



Michigan Department of Health & Human Services

Michigan Medicaid Program Policy Updates

June 2018

Presentation Objectives

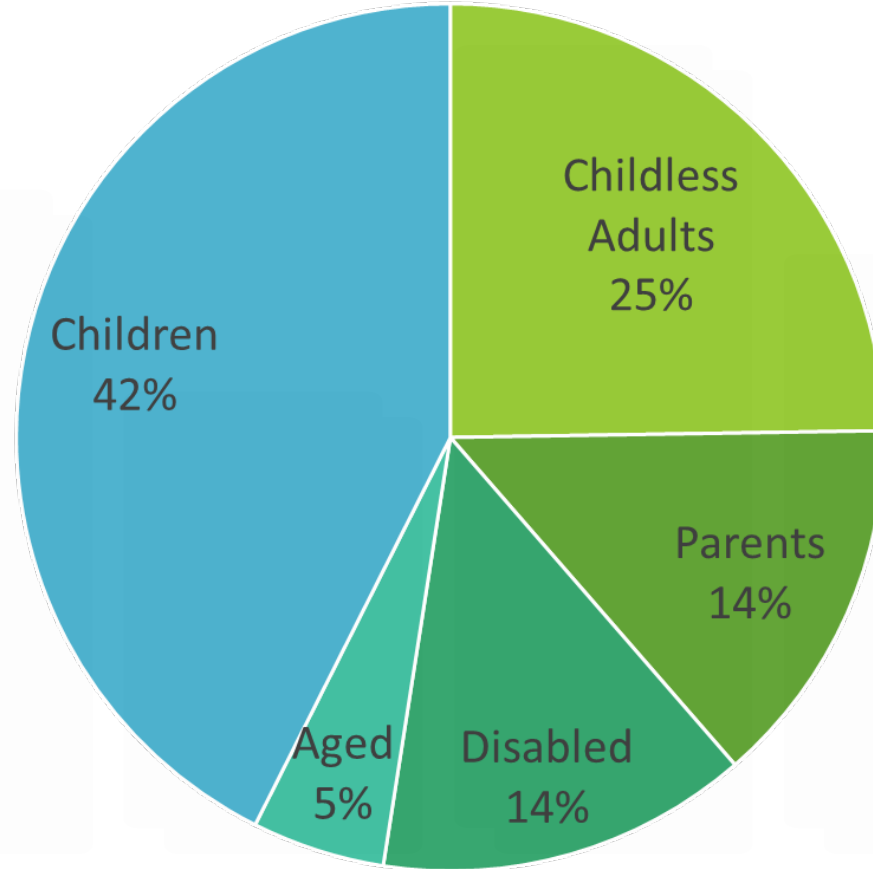
- Medicaid Program Population
- Policy Promulgation and Updates
- Program Resources

Medicaid Eligible Population

Michigan Medicaid covers many different populations, including:

- 1.2 million children
- 680,000 receive health care under the Healthy Michigan Plan
- 150,000 Michigan seniors get their health care through Medicaid
- 340,000 people with disabilities receive the care and support they need to live independently
- Nearly 50% of the births in Michigan covered

Michigan Medicaid Population



Michigan Medicaid Eligible Beneficiaries May 2018: 2,522,050

Medicaid Policy Process

- MDHHS issues notices of proposed changes to Michigan Medicaid policy.
- Proposed policy undergoes a 30-day public comment period before it becomes final.
- Comments may be submitted electronically or by postal mail before the comment due date.
- Final Bulletins are incorporated into the Medicaid Provider Manual quarterly.

Medicaid Policy

FAQs

Contact Us

MDHHS Home

 MI.gov



Michigan Department of Health & Human Services

Assistance Programs

Adult & Children's Services

Safety & Injury Prevention

Keeping Michigan Healthy

Doing Business with MDHHS

Inside MDHHS

Doing Business with MDHHS

Birth, Death, Marriage and Divorce Records

Boards and Commissions

Bridge Card Participation

Child & Adult Provider Payments

Child Care Fund

Child Welfare

Contractor Resources

Community & Faith-Based Initiative

Forms & Applications

MIBridges Partners

Health Care Providers

Certificate of Need

Civil Monetary Penalty (CMP) Grant Program

Community Mental Health Services

Departmental Forms

Health Professional

MDHHS / DOING BUSINESS WITH MDHHS / HEALTH CARE PROVIDERS

Policy, Letters and Forms



Medicaid Provider Manual

The Medicaid Provider Manual contains participation coverage and reimbursement policies related to Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, and other healthcare delivery programs administered by the Michigan Department of Health and Human Services.



MAGI Related Eligibility Policy Manual

The MAGI Related Eligibility Policy Manual contains modified adjusted gross income (MAGI) related eligibility policy used for determining financial eligibility for various programs administered by the Michigan Department of Health and Human Services.



Michigan Medicaid Approved Policy Bulletins

The Michigan Department of Health and Human Services periodically issues notices of policy. These documents inform providers of changes in Michigan Medicaid policy.

2018

2017

2016

2015

2014

2013

2012

2011

2010

2009

2008

2007

2006

2005

2004

2003

2002

11/2000-12/2001



Michigan Medicaid Proposed Policy

These documents inform interested parties of proposed changes in Michigan Medicaid policy. Proposed new policy and changes to existing policy must undergo a public comment period before becoming final.

Numbered Letters

Numbered letters are utilized to communicate new developments, information, policy clarifications, etc.



Forms


Michigan Department of Health & Human Services

6

Medicaid Policy - Proposed

Proposed Policy: 1806-Hospital

Inpatient LARC Device Reimbursement
Comments until June 21, 2018

Proposed Policy: 1807-BHDDA

Opioid Health Home Pilot Program
Comments until June 26, 2018

Medicaid Policy Updates

Laboratory Reimbursement Rates Updated

- MSA 18-11 - Effective July 1, 2018
- Aligning with the Medicare Clinical Laboratory Fee Schedule

Expanded Access to Dental Benefits for Pregnant Women

- MSA 18-18 - Effective July 1, 2018
- For Medicaid Health Plan enrolled pregnant women eligible for a FFS dental benefit, their dental services will be covered by their Medicaid Health Plan

Medicaid Program Updates

Healthy Michigan Plan Updates

- Waiver Renewal
- MI Marketplace Option
- Workforce Engagement Requirements



Medicaid Program Resources

[FAQs](#) [Contact Us](#) [MDHHS Home](#) [MI.gov](#)


Michigan Department of Health & Human Services

[Assistance Programs](#) [Adult & Children's Services](#) [Safety & Injury Prevention](#) [Keeping Michigan Healthy](#) [Doing Business with MDHHS](#) [Inside MDHHS](#)

[Assistance Programs](#)
[Cash Assistance](#)
[Child Care Assistance](#)
[Children's Special Health Care Services](#)
[Emergency Relief: Home, Utilities & Burial](#)
[Food Assistance](#)
[Health Care Coverage](#)
[Help from Other Programs](#)
[Medicaid](#)
[Migrant Services](#)
[Refugee Assistance](#)
[Women, Infants & Children](#)

MDHHS / ASSISTANCE PROGRAMS / MEDICAID

Michigan Medicaid Program - www.michigan.gov/medicaid
Welcome to Michigan Medicaid. This site contains information for:

- **Individuals** - People looking to apply for benefits, learn more about Medicaid programs, or find help
- **Providers** - Health care providers who are enrolled with Medicaid or would like to enroll and need more information about billing, Medicaid programs, and help resources
- **Reports** - People looking for reports about Medicaid programs
- **Program Resources** - People who want general information about Medicaid programs which includes federal and state resources


Individuals


Providers


Reports


Program Resources

Medicaid Program Resources

PROVIDER SUPPORT HELPLINE: 1-800-292-2550
providersupport@michigan.gov

PROVIDER ENROLLMENT: 517-335-5492
providerenrollment@michigan.gov

MEDICAID POLICY
msapolicy@michigan.gov

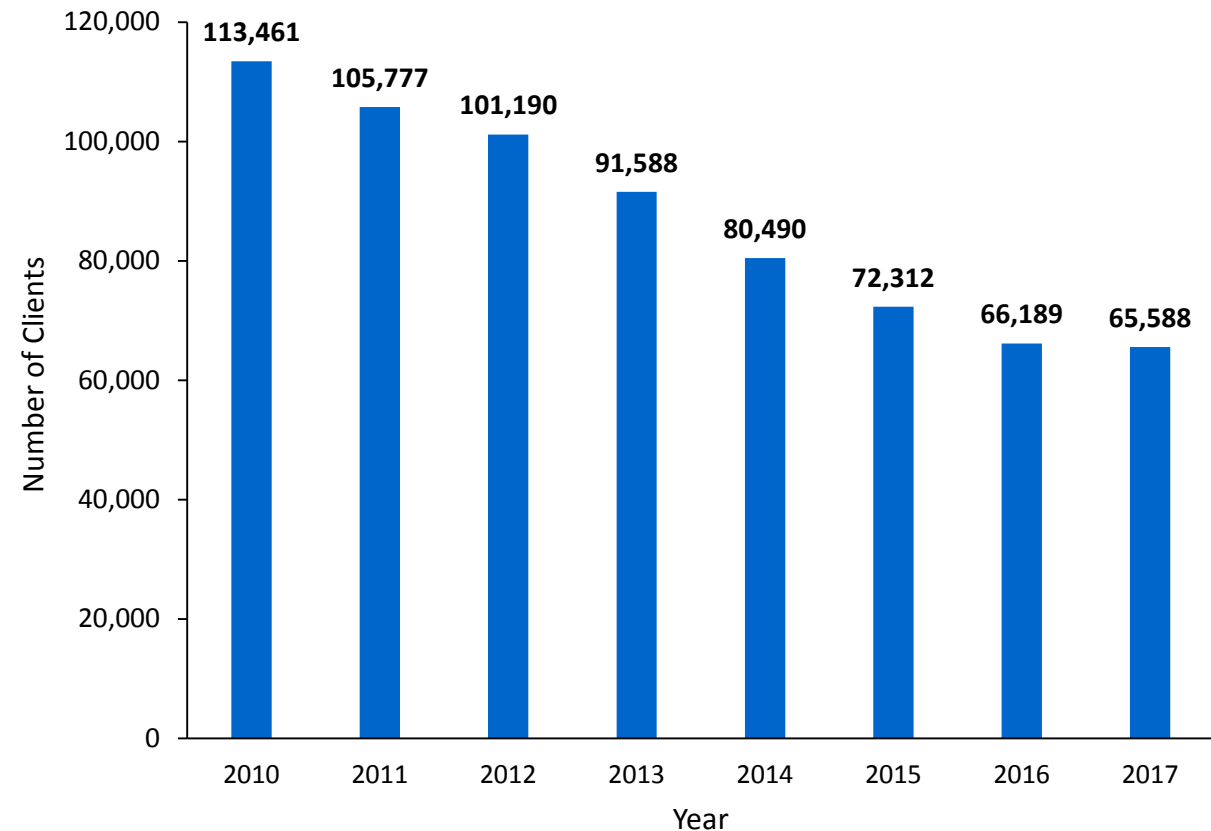
Family Planning Annual Report (FPAR) Trends (2010 – 2017)

CHELSEA ABSHIRE, MPH

FAMILY PLANNING EPIDEMIOLOGIST

Total Family Planning Clients

- The total number of clients visiting Michigan's Title X Family Planning Agencies decreased every year between 2010 and 2017.
- In fact, between 2010 and 2017, there was a 42.2% decrease (from 113,461 to 65,588) in total clients.



FPAR Reminders – User & Encounter

- Family Planning User: individual who has at least one family planning encounter at a Title X service site during the reporting period.
- Family Planning Encounter: face-to-face contact between an individual and a family planning provider and written record of services provided must be documented in client record.

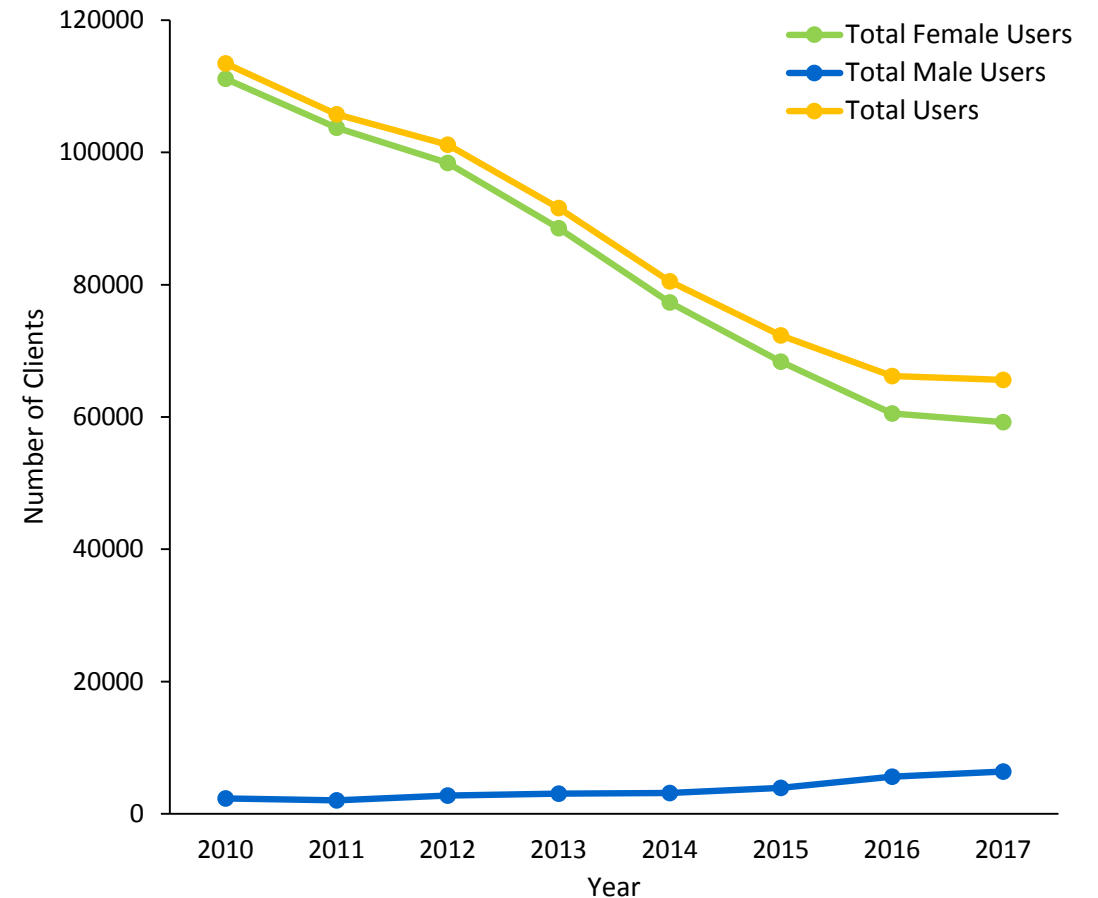
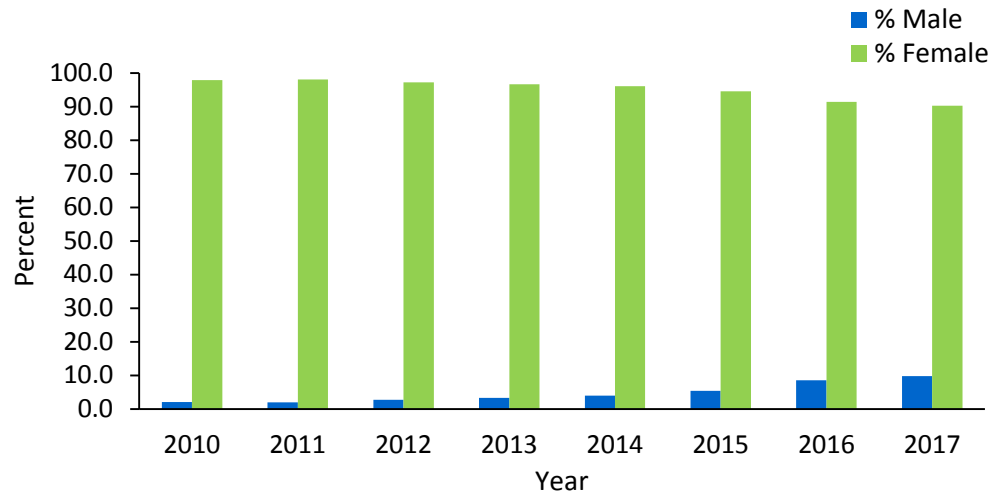
FPAR Reminders – Not FP User

Which clients do not count as a Family Planning user?

