Evaluation
- Case Management and Supports Coordination
- Parent Education

Specialty Services and Supports--Home-based Services, birth-3 yrs.

- **Home-based Services** (required)

ELIGIBILITY CRITERIA, Per Medicaid Provider Manual
The criteria for home-based services are described below for children birth through age three, ….. **These criteria do not preclude the provision of home-based services to an adult beneficiary who is a parent for whom it is determined home-based services would be the treatment modality that would best meet the needs of the adult beneficiary and the child**. This would include a parent who has a diagnosis within the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) that results in a care-giving environment that places the child at-risk for serious emotional disturbance. These criteria do not preclude the provision of home-based services when it is determined through a person-centered, family-driven and youth-guided planning process that these services are necessary to meet the needs of the child and family.

Specialty Services and Supports-- Prevention-Direct Service Models

- **Prevention-Direct Service Models**
  Prevention-direct service models are programs using individual, family and group interventions designed to reduce the incidence of behavioral, emotional or cognitive dysfunction, thus reducing the need for individuals to seek treatment through the public mental health system. One or more of the following direct prevention models must be made available by the PIHP or its provider network:
  - Child Care Expulsion Prevention
  - School Success Programs
  - Children of Adults with Mental Illness/Integrated Services
  - **Infant Mental Health** when not enrolled as a Home-Based program
  - Parent Education

Specialty Services and Supports-- Prevention Direct Service Models

- **Infant Mental Health**
  Provides home-based parent-infant support and intervention services to families where the parent's condition and life circumstances, or the characteristics of the infant, threaten the parent-infant attachment and the consequent social, emotional, behavioral and cognitive development of the infant. Services reduce the incidence and prevalence of abuse, neglect, developmental delay, behavioral and emotional disorder. PIHPs or their provider networks may provide infant mental health services as a specific service when it is not part of a Department certified home-based program.

Infant Mental Health Model

Infant Mental Health Model

- Goals
  - To promote positive parent-infant interactions and healthy infant development.
  - To reduce the incidence and prevalence of abuse, neglect, developmental delay, and social-emotional-behavioral disorders.
- Service Population Characteristics
  - Families in which the parent's condition and life circumstances or the characteristics of the infant threaten the parent-infant attachment and the consequent social, emotional, behavioral and cognitive development of the infant.

Infant Mental Health Model

- Infants may be:
  Premature, underweight, failing to gain, failing to thrive, medically compromised, chronically ill, constitutionally fragile, and temperamentally difficult to care for, irritable, inconsolable, experiencing regulatory disturbances, unresponsive, listless, depressed or hypersensitive, highly active, difficult to care for.
- Toddlers may have:
  Regulatory disturbances (sleep, eating, emotional response), sensory processing difficulties, behavioral difficulties (tantrums, biting), suspected or confirmed developmental delays, identified disabilities, disorders or disturbances.
- Parents may be:
  Adolescent, impoverished, undereducated, unemployed, substance abusing, depressed, stressed, experiencing marital conflicts with histories of unresolved losses that affect their parenting abilities.

Infant Mental Health Model

Characteristics of IMH Services:

- Parent-infant support and intervention services are provided in the home
- Needs of the infant and other young children in the family and the mental health needs of the mother are addressed

Services are:

- Comprehensive and intensive (weekly or more often during crisis)
- Affirming and strengths based
- Flexible and individualized

Infant Mental Health Model

IMH Service Components (1)

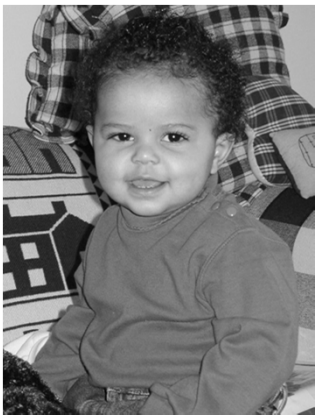
- Concrete Assistance (food, formula, medical care, housing, etc.)
- Emotional Support (to families facing immediate crises to reduce family/parental stress)
- Developmental Guidance (information that is specific to the baby's development and needs for care)
- Early Relationship Assessment and Support (relationship with practitioner is used to nurture, protect, steady and enhance the parents' understanding of their infant)
- Advocacy (speaking for those that cannot—infants and/or parents; negotiating systems)
- Infant-Parent Psychotherapy ("exploration about parenthood and the infant-toddler's continuing needs for care")

Infant Mental Health Model

- Who Provides IMH Services in Michigan?
  - All Community Mental Health Services Programs (CMHSPs) provide Home-based services for families with infants (birth to 47 months) who meet criteria. Home-based Services clinicians use the IMH model. Providing Prevention-Direct Service Model ---Infant Mental Health is an option for CMHSPs.
  - Some Mental Health Agencies provide IMH Services with funds from sources other than Medicaid, but these services are relatively few in the state.
  - MIHP has IMH Specialists who provide limited IMH services.

