# QUESTIONS FROM LABOR OF LOVE SUMMIT NOVEMBER 6, 2015

These are answers to questions posed at the Labor of Love Infant Mortality Summit on Nov. 6, 2015 that we were not able to answer due to time constraints. If the questioner posed the question to a specific person on our panel, we have tried to get an answer from that person (still awaiting an answer or two there); if the question was more general, we have provided answers written by subject matter experts at the State Department of Health.

1. ***Where does someone with HIP (over 18) get immunizations (Tdap, Hep B, Hep A, Flu)? Our health department can't take HIP as insurance since we or Vaxcare can't bill it. We also can't bill adult Medicaid patients.***

   The Indiana State Department of Health encourages all local health departments to work toward building the capacity to be able to bill all types of insurance for services that they provide. Recent literature suggests that referring a client to another location for immunization services creates a missed opportunity for vaccination and results in the individual going unvaccinated more than 60 percent of the time.

   Starting October 1, 2015, the Office of Medicaid Policy and Planning affirmed that adults that have Medicaid coverage and individuals participating in HIP 2.0 can seek immunization services at pharmacies located throughout Indiana. These create a network of immunization providers in all 92 counties to vaccinate adults with Medicaid or HIP 2.0.

   Please see the attached Medicaid banner for details.
   http://provider.indianamedicaid.com/ihcp/Banners/BR201539.pdf

2. ***My 27-year-old daughter signed up for HIP. They don't cover what she needs: Root canal, orthodontia and crowns. All other dental services she gets for free as she is in dental school.***

   As announced in provider bulletin BT201503, dental benefits under the Healthy Indiana Plan (HIP) are administered by DentaQuest, LLC, on behalf of the three managed care entities (MCEs).

   Dental benefits under HIP:

   HIP Plus benefits include:
   - Evaluations and cleanings (two cleanings per year)
   - Bitewing X-rays
   - Comprehensive X-rays
   - Minor restorative procedures, e.g. fillings (4 fillings per person per benefit year)
   - Major restorative procedures, e.g. crowns (1 per person per benefit year)

Members enrolled in HIP State Plan-Plus or HIP State Plan-Basic are eligible to receive medically necessary dental benefits as outlined in the Medicaid Medical Policy Manual, beginning on page 131 (**http://provider.indianamedicaid.com/general-provider-services/manuals.aspx**).

HIP State Plan-Basic members are subject to a $4 outpatient co-pay per date of service (DOS).

Members enrolled in HIP Basic are not eligible for dental benefits.

Note: All pregnant members enrolled in HIP benefit plans will be eligible for state plan dental benefits. Dental services covered for all 19- or 20-year-olds, regardless of HIP plan, are detailed in the Health Watch/Early and Periodic Screening, Diagnosis and Treatment section in the Provider Manual (http://provider.indianamedicaid.com/general-provider-ervices/manuals.aspx).

*DentaQuest can be reached directly at 1-888-201-3762 with specific questions, as it administers the HIP dental benefit programs for the MCEs.*

3. ***Has there been any data to show that pregnant women on HIP 2.0 have had better health outcomes? (Increased prenatal visits, assistance with smoking cessation, etc.)***

The HIP 2.0 program went live in February 2015. FSSA is tracking measures on both pre- and post-natal care and the utilization of smoking cessation services. We anticipate having outcome data to review in the summer of 2016.

At present, it's too early in the program to provide any real assessment of health outcomes. The HIP 2.0 program is designed to allow a pregnant woman the option to stay in HIP 2.0 and receive additional maternity services while having all cost-sharing suspended or to move into the Hoosier Healthwise program. FSSA expects quality care and positive outcomes across all our programs and we monitor accordingly.

4. ***In my work with pregnant women, I have been told by clients that their doctor has discouraged sudden tobacco cessation because it's too stressful to baby. Is there any validity to this? Why would a doctor discourage tobacco cessation?***

Smoking during pregnancy negatively affects the pregnant mother as well as the baby's health before, during and after the baby is born. Quitting smoking is one of the best ways an expecting mother can protect herself and the health of her baby. While this process will be challenging, it is the most important step women can take for their health and the health of their babies. There are lots of proven methods to help them.

The Centers for Disease Control and Prevention (2015) provides some important recommendations for healthcare providers to address smoking during pregnancy:

- Pregnancy-specific counseling (e.g., counseling based on the 5A's model) increases smoking cessation in pregnant women. Steps of the 5A's include the following:
  - Ask the patient about smoking status at first prenatal visit and follow up at subsequent visits.
  - Advise the patient to quit.
  - Assess the patient's willingness to quit.
  - Assist the patient by providing resources.
  - Arrange follow-up visits to track the progress of the patient's attempt to quit.