- Sterilized individuals of reproductive age who are not existing clients
- Post-menopausal clients
- New clients receiving STD services, but no counseling, education, or clinical services aimed at avoiding unintended pregnancy or achieving intended pregnancy
- New clients receiving STD services who receive condoms or counseling about using condoms but does not receive counseling, education, or clinical services aimed at avoiding an unintended pregnancy or achieving an intended pregnancy

Male vs. Female Clients

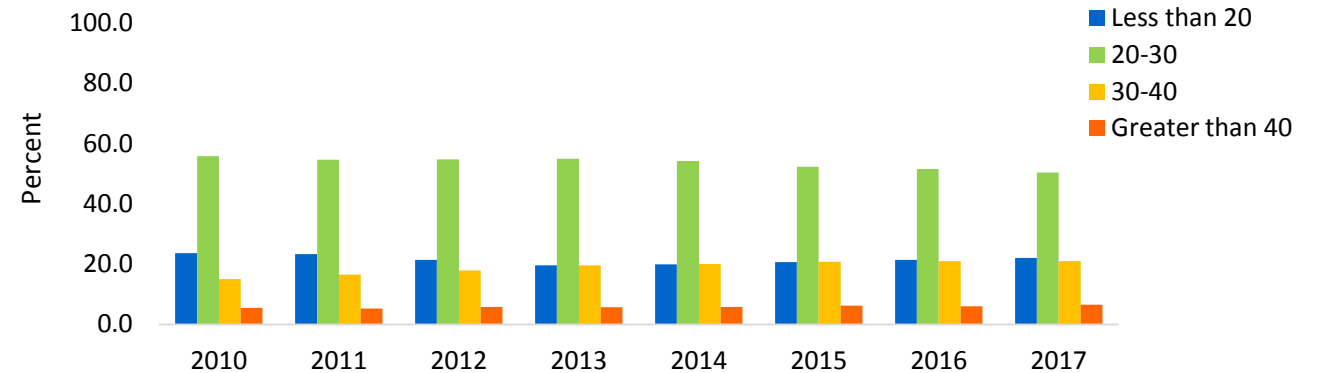
- Between 2010 and 2017, the number of female clients decreased by 46.7% (from 111,123 to 59,204) .
- Oppositely, the number of male clients increased by 173.1% (from 2,338 to 6,384).



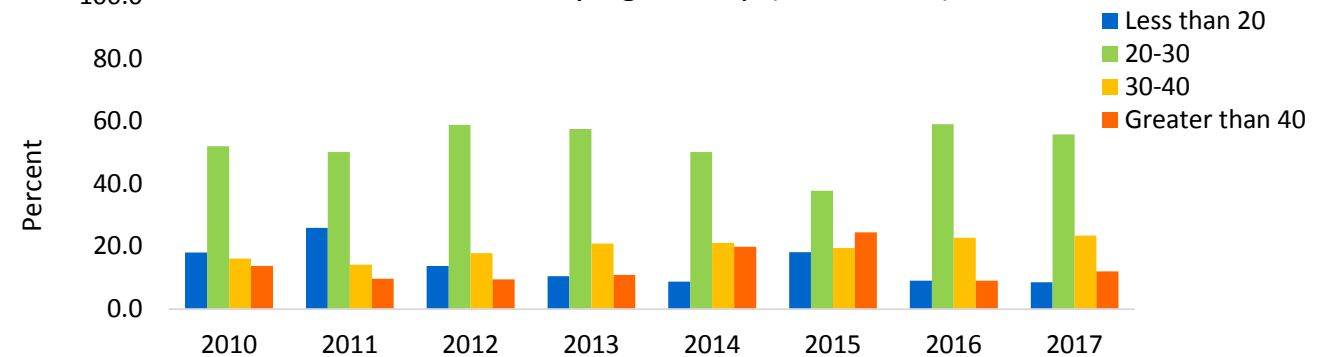
Male vs. Female Clients by Age Group

- Between 2010 and 2017, Michigan's Title X Family Planning Agencies primarily served female and male clients between 20-30 years of age.
- The second largest age group served consisted of male and female clients that were less than 20 years old.

Female Clients by Age Group (2010-2017)



Male Clients by Age Group (2010-2017)

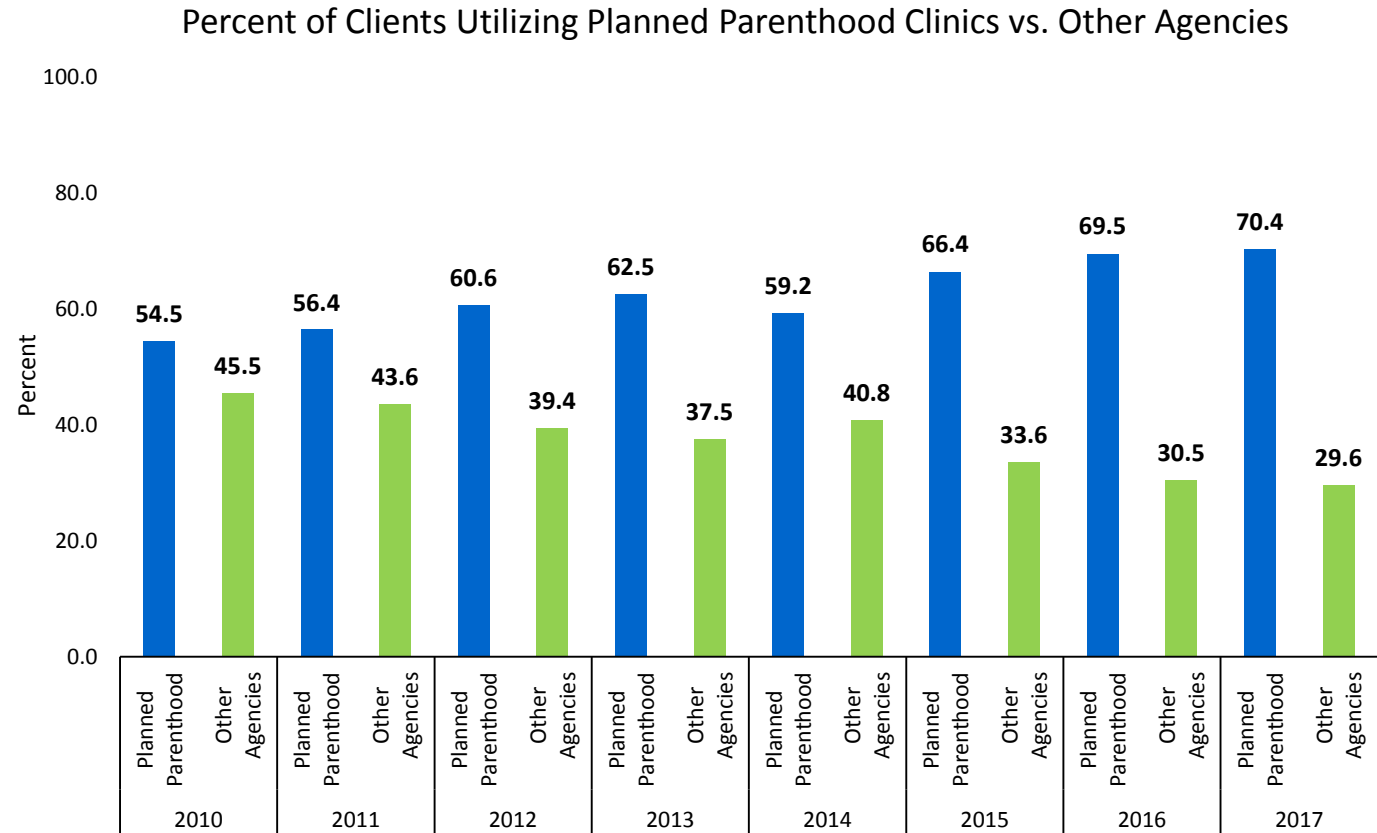


28 Select Agencies

- Bay
- Benzie-Leelanau
- Berrien
- Central Michigan DHD
- Chippewa
- Delta-Menominee
- Dickinson-Iron
- District #2
- District #4
- District #10
- Genesee
- Grand Traverse
- Huron
- Ingham
- Lenawee
- LMAS
- Macomb
- Marquette
- Midland
- Mid-Michigan
- Monroe
- Northwest MI Comm.
- Ottawa
- Planned Parenthood
- Saginaw
- Taylor
- Tuscola
- Western U.P.

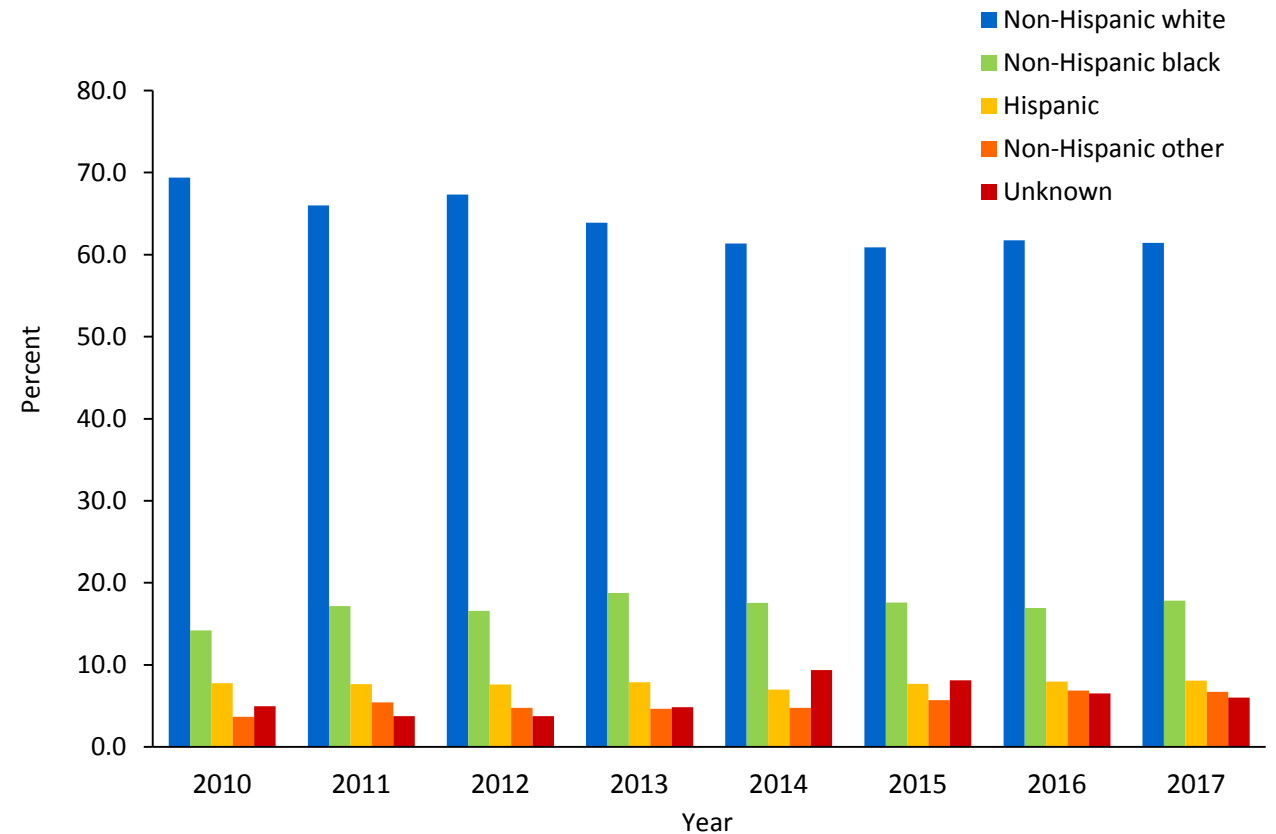
Total Clients by Agency

- Between 2010 and 2017, the agencies that served the most clients were:
 1. Planned Parenthood
 2. Saginaw
 3. Ingham
- Planned Parenthood served a greater percentage of total clients than other agencies combined for all reporting years.



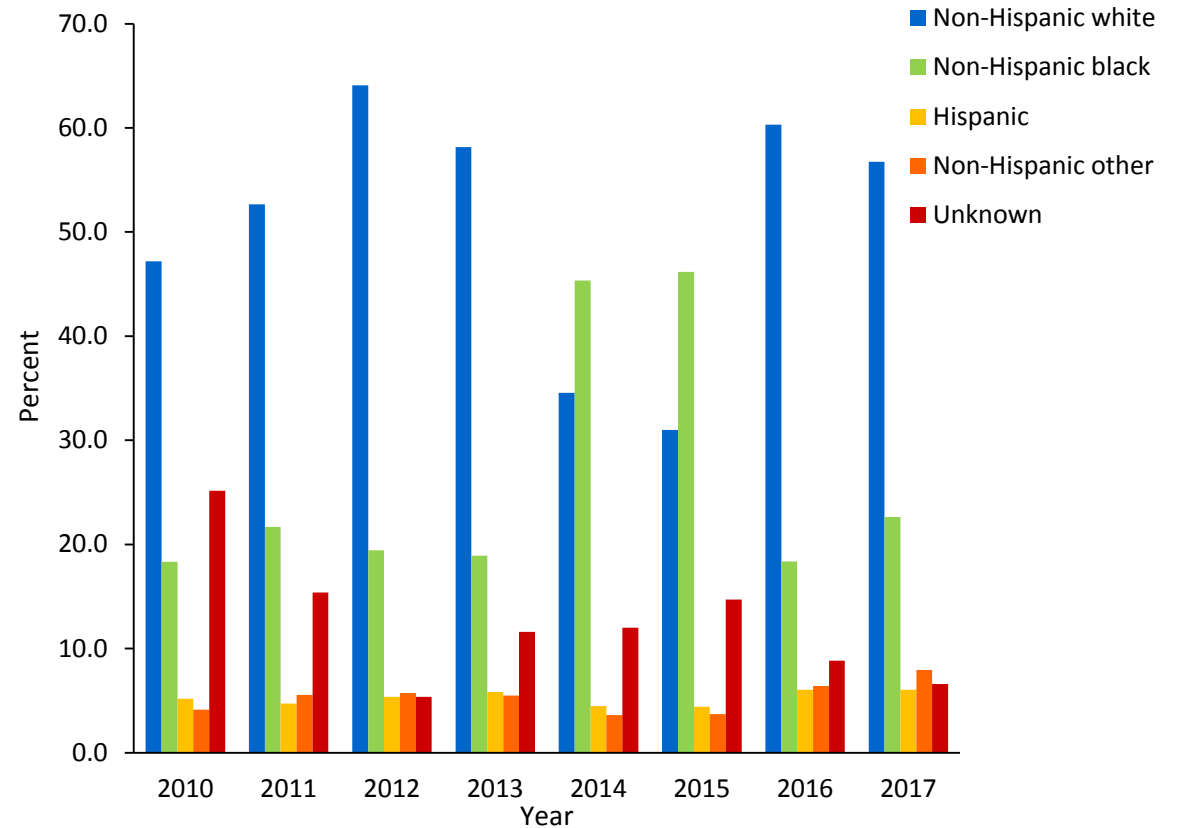
Female Clients by Race/Ethnicity

- Each year, between 60% and 69% of female clients served were non-Hispanic white.
- There was a slight increase in non-Hispanic black female clients between 2010 and 2011 from 14% to 17%, but from 2011 to 2017 the percentage stayed fairly consistent.
- The percent of Hispanic female clients stayed consistent for all years at roughly 8%.