Beginning the conversation…

One of the goals of this presentation is to encourage you to begin the conversation about **Home-based Services/Infant Mental Health Services** with your local CMHSP to assist with access to the service for MIHP beneficiaries, ensure coordination, and to access effective interventions for families with Medicaid. But first….



Possible Reasons for Referral…

- ***Possible Reasons for Referral to an MIHP Infant Mental Health Specialist or to CMH for an Assessment*** has been developed as a guide for MIHP professionals to help determine when referral to the MIHP Infant Mental Health Specialist or to Community Mental Health (CMH) for a behavioral health assessment is indicated.
- Possible reasons for referral for an assessment are categorized under the headings of *During Pregnancy* and *After Birth of Infant*.

Possible Reasons for Referral….

- MIHP professionals may conclude that one or more of the reasons listed apply to a woman/infant based on information obtained through administration of the *MIHP Maternal and Infant Risk Identifiers* (including perinatal depression or ASQ-SE screening), subsequent conversations with the pregnant woman/mother, or observations of mother-infant interactions.
- Referral for an assessment does not replace the need to implement MIHP interventions.

Working with your CMHSP

- Do you have a relationship with an CMHSP Supervisor of Home-based Services or Infant Mental Health Services or the Access Center Staff that you can discuss the "reasons for referral" for a particular woman? A woman with an infant?
  - Please remember to discuss if you have completed a screen (maternal depression, social-emotional screen for the infant) and the outcome of the screen.
  - Ask their assistance with the CMHSP Access Center/access process for your beneficiary.

Advocating for an MIHP Beneficiary

- If referring for a woman (pregnant, or with an infant) for access to mental health services, you will need to advocate for involvement in Infant Mental Health Services (or Home-based Services). The access center will be assessing for adult or child mental health services, traditionally.
- Don't assume that the access center will inquire about the adult's ability to parent or need to address their attachment/interaction with their infant/toddler.

Advocating for an MIHP Beneficiary

- Just remember…..if you go to a cardiologist, they don't always ask about your digestive issues or respond if you bring them up. Likewise, you—the MIHP provider—need to advocate for the mental health service(s) that address both the infant's and the parent's mental health needs.
- Please be advised that a beneficiary can appeal a decision regarding access to the CMHSP system.

References

(1) Weatherson, Deborah J., *The Infant Mental Health Specialist*, Zero to Three, October/November 2000.

Questions

For Further Information

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Ludtkem@Michigan.g
517.241.5769

Michigan Mental Health Code

Serious Emotional Disturbance (SED) Definition

"Serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the department and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance:

(a) A substance abuse disorder.

(b) A developmental disorder.

(c) "V" codes in the diagnostic and statistical manual of mental disorders."

Criteria

The criteria for Medicaid eligibility for specialty mental health services and the framework for general fund priority for non-Medicaid children is based on the definition of serious emotional disturbance delineated in the Mental Health Code (Section 330.1100d) which includes the three dimensions of diagnosis, functional impairment and duration.

Definition of Infant-Toddler with SED, 0-3 years of age

- Diagnosis--"criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association consistent with the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition*™"
- To assist in determining functional impairment, a standardized, validated, age appropriate assessment tool is used: ***Devereux Early Childhood Assessment (Infant, Toddler, Clinical versions)***

Definition of Infant-Toddler with SED, 0-3 years of age

- Functional Impairment--Interference with, or limitation of, an infant/toddler's proficiency in performing developmentally appropriate skills as demonstrated by at least 1 indicator drawn from 2 of the following 3 functional impairment areas:

  (1) General and/or specific patterns of reoccurring behaviors or expressiveness indicating affect/modulation problems.

  (2) Behavioral patterns coupled with sensory, sensory motor, or organizational processing difficulty (homeostasis concerns) that inhibit the infant or toddler's daily adaptation and relationships.

  (3) Incapacity to obtain critical nurturing as determined through the assessment of infant/toddler, parent/caregiver and environmental characteristics.

Definition of Infant-Toddler with SED, 0-3 years of age

- Duration/History--The very young age and rapid transition of infants and toddlers through developmental stages makes consistent symptomatology over time unlikely.
  - There are indicators that a disorder is not transitory and will endure with out intervention include:
    - Disorder is affected by persistent multiple barriers to normal development;
    - Infant/toddler has been observed to exhibit the functional impairments for more days than not for a minimum of 2 weeks;

    or

    - An infant has experienced a traumatic event.