- If women are unable to quit with counseling alone, ACOG (American College of Obstetricians and Gynecologists) recommends that nicotine replacement therapies be considered under the close supervision of a provider.

- Quitlines (1-800-QUITNOW or QuitNowIndiana.com) can be used to support pregnant smokers in their goal to quit. Quitline counseling is available in every state, is easy to use and is generally provided at no cost to the user. The Indiana Tobacco Quitline offers a robust program to help women quit.

***5. When does the risk of SIDS decrease? When are "safe sleep" practices no longer as necessary? (Sleeping on your back, for example). When are we "okay"?***

Most safe sleep deaths occur in babies between 1 month and 4 months of age and the majority (90 percent) of these deaths occur before a baby reaches 6 months of age. However, safe sleep deaths can occur anytime. Safe Sleep practices, such as placing the infant on its back, alone and in a crib at naps and nighttime, should be followed until the infant reaches his or her first birthday.

**Other recommendations include:**

1. **Every sleep time counts--**that's why it is important for everyone who cares for your baby to place him or her on the back to sleep for all sleep times, including naps.
2. **The baby's crib should be** in the parents' room, if possible (room-sharing without bed-sharing). It should have a firm mattress that is closely fitted to the sides of the crib, and a tight-fitting sheet. Car seats and other sitting devices are not recommended for routine sleep, and wedges and positioners should not be used.
3. **Take care of yourself and your baby** – eat well and see your doctor regularly; get all required immunizations for your baby.
4. **Do not overheat your baby** – if you're comfortable, your baby is comfortable.
5. **No smoking around the baby** – this goes for you and anyone else around your baby; smoke increases the risk of an unsafe sleep environment and other health problems.
6. **Breastfeed your baby if you can** – babies who are breastfed or fed with breast milk for the first six months of life are at lower risk of SIDS, and breastfeeding has many health benefits for mothers and babies.

7. **Consider offering a pacifier** at nap time and bedtime once breastfeeding has been established.
8. **Supervised, awake tummy time** - recommended daily to facilitate development and minimize the occurrence of positional plagiocephaly (flat heads).

***6. This might be too broad of a question to answer, but being just one person, working in a job where you only reach one person at a time (WIC clinic) and not the masses, how do you help change the inequality and disparities that would bring greater awareness and impact to an entire community? I feel like our efforts, while there, reach only a few, while there are so many more that could be reached.***

There are so many ways to answer this question, but at the end of the day it takes both big programmatic efforts (like WIC) and then every individual encounter with every individual human being (those coming to WIC and working with WIC) to make the world a better place.

Without both pieces of the puzzle, the whole thing falls apart. So - keep soldiering on! To keep your passion fueled, be a part of something bigger as well, whether volunteering for an organization or taking a leadership role.

***7. Where can we get drilled-down data on infant mortality for each county? Not just our ranking.***

Statistics for natality by year can be found in the link below. Table 32 is very useful for county-level natality data. The most recent finalized birth data is 2013. https://secure.in.gov/isdh/19095.htm

Statistics for mortality by year can be found in the link below. Table 8 is very useful for county-level infant mortality data. The most recent finalized death data is 2013. https://secure.in.gov/isdh/19096.htm

The MCH Outcomes Report will be posted by the end of the year. This report will include data for 2004-2013.

***8. Can you give a "Real World" example of how Institutional change manifests?***

At Advantage Dental in Oregon and Ellis Medicine in New York, the analysis of the environments of economic class resulted in institutional and program design/redesign in treatment models and preventive care.

Here are some examples of the insights of these providers and how they redesigned the institutional process. First, you see the insights the providers developed by using the Bridges lens; below that are some sample best practices.

Poverty drives us in these directions-

Avoiding the office visit until the issue is emergent or renders one in able to live with it.

**BEST PRACTICE REDESIGN**: Every dental clinic keeps a chair open for walk-in emergencies-typically these are patients in poverty. The open chair has been recently renamed "the Urgent Chair." Clinical health providers might leave open slots to allow for and expect such walk-ins. It is less expensive for the system to do this than to have the ED used for primary care visits such as ear infections.

Being more focused on the present and survival results in an environmental push toward the "hidden rule" - "It ain't a problem until it's a problem." Since many people in poverty lose their teeth at an earlier age and are at increased risk of poor health, it may become accepted that you will lose your teeth – and your health -- at an earlier age.