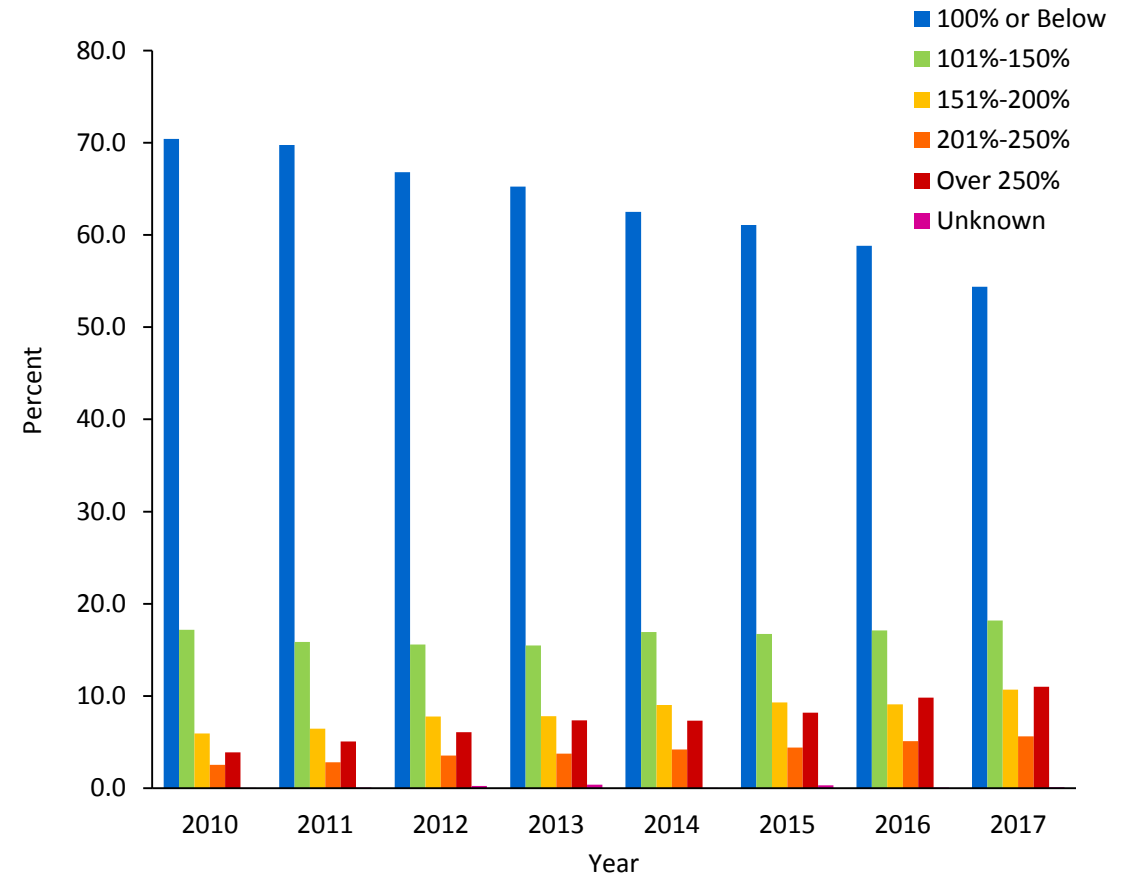
Male Clients by Race/Ethnicity

- For all years except 2014 and 2015, the majority of male clients were non-Hispanic white.
- In 2014 and 2015, the majority of male clients were non-Hispanic black.
- Between 2010 and 2017, the number of male clients of unknown race/ethnicity decreased by 28% (from 588 to 421) .



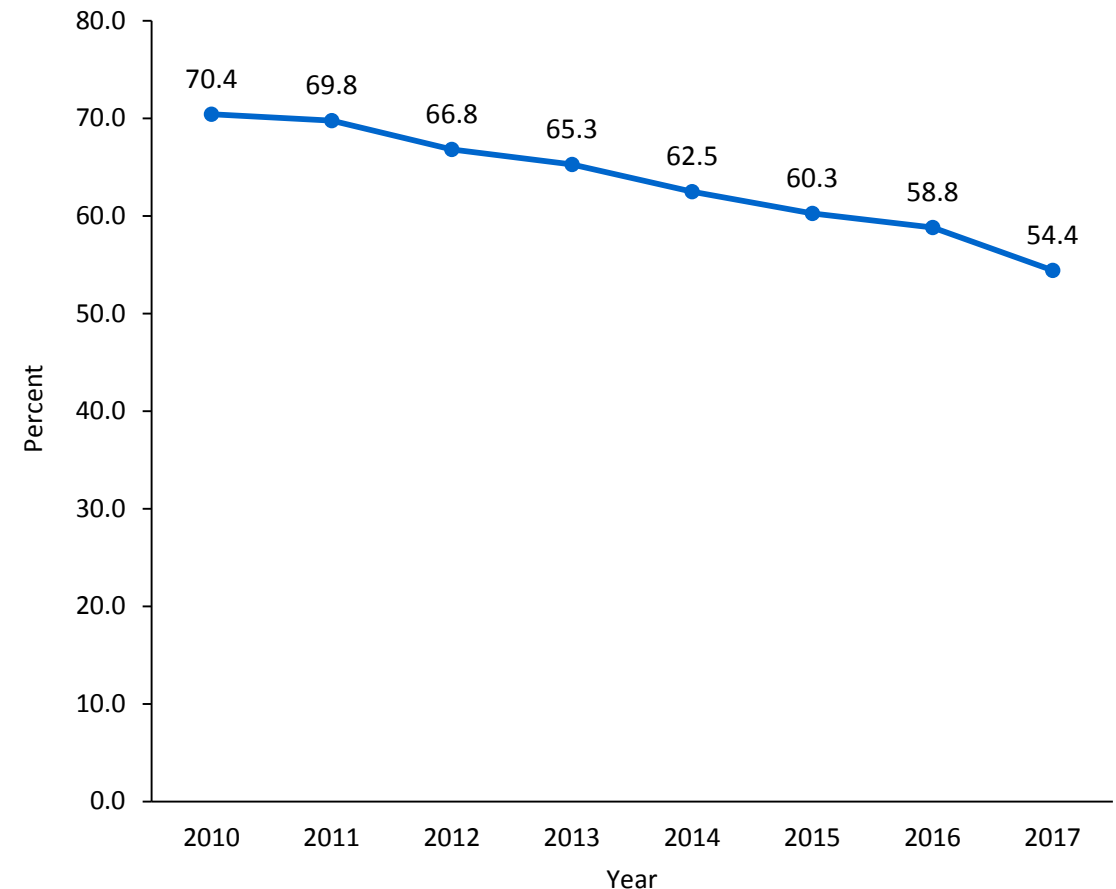
Income as Percent of the HHS Poverty Guidelines

- In 2017, 54% of clients served were at 100% or below of the HHS poverty level.
- Interestingly, the percent of clients over 250% of the HHS poverty level increased each year with a total increase of 64.4% (from 4,394 to 7,223) between 2010 and 2017.

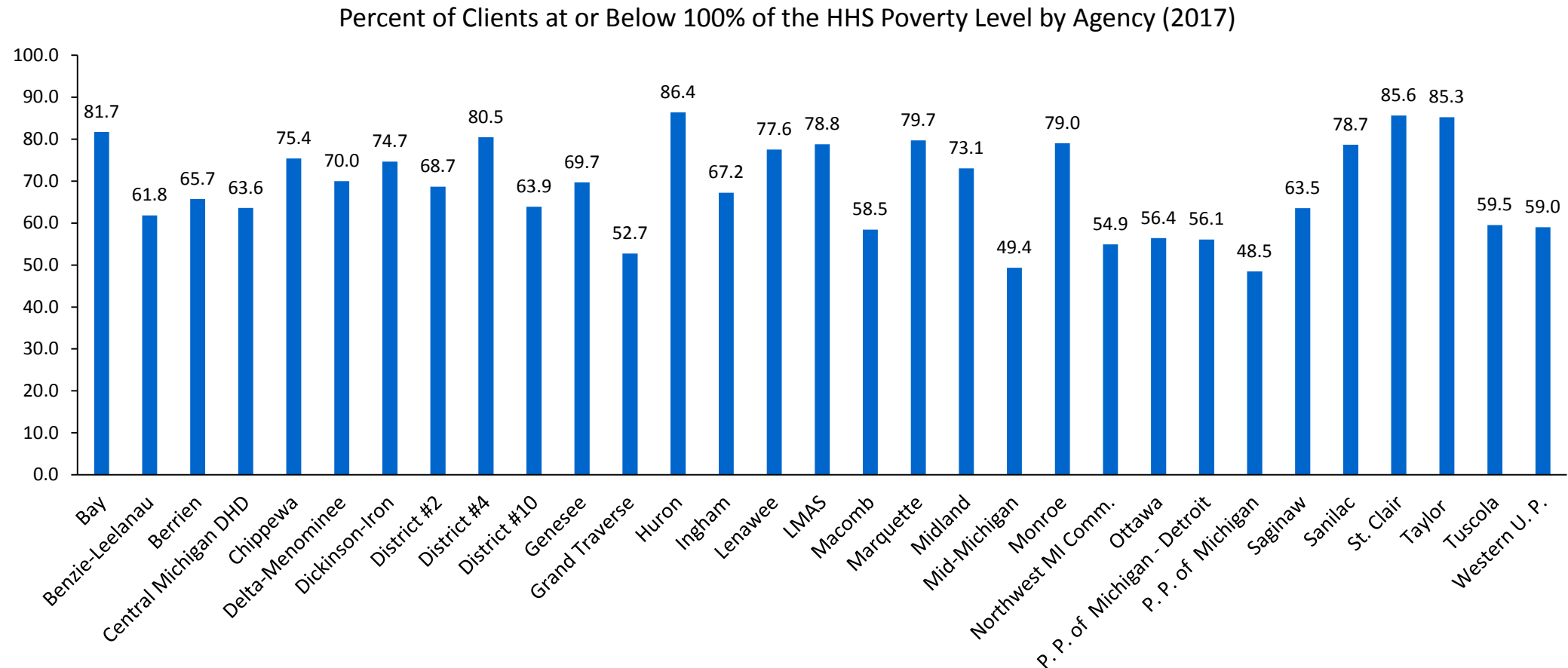


Percent of Clients at 100% and Below of the HHS Poverty Guidelines

- The percent of clients at or below 100% of the HHS poverty level decreased each year for the eight years studied.
- In fact, between 2010 and 2017, the number of clients at or below 100% of the HHS poverty level decreased by 22.7% (from 79,905 to 35,671) .

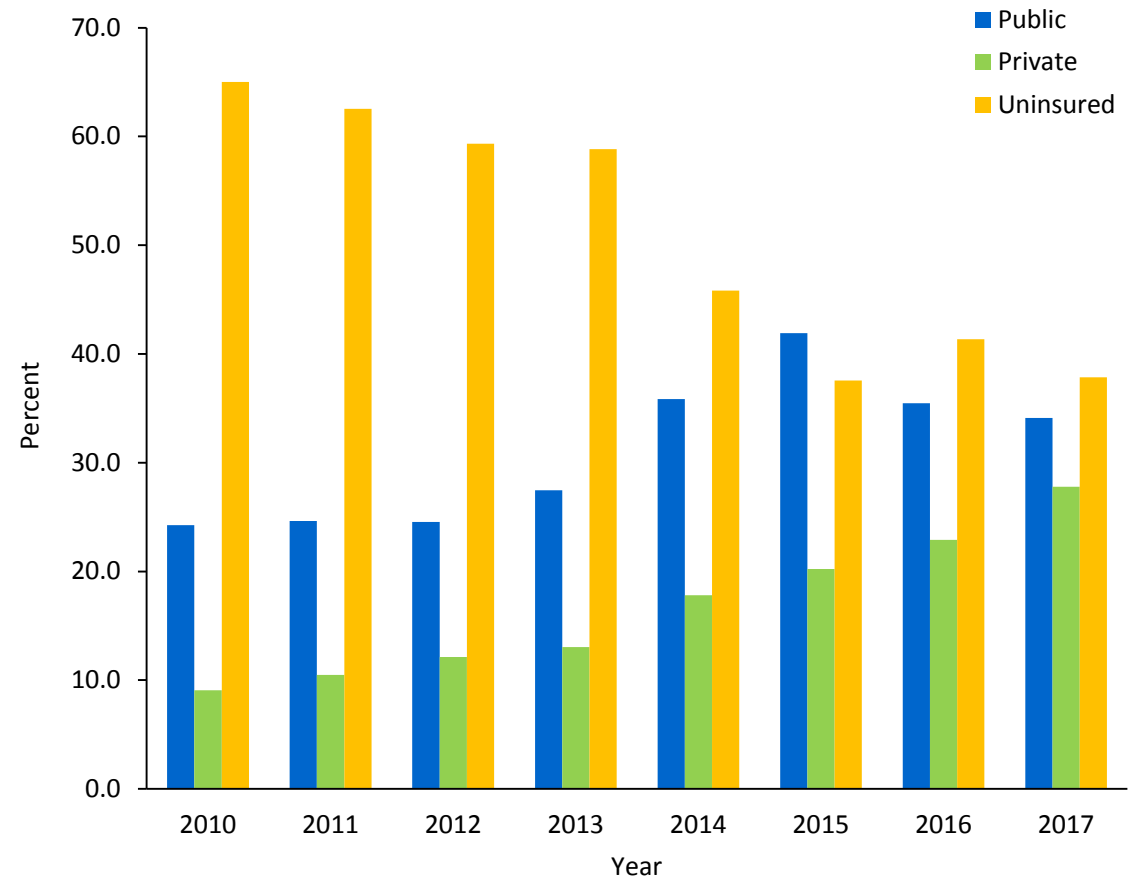


Percent of Clients at or Below 100% of the HHS Poverty Level by Agency (2017)

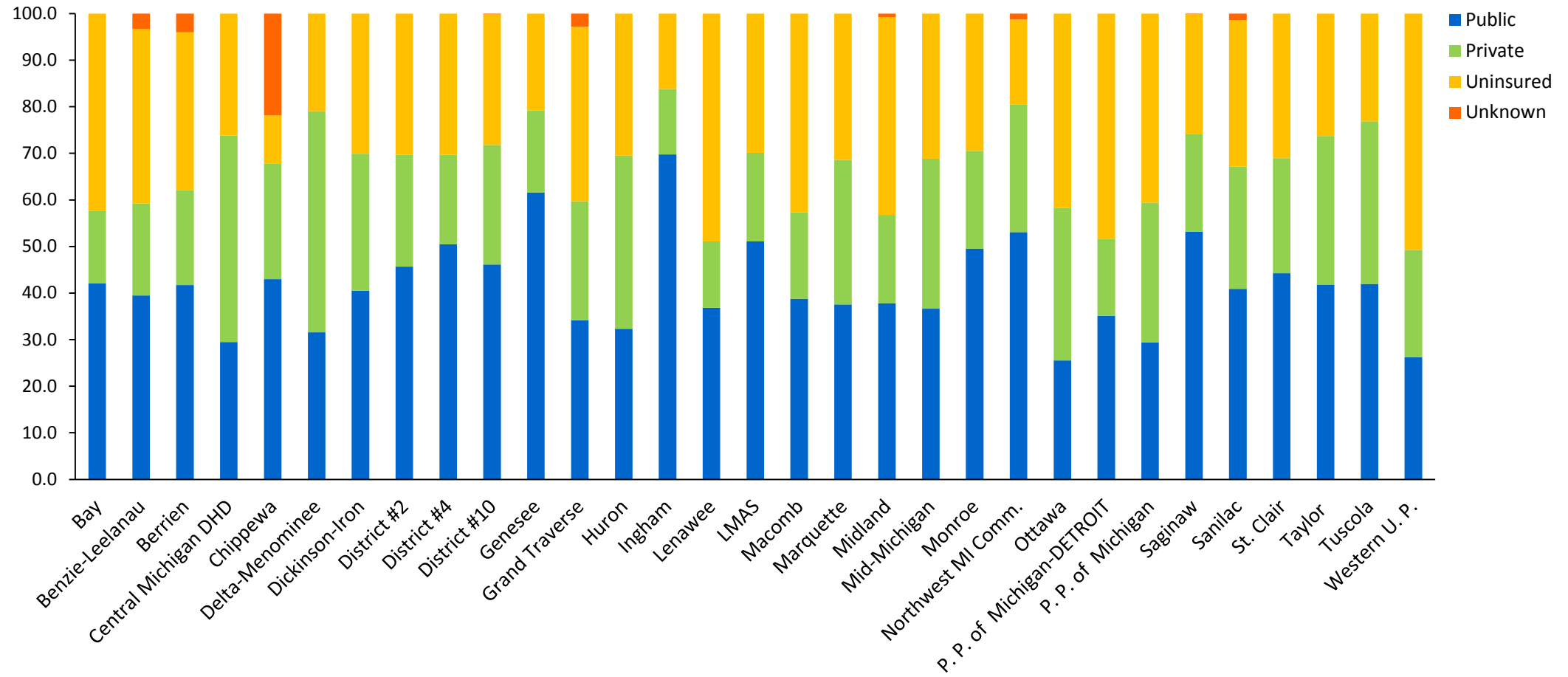


Principle Health Insurance Covering Primary Medical Care

- Between 2010 and 2017:
 - The percent of publicly insured clients increased from 24.2% to 34.1%.
 - The percent of privately insured clients increased from 9.1% to 27.8%.
 - The percent of uninsured clients decreased from 65.0% to 37.9%.