Diabetes and Pregnancy

KIM LOMBARD, MS, RD, CDE

PUBLIC HEALTH CONSULTANT

MDHHS
Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

Objectives

- Identify three types of diabetes
- Understand differences in pre-existing/pre-gestational and gestational diabetes
- Identify the potential impact of diabetes in pregnancy
- Verbalize action steps post-delivery

Types of diabetes

image source: http://www.pixabay.com

Type 1 Diabetes

- 5-10%
- Typically diagnosed in children
- Can be diagnosed at any age
- Lack of or near lack of insulin production
- Beta cells of the pancreas are damaged

Type 2 Diabetes

- 90-95%
- Typically diagnosed in adults
- Characterized by insulin resistance
- Several risk factors

Gestational Diabetes (GDM)

- Glucose intolerance identified in the second or third trimester
- 5% of women develop GDM

What is NOT Gestational Diabetes

- Women with pre-existing/pre-gestational diabetes
- Diabetes diagnosed in the first trimester
- High blood glucose after delivery

Diagnosing diabetes in pregnancy

- Test for undiagnosed T2 at first prenatal visit for those with risk factors
- Testing recommended at 24-28 weeks for gestational
- One of two methods recommended
  - 1-step
  - 2-step

1-Step

- Used for women with no known prior diabetes
- OGTT
  - Fasting
  - 1-hour
  - 2-hour
- 1 failed step is a diagnosis
- Must be fasting for test

2-Step Process

- Glucose load given
  - Step 1 - 1 hour post prandial check
  - Step 2 – 3-hour post prandial tested with larger glucose load if Step 1failed
  - No fasting required

Pre-existing/Pre-gestational Diabetes

- Diagnosis in first trimester OR
- Known T1 or T2 prior
- Preconception counseling extremely important
- Early pregnancy
  - Early pg creates more insulin sensitivity
  - Reverses rapidly in 2nd and early 3rd trimester
  - Treatment adjustments needed

Monitoring and Targets

- Pre- and postprandial glucose monitoring critical
- Specific targets for pre-existing vs GDM

Targets

Pre-existing*

- Fasting ≤ 90 mg/dL
- 1-hour postprandial ≤ 130-140 mg/dL
- 2-hour postprandial ≤ 120 mg/dL

- *If they can be achieved safely

Gestational

- Fasting ≤ 95 mg/dL and either
- 1-hour postprandial ≤140 mg/dL or
- 2-hour postprandial ≤ 120 mg/dL

- Depending on the population, studies suggest GDM can be controlled with lifestyle modification alone in 70-85% of women

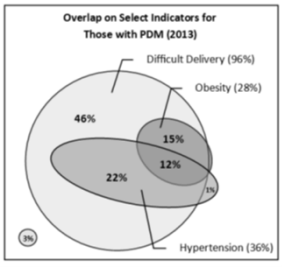
Diabetes impact

WHY DO WE CARE…

Prevalence

- Prevalence is increasing
  - MI – 1:10
- Cost of caring for diabetes increasing
  - Nationally $636 million spent on GDM alone

Michigan Medicaid – delivery data



http://www.michigan.gov/documents/mdch/Medicaid-Diabetes-In-Pregnancy-2014_476583_7.pdf

Risks of diabetes and pregnancy

image source: http://www.pixabay.com

Risks

- Larger than normal babies
  - Difficult delivery
  - Higher risk of vaginal tearing
  - Higher risk of bleeding
  - Higher C-section risk
- Pre-existing/pre-gestational
  - Birth defects
  - Miscarriages
  - preeclampsia

Impact on baby?

- Immediate and future impact
- Hypoglycemia
- Shoulder dislocation
- Future diabetes risk – T1 and T2
- Hypothesis – impact on hypothalamus

Treatment options

Diabetes Self-Management Education

- Collaboration of healthcare disciplines
- A critical element of care for all people with diabetes
- Necessary to improve patient outcomes
- Helps patients gain knowledge and skills to self-manage their disease
- Four critical times for referral

Treatment Options - GDM

- Lifestyle modification
- Pharmacological treatment
  - Insulin is preferred
  - Role of metformin and glyburide

Treatment Options Pre-existing

- T1
  - Insulin is preferred
- T2
  - Insulin is preferred if lifestyle change and metformin not effective

Postpartum Care

- Breastfeeding
- Follow-up
  - Future risk
  - Screening

Referrals

- Pre-existing
  - Pre-conception help for BG control
  - During pregnancy
  - Post partum
- GDM
  - Upon diagnosis
  - Potentially follow-up during pregnancy
  - Consider referring to Diabetes Prevention Program post-delivery
- ADA four critical times

Reference

- Standards of Medical Care in Diabetes - 2016
- http://care.diabetesjournals.org/content/suppl/2015/12/21/39.Supplement_1.DC2/2016-Standards-of-Care.pdf
- http://www.michigan.gov/documents/mdch/Medicaid-Diabetes-In-Pregnancy-2014_476583_7.pdf
- http://www.michigan.gov/documents/mdhhs/Diabetes-in-Michigan-Update-2015_516855_7.pdf
- DSME Impact Video: https://www.youtube.com/watch?v=3HdWDTYFDkc
- Powers, M., et al (2015). Diabetes Self-management Education and Support in Type 2 diabetes. *The Diabetes EDUCATOR*, *Xx*(X). Retrieved from https://www.diabeteseducator.org/docs/default-source/practice/practice-resources/position-statements/dsme_joint_position_statement_2015.pdf?sfvrsn=0.

Thank you!