**BEST PRACTICE REDESIGN**: After screening Early Head Start and other preschool children, Advantage Dental contacts parents through home visits (or porch visits) if there is significant decay and eventually wins most parents over in the motivational interview process. At just the right time the parent is asked, "Would you be interested in knowing how your child can keep her teeth for her lifetime?" This experience is so rare in poverty that almost every parent is willing or even happy to know. Providers can design better prevention and treatment interventions if the message resonates with the population (Robert Sapolsky).

Lack of access to external resources such as transportation impacts the ability of patients in under-resourced environments to be on time or show up for appointments.

**BEST PRACTICE REDESIGN**: Provide several mornings of open scheduling and walk-ins. This was done in the dental clinic at the Ellis Medicine Medical Health Home. Patients that were typically late and/or no shows continued to come in on open scheduling days. Most of these patients are on Medicaid or other lower-income plans.

Healthcare messages about health and choices resonate well with stable-resourced patients such as the middle class, who are more likely to have seen that good choices translate to a better future. Under-resourced environments have increased risk factors and minimal protective factors, so choices may not be perceived to hold as much power in influencing a better future. Communication is also a barrier.

**BEST PRACTICE REDESIGN**: Advantage Dental realized that the health message must resonate with the environmental hidden rules of the patient and that it matters WHEN the message is delivered. The provider delivers oral health prevention in the form of motivational interviewing WHEN THE PATIENT COMES TO THE DENTIST IN PAIN. Formerly, oral prevention messages were offered at community sessions that were poorly attended by individuals in poverty. Each office keeps an open chair for patients who walk in needing critical dental care.

While in the waiting area or exam room, the provider offers motivational interviewing in the CONCRETE MOMENT within the painful experience - either

before or after the treatment. The provider first gets to know the patient, and asks the patient to tell them what happened that resulted in the office visit. If trust seems to be present, the interviewer asks the patient if they would like to hear some ideas about what they can do to avoid being in the office in such critical pain in the future. Literally, no patient has said no to that question and are eager to hear the HOW of avoiding such discomfort. The new prevention strategy is very effective for people who have to focus on the "now" or surviving in the moment.

**BEST PRACTICE REDESIGN**: Within the process described above, the interviewer allows at least 10 minutes for the telling of the patient's story of how they got to the critical point with their dental issue. Typically, when we are in marginalized environments, the usual " 2-minute chit chat" of the middle class "world" that takes place prior to "getting down to business" is unsuccessful in letting us know we are truly being " seen" and heard by the provider who represents the "system."

Providers might allow more time with patients who use 10 minutes rather than 2 minutes, have a casual concrete vocabulary (also called language register) and use a circular story structure that drifts with little chronological structure. If the dentist or physician cannot offer this much time due to driving forces of managing patient volume, then a nurse or navigator should be allotted the time needed for the patient. The doctor or dentist can be debriefed and better prepared for the context of the patient and their visit. If the provider looks at their watch during the discourse, it is likely that relationship with the patient is broken. If patient engagement is unsuccessful, what are the chances that health outcomes/lower costs will be achieved?

For more information, please see the article "Outreach, Prevention and the Urgent Chair" at http://www.ahaprocess.com/wp-content/uploads/2015/11/Outreach-Prevention...Shirtcliff-Dreussi-Smith-Northwest-Dentistry.pdf

You can also contact me directly at TDSmithBridges@gmail.com.

9. ***We heard from everyone today about making sure we have everyone at the table. Today, we've heard from four doctors, an author/consultant, and a media celebrity. How can we make sure those we are trying to serve have an equal voice – even at meetings like this?***

   Great idea! We will definitely incorporate this feedback into our planning for next year.

10. ***As we've seen with vaccine refusers, technology is a double-edged sword. Websites with bad research and misinformation are quite popular and propagate bad science. Even if we put technology into the hands of the 16 million people without access now, how do we ensure that it works to improve public health – not weaken it?***

    Great question. I think reputation is key and the human connection between people and technology to guide folks to good information is paramount.

In order to make health information technology beneficial to consumers, we must ensure the information provided is relevant and timely for the targeted population. There must be a strategic collaboration between the creator(s) and the target population to ensure the intent and delivery mechanism are appropriately aligned in a way that offers the most benefit to the end user.

11. ***Many patients who apply to HIP 2.0 have low literacy levels. Even with the help of an insurance navigator, our clients are unable to navigate the cumbersome paperwork that comes in the mail. The verbiage is too complicated for people with low literacy who are not used to being consumers. What plan does HIP have to eliminate this problem to prevent people who have applied from being dropped because they do not understand or they simply don't open their mail?***

We fully understand and appreciate the complexities of health insurance in general, let alone of the Healthy Indiana Plan. As with all our programs, we make every attempt to communicate completely and clearly, keeping literacy levels in mind. We require our managed care plans to publish written materials with a 5th grade reading level, which we evaluate for compliance prior to release. An effort is underway to reexamine the content of our website, HIP.IN.gov, to make the messaging as clear as possible.