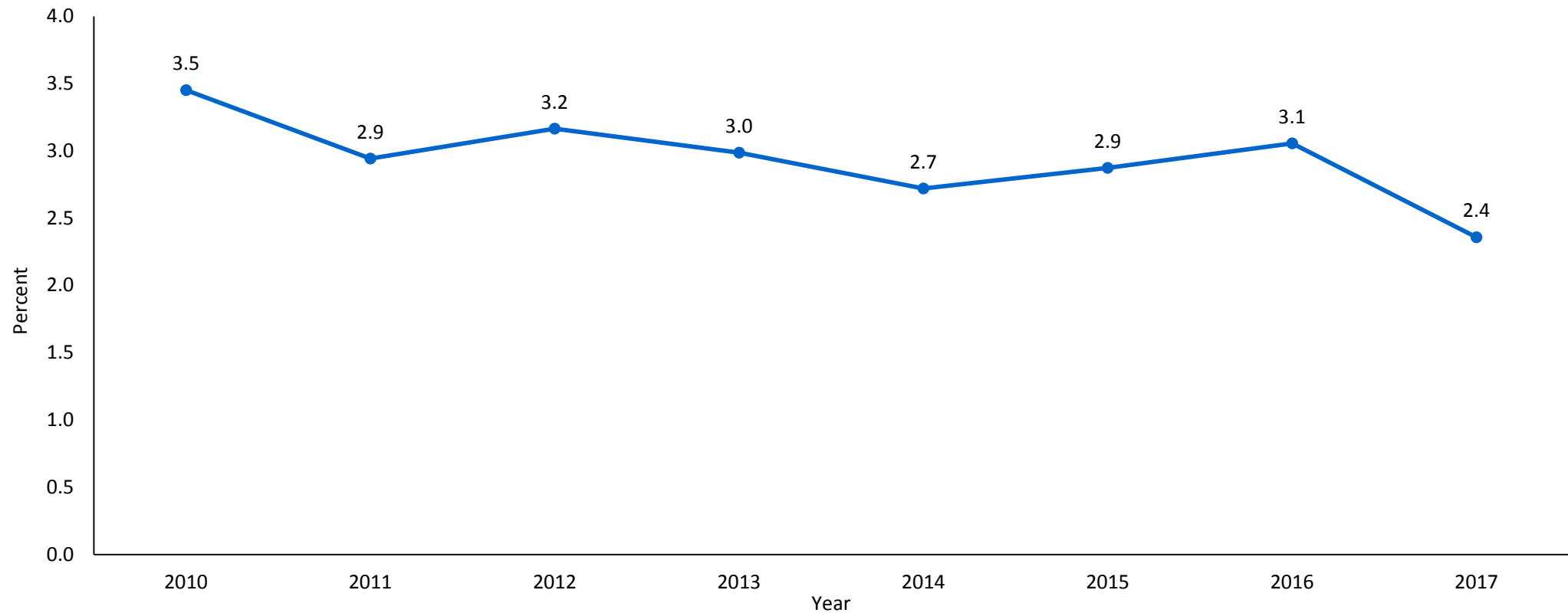
Client Health Insurance Coverage Status by Agency (2017)



FPAR Reminders – Tables 2 - 5

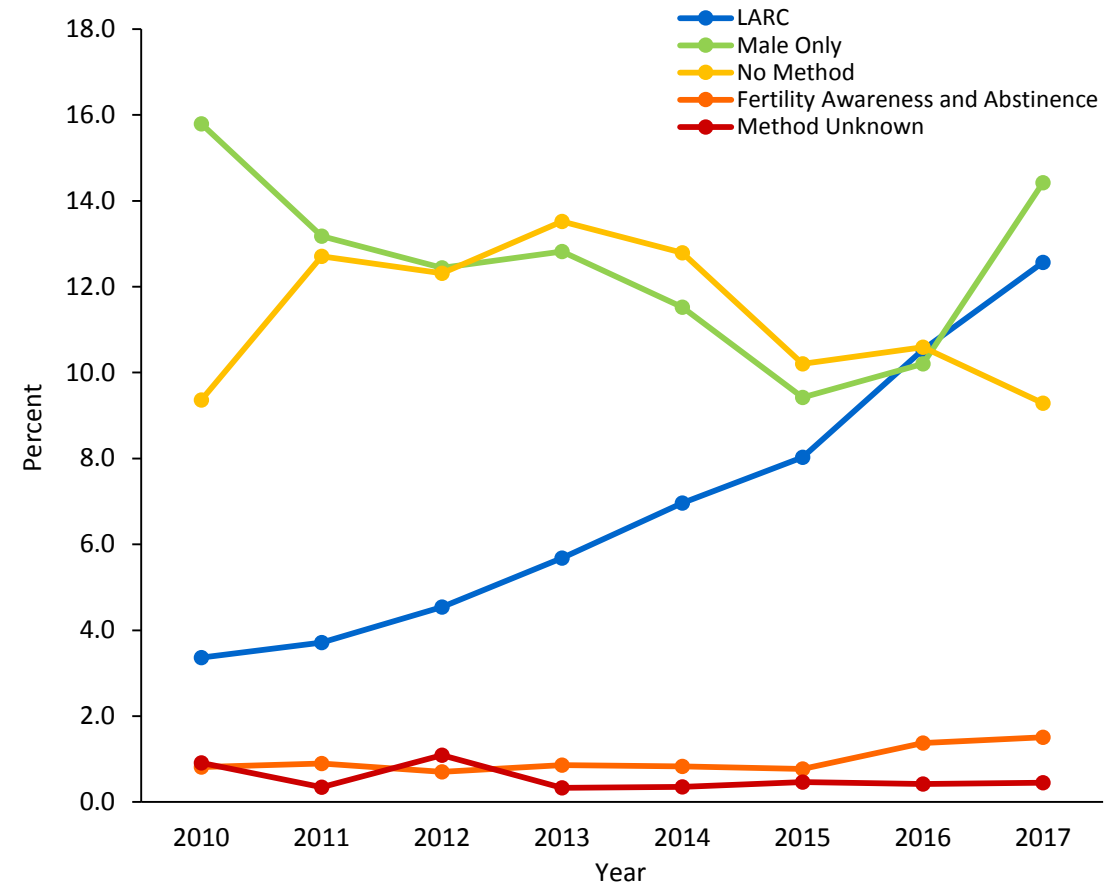
- Gender: Unknown/Not Reported needs to be $\leq 10\%$ for program overall
- Race/Ethnicity: Unknown/Not Reported needs to be $\leq 10\%$ for program overall
- Income Level: Unknown/Not Reported needs to be $\leq 5\%$ for program overall
- Insurance Status: Healthy Michigan Plans need to be recorded as public insurance, Unknown/Not Reported needs to be $\leq 5\%$ for program overall

Percent of Clients with Limited English Proficiency (LEP)



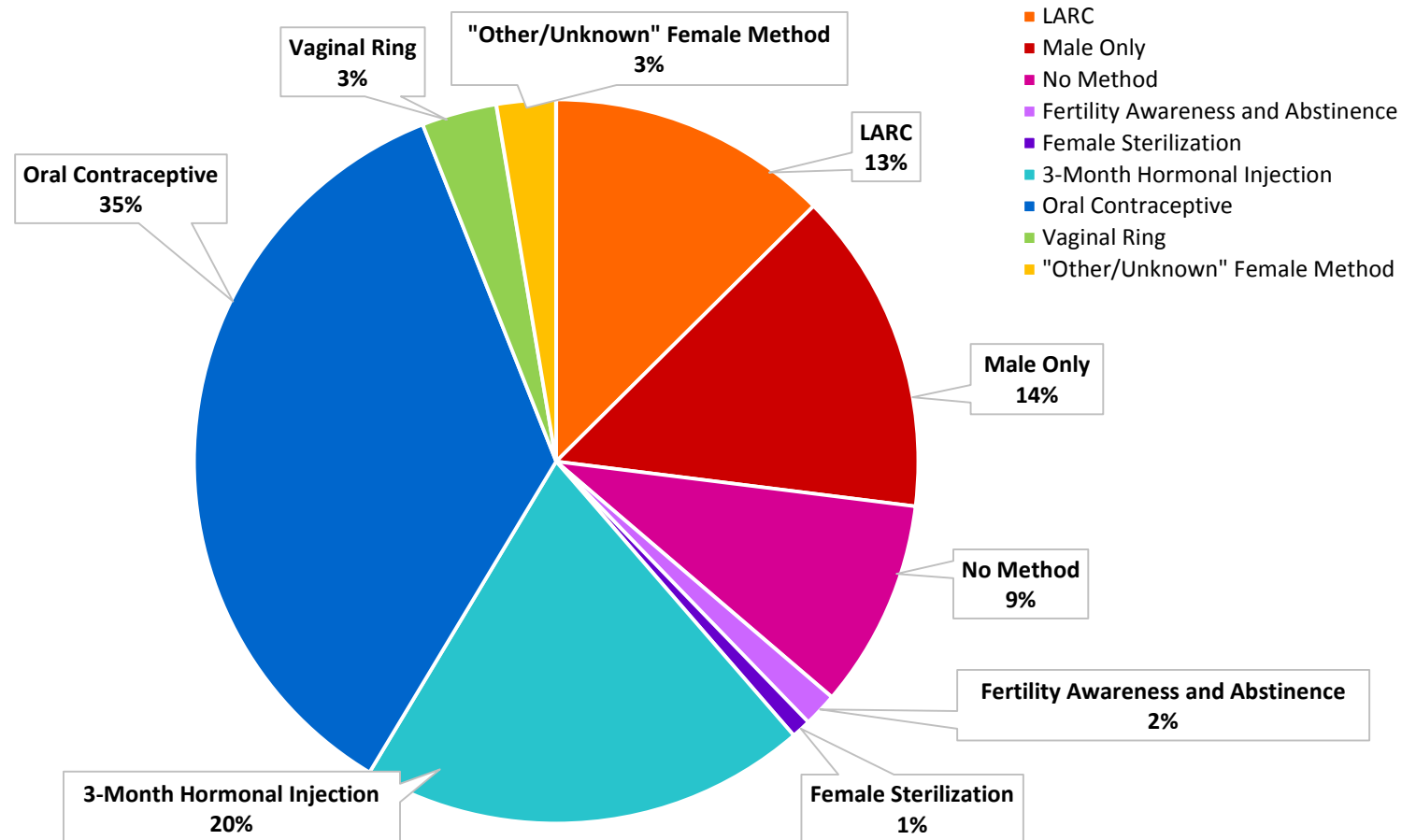
Primary Method of Contraception Relied on by Female Clients 15 – 44 years of age

- The number of female clients relying on a LARC increased by 98.3% (from 3,613 to 7,166) between 2010 and 2017.
- The percent of female clients relying on only a male method decreased steadily between 2010 and 2016, and then increased greatly between 2016 and 2017.
- The percent of female clients relying on no method increased steadily between 2010 and 2014, and then decreased between 2014 and 2017.
- The percent of female clients relying on fertility awareness and abstinence or an unknown method remained fairly steady between for all years studied.



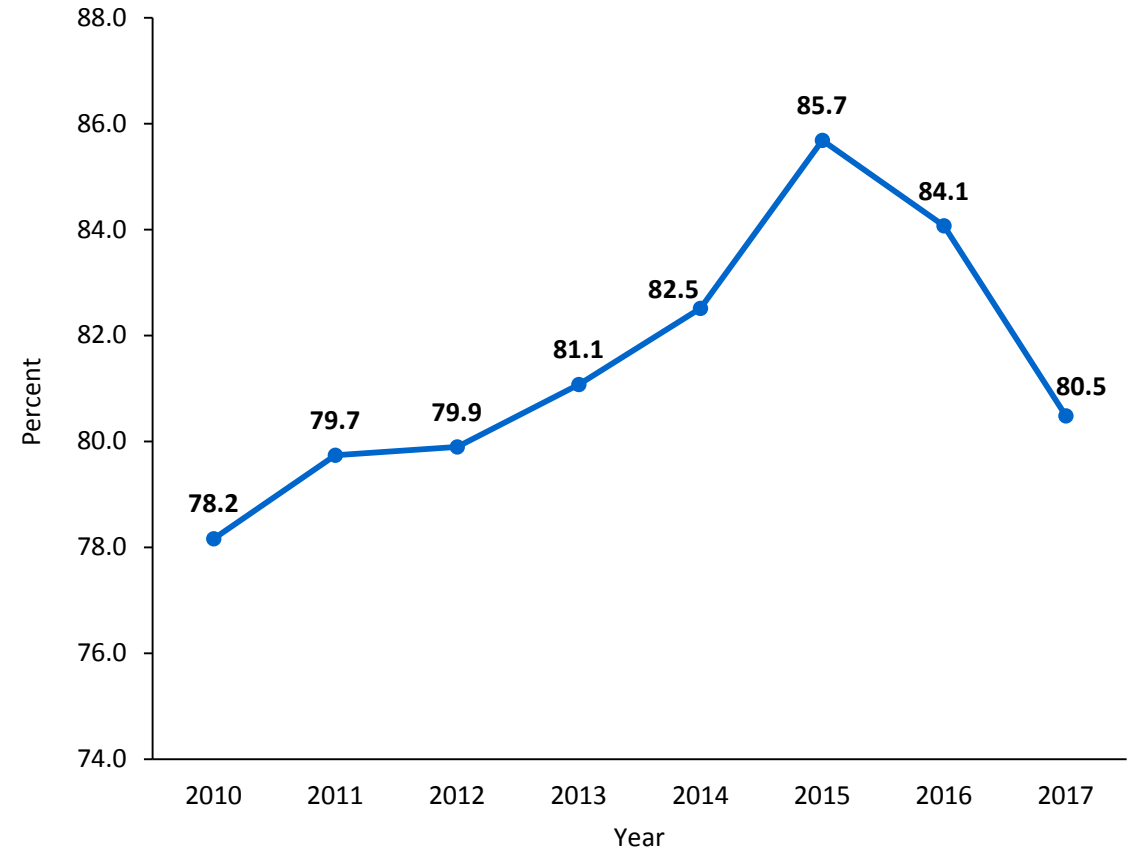
Primary Method of Contraception Relied on by Female Clients 15 – 44 years of age (2017)

- Between 2010 and 2017, the most commonly reported methods of contraception by female clients were oral contraception, 3-month hormonal injection, and male condoms.



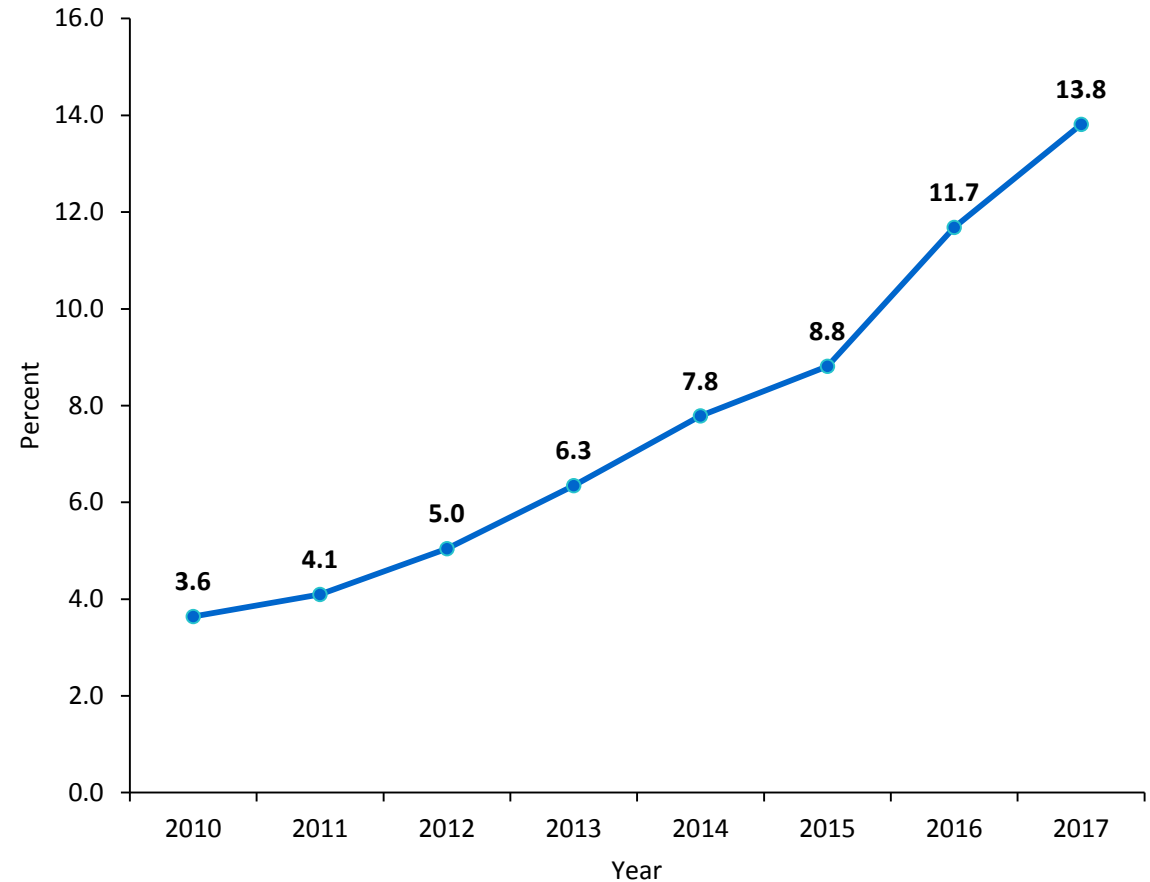
Percent of Female Clients Using a Most or Moderately Effective Form of Contraception

- For all years studied, between 78% and 86% of female clients reported using a most or moderately effective form of contraception.
- Most or Moderately Effective Forms of Contraception include:
 - Female Sterilization
 - Vasectomy
 - Intrauterine Device (IUD)
 - Hormonal Implant
 - 3-Month Hormonal Injection
 - Oral Contraceptive
 - Hormonal/Contraceptive Patch
 - Vaginal Ring
 - Cervical Cap/Diaphragm



Percent of Female Clients Relying on a LARC

- Between 2010 and 2017, the percent of female clients aged 15-44 that reported that they relied on a LARC increased each reporting year.