Further, our agency communications team reviews and edits each of the notices that are legally required to be sent by mail to HIP clients, such as the redetermination mailers that are currently being sent to clients. Even with these efforts, however, we anticipate that there could be confusion among clients. That is why the core of the communications strategy for HIP 2.0 has been—and will continue to be—stakeholder outreach and education. Since the spring of 2014, the FSSA Office of Communications and Media has been working to build and maintain the engagement of a wide swath of stakeholders, most of whom work directly with clients in the field. This includes provider associations, community organizations, navigators, etc.

We most recently reached out to this group to inform them of the upcoming redetermination process and what would be expected of clients. As with all of our agency communications, we believe success is most likely to occur when our clients are informed directly of their responsibilities but the stakeholders who work directly with these clients are also educated and informed. There isn't much we can do if people don't open their mail; public assistance does require engagement from the member. We do, however, provide a variety of ways to make being engaged and current easier through the attached list of resources, our enrollment broker Maximus, and the managed care plans' customer call centers.

12. ***How can we pick the "pearls" of existing but duplicate programs (and put egos aside) to impact disparities with the best of related programs?***

The Indiana State Department of Health prides itself on continually and actively establishing collaborative relationships and partnerships across Indiana with a diverse group of entities. We are open to innovative ideas and always willing to meet with external partners from the community to discuss how to best address

the needs of all Hoosiers. We are also more than willing to facilitate interactions and relationship building within communities.

The hard truth is, sometimes, someone has to be the bad guy. Let outcomes speak and allow programs that work go to scale. This involves hard decisions, sometimes hurt feelings, and gentle collaboration with a long-term vision. Not easy, but absolutely necessary to get to the next level.

13. ***Any explanation for widening gaps in disparities? Perhaps some social programs intended to help actually promoted dysfunction and dependence rather than empowering all and "being with"/assisting those in most need with education/trade skills/finances as needed/indicated. One "easy" suggestion: Urine Pregnancy Tests – free and multiple access sites 24/7 whenever possible. Education if not pregnant—prevention or pre-conceptual information (folic acid—PNV). Education, Medicaid application referral or 1st appointment with an OB provider (MD, CNM, NP)***

    There are a number of factors that contribute to the widening gap in disparities, making it very difficult to pinpoint a true cause. In Indiana, we see the greatest factors to be among race and geography (rural vs. urban). A number of programs funded through the ISDH Maternal and Child Health Division (MCH) address the above program suggestions (i.e. Free Pregnancy Test program, Early Start, Nurse Family Partnership, and Preventing Unplanned Pregnancies).

    Please reach out to the MCH Division for more information on specific programs: http://www.in.gov/isdh/19571.htm

14. ***What's it look like when a health clinic or organization uses Bridges to Health (for Terrie Dreussi-Smith)?***

    The Bridges to Health and Healthcare provider champions use the Mental Model of Poverty as a starting point and interface the experience of poverty with how the institution is designed. Healthcare reform models tend to be driven by health outcomes and maintaining or lowering cost for the provider.

    This is relative to the "achievement" that is a driving force in middle-class environments. In under-resourced environments, we are more driven by RELATIONSHIPS because our other resources have been eroded by poverty. Therefore, in this world, patient engagement is critically linked to health outcomes and lower costs.

15. ***What policy measures are being taken to address the disparity in health outcomes? So, even with the expansion and Medicaid, we still see 2.5 to 3X infant mortality among minority groups. What is in store to close this huge gap?***

    There are a lot of tools in our infant mortality "toolkit"—everything from smoking-cessation efforts that include a highly successful program like Baby & Me-Tobacco Free to a Levels of Care program that will make sure high-risk babies are cared for at hospitals that can meet their needs, from a Labor of Love

campaign that addresses practice gaps and focuses on high-risk mothers in areas of the state where we especially see health outcome disparities to a PRAMS program that asks new mothers about their behaviors before, during and after pregnancy so we can better understand how to design and promote programs that make a difference. If you know of an evidence-based intervention that we're not pursuing or a part of the state where we need extra effort, please let us know.

***16. Adams County has a large Amish population (different Amish than LaGrange County, etc.). Minimal technology. Any suggestions to reach them?***

The best way to reach the Amish community is to establish a relationship with a trusted liaison to the community or cultural broker in order to gain access into the community. Each community also has a governing board or council within the church that governs the particular Amish population under their authority