FPAR Reminders – Table 7

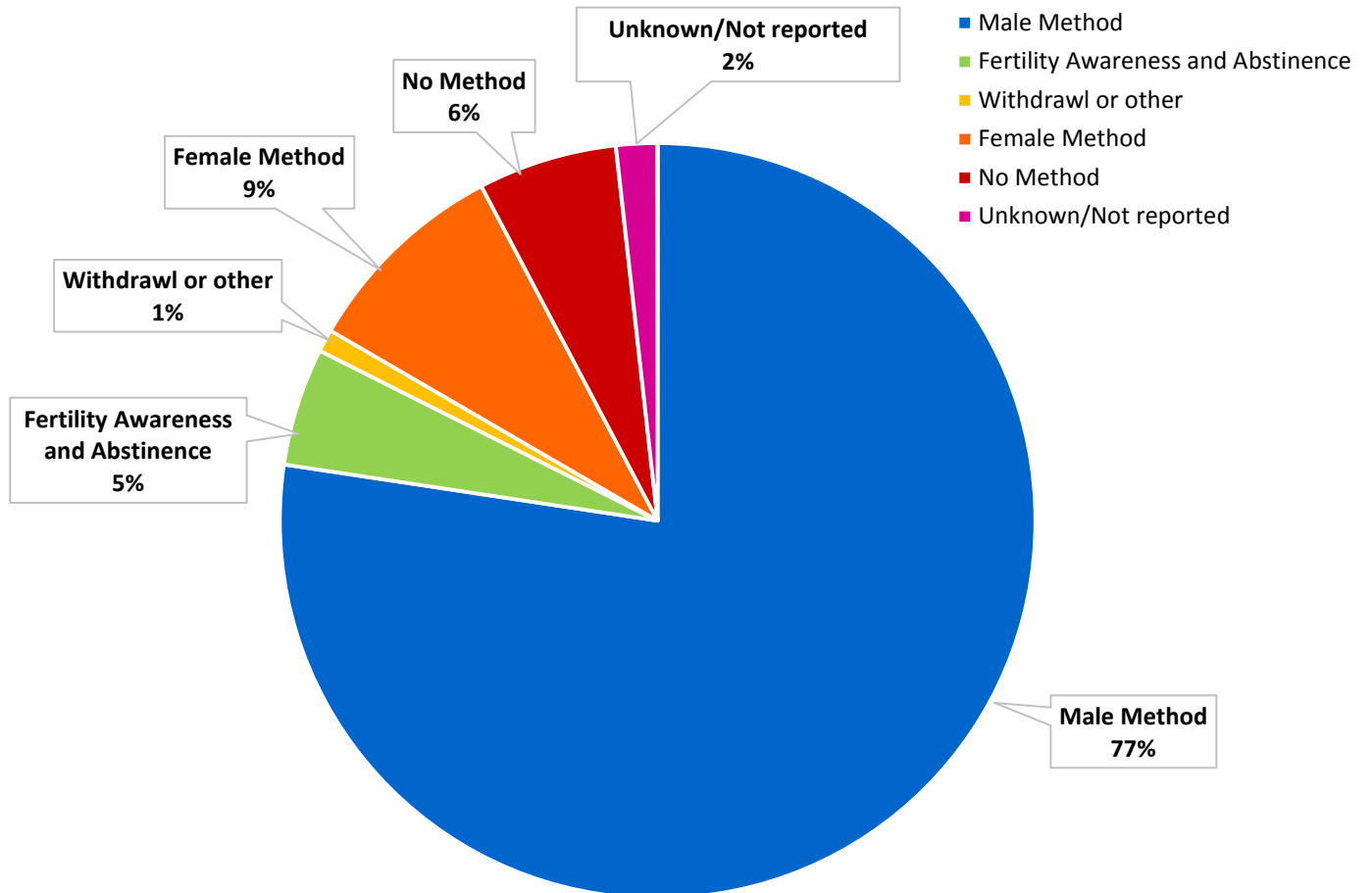
- Sterilizations recorded for females users <20 years, Consultant will confirm not performed by Title X service site
- Female users <18 years old who report relying on vasectomy. Consultant will confirm client received non-coercion counseling
- Female users who practice non-vaginal sex to prevent pregnancy need to be recorded as Withdrawal or Other Method
- Female users who exit the encounter with emergency contraception only need to be recorded as Withdrawal or Other Method
- Females users who report dual method use or exit with two methods, report the most effective method for FPAR

FPAR Reminders – Table 7

- No Method-Other Reason: Sterile clients who did not receive a surgical procedure, clients who were rendered sterile from a non-contraceptive surgical procedure, or clients with a same sex partner
- Method Unknown/Not Reported: Primary family planning method at exit from the last family planning encounter is unknown or not reported
- Need to keep each category, Withdrawal or Other Method, No Method-Other Reason, and Method Unknown/Not Reported, at $\leq 10\%$ for program overall

Primary Method of Contraception Relied on by Male Clients (2017)

- The majority of male clients reported using a male method for all reporting years.
- The percent of male clients relying on all other types of contraception remained low and steady for all reporting years.

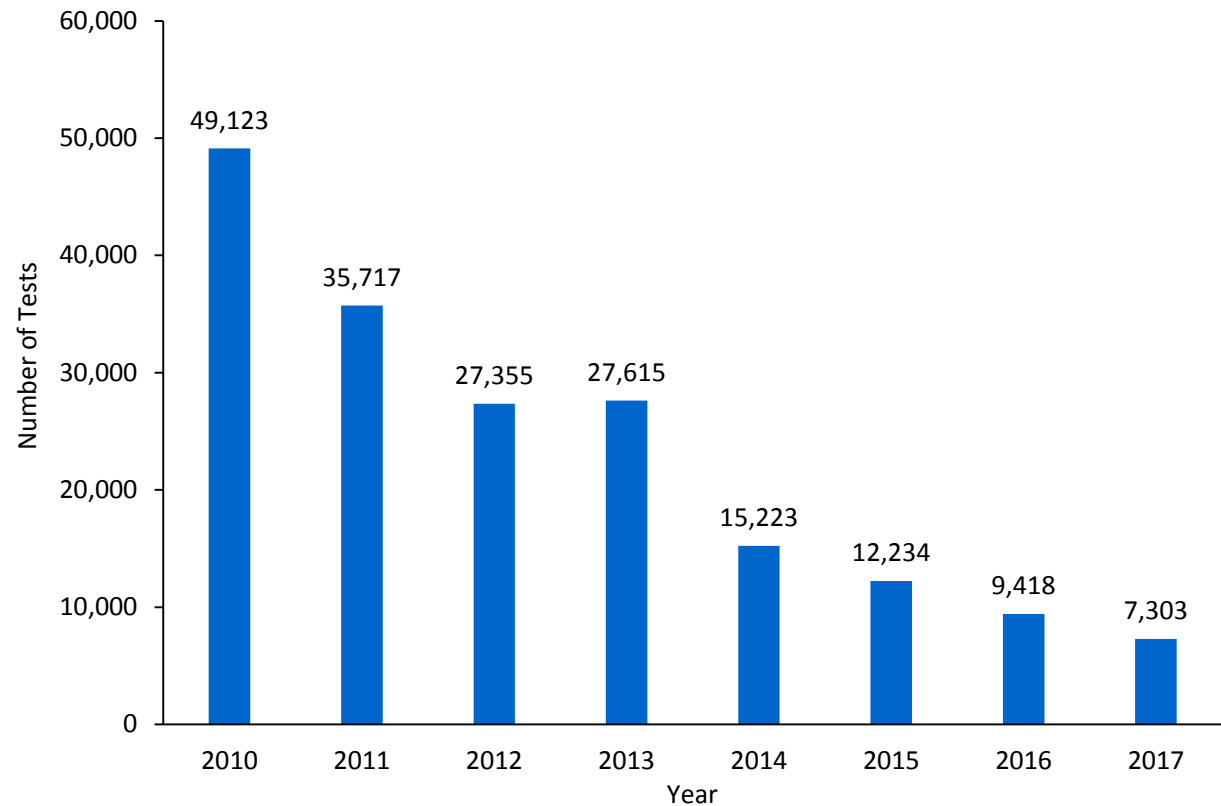


FPAR Reminders – Table 8

- Vasectomies recorded for males users <20 years, Consultant will confirm not performed by Title X service site
- No Method-Other Reason: Sterile clients who did not receive a surgical procedure, clients who were rendered sterile from a non-contraceptive surgical procedure, or clients with a same sex partner
- Method Unknown/Not Reported: Primary family planning method at exit from the last family planning encounter is unknown or not reported
- Need to keep each category, Withdrawal or Other Method, No Method-Other Reason, and Method Unknown/Not Reported, at $\leq 10\%$ for program overall

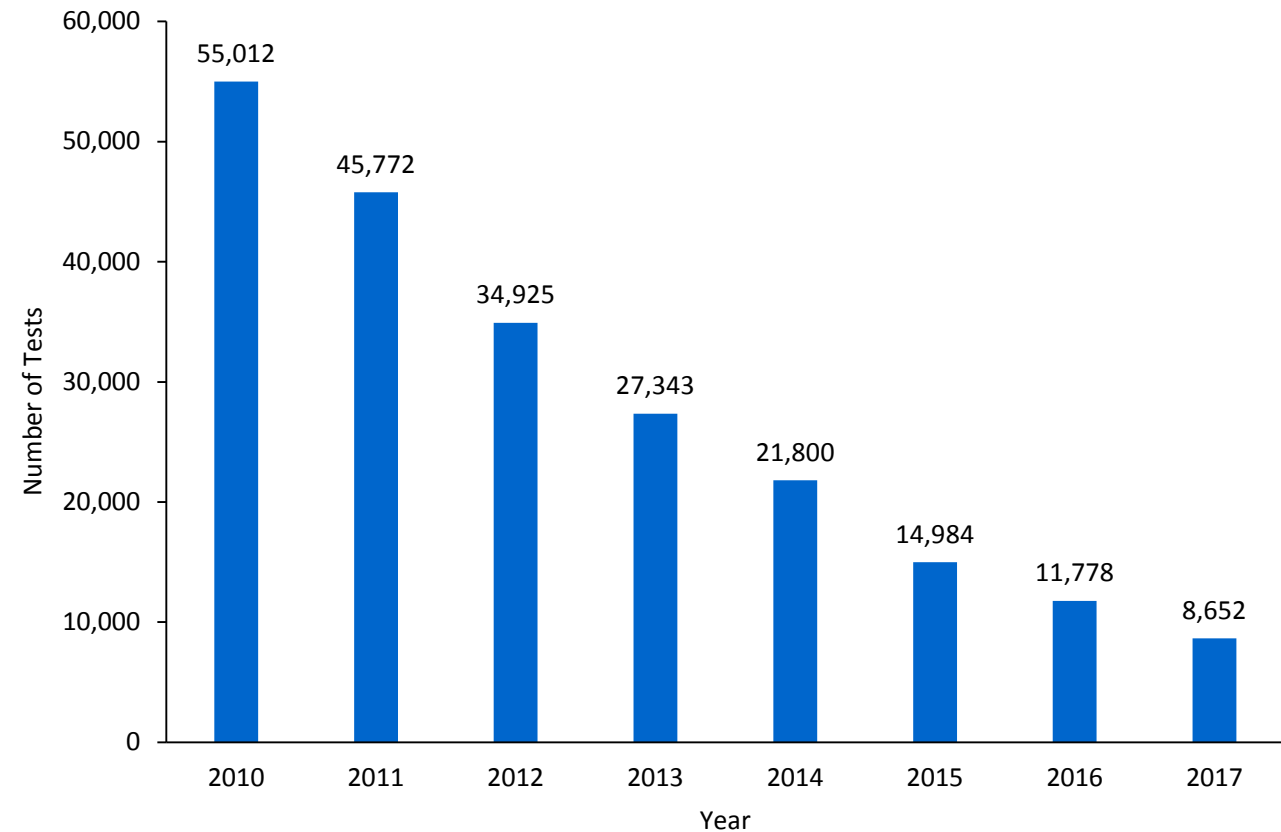
Number of Pap Tests Performed

- Between 2010 and 2017 the number of Pap tests performed decreased by 85.1% (from 49,123 to 7,303).
- 2010 screening criteria: 21 or 3 years after becoming sexually active and yearly thereafter
- 2017 screening criteria: 21 yrs every 3 yrs for neg results; 30 yrs w/neg pap and neg HPV every 5 yrs



Number of Clinical Breast Exams

- Between 2010 and 2017 the number of clinical breast exams performed decreased by 84.3% (from 55,102 to 8,652).
- 2010 screening criteria: Everyone
- 2017 screening criteria: 21 yrs and yearly or sooner based on risk/indication



FPAR Reminders – Tables 9 & 10

Cervical Cancer Screening

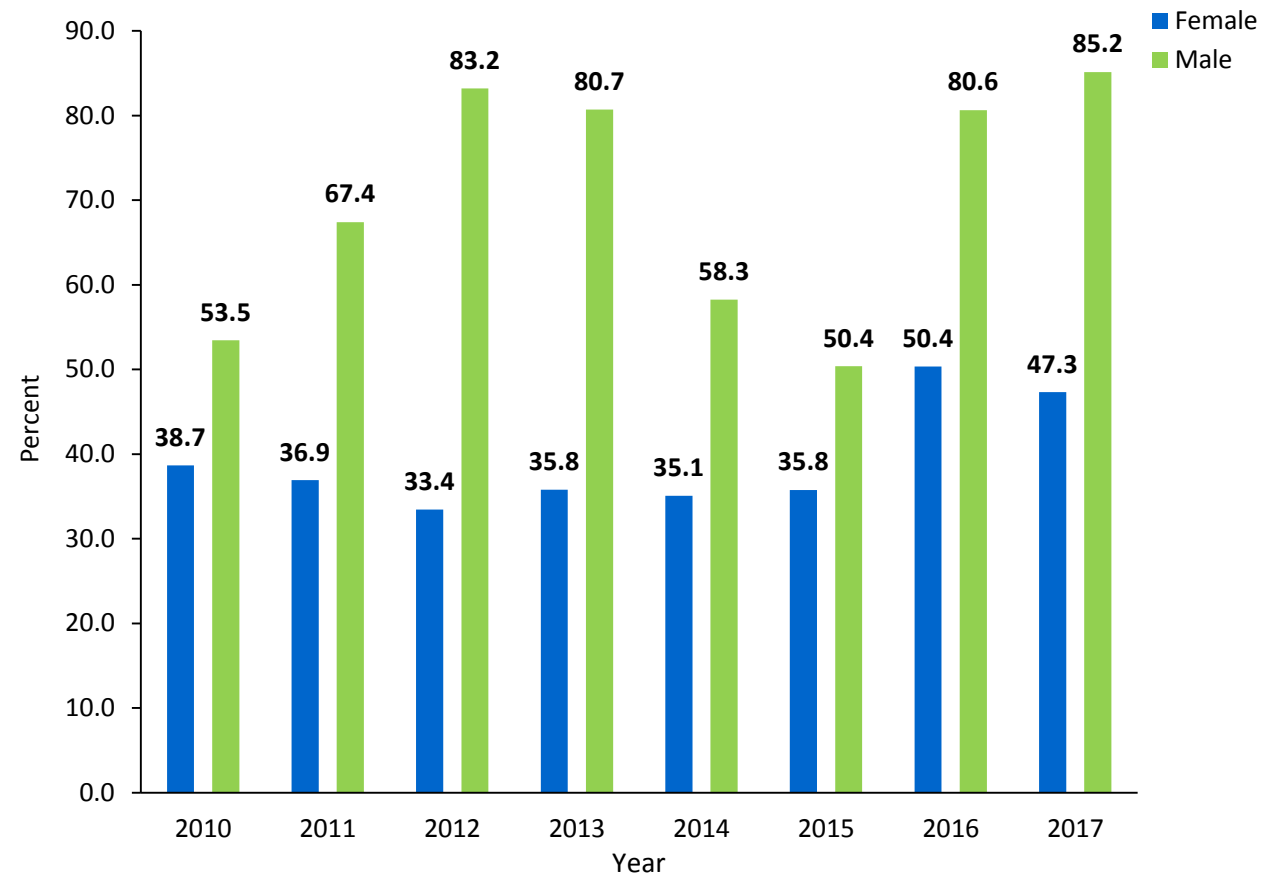
- # of HSIL or higher results are included in the # of tests with an ASC or higher results
- # of abnormal pap tests need to match # of ASC or higher
- # of follow-up on abnormal pap tests should match # of abnormal pap tests and ASC or higher

Clinical Breast Exams

- Referral row should exclude referrals for routine mammograms

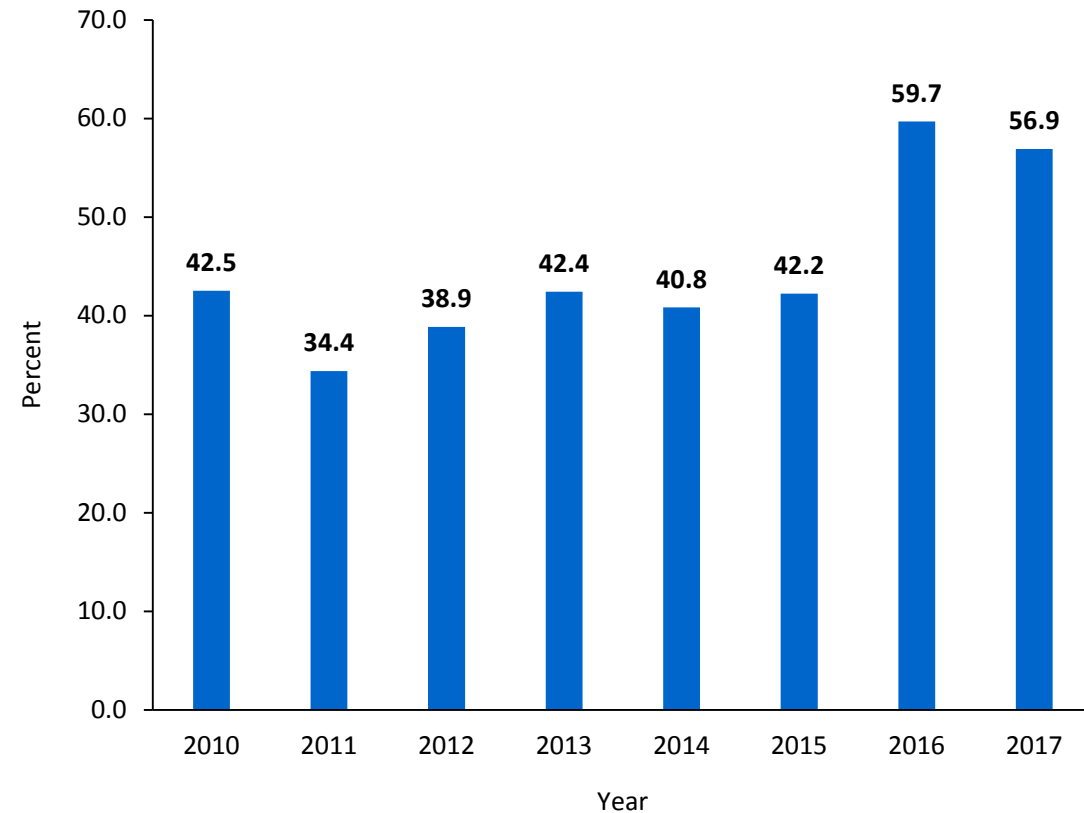
Percent of Clients that Received a Chlamydia Test By Sex

- The percent of female clients that received a Chlamydia test remained fairly steady between 2010 and 2015, and then increased slightly between 2015 and 2016.
- The percent of male clients that received a Chlamydia test increased between 2010 and 2012, decreased between 2012 and 2015, then increased between 2015 and 2017.



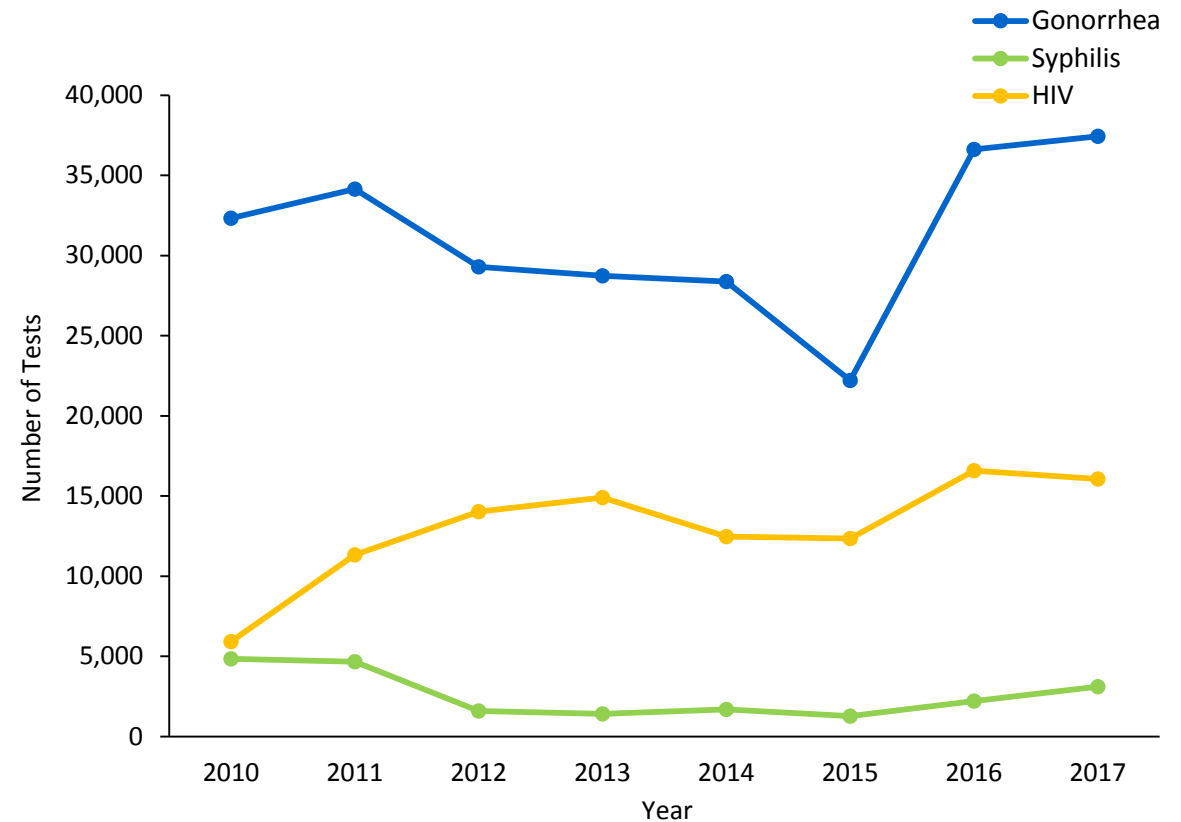
Percent of Female Clients <25 Years of Age that Received a Chlamydia Test

- The percent of female clients under 25 years of age that received a Chlamydia test remained fairly steady between 2010 and 2015, then increased between 2015 and 2016.
- 2010 screening criteria: ≤ 24 yrs strongly recommended based on risk/indication, preg test screening not routine practice
- 2017 screening criteria: ≤ 24 yrs at any core visit, including preg tests/EC visits



Number of Gonorrhea, Syphilis, and HIV Tests

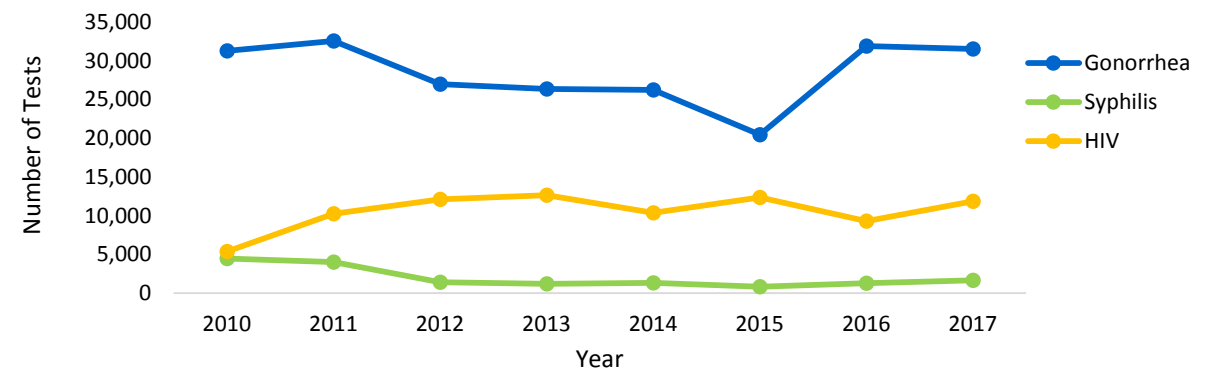
- The number of Gonorrhea tests decreased by 31.3% (from 32,337 to 22,210) between 2010 and 2015 and then increased by 68.6% (from 22,210 to 37,444) between 2015 and 2017.
- Between 2010 and 2017, the number of Syphilis tests decreased by 35.9% (from 4,857 to 3,115).
- Between 2010 and 2017, the number of HIV tests increased by 171.3% (from 5,919 to 16,057).



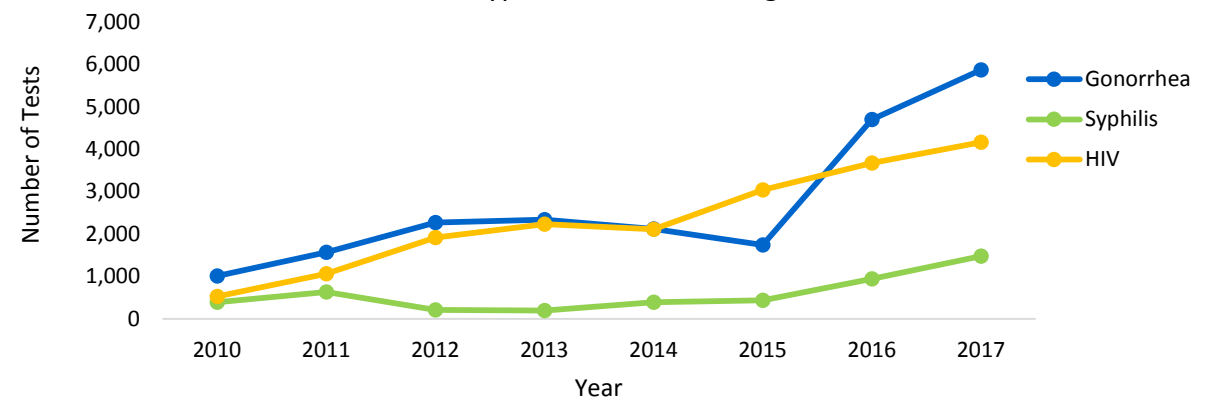
Number of Gonorrhea, Syphilis, and HIV Tests in Male vs. Female Clients

- The number of Gonorrhea, Syphilis, and HIV tests given to female clients remained fairly steady between 2010 and 2017.
- On the other hand, in male clients the number of Gonorrhea tests increased by 479.8% (from 1,013 to 5,873), the number of Syphilis tests increased by 277.0% (from 392 to 1,478), and the number of HIV tests increased by 694.1% (from 525 to 4,169).

Number of Gonorrhea, Syphilis, and HIV tests given to Female Clients

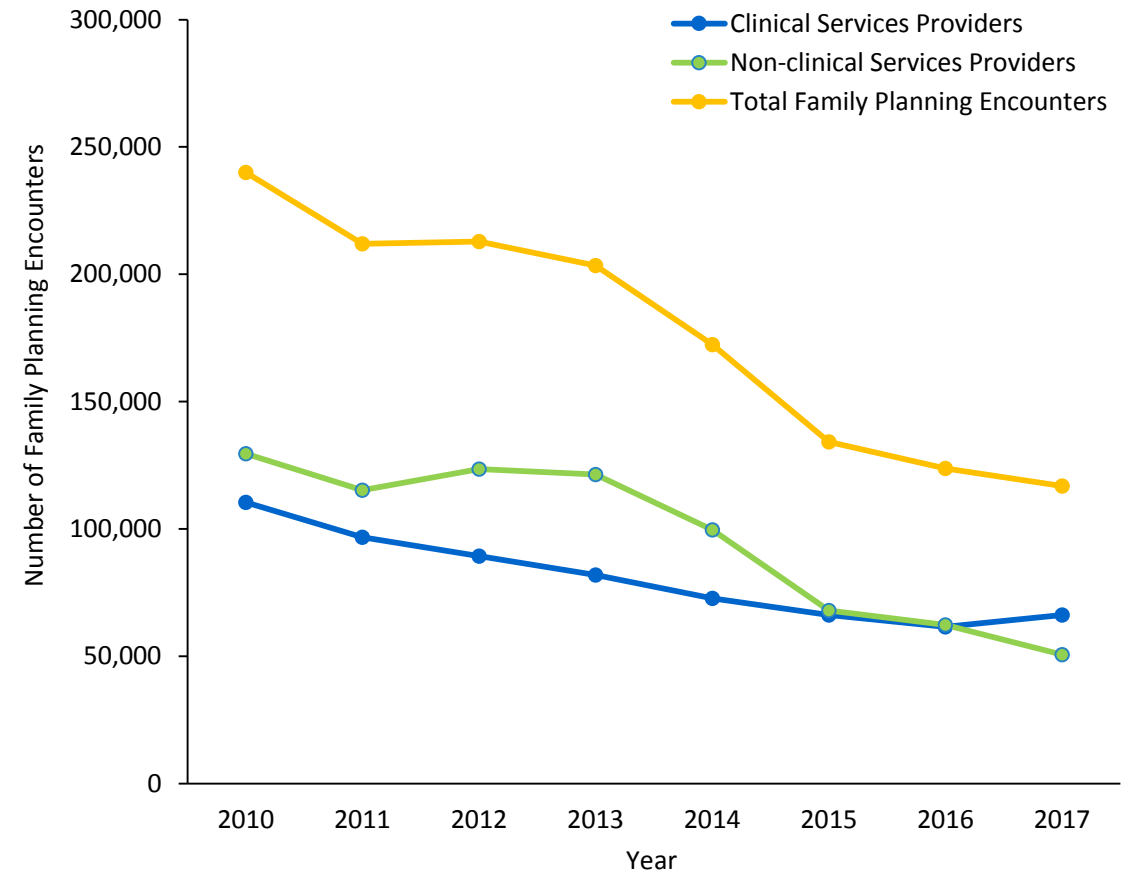


Number of Gonorrhea, Syphilis, and HIV tests given to Male Clients



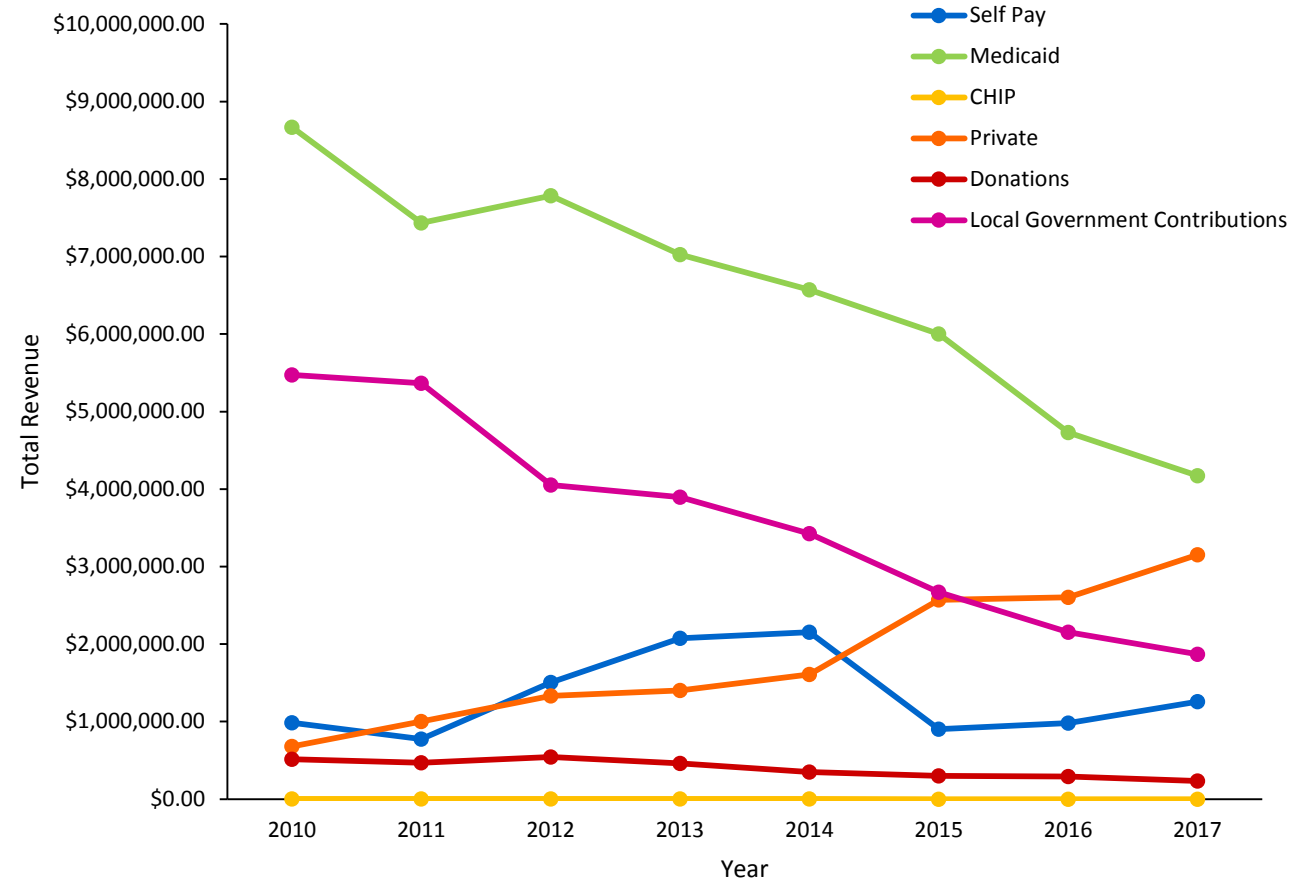
Number of Family Planning Encounters By Type of Provider

- Between 2010 and 2017, the number of Family Planning Encounters by clinical services providers decreased by 40.1% (from 110,450 to 66,205).
- Between 2010 and 2017, the number of Family Planning Encounters by non-clinical services providers decreased by 60.9% (from 129,603 to 50,629).
- Between 2010 and 2017, the total number of Family Planning Encounters decreased by 51.3% (from 240,053 to 116,834).



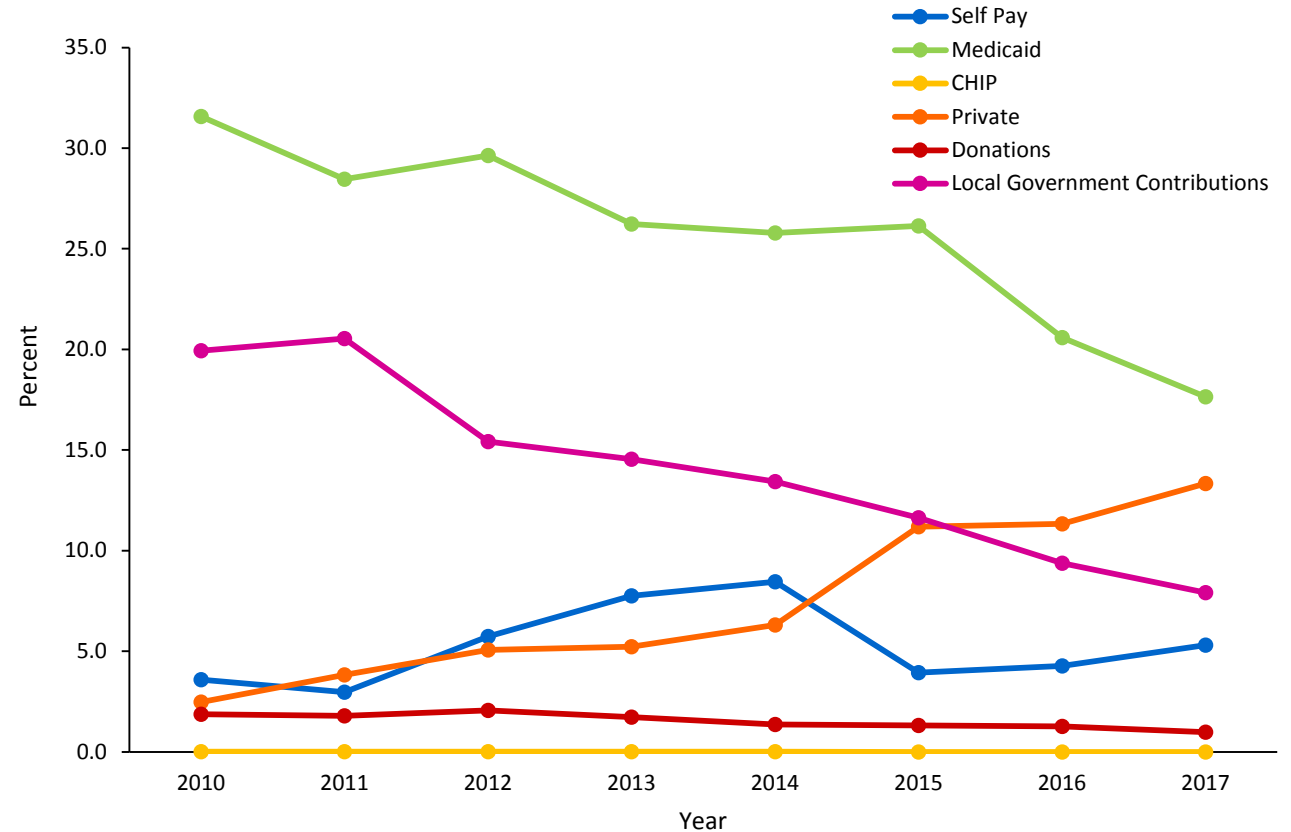
Revenue Report

- Between 2010 and 2017, revenue from Medicaid decreased dramatically from just under 9 million dollars to just under 5 million dollars.
- Similarly, between 2010 and 2017 revenue from local government contributions decreased greatly from around 5.5 million dollars to around 2 million dollars.
- The only increase was revenue from private health insurance which increased from just under 1 million dollars to around 4 million dollars.



Percent of Total Revenue by Source

- The percent of total revenue from self pay increased between 2010 and 2014, decreased between 2014 and 2015, and increased slightly between 2015 and 2017.
- The percent of total revenue from Medicaid and local government contributions decreased greatly between 2010 and 2017.
- The percent of total revenue from CHIP and donations remained fairly consistent each year.
- The percent of total revenue from private insurance increased each year between 2010 and 2017.

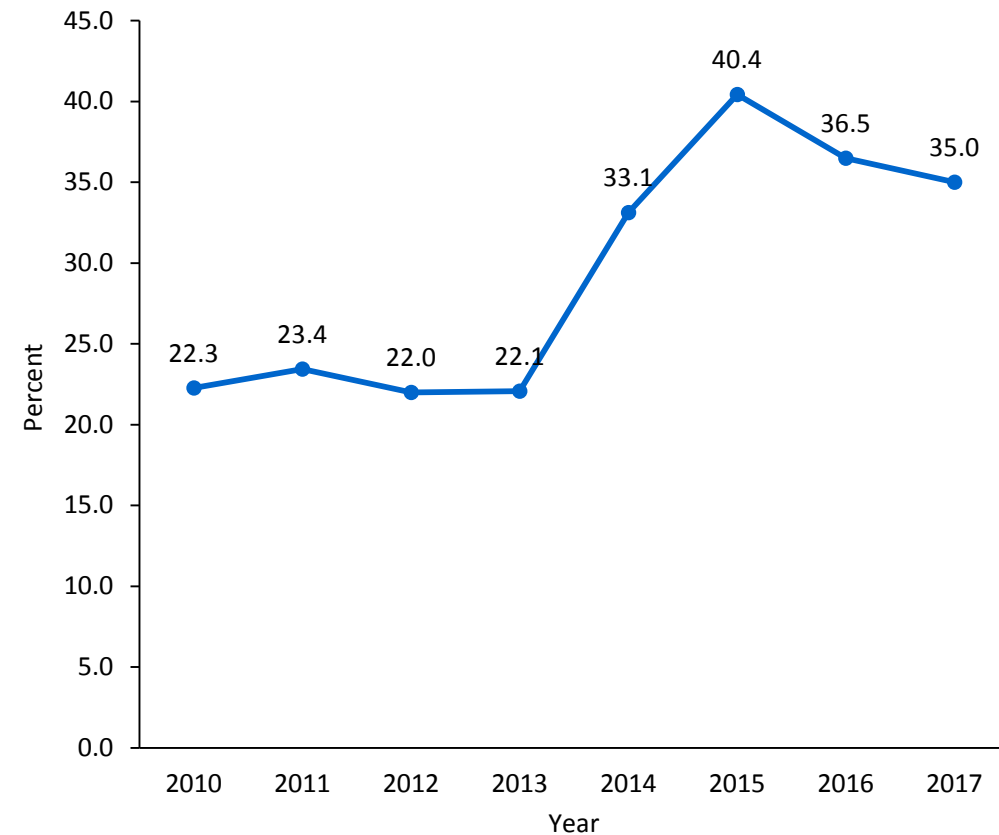


FPAR Reminders – Table 14

- Record Healthy Michigan Plan revenue on Line 3a as part of Medicaid Revenue
- Record local MCH funding on Line 9 as part of Local Government Revenue
- Record Medicaid Cost-Based Reimbursement on Line 16 as Other, Specify
- If your agency receives state funding as part of your Title X allocation, record state funding as part of Title X allocation on Line 1

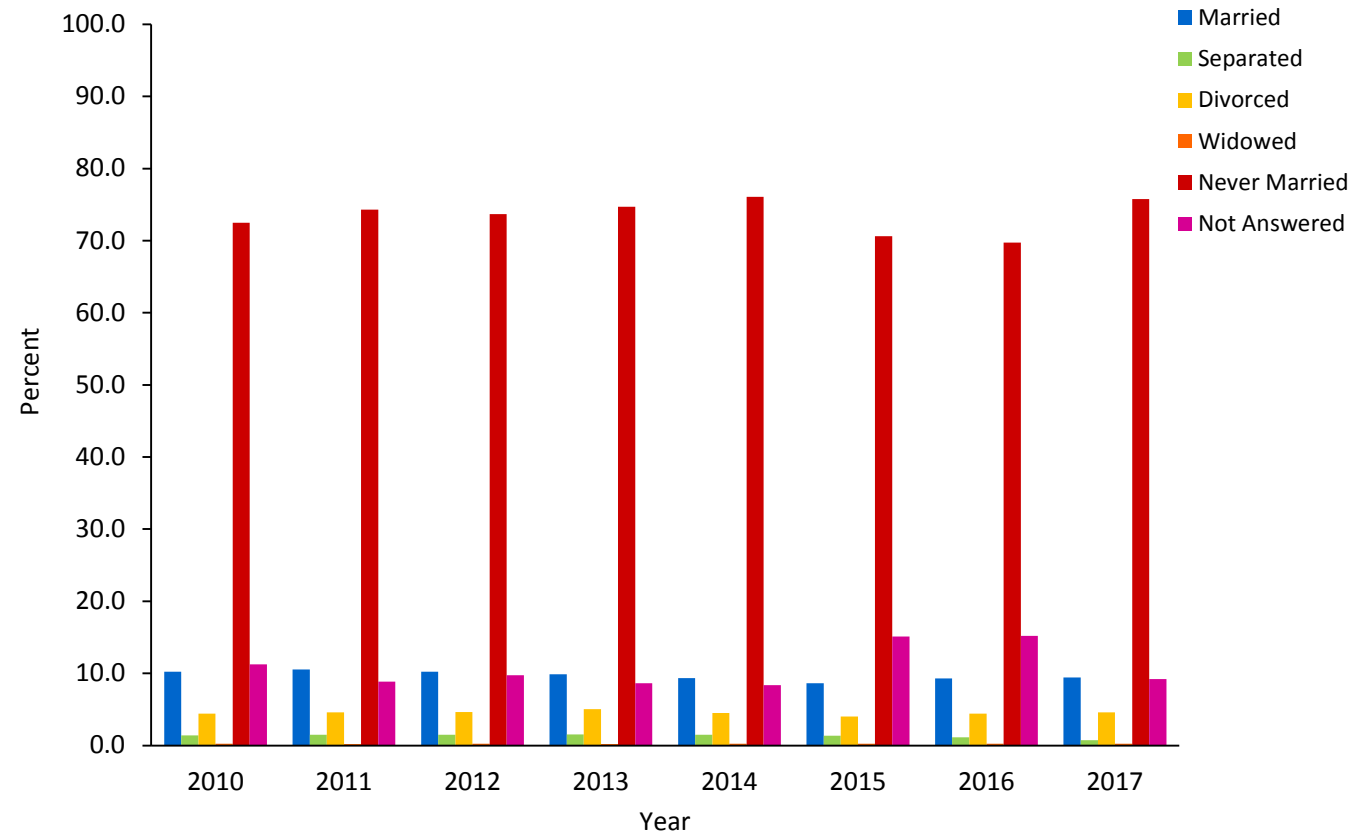
Clients Covered by Medicaid

- The percent of clients covered by Medicaid remained steady between 2010 and 2013, increased between 2013 and 2015, and then decreased slightly between 2015 and 2017.



Client Marital Status

- For each year studied, greater than 70% of clients reported that they were never married.



Contact Information

- Chelsea Abshire, MPH
- Birth Defects and Family Planning Epidemiologist
- Phone: 517-373-1574
- Email: abshirec@Michigan.gov

Family Planning Administrative Updates

JESSICA HAMEL, MA

FAMILY PLANNING CONSULTANT

2018 FPAR Reporting

- Calendar Year: January 1 – December 31
- Semi-Annual Submission
 - Mid-Year Due Date: July 15, 2018
 - Year-End Due Date: January 13, 2018
- New FPAR Table 15
 - # of IUDs inserted on-site
 - # of implants inserted on-site
 - # of IUDs inserted by referral
 - # of implants inserted by referral
 - Total LARC insertion
 - # of LARC removals, includes both IUD and implants

Communication – Memos of Interest

Fall 2017

- FY 2018 Title X Priority Project Funding
- Michigan Contraceptive Access Learning Collaborative

Winter 2018

- Title X Standards & Guidelines Manual, 2018
- Revised Breast & Cervical Cancer Screening Protocol
- 2018 LARC Funding
- 2018 Teen & Consumer Client Satisfaction Survey
- 2018 DHHS Poverty Guidelines
- 340B Recertification for Title X
- MDHHS Title X Competitive Grant Application – Letter of Commitment
- Additional FY 2018 Title X Funds & Caseload

Administrative Policy Review

General Consent Form Assurances

- Family Planning services will be provided to clients...
 - On a voluntary basis
 - Without coercion to accept services or any particular method of family planning
 - Without making acceptance of services a prerequisite to eligibility for any other service or assistance in other programs
- Other Administrative Requirement: Confidentially, except as required by law or as necessary to provide services
- Clinical Requirement: Pregnancy testing services

Administrative Policy Review

Information & Education Committee

- Meets at least annually, broadly represents community, between 5 to 9 members
- Demonstrate recruitment efforts, member composition, member representation
- Family Planning staff can provide administrative and clinical support, cannot be voting members
- I & E Committee by-laws or policy statement required
- MDHHS Clinic Brochure Review Form required, members and/or clients complete

Administrative Policy Review

Information & Education Committee

- Record of comments must be kept – forms or comment summary
- Meeting minutes must be kept, must reflect the determinations for each item reviewed
- Committee approval for materials requires at least one half of voting members
- Master listing of reviewed and approved materials must be maintained
- Previously approved materials must be reviewed at least every three years
- Agency developed handouts must contain this statement: This public was supported by Award No. 4 FPHPA056287-01-04 from the Office of the Assistant Secretary of Health (OASH). Its contents are solely the responsibility of its authors and do not necessarily represent the official views of OASH.

Administrative Policy Review

Cost Analysis/Setting Fees

- Cost analysis informs fee schedule/fee setting
- Fee schedule should recover actual cost of providing services
- Fees set below actual cost of recovering services requires Board Approval and policy or meeting minutes must outline percent below cost for each service or note the range
- Fees should be assessed annually, once every three years required
- MDHHS Cost Analysis Tool – available for local agency use
- Consultants/Auditors will ask for additional information and documentation on cost analysis methodology if MDHHS Cost Analysis Tool not used

Administrative Policy Review

340B Safeguards

- Local agencies must ensure Title X purchased 340B products are only provided to Title X clients
 - All staff understand eligibility for Title X services
 - Maintain accurate agency information in OPA Title X and HRSA 340B databases
 - No duplication of discounts with agency claims
 - Billing Medicaid at 340B acquisition price for medications
 - Able to separate 340B records from other inventory
 - Regularly evaluates 340B utilization

* Reminders: Annual 340B recertification is required, new clinics must appear in Title X OPA Database prior to 340B enrollment, 340B enrollment is on a quarterly basis

Accreditation Administrative Indicator Review

Family Planning agencies continue to do well!

Year	Missed MPR 8.1/9.1	Missed MPR 14.1	Missed MPR 17.1	No Missed Admin MPRs
2016	2	1	0	6
2017	2	1	1	4
2018	2	1	1	2

Family Planning Accreditation - 2018 Tool Changes

Administrative Cycle 7 MPR Changes:

- **MPR 2.1** *Voluntary services, without coercion*
- **MPR 10.2** *Information & Education (I&E) Committee*

Family Planning Accreditation - 2018 Tool Changes

MPR 2.1 adds the following requirement:

- The agency's general consent for services must include a statement that services are provided on a voluntary basis, without coercion to accept services and without prerequisite to accept any other services
 - This change follows recommendations from our OPA federal review

Family Planning Accreditation - 2018 Tool Changes

MPR 10.2 adds the following requirements:

- Written description of I&E committee review & approval process (policy, by-laws, or committee document)
- Membership must broadly represent the community served (roster identifies members' community representation)
- Documentation of approval of materials must include:
 - Master list of approved materials and dates
 - Record of individual member evaluation of materials
 - Use of MDHHS approved evaluation form
 - Additions follow recommendations from our OPA federal review

MDHHS Family Planning – Special Projects

Michigan Contraceptive Access Learning Collaborative

- Six local agencies are working to improve LARC use among women aged 15 to 44
- Assessed individual and organizational contraceptive access barriers and selected strategies associated with one to two best practices
- Agencies are focused on small changes that have high impact
- Performance is monitored using National Quality Forum endorsed contraceptive measures
- Project timeline is May 2018 to October 2018
- MDHHS provided \$5,000 to support travel and staff time

MDHHS Family Planning – Special Projects

Male Outreach Initiative

What: Partnership with FPNTC, MDHHS and 6 MDHHS Delegate Agencies

Why: Increase Title X visibility and access to X services for males

How: PDSA – Plan Do Study Act Methodology

Strategies:

- Condom Distribution
 - Targeted, Male Focused, User-Friendly,
- In-Reach
 - Educating existing female clients on available services for males (partners, uncles, brothers, fathers, friends)
- Campaign
 - Man-Up, Men's Health Week, Open Houses

Training & Education

Family Planning Update

- September 12-14 at Royal Park Hotel in Rochester
- Clinical Practicum – Male Exam (9/12)
- Clinical Practicum – Kyleena (9/13)
- Title X 2.0 – MDHHS Staff (9/12)
- Presentations
 - Dr. Brent Davidson
 - Dr. David Bell
 - NFPRHA – 340B
 - Sister Song
 - From our Providers: RAAPS and MiCALC

Title X Training Needs Exercise

MDHHS Needs Your Input

Goals:

1. What are the individual, clinic and network training and education needs of MDHHS's Title X delegates?
2. How are training resources best delivered in our network?
3. Have you had a training or educational experience that should be replicated for our Title X service delivery network?

LUNCH TIME!!



[This Photo](#) by Unknown Author is licensed under [CC BY-SA](#)

Trauma, Toxic Stress & Reproductive Health

Mary Mueller, LMSW

Agenda

- **Overview of NEAR – “Resilience”**
- **Connections to Reproductive Health Services**

Fri: A0876-X
Sa: 3
Im: 13 / 596
Em: 57

0x008557A4

00142.3

13.13.12.21

RESILIENCE

THE BIOLOGY OF STRESS & THE SCIENCE OF HOPE

fig1

The background of the slide features a series of thin, curved lines in a light gray color, creating a sense of motion and depth. These lines are more prominent on the left side and fade towards the right.

How Does the Science Connect to Reproductive Health Services?

- How might the people you serve be impacted by toxic stress?
- What are the implications for provision of reproductive health services?
- What else do you want to know or do?

Thank you for
your time!

Mary Mueller, LMSW

MI Department of Health & Human Services

muellerm1@michigan.gov

www.michigan.gov/traumatoxicstress

Michigan Family Planning Coordinator's Meeting June 19/22, 2018

Clinical Update

LINDA GREGG, JANET ISABELL & SUE MONTEI
FAMILY PLANNING NURSE CONSULTANTS
REPRODUCTIVE HEALTH UNIT



Content To Be Covered

Findings and reminders from Cycle 6-7 Accreditation Reviews

Clinical communications and memos

Clinical changes to Standards and Guidelines

Fertility Awareness Refresher

Quality Assurance Measures



Review of Missed Indicators (2016 – May 2018)

Family Planning Agencies continue to do well!

- ▶ Most agencies have 2 or less missed indicators
- ▶ 2017 – Reviews focused on TA in preparation for changes to the 2018 tool
- ▶ Missed indicators vary widely—no one indicator stands out

Year	Missed MPR 8.1/9.1	Missed MPR 11.1	Missed MPR 11.2	Missed MPR 14.1	Missed MPR 17.1	No Missed MPRs
2016	2	1	1	1	0	6
2017	2	1	2	1	1	4
2018 so far (4 reviews)	2	1	2	1	1	2

Indicator 11.1

- ❖ **MPR 11.1** states that agencies will have clinical protocols in accordance with national standards and signed annually by Medical Director

Changes to the FP Accreditation Tool for Cycle 7 (2018 Tool)

- ❖ MDHHS made changes to the following clinical MPRS for Cycle 7:
 - ❖ MPR 2.1 Voluntary Services, Without Coercion
 - ❖ MPR 5.1 Pregnancy Testing and Options Counseling
 - ❖ MPR 11.2 History and Physical Examination Elements
 - ❖ MPR 11.5 Federal and State Laws Related to Dispensing of Pharmaceuticals

Indicator 5.1 - Pregnancy Testing and Options Counseling

- ❖ MPR5.1 - New requirement adds the following criteria:
 - ❖ Zika risk assessment to pregnancy test visits
 - ❖ Chlamydia testing is offered to females under 25 and as indicated by risk factors to women 25 and older
 - ❖ These changes follow current national standards of care and practice
 - ❖ Other Assessments
 - ❖ Family Involvement
 - ❖ Coercion
 - ❖ Abuse

Indicator 11.2 – History and Physical Examination Elements

❖ MPR 11.2 Requirements:

- ❖ Zika Assessment & referral for screening as appropriate must be incorporated into family planning core services
- ❖ Chlamydia testing must be offered annually to females <25 and as indicated by risk factors to females 25 and older
- ❖ Clarification of required elements of the core services – Achieving Pregnancy
 - ❖ These changes follow current national standards of care and practice.

Indicator 11.5 – Federal and State Laws related to Dispensing of Pharmaceuticals

- ❖ MPR11.5 – Clarifies the labeling requirements for medications dispensed in FP clinics
 - ❖ Prescription labels include the medical director and prescribing practitioner
 - ❖ Complies with Michigan Pharmacy Law, amended 2014 Act 525

LARC Access and Utilization

A huge **CONGRATULATIONS** to our agencies on moving towards having LARCs available on site and many are moving towards same day inserts!!!!

Male Caseload

- ❖ Males can be seen in each of the core services, except pregnancy testing and counseling

Clinical Communications and Memos

❖ Protocols to Website

❖ Breast and Cervical Screening Protocol

Breast & Cervical Update

❖ BREAST AND CERVICAL CANCER SCREENING PROTOCOL

Effective Date: March 1, 2018

- ❖ This contained clarification of breast exam to coincide with our State Breast and Cervical Program-BCCCNP

Fertility Awareness Based Method

- ❖ Where we are?
- ❖ Where we are going?
- ❖ Why we are going?

Where we are – Current protocol

❖ Standard Days (CycleBeads) Method



Definition

- ❖ Set of practices used to determine fertile and infertile phases of a woman's cycle
 - To avoid pregnancy
 - To achieve pregnancy
 - To monitor gynecologic health

2019 FABM Protocol Will be More Inclusive

1. Calendar Method – Cycle Beads and Standard Days
2. Cervical Mucus Method – Two Day Method
3. Temperature Method
4. Sympto-thermal - is a combination of 2 & 3
5. Lactational Amenorrhea Methods

Why?

- No new guidance from OPA – just more reference to “Natural Family Planning”.
- We will take the time to improve on what we have.
- PRAMS- survey revealed a group of women that would be good candidates for FABM.

Resources:

- Webinar on FABM – archived- www.fpntc.org
- ACOG-www.acog.org
- HHS/OPA -National Training Center-www.fpntc.org
- Bedsider- www.bedsider.org
- Planned Parenthood- www.plannedparenthood.org
- Apps

Quality Improvement

MEDICAL AUDITS/
CHART AUDITS

Title X Requirements

- ❖ Agencies must have a system in place that provides for the ongoing evaluation of quality improvement.
- ❖ The system should include the measurement of at least one quality measure as suggested in the QFP (Table 4 on page 24).
- ❖ Audits are done to rate quality.
- ❖ A Quality Improvement Committee should be in place to meet monthly to discuss quality assurance issues and make recommendations for corrective action when deficiencies have been noted.

TABLE 4. Suggested measures of the quality of family planning services

Type of measure and dimension of quality	Measure	Source
Health outcome	Unintended pregnancy Teen pregnancy Birth spacing Proportion of female users at risk for unintended pregnancy who adopt or continue use of an FDA-approved contraceptive method (measured for any method; highly effective methods; or long-acting reversible methods) [Intermediate outcome]	PIMS*
Safe (Structure)	Proportion of providers that follow the most current CDC recommendations on contraceptive safety	
Effective (Structure, or the characteristics of the settings in which providers deliver health care, including material resources, human resources, and organizational structure)	Site dispenses or provides on-site a full range of FDA-approved contraceptive methods to meet the diverse reproductive needs and goals of clients; short-term hormonal, long-acting reversible contraception (LARC), emergency contraception (EC). Proportion of female users aged ≥ 24 years who are screened annually for chlamydia infection. Proportion of female users aged ≥ 24 years who are screened annually for gonorrhea. Proportion of users who were tested for HIV during the past 12 months. Proportion of female users aged ≥ 21 years who have received a Pap smear within the past 3 years.	PIMS*
Client-centered (Process, or whether services are provided correctly and completely, and how clients perceive the care they receive)	Proportion of clients who report the provider communicates well, shows respect, spends enough time with the client, and is informed about the client's medical history. Proportion of clients who report that Staff are helpful and treat clients with courtesy and respect. His or her privacy is respected. She or he receives contraceptive method that is acceptable to her or him.	CAHPS+ RQIP§
Efficient (Structure)	Site uses electronic health information technology or electronic health records to improve client reproductive health.	PIMS*
Timely (Structure and process)	Average number of days to the next appointment. Site offers routine contraceptive resupply on a walk-in basis. Site offers on-site HIV testing (using rapid technology). Site offers on-site HPV and hepatitis B vaccination.	PIMS*
Accessible (Structure and process)	Site offers family planning services during expanded hours of operation. Proportion of total family planning encounters that are encounters with ongoing or continuing users. Proportion of clients who report that his or her care provider follows up to give test results, has up-to-date information about care from specialists, and discusses other prescriptions. Site has written agreements (e.g., MOUs) with the key partner agencies for health care (especially prenatal care, primary care, HIV/AIDS) and social service (domestic violence, food stamps) referrals.	PIMS* CAHPS— PCMH item set on care coordination+
Value	Average cost per client.	CDC¶

Abbreviations: CAHPS = Agency for Healthcare Research and Quality's Consumer Assessment of Health Care Providers and Systems; FDA = Food and Drug Administration; PIMS = Performance Information and Monitoring System.

Medical Audits

- ❖ A medical audit is conducted by the Medical Director to determine if agency protocols, current standards and acceptable medical practices are being met.
- ❖ Medical audits are needed to identify deficiencies and make necessary corrections to improve patient care.
- ❖ Medical audits must be conducted quarterly.
- ❖ A minimum of 2-3 charts per clinician must be reviewed.

Components of a Medical Audit

❖ Medical audits can assess:

- ❖ Proper client selection for the contraceptive choice (Medical Eligibility Criteria per CDC).
- ❖ History is complete and indicates no contraindications for contraceptive method prescribed.
- ❖ Physical exam done as indicated.
- ❖ Assessment/diagnosis supported by documentation.
- ❖ Appropriate lab tests performed.
- ❖ Lab results interpreted correctly.
- ❖ Prescriptions written per protocol.
- ❖ Appropriate follow-up done.

Chart Audits

- ❖ Clinical audits are the review of the activities of all aspects of the clinical care of patients by medical and paramedical staff.
- ❖ Chart audits are completed to determine the completeness and accuracy of the medical record.
- ❖ Chart audits must be done quarterly and must represent a minimum of 3% of the agency's quarterly caseload.
- ❖ All clinical sites should be represented in the chart sampling.

Chart Audits

- ❖ A chart audit is an examination of medical records to determine what is done and to see if it can be done better.
- ❖ You can conduct a chart audit on any aspect of patient care to measure some component of performance. The ultimate goal of chart audits is quality improvement.
- ❖ The general steps in conducting a chart audit are:
 1. Select a topic
 2. Identify measures
 3. Identify patient population
 4. Determine sample size
 5. Create audit tool
 6. Collect data
 7. Summarize results
 8. Analyze and share results

Selecting an Audit Topic/Creating a Tool

- ❖ Any topic can be selected for a chart audit.
- ❖ You may want to consider your high volume services or any new service you may be offering to ensure new protocols are understood and being followed.
- ❖ Your audit tool is created to reflect current protocols.
- ❖ Some chart audits will be mandated by external bodies. A common example is insurance company review for HEDIS measures.

Sample Audit Tool: IUC Insertion Audit

❖ Date of Review

❖ Auditor

❖ Number of charts reviewed

❖ Criteria

❖ Clients who had an IUC inserted between specified dates

Audit Indicators:

1. Client has signed the general medical consent
2. Client signed specific procedure consent on day of insert
3. LMP is documented
4. Client has negative pregnancy test if she has had any unprotected intercourse since LNMP or has had any irregular menses recently or any symptoms of pregnancy

Sample Audit Tool: IUC Insertion Audit

- 5. Client has no CDC category 4 conditions
- 6. If client has any CDC category 3 conditions, individualized management is approved by medical director.
- 7. Client education regarding IUC use is documented.
- 8. Client has normal pelvic exam at time of insertion.
- 9. Uterine position and sounding of uterine size is documented.
- 10. Length of stings documented.
- 11. IUD type, lot number and expiration date are documented.
- 12. Client instructed on when to seek urgent care for IUC-related problems.
- 13. Clients instructed on IUC removal date.

Sample Audit Tool – Combined Oral Contraceptive

1. General Medical Consent signed by client.
2. Chief complaint/reason for visit documented.
3. Client's source of primary care documented.
4. Medical history obtained is appropriate to the type of service provided.
5. Reproductive Life Plan documented.
6. Zika Risk Assessment documented.
7. Physical exam provided as indicated.
8. Blood pressure, height weight and BMI documented.
9. Chlamydia screen offered to all females <25 years old.
10. Client education on contraceptive methods documented.
11. Initial client instructed on when to start COC's.
12. For clients <18 years, counseling on parental involvement and resisting coercive sexual activities documented.
13. Client advised when to call/RTC or seek urgent care documented.

Summary

Chart audits are meant to measure performance and improve quality.

Audit results need to be shared with all involved staff to ensure any identified deficiencies are communicated and steps for improvement are explained.

Any significant deficiencies should be reaudited after staff have been informed.

Audit results can reinforce that you are providing quality care for your clients!

Questions?????????

Contact Info:

Linda Gregg RN, BSN, WHNP

Contractual Clinical Consultant

lgregg5@hotmail.com

Janet Isabell RN, BSN, WHNP-BC

Contractual Clinical Consultant

Janet_isabell@hotmail.com

Sue Montei, RN, BSN, NP

Contractual Clinical Consultant

montei626@gmail.